SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU
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PEOPLE OF THE STATE OF NEW YORK by
LETITIA JAMES, Attorney General of the
State of New York,

Petitioner,

AFFIDAVIT OF DETECTIVE JOHN M. TARPEY

-against-

FULTON COMMONS CARE CENTER, INC.; MOSHE KALTER; AARON FOGEL; FRADY KALTER; ESTHER FOGEL; MINDY STEGER; SHEINDY SAFFER; CHANA KANAREK; DOVID KALTER; YITZCHOK KALTER; ARYEH KALTER; SHEVA TREFF; CHAYA LIEBERMAN A/K/A SARA LIEBERMAN; THE NEW FULTON COMMONS COMPANY LLC; FULTON COMMONS REALTY CO., L.P.; FULTON COMMONS REALTY CO., INC.; THE NEW BRIDGE VIEW COMPANY LLC; STEVEN WEISS; and CATHIE DOYLE,

Respondents.
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State of New York)
) ss.:
County of Nassau)

Detective John M. Tarpey, being duly sworn, deposes and says:

1. I am a Detective currently employed by the New York State Office of the Attorney General, Medicaid Fraud Control Unit ("MFCU") assigned to the Hauppauge Regional Office.

2. I have been a Detective with MFCU for approximately 10 years. In my current position, I am charged with conducting civil and criminal investigations into Medicaid provider fraud and resident neglect, abuse, and mistreatment in nursing homes and board and care facilities,

as well as protecting the integrity of the publicly-funded Medicaid Program. While serving at MFCU, I have been involved in numerous investigations involving resident abuse at nursing homes, thefts of narcotics, and financial crimes committed against the Medicaid Program.

3. Prior to being appointed as a Detective with MFCU, I was employed as a Supervisory Special Agent with the United States ("U.S.") Department of Homeland Security ("DHS"), Homeland Security Investigations ("HSI") where I served for over 25 years. As an HSI Special Agent, I was assigned to units that were charged with the investigation of transnational criminal organizations utilizing U.S. financial and transportation systems as conduits of criminal activity. These assignments included investigations relating to violations of federal and state law involving financial crimes, immigration law, cargo theft, narcotics smuggling, commercial trade violations, and computer crimes. I retired from DHS in 2013.

4. During my time as a law enforcement officer, I also served in the reserve component of the United States Navy ("USN") for approximately 34 years. My assignments in the military included service in four reserve unit Commanding Officer positions. During 2006, I was recalled to active duty as the Executive Officer of a detachment deployed to a combat zone in the U.S. Central Command. I retired from military service in 2017 at the rank of Captain, USN.

5. Since 2020, I have been an actively involved in MFCU's investigation of resident neglect, abuse, mistreatment, and Medicaid provider fraud at Fulton Commons Care Center, Inc. ("Fulton Commons"), located at 60 Merrick Avenue in East Meadow, New York. Fulton Commons is a for-profit nursing home registered with the New York State Department of Health ("DOH") as having a capacity of 280 beds. A "bed" is simply a measure of resident capacity.

6. MFCU has received numerous complaints from Fulton Commons employees, residents, and the family members of residents, and has also reviewed media reports, regarding

neglect of and harm to residents as a result of inadequate staffing, insufficient services and supplies, and violations of infection control, leading to Fulton Commons' failure to meet the care needs of its residents.

7. MFCU's investigation was commenced in or about 2018. During the course of the investigation, MFCU has interviewed past and present employees of Fulton Commons, residents of Fulton Commons, and family members of residents. The sum and substance of some of these interviews are set forth below.

8. This Affidavit and the facts stated herein are based upon my personal knowledge and upon information and belief. The sources of this information and basis for this belief are specified herein. Because this Affidavit is being submitted for the limited purpose of supporting the Petition, I have not included details of every aspect of the investigation. Where actions, conversations, and statements of others and the contents of documents are related herein, they are related in sum and substance, except where otherwise indicated.

9. **Witness Interviews: Reliability and Methodology**: Each of the witnesses described below are persons I deem reliable as to the facts reported by them that are contained herein. All the interviews described below were conducted live–either in person or by telephone or video conference. Either I or one of my colleagues confirmed that the witnesses are who they purported to be and were in a position to make the observations reported. For example, if a witness purported to be a staff member at Fulton Commons, we confirmed that the person appeared in staffing records produced by Fulton Commons during the relevant time period. If a person was a resident or family member of a resident, we confirmed that the individual was an in-patient resident during the relevant time period, or that the family member was providing information about an individual who was an in-patient resident at the relevant time, through documents produced by

Fulton Commons, Medicaid or Medicare reimbursement claims submitted by Fulton Commons, or other documentation—such as emails exchanged between the family member and Fulton Commons staff.

10. **Fear of Retaliation from Fulton Commons by Residents, Family Members, and Staff, Resulting in Confidentiality Concerns**: Some of the witnesses in this investigation expressed strong concerns that they may face retaliation from Fulton Commons for cooperating in this investigation. Other witnesses refused to speak with me or other detectives in this investigation after expressing a fear that if they cooperated in this investigation, they or their family members would face retaliation from Fulton Commons. As the residents are entirely dependent on Fulton Commons for all their needs, the family members often expressed concern on behalf of their loved ones.

11. Similarly, staff members of Fulton Commons have articulated concerns of retaliation by Fulton Commons and/or by other for-profit nursing homes (as it is common for the same individuals and/or their family members to have ownership interests in multiple for-profit nursing homes in New York State). Many of these staff members asserted that they are entirely dependent for their livelihood on the nursing home industry, live paycheck to paycheck, and often need to work multiple jobs in the industry to make ends meet.

Fulton Commons Staff Report Chronic Insufficient Staffing Resulting in Resident Neglect[1]

Certified Nurse Aide Employee #1: Fulton Commons' Insufficient Staffing Resulted in Resident Neglect

12. I interviewed Employee #1, an individual whose full name and identity is known to me, on November 19, 2021 and November 22, 2021. Employee #1, a Certified Nurse Aide ("CNA"), has been employed by Fulton Commons since 2003.

13. Employee #1 stated that there were already staff shortages at Fulton Commons prior to the onset of the COVID-19 pandemic. As staff shortages worsened, Fulton Commons responded by assigning staff to work extra hours or even shifts to fill the gaps in its staffing schedule. Employee #1 stated that as a result of the staffing levels at Fulton Commons, the staff were weary. Nevertheless, the staff continued to come to work and do the best they could.

14. Employee #1 stated that prior to the COVID-19 pandemic, Fulton Commons staff would check on and administer care to each resident three times over a normal eight-hour shift. Once the COVID-19 pandemic began, there were periods of time in which residents were only checked on and cared for twice per shift due to low staffing. As a result of this decline in staffing, resident care suffered. As an example, the employee euphemistically stated that residents who required some assistance to walk to a restroom to use the toilet might not have gotten such assistance to go to the restroom as often as the residents would have liked.[2]

[1] New York State law defines "neglect" as the "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living." (*See* Affidavit of Medical Analyst Mary E. Conway, RN ["RN Conway Aff."] at ¶ 18, *citing* 10 NYCRR § 81.1[c].)

[2] A nursing home's failure to operate with sufficient staff to provide necessary continence care is neglect that increases the risk of urinary tract infections and often causes resident injury from falls when frustrated residents try to walk by themselves to the toilet. (*See* RN Conway Aff. at ¶ 80.)

15. Employee #1 stated that due to the decline in staffing, there were occasions when there was not enough time for her to accomplish all the tasks that were assigned to her for a given shift. Employee #1 stated she raised this issue with Registered Professional Nurse ("RN") Rose Marie Haye and Licensed Practical Nurse ("LPN") Nicole Caruso, but nothing really changed. Employee #1 further stated that, although "work was scary" the staff "work[ed] harder than [they] complained."

16. Employee #1 stated that there were times during the COVID-19 pandemic when Fulton Commons staff were not provided with adequate personal protective equipment ("PPE"). Employee #1 further stated that when Fulton Commons failed to provide their staff with PPE, Fulton Commons staff resorted to using garbage bags in place of gowns. Fulton Commons administrator at the time, Respondent Cathie Doyle, instructed Fulton Commons staff not to use garbage bags as PPE; however, she did not provide an alternative until gowns were distributed to staff approximately two weeks later.

17. Employee #1 stated that in or about May 2020, she contacted the SEIU 1199 parent union to report Fulton Commons staff's concerns about the poor working conditions: specifically, the low staffing levels (both before and during the COVID-19 pandemic) and insufficient PPE. After her complaint to the SEIU 1199 parent union, Fulton Commons finally provided its staff with masks and gowns. However, Fulton Commons advised staff that the masks and gowns would need to last for an extended period of time.

CNA Employee #2: Fulton Commons' Chronic Insufficient Staff Resulted in Resident Neglect

18. I interviewed Employee #2, an individual whose full name and identity is known to me, on March 28, 2022. Employee #2 has been a CNA at Fulton Commons since 2010. Employee #2 reported that Fulton Commons regularly failed to staff enough CNAs on each floor.

During the weekend of March 25, 2022 through March 27, 2022, Employee #2 worked at Fulton Commons and found that there were an insufficient number of CNAs working each day on her assigned unit. Employee #2 had previously spoken to a union representative about the short staffing, but nothing changed or improved. Employee #2 stated she knew of staff complaints to Fulton Commons' management regarding the lack of staff, but that Respondent Doyle was not receptive to these complaints. Employee #2 stated that she cannot take a lunch break or a 15-minute break, because if she were to do so, residents would not receive the care they needed. Employee #2 also stated that a big problem is that many residents are sitting around in dirty disposable briefs and not brought to the bathroom. Employee #2 reported that it was difficult to take care of all of the residents when there was one CNA in the dining room, two CNAs on break, and only one CNA on the floor.[3]

Residents' Families Report Neglect and Insufficient Staffing at Fulton Commons Before and During the COVID-19 Pandemic

Resident's Son: Fulton Commons' Poor Care Before He Began Tipping Staff

19. I interviewed a person whose full name and identity is known to me, who was the son of a former Fulton Commons resident, on March 22, 2022. His mother was a resident at Fulton Commons from 2017 until she died in 2019. He visited his mother two to three times per week while she resided at Fulton Commons.

20. He stated he was unhappy with the care that Fulton Commons provided to his mother while she was a resident there. Fulton Commons staff did not provide the residents with exercise and offered very little mental stimulation. On one occasion, he observed a resident crawling on the floor at Fulton Commons. When he commented on the resident crawling on the

[3] Each unit at Fulton Commons housed up to 40 residents.

floor to a Fulton Commons staff member, the Fulton Commons staff member told him simply, "It's okay."

21. He stated that he received minimal communication from Fulton Commons regarding his mother's care. Because he was concerned about her care at Fulton Commons, he began "tipping" the Fulton Commons staff that cared for his mother in hopes that providing additional money would mean her needs would be met. He estimates that he gave approximately $500 in cash per month to Fulton Commons staff. Once he began tipping Fulton Commons staff, his mother's care improved; she was cleaner and better groomed, and Fulton Commons caregivers provided his mother with more exercise and walks than they had before he distributed the monetary tips.

22. When families of nursing home residents feel compelled to tip nursing home staff to prevent their loved ones from being neglected or perform the care themselves that their loved ones need, it is an indication that the nursing home has insufficient direct care staffing to provide the required care to the nursing home residents—and often insufficient supervising staff to ensure that the direct caregivers performed their assigned duties. (*See* RN Conway Aff. at ¶ 37.)

Resident V.P.'s Daughter: Fulton Commons' Neglect of V.P. and Insufficient Staffing Before and During the Pandemic

23. On March 23, 2022, I interviewed Diane Lawlor ("Lawlor"), the daughter and healthcare proxy of V.P., a former resident of Fulton Commons. Lawlor stated that V.P. lived at Fulton Commons from approximately June 2014[4] to May 2020. Prior to June 2014, V.P. had lived with her brother until he died, at which time she moved in with Lawlor, with whom she lived until

[4] MFCU's review of Fulton Commons records produced in response to an Executive Law § 63(12) subpoena reflect that Resident V.P. was admitted to Fulton Commons on June 1, 2014.

she was ultimately admitted to Fulton Commons. V.P. was 98 years old in May 2020 when she was discharged from Fulton Commons to a local hospital.

24. Lawlor stated her mother was diabetic and had a blood condition. When V.P. was admitted, a nurse supervisor stated that it was Fulton Commons' policy that all residents wear disposable briefs to prevent "accidents" and that all residents are placed in wheelchairs to prevent falls. Lawlor stated that when V.P. entered Fulton Commons, she was of sound mind and body and could communicate what was going on. Lawlor visited her mother every day until on or about March 10, 2020, when Lawlor received a voicemail message from Respondent Doyle stating that the facility was on lock-down[5] due to COVID-19.

Insufficient Staffing: Residents Screaming Out, "I Have to be Changed!"

25. In early 2018, Lawlor began to notice a change in the staff at Fulton Commons. There appeared to be significant turnover of employees and the employees did not know the names of either Lawlor or Resident V.P. There was also a lack of staff on duty at the facility. When Lawlor visited V.P. at Fulton Commons, she heard bells ringing constantly and residents screaming out, "I have to be changed!"

26. During meal times at Fulton Commons, Lawlor would often see only one staff member supervising 40–50 residents. Some of the residents had their faces in their plates, while others who appeared to need help with eating did not receive any such assistance from staff. Lawlor stated V.P. did not want to see this and chose to eat her meals in her room instead.

[5] The COVID-19 lock-down refers to the period of time beginning on or about March 13, 2020 through the summer of 2020, when DOH directed all nursing homes in New York State to stop visitation. (*See* the accompanying Affidavit of Senior Auditor-Investigator Kristen Ronan ("Ronan Aff.") Ex. 15.) The end of the lock-down cannot be stated definitively, as many nursing facilities reopened for short periods of time and then shut down again due to COVID-19 cases among their residents and staff.

Fulton Commons Deprived Resident V.P. of Her Clothes, Dentures, and Cell Phone

27. Lawlor did Resident V.P.'s laundry during her first four years at Fulton Commons. Sometime in 2018, Lawlor allowed Fulton Commons' staff to handle V.P.'s laundry. Thereafter, V.P.'s clothes began to disappear.

28. While V.P. was at Fulton Commons, the nursing home lost two sets of her dentures. Fulton Commons staff told Lawlor that the dentures probably fell out or that V.P. took the dentures out and they got wrapped up in the sheets and sent to the laundry. Each time her dentures were lost, V.P. had to be on a diet of pureed food until new dentures could be obtained.

29. Lawlor spoke to her mother approximately three times per day on her cell phone while V.P. was a resident at Fulton Commons. At one point, Lawlor called V.P.'s cell phone, but the call went to voicemail. The nurse manager told Lawlor that V.P.'s cell phone was missing. Thereafter, Lawlor had to call the nurse's station to check on V.P., which often involved waiting approximately 25 minutes for someone to answer the telephone.

30. During the COVID-19 lock-down, Lawlor was only able to communicate with her mother once over FaceTime. Lawlor was horrified when she saw how her mother looked. On or around April 23, 2020, there was a period of time lasting more than two weeks when Lawlor was not able to get in touch with V.P. It was very stressful for her to not be able to communicate with her mother.

Fulton Commons Staff Sought Tips for Prioritization of Care

31. Lawlor stated that she tried to treat the Fulton Commons staff well financially, especially during the holidays. Lawlor gave what she considered "key" staff members $100 gift cards. Thereafter, Fulton Commons staff left notes on V.P.'s dresser saying that extra care was given to V.P. and that V.P.'s hair had been washed. One staff member told Lawlor that her mother

was given a "special shower." Lawlor understood this to mean that the CNA was soliciting a monetary tip from her. Initially, Lawlor gave $20 to the aides who she believed provided this extra care, but she later stopped tipping as she felt she would end up in the "poorhouse" with the money she was giving out to have her mother taken care of.

V.P.'s Falls and Injuries Due to Neglect at Fulton Commons and Fulton Commons' Failure to Inform Her Family of COVID-19 Infection

32. Lawlor stated that Resident V.P. fell twice while residing at Fulton Commons. The first time V.P. fell was on or about December 10, 2017. A Fulton Commons CNA told Lawlor that V.P. had been left unattended in the bathroom when she fell asleep and fell off the toilet. As a result of that fall, V.P. broke her hip and required surgery. The second time V.P. fell was on or about April 23, 2020. A Fulton Commons nursing staff member told Lawlor that V.P. was once again left unattended in the bathroom when her knees buckled, causing her to fall. V.P. was taken in an ambulance to Mercy Hospital in Rockville Centre, N.Y. When Lawlor saw her mother at the hospital, V.P. looked horrible. Lawlor was told to stay away from V.P. because V.P. had COVID-19. Fulton Commons never informed Lawlor that V.P. had COVID-19.

33. Lawlor requested V.P.'s medical records from Fulton Commons. In reviewing these records, Lawlor learned for the first time that Fulton Commons gave V.P. Hydroxychloroquine, an experimental drug used to treat COVID-19 for a brief period of time early in the pandemic. Fulton Commons failed to inform Lawlor, the healthcare proxy, about the use of this drug as part of V.P.'s care.

34. On or about May 9, 2020, V.P. was transferred from Mercy Hospital to East Neck Rehabilitation and Nursing Center, where she died the next day. The death certificate issued for V.P. listed COVID-19 as her cause of death.

35. When Fulton Commons staff members packed up V.P.'s belongings, they found V.P.'s missing cell phone under a pile of clothes in a bottom drawer across the room.

Fulton Commons Administrator Cathie Doyle Misled Families into Believing Fulton Commons Was COVID-Free Despite Residents Being Treated for and Dying of COVID-19

36. Pursuant to an Executive Law § 63(12) subpoena, MFCU received and reviewed telephonic recordings of phone messages sent to hundreds of Fulton Commons families (i.e., "robocalls"). MFCU received and reviewed 43 recorded robocalls sent to Fulton Commons families between March 12, 2020 and June 15, 2020. An analysis of these robocalls revealed that Fulton Commons and Respondent Doyle told residents' family members that there was no COVID-19 in Fulton Commons through at least March 24, 2020, despite Fulton Commons treating residents with COVID protocols prior to that date and ultimately reporting those residents to DOH as suspected and/or presumed COVID-19 residents. (*See* Ronan Aff. at ¶¶ 137–140.) This information corroborates witness accounts in which family members advised they had received robocalls indicating there was no COVID at Fulton Commons during the period their family members were residents at the facility (*see, e.g.,* Affidavit of John Costa at ¶ 14) even though MFCU's investigation has determined that there were, in fact, presumed COVID-positive residents at the facility.

RN Llorente: Fulton Commons Hid COVID-19 Infections from Residents, Families, and Staff

37. I have reviewed excerpts of the transcript of the Executive Law § 63(12) examination under oath of RN Elfa Llorente ("Llorente"), taken on October 19, 2020, which is attached to the Ronan Aff. as Exhibit 19. As reflected in that transcript, Llorente testified, in sum and substance, to the below information.

38. Llorente is a licensed RN and has been employed as RN Unit Manager of Unit 3 West at Fulton Commons since 2009. (*See* Ronan Aff. Ex. 19 at 30.) As RN Unit Manager, she is responsible for supervising LPNs and CNAs. (*Id*. at 27–28.)

39. Llorente testified that Respondent Doyle gave a "directive" to Fulton Commons staff that Fulton Commons did not have cases of COVID-19 in the facility. (*Id*. at 116.) Llorente reported that Doyle made announcements via overhead speakers in Fulton Commons that there was no COVID-19 in Fulton Commons and that Fulton Commons was a COVID-free facility. (*Id*. at 116, 119.) Llorente understood this to mean that Fulton Commons staff were not to tell residents or family members of residents that there may be cases of COVID-19 in the building. (*Id*. at 118–119.) Llorente testified that although Doyle did not directly tell her not to share information related to COVID-19, it was implied in the announcements. (*Id*. at 119.)

40. Llorente testified that she felt that she was put in an unfair position, as she was not able to give families full information regarding their loved ones' care due to Doyle's directive that there was no COVID-19 in the building. (*Id*. at 121–122.)

41. Llorente further testified that she was concerned that Fulton Commons was not testing residents for COVID-19 but still claiming that there was no COVID-19 in the facility. Llorente stated she voiced these concerns to then-Fulton Commons Director of Nursing ("DON"), Carol Frawley, but that Frawley told her that Doyle did not want to test residents because that was the directive of DOH or of Governor Cuomo.[6] (*Id*. at 116–117.)

[6] Administrator Doyle's reported directive to staff was inconsistent with DOH Guidance, which provided that downstate nursing homes in various locations, including Long Island, where Fulton Commons is located, did not need to test residents, but should presume that any residents exhibiting symptoms consistent with COVID-19 (such as fever and/or respiratory illness) were COVID-19 positive and therefore implement appropriate infection control protocols. DOH's directive included cohorting the residents with dedicated staff to care for them. Further, DOH required nursing homes to report the number of their residents who had been diagnosed with COVID-19 as well as the number of residents who had died of confirmed or presumed COVID-

Fulton Commons Administrator Cathie Doyle Sidelined Its Infection Preventionist and Failed to Include Her in any Infection Control Decisions

42. I have also reviewed excerpts of the transcript of the Executive Law § 63(12) examination under oath of Marise Jean-Baptiste, former Fulton Commons infection preventionist ("IP"), taken on October 14, 2020, which is attached hereto as Exhibit 1. As reflected in the attached transcript, IP Jean-Baptiste testified, in sum and substance, to the below information.

43. Jean-Baptiste has been a licensed RN since August 1998 and has worked at Fulton Commons on and off since 2014. (Ex. 1 at 21, 24.) She became one of two Assistant Directors of Nursing at Fulton Commons in 2017, and then also took on the role of the infection preventionist in 2019. (*Id*. at 24–25.) As the IP, she was responsible for collecting data and tracking infections, including COVID-19, at Fulton Commons. (*Id*. at 35.) Despite being the IP, Jean Baptiste stated that her infection control suggestions throughout the height of the pandemic[7] were generally dismissed. (*Id*. at 55–64.) She was excluded from infection control discussions and felt like she was not a part of the team. (*Id*. at 59–62.) Jean-Baptiste further advised that she was not allowed to perform her job and was afraid because she had a leadership title, yet she lacked the power to implement anything. (*Id*. at 150.)

44. Specifically, in or around April 2020, Jean-Baptiste suggested to Respondent Doyle that Fulton Commons residents be tested for COVID-19, but Respondent Doyle told her it was not necessary to do so. (*Id*. at 55-56.) This did not make sense to Jean-Baptiste because Fulton Commons needed to have a baseline in order to prevent the infection from spreading in the facility,

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19. This directive and data collection is inconsistent with Fulton Commons' many affirmative statements of false information to resident families that there was no COVID-19 at Fulton Commons.

[7] The height of the pandemic refers to the first wave of the COVID-19 pandemic, which is the period between March 1, 2020 and May 31, 2020.

and such a baseline was never established. (*Id*. at 56.) Jean-Baptiste did not believe this was the appropriate way to handle the pandemic, but she had no power to do anything because she was told that the medical director had to make the decision. (*Id.* at 56–57.)

45. Jean-Baptiste further advised that on or about April 2020, Respondent Doyle made an announcement over the loudspeaker at Fulton Commons that there were no COVID-19 cases in the building. (*Id*. at 116.) At the time this announcement was made, Jean-Baptiste believed that there were residents in Fulton Commons who were actively being treated with COVID-19 protocols. (*Id*. at 117–120.) Accordingly, Jean-Baptiste testified, "I thought [that] was a very audacious comment to make. And how could you say that, because I thought it was misleading." (*Id.* at 120.)

46. Jean-Baptiste acknowledged that Fulton Commons failed to cohort residents based on their COVID-19 status, and that this failure could have jeopardized Fulton Commons' operating license. (*Id*. at 166–168.) Jean-Baptiste conceded that failing to properly cohort residents on particular units constituted neglect by Fulton Commons. (*Id.* at 246.) She further acknowledged that Fulton Commons endangered its residents throughout the COVID-19 pandemic. (*Id.* at 249.)

47. Moreover, Jean-Baptiste stated that Fulton Commons residents were not tested for COVID-19 until June 2020, when a state agency came in to test the residents. (*Id*. at 176–178.)

Fulton Commons' Failure to Inform Non-Nursing Departments that COVID-Presumed Residents Were Housed on Non-COVID Units Put Residents and Staff at Risk

48. I have also reviewed excerpts of the transcript of the Executive Law § 63(12) examination under oath of Michael Andrews, the Fulton Commons Director of Housekeeping, taken on November 19, 2020, which is attached to the Ronan Aff. as Exhibit 24. As reflected in that transcript, Andrews testified that he had been employed in the housekeeping department at Fulton Commons for approximately 18 years and became the Director of Housekeeping in

approximately 2016 or 2017. (*See* Ronan Aff. Ex. 24 at 21–22.) In that role, he was responsible for supervising approximately 23 housekeeping department employees. (*Id*. at 30.) He, in turn, reported directly to Respondent Doyle. (*Id*.)

49. Among other tasks, the housekeeping department at Fulton Commons is responsible for terminal cleaning of rooms in the facility, which involves "tak[ing] everything out of that room, terminally clean[ing] it, disinfect[ing] that room completely and then put[ting] it back together." (*Id.* at 54–55.) Andrews explained that terminal cleaning is an important aspect of infection control as it removes infections from the room prior to a new resident being placed therein. (*Id.* at 80.) Specifically, putting a new resident into a room that has not been terminally cleaned has the potential to expose a resident to various infections that the prior resident might have had. (*Id.* at 81.)

50. Andrews further testified that Fulton Commons housekeepers were not advised by nursing staff which rooms housed residents who may have been diagnosed with COVID-19. (*Id.* at 111.) Rather, Fulton Commons had a COVID-19 Unit, Unit 1 East. On that unit, housekeeping staff took extra precautions and did not go into the residents' rooms unless it was absolutely necessary to go in. (*Id*. at 114–115, 152, 155–156.) On every other unit, housekeeping staff still went into the residents' rooms and were able to clean them. (*Id.* at 152, 155–156.)

51. Andrews further acknowledged that Fulton Commons' nursing staff's failure to notify housekeeping staff that there were presumed or confirmed COVID-19 residents on the non-COVID units could have placed non-COVID residents at risk for contracting COVID-19 and that such failure constituted neglect of those non-COVID residents. (*Id.* at 242.)

Respondent Doyle's Refusal to Test Fulton Commons Residents for COVID-19 Put Residents at Risk

52. As noted above, despite IP Jean-Baptiste's recommendation to test Fulton Commons residents for COVID-19, Respondent Doyle refused to implement any such testing. (*See* ¶ 44 above.)

53. I reviewed numerous e-mail exchanges involving various Fulton Commons employees, which were obtained from Fulton Commons through a record request under MFCU's authority pursuant to 18 NYCRR § 504.3(a). Specifically, I reviewed a May 28, 2020 e-mail exchange between Respondent Doyle and DOH epidemiologist Marie Ciacco Tsivitis in which DOH offered to test all Fulton Commons residents for COVID-19 at no cost to Fulton Commons. These e-mail excerpts, attached as Exhibit 2, show that Respondent Doyle resisted DOH's offer to test Fulton Commons' residents.

54. Specifically, in the series of emails between Doyle and Tsivitis, Respondent Doyle questioned whether COVID-testing of facility residents was required, to which Tsivitis advised that testing of all facility residents who had not previously tested positive for COVID-19 was required. Tsivitis further advised in the May 28, 2020, email that DOH could provide free one-time testing of facility residents and offered to have a telephonic discussion with Respondent Doyle to answer any questions she may have. The attached emails indicate that, thereafter, Respondent Doyle forwarded the email communications to Dr. Olaf Butchma, Fulton Commons' Medical Director, stating, "This woman is telling me that this is 'required'. . . please advise." (*Id*.)

55. I have reviewed excerpts of the transcript of the Executive Law § 63(12) examination under oath of then-DON Carol Frawley, taken on October 15, 2020, which is attached to the Ronan Aff. as Exhibit 23. As reflected in that transcript, Frawley testified that she has been licensed as an RN since 1975 and was employed as the DON at Fulton Commons as of January

2017. (*See* Ronan Aff. Ex. 23 at 21; 28–29.) Upon information and belief, Frawley's employment at Fulton Commons was terminated at the end of September 2022.

56. Frawley testified that Fulton Commons had its first presumed COVID-19 case in March 2020. (*Id*. at 79.) Nonetheless, Fulton Commons did not test that resident, or any other resident, for COVID-19 during March 2020. (*Id*. at 91–92.) Frawley testified that Doyle and Dr. Butchma instructed Frawley not to test the residents of Fulton Commons for COVID-19 and to treat patients as presumed COVID-19 positive. (*Id*. at 95.) Frawley acknowledged that testing for COVID-19 would have been helpful and believed that residents at Fulton Commons may have been saved if Fulton Commons had tested for COVID-19. (*Id*.) Nonetheless, Fulton Commons made no efforts to test its residents in the height of the pandemic. (*Id*. at 93–95.)

57. I have reviewed excerpts of the transcript of the Executive Law § 63(12) examination under oath of Respondent Doyle taken on January 27, 2021, which is attached hereto as Exhibit 3. As reflected in the attached transcript, Respondent Doyle testified that, absent guidance from DOH or the Centers for Medicare and Medicaid Services ("CMS") directing Fulton Commons to test residents for COVID-19, she would not have tested any resident for COVID-19. (*Id.* at 430.)

Residents' Families Report Fulton Commons Hid COVID-19 Illnesses and Violated Infection Control Protocols During the COVID-19 Pandemic

Resident's Daughter: Fulton Commons Sent False Robocalls Stating There Was No COVID-19 in the Building and Failed to Disclose her Mother's Deteriorating Condition

58. I interviewed an individual, whose full name and identity are known to me, on May 18, 2020. Her mother was a Fulton Commons resident for 10 years until she died in April 2020.

59. She stated that she generally visited her mother once a week at Fulton Commons, and that in or around March 2020, her mother became very sick. Fulton Commons staff told her

that her mother had a urinary tract infection. However, she later learned that her mother had bilateral pneumonia and high fevers. Her mother was never tested for COVID-19 while she was a resident of Fulton Commons.

60. During the month of March 2020, the witness received robocalls from Fulton Commons, all of which reported that there were no cases of COVID-19 in Fulton Commons.

61. On or about March 30, 2020, the witness went to Fulton Commons to see her mother. A security guard at Fulton Commons refused to let her enter the home and refused to contact Respondent Doyle. The witness called the Nassau County Police Department, who stated they could not intervene.

62. On or about March 31, 2020, the witness and her brother met with Respondent Doyle and told her that they planned to remove their mother from Fulton Commons. Doyle informed them that their mother could not be removed from Fulton Commons and that Doyle would contact them if there were any changes in their mother's condition. They argued with Doyle, until Doyle agreed to let them visit their mother briefly. When they got to their mother's room, she was thrashing her body on the bed and appeared to be in pain. No Fulton Commons staff member was present in their mother's room. The witness asked for pain medication for her mother and observed that some Fulton Commons staff were wearing PPE and some were not. This was the last time the witness ever saw or spoke to her mother.

63. On or about the morning of April 1, 2020, the witness called Fulton Commons to check on her mother's medical condition. A Fulton Commons staff member told her that her mother was fine, that she was eating, and did not have an elevated temperature.

64. Her mother died shortly thereafter, in April 2020. Upon learning of her mother's death, the witness called her mother's treating doctor. The doctor advised her that with regard to her mother's passing, "she was sure it was COVID."

Resident H.G.'s Daughter: Fulton Commons Failed to Provide Diagnosis and Treatment of H.G. for COVID-19

65. I interviewed Robin Fitzgerald ("Fitzgerald"), daughter of Fulton Commons Resident H.G., on June 7, 2022. H.G. was a resident of Fulton Commons from on or about April 19, 2019, until his death on April 7, 2020, at the age of 95. Fitzgerald stated that she visited H.G. at Fulton Commons two to three times per week and last visited H.G. before the COVID-19 pandemic lock-down on March 10, 2020. Fitzgerald's husband and child last visited H.G. on March 11, 2020.

66. In or about the beginning of April 2020, the head nurse from Fulton Commons Unit 3 West, who she believed was "Elsa,"[8] informed Fitzgerald that H.G. had a little fever.

67. On or about April 6, 2020, Fitzgerald asked a Fulton Commons staff member to set up a FaceTime video call so that Fitzgerald could see and speak with her father. The nurse told Fitzgerald that Fulton Commons would arrange a call with H.G. that day or the next day, and that H.G. was fine. On or about April 7, 2020, at approximately 8:00 p.m., a Fulton Commons staff member used her own cell phone to coordinate a FaceTime video call with Fitzgerald, so that Fitzgerald, her husband, and her child could speak to H.G. During this call, Fitzgerald observed that her father was incoherent, prompting her to call Fulton Commons and express her concerns about H.G.'s condition to a supervising nurse named Dorothy.

[8] Upon information and belief, Fitzgerald is referring to Elfa Llorente, the RN Unit Manager for 3 West.

68. On or about April 7, 2020, at approximately 9:00 p.m., Fitzgerald called Fulton Commons again and spoke with Dorothy. Dorothy stated that she had checked on H.G. and that his vitals and blood work were fine. Dorothy told Fitzgerald that there was no need to worry about H.G.

69. Just hours later, at approximately 1:34 a.m., Fitzgerald received a telephone call from a Fulton Commons employee informing her that H.G. died at 11:30 p.m. that night. Fitzgerald went to Fulton Commons at approximately 2:00 a.m. to see her father. Upon her arrival at Fulton Commons, Fitzgerald observed that there was no infection control signage at the door to H.G.'s room. Fitzgerald also observed that H.G. had a new roommate. Notably, approximately one week before H.G. died, his former roommate had died.

70. Fitzgerald stated H.G.'s death certificate initially only listed cardiac arrest as the cause of death, but it was later amended to include COVID-19 pneumonia as a contributing factor in H.G.'s death. The original death certificate is attached hereto as Exhibit 4, and the amended death certificate is attached to the Ronan Aff. at Exhibit 16.

Fulton Commons' Violation of Infection Control Protocols Increased Resident Risk

71. When a nursing home violates infection control protocols, especially during a global pandemic when residents of the facility are displaying symptoms of the infection, the nursing home increases the risk that infection will spread to other residents and to staff, and, therefore, increases the risk of harm to residents. (*See* RN Conway Aff. at ¶¶ 47, 51.)

72. Fulton Commons' records revealed that H.G.'s former roommate passed away at the end of March 2020, after developing an elevated temperature and undergoing treatment pursuant to Fulton Commons' COVID-19 protocols. (*See* Ronan Aff. at ¶ 118.) MFCU's review further revealed that H.G. developed COVID-19 symptoms, including a fever, the day before his roommate's death, causing H.G. to also be treated with COVID-19 protocols. (*Id*. at ¶ 119.)

Nonetheless, despite H.G. continuing to exhibit symptoms consistent with COVID-19, Fulton Commons moved a non-COVID resident into H.G.'s room on the same day that his former roommate died. (*Id*..) As noted in ¶ 70, above, Resident H.G.'s death certificate indicates that COVID-19 pneumonia was a contributing factor in his death just days later, on April 7, 2020.

Resident's Daughter: Fulton Commons' Failure to Inform Family of Fever and COVID-19 Illness

73. I interviewed a person on May 15, 2020, whose full name and identity are known to me. Her father was a Fulton Commons resident until his death in March 2020. She stated that she visited her father two to three times per week. She further stated that it was always difficult to get a hold of the employees at Fulton Commons.

74. She advised that her father was sick for approximately four weeks beginning on or about March 5, 2020, and was diagnosed with double pneumonia on March 11, 2020. On or about March 25, 2020, he had a fever of 103 degrees, but Fulton Commons nursing staff failed to inform his attending physician. His daughter knows this because his attending physician did not know about the fever until she told the physician herself.

75. On or about March 27, 2020, a Fulton Commons doctor working on Unit 4 West told the witness that her father was very sick and probably dying. She last saw her father in the end of March 2020, on the day he died. Her father was never tested for COVID-19. She stated that a Fulton Commons staff member told her that Fulton Commons would not test residents for COVID-19 and that COVID-19 testing was the responsibility of the Centers for Disease Control and Prevention ("CDC").

76. The witness stated that her friend was also a resident at Fulton Commons. Her friend resided in a room on the second floor with a roommate, and her friend's roommate died in

the room. Her friend was left in the room with her roommate's corpse for several[9] hours before the body was removed.

Resident G.S.'s Nephew: Fulton Commons Failed to Diagnose, Treat, or Inform Family of G.S.'s COVID-19 Infection

77. I interviewed Charles Odekirk ("Odekirk") on May 22, 2020. Odekirk is the nephew of G.S., who had been a resident at Fulton Commons for approximately two years prior to her death on April 13, 2020, at the age of 90. Odekirk stated that G.S suffered from diabetes and knee problems.

78. Odekirk stated that he visited G.S. weekly at Fulton Commons until the COVID-19 lock-down. Odekirk stated that the last time he saw G.S. in person was in or around March 2020.

79. Odekirk stated that G.S.'s roommate at Fulton Commons was her boyfriend, who had a broken hip and was diagnosed with Parkinson's disease and dementia. Odekirk advised MFCU that G.S.'s boyfriend developed flu-like symptoms on or about April 3, 2020, including coughing, sneezing, and fever. Odekirk stated that G.S. was not isolated from her boyfriend during this period. Odekirk also stated that G.S. developed a cough on or about April 5, 2020, and that on or about April 7, 2020, Fulton Commons nurse "Dorothy" told him that G.S. was very sick.

80. Odekirk stated that in early April 2020, G.S.'s boyfriend died. G.S.'s medical condition declined rapidly after his death, and G.S. developed difficulties breathing. Fulton Commons staff told Oderkirk that G.S. was grieving for her boyfriend.

81. Odekirk stated that on April 12, 2020, G.S. was very weak, and he could barely hear her voice when they spoke on the telephone. Odekirk stated that G.S. told him that she could

[9] MFCU's review of Fulton Commons records reflect that the resident's roommate was pronounced dead at 12:10 p.m., but that the body was not picked up by the funeral home until 4:15 p.m.

not breathe and that she was dying. Later that day, Odekirk was contacted by a Fulton Commons staff member who told him that G.S. was dying. Indeed, G.S. died the next morning.

82. Odekirk stated that neither G.S. nor her boyfriend were tested for COVID-19 by Fulton Commons, nor were they sent to the hospital for care. Odekirk further stated that while Fulton Commons staff told him that G.S. did not die of COVID-19, the funeral home that received G.S.'s body stated that G.S. had died of COVID-19.

83. MFCU's review of the New York State Death Registry disclosed that COVID-19 was listed as a cause of death for G.S., and as a secondary cause of death for G.S.'s boyfriend.

84. Odekirk stated that no one at Fulton Commons told him that there was COVID-19 in Fulton Commons. He further explained that he had received robocalls from Fulton Commons two to three times a week that indicated there was no COVID-19 among the facility's residents.

Fulton Commons Underreported COVID-19 Deaths

85. I have reviewed excerpts of the transcripts of the Executive Law § 63(12) examination under oath of Medical Director Dr. Olaf Butchma ("Butchma"), taken on February 25, 2021 and March 10, 2021, which are attached hereto as Exhibit 5. As reflected in these transcripts, Butchma testified that he has served as the Medical Director at Fulton Commons since its opening just after September 11, 2001. (*Id*. at 32–33.) He also serves as an attending physician for one unit at the facility. (*Id*. at 24–25.)

86. Butchma approximated that in March 2020, 10–12 Fulton Commons residents died on a single unit during a three-or four-day period. (*Id*. at 129.) Given that Fulton Commons did not test its residents in March of 2020, the only confirmed COVID-19 positive death during that short time period tested positive at the hospital. (*Id*. at 130.) Although Butchma conceded that

accurate death reporting was critical to New York State's response to the COVID-19 pandemic (*id*. at 417–418), the first time that he identified COVID-19 as a cause of death on a death certificate was "probably" not until after Fulton Commons started testing its residents. (*Id*. at 446.)

87. Butchma admitted that testing would have helped control outbreaks, especially with respect to asymptomatic carriers. (*Id*. at 365–366). However, once residents had another cause for their symptomology, he did not consider them as suspected COVID-19 positive; they were no longer "of interest" with respect to COVID-19 and therefore he did not include it on their death certificates. (*Id*. at 439, 444).

88. Importantly, Butchma admitted that the failure to properly implement the infection control directives of the CDC and New York State could potentially constitute neglect. (*Id*. at 464).

A Social Media Search Revealed Numerous Complaints Regarding Fulton Commons

89. My colleague, Legal Assistant Allison Gionta, searched online resources including Google, Caring.com, and Yelp for reviews of Fulton Commons written by various individuals such as residents, employees, and family members of residents. Below are samples of these reviews, downloaded by Ms. Gionta, for the time period of March 2019 through November 2021. We were unable to verify the identity of the persons writing the reviews. Exhibits 6 through 14 are true and correct copies of the online reviews Ms. Gionta downloaded.

Google Reviews

90. As shown in Exhibit 6, "Sophia L." left a Google review in 2019 regarding the care her mother received:

> *"This place is HORRIBLE the administration is never there when you need information. The staff are overwhelmed with work. They would have one nurse caring for over 10 patients on one floor, it's even worse at night. At night I'd have to leave my job early to go over there and clean my mother up and put her to bed.*

The night staff would lined [sic] up the patients outside their room waiting to be cleaned. And there are times when I'm there; The hallway are [sic] cold and patients are freezing, patient are trying to escape, and crying for help. That place is dreadful PLEASE I URGE ANYONE TO NOT PUT YOUR LOVE ONES AT THAT PLACE!!! THIS PLACE NEED TO BE SUED AND SHUT DOWN!!! It was too hard to witness this everyday. I had to transferred [sic] my mother out of there."

91. As shown in Exhibit 7, "Lia Rodriguez" left a Google review in 2020 regarding the care her grandmother received:

"...the nurses on the floor DO NOT CARE about the residents. My grandma will hit her call button to use the bathroom, and no one will show up until an hour later or they don't show at all. I've seen this with my own eyes multiple times. They take so long to the point that she has to get herself out of bed and she fell and got hurt - she had to drag herself across the DIRTY floor to get to her call button. she laid there until someone finally showed up."

92. As shown in Exhibit 8, "Tom Ferguson" left a Google review in 2021 regarding the care a loved one received:

"This facility is poorly run from the top down. I had a loved one who was admitted for Rehabilitation and stayed for just under 2 weeks. In that time I was constantly being the middle man between my loved one and the facility for simple things like ringing the bell because they could not get out of bed themselves to use the lavatory. I was told they were waiting for close to 15 minutes for someone to help them to the point they picked up their cell to call me so that I could call the facility to let them know they had to go to the bathroom. And then I was placed on hold for 20 minutes until someone from that unit could pick up the phone to even listen to my request!"

<u>Yelp Reviews</u>

93. As shown in Exhibit 9, on April 23, 2019, "Rose M." left a review on Yelp regarding the care of her husband:

"DO NOT LEAVE YOUR FAMILY MEMBER HERE! My husband was in rehab for 1-1/2 months last summer it is disgusting! I myself had to bring cleaning products to clean the bathroom and his area. Every night i [sic] would go and change his bed and blankets myself because the aids [sic] would disappear and not change his bedding. I brought in a cooler so he would have food to eat. Yogurt, pb&j, etc... along w snacks."

94. As shown in Exhibit 10, on March 27, 2020, "Lisa P." left a review on Yelp regarding the care her father received:

> *"This facility is horrible! Do not send your loved one here. My father couldn't get into the rehab we were hoping for and we placed him here. He declined so rapidly there. He lost tons of weight. He was so drugged up he couldn't have a telephone conversation at night. He sat in his own pee for quite a while before being helped and developed awful rashes. He was ignored when he asked several times for extra blankets at night while he laid there cold. The smell in the place was horrid. They didn't want to release him because they wanted the money. His doctor had [sic] demand he be released because he couldn't believe his rapid decline in the three weeks he was there. Horrible!!!!!!"*

95. As shown in Exhibit 11, on June 5, 2020, "Ruth B." left a review on Yelp regarding the care her mother received:

> *"This place should have negative stars. Please, even if you do not like your loved one, do not put them here. It is a slow torture of death. The state must get involved to shut this place down. Do not be fooled by the outside. It is beautiful. Then once your loved one is there..(My mother.) it is an endless torture room. You sit in your own feces for hours. There was even a point where they pushed my mother and kicked her."*

96. As shown in Exhibit 12, on March 31, 2021, "Rip Bryan Y." left a review on Yelp regarding the care their father received:

> *"My Dad was in this facility from Nov 2019- Jan 2020. THEY DO NOT HAVE ENOUGH STAFF. Took over 15 minutes to get help for bathroom, did not keep eye on patients. My dad kept falling out of bed so we had to HIRE a person to stay at his bedside at night. You have to be there 24/7 to make sure they are cared for! Sad."*

Caring.com Reviews

97. As shown in Exhibit 13, "Ridiculou" left a review to Caring.com on October 2, 2020, regarding the care their mother received:

> *"My mom had a horrible experience in this place. Many of the people were unkind and mean. If you needed assistance, it would take hours for a response. My mom went 6 days without heat and hot water. The food was awful. All, in all, this place should loose [sic] it's license."*

98. As shown in Exhibit 14, on November 15, 2021, former resident "RB61" left a review on Caring.com regarding the care they received:

> *"Just awful, should be investigated. I was in for rehab after knee replacement surgery and they ignored a chronic condition in my legs that the hospital had been treating, causing me to be bedridden for 4 days before they finally took action. With a few exceptions, the staff is rude and unresponsive. One aide actually tried to make me sit on a feces-smeared toilet seat, when I asked her to clean it she made a half-hearted attempt and left me to finish the job myself."*

Exhibits

99. Attached hereto as **Exhibit 1** is a true and correct copy of the transcript of the Executive Law § 63(12) examination under oath of Marise Jean-Baptiste.

100. Attached hereto as **Exhibit 2** is a true and correct copy of an e-mail exchange between Respondent Doyle and DOH epidemiologist Marie Ciacco Tsivitis, dated May 28, 2020.

101. Attached hereto as **Exhibit 3** is a true and correct copy of the transcript of the Executive Law § 63(12) examination under oath of Cathie Doyle.

102. Attached hereto as **Exhibit 4** is a true and correct copy of the original death certificate for resident H.G.

103. Attached hereto as **Exhibit 5** is a true and correct copy of the transcript of the Executive Law § 63(12) examination under oath of Olaf Butchma.

104. Attached hereto as **Exhibit 6** is a true and correct copy of the Google review of Fulton Commons left by user, "Sophia L."

105. Attached hereto as **Exhibit 7** is a true and correct copy of the Google review of Fulton Commons left by user, "Lia Rodriguez".

106. Attached hereto as **Exhibit 8** is a true and correct copy of the Google review of Fulton Commons left by user, "Tom Ferguson".

107. Attached hereto as **Exhibit 9** is a true and correct copy of the Yelp review of Fulton Commons left by user, "Rose M".

108. Attached hereto as **Exhibit 10** is a true and correct copy of the Yelp review of Fulton Commons left by user, "Lisa P".

109. Attached hereto as **Exhibit 11** is a true and correct copy of the Yelp review of Fulton Commons left by user, "Ruth B".

110. Attached hereto as **Exhibit 12** is a true and correct copy of the Yelp review of Fulton Commons left by user, "Rip Brian Y".

111. Attached hereto as **Exhibit 13** is a true and correct copy of the Caring.com review of Fulton Commons left by user, "Ridiculou".

112. Attached hereto as **Exhibit 14** is a true and correct copy of the Caring.com review of Fulton Commons left by user, "RB61".

WHEREFORE, based upon the foregoing, I respectfully request that the Court grant the relief described in the Verified Petition.

John M Tarpey

Detective John M. Tarpey

Sworn to before me this
7th day of December, 2022

Allison Gionta

Notary Public

ALLISON GIONTA
Notary Public, State of New York
Qualified in Monroe County
No. 01GI6362539
Commission Expirers July 31, 2025

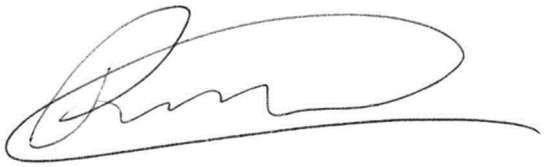
CERTIFICATION PURSUANT TO RULE 202.8-b

I, Prabhjot Sekhon, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 9,031 words, excluding the parts of the Affidavit explicitly exempted by Rule, and that Petitioner's request for permission to file an oversize submission as provided in Rule 202.8-b(f) is forthcoming.

Dated: Hauppauge, New York
December 12, 2022

Respectfully submitted,
Letitia James
Attorney General of the State of New York

By:



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NEW YORK STATE: ATTORNEY GENERAL'S OFFICE

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In the matter of

FULTON COMMONS CARE CENTER, INC.; an Investigation by the New York State Attorney General, made pursuant to the New York State Executive Law, et seq.

----------X

63(12) Examination under oath of MARISE JEAN-BAPTISE, taken via WebEx video conference, held on October 14, 2020, commencing at 10:00 a.m.

Reported by

Sivan Dahan

A P P E A R A N C E S:

NEW YORK STATE ATTORNEY GENERAL'S OFFICE
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
BY: PRABHJOT SEKHON,
Special Assistant
Attorney General
BY: BENJAMIN SMITH,
Special Assistant
Attorney General

ALSO PRESENT:
Elysia Doherty, Investigator
Mary Gail Kowtna,
Audit Investigator
Mary Conway, Nurse Analyst

M. JEAN-BAPTISE

(Subpoena was premarked as State's Exhibit 1, for identification; 10-14-20, S.D.)

(Four-page document was premarked as State's Exhibit 2, for identification; 10-14-20, S.D.)

(CMS February 6th guidance was premarked as State's Exhibit 3, for identification; 10-14-20, S.D.)

(Four-page document was premarked as State's Exhibit 4, for identification; 10-14-20, S.D.)

(March 4, 2020 CMS guidance was premarked as State's Exhibit 5, for identification; 10-14-20, S.D.)

(March 11th, 2020 guidance was premarked as State's Exhibit 6, for identification; 10-14-20, S.D.)

(March 13, 2020 guidance was premarked as State's Exhibit 7, for identification; 10-14-20, S.D.)

(March 13, 2020 DOH guidance was premarked as State's Exhibit 8, for identification; 10-14-20, S.D.)

M. JEAN-BAPTISE

(March 20, 2020 guidance was premarked as State's Exhibit 9, for identification; 10-14-20, S.D.)

(One-page document was premarked as State's Exhibit 10, for identification; 10-14-20, S.D.)

(Three-page document was premarked as State's Exhibit 11, for identification; 10-14-20, S.D.)

(Three-page document was premarked as State's Exhibit 12, for identification; 10-14-20, S.D.)

(Three-page document was premarked as State's Exhibit 13, for identification; 10-14-20, S.D.)

(Two-page document was premarked as State's Exhibit 14, for identification; 10-14-20, S.D.)

(Daily census sheet was premarked as State's Exhibit 15, for identification; 10-14-20, S.D.)

(Daily census sheet was premarked as State's Exhibit 16, for identification; 10-14-20, S.D.)

M. JEAN-BAPTISE

(Two-page document was premarked as State's Exhibit 17, for identification; 10-14-20, S.D.)

(24-hour condition report was premarked as State's Exhibit 18, for identification; 10-14-20, S.D.)

(24-hour condition report was premarked as State's Exhibit 19, for identification; 10-14-20, S.D.)

(Terminal cleaning log was premarked as State's Exhibit 20, for identification; 10-14-20, S.D.)

(19-page document was premarked as State's Exhibit 21, for identification; 10-14-20, S.D.)

M-A-R-I-S-E J-E-A-N-B-A-P-T-I-S-E, having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

EXAMINATION BY

MS. SEKHON:

Q. Please state your name for the record.

A. Marise Jean-Baptise.

M. JEAN-BAPTISE

Q. What is your address?

A. [redacted], New York [redacted].

Q. Good morning, Ms. Jean-Baptiste. My name is Prabhjot Sekhon. I am a Special Assistant Attorney General with the New York State Attorney General's Office and the Medicaid Fraud Unit. I will ask my colleagues to introduce themselves as well.

MS. CONWAY: Mary Conway, medical analyst from the New York State Attorney General Office.

MS. KOWTNA: I am Mary Gail Kowtna. I am an auditor with the Attorney General Office.

MR. SMITH: Good morning. My name is Benjamin Smith. I am a special assistant with the Attorney General Office.

MS. DOHERTY: Good morning. My name is Elysia Doherty. I am a special agent with the Department of Health Services.

MS. SEKHON: I will ask the rest

M. JEAN-BAPTISE

of my colleagues to mute themselves at this time and to turn off their videos so that I can conserve bandwidth and hopefully the rest of our examination will run pretty smoothly thereafter.

Q. Ms. Jean-Baptiste, what city and county are you sitting in right now?

A. I am in [redacted], New York, [redacted].

Q. Are you sitting at home at this time?

A. Yes.

Q. Is there anyone else in the room with you at this time?

A. No.

Q. We are conducting this examination remotely in order to ensure the health and safety of all participants due to coronavirus-related concerns. The examination is being recorded by stenographic means by a court reporter certified to record the examination in the State of New York. Any exhibits that we're going to show you will be presented

M. JEAN-BAPTISE

electronically.

Your testimony today has been taken pursuant to a subpoena that was issued by the attorney general's office pursuant to which I and Benjamin Smith, as special assistant attorneys general, are authorized to take proof and make a determination of the relevant facts in connection with an investigation that deals with the resident care provided by the Fulton Commons Care Center.

You were an employee with them, correct?

A. Pardon me?

Q. You were an employee at Fulton Commons Care Center, correct?

A. Yes.

Q. At this time I ask that the witness be shown what has been premarked as Exhibit 1.

Ms. Jean-Baptiste, do you see on your screen a copy of the subpoena that was issued and served on you directly?

A. Yes.

M. JEAN-BAPTISE

Q. If we can go down to the bottom of the second page.

A. I made a correction because they had my name as Baptise, but it is Jean-Baptise. Jean and Baptise are hyphenated.

Q. Yes, I apologize for that, thank you for correcting that.

That is your signature that appears?

A. That is my signature, yes.

Q. Great. So I am going to let you know also, because we have a stenographer who is taking down this testimony, it is important that we not speak over each other. It's really important that you allow me to finish asking my question before you begin to answer. I know that that might be hard sometimes. There are going to be times when you know exactly what I'm asking and it's a natural reaction and inclination to just want to go ahead and give the answer, but please just make sure that I'm -- try to hold back a second and just make sure I am

M. JEAN-BAPTISE

done asking my questions before you begin to answer.

A. All right. Sorry about that.

Q. No problem. The subpoena that we just showed you, that required you and compelled you to appear for a virtual interview today; is that correct?

A. Yes.

Q. And you understand that your virtual appearance here today is pursuant to that subpoena which compels you to appear and give testimony, correct?

A. Yes.

Q. Before we begin, I would like to take a moment to discuss some of your rights. Pursuant to the Fifth Amendment of the United States Constitution as well as the New York State Constitution, you have a right to refuse to answer questions if your truthful answer to that question will tend to incriminate you.

Do you understand that?

A. Yes.

Q. Please be aware however, that

M. JEAN-BAPTISE

should you choose to invoke your Fifth Amendment right, a negative inference can be drawn against you in any future noncriminal proceeding.

Do you understand that?

A. Yes.

Q. You took an oath a moment ago to tell the truth, the whole truth, and nothing but the truth. Should you intentionally make any false statements during this proceeding, and by that I mean a statement you do not believe to be true, then you may be prosecuted for perjury.

Do you understand that?

A. Yes.

Q. We also have on this call Elysia Doherty, who is a federal agent, and I will also advise you that lying to a federal agent is a crime.

Do you understand that?

A. I didn't hear that.

Q. Sure. We do also have on this call Elysia Doherty who introduced herself earlier. She is a federal agent, and the

law provides to you that lying to a federal agent is a crime.

Do you understand that?

A. Yes.

Q. I am going to ask you questions which are relevant to the Attorney General's Office of Investigation and to both the general resident care provided by Fulton Commons Care Center and more specifically, the resident care provided by the center during the coronavirus pandemic.

If I say "Fulton Commons" or "Fulton" from here on out, would you understand that I am referring to Fulton Commons Care Center?

A. Yes.

Q. Just some ground rules: As we already discussed, we do have a stenographer here today and she's recording this interview, and it's important that she hears everything that we say. As I indicated before, we cannot speak over one another because she won't be able to get us together at the same time.

M. JEAN-BAPTISE

It's also important that you give verbal responses to all of my questions. Nods of the head, shrugs of the shoulders, uh-huh, uh-uhs, those things just don't translate on the record. If you do any of those things I just ask that you also accompany it with a verbal response.

If you do not understand my question, please let me know and I will do my best to rephrase it for you. If you answer any question I can only assume that you understood it as I asked it.

If you need to take a break for any reason, that's fine. I just ask that if there's a pending question that you answer my question before leaving the camera frame.

I will also let you know, we will take a break every hour and a half or two hours just so everyone can stretch their legs. But if you need a break before we've started one, please let me know and we'll do our best to accommodate you.

Do you understand the instructions as I have given them?

A. Yes.

Q. Sometimes you may give an answer as completely as you can and then later remember additional information. If that happens to you, please tell me that you would like to add something to your earlier answer and we will do that right then while it's on your mind. Will you do that?

A. Yes.

Q. In addition, it might occur to you at some point that a previous answer you gave was not completely accurate. If that happens, will you tell me and we will make necessary corrections to your answer at that time?

A. Yes.

Q. This proceeding is confidential. You are not entitled to a copy of the transcript of the testimony or any exhibits that are being marked today.

Do you understand that?

A. Yes.

Q. As this is a confidential proceeding, there should be no recording

made during the taking of this testimony. So although Webex, the platform we are using, does offer recording capabilities, I give you my assurance that we are not recording this via Webex. The only way the testimony is being recorded by the attorney general's office is via the stenographer as we discussed before.

Do you also agree not to record this examination in any way?

A. Yes.

Q. Similarly, due to confidentiality we request that you do not discuss this matter, your testimony here today, or any documents you may view or later produce in connection with today's testimony with anyone. Unless we are on a break, there shall be no private communications with anyone. That includes phone calls, passing of notes, texting, e-mailing, or any other means of communications that may or may not be visible on the camera.

You had mentioned that right now there is no one else in the room. If there

does come a time where someone enters the room, please let us know and we will take a break until that person leaves the room, okay?

A. Yes.

Q. I will ask that if possible, if you can mute your phones or any other electronic devices to prevent any distractions during the following testimony.

Have you taken any drugs or alcohol within the past 24 hours that may have an impact on your ability to testify here today truthfully and to the best of your knowledge?

A. No.

Q. I am just going to ask you -- I don't know if you can adjust the camera a little bit, but right now I'm just seeing your forehead. Okay, that's better. Thank you.

Are you aware of any physical or mental disability or defect that may interfere with your ability to understand my questions or your ability to respond

truthfully and completely?

A. No.

Q. Did you discuss the fact that you were subpoenaed here today with anyone?

A. No.

Q. Did you have any discussions with your employer about the fact that you were subpoenaed?

A. No.

Q. Did you have any discussions with Cathie Doyle about the fact that you were subpoenaed?

A. I haven't spoken to her, no.

Q. Have you spoken to anyone in preparation for your appearance here today?

A. No.

Q. Did you review any documents to prepare for your testimony today?

A. No.

Q. Have you ever testified under oath before?

A. Yes.

Q. In what setting?

A. At a lawyer's office.

M. JEAN-BAPTISE

Q. When was that?

A. I don't remember exactly when it was, but that was sometime -- I want to say either 2018 or 2019. I am not quite sure, but I have before.

Q. Was that a deposition or some other proceeding?

A. A deposition.

Q. What was that in relation to?

A. That was -- that was in relation of a former work place. It was about another issue, another case.

Q. Okay. Was that the only time that you testified under oath before?

A. Yes.

Q. Just so I am clear, did that have to do with anything with respect to Fulton?

A. No.

Q. Unless I give you a specific date or a time period, all of the following questions will pertain to the time period of January 1, 2020 through June 1, 2020.

Do you understand?

A. Yes.

M. JEAN-BAPTISE

Q. What is your cellphone number?

A. [redacted].

Q. Who is your provider?

A. Verizon.

Q. Do you have a home phone as well?

A. Yes.

Q. What's the home phone number?

A. [redacted] -- I don't use it a lot so I have -- I don't remember the phone number. Let me try to remember it. [redacted].

Q. Thank you. Who is the provider for that?

A. It's through the cable, the cable that we get.

Q. Who is the cable company?

A. I am not sure. I want to say Optimum but I think my husband has changed it. I don't watch much television so I don't remember.

Q. Could you just give us a brief background on your education?

A. I went to school at Nassau Community College from like January of 1995 to May of 1998. I am currently going to

school at St. Joseph's College.

Q. What are you currently pursuing at St. Joseph's?

A. My bachelor's degree in nursing.

Q. What degree did you obtain from Nassau Community College, if any?

A. An associate degree.

Q. In what area?

A. Nursing.

Q. How long have you been attending St. Joseph?

A. Since last spring, 2020.

Q. Do you hold any licenses or certifications?

A. Pardon me?

Q. Do you hold any licenses or certifications?

A. Yes.

Q. What licenses do you hold?

A. I have a license as a registered nurse.

Q. When did you become licensed?

A. August 2000 -- sorry, August 1998.

M. JEAN-BAPTISE

Q. Have you maintained that license continuously since August 1998?

A. Yes.

Q. Was your license ever revoked or suspended for any reason?

A. No.

Q. To maintain that license, do you take any continuing education?

A. Yes. We get in-services and courses, yes.

Q. How often do you renew your RN license?

A. Every three years.

Q. Are there any courses that you are required to take in order to renew your license?

A. Mostly infection control courses, that's one of the requirements.

Q. Other than your RN license, do you hold any other licenses?

A. No.

Q. Do you hold any certifications?

A. No.

Q. Where are you currently employed?

M. JEAN-BAPTISE

A. At Gurwin Jewish.

Q. At Gurwin. And how long have you been working at Gurwin?

A. Almost five years.

Q. Just so the record is clear, is Gurwin Jewish also a rehabilitation center and a nursing home?

A. Yes.

Q. What is your title at Gurwin?

A. I work as a nursing supervisor.

Q. Has that always been your title?

A. Yes.

Q. Are you working there full time or part time?

A. I work full time.

Q. Have you always worked there full time?

A. Yes.

Q. Do you have a set schedule?

A. Yes.

Q. What is your current set schedule?

A. 11 to 7.

Q. Is that 11 p.m. to 7 a.m.?

A. Yes.

Q. Has that always been your schedule there?

A. Yes.

Q. Do you work five days a week?

A. Yes.

Q. Do you work the same five days or do they rotate?

A. Rotates sometimes.

Q. Have you always worked five days a week at Gurwin?

A. Yes.

Q. What are your duties and responsibilities as an RN supervisor at Gurwin?

A. We are responsible for coordinating the care and address any issues that pertain to the residents. That includes rounding, doing assessments at night, whatever comes during the shift that are the responsibilities.

Q. Typically how many units do you supervise during your shift?

A. On a regular basis, six units.

Q. How many units are there in total at Gurwin?

A. Twelve.

Q. So typically you are handling half of the units during your shift?

A. Half of the building, yes.

Q. We discussed before that you previously were employed by Fulton Commons; is that correct?

A. Yes.

Q. When did you start working at Fulton?

A. Initially I was working at Fulton as a per diem nurse supervisor every other weekend. That was in 2014 -- from 2014 until 2016, for two years. And then I started again there in April of 2017.

Q. At that time when you started in April of 2017, what was your title?

A. I worked as the assistant director there.

Q. Was that assistant director of nursing or assistant director of something else?

A. Assistant director of nursing.

Q. How long were you the assistant director of nursing?

A. For three years.

Q. Did that remain your title until you terminated your employment with Fulton?

A. Yes.

Q. Did you hold any other titles during that time?

A. Well, during that time I remember from I think it was last year we had an infection control nurse. I believe she left and then that was added to my work. I don't remember exactly at what point, but I know it was the end of last year. I want to say mid-2019. And I was doing both. I was responsible to do the infection control and also doing my job as the assistant director.

Q. Why did you leave your job at Fulton?

A. I didn't actually leave. I was let go.

Q. Why were you let go?

A. I am not too sure. I am not too

M. JEAN-BAPTISE

sure, to tell you the truth.

Q. Who advised you that they were letting you go?

A. The administrator.

Q. And who was the administrator?

A. Cathie Doyle.

Q. What did Ms. Doyle say to you when she was letting you go?

A. Let me try to capture everything. She came to me and she said she wasn't satisfied with my work and that -- something like that. And then I said, What happened? And she said that -- and there are other things, she didn't really specify. And I said, What happened? I said, I am doing all my work. What's going on? And she said okay, she doesn't want me there. And I said, Okay. I didn't really argue.

Q. Did she give you any examples of instances that made her dissatisfied with your work?

A. She just told me that she was not satisfied with my work and I -- because I was doing the infection control and I had --

M. JEAN-BAPTISE

I was sick during the pandemic from -- from end of March until April. April 9th I returned to work. So I had -- I was a little behind in my work but I kept up and I stayed late and did everything that I was supposed to do. And that was on June 18th, she was asking me for -- because when you do infection control, it's just that everything is always a little behind, because you have to wait for one month to finish before you proceed with -- to complete whatever happened over the course of a month. So it's ongoing but it's also you go back for the entire month.

Let's say if something happens in October now, you would have to wait for the end of the October to do everything for that month, to summarize everything that occurred during that period. It's not ongoing. It's ongoing but at the same time you have to wait to compare to figure out what happened, you know, the difference, the comparison.

So when she was asking me for June on June 18th, I said that I just

completed the month of May, I don't have the month of June ready. It's ongoing, but I have to wait for the month to complete in order to do an analysis.

And she didn't like that, and she said that lately she hasn't been satisfied with my work and then that she was going to let me go. So I said okay, Really? And then she said, Yes. I said, Okay.

Q. So that conversation took place on June 18th?

A. Yes, that was the last day I worked there.

Q. I would like to take a few minute to talk about your duties and responsibilities. And I understand that you had two different roles, so let's break it up.

Let's talk first about as the assistant director of nursing. First off, were you the only assistant director of nursing at Fulton during that time period?

A. Pardon me?

Q. Were you the only assistant

director of nursing at Fulton during this time period?

A. No, there were always two.

Q. Okay. And what were your duties and responsibilities as the assistant director of nursing?

A. I had one side and the other assistant had another side of the building. And I was responsible to conduct the operations on my side, which entails to coordinate the care and make sure that, you know, make rounds, make sure that everybody was -- I was like a supervisor on the unit to ensure that everything was done right. The operations included getting reports, give reports, ensure the residents were safe, everything in the units were kept up to par. You know, everything.

It was just like being a supervisor, and also we had to -- it entails a lot, because when you have to explain to somebody what you do, it seems like a lot. But when you explain what it is -- if somebody is not on the field

it's hard for them to understand or to conceptualize what you are saying, but it's like being another supervisor.

Q. What was your shift at Fulton?

A. At Fulton I worked from 10 to 6.

Q. That's 10 a.m. to 6 p.m.?

A. Yes.

Q. Did you work set days or did you have rotating days?

A. I worked Monday through Friday.

Q. You did mention that you had one side of the building as the ADNS. When I say, "ADNS," would you understand that to mean the assistant director of nursing services?

A. Yes.

Q. As one of the two ADNSs you indicated you had one part of the building -- or one side of the building, rather. What side did you have?

A. I had the east side of the building. It's east and west.

Q. Okay.

A. So I had the east side of the

building.

Q. How many floors are there at Fulton?

A. There are four floors but there are seven units.

Q. What are the names of the units?

A. We have 1 East, 2 East, 2 West, 3 East, 3 West, 4 East, and 4 West.

Q. Is it fair to say that as the ADNS you were responsible for 2 West, 3 West and 4 West?

A. No. I was responsible for 1 East --

Q. Oh, I apologize.

A. -- Two East, 3 East and 4 East.

Q. Thank you, my apologies.

You were responsible for the east side of the building?

A. Yes.

Q. Who was the other ADNS?

A. Lisa Peterson.

Q. And was Ms. Peterson responsible then for 2 West, 3 West and 4 West?

A. Yes.

M. JEAN-BAPTISE

Q. I will ask at this time that the witness be shown Exhibit 2. It's been premarked Exhibit 2 and it's a four-page document.

Do you see it on your screen, Ms. Jean-Baptiste?

A. Yes.

Q. Can we rotate it then? Thank you.

Looking at the first page of Exhibit 2, Ms. Jean-Baptiste, do you recognize this?

A. Yes.

Q. What is the first page of this exhibit?

A. I see the entrance of the building. One side is 1 East, that's the first floor, and the other side is the administrative part of the building.

Q. Does this appear to be a layout of the first floor of Fulton?

A. Yes.

Q. Do we also see what appear to be room numbers on this layout, on the right

side of it?

A. Yes.

Q. If we go to page 2 of this document, Ms. Jean-Baptiste, what do we see on page 2 of this document?

A. The second floor.

Q. Does this document depict the facility layout of 2 West and 2 East?

A. That's correct.

Q. Does this page also have room numbers listed?

A. Yes.

Q. If we can just go to page 3, Ms. Jean-Baptiste, what does page 3 appear to be?

I'm sorry, I didn't hear if you responded. Can you tell me what we see on page 3?

A. The third floor.

Q. What units does it show us on the third floor?

A. Three East and 3 West.

Q. And does it also depict the room numbers of both of those units?

M. JEAN-BAPTISE

A. Yes.

Q. Going to the final page of this document, that's page 4.

Ms. Jean-Baptiste, do you recognize what's depicted on page 4 of this document?

A. Fourth floor, 4 West and 4 East.

Q. Does the document depict the room numbers of 4 West and 4 East?

A. Yes.

Q. Do these appear to be accurate depictions of the facility layout for all four floors?

A. Yes.

Q. Okay, great. Thank you, we can take that down then.

Ms. Jean-Baptiste, I would like to talk now about your duties and responsibilities with respect to infection control.

First and foremost, can you tell us what was your title with respect to that?

A. Well, I was the ADNS, and then it

was an additional title that I was the infection control nurse.

Q. What were your duties and responsibilities as the infection control nurse?

A. To collect the data on the infections, how many people had UTI -- urinary tract infections which usually are called UTI -- or any upper respiratory infection, any sort of infection, any infection that requires antibiotics. Anybody who was being treated with an antibiotic, we had to track the antibiotic, the people with the medication they were given, and how they responded to the medication, and how long it took for them to be treated and if there is any follow-ups and so on and so forth.

Q. Were you the only infection control nurse or were there other people under that umbrella?

A. I was the infection control nurse but I was only supposed to track the people on the east side and Lisa Peterson was to

track the people on the other side. But during the pandemic, it was -- it became a little different.

Q. How did it change during the pandemic?

A. During the pandemic, we had to track people who -- and employees, everybody, who -- I don't know what to say, and vendors -- all the employees had to be tracked if anybody had symptoms or if they came back positive with COVID, then we had to track everybody, so it was a little different. We were not only tracking the residents, but we also had to track the employees.

Q. During the pandemic, were you still only responsible for tracking the east side of the building?

A. During the pandemic, like I said, I was sick for two weeks and when I came back, it was -- we were still tracking -- Lisa was still tracking on the east side of the building. But then she had other responsibilities, because while I was out

she had to be doing all of the employees. So as a result of that, I had -- she was tracking the residents on the west side, but at the end -- at the end, anyway -- from the beginning, at the end I would get whatever data that she had collected and then I would get all the other data and gather everything together and we will have one analysis for the entire building.

Q. I want to break this down a little bit more. I understand that you were out sick for a period of approximately two weeks, a week and a half or two weeks. Other than that period, were you still responsible only for tracking the east side of the building and Lisa was responsible for tracking the west side of the building?

A. Yes.

Q. Okay, except for that period of time when you were out, at which time Lisa tracked the whole building; is that correct?

A. Yes.

Excuse me, because my son is trying to get in the room.

M. JEAN-BAPTISE

Q. Sure.

A. Just give me one second.

Q. We can take a five minute break.

A. Okay.

(Whereupon, a lunch break was taken.)

Q. Ms. Jean-Baptiste, other than that Lisa Peterson, did anyone else assist you with infection control with tracking in the building?

A. No. Well, I have to say the nurse managers did unit tracking. That was from the time I took over, which I would say was June of 2019 up to January -- up to February. They did their own tracking, but during the pandemic some of them couldn't do their own tracking because they were overwhelmed.

Q. Were there particular documents used for the tracking?

A. The documentation includes the name of the residents, of course, with whatever infection they developed and the test done to determine the infection,

whether it's a chest x-ray or urine analysis and culture or any other specimens that were obtained, and the antibiotic that they received and the course of the antibiotic, the duration, and their response to the antibiotic.

Q. What is the name of the document that this information was recorded on?

A. We had a form, the McGeer's criteria, M-C-G-E-E-R's criteria.

Q. Could you define the McGeer criteria?

A. Well, the McGeer criteria is to determine -- it was -- it's done as a way to prevent the -- to control how long, how many days a resident is getting an antibiotic and see if the resident responds to this antibiotic, let's say for five days as opposed to being on an antibiotic for seven, 10, or 14 days, which is to prevent them from become resistant to antibiotic therapy. So that's the point of having the McGeer criteria.

But there is another form that

the unit managers would fill in, but I forgot the title name but I don't want to say the wrong name because I am under oath. It's an infection control form. I don't remember specifically the head -- the title. But I know they track UTI separately from upper respiratory infection, and we also have one for the skin, any kind of skin issues. We had three different forms to track the infections because they were each separate.

Q. Are you familiar with the term "line list"?

A. Yes.

Q. What is a line list?

A. The line listing we were doing during the pandemic was for residents who developed any kind of symptoms such as fevers or cough or anything like that. And we also had a different line list for employees during the pandemic because we had to report to -- I know specifically I had to report to Nassau County on a daily basis of whoever became positive or whoever had

fevers.

Q. The information that was maintained on the line listing, did that include the information that you just mentioned to us, the name, the infection, the tests done, whether they were on antibiotics and the course and duration?

A. The line listing for COVID was a little different. I don't have a copy right in front of me. It's totally different forms. I don't want to tell you specifically, but I know for COVID it was mostly for the employees that I reported to the Nassau County health department on a daily basis if we had anybody that became positive.

Q. Was the line listing also done for the residents?

A. There was, yes, a line listing for the residents.

Q. What information was documented on line listing for the residents?

A. Anybody with fever, with cough, with any symptoms.

M. JEAN-BAPTISE

Q. Are you familiar with the term "surveillance tracking form"?

A. Yes, this is the same thing as a line listing.

Q. Okay. So the form that you talked about earlier where you used the McGeer criteria, do you recall if that was referred to at Fulton as a line listing or if it was referred to as surveillance tracking form or something else all together?

A. It was more nosocomial infections, it was different. The McGeer criteria is more anything that happens during the resident's stay at the facility. It didn't even pertain to people who came from a hospital because they wouldn't have met the criteria because they came with the infection from -- it could be health care acquired infection as opposed to an infection that developed inhouse.

Q. Just to make sure that I understand, the McGeer criteria was utilized to identify infections that were obtained

within the facility; is that accurate?

A. Correct.

Q. The COVID line listing, was that done in connection with the McGeer criteria or was that completely separate?

A. It was done under the title of the McGeer criteria because of the level of inhouse for the resident.

Q. Do you recall when you first suspected that a resident developed COVID inhouse at Fulton?

A. No.

Q. Ms. Jean-Baptiste, I know we discussed that in order to renew your license you are required to take an infection control class. Other than that, have you taken any trainings or courses on infection control and the best practices?

A. Once, I know -- like I said, I started in July of 2019 -- in June of 2019, excuse me, as the infection control nurse. And in July of 2019, I went for a course and I registered with APIC, which is the infection control -- it's APIC, this is the

abbreviation. After that, I went in August for a class, and in September we were adjourned because it was the -- I don't know, for summer, they didn't have any course. And I remember going to another class for infection control that was for another seminar in either January or February. And then it was -- then came the pandemic.

Q. The course you attended in July of 2019, what was the duration of that course?

A. I want to say three hours.

Q. What was the duration of the course you took in August of 2019?

A. Maybe three hours again. I don't remember exactly, so please, I don't remember exactly.

Q. That's fine. An approximation is fine. So it seems like it was about a half-day course?

A. Yes, it wasn't a whole day.

Q. The seminar that you went to in either January or February of this year, how

long was that course?

A. It was a whole day.

Q. That was just one day?

A. That was only one day.

Q. These seminars, were they in person or virtual?

A. In person.

Q. Where were they held?

A. I had the -- the seminar that was in Amityville, that was at this -- I don't remember the name of the -- the -- it was a hospital there but I don't remember the name.

Q. It's fair to say that these were local?

A. Yes.

Q. Were all of these seminars and courses sponsored by APIC?

A. No, the facility. I don't know if -- Cathie Doyle always made the arrangements for me to go to those courses.

Q. Do you know what organization had arranged those courses?

A. I want to say the one that I

went -- the first one that I went to was sponsored by APIC and then the second one I don't know, I don't remember. I have the papers but I don't remember exactly who sponsored it, but I think it was a New York State seminar.

Q. APIC, do you know if that stands for the Association For Professionals in Infection Control?

A. Yes.

Q. Who was responsible for ensuring that Fulton's policies and procedures on infection control were meeting industry standards?

A. Can you repeat the question?

Q. Sure. Who at Fulton was responsible for ensuring that the facility policies and procedures with respect to infection control were meeting industry standards?

A. Well, everybody is responsible to ensure that infection control regulations are followed in the facility, every RN. As an RN, everybody -- all RN is responsible

for that.

Q. But who was responsible for making sure that the policies and procedures were up to date?

A. Up to date?

Q. Yes.

A. I would say the director of nursing.

Q. Did anyone else attend these infection control seminars from Fulton or were you the only one?

A. I was the only one.

Q. As far as you're aware, Lisa Peterson did not attend any infection control trainings?

A. I don't want to say that. I don't know.

Q. Did you ever see her at any of the infection control trainings that you went to?

A. No.

Q. Did you play any role in reviewing the policies and procedures at Fulton with respect to infection control to

ensure the facility was implementing best practices?

A. No, I was not in charge of reviewing policy. The director of nursing and the administrator were the ones reviewing policies. I was not ever told to review policies or update policies.

Q. Are you aware of whether the administrator ever attended any of the infection control courses or seminars?

A. I don't know, because sometimes people attend classes online. I don't know.

Q. Did they ever attend any of the seminars that you attended?

A. No.

Q. The director of nursing at Fulton, who was that?

A. Carol Frawley.

Q. Did Carol Frawley ever attend any of the courses or seminars that you attended with respect to infection control?

A. No.

Q. Did you ever go back to Carol Frawley or Cathie Doyle after attending

these seminars to let them know what information you learned?

A. Yes, I always share whatever I learned.

Q. Do you know if any of the information that you shared was ever incorporated into the policies and procedures with respect to infection control?

A. Yes, I am sure.

Q. Did you ever see that they were incorporated?

A. I know that Carol Frawley had updated a policy on infection control.

Q. When was that updated?

A. I don't remember the date specifically, but I know it was this year.

Q. Was that before or after the pandemic had hit?

A. I think it was at the beginning of the year, I want to say. I'm not sure of the date.

Q. Okay. But you believe it was around the beginning of the year?

A. Yes.

Q. Did Ms. Frawley ever show that policy to you and ask you to review it to make sure that it was in line with the best practices that you learned at the seminars you attended?

A. Yes.

Q. And did you review that policy?

A. I saw it and it was up to standards, yes.

Q. I think it will be helpful if we just talk very quickly about some abbreviations that I'll probably end up using for the rest of the day. First and foremost, are you familiar with the Centers for Medicare & Medicare Services?

A. Yes, I would say yes, somewhat.

Q. If I say "CMS" from here on out, will you understand that I am referring to the Centers for Medicare & Medicaid Services?

A. Yes.

Q. Are you familiar with the New York State Department of Health?

A. Yes.

Q. If I say "DOH" from here on out, will you understand that I'm referring to the New York State Department of Health?

A. Yes.

Q. Okay. And we have been talking about it so I know that you are, of course, familiar with the coronavirus or COVID-19. If I use the term "COVID" or "coronavirus," would you understand that I am referring to COVID-19?

A. Yes.

Q. Are you familiar with the term, "personal protective equipment"?

A. Yes.

Q. If I say, "PPE," will you understand that I'm referring to personal protective equipment?

A. Yes.

Q. Okay. Are you familiar with the term, "transmission-based precautions"?

A. Yes.

Q. What are transmission-based precautions?

M. JEAN-BAPTISE

A. Well, it's a known infection already that we know of, and this is to protect the spreading and to make sure that everybody wears the appropriate equipment.

Q. Are there different types of transmission-based precautions?

A. Different types of transmission -- yes.

Q. Are contact precautions a type of transmission-based precaution?

A. Yes.

Q. What are contact precautions?

A. Contact precautions is anything that -- everybody has to be aware that we can -- everybody is considered infectious. This is our contact precaution.

Q. What sort of PPE is necessary if a facility has to implement contact precautions?

A. Contact precautions, people have to wear gloves, gowns.

Q. Did they have to wear masks?

A. For contact, not necessarily.

Q. Is there any other PPE that must

be utilized for contact precautions other than gloves and gowns?

A. The glove, gowns. People can wear a mask for contact precautions.

Q. So they can wear a mask but it's not required; is that correct?

A. If the people are on contact precaution and need to deal with droplet precautions, people have to wear a mask and all their gear including a hat to prevent droplets from getting to their hair and stuff like that.

Q. So I will get to droplet precautions in a moment. Generally for contact precautions, it would be gloves and gowns; is that correct?

A. Yes.

Q. Droplet precautions, what would that entail?

A. Droplet precautions include glove, gown, mask or goggles, hair net.

Q. Are there any other -- sorry, go ahead.

A. I said mask, goggles, or face

mask.

Q. Are there any particular types of mask that should be utilized?

A. Yes, N95.

Q. Should the N95 need to be fit tested?

A. Some places they do fit testing, some places they don't do fit test.

Q. Just so the record is clear, what is fit testing?

A. To ensure that the person wearing the mask is able to tolerate that kind of mask for the period of time that this person is going to wear that mask and to ensure that they have the right -- they have the right mask.

Q. If an N95 is not fit tested, is it possible then that it's either too big or too small for the person who is wearing it?

A. That's possible.

Q. If an N95 is either too big or too small for the person wearing it, is it as effective if it was fit tested and fit correctly?

A. It would not be the same.

Q. Did Fulton fit test any of its N95 masks during the coronavirus pandemic?

A. No.

Q. Did you ever suggest to anyone that the mask should be fit tested during the pandemic?

A. I suggested many things but I was not really listened to.

Q. What were the many things that you suggested and who did you suggest them to?

A. To my boss.

Q. Which boss?

A. The thing is that because I had -- I was doing the infection control, I would go sometimes to Cathie Doyle and I would tell her that -- you know, I would make some suggestions to her and she -- sometimes she would listen, sometimes she would not.

Q. What were the suggestion you made to Cathie Doyle that she did not accept?

A. Like during the pandemic, I said

that maybe some residents should be tested for COVID and I was told that they didn't have to be tested.

Q. When did you make that suggestion to Cathie Doyle?

A. That was when I came back from -- I would say April, when I came back after being sick.

Q. Did Cathie Doyle ever explain to you why the resident did not need to be tested?

A. She did not really -- I was told that it was not -- it wasn't necessary.

Q. Did that make sense to you?

A. No.

Q. Can you explain why that didn't make any sense to you?

A. It didn't make sense to me because we needed to know at least to have a baseline of what was happening and we never got a baseline and I didn't feel that was the appropriate way to deal with it. But I had no power to do anything because I was told that the medical director had to make

the decision and I was not the medical director so I had no say in the matter at that point.

Q. Could you explain why a baseline would be important from an infection control standpoint during a pandemic?

A. Yes, that would have permitted us to know if anyone was infected at that point and we could have prevented it from spreading throughout the facility. And like that we would have known that maybe these people were not sick at that time but became sick after as opposed to we don't know what happened to them.

Q. What other suggestions did you make to Cathie Doyle that she did not implement?

A. I don't remember anything else that -- I don't know. Maybe things will come back to me but I don't remember things from the top of my head now. But I know at the beginning of the pandemic we did everything that we were supposed to do by putting the signage throughout the building

to make sure that everybody was aware and everybody was doing the right thing to -- handwashing, to make sure.

I think it was a good start, but I don't know at what point that everything just started to deteriorate in terms of the virus spreading. It was a pandemic but I don't understand, you know, what truly happened at that point. Because I remember, from the beginning of March there were in-service training being done throughout the facility to prevent the spread of the virus. We had all the signs in place, all the -- every measure was taken to prevent the spread. But you have people coming in and out, and we had to stop visitation very early to prevent the family members from coming sick to infect the residents. So it was a good start, I must say, but I don't know at what point that things happened.

But I know when I came back from being sick, I notice a little change in the -- I don't know, in the setting. Everything was a little different and I

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didn't know what was going on.

Q. In what way was it different when you returned?

A. I don't know. I didn't feel as if I was part of the team anymore for some reason. I don't know why, it was just a different atmosphere.

MS. SEKHON: Let's take five minutes. Everyone can stretch. It's 11:39 now, let's resume at 11:45.

(Whereupon, a short recess was taken.)

MS. SEKHON: We'll go back on the record. We did take about a 15-minute break. It's 11:54 now and we did a quick roll call off the record to make sure that everyone is still here. Everyone is still present at this time.

Q. Ms. Jean-Baptiste, right before we broke off you had said that when you came back at the beginning of April that you felt like you weren't a part of the team anymore. Was there something in particular that happened that made you feel that way?

M. JEAN-BAPTISE

A. It wasn't really from -- I don't know. It wasn't really from me, it was more them. I don't know what -- how to explain it because -- it's hard to tell people because it's very subjective, it's just something that I cannot really explain it but it was -- there was a difference in the dynamic. I don't know what it was specifically, but I -- I don't know.

Q. Were you treated differently by anyone?

A. Like I said, I felt that there was a pressure put on me that -- about the -- my understanding was that everybody was stressed because of the pandemic, you know, and rightfully so. Everybody was in the midst of this thing going on. Everybody was stressed so I didn't really attribute it to anything except for that fact.

Q. But I don't think that just everyone being stressed would make someone feel like they are no longer part of the team, so I am just trying to get to what it was that made you felt that way. Did you

feel like you were excluded from certain discussions or --

A. Yes.

Q. Okay. What discussions did you feel like you were excluded from?

A. Mostly the infection control discussions I was being excluded from. I didn't know what was going on. I felt as if I was not part of the team, like I said. Because of that, it seemed as if something going on and I was not let in on it, I don't know. This is the way I felt. I cannot -- I cannot tell you what it was because I wasn't part of what was discussed, but I felt that way.

Q. Do you know who was involved in those discussions relating to infection control?

A. Yes, many times.

Q. Well, who were the individuals who were involved in the infection control discussions, if not you?

A. It was Cathie Doyle and Carol Frawley. And I don't know who else, but I

know those two.

Q. So despite the fact that they sent you to all these seminars and signed you up for all these courses so that you would be the expert in infection control, they did not include you in any of their discussions after you came back to work in the beginning of April?

A. Right, it was that I had no say in any kind of matter, it was just -- except that things that were really -- that I was already doing. Let's say, call the Nassau County Department of Health and the stuff -- about the precautions and the handwashing, make sure the procedures were maintained and followed. But after that, I didn't know anything else that was really going on. I felt that I was not part of what was -- of any discussion.

Q. You mentioned that when you came back at the beginning of April that you had suggested that the residents should be tested for COVID. Was there anything in particular that made you think that that was

important?

A. It was important because other facilities were doing so, so we just go according to comparisons from what other facilities were doing. So that's what -- you know, the question, why wasn't anyone being tested, you know.

Q. Was there anything in particular going on at Fulton that was concerning to you that you thought would require or necessitate testing?

A. Because a lot of people had died.

Q. Were any of the deaths attributed to COVID at that time?

A. I don't know, because they weren't tested.

Q. Were any of those deaths of residents who were suspected of having COVID?

A. I would say that they had -- they were symptomatic.

Q. To your knowledge, when you had the discussion with Cathie Doyle, when you suggested that the facility should test, at

that point, had Fulton made any efforts to obtain test kits?

A. No.

Q. Do you know for a fact that they did not make any efforts at that time?

A. Well, nobody was being tested.

Q. Other than Cathie Doyle, did you ever make the suggestion to anyone else that the residents should be tested?

A. I told Carol Frawley.

Q. And what was her response?

A. She told me that the medical director didn't think it was a good idea. They're doing all the -- they have everything in place for the people who are symptomatic.

Q. Did Ms. Frawley explain to you why the medical director didn't think it was a good idea?

A. He didn't specifically tell me why he thought so it was a good idea but I -- whenever I mentioned that, I see that it was a hot issue and to stay away from that conversation.

M. JEAN-BAPTISE

Q. Why do you believe that Fulton didn't test any of the residents?

A. Because they weren't tested.

Q. But why --

A. They were tested after the whole thing, but not during -- at the height of the pandemic.

Q. Why do you believe that the administration chose not to test the residents early on?

A. I don't know.

Q. Can you think of any reason why, from a resident-care standpoint the administration would have made that decision?

A. I cannot make any assumption as to why they didn't do it because they didn't. That I know for a fact, that they didn't. But I cannot say I know -- then I will assuming as to why because nobody has ever expressed that to me, why they did not do it.

Q. I understand that. I am not asking you to assume why they didn't. I am

just asking why you think they didn't?

A. That I don't know.

Q. Would there have been any downside to testing the residents early on in the pandemic?

A. Can you please repeat that?

Q. Sure. Could there have been any downside to testing the residents at that point in the pandemic?

A. I don't think it would have been a downside. I am thinking it would have been a good thing had they tested them. It would have made the facility stronger in terms of knowing where they stand and how to approach the whole situation.

Q. You did mention that you were out sick for a period of time from the end of March to beginning of April. Were you pressured at all to come back to work earlier than you were ready to?

A. I would not say that I was pressured but I know that when I went to work on that date, I believe it was the 25th of March, and when they checked my

temperature, I had a temperature and I was very shocked because I usually don't get sick. And I said, What happened? So my temperature was elevated so I said then, I have to leave. I told my boss, Ms. Frawley, I have to leave the facility because I am not even supposed to be here because I have a temperature. So I went home. On my way home I called my doctor and I told him that I had a temperature and I had some pain. And he said, Well, then I am going to say that you are going to be quarantined for seven days. He said after seven days call me and I can tell you how to proceed from how you feel. And I stayed home, but I ended up staying home for two weeks because I had a fever that lasted almost a week. Then I call my doctor and he told me that, Okay, after you don't have a fever for 72 hours, if you are fever-free for 72 hour, then you can go back to work and I will send a note to your workplace.

Q. On March 25th, when you told Carol Frawley that you have to go home, what

was her reaction in response?

A. I didn't really see her. I saw another nurse, one of the nurses, and I told her that I have to go home because I don't feel -- I can't stay because I know I felt some back pain last night but I didn't know that -- I didn't have a fever. But this morning when they check my temperature I have a temperature, so I have to go home. And she said, Do you want me to call Mrs. Frawley, because she was in a different office. I said, Tell her that I have to leave, I'll call her, because I am not supposed to stay in the facility because I have a fever. I left. And when I got home she called me and she asked, Where are you? And I said, I went home because I have a fever. And after that she called me a few times to see how I was doing. But sometimes I didn't even know that somebody was calling me because I didn't have access to my phone.

Q. Did she express any frustration or anger at you at the fact that you had to stay home?

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A. I don't know if people -- sometimes when you are sick, some people at work think that you are not really sick and you just want to stay home, but nobody wants to stay home if you feel well.

Q. Did Ms. Frawley express to you that she felt you did not need to be home?

A. No, she never said.

Q. The day that you went in to Fulton, so on March 25 when you went there and you had a temperature, were you able to still enter the building?

A. I didn't enter the building, I sit in the lobby. I never entered the building.

Q. Do you know if there were other staff who were also out sick over the course of the pandemic?

A. A lot of people.

Q. Do you know if any of those staff were pressured to come back earlier than they should have?

A. I am not sure. I am sure that some people that were called just to follow

up how they were doing and just -- but I don't know if they were pressured to come back. I don't believe anyone was -- I don't know. But I don't know that from my end. I never called anybody to pressure them to come back or -- I would just ask them if they went and they got tested because sometimes we need to know if they are out for a number of days, so they have to follow up with their testing, because at that time we had to be tested twice a week. We just wanted to ensure that everybody after the test -- or if they are about to come back after the two-week quarentine if they had gone to see their doctors or if they had gone for testing just to make sure when they come back they had a negative test result before they come back.

Q. Did any of the other employees at Fulton ever complain to you that they were pressured to come back to work sooner than they should have after being sick?

A. As I said before, when I come back, Lisa was the one mostly dealing with

the employees. I was not dealing with them given that the infection -- you know, we had such a high prevalence of infection for months, so it was a little overwhelming, so she was dealing mostly with the employees.

Q. While you were out sick, did you have any contact by phone, e-mail or any other means with Cathie Doyle?

A. No, never.

Q. All right, I'm just going to backtrack for a minute. We talked a little bit about N95 mask and being test fitted. Just so I am clear, did you ever suggest to Cathie Doyle or Carol Frawley or anyone at Fulton that the N95 mask worn by the staff should be fit tested?

A. I may have mentioned it to them, but it was not something that was taken into consideration.

Q. Who do you think that you may have mentioned that to?

A. To Cathie, because she was the one ordering masks before I became sick. I was ordering masks, I was telling her that

we're going to need a lot of masks, we're going to need PPE for the staff and because it was spreading, the virus was spreading through out New York State and New York City so I told her that we have to implement some measures to ensure that everybody gets the appropriate gear.

Q. So you believe you had recommended fit testing to Ms. Doyle before you were out sick?

A. I know that I mentioned that we are going to need the N95 and I did mention fit testing because, obviously, and I mentioned that to Mrs. Frawley and she said that she was going to call the respiratory therapist to come and do the fit testing on the staff.

Q. When did you have that conversation with Ms. Frawley?

A. Now, I want to say that when I came back.

Q. Okay. So that's probably in April?

A. In April.

M. JEAN-BAPTISE

Q. Were the masks ever fit tested, to your knowledge?

A. No.

Q. Going back now, we talked about contact precautions and droplet precautions. Are you familiar with the term, "airborne precautions"?

A. Yes.

Q. What are airborne precautions?

A. Airborne precautions, like during the COVID, it's an airborne precaution because at one point we had to stop everybody who were on any kind of nebulizer treatment so it would not -- so the virus would not spread through out the facility.

Q. Other than stopping nebulizer treatments and other aerosol treatments, are there any other airborne precautions that should be taken when necessary?

A. Yes, close the doors and the staff wear the appropriate gears that were provided to them.

Q. What are appropriate gears for airborne precautions?

M. JEAN-BAPTISE

A. They wear their mask, they wear their hair net, of course gloves always there, and some of them even had to wear something over their shoes to protect them from -- they wear those jump suits.

Q. Is there a negative pressure room necessary for airborne precaution?

A. Well, in the case of TB, it is. But we don't have a negative air pressure room at Fulton. So if anybody was tested for TB they would have to be sent to a hospital wearing a mask. Of course their mask, I forgot to mention that, the N95. They wore their N95. And some of them had to wear another mask over the N95, that other mask -- so they are to remove it because the N95 is a mask that they had to wear for a couple of days, so they didn't have an N95 to be with every resident so they were told to wear another regular mask over the N95 and they had to remove that mask every time they come in contact with a resident.

Q. Was that a surgical mask?

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A. Not a surgical mask, just a regular yellow -- yes, that other little blue mask they wore over the N95 just to prevent them from carrying whatever germs they come in contact with to go around to other residents. And they still had to maintain handwashing between the resident care because it's part of the universal precautions as well.

Q. Are you familiar with the term, "terminal cleaning"?

A. Yes.

Q. What is terminal cleaning?

A. Terminal cleaning is after a resident come out of isolation, came out of a room or is discharged, they have to get the housekeeping to come and clean the room entirely and disinfect the room.

Q. Should that be done to every room that is vacated by a resident?

A. Yes, any resident that leaves a room has to be terminally cleaned. Whenever a patient is discharged, a resident, that room has to be terminally cleaned and

disinfected.

Q. What if there is an inhouse transfer, does that room need to be terminally cleaned?

A. Yes, all the time. Whenever there is one person leaves a room, a bed, it has to be terminally cleaned. This is a standard.

Q. Why is terminal cleaning necessary from an infection control standpoint?

A. To prevent the spread of infection within the facility.

Q. If a room is not terminally cleaned after a resident vacates and a new resident is placed into that room, what can happen?

A. The other resident can get contaminated. It's not even -- contamination is one thing, infection is one thing. But from another aspect, from a dignity standpoint, it's not the appropriate thing to do. The room has to be terminally cleaned at all time.

M. JEAN-BAPTISE

Q. If a room is not terminally cleaned and a new resident is moved in, does that put the resident's safety at risk?

A. Definitely.

Q. And would that be endangering that resident?

A. Correct.

Q. You mentioned earlier the medical director. Who was the medical director at Fulton through the pandemic?

A. Dr. Olaf Butchma.

Q. Did you ever have any conversation with Dr. Butchma regarding the suggestions you were making for testing the residents for COVID and for fit testing the staff with the mask or anything else?

A. No, I never had any conversation with Dr. Butchma personally.

Q. Who was the owner of Fulton?

A. Pardon?

Q. Sure. Who owned Fulton?

A. I don't know.

Q. Have you ever had any conversation with anyone you understood as

an owner of Fulton?

A. No.

Q. Do you recognize the name Steven Weiss?

A. I heard, yes. I heard of that name.

Q. Do you know who Steve Weiss is?

A. I know that he is a CEO or something. I don't know him in other capacity.

Q. Have you ever had any interactions or conversations with Steve Weiss?

A. No.

Q. Did you ever communicate with Steve Weiss electronically or in any other way?

A. No.

Q. All right. So what I would like to do is kind of go over the steps that Fulton took to prepare for the pandemic and I am going to go through it month by month and some things might be difficult -- I mean I know in retrospect it might be hard to say

when certain things were implemented or when certain policies were put into place -- but to the best of your recollection and knowledge, just let me know when certain things occurred.

I want to start first with January 2020, so the first month of the year. Did Fulton take any steps at that time to prepare for the possibility of a COVID-19 outbreak?

A. Yes, I would say that -- they were -- there were meetings held that spoke of the virus and staff were told and they were educated to precaution.

Q. Who was present for the meetings that were held?

A. Usually the nurse managers are present for the meeting, because we used to have morning meeting twice a week and sometimes we would have some ad hoc meetings just to talk about the pandemic.

I would say the nurse managers, the dietician, the head of dietary, housekeeping, recreation, everybody. The

whole multidisciplinary team would attend those meetings.

Q. Was the administrator present at those meetings?

A. Who?

Q. Cathie Doyle, the administrator, was she present at those meetings?

A. Yes, always, always.

Q. Was Carol Frawley present at those meetings?

A. Yes, yes.

Q. You also mentioned that the staff were educated on precautions they should take. Who provided that education?

A. Everybody. Carol Frawley would do it, I would do it, some of the in-services. Yes, it was mostly the two of us.

Q. Yourself and Carol Frawley?

A. Yes, and the nurse managers because sometimes -- and the supervisors on the off shifts, the 3 to 11 and 11 to 7, they would do the in-service for their staff.

M. JEAN-BAPTISE

Q. Were there any attempts to obtain PPE needs in January 2020?

A. No, I don't remember that.

Q. I believe that you said at the beginning of the year there were some updates to the infection control policy; is that correct?

A. Yes. I don't know exactly at what time, sorry.

Q. Okay.

A. But, there was an update in the policy, I don't know what month, specifically. I don't remember.

Q. In January, did you have any other involvement in preparing for the pandemic?

A. No, we were mostly in-servicing the staff and tell them about the precautions that is needed and at that point we didn't have anything implemented in terms of the families were still visiting, we had no -- we were not really -- we were doing in-services, we were -- everybody was aware of what was happening, but there was no plan

in place at that point, in January.

Q. What precautions were the staff instructed on in January?

A. They were told about handwashing, which is always the first thing to do, and just to make sure that they wash their hands from Resident A to residents, and you know, this kind of infection protocol that is always in place at every facility.

Q. Other than those morning meetings, did you have any other discussion with Carol Frawley regarding preparing for the pandemic in January?

A. No.

Q. Other than those morning meetings, did you have any other discussions with Cathie Doyle regarding preparing for the pandemic?

A. I know in January Cathie Doyle had given -- I want to say late January or early February, but I am not too sure now because I don't have the data in front of me. Forgive me if I am a little off with the days, the times of the month and stuff

like that because I don't have the data. I cannot recollect everything that took place. But I know that at one point that she had an in-service about responsibility in terms of response to the pandemic.

Q. Who attended that in service?

A. Everybody, the head of dietary, the head of housekeeping, nursing, social services, everybody.

Q. What was talked during that in-service?

A. She was talking about ways to prevent the spread of the infection, how to respond to the pandemic, just in case -- you know, certain measures. It was every discipline had their responsibilities as to how to respond in the case of the pandemic, that was before March. But I don't remember specifically the date of that in-service, but there was an in-service to that effect.

Q. The morning meetings that you talked about earlier where the interdisciplinary teams would be present, what was discussed during those morning

meetings with respect to preparing for the COVID pandemic?

A. Everybody was told that all the -- nurses were told to ensure that the staff, the CNAs and the nurses are doing the right -- utilizing the right infection measures to prevent the residents from getting infected through handwashing and to ensure that they wipe everyplace. Housekeeping was involved, everybody was doing what they had to do.

Q. In February of this year, did Fulton take any steps to prepare for the possibility of a COVID-19 outbreak?

A. I can't say in February. In February I don't remember. I remember from March on, that's when we started to put those signs, to stop with visitation. Nobody was even wearing masks at the time, you know. I think people started to wear mask maybe mid-March to -- I don't remember that before, before that.

Q. Do you know if there were any attempts made in February to obtain PPE?

M. JEAN-BAPTISE

A. I don't know if -- there was an attempt made by Cathie Doyle in February but it was very -- it was such a long wait. I don't know if anything was -- if she was able to get anything at that time because everything was such a long wait. To order anything at that time it seems you weren't going to get until April or something like that. It was a six-week time period to wait, to open anything at that point. So I don't remember if it was early March or if it was in February. I don't -- I cannot tell you exactly what month it was, but I know there was an attempt, from my knowledge.

Q. Do you know if at that time the order was still placed or if Cathie Doyle attempted to obtain PPE from some other way?

A. I want to say that she had ordered some PPE. I don't know specifically what they were.

Q. Are you familiar with CMS guidance that was issued on February 6, 2020 with respect to preparing for a potential

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COVID-19 outbreak?

A. Yes.

Q. I am going to ask if you could show the witness Exhibit 3.

Ms. Jean-Baptiste, you are being shown Exhibit 3. This is a three-page document.

Is this the February 6th guidance that was issued from CMS?

A. Yes.

Q. And you have seen this before, correct?

A. I don't know if I saw that one, it's for, it was -- or if there is one after it. I don't remember if I saw that one specifically. I may have seen that one. I know I saw a CMS guideline but I don't remember the date. I don't know if there was another one following it.

Q. Okay. We will go through all of them.

This particular one on February 6th, you are not sure if you actually saw this one; is that fair to say?

M. JEAN-BAPTISE

A. Yes, that's fair to say.

Q. Okay. We're going to take a look at this anyway, and so I'm going to direct your attention to the memorandum summary. So on your screen it's the little gray box. And the second bullet point on there reads, Health Care Facility Expectations.

"CMS strongly urges the review of CDC's guidance and encourages facilities to review their own infection prevention and control policies and practices to prevent the spread of infection."

Did Fulton do that?

A. Yes.

Q. Other than the policy and procedure that you mentioned earlier with Ms. Frawley that was updated -- you said either in January or February of this year -- were there any other policies and procedures that were updated in accordance with this guidance?

A. Yes, I am sure there were.

Q. Would those policies and procedures indicate that they were reviewed

or revised at that time?

A. Yes.

Q. How would they indicate that?

A. How?

Q. Yes.

A. It would show that the policy was revised or updated.

Q. Would the date appear somewhere on the policy say to indicate that?

A. I am sure.

Q. I am going to direct your attention at this time to the third page of this exhibit. We see that on this page there were a number of links that appear, so one of them is toward the middle of your screen right now. It says, "CMS nursing home infection prevention training."

Did you ever utilize that training?

A. Yes.

Q. When did you utilize it?

A. I utilized it several times via Webex, yes.

Q. What did you learn when you

utilized it?

A. We learned about the -- what was happening. It was a weekly -- every Thursday they had a seminar to update all the attendees about what was going on about the pandemic.

Q. I just want to confirm, that seminar, that was hosted by CMS as opposed to DOH?

A. No, it was the DOH that we attended every week.

Q. Okay. But looking at this page though we see it's CMS, a Nursing Home Infection Prevention Training.

Do you recall utilizing this particular training?

A. Not the CMS training. The DOH seminars I attended.

Q. Looking at the next item, so the next link, Nursing Home Infection Control Worksheet.

Did you ever utilize that worksheet in February 2020?

A. Where is that located?

M. JEAN-BAPTISE

Q. It's right under the link we were looking at before.

A. If I use that worksheet?

Q. Yes.

A. No.

Q. Why not?

A. Because we used the other worksheet that we had. We had a nosocomial surveillance sheet that we used. I was never told to use that sheet.

Q. Were you aware that this worksheet existed?

A. If I was aware? No.

Q. To your knowledge, did anyone at Fulton ever utilize that Nursing Home Infection Control Worksheet?

A. I don't see that sheet. I don't know if you could open the link so I could see it because I'm only thinking -- I don't even know what it looks like.

Q. Okay. Let's do that.

So let's take a look at Exhibit 4. This has been premarked and it's an 18-page document that's going to be shown

to you.

Ms. Jean-Baptiste, do you see on your screen now the first page of Exhibit 4?

A. Yes, Attachment 1.

Q. At the top it says, Centers For Medicare & Medicaid Services, Long-Term Care LTC, Infection Control Worksheet. Then it says, LTC Facility Self-Assessment Tool.

Have you ever seen this document before?

A. Yes.

Q. When did you first see this document?

A. I would say in February. I believe that's when we -- when this e-mail came, that's when it was distributed. I think that's when Cathie Doyle had the in-service with all the staff about the pandemic, about the outbreak at the time.

Q. To your knowledge, was this worksheet utilized by Fulton in preparing for the pandemic?

A. Yes.

Q. Did you personally utilize this

worksheet in preparing for the pandemic?

A. Well, we didn't -- I didn't really go according to the worksheet, but this is everything that they have as an infection control practice. That's what the facility has been doing, because I know.

Q. I am going to direct your attention to the third page of this document. Towards the top of the page we have Section D-2, and it reads, "The facility has a system in place for early detection and management for potentially infectious symptomatic residents at the time of admission including implementation of precautions as appropriate."

Did Fulton have such a system in place in February 2020?

A. Yes.

Q. What was that system?

A. Pardon?

Q. What was that system in February 2020?

A. When did they have an infection -- they always had a policy and upon

admission everybody was -- everybody was -- they did everything that was to assess if anybody had any kind of infection and this was what we were doing essentially, if anybody came on antibiotic therapy and we would know what the reason why the person was being treated on antibiotic and what was the nature of their infection.

Q. Is that going back to the tracking form that we talked about earlier?

A. Yes.

Q. Did Fulton's system for early detection and management of infectious symptomatic residents change in any way during the course of the pandemic?

A. Can you please repeat that?

Q. Sure. So the system that Fulton had in place for the early detection and management of potentially infectious symptomatic residents at the time of admission, did that system change in any way over the course of the pandemic?

A. Over the course of the pandemic, there were -- there was not -- there were no

admissions taking place. But at one point during the, maybe I would say late April or May, I am not sure at what point when they started to take new residents, they had to be -- they had to have two negative swabs before they were admitted. And when they came, they had to be quarantined for a number of seven days after they were negative -- after they had two negative swabs. And they were kept on a separate unit at that point.

Can I say something?

Q. Yes, absolutely.

A. Earlier on I said that we had an in-service coordinator who also was doing in-service, but she was pregnant and then she had to be on leave I think by the end of, I don't know, either March or April. I think it was the end of March. She had to be on leave because she had -- I think she was ready to have the baby. So I didn't see her, she didn't come back since I left. I don't know if she returned. But she was an in-service coordinator as well.

M. JEAN-BAPTISE

Q. What was her name?

A. Her name was Rose.

Q. Do you remember her last name?

A. Her last name, let me spell it for you: E-L-I-Z-I-E-R.

Q. Thank you.

And when she went out on leave, did anyone take over for her temporarily?

A. I am not too sure.

Q. Going back to Exhibit 4, I am just going to direct your attention now to Section D-3. And that reads, "The facility has a system in place as an example, notification of infection prevention (IP) by clinical laboratory for early detection and management for potentially infectious symptomatic residents including implementation of precautions as appropriate."

Did Fulton have a system in place for that?

A. Yes.

Q. What was Fulton's system for that?

A. To detect infection?

Q. Yes.

A. If anybody exhibits any kind of symptoms accompanied with fever, we have two indicators or three indicators. With a fever, only the doctor will be called. And from that point on they will be -- there will be x-rays and labs ordered to see what's really going on with the resident. And based on the results, the doctor will follow up with antibiotics or cough suppressants and, of course, Tylenol for fevers. And when the lab result or the x-ray result would come they would order an antibody that's sensitive to the organism.

Q. Is that the system Fulton had in place throughout the entirety of the pandemic?

A. Yes.

Q. Let me direct your attention now to page 6. Under Section H we have Transmission-Based Precautions. And looking specifically at Section H-2, under the note it indicates, "Resident placement, as an

example, single/private room or cohorted, is made on an individual case basis based on presence of risk factors for increased likelihood of transmission."

It further indicates that, "The facility should have a process to manage residents on transmission-based precautions when no single or private room is available."

Did Fulton have a such a system in place in February 2020?

A. Yes.

Q. What was that system in February?

A. Well, if anybody had any kind of transmission-based organism, they would be cohorted if there is -- if there are more than one person who would have the same organism or there would be a private room for that person with, let's say CD for instance.

Q. And so that system, just to verify, that was in place in February of this year?

A. Yes.

M. JEAN-BAPTISE

Q. Did that system change in any way over the course of the pandemic?

I'm sorry, if you answered, I didn't hear you.

Did that system change in any way over the course of the pandemic?

A. No, it didn't change. Didn't change.

Q. So now I am going to direct you to page 7 of the same exhibit, of Exhibit 4. At the top of the page we have Section A-4.

It says, "The facility has written policies and procedures to ensure that after resident discharge, all visibly or potentially contaminated surfaces are thoroughly cleaned and disinfected and all linens and towels are replaced."

Is that the terminal cleaning that we spoke about earlier?

A. Yes.

Q. Did Fulton have written policies and procedures on terminal cleaning in February of this year?

A. Yes, they did.

M. JEAN-BAPTISE

Q. Did the policies and procedures on terminal cleaning change in any way over the course of the pandemic?

A. No, it remained the same. As a matter of fact, people were more cautious during the pandemic in terms of they wanted to make sure everybody was following the steps. Not that they didn't follow them before, I must say. But it was even more -- it was reinforced, I would say.

Q. I am going to direct your attention to page 13 of Exhibit 4.

Under Section P-1, which is towards the top of the screen, it reads, "Cleaning -- " well, Section P in general is Cleaning and Disinfection of Environmental Surfaces and Reusable Equipment.

P-1 reads, "The facility has cleaning/disinfection policies which include routine and terminal cleaning and disinfection of resident rooms and high-touch surfaces in common areas."

A. Yes, that was being done.

Q. Okay. So Fulton was in

compliance with that particular section as well in February of 2020?

A. Yes. That was before the pandemic had spread, but people, you know, were very careful with that. Housekeeping was ensuring that the surfaces were disinfected on a regular basis.

Q. Did housekeeping document whenever a room was terminally cleaned?

A. I am sure they keep a log.

Q. Have you ever seen the log?

A. No, I have not.

Q. So when you say that you are sure they keep a log, are you assuming that they keep one or do you know that they keep one?

A. But terminal cleaning is something that they do routinely whenever somebody is discharged and I know that the nurse manager would call housekeeping and have the room terminally cleaned, disinfected. I would call myself to ensure that there would be disinfected. As to whether they keep a log on every room that they disinfect, I don't know. But I know

that it's a routine, it's a practice that is routinely done and I don't doubt that they are doing it.

Q. Would it be important to keep a record of what rooms were terminally cleaned or weren't?

A. It would be a little tedious to do that, to me, because the rooms have to be cleaned routinely, unless if -- I know that they should have rooms that are cleaned. I don't know if they keep logs on every room but I know that the nurse managers would call housekeeping whenever a room is free and before somebody else comes in the room to have it terminally cleaned.

Q. Can we agree that there is a difference between routine cleaning and terminal cleaning?

A. Yes.

Q. From a naked-eye observation, can you tell the difference between if a room has been routinely cleaned or terminally cleaned?

A. Okay. From the eye level, you

would not be able to see that because the room is a clean room. But when we mean terminally cleaned, that means somebody was there and left the room and now the room has to be totally disinfected: The mattress, the bed, all the areas, the closets, everything is terminally cleaned, totally disinfected, including the bathroom, everything, before somebody else comes in.

Q. So because terminally cleaning a room wouldn't be obvious to the naked eye versus a routine cleaning of the room, would you agree that it would be important to keep a documented list of the rooms that have been terminally cleaned to know that that room is safe for a resident?

A. Yes, I would agree with that.

Q. And without having that sort of documentation would you agree that it would be impossible for someone to know by looking at a room whether it's safe for a new resident?

A. Well, yes, I would say that. Because what I was going to say is really

befitting the whole what you said. But I would agree with you on that.

Q. Okay, thank you.

I am going to move on to March of this year. In March, did Fulton take any steps to prepare for the possibility of a COVID-19 outbreak?

A. Yes, I would say that there was a letter sent to the family members to stop visitation to prevent them from coming to -- so they would not -- you know, if they had the virus, not to come to their loved ones and have their loved ones get it. And there were signs throughout the facility to alert people when they come in and there was hand sanitizer placed throughout the building and we had started taking the temperatures at that time, that was in March.

In terms of PPE, I don't remember that people were wearing masks at the time yet, not the staff. There were no PPEs at that point.

Q. What was your involvement in March of this year in preparing for the

pandemic?

A. Like I said, I did handwashing on most of the staff during their shift, and with the help of the nursing supervisor as well as the in-service coordinators, we all put together and we ensured that everybody knew what they were to do and how to -- well for the PPE, I had to say, I had to do in April when I went back, because that's when they had PPE and they were shown how to don and doffing the PPEs and not to contaminate themselves or others.

Q. So the staff were trained on that in April, the donning and doffing of PPE?

A. Yes.

Q. To your knowledge, did anyone train the staff on donning and doffing PPE prior to April 2020?

A. I don't know if I had that in-service with them myself because I don't know if Rose did, but I know that we didn't have any PPE at that point. So it was not -- because in order to do an in-service about something, they have to have -- no,

they had, we did. Excuse me about that. We did in terms of we had -- yes, there was in-service in March about donning and doffing the PPE. Now I remember, because I did myself, I did this in-service with them. And I did it again in April after that.

Q. Was there any documentation of that in-service in March?

A. Yes.

Q. What is that documentation, was it a sign-in/sign-out sheet or something else?

A. It was sign-in and sign-out. They were provided with the flyers to show how to don and doff the PPE. In April it was done more in depth because the PPEs, they were able to show how to put them on and remove them and what to remove first and so on and so forth. So they had become really good at knowing how to remove them without contaminating themselves.

Q. At this time, we are going to show you what's been premarked as Exhibit 5. This is a four-page document.

M. JEAN-BAPTISE

Ms. Jean-Baptiste, I should actually ask you, are you familiar with CMS guidance that was issued on March 4th of 2020 related to infection control and prevention with COVID-19?

A. Yes, I remember this one.

Q. The document in front of you, Exhibit 5, is this that March 4, 2020 CMS guidance?

A. Yes.

Q. What were the circumstances in which you saw this before?

A. I usually get those on CMS documentation.

Q. Do you get the e-mail directly from CMS or does somebody give it to you?

A. I get it in my box.

Q. Is that a mailbox?

A. A mailbox.

Q. Is that a physical mailbox or an e-mail box?

A. A physical mailbox.

Q. Who usually puts the guidance into your mailbox?

M. JEAN-BAPTISE

A. I want to say it's Carol Frawley.

Q. I am going to direct your attention to the first page of your infection guidance, so towards the bottom of the page. Beginning with the third sentence under "guidance" it says, "Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, health care personnel, and visitors at the facility. To do so, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infections as needed throughout the day. Furthermore, we encourage facilities to take advantage of these courses that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices."

So you are aware of this guidance in March of 2020, correct?

A. Yes.

Q. Looking at the third page of that guidance under the section, "When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital." The second sentence reads, "Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality."

Were you aware of that in March 2020?

A. Yes.

Q. Did Fulton have a plan in March 2020 for early detection of asymptomatic residents?

A. Can you please repeat it?

Q. Sure. Did Fulton have a plan or a system in place in March 2020 for early detection of residents infected with COVID-19 who were asymptomatic?

A. No, because they weren't tested. I said before, that how would people be able to know if somebody who is asymptomatic is

positive without being tested.

Q. But would you agree with me that testing would be essential to identifying asymptomatic infectious residents?

A. Yes.

Q. Going to the fourth page, this is the last page of that guidance. Under the CDC resources we see again, "Infection Prevention and Training" and the link thereafter.

Did you utilize that training in March 2020?

A. I attended a mini-training given by the CDC and DOH. I don't remember specifically if that was one of the trainings I attended, though. But I know that whenever there is a training, Cathie would send me an e-mail and I would make sure that I would attend the webinar.

Q. To your knowledge, did Cathie Doyle attend any of these trainings on infection prevention?

A. I cannot say.

Q. Did she ever indicate to you that

she attended any of the trainings on infection prevention?

A. No.

Q. To your knowledge, did Carol Frawley ever attend any of these trainings on infection prevention?

A. When I attend those webinars it's always in my office, I am always by myself. I remember that one time I asked Rose to come to attend one of the webinars with me. I don't remember specifically which one it was, but that was the only time that someone had come to my office to attend the webinar with me. So I am not saying that nobody attended the webinars, but I am not aware of that.

Q. Did anyone ever indicate to you that they had also attended any infection prevention training?

A. I don't recall that.

Q. I am going to direct your attention to Exhibit 6. This is a premarked exhibit. This is a six-page document. While Ben gets it up on the screen I will

ask you, Ms. Jean-Baptiste, if you are familiar with DOH guidance that was issued on March 11th, 2020 related to COVID-19?

A. Yes.

Q. It should be in front of you now. So looking at Exhibit 6, do you recognize this document?

A. Yes.

Q. Is this the March 11th, 2020 guidance?

A. Yes.

Q. What were the circumstances under which you had come across this before?

A. Again, this document was left in my mailbox and I read it, yes. There were in-services done throughout the facility again about the spread -- about the outbreak of COVID.

Q. Was that done following this guidance?

A. Yes.

Q. I am going to direct your attention to the third page. Towards the bottom of the page, towards the middle of

your screen right now, the last full paragraph, it starts with the state regulations.

The second sentence in that paragraph says, "All nursing home must review and reinforce their policies and procedures of all staff, residents, and visitors regarding infection prevention and control, including standard droplet and contact precautions applicable for the care of all resident for their staff."

Was it due to this particular section of the guidance that the staff was re-in-serviced again?

A. Yes.

Q. Who conducted the in-service for the staff at that time?

A. I think Rose was still in the building at that time and she conducted a lot of the in-services. Like I said before, everybody was actively doing in-services because it was just the moment, because we were getting these letters every day about the spread of the virus. So everybody was

being in-serviced about the coronavirus and how to protect the residents and themselves and how to avoid spreading it throughout the facility.

Q. You mentioned before that in March Fulton put a stop to visitation, or to in-person visitation, I should say. Do you recall exactly when that occurred?

A. There was a letter issued by Cathie Doyle. I don't remember exactly the time, but I have to say it must have been before March 25th, because before that the visitation had stopped before that. It was -- I would say between March 10 and March 20, 2020 I would say. Within that time frame.

Q. Do you know what prompted that letter?

A. I think it was a measure to prevent the spread of the virus based on the literature we were getting almost on a daily basis from those governing bodies, so they had to follow the regulation.

Q. How was it communicated to the

family and residents that visitation was being put on hold?

A. I know that many times she would do robocall, and I don't remember exactly what dates they were made, but I know that there were several robocalls made to the family members. I am sure there were letters issued to them also to tell them about the reason why the visitation was stopped.

Q. Did you have any role in preparing the robocalls, either by way of getting information to Cathie Doyle to present on the calls or anything else?

A. No, no. She did all the robocall, I must say. Nobody else did them.

Q. Did you ever listen to the robocalls to ensure that she was providing accurate information to the family members?

A. Not before, I listened to them after. Not before. She never consulted me about how to phrase them, what to say. I would hear the robocall.

Q. When you say you listened to it

"after," what do you mean?

A. Because sometimes my phone would ring and it would be one of the robocalls, because it issued out for the staff. When it's for the staff, she issued it out to everybody, so I would get a call. But I don't know for the family, for the families I don't know what she said to the family, really. I don't know what she verbalized to the family.

Q. Just so the record is clear, did you ever hear any of the robocalls that were sent to the family members?

A. No, because if it is for the family only, it will go only to the family members, because I would not get such a phone call. If it's for the staff I would get the call, but if it's for the family then I would not know.

Q. Did you ever have any concerns about anything you heard per se on the robocalls that were for the staff?

A. I know that in April a family member had called to one of the nurse

managers, and I don't remember specifically who it was at that point. But I overheard the person say that a family member called, and she was concerned about one of the robocalls because Cathie had mentioned that there was no COVID cases from the building. And I heard that one time.

One day I was there and she made an announcement that there were no COVID cases in the building. And it was just a moment where I was like, How come she said that? Because we didn't really test anybody. How can we know that for a fact? We don't know.

Q. Ms. Jean-Baptiste, do you remember when it was that you heard that announcement?

A. It was when I came -- after I came back from being sick, so I would say mid-April. I am not sure, please forgive me. I don't know.

Q. Okay, that's fine. But it was after you came back from being sick?

A. Yes, after I came back.

M. JEAN-BAPTISE

Q. Are you fairly confident that it was sometime in April?

A. I want to say it was April.

Q. Was that an announcement just on the overhead intercom system?

A. Overhead. I believe that she had said that on one of her robocalls.

Q. Did you ever ask her about it and how she was making that assertion?

A. I know that at one time, I don't know if it was in April or May, but I know that was before June and we were in one of the offices and she asked how -- what do you think that we should have done that we didn't do? And I told her we should have tested the residents and if they were positive, we should have transferred them to a hospital.

Q. What was her reaction to that?

A. She just looked at me and she -- I guess she agreed with me but she didn't really say anything.

Q. At the time that you heard that announcement overhead saying there were no

M. JEAN-BAPTISE

COVID cases in the building, did you believe that that was a lie?

A. If I believe what?

Q. Did you believe that was a lie?

A. Well, I was shocked at the -- such an assertion. Because how can you prove that, given the fact that we did not test anybody? So we didn't know that. And the doctors were treating people with whatever they had in place at the moment to treat the people who had the positive COVID. So although they weren't tested, they were still being treated empirically for COVID. So it was a little difficult for me to understand that.

Q. At the time that she made the announcement, the facility was actively treating residents with COVID treatment?

A. Well, when I came back, there were different protocols that I see that every day there was a different protocol as to how to treat the people who exhibited the symptoms such as fevers, coughs, anything that was pertinent to the outbreak.

M. JEAN-BAPTISE

Q. So I think that we can agree, correct, that the way that the medical community treated COVID and COVID-presumed and COVID-confirmed residents did evolve over time?

A. M-hmm.

Q. I need you to say yes or no.

A. Yes.

Q. I know there was a period of time, for instance, when the residents were treated with hydroxychloroquine; is that correct?

A. Yes, correct.

Q. And then was there a period of time when that switched over and individuals who were presumed as having COVID were treated with a Z-Pak and IV?

A. Correct.

Q. So to your knowledge, at the time that Ms. Doyle made the announcement that there was no COVID in the building, were there residents that were actively being treated with COVID protocols?

A. I am sure there were residents

being treated, yes, with the protocols and that's what I thought was a very audacious comment to make. And how could you say that, because I thought it was misleading.

Q. Did you ever express that concern to Carol Frawley?

A. Yes, I told her that. But like I said, there were times that even when I came back and I was asking how many people had died, because I know people had died, and I was told that there were -- that they died of pneumonia or somebody was already sick and they were -- you know, it was a lot of misleading information that I was getting and I ended up saying that -- to me it's a lot of people who died compared to last week or even when I was doing the infection control analysis, it was so much -- such a high prevalence of pneumonia and the comparison was so remarkable, it was beyond. I couldn't express that. I was like, what happened?

Q. Did you believe that some of those deaths were COVID related?

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A. Because people were not tested I cannot assume that they were. I don't know what the -- what is on their death certificate. I have no idea what they died of for me to make that -- but I know that under normal circumstances a lot of them would not have died if it wasn't for the outbreak.

Q. Okay. I think this is probably a good time for us to take a break. It's just about 1:30. We will take a half hour break. Get some water. We will resume at 2:00. Thank you very much.

(Whereupon, a lunch break was taken.)

MS. SEKHON: We are ready to go back on the record. The time is 2:05. We took an approximately half-hour break. We did a quick roll call off the record and I confirmed that everyone who was present this morning is still present at this time.

Q. I would like to -- may I ask you this, Ms. Jean-Baptiste, are you familiar

M. JEAN-BAPTISE

with CMS guidance that was issued on March 13, 2020 related to infection control prevention and COVID-19?

A. Yes.

Q. We are going to show you now what was premarked as Exhibit 7. This is a six-page document.

Is this that March 13, 2020 guidance?

A. Yes.

Q. Was this also left in your mailbox for you to review?

A. Yes.

Q. I am going to direct your attention to the bottom of the first page.

Under "guidance," the third sentence says, "Per CDC, prompt detection, triage, and isolation of potentially infected residents are essential to prevent unnecessary exposures among residents, health care personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities

should consider frequent monitoring for potential symptoms of respiratory infection -- "

A. You were cut off.

Q. I'm sorry. I will go back a little bit.

"Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day.

"Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices."

Were you aware of that guidance in March of 2020?

A. Yes.

Q. Just going now a little bit further down on page 2, so under the guidance for limiting the transmission of COVID-19 for nursing homes.

M. JEAN-BAPTISE

The first section says, "For all facilities nationwide, facilities should restrict visitation of all visitors and non-essential health care personnel except for certain compassionate care situations, such as an end-of-life situation."

Ms. Jean-Baptiste, is that the guidance that we talked about earlier that prompted Fulton to put a stop to visitation in person?

A. Yes.

Q. What did Fulton do to facilitate other means of communications between residents and their families?

A. They had implemented some virtual ways for people to speak to their relatives.

Q. What virtual ways were implemented?

A. They had -- not a laptop, but they had the iPad and they had the family members speak with their relatives on a regular basis. I guess not everyone understands this but they had scheduled times for residents to speak to their loved

one.

Q. Who was responsible for facilitating that communication?

A. It was the recreation department.

Q. Did any other department assist recreation in that regard?

A. Yes, nursing and social services.

Q. Were you familiar with DOH guidance issued on March 13, 2020 with regard to COVID-19?

A. Yes.

Q. At this time I am going to show you what's been premarked as Exhibit 8. It's a two-page document.

Ms. Jean-Baptiste, looking at Exhibit 8, is this that March 13, 2020 DOH guidance?

A. Yes.

Q. I will direct your attention to the second page.

Under No. 5, it reads, "Do not float staff between units. Cohort residents with COVID-19 with dedicated health care professional (HCP) and other direct care

providers."

Were you aware of that guidance on March 13, 2020?

A. Yes. There was a -- the staff was told to -- not the staff, but there was a stipulation not to float staff from unit to another unit. That also was implemented.

Q. Was that implemented following this guidance on March 13?

A. Yes, yes.

Q. And this particular guidance, was this also placed in your mailbox for your review?

A. Yes.

Q. From the infection prevention standpoint, why was it important to cohort staff since they were no longer floating from unit to unit?

A. Because that was a way to prevent -- if a unit has it, so not to spread it from one unit to the next unit, at least it would remain stationary as opposed to a wide spread throughout the building.

Q. Other than just directing staff

not to float from one unit to another, were staff cohorting in any other way?

A. Yes, they were told not to be going all over the place. They had to remain on their unit even on break time. They had closed the cafeteria. So people were to remain on their unit to take their break. It was just, you come to work, you stay on your unit until you are done, and then you go straight home. There was no going back and forth, visiting, or anything like that, in the building.

Q. At the time that this guidance was issued in March of 2020, were there any residents at Fulton who were presumed as having COVID-19?

A. No one was presumed at that time.

Q. Was anyone suspected at that time?

A. No. I would say no, because we didn't have any kind of protocol that was put in place for anybody to be -- we didn't have -- people was -- had a regular -- I would say that -- I didn't see an increase

M. JEAN-BAPTISE

in infectious process, I would say, at that time, between that time, for that week I would say.

Q. I am going to show you now Exhibit 9. This is a 28-page document.

As it's coming up on the screen I'll first ask you, Ms. Jean-Baptiste, if you were aware of CMS guidance issued on March 20 of 2020?

A. Yes.

Q. Looking at Exhibit 9 on the screen, is this that March 20, 2020 guidance?

A. Yes.

Q. Was this also placed in your mailbox at Fulton for your review?

A. Yes, I saw this document.

Q. Scrolling to the bottom of the first page just a little further down in the memorandum summary, that little gray box, towards the bottom there's a bullet point that says, Targeted Infection Control Surveys.

And it reads, "Federal CMS and

State surveyors will conduct targeted infection control surveys of providers identified through collaboration for the Centers for Disease Control and Prevention, CDC, and the HHS Assistant Secretary for Preparedness and Response."

Were you aware of that announcement?

A. Yes.

Q. The following section still on that page reads, "Self-assessment: The infection-control checklist referenced above will also be shared will all providers and suppliers to allow for voluntary self-assessment for their infection-control plan and protection."

Did you utilize an infection-control checklist issued by CMS at that time?

A. Yes.

Q. When did you utilize that?

A. It was utilized, I guess, from the week of the 25th of March. While I was out it was implemented, and when I came back

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I followed the weekly checklist.

Q. Who began the implementation of it?

A. I want to say it was Lisa Peterson who started it because she was the one who had given me a copy of it and I was asked to follow up with her on a weekly basis.

Q. So on a weekly basis you conducted a self-assessment of the facility?

A. Yes, along with Carol Frawley, I would ask her for some of the documentation that was needed to fulfill the documentation.

Q. Did you keep a copy of the assessments that you conducted?

A. Everything was in the infection control book. Everything was there. A copy was given to Cathie Doyle and I kept the original in the infection control workbook.

Q. I am going to direct your attention to page 14 of Exhibit 9. Can we locate that? Okay.

At the top of this page, the

first question is, "Has the facility isolated residents with known or suspected COVID-19 in a private room, if available, or taken other actions based on national, CDC, state, or local public health recommendations?"

Had the facility done this on March -- well, I suppose you were out the week of March 25th. But when you came back to work in April, did you find that the facility was complying with this section in the infection-control guidelines?

A. As far as I am concerned, when I came back the Unit 1 had became the COVID unit where they would have the people who -- one side they had people who came from the hospital being on quarentine and the other side there was -- on the other aisle there were the people not -- it -- they separated the unit. People who came from the hospital with negative results and the people on the investigation were on the other side of the unit. So they kept them separated and the staff was in-serviced as to how they had to

split the staff as to who was going to take care of residents who were presumably -- they were quarantined because they had to follow the seven-day quarantine guideline and those who had no testing but they were suspicious or they were on the protocol.

Q. When you came back on approximately April 10, do you know what unit had already been designated as the COVID unit?

A. Yes.

Q. Just so I get a clear picture of what that meant, did all new admissions go onto Unit 1 East before going into a different unit?

A. Yes.

Q. Okay. So they all had to come first onto Unit 1 East, complete their quarentine and then they could be placed on a different unit?

A. They remained a lot on 1 East. That was the designated unit and they wanted to make sure they didn't go on the other units because -- only because, at that time,

only the people who came from the hospital with negative COVID result were the only ones that we knew were tested at that time.

Q. Were those residents who came in from the hospital with a negative test, were they also placed on 1 East?

A. They were placed on 1 East, but they were cohorted on one side of the unit, and they were assigned to a designated team of nurses and CNAs to care for them.

Q. Unit 1 East was broken up into two separate sides?

A. Two separate sides.

Q. Was there a name for those sides?

A. It was quarentine. They were both quarentine, but there was one that -- after the seven days, they were clear and the other side was already -- they were not tested but they had no symptoms of COVID.

Q. Let me go back for a minute. So 1 East, was there a high side and a low side?

A. There is a high side and a low side.

M. JEAN-BAPTISE

Q. Which side was for residents who came in from the hospital with negative tests?

A. I want to say it was the high side.

Q. So those were people who had tested negative for COVID?

A. Yes.

Q. And then which individuals were being placed on the low side?

A. On the low side were people who were there. They were existing residents, they were there before the pandemic.

Q. So those were residents who were already housed on 1 East?

A. Let me see. Give me one second to recollect. I am a little -- I don't know if I am saying it right. I think the low side -- on the low side were the residents with negative COVID.

Q. So then the high side --

A. I am a little fuzzy about it.

Q. Okay. So on one side we have residents who tested negative for COVID and

the other side we have residents who were pre-existing on the unit?

A. They were staying on the unit. Everybody remained on the unit, including the staff.

Q. So, one side is people who tested negative for COVID from the hospital. The other side were people who were already in the facility. Were they already on Unit 1 East?

A. Yes, and they all wore masks. At the time they followed the protocol.

Q. And those individuals were all asymptomatic; is that correct?

A. They were asymptomatic, yes.

Q. Those individuals were not suspected of having COVID; is that correct?

A. They were not suspected of having COVID, and upon discharge they would be tested to make sure that they are negative before they are discharged to community.

Q. But at that time Fulton was still not testing their residents, right?

A. No, unfortunately they were not.

M. JEAN-BAPTISE

Q. So we talked about residents who came in from the hospital with a negative COVID test. What about residents who came in from the hospital COVID positive, where were they housed?

A. They didn't have anybody. They didn't take anybody who had positive COVID.

Q. Is that your understanding, that in April they were not taking anyone who was COVID positive?

A. That's correct.

Q. What are you basing that understanding on?

A. Based on the admissions that we were getting. They are PRI reviewed and it was stated that they had two negative test results for COVID.

Q. Okay, we will go through the admission together in a little bit.

How is it decided that the resident would be put on 1 East as opposed to some other unit?

A. I don't know how it was determined, but that was what I found when I

came back.

Q. Do you know who made the decision to make Unit 1 East the COVID unit?

A. I wasn't there but I am leaning to say that it was Cathie Doyle who made that decision.

Q. You did mention that there were separate staffing team on the unit. Can you elaborate on that?

A. Yes. The unit usually has four or five CNAs, so two of them would be designated for the people who were quarantined. And then the other that was in the morning, will be on the other side, or vice versa. Whoever had more residents at any particular time, it would be distributed evenly. And they did the same on evening and night shift.

Q. Why was it important to break the staffing up into two separate groups like that?

A. Because the people who were quarantine, we didn't want to contaminate the other group who were not from the

hospital, because the one who came from the hospital were still quarantined and they were being -- the ones on the other side, they were already -- they had already met the criteria of not being on the suspicion anymore, under surveillance anymore. They had gone through the seven days of quarantine and moved onto the other side.

Q. So from an infection control standpoint, if you had staff mixing -- so by that I mean, travelling from a room with someone who is quarantined to a room with someone who is not quarantined -- what can happen?

A. It can be transmitted. You can be transmitting the virus to the other group that that's not quarantined.

Q. And would that, in turn, put residents at risk?

A. Yes.

Q. Did you conduct any training with the staff on 1 East instructing them that they should be cohorting in such a method?

A. Yes.

M. JEAN-BAPTISE

Q. When did you conduct that training?

A. That was in April. I don't remember exactly the date, but that was in April.

Q. Who was the unit manager for Unit 1 East?

A. Pardon me?

Q. Who was the unit manager for Unit 1 East?

A. It was -- what's her name. Sorry, I forgot her name. I don't remember her name.

Q. Was it Latasha Waller?

A. Latasha Waller, yes.

Q. Did Latasha Waller ever express any concerns to you about the staffing on Unit 1 East throughout the pandemic?

A. There were staffing issues at one point during the pandemic and because a lot of the staff members were sick and it was -- they always gave preference to that unit because of that outbreak. I don't believe that they had any big staffing issues on

that particular unit.

Q. Did Latasha Waller ever express to you that staff were caring for residents who were both quarantined and not quarantined?

A. No.

Q. Were you ever made aware that staff were caring for residents who were both under quarantine and not under quarantine?

A. Well, if she did, and that's one of the reasons why staff were in-serviced about not to be attending to the residents or as I was told by one of the infection control nurses from the -- I don't know from which department that used to contact us almost on a daily basis to inform us of -- I forgot her -- her name was Marie, but I forgot which department she came from, she was calling me from. And about the -- the staff would be able to care for the residents if they know that they have the virus, and they can go from one -- that was to address the PPE allocation because of the

shortage that we had with PPE at one particular point. She advised me that they would be able to use the PPE if they have the same virus, so they can use them. But they cannot be used -- for instance, they can take care of people with the PPE if they have not the virus providing that they maintain their infection control rules the same way that they're supposed to. But if they take care of somebody, let's say quarantine, they cannot go and take care of somebody who is not with the same PPE. So this is why I told the staff that they couldn't take care because they were worried about their suit that they wear, and that they had to clean it every time that they went from a room and took care of a resident and then they had to spray themselves with whatever disinfectant that was provided for them to wipe down before they could go to another room and wash their hands and make sure they don't transmit the disease, the virus, from one person to the next.

Q. So I just want to be clear, were

you ever made aware by Latasha Waller that her staff on a single given shift were caring for both residents who were not under quarantine and residents who were under quarantine?

A. No.

Q. If you had been made aware of that, what would you have done?

A. I would have in-serviced the staff, which I did prior to that. But I have never been told by Latasha about that particular situation.

Q. Would you agree that if staff were doing that, that they were failing to engage in proper infection control protocol?

A. Let me recall. I don't remember being told that.

Q. My question is, would you agree that if staff were travelling between a quarantine resident's room and a non-quarantine resident's room, that they were then failing to engage in proper infection control?

A. Absolutely.

M. JEAN-BAPTISE

Q. Would you agree with me, then, that they were placing the residents who were not under quarantine at risk for contracting an infectious disease?

A. Yes.

Q. So I am just going to go back to Exhibit 9 then, and if we could go to page 15.

So under No. 6, the second box says, "How does the facility convey updates on COVID-19 to all staff?"

I know you did mention already that there were robocalls. Were updates conveyed to the staff in any other way?

A. I remember there was a memo issued by Cathie Doyle. I don't recall exactly when it was issued, but it was -- there was a memo. I don't know if there was more than one but I remember specifically one.

Q. What was that memo in relation to?

A. I don't remember the content of the memo, but I know there was a memo issued

at one particular time. But I don't remember exactly the content of the memo.

Q. Were staff kept updated as to if and when there was a resident suspected of COVID-19 in the building?

A. No.

Q. Are you familiar with DOH guidance that was issued on March 21 of 2020?

I am sorry, if you answered, I didn't hear you.

A. I have to think. I think I remember that.

Q. So we will show you what's been premarked as Exhibit 10. This is a one-page document.

Do you recognize this document?

A. Yes.

Q. Have you seen this before?

A. Yes, I have.

Q. Was this also placed in your mailbox for your review at Fulton?

A. Yes.

Q. Going to the second paragraph of

the memo, it says, "Any febrile acute respiratory illness or clusters of acute respiratory illness, whether febrile or not, in nursing homes and adult care facilities in New York City, Long Island, Westchester County, or Rockland County should be presumed to be COVID-19 unless diagnostic testing reveals otherwise."

Were you aware of that guidance on March 21, 2020?

A. Yes.

Q. How did Fulton implement that guidance?

A. Well, that's when I had brought to Cathie Doyle and Mrs. Frawley if they are not going to test any of the residents, and I was told that Dr. Butchma was saying no. So, no.

Q. Were there residents at Fulton who were being treated as if they had COVID and isolated as if they had COVID despite not being tested?

A. At that time, no.

Q. So March 21, at that time, there

were no residents suspected of having COVID in the building, to your knowledge?

A. Not to my knowledge.

Q. In April 2020, did Fulton take any steps to respond to the COVID-19 pandemic?

A. Yes, they had PPE at the time and the staff were following the protocol.

Q. Was that the protocol issued by CMS and DOH?

A. Pardon me?

Q. The protocol that the staff was implementing, was that the protocol that was suggested or required by DOH and CMS?

A. Yes.

Q. Were there attempts to obtain PPE made in April 2020?

A. Yes, they had obtained PPE at the time when I got back and the staff were wearing the PPEs at the time.

Q. Were there any in-services conducted in April 2020?

A. Yes. There were many in-services conducted in April of 2020?

Q. On what topics?

A. On donning and doffing of the PPE, handwashing, whole infection control protocol with all this stuff, including housekeeping department, everybody.

Q. Who was responsible for conducting those in-services?

A. I was at the time because Rose was no longer there and I was doing a lot and a lot of the nursing supervisors helped me, and night shift, they also followed through. And Latasha Waller was instrumental in in-servicing the staff, because she would come earlier and she would in-service both the 7 to 3 and the 11 to 7 staff at times.

Q. Did you have any discussions in April 2020 with Dr. Butchma regarding responding to the pandemic?

A. I never had any communications directly with Dr. Butchma.

Q. Is that in general that you never had any direct communications with him?

A. In general, yes.

M. JEAN-BAPTISE

Q. Other than your suggestion on testing, did you have any other discussions with Cathie Doyle regarding responding to the pandemic in April 2020?

A. When I came back, I asked Mrs. Frawley and Cathie Doyle what was going on with the -- what was the situation, and I was told what they had done on 1 East. As far as the other units, I asked if they were cohorting the residents and I was told there were no COVID-19 residents in the building, except for the people who came from the hospital.

Q. Again, it's your understanding, the people who came from the hospital were COVID negative or that they were COVID positive?

A. There were COVID negative as per their test results from the hospital. But in terms of the other residents upstairs on the second, third and fourth floor, I was told that nobody had tested positive.

Q. To your knowledge --

A. Sorry, there were no negative

cases.

Q. I am sorry --

A. I am sorry, there were no positive cases.

Q. To your knowledge, did Fulton ever admit a COVID positive resident?

A. No, not that I am aware of.

Q. You mentioned a little bit before that when you came back to work after being sick that you felt like you weren't a part of the team anymore. I know you also said you felt you were cut out of the decision making and the discussions. So who was making the infection control decisions at that point from when you came back after being sick?

A. Can you please repeat that? I have a plane going by.

Q. No problem. When you came back after being sick, so in early April 2020, who was making the infection control decisions at Fulton?

A. Mostly Cathie Doyle, I would say.

Q. Did that continue for the rest of

your tenure at Fulton?

A. Yes, for the most part, yes.

Q. You mentioned before that you were cut out of the some of the discussions. What effect did that have, if any, on your ability to do your job as the infection control nurse?

A. I was not able to perform my job and I was getting a little scared about it because I am saying here I am here with this title and meanwhile I have no power of doing anything or implementing anything and everything that I say I feel as if I was just cut out. I got a lot of pushback and I said there is nothing I can do so I was mainly -- I would do whatever I had to do, whatever was within my capacity, I did. But in terms of implementing anything, I didn't have that power.

Q. Did you bring this concern to anyone's attention?

A. I told Mrs. Frawley, What is going on? Because every time I ask questions, I feel as if I am being -- like I

am the enemy because even when somebody died, I would say, What was their cause of death? And they would be telling me, oh, this person was just very sick and this and that and the other and they never really told me the truth in terms of what transpired as if they didn't trust me. I don't know why because I was working for the facility.

Q. When you brought this concern to Ms. Frawley's attention, that you felt like you weren't being included and that you had a concern about you doing your job, what did she tell you?

A. That it is Cathie's decision.

Q. Did you ever speak to Ms. Doyle about your concern?

A. Ms. Doyle was very temperamental at that time and she was always on the phone or busy or doing something. And when she spoke to me it was more about, did you call the Nassau County community department, do this, did you do that? And I would say, Yes, I did. And she would say, Did you

in-service the housekeeping staff? Then we had the State survey, I don't remember exactly what month it was, I want to say it was May. It was not in June. I want to say it was in May. And I had to -- there was -- something -- somebody, one of the housekeeping staff had not followed a procedure, a protocol, and I had to in-service the whole housekeeping staff and we had to implement a plan of care because of that. So I in-serviced the whole housekeeping staff, all the staff, I would say, after that. And did one-to-one in-service with the person who was responsible for that.

But I never really got any clear response from Cathie whenever I ask her what was going on, how are we going to proceed with going forward.

Q. Were you familiar with CMS guidance that was issued on April 2, 2020?

A. I would have to see that. I may have seen it maybe after, yeah.

Q. We are going to show you what was

M. JEAN-BAPTISE

premarked Exhibit 11. This is a three-page document.

MS. SEKHON: Everyone, just give me one minute.

Q. We have in front of you Exhibit 11. This is a three-page document that indicates it was issued by CMS April 2, 2020?

Do you recognize this?

A. I am looking at it, please.

Q. Sure, let me know when you are ready.

A. Yes.

Q. If you scroll down a little bit on the first page, No. 1 in bold says, "Nursing homes should immediately ensure that they are complying with all CMS and CDC guidance related to infection control."

The second bullet point there under says, "CMS has also recently issued extensive infection control guidance including a self-assessment checklist that long-term facilities can use to determine their compliance with these crucial

infection-control actions."

Were you aware of this guidance on April 2?

A. I didn't see that on April 2 because I was not at work on April 2.

Q. Okay, and are you right. So I will rephrase the question.

When you came back to work on April 10, were you made aware of this guidance?

A. I don't remember seeing that guidance.

Q. I am going to refer your attention now to the last page.

Towards the top of the last page, the first bullet point says, "Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not or have an unknown status."

Were you aware of that guidance in April of 2020?

A. Yes.

Q. When you returned to work on

April 10, 2020, were you aware of whether there were any residents in the building exhibiting COVID-19 symptoms?

A. When I came back I saw they had numerous protocols that were established in providing care to the residents who exhibited symptoms like fevers and cough and other related symptoms.

Q. Those residents who were exhibiting those symptoms of fever and cough and other related COVID symptoms, were they isolated in any way from the rest of the residents in Fulton?

A. No.

Q. So they were not cohorted on any wings or anything like that?

A. Not that I recall.

Q. Should they have been?

A. I asked Carol Frawley when I came back, I said, Are they cohorting anybody? And she told me that they had done some cohorting while I was out, she said. I don't know if that's true or not because I was out. I cannot vouch for that. But

Cathie had stopped it because it didn't work. So I don't know what happened during that period. But when I came, I asked, and I was told it was not necessary because Cathie Doyle had issued that statement, that robocall and over the head statement that nobody in the building had COVID.

Q. Setting aside what Cathie Doyle said that may or may have been misleading, in your opinion, should the residents who were exhibiting COVID symptoms have been cohorted?

A. Yes.

Q. Was that, in fact, the CMS in DOH guidance that those residents should be cohorted?

A. Yes.

Q. But as far as you are aware, Fulton did not implement that; is that correct?

A. Not that I am aware of.

Q. So it's fair to say that Fulton was not in compliance with the DOH and CMS guidance; is that correct?

M. JEAN-BAPTISE

A. I want to say yes.

Q. Okay. Thank you.

I am going to show you now Exhibit 12. This is a three-page document. Ms. Jean-Baptiste, if you can just take a look at it and let me know if you recognize this document.

A. Yes.

Q. Have you seen this before?

A. Yes.

Q. If you look at the top left-hand corner, it has a date. It says, Version 4/10/2020?

A. Yes.

Q. Did you see this document when you returned to work in early April?

A. Yes. I believe there was one previous to that one and that was a second version.

Q. So this particular document, which indicates that it's a nursing home COVID-19 preparedness self-assessment checklist, did you utilize this self-assessment tool in April 2020?

A. I used it, yes.

Q. I am going to direct your attention to the third page of this document. So the first box at the top, it says, "Take action to ensure further transmission does not occur by selecting the appropriate location within the facility to care for a resident suspected or confirmed COVID-19."

Is it is fair to say that Fulton was not in compliance with this guideline?

A. What I want to say is that they had residents on -- because they didn't test anybody so I cannot say that people were positive or not and that's the reason why I had asked Cathie and Mrs. Frawley, Why are we not testing the residents? If they are sick, we can know at least who is sick, we can separate who is sick from who is not sick. If somebody is sick then we need to know. And I was told that Dr. Butchma doesn't think it's necessary. And as the medical director, we had to follow his directives. Nobody can really implement

anything without him giving us the directive.

Q. I understand that. But this particular section doesn't just say confirmed COVID-19, it also says, suspected COVID-19. So is it fair to say that by failing to cohort residents being treated for COVID-related symptoms, that Fulton was not in compliance with this particular guidance from DOH?

A. I would say yes.

Q. Are you familiar with CMS guidance that was issued on April 19, 2020? We can put it on the screen. It's premarked as Exhibit 13. It's a three-page document.

Ms. Jean-Baptiste, have you seen this before?

A. Yes.

Q. I am going to direct your attention to the second page.

Under the resident and resident representative reporting, the fifth line down in the middle of the sentence it starts saying, "Nursing homes must inform residents

and their representatives within 12 hours of the occurrence of a single confirmed infection of COVID-19 or three or more residents or staff with new onset of respiratory symptoms that occur within 72 hours."

Are you aware of that guidance?

A. Yes.

Q. Did Fulton comply with that guidance?

A. The facility -- the families, rather, were informed when the residents were sick. I don't know if they were told specifically what the diagnosis was because we cannot really diagnose. But whenever somebody was sick, the person was told -- the family were told of the symptoms exhibited and they were informed of the plan of care.

Q. Who was responsible for notifying the residents and their representatives regarding these incidents?

A. The nurse managers informed the families and the families were kept informed

on a daily basis of what was going on.

Q. Is that by the robocalls that you discussed before?

A. No, they were called on a unit basis. The nurse manager individually called family members to notify them of what was going on.

Q. Under this particular guidance that is we just went over, nursing homes were required to notify all residents and all of the representatives of residents either with 12 hours of a confirmed case or within 72 hours of three or more residents or staff with new onset of symptoms.

To your knowledge, did Fulton comply with that requirement?

A. Can you please repeat the question?

Q. Sure. Actually, let's put it up again. The second page of Exhibit 13 so we can look on it together. If we go four lines down, towards the end we can begin at the beginning of the sentence.

"At a minimum, once these

requirement are in place nursing home must inform residents and their representatives within 12 hours of the occurrence of a single confirmed infection of COVID-19 or three or more residents or staff with new onset of respiratory symptoms that occur within 72 hours."

My reading of this, Ms. Jean-Baptiste, is that every resident was required to be notified if this occurred.

To your knowledge, did Fulton comply with that requirement?

A. Yes.

Q. How did it comply?

A. They did inform the families about resident symptoms and their plan of care.

Q. Were other representatives of other residents were also notified when there was a new case of COVID in the building?

A. Like I said, if you want to say suspicious COVID, but because nobody was

tested I cannot make that assertion.

Q. That guidance also said, new onset of respiratory symptoms -- if there were "three or more instances of new onset of respiratory symptoms between residents and staff."

So to your knowledge, did Fulton comply with that requirement?

A. I would say yes. They complied in the sense that the families were informed of the symptoms exhibited by those residents and the plan of care that was implemented by the physician. That's the aspect that I would say that they followed the protocol.

Q. In the instance where three or more residents or staff exhibited new symptoms of respiratory illness, were all of the residents in the building notified along with the representatives?

A. Everybody -- all the families were called, like I said, on a daily basis.

Q. And that was via the robocalls you mentioned before?

A. No, they were called by the nurse

managers on a regular basis, on a daily basis. The unit managers will call all the family members on a daily basis to update them of the resident's condition. On weekends there was a dedicated supervisor who called the family members and update them of their family member's condition.

Q. Were those for all the residents in the facility or just those residents exhibiting COVID symptoms?

A. I want to say it was all the residents. Because families were concerned and because of not being able to visit their loved ones and everything that was going on.

Q. Are you familiar with a letter sent by the Department of Health to nursing home administrators dated April 29, 2020?

A. I would like to see it to see if I know it.

Q. Sure. Let's take a look at Exhibit 14. It's a two-page document. Ms. Jean-Baptiste, if you can look this over and let me know if you have seen this before.

A. Yes. I was told about this

letter. I don't know if I saw it, but I was told of it.

Q. Is it possible that you did see it?

A. I might have seen it, yes, but I am aware of what the content is.

Q. You did mention that you were told about it. So who were you told about it by?

A. By Carol Frawley.

Q. What did she tell you about?

A. She told me in the case of imminent death, the family members would be able to attend -- to come to the resident with respect to the protocol and they had to wear appropriate gear and it had to be one person at a time can visit the family member.

Q. When did Ms. Frawley tell you that?

A. I am not sure. I guess after it came. The letter had come maybe the next day, I don't know if it was end of week. If not -- but she had told me about it.

M. JEAN-BAPTISE

Q. Let me just get the letter back up on the screen.

On the first page it says -- Right above the first bullet point, "As care pertains specifically to COVID-19, state and federal rules and regulations require nursing homes must adhere to appropriate safety measures including but not limited to."

And if you go to last bullet point here it says, "Having protocols to separate residents into cohorts of positive, negative and unknown, as well as separate staffing teams to deal with COVID-positive residents and non-positive residents."

Were you aware of that guidance in April of 2020?

A. Yes.

Q. Is it fair to say that all the guidance that we've looked at thus far, April 2020, suggested and directed that nursing homes separate residents into cohorts of COVID negative, positive, and suspected?

A. Yes.

Q. As we've already discussed, Fulton failed to adhere to that guidance by not cohorting residents that were suspected of having COVID-19; is that correct?

A. I want to say yes.

Q. If we could just get that letter back up one more time, just going to the last part, the last paragraph.

It says, "If your facility is unable to meet cohorting standards or any infection-control standard, admission must be suspended to the facility. Failure to adhere to these standards will result in civil monetary penalties and/or revocation of your license."

Is it fair to say that if DOH had learned that Fulton was failing to properly cohort its residents, Fulton was facing potential revocation of its operating license?

A. This is the law.

Q. So that would be accurate, correct?

M. JEAN-BAPTISE

A. Pardon me?

Q. So it's accurate to say, then, that if DOH had been aware of Fulton's failure to cohort the suspected COVID-19 residents, then Fulton could have had its operating licence revoked, correct?

A. Yes.

Q. Okay, thank you.

Ms. Jean-Baptiste, in your opinion, did Fulton Commons and have sufficient PPE through the pandemic?

A. No.

Q. Can you elaborate on that?

A. Because when I came back and the staff had no PPE and I went to Carol Frawley and I expressed it to her I was on the verge of crying and I was very emotional at that time and I was saying, What happened with the PPE? I said, The staff cannot work without the proper gears because then we will have a problem with that if we don't follow the guideline. I was told that there were no PPEs available as of yet and the next day when I came, which was the 10th of

M. JEAN-BAPTISE

April, then they had PPEs for everybody?

Q. What PPE in particular was Fulton lacking in?

A. What were they --

Q. What were they lacking it?

A. I don't know if anybody was using a mask while I was away, but I know that -- they were lacking in everything except for the gloves. I don't know if they -- I know from the 10th, from April 10th going forward they had PPE. I don't know if because it was a very difficult time, but I know from the 10th everybody was provided with equipment to care for the residents.

Q. Did you return to work on April 9th?

A. Pardon me?

Q. What day was it that you returned to work, was that April 9th or April 10th?

A. I went back to work on April 9th and I addressed the PPE situation to Carol Frawley and I think the next day I came everybody was -- I don't know if they had implemented it from the night shift, but

when I came the next day on the 10th, everybody was provided with masks, with all the appropriate gears to care for the resident.

Q. When you went out sick on March 25th, let's go back a day -- your last day in the facility prior to that -- did you find that there was a PPE issue at that time?

A. Yes there was a PPE issue at that time.

Q. What was missing at that time, what sort of PPE was missing?

A. I don't know if it was the gears -- I am sorry, the shield, the face shields were probably missing at that time.

Q. Do you know if the facility ever attempted to obtain PPE through the Office of Emergency Management?

A. They did. Apparently those are the PPEs that they started to use. I don't know what transpired because, as I said before, that I felt -- I don't know if because I went and really I was very adamant

about the PPEs because that is the only thing I had really to push for, I said they have to have PPE, this is not going to work like that. We cannot have that. Everybody is going to be sick and this is not a good way. I don't know if it is at that moment that they kind of start to sideline me, but I felt that I was not being updated on anything after that.

Q. Did it seem to you that because you were bringing these concerns to the administration's attention that they started to push you away?

A. Yes, I believe so. Because I felt as if I was not trusted. I couldn't stand for that. That was the only thing I could do, really, go and express that concern. And I didn't really care at that point, but I said, I have to say something. I cannot let it go by.

Q. Are you familiar with the term, "person under investigation," or "PUI"?

A. Yes.

Q. What is a PUI, what does that

mean?

A. Okay, that is where somebody is coming from a hospital or they have -- maybe they have been exposed to someone with positive results or any other reason or from coming from a hospital, even coming from the hospital with a negative COVID, if people travel in the ambulance, they are considered under investigation because they don't know at that moment while they are being transferred if they had not been exposed, although they were negative. So they would be quarantined and placed on a PUI unit considered under investigation.

Q. So the record is clear, those are people who may have been exposed to COVID?

A. People who had the potential of exposure because of -- no one knows at what point people get infected. Because I have a negative result today, that doesn't mean that I could be infectious if I am exposed to someone after I was swabbed. I could be -- so in the nursing homes, people under investigation are the people who come from

the hospital and although they have negative COVID, but they are placed on a PUI unit because there is the potential that they could have been exposed to the virus.

Q. Would an individual who is exhibiting symptoms of COVID-19 also be considered a PUI?

A. Yes, if they are exhibiting symptoms.

Q. When did Fulton have its first PUI case?

A. I don't know exactly because, like I said, when I came back on the 9th of April, that's when I noted they had people being quarantined on 1 East. I don't know the date exactly that that took place.

Q. When you left at the end of March, at that time, was there anyone at Fulton who was suspected of having COVID, to your knowledge?

A. No, not to my knowledge. Not that there were none, but not to my knowledge.

Q. But then when you came back in

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April, at that time, you were aware there were people in the building who would be considered a PUI; is that correct?

A. That's correct.

Q. At that time, the individuals who were in the building who were considered PUIs, were they in private rooms or did they also have roommates?

A. There were in the same room. But what happens, everybody was kept in their rooms. They were not allowed to be in the hallway for fear of being contaminated. So they had no dining room services. Everybody remained in their room.

To answer your question is other than 1 East, I cannot say that people were being cohorted at that time.

Q. The residents on the other units, the ones who were not being cohorted that were exhibiting symptoms of COVID-19, were they kept in private rooms or did they have roommates?

A. They were -- they had roommates.

Q. Were any steps taken to protect

the roommates from potentially contracting COVID?

A. What I can say is that they were -- most of them were exhibiting the same symptoms at the same time so there was no -- if somebody had a cough they both had the same problem, so if you consider that to be cohort, then I would say yes.

Q. Were there any instances where one resident was exhibiting COVID symptom but their roommate was asymptomatic?

A. That I cannot answer directly. I would say -- I don't recall that.

Q. From an infection control standpoint, if such a scenario occurred, what would be done about the roommate?

A. The roommate would have been in a different -- placed in a different room. But with COVID, it's just if somebody has already been exposed, then you would have to have a segregated area to put everybody who is not exhibiting any symptoms on one side. The ideal would have to put everybody who is not exhibiting any symptoms on one side and

be considered persons under investigation, and the ones who are exhibiting the symptoms would be on the other aisle of the unit so they could be cohorted that way.

Q. To your knowledge, was that ever done at Fulton?

A. No. It's not because I didn't know what to do, it's just I was not allowed to do what I was supposed to do.

Q. Is that the because you were cut out of all the discussions?

A. I was cut out of all the discussions. I saw that from the beginning. I was not allowed to anything -- it was unbearable.

Q. At what point did Fulton begin to test its resident for COVID-19?

A. I want to say after we had the survey, the infection control survey, pardon me. Then we had -- I had -- I cannot remember the name of that community, that infection control person. But I know her name was Marie. I don't remember her last name, and she used to call me every day and

she had suggested to me that we do, we have to test all of the residents.

And I told her that I am going to bring that up because I think it's a great idea, and this is something that I always wanted to do but now that you mentioned it, I am going to bring it to them, meaning Cathie Doyle and Mrs. Frawley. I said, let me speak to the leadership and see what they will say. And at that time they were in agreement with me for the first time. And I said, I spoke to this lady, from I forgot, I am sorry. And she advised that we should test everybody in the facility and they provided us -- she provided me with all the information and how to do it and they sent a team and they did everybody in the facility in one date.

Q. Was that the state that did that?

A. The state did that, yes. But that lady was the one who helped me to do that, to accomplish that. It was very meticulously -- and it was a complete success.

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Q. You believe that was after the DOH infection control survey took place?

A. That was after the DOL infection control took place, that was definitely after that.

Q. Did those tests have any effect on where the residents in the facility were housed?

A. It was done in June and I think it was the time that after that I was let go so I don't even know the results. I think the results started to come, but I was not even in the knowing what happened, who tested positive. I cannot tell you that, I have not seen one of the results because it sent directly to Cathie Doyle or Frawley. I didn't have that access, although, I was the one who made sure they had everything done, but after that I was totally cut out.

Q. To your knowledge, did the State get any pushback from either Cathie Doyle or Carol Frawley with respect to testing the residents?

A. Before when I had mentioned it to

them, I got a lot of pushback, but after the survey, I guess they probably realized that it was the best course of action and they agreed to have it done. Because whenever I had mentioned it I said, the lady is suggesting that we -- to test all the residents and she's going to emphasize to have the state people come and it's going to be done very swiftly. We don't have to spend any time swabbing the people, they will do everything. Swabbing, they will do everything. But after that I was let go, so I don't know the result, what it was. I have no idea.

Q. We talked before about 1 East being the designated COVID unit. To your knowledge, were any other areas of Fulton ever designated as a COVID area or COVID unit?

A. No.

Q. Just to verify, it was your understanding that all residents who were admitted to the facility were supposed to be funneled through 1 East; is that correct?

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A. That's correct.

Q. Who was responsible for assigning residents to rooms during the COVID pandemic?

A. Usually admission does the assignment of the rooms where new residents go to. Unless if there is a specific reason why somebody should not be going to such-and-such room.

Q. Do you know if it continued to be the responsibility of admissions throughout of pandemic?

A. I would say if not, then Carol Frawley reviews the PRI so she will be assigning the rooms or working I would say in conjunction with admission as to where the resident would go.

Q. I am going to show you what's been premarked as Exhibit 15. This is a four-page document. Ms. Jean-Baptiste, are you familiar with what we are looking at here?

A. Yes.

Q. The top of it says, Fulton

Commons Care Center, daily census sheet. Have you seen this sort of document before?

A. Yes.

Q. This is a business record of Fulton Commons, correct?

A. Yes.

Q. All right. So, at the top this we see that there is a date, and it's April 17, 2020; is that right?

A. Yes.

Q. Looking at this document it looks like there's a breakdown of each of the units in the facility with the census for that date on that unit broken up by mail and e-mail; is that right?

A. Yes.

Q. And then, if we go down to the middle of the page where it says admissions and readmission. Do you see that part?

A. Yes.

Q. In this section here where it says "admissions and readmissions," would that -- looking at the section in the middle, would that have listed there the

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name of every admission, the room they were assigned to, what their diagnosis is and where they came from, whether a community, another facility, or hospital?

A. Yes.

Q. If we take a look at admission and readmission, we have three residents that are listed here, correct?

A. Yes.

Q. And so we have -- the first one is put into Room [redacted]. Is that on 1 East?

A. [redacted] is on 1 East.

Q. And that resident's last name is Resident #31, first name, Resident #31, correct?

A. Yes.

Q. And with the diagnosis of COVID-19, right?

A. Yes, that's the diagnosis.

Q. So that person came in COVID positive, correct -- according to this document?

A. Yes, according to this document. According to this document. But not to cut you, I was told that nobody had COVID-19 and

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I don't know why they carry the diagnosis of COVID-19.

Q. Okay. I understand that you said that you were told that nobody was COVID positive. But according to this document, it looks like this individual came in COVID positive, correct?

A. Correct.

Q. The next person listed here as an admission, their last name is Resident #5, first name, Resident #5 ; correct?

A. Correct.

Q. Their diagnosis is also listed as COVID-19, right?

A. Yes.

Q. And they're placed into Room [redacted], correct?

A. Yes.

Q. That's on 3 West, right?

A. 3 West.

Q. The third person on this document, we have the name of Resident #6 , and their diagnosis was also COVID-19, right?

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A. Yes.

Q. They are put into Room [redacted], correct?

A. Yes.

Q. That's also west?

A. Yes.

Q. Is it fair to say that, according to this page, on [redacted] [redacted] there were three COVID-positive residents admitted to the facility, and they were put on two separate units. One was placed on 1 East while the other two were placed on 3 West?

A. That's correct.

Q. At this time, 1 East is already established as the COVID unit; correct?

A. Yes, yes.

Q. How many beds are there on 1 East?

A. Forty.

Q. If we just go to the top of this document where we see the list for Unit 1 East, we see the census count is -- the total count is 34. So that means there were six empty beds on 1 East; is that

correct?

A. Correct.

Q. I will go to page 2 of this document. The date at the top is April 21, right?

A. Yes.

Q. If we look at 1 East, the census on that date was only 30, correct?

A. Yes.

Q. So there are ten empty beds, right?

A. Yes.

Q. If we go to the middle of the page under admissions and readmissions, we see that there were three residents admitted on that date; is that right?

A. Right, that's correct.

Q. And all three of those residents, according to this document, have a diagnosis of COVID-19, correct?

A. Correct.

Q. If we look at the room assignments, two of them were put on 3 West and one of them was put on 1 East; is that

right?

A. Yes.

Q. Going to the third page, the date on this one is April 24th; is that right?

A. Yes.

Q. On that date, the census on 1 East was 32. So there are still eight empty beds; correct?

A. Correct.

Q. And we have -- if we look at the admissions and readmissions, we have five individuals who were admitted to Fulton that date; is that right?

A. Yes.

Q. Of those five residents, we have one by the name of Resident #49 with a diagnosis of COVID-19, right?

A. Yes.

Q. And she was put in Room [redacted], correct?

A. That's correct.

Q. Is that Unit 4 East?

A. That is Unit 4 East.

Q. The fifth resident on this list,

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we have Resident #44 , who also came in with a positive diagnosis of COVID-19 according to this document; correct?

A. Correct.

Q. And she is put into Room [redacted], which is on 1 East, right?

A. Correct.

Q. The other three residents on this sheet, the first one is Resident #23 , we have Resident #75 and Resident #76 , their diagnosis on this sheet do not indicate COVID; is that correct?

A. That's correct.

Q. So looking at this, it looks like these residents are COVID negative?

A. Yes.

Q. And of those three, two of them were placed on 1 East; is that right?

A. Yes, that's right.

Q. And one of them was placed in Room [redacted], so on the third floor, right?

A. That's 3 West.

Q. Three West. Now looking at the last page of this document, the date on this

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is April [redacted]; is that right?

A. Yes.

Q. And we have in 1 East the total census is 33, which means that there were 7 free beds, correct?

A. Correct.

Q. We have one admission by the name of Resident #50 who comes in COVID-positive, right?

A. Yes.

Q. And she goes to the fourth floor?

A. Yes.

Q. From an infection control standpoint, these records make it seem as if Fulton was engaged in proper infection control?

A. No.

Q. According to these documents, was Fulton engaged in proper cohorting of residents?

A. Yes.

Q. I'm sorry. These records indicate that Fulton was properly cohorting residents?

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A. No.

Q. Thank you.

I am going to ask you to look now at Exhibit 16. This is a seven-page document.

In looking at this, these are more daily census sheets from Fulton; is that right?

A. Yes.

Q. On the first page, we have a date of [redacted], 2020. Do you see that at the top?

A. Yes, I do.

Q. I'm just going to have you look down at the admission and readmission. We have three people admitted that day. The first person, by the name of Resident #48 came in with a diagnosis of COVID positive, right?

A. Yes.

Q. And she is put into Room [redacted], correct?

A. Correct.

Q. The next person on there has the

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name Resident #77 . Her diagnosis, at least listed here, does not indicate COVID; is that right?

A. No.

Q. She is put into room and bed [redacted]; is that right?

A. That's correct.

Q. Is she sharing a room at this point with Resident #48 ?

A. Based on the documentation, yes.

Q. And this documentation indicates that there is a COVID-positive and a COVID-negative resident sharing a room; is that right?

A. That's correct.

Q. Is that proper infection control?

A. No.

Q. Going to the second page, the date is [redacted], 2020. Let's go straight down to the admissions and readmissions. We have three people who were admitted that day; is that right?

A. Yes.

Q. Of the three individuals, only

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one of them has a diagnosis of COVID-19, correct?

A. Correct.

Q. But all three of these residents were placed in the same unit based on the room numbers; is that right?

A. Yes. But [redacted] is a private room.

Q. Okay. But the other two residents who do not have a diagnosis of COVID-19 were still placed on the same unit as somebody who is indicated to be COVID-positive, correct?

A. Yes, you are correct.

Q. Going to the next page, we have a date of [redacted]. We have two residents who were admitted that day; is that right?

A. According to the documentation, yes.

Q. According to this document, neither of those individuals have a diagnosis of COVID-19; is that correct?

A. That's correct.

Q. And they are all placed on 1 East as well; is that right?

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A. That's correct.

Q. Going to the next page which is the date of [redacted], we again have one resident admitted and there's no indication that her diagnosis is COVID-19, at least on this, correct?

A. Correct.

Q. And she is also placed on 1 East, correct?

A. One East, yes.

Q. The following page is [redacted]. I think we already looked at this a little bit on the previous packet, but we have two residents admitted, Resident #23 and Resident #75, who do not have a listed diagnosis of COVID-19 but they are admitted on to 1 East; is that right?

A. Yes.

Q. From looking at the following pages, [redacted], 2020, we have three residents total who were admitted that day according to this; is that right?

A. Correct.

Q. The first one, Resident #36 is

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admitted with COVID-19 and is admitted to Unit 1 East, right?

A. Yes.

Q. The third resident, Resident #22 , does not have a COVID-19 diagnosis listed, but is nonetheless put on 1 East; is that right?

A. That's right.

Q. Looking at the last page, which is [redacted], we have two residents admitted that day, one with a COVID-19 diagnosis, one without a COVID-19 diagnosis, but both are placed on Unit 1 East; is that right?

A. That's right.

Q. Did these documents indicate that Fulton was engaged in proper infection control?

A. No.

(Whereupon, a lunch break was taken.)

MS. SEKHON: Back on the record. We took approximately a five-minute break and we did a roll call off the

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record and everyone who was present this morning is still present, so we are ready to continue.

Q. Ms. Jean-Baptiste, you talked a little bit about the infection control survey that occurred in May. Did that occur on May 4?

A. I want to say that, yes.

Q. Was that a Monday?

A. Yes, it was a Monday.

Q. Did you learn about that survey in advance?

A. No, not really.

Q. Did you suspect that that survey was going to be happening?

A. I don't know. It was somewhat expected but I didn't really know anything about that survey or anything like that. But I know that at one point we were going to have an infection control survey.

Q. When you say it was kind of expected, what made you kind of expect it?

A. Because we had a lot of deaths in the facility so we were look -- the facility

was looked at as high risk. We have a high prevalence of mortality and I don't know, I think that would have triggered a survey. Looking at the infection control at this point in the facility.

Q. How many deaths were there in the facility?

A. I am not 100 percent sure as to how many deaths, but I know that there were many, many deaths, unlike the regular times. It was exponentially higher than we had ever seen before. So I would say that.

Q. Those residents who passed away, did they pass away inhouse or were they transferred to hospitals prior to their passing?

A. I want to say most of them died inhouse.

Q. Did anyone from Fulton's administration ever direct that residents should be discouraged from being transferred to hospitals?

A. Can you please repeat that?

Q. Sure. Did anyone from Fulton's

administration ever direct that residents should be discouraged from being transferred to the hospital?

A. They have not really transferred anybody to the hospital, except I believe in maybe one case or two cases that a resident was transferred or two residents. I am not too sure as to -- but I don't remember having seen anyone being transferred out when I was there during the pandemic. I believe before I came there was a resident who was sent to the hospital and she eventually -- she subsequently died. So I don't recall too many people being transferred to the hospital.

Q. Is that because administration was discouraging residents from being transferred?

A. Yes.

Q. Why were residents being discouraged from being transferred?

A. I cannot tell the reason.

Q. Did you think that it was right that residents were being discouraged from

transferring to the hospital?

A. No. In fact, I was for residents to be tested and be transferred if they required the level of care that they would require to survive or to -- at least we would know what's going on with the population.

Q. Who in particular from the administration was discouraging transferring residents to hospitals?

A. Everybody.

Q. Who is everybody?

A. Cathie Doyle, Carol Frawley, and I guess the leadership, I would say. Lisa and I didn't have too much say about who was coming in or who was going out in terms of and making this kind of decision.

Q. You mentioned Cathie Doyle, Carol Frawley, was anyone else involved in discouraging residents from being transferred to hospital?

A. I don't want to say Dr. Butchma, because I was not sure about what his position was in terms of -- I know that he

didn't want anybody tested so I don't know what else to -- but I cannot say because I never spoke to him so that would not be fair for me to say something about him. I don't know.

Q. But Cathie Doyle and Carol Frawley expressed to you directly that they did not want to transfer residents to hospital?

A. Yes, they did.

Q. Was that in person, over the phone, in an e-mail?

A. In person, that if we say that somebody was sick and the person needs to be evaluated, not even during the pandemic, even before that, but during the pandemic, it was more so than before. I don't know the reason why, but it was the order of whatever -- of the day. Whatever they say, that's what we had to go by.

Q. Did they ever explain to you why they didn't not want residents going to the hospital?

A. No. They never explained to me

why.

Q. So we talked about this DOH infection control survey in early May, May 4th. To your knowledge, did Fulton take any steps in preparing for that survey?

A. I know I in-serviced the staff prior to that. I did whatever I needed to do as an infection control nurse within my abilities and I did my part. I don't know -- at that point we have the PPE in place and the staff were well-versed as to put them -- of all the precautionary measures, so that was my job, to make sure they know what to do, what is -- what they are supposed to do on a daily basis, not only for the survey, but what they are supposed to do. And they did -- most of them did very well, I would say. During that survey, they followed the protocol.

Q. Were you interviewed during the course of that survey?

A. Yes.

Q. What were you asked?

A. I don't remember everything. But

I was mostly asked questions as to what people didn't do well. They were asking me questions about the people who didn't do quite well. I was told of a housekeeper who didn't do very well and that triggered a whole plan of correction and in-service of the whole staff again about the whole thing and I had to do a one-to-one in-service with that particular person because he failed to follow the protocol. Those were the questions I was asked about if these people were in-serviced and I had to provide proof they were in-serviced and then they had to be in-serviced again.

Q. Do you know what the results of that DOH survey were?

A. I didn't see the results but I was told to do a plan of correction for people not to -- to wear their gears appropriately, and that's because of some people who had failed to do so and they were observed not observing -- not practicing the proper infection control procedure.

Q. Did you have any conversations

with Cathie Doyle following DOH's findings?

A. Pardon me?

Q. Did you have any conversations with Cathie Doyle following DOH's findings?

A. What she told me -- well, she told me was that someone needed to be in-serviced and there was no particular name, it was mostly we had to really -- the gentleman from housekeeping, I was told who he was, and then I did in-service him, educated him right away. And then there were maybe one or two DNAs who didn't follow the procedures. There weren't that many people, but they were reeducated as to proper use of the PPEs and stuff like that.

Q. Other than re-in-servicing the residents and being told what exactly the findings were, did you have any conversations with Cathie Doyle regarding the implications of the DOH results?

A. I had to do a plan of corrections. I think she -- and Mrs. Frawley, I don't know if she was the one with plan of corrections, but I know Cathie

was actively involved and she wanted me to follow up with ensuring that the staff were doing the appropriate things and we had to do the plan of correction for a number of weeks. That was supposed to end in July but I wasn't there until July so I am sure that somebody else had to follow with the plan of correction.

Q. Other than what we've already discussed, did you have any conversations with Carol Frawley regarding DOH's findings?

A. Not really. It's just that there were not -- they didn't feel as if -- because the survey was mostly based on the infection control procedures, whether they were being followed or not being followed. Most of the people followed the procedure and they didn't -- they were not considered as a failure in that survey because it was mostly based on are they wearing their PPE and do they know what to do when they come out of a room, and they were observed and it was all seven units and everybody did well.

Q. That survey we said took place on

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May 4th, which was a Monday. I want to take you back to that Friday, May 1st. Are you familiar with the number of room changes that occurred on May 1st?

A. No.

Q. You had no involvement in any room changes that occurred on May 1, 2020?

A. No.

Q. No one brought to your attention that there were a number of room changes that occurred on May 1, 2020?

A. No ma'am.

Q. I want to show you what's been premarked Exhibit 17. It's a two-page document.

Ms. Jean-Baptiste, are you familiar with the document that we are looking at?

A. No, I have never seen this document.

Q. You have never seen a document like this before?

A. No.

Q. Let's take a look at it and let's

see if we can figure out what it is together.

At the top of the page we see it says Fulton Commons Care Center, Inc. and then it says "patient activity log." Under that it looks to me like a date, 05/01/2020, so May 1, 2020. Is that what it looks like to you?

A. Where is that? Oh, yes, yes. Because I am looking at June 11th, so that's when it was printed maybe?

Q. I think so, I think that's the day it was printed. If we look at the first column, we have "date and time." Just take a quick look. Scrolling down, it looks like the date on all of these documented records is May 1. Does that look like the same thing to you?

A. If it looks what?

Q. Does it seem to you that the date on all of these entries are May 1?

A. Yes, yes. I see it.

Q. Starting from the top, we see next to the date -- so we have the date May

1, 2020, and then next to that under "activity" it says "bed transfer" and then we have the word, "to" -- so bed transfer to -- and then an arrow with a new room. Above it is a resident's name.

Does this appear to be a bed transfer log from Fulton Commons from the date May 1?

A. Yes.

Q. If we go down this log, we have Resident #12 , Resident #13 , Resident #8 , Resident #7 , Resident #14 , Resident #15 , Resident #16 , Resident #17 , Resident #18 , Resident #19 , Resident #20 , Resident #5 , Resident #21 , Resident #22 , Resident #23 , Resident #24, Resident #25 , Resident #26 .

So in total I think I counted 18 names on this date. Does that seem right?

A. Yes.

Q. Some of these are names we looked at before, right? They were names that came up on our daily census sheet, residents who

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were COVID-negative and put onto 1 East and residents who were Covid-positive but placed onto 3 West, for example, correct?

A. Correct.

Q. So it looks like all of these people, all of these resident rooms were changed on May 1, the Friday before DOH showed up at the facility for the infection control survey; is that correct?

A. That's correct.

Q. If we take a look -- and we can go down together at all these residents -- in total it looks like most of them are moved into units other than 1 East. What I mean by that, according to this we don't see the bed they were transferred out of, we only see the bed they were transferred to?

A. No. It just pointed to where they were going.

Q. Right, so we only have the new room listed.

A. Yes.

Q. So if we look on this log, we have Resident #8 and Resident #7, those

are two residents who were moved onto 1 East. And then if we continue going down, at the bottom we have Resident #20 and Resident #5 who were put onto 1 East.

So according to this, there were four residents moved onto 1 East on May 1, the Friday before DOH showed up; is that right?

A. According to the documentation, yes.

Q. So now I would like to show you Exhibit 18, and if we could just rotate that I'd appreciate it.

Ms. Jean-Baptiste, do you recognize Exhibit 18?

A. Yes.

Q. Is this a 24-hour condition report from Fulton Commons?

A. Yes.

Q. Looking at this, the first resident -- before we get to that, does this indicate what unit this report relates to?

A. It says 3 West.

Q. What's the date on this?

A. May 1, 2020.

Q. Underneath it, it says "Friday"; is that right?

A. That's correct.

Q. The first resident's name on here is Resident #6 ; is that right?

A. That's correct.

Q. This is a name that actually didn't even appear on the bed transfer log that we just looked at; is that correct?

A. That's correct.

Q. This individual reportedly initially was in Room [redacted], and if we look at the presenting problem it says, "Transferred to 1 East; is that right?

A. Yes.

Q. So that was the fifth resident who was transferred to room 1 East on May 1, correct?

A. Correct.

Q. Let's take a look now at Exhibit 19. This is a 15-page document.

Mrs. Jean-Baptiste, is this also a 24-hour condition report from Fulton

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Commons?

A. Yes.

Q. What unit does this pertain to?

A. It says 1 East.

Q. What's the date on it?

A. May 1, 2020.

Q. If we can go ahead and skip to page 12, and if we can just scroll down a little bit.

Ms. Jean-Baptiste, looking at page 12, starting at the top, we have a resident by the name of Resident #21 ; is that right?

A. Yes.

Q. This indicates that she was in Room [redacted] on 1 East; is that right?

A. M-hmm.

Q. Is that a yes?

A. Yes. I am sorry.

Q. That's okay, I'll prompt you.

It says the presenting problem, it indicates "room change"; is that right?

A. Yes.

Q. Next to that it says, "Room

change, [redacted] to [redacted], in stable condition," correct?

A. Correct.

Q. The next resident, last name Resident #13, was in Room [redacted]. It also indicates a room change, and this one says, "Room change [redacted] to [redacted], in stable condition"; is that right?

A. That's correct.

Q. The third one, Resident #16, Room [redacted], room change is the presenting problem. It says, "Room change from [redacted] to [redacted] and stable condition"; is that right?

A. That's correct.

Q. Next we have Resident #12 in Room [redacted], room change, the note says, "Room change from [redacted] to [redacted], in stable condition," right?

A. Yes.

Q. Next we have Resident #17, Room [redacted], presenting problem, room change. And the note says, "Room change, [redacted] to [redacted] -- " I think that said "[redacted]" but it's crossed out to an "[redacted]" -- "in stable condition"; is that

right?

A. Yes.

Q. The following one is Resident #14, Room [redacted], room change is the presenting problem, and the notes say, "Room change [redacted] to [redacted], in stable condition"; is that right?

A. Yes.

Q. The last one Resident #26 --

A. Yes.

Q. Room [redacted], presenting problem, room change. And the notes say, "Room change [redacted] to [redacted]," right?

A. That's correct.

Q. So we have, on this page, seven residents moved off of Unit 1 East and spread out throughout the unit, correct?

A. Yes.

Q. If we go to the second page we have another seven residents. And if you look at the notes, these seven residents also seem to have been moved off of 1 East onto another unit in the facility; is that right?

A. Yes.

Q. And some of these are residents that we looked at before who, according to their admitting diagnoses, were COVID-negative but were nonetheless placed on 1 East at admission; is that right?

A. That's correct.

Q. So we have 14 residents moved off of Unit 1 East and five residents moved onto Unit 1 East on May 1, the Friday before DOH shows up for an infection control survey; is that right?

A. That's correct.

Q. Is it fair to say, Ms. Jean-Baptiste, that because of these room changes when DOH showed up on Monday, May 4, it made it appear that Fulton Commons had been properly cohorting COVID-positive residents in one unit and properly cohorting non-COVID residents on other units?

A. No.

Q. It's not fair to say that?

A. It's fair to say that.

Q. It is fair to say that.

M. JEAN-BAPTISE

So it's fair to say that because of these room changes, when DOH came in, they could have been misled about Fulton's actions throughout this pandemic?

A. Yes.

Q. Now I am going to show you Exhibit 20. This is a six-page document.

I know you mentioned to me before you were not sure if there was a housekeeping log maintained by Fulton Commons. But I will ask you to take a look at this and let me know if that is what this appears to be, if this appears to be a terminal cleaning log.

A. I have never seen their terminal cleaning log before, so I cannot -- what it looks like or what. I don't know.

Q. Okay. Are you familiar with any of the names of the housekeeping staff?

A. Yes.

Q. Do the names that you see on this document appear to be the names of the housekeepers that you are familiar with at Fulton Commons?

A. Yes.

Q. If we look at this log together, in the first column we have date discharged or transferred, correct?

A. Yes.

Q. The second column is date cleaned?

A. That's correct.

Q. And the last column has the bed number; is that right?

A. Yes.

Q. And this document itself, the title on it is, Terminal Cleaned, COVID-19, right?

A. Yes.

Q. Does this appear to be a terminal cleaning log maintained by Fulton Commons?

A. Pardon me?

Q. Does this document appear to be a terminal cleaning log maintained by Fulton Commons?

A. As I said, I have never seen a terminal cleaning log, so I don't know.

Q. Okay. I understand that you --

M. JEAN-BAPTISE

A. As I mentioned before, I never saw a terminal cleaning log.

Q. Okay. I understand that you've never seen one before and so this is not a document that's familiar to you. My question is only whether, looking at this document, does it seem like that's what it is?

A. I cannot answer that because I never saw the document and I don't know -- I never even knew that it existed.

Q. Okay. So, understanding that you've never seen this document before, if we look at the first line where we have "date discharged or transferred," we have a date of March 26, 2020. In the second column, that's the "date cleaned," we have March 27, 2020. We have "assigned housekeeper" and then we have a name, a first name and a last initial. And we have a bed number, 4W[redacted]. That's probably 4 West, Room [redacted]?

A. Yes.

Q. Does this document seem to

suggest that a resident was discharged or transferred on March 26 and that the room on 4 West, [redacted], that that bed was cleaned on March 27th by Kim A?

A. Yes.

Q. I am going to take you down to -- let's go to page 4. The last date of discharge on page 4 is April 30, 2020; is that right?

A. Yes.

Q. And now going to page 5, the next page, the first date is May 1, 2020, correct?

A. Yes.

Q. Is it fair to say that on this document there is only one entry for May 1, 2020, for one room?

A. Yes.

Q. So together we have established that there were 19 transfers on May 1. Is it fair to say that, despite there being 19 transfers, we only see one documented on this log?

A. Yes.

Q. So this log does not indicate that 18 of those rooms have been terminally cleaned; is that right?

A. Yes, based on this document, yes.

Q. I just want to go back to Exhibit 18 for a moment -- I'm sorry, not 18, Exhibit 19, my apologies. If we go to page 12 at the bottom, resident Zaratehernandez, it indicates that she was moved out of Room [redacted].

A. Yes.

Q. On the top of page 13, the following page, the resident, Long, was moved out of [redacted]; is that right?

A. Yes.

Q. And the last resident on that page, Strancewilko, was moved from Room [redacted], Bed [redacted]; is that right?

A. Yes.

Q. Going to the following page, this is page 14, we have Resident #7 , and it says, "inhouse transfer" and the room listed is [redacted]; is that correct?

A. Yes.

M. JEAN-BAPTISE

Q. And the following resident listed is Resident #5 and the room listed is [redacted] for inhouse transfer, correct?

A. Correct.

Q. So according to this document, we have two residents being moved into Room [redacted], Beds [redacted] and [redacted], after two residents earlier in the day had been moved out of that room, correct?

A. That's correct.

Q. And looking at what appears to be a terminal cleaning log that we just reviewed, it does not appear that that room was cleaned that day; is that right?

A. That's correct.

Q. Now if we can just go to page 6 of this exhibit.

The only resident listed on here, the last name is Resident #6 -- the first name rather, Resident #6 -- and we have Room [redacted]. But this was also a room that had been recently vacated that day, correct?

A. According to the documentation, yes.

M. JEAN-BAPTISE

Q. Yes, according to the documentation, thank you.

And according to the housekeeping log that we looked at, there is also no indication that that room was cleaned prior to this resident being moved in; is that right?

A. That's correct.

Q. Is that following proper infection control?

A. No.

Q. I am going to show you now Exhibit 21. This is a 19-page document.

I know we spoke earlier and you told us that you were not involved in the creation of policies and procedures at Fulton. But as the infection control nurse, I would assume that you were familiar with them; is that right?

A. Yes.

Q. I am going to direct your attention to the first one which is called Bioterrorism Pandemic Influenza/Virus.

Is there a date on this?

M. JEAN-BAPTISE

A. February 26.

Q. That's 2020?

A. 2020.

Q. Do you know who created this document on February 26?

A. I don't know. That was the in-service that Cathie gave and we had everybody in that meeting, all the disciplinary team attended that meeting.

Q. So just directing your attention to the section -- it's a whole section that says, Monitoring residents for pandemic influenza and instituting appropriate control measures.

When this says, "pandemic influenza," does this also apply to COVID?

A. I didn't hear you. Can you please repeat that?

Q. Yes. Although this indicates "pandemic influenza," does this also apply to coronavirus?

A. Yes.

Q. So under that bold heading, the first paragraph, the one sentence says,

"Early detection of the presence of pandemic influenza in a facility is critical for ensuring timely implementation of infection control measures."

As we discussed already, this applied to COVID, right?

A. Yes.

Q. Would you agree with me that a virus like COVID, that can be infectious prior to the development of any symptom, testing is critical to early detection?

A. I agree, yes.

Q. The second bullet point reads, "If symptoms of pandemic influenza are apparent, implementation of precautions for the resident and roommate, pending confirmation of pandemic influenza virus infection."

And again, this would also apply to COVID, correct?

A. Yes.

Q. Is it fair to say that the only way a facility would obtain confirmation of an infection is by testing a resident?

M. JEAN-BAPTISE

A. That's correct.

Q. The third bullet point says, "Cohort residents and staff on units with known or suspected cases of pandemic influenza."

And again, does this apply to COVID?

A. That's correct.

Q. And you would agree with me again that Fulton failed to cohort residents on units with suspected cases of COVID, correct?

A. That's correct.

Q. Going to the second page, under the bold section, environmental cleaning and disinfection, the first sentence says, "Cleaning and disinfection of environmental surfaces are important components of routine infection control in health care facilities."

Would you agree with that?

A. I didn't hear you, I am sorry.

Q. The first section reads under this heading, "Cleaning and disinfection of

environmental surfaces are important components of routine infection control in health care facilities."

Would you agree with that?

A. Yes.

Q. And under Cleaning and Disinfection After Resident Discharge Or Transfer, it reads, "Following standard facility procedures for post-discharge cleaning of an isolation room."

And the second indicates, "Clean and disinfect all surfaces that were in contact with the resident or might have become contaminated during resident care."

Does that refer to terminal cleaning?

A. Yes.

Q. Should that be done before moving any resident into a recently vacated room?

A. Absolutely.

Q. Why is it essential that it be done before moving a new resident in?

A. To prevent the spread of infection or micro-organisms.

M. JEAN-BAPTISE

Q. Moving on to the third page of this policy, under the section, Resident Placement it reads, "Place resident with influenza in a private room or cohort with other residents with influenza."

And this also applies to COVID, correct?

A. Correct.

Q. And there is a little asterisk there, and the asterisk indicates, "During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible"; is that right?

A. That's right, that's correct.

Q. And during March and April, the early stages of the COVID coronavirus pandemic peak, did Fulton make any efforts to test any of its residents for COVID-19?

A. That's correct.

Q. I'm sorry. Just to verify, to your knowledge, Fulton did not take any steps at all; is that correct?

A. That's correct.

M. JEAN-BAPTISE

Q. I am just going to draw your attention now to the next policy. It starts on page 4 and the policy name is "COVID-19."

Do you know when this policy was created?

A. I am not sure. I don't see a date and I'm not sure. I know if it's from February 26th I am led to believe that the time it could have been after that. But I don't even remember this policy at all.

Q. Have you ever seen this before?

A. No.

Q. So from the time that you were the infection control nurse through this pandemic -- so from January 1, 2020 through when you left June 18, 2020 -- you had never seen this policy before?

A. No.

Q. So is it fair to say that if you never saw this policy before, you certainly were not able to give any in-services to any of the staff regarding this policy?

A. We did have coronavirus in-service but not according to this policy,

because I've never seen this policy before.

Q. As the infection control nurse, should any such policies be given to you or brought to your attention by administration?

A. Yes, but I never see it. Not that I have never heard of the coronaviruses, but I have never seen the coronavirus or viruses. But I've never seen this policy.

Q. By the way, is it abnormal that there is no date on this policy?

A. It should be a date. There should be a date on every policy because when you revise it you have to know when it was implemented and when it was amended. So I don't see any date on that policy and I've never seen this policy before.

Q. Okay. I'm going to skip ahead to the next policy and procedure that starts on page 11 of this packet. And this one is titled, Protocol For Residents With Suspected COVID As Well As Residents Admitted From Hospital With Confirmed COVID.

Have you ever seen this policy

before?

A. No.

Q. Can you tell by looking at it if there is any date on this policy?

A. No.

Q. Again, is that abnormal in your experience for there to be no date on it?

A. Like I said, there should be a date on every policy and it -- because if you have to amend it, you have be able to know when it was implemented so when it is amended, then you know when the policy was revised, when it was changed so we can keep track if whether people violated policies or not. So if it has no date, it's just -- it's not professional to do that.

Q. I know you said you've never seen this policy before, but would be it fair to say that you don't know who created this policy?

A. No, I don't.

Q. Okay. I am going to take a quick look through this policy with you even though I know you said you've never seen it

before.

Just looking at the first page, the first section which says, Protocol For Inhouse Resident With a Suspected COVID Diagnosis.

Item No. 1 says, "Any resident residing in the facility that has a fever of 100 will be assumed a suspected case of COVID and will be placed on isolation precautions immediately. The resident will be transferred to the designated unit unless they are in a private room."

To your knowledge, did Fulton implement that part of the policy while you were working there throughout the COVID pandemic?

A. No, because if they had a policy like that, then they violated their own policy.

Q. I am going to go to the next policy and procedure. It's called, Terminal Cleaning, it says, COVID-19.

Is there a date on this policy?

A. I don't see a date on this

policy.

Q. Have you ever seen this policy before?

A. I want to say yes, I have seen this policy. I don't know if it is the same policy that I have seen because I had to speak to the housekeeper that we discussed earlier about -- was it terminal cleaning? I don't think so. No, I don't think I saw this policy. I don't think I saw this policy. Because it wasn't about terminal cleaning I had in-serviced him about. I didn't see that policy. Not that it didn't exist, but I'm not aware of it.

Q. So you've never seen this policy before, and as we discussed, there's no date on it so we don't know when it went into effect; is that correct?

A. That's correct.

Q. Let's go to the next page.

The next policy and procedure says, COVID Surveillance and Tracking Methods.

Have you ever seen this policy

and procedure before?

A. COVID Surveillance and Tracking Methods. We were not tracking COVID because I was told that we had no COVID in the facility to begin with.

Q. Okay. Just going back, have you ever seen this policy before?

A. No.

Q. Is there a date on this policy?

A. No.

Q. Do you know anything about when it was created or who created it?

A. I have no idea.

Q. Since you've never seen this before I won't even ask you about it.

So looking at the next policy and procedure, the top says, Protocol For Screening of Employees.

Have you ever seen this policy before?

A. No.

Q. Is this policy dated?

A. No.

Q. Do you know who created this

policy or when?

A. No.

Q. I will skip ahead to the following page then.

This one is titled, Communication/Notification During COVID-19 Pandemic Protocol.

Have you seen this policy before?

A. Yes.

Q. Does this policy have a date on it?

A. Yes. It says, "revised April 24, 2020," but I don't see the original date. I think it was not a revision, it was the implementation of this policy.

Q. Let's go to the bottom of the page for a minute. In the lower left-hand corner we see some notation. Can you tell us what those notations mean?

A. It says 3/12/2020 and 4/10/2020, then revised again 4/24/2020.

Q. It looks like there's an initial behind it, "CD." Is that for Cathie Doyle?

A. Cathie Doyle.

M. JEAN-BAPTISE

Q. So unlike the other policies that we looked at that you've never seen before, this policy actually has a date on it and also indicates that it was revised and/or reviewed, correct?

A. Correct.

Q. Is that how the policies and procedures should be if they were properly implemented, they would have a date on them and indicate if they were ever reviewed or revised?

A. Yes, ma'am.

Q. If we take a look at the next page, this has the same title, Communication/Notification During COVID-19 Pandemic Protocol.

What is the effective date on this one?

A. April 10, revised. April 10.

Q. Okay. Does this seem to be the earlier policy from the one we were just looking at?

A. That's correct.

Q. Looking at the next page, again

we have the same title, and we have an effective date now of March 12, 2020.

Does this seem to be the original policy?

A. Yes, correct.

Q. Is it striking to you that the other policies that we looked at that you have never seen before have no date on them?

A. Can you rephrase the question please?

Q. Sure. Do you find it interesting at all that the policies and procedures that you've never seen have no date on them?

A. It is interesting, yes.

Q. Does that is seem odd to you that those have no date on them and that you, as the infection control nurse, have never seen them before?

A. Yes, because as I said before, it's not professional to have policies that have no date on them and if you revise them, then how do we know when it was implemented and who knows when the policy is being followed or if it's violated? It doesn't

make any sense.

Q. Is it problematic also to have policies related to the infectious disease that you, as the infection control nurse, are not even aware of?

A. Yeah, I am not even aware of these policies.

Q. Would you agree that that's problematic, because if you don't know about them, you can't implement them; is that correct?

A. That's correct.

Q. I am going to draw your attention now to page 18 on Exhibit 21. It's titled, Updated Protocol For Coronavirus, and there is a date on this one. It's purportedly implemented March 10, 2020.

Have you seen this before?

A. Let me look at it. Yes, I have seen this policy.

Q. I'm going to direct your attention -- well first let me ask you, who created this policy?

A. I am not sure if Ms. Frawley or

Cathie Doyle. It could have been either one of them.

Q. So directing your attention to No. 6 on this policy, it says, "Ms. Baptiste, RN, ADNS, infection control or their RN unit manager must evaluate any staff displaying any signs or symptoms of illness. Any employee ill will be sent home immediately."

Did you personally evaluate any staff for illness during the course of this pandemic?

A. Yes, when people came and if they had any kind of fever they were sent home and it was reported to the Nassau County Department of Health. And we had a line listing on them and they were called after two weeks to see if they had followed up with their physician and if they had been tested again to see if they had a negative result and if they were able to come back to work.

Q. Do you recall how many staff were sent home for displaying symptoms of COVID

during the pandemic?

A. As I said earlier, when I came back, Lisa was in charge of the employee line listing and she would be able to know -- she would be the one knowing exactly how many people were sick because she was taking care of that particular group.

So she was responsible for the employees. But I would still follow up with them but I was not keeping a log of the employees anymore because she kept that log.

Q. Were any staff who were displaying symptoms of illness permitted to remain at work?

A. You're being cut off a lot, I'm sorry.

Q. That's okay. I will repeat.

Were any staff who exhibited any symptoms of being ill ever permitted to remain at work?

A. No. Not to me. Once I assess somebody, if somebody had a mere cough or they were not -- I hear them, I said, "No you cannot stay, you have to go home."

Although many times I was reprimanded, but I said that I cannot keep them because if anything happens, then I would be held liable. So I didn't want them to stay if they were not feeling well.

Q. I am just going to show you now from Exhibit 21 just the last page. This one is entitled, Protocol For Residents Exhibiting Various Symptoms During This Pandemic.

Have you ever seen this policy before?

A. They had different protocols I saw, but I've never seen this policy. They had many different protocols in place and they kept changing the protocol. I guess on a weekly basis they were changing protocols. Because when I came back I saw a lot of protocols that were implemented and it kept changing it. They kept changing them.

Q. There was no date on that policy, correct?

A. No date.

Q. Ms. Jean-Baptiste, did anyone

ever discuss with you the alteration of any documents over the course of this COVID-19 pandemic?

A. Any what?

Q. Did anyone ever discuss with you the alterations of any documents over the course of this pandemic?

A. No.

Q. Did anyone ever complain to you that they were being asked to alter or falsify any documents over the course of this pandemic?

A. No.

Q. Did you ever hear any rumors in the facility regarding the potential alteration of documents in connection with this pandemic?

A. No.

Q. Did you ever become aware of nursing staff being instructed not to discuss COVID-related questions with families under the threat of immediate termination?

A. I don't know that as a fact.

M. JEAN-BAPTISE

Q. Did you hear anything about that from anyone such as a rumor or anything like that?

A. I believe I heard that once, but it wasn't confirmed. So am not sure even who said it. But I overheard someone discussing it with another employee but I am not aware of that myself. I am not surprised, though, if that happened. I'm not surprised.

Q. Can you elaborate a little more when you say that you are not surprised that that happened?

A. I am not surprised because of the culture. Sometimes it could be a very unprofessional atmosphere and the threat --

For instance, I remember during the month of March -- that was before I was sick -- and a staff member was wearing an N95 and that person was reprimanded because why were they wearing an N95? That suggested that there was something going on at the facility because nobody else had an N95. And some people were buying their own

N95 or I don't know where they were getting them from but they were protecting themselves, and they were told not to use those -- the N95s -- because it's not appropriate.

Q. Who told them not to use the N95s because it was inappropriate?

A. The leadership.

Q. Who in particular from leadership?

A. Cathie Doyle.

Q. Did you, yourself, overhear her telling them not to use N95 masks?

A. Yes.

Q. Now, you did say that you overheard two employees potentially talking about not being allowed to discuss COVID in the building. What exactly did you hear?

A. They were not actually talking to me but I overheard them say that --

First of all, when I came back from being sick -- I keep saying that, but because I was out for two weeks, and two weeks during the pandemic was a big deal

M. JEAN-BAPTISE

because I didn't know anything that was going on and that was at the height of the pandemic where mostly everything took place, when I was sick myself.

But when I came back, I was told that some family members were very upset and were very concerned over the fact that they were not -- they were misled or they were not told about the appropriate -- they were not given the appropriate information.

And the way they were telling me is, somebody from -- somebody -- so many things that these people know, somebody who know must have told them something.

So I was thinking, I hope they don't think I'm saying anything to anybody because I don't know anything to tell to anybody, and I am not really in contact with anybody there in terms of giving information about what is happening.

So, I was told that -- so I heard an employee said after that, I overheard two people were talking and they said that, "Can you believe that she said -- " but they

didn't say who, because that's why I didn't want to say it, that if there is any suspicion that any employees speak to a family member they would be fired.

Q. Who were those employees that you overheard?

A. Right now I cannot tell you who were the two employees because at the time it didn't make any sense to me and I didn't know who was the "she" and what they were talking about. It was not really -- I didn't hear a name, I didn't hear anything, so that's why I didn't want to say that.

Q. Do you recall the employees that you overheard talking, do you recall what unit they worked on or what their titles were?

A. No, I don't remember. I don't remember exactly. That's why I really didn't want to bring it, because I cannot back it up with any fact.

Q. Listen, I asked if you heard rumors and you overheard anything, so you are doing the right thing by being honest

and letting me know what you heard. And it's fine if you don't remember any more about it.

Did you ever become aware of nursing staff being required to sign in-service sheets acknowledging they were not permitted to discuss COVID with residents' families?

A. No, that I am not aware.

Q. Did you ever become aware of any employees of Fulton being asked to sign in-service sheets for in-service lessons that they didn't actually attend?

A. No, I always make sure that I give the in-service if they were going to sign because I didn't trust anybody that way.

Q. Did you ever sign any in-service sheet for an in-service lesson that you did not receive?

A. No, because I would make sure that I read the in-service if I was not given because I want to make sure that I know what's going on.

M. JEAN-BAPTISE

Q. Did anyone ever ask you to sign an in-service sheet for a lesson that you did not actually attend?

A. No.

Q. Did you ever become aware of nursing staff being prohibited from discussing the increase of illnesses and deaths at Fulton?

A. Like I said, I overheard people and -- I think there was a overheard call at one point that stated specifically for anybody not to discuss anything with anybody.

Q. I'm sorry, say that again.

A. There was a overheard call made by Cathie Doyle for the staff not to discuss anything with anybody.

Q. When was that?

A. I don't know if it was in March or if it was in April or May. But I heard that coming from her personally.

Q. Was that over the intercom?

A. Over the intercom, yes.

Q. Did she elaborate on what you

should not be discussing?

A. It wasn't specific. It was a general statement.

Q. Not to discuss anything with anyone?

A. Anything with anyone.

Q. Are you familiar with the term, "neglect"?

A. Yes.

Q. And have you received in-services on abuse, neglect, and mistreatment?

A. Yes.

Q. Were you given definitions of each of those three things during those in-services?

A. Yes.

Q. Would you agree that neglect is failure to render timely, consistent, safe, adequate and appropriate services, treatment and/or care to a resident?

A. That's correct.

Q. Were you told during those in-services that abuse, neglect, and mistreatment are against the law in New

York?

A. Yes.

Q. Would you agree that failing to properly cohort COVID and non-COVID residents put the non-COVID residents at risk of contracting COVID?

A. I didn't hear the end.

Q. Would you agree that failing to properly cohort COVID and non-COVID residents on separate units put the non-COVID resident at risk of contracting COVID?

A. Yes.

Q. Would you agree that failing to properly cohort residents on particular units is neglect on behalf the facility?

A. Yes.

Q. Would you agree that if the facility failed to cohort staff -- and by that I mean allowing staff members to care for COVID and non-COVID residents -- that puts the non-COVID resident at risk of contracting coronavirus?

A. Yes.

M. JEAN-BAPTISE

Q. And would you agree that that also is neglect?

A. Yes. Can I say something?

Q. Yes.

A. When I was sick and when I went back and asked some of the nurse managers, I said that --

Oh, and, "How come you weren't here? You weren't here." I said that I was sick, and they never even told them I was sick.

Q. Ms. Jean-Baptiste, throughout this pandemic, I think you mentioned before that you were working at Gurwin, as well, full time while you were working at Fulton full time; is that right?

A. Yes.

Q. Were there any policies at procedure that Gurwin implemented that Fulton did not that you would have recommended that Fulton implement?

A. A lot of things I mentioned to them because -- it was two different entities. So I was trying to implement

whatever they had going on at Gurwin which was great. They did a great job with their quarantine and still are following the procedures and protocols there. They're doing very well. So I was trying to implement that, but you can't if the leadership does not comply and collaborate. I was getting so many pushbacks and I couldn't even do anything, really. It was just night and day.

Q. Can you just once again describe for us what sort of policies you wanted to implement at Fulton for which you received pushback?

A. Like the quarantine to make sure that people were separated and to test them. To make sure that we had a baseline of maybe who had maybe the virus and who did not have it. Because I'm sure not everybody had it but at least we could protect the once who didn't have it from getting the virus. And make sure we were doing in a proper way, but it was -- I was not given that opportunity to do it. Even -- it was a nightmare.

M. JEAN-BAPTISE

Q. Ms. Jean-Baptiste, do you believe that Fulton's actions throughout this pandemic endangered its residents?

A. Yes.

Q. Do you believe that throughout this pandemic Fulton's actions neglected its residents?

A. Yes, if you follow the definition, yes.

MS. SEKHON: I don't think I have any other questions for you. What I am going to do is just open it up to everyone else who has been patiently listening on this line.

Ben, I will go to you if you have any questions you would like to ask her?

MR. SMITH: No, I don't have any questions for you, Ms. Jean-Baptiste. Thank you for taking the time to talk to us.

THE WITNESS: Thank you.

MS. SEKHON: So Mary Conway, I'll go to you. Do you have any questions?

M. JEAN-BAPTISE

I'll take that as a no.

MS. CONWAY: I'm sorry, I was on mute. I have no further questions. Thank you for your time, Ms. Jean-Baptiste.

THE WITNESS: My pleasure.

MS. SEKHON: Okay. Mary Gail, do you have any questions?

MS. KOWTNA: No, I do not. Thank you.

MS. SEKHON: Elysia, do you have any follow-up questions.

MS. DOHERTY: I don't. Thank you so much.

MS. SEKHON: Again, Ms. Jean-Baptiste, I would like to thank you for your time today. It's been a long day and we really do appreciate you speaking to us. Is there anything you would like to say that has not already been said today.

THE WITNESS: Pardon me, I didn't hear the second portion.

MS. SEKHON: Is there anything

M. JEAN-BAPTISE

you would like to tell us or say that we haven't already discussed today?

THE WITNESS: I don't know. It's so many things. For right now I am very tired so I don't even know if I can think of anything anymore.

MS. SEKHON: Okay. Well, you do have my number and you have my e-mail address and I know you have been in touch with our investigator, as well. So if you think of anything you would like to tell us, please feel free to reach out.

THE WITNESS: All right.

MS. SEKHON: Thank you. That concludes this hearing. Thank you very much, everyone for your patience. Everyone enjoy the rest of your night.

(TIME NOTED: 5:14 P.M.)

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CERTIFICATION

I, SIVAN DAHAN, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 14th day of October 2020.

SIVAN DAHAN

To: Carol Frawley[cfrawley@bvnh.com]; marie.tsivitis@health.ny.gov[marie.tsivitis@health.ny.gov]
From: Cathie Doyle[cathie.doyle@bvnh.com]
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To: Carol Frawley <cfrawley@bvnh.com>; Tsivitis, Marie C (HEALTH) <marie.tsivitis@health.ny.gov>
Subject: RE: NYSDOH COVID swab team initiative- Sands Point NH

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Hi Marie – my name is Cathie Doyle, Administrator at Fulton Commons. Can you please advise as to whether testing of residents in New York State is required at this time? Thank you, Cathie Doyle

From: cfrawley@bvnh.com
Sent: Thursday, May 28, 2020 3:04 PM
To: Cathie Doyle <cathie.doyle@bvnh.com>
Subject: FW: NYSDOH COVID swab team initiative- Sands Point NH

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From: "mbaptist@bvnh.com" <mbaptist@bvnh.com>
Sent: Thursday, May 28, 2020 2:06pm
To: "Carol Frawley" <cfrawley@bvnh.com>
Subject: FW: NYSDOH COVID swab team initiative- Sands Point NH

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From: "Tsivitis, Marie C (HEALTH)" <marie.tsivitis@health.ny.gov>
Sent: Tuesday, May 26, 2020 6:54pm
To: "mbaptist@bvnh.com" <mbaptist@bvnh.com>
Cc: "Abrego, Meaghan (HEALTH)" <meaghan.abrego@health.ny.gov>, "Nemeth, Robert" <rnemeth@nathealthcare.com>
Subject: NYSDOH COVID swab team initiative- Sands Point NH

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If you decline, please advise how your facility will meet the requirement of CMS (ex. Testing all residents by facility, hiring a service to perform testing, etc)

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NYSDOH can send a nursing team to test your facility this week.

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me or a colleague in NYSDOH.

Please provide the following

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3. Complete the spread sheet template with the names of all residents who are to be tested within 48 hours of this email message (sample Excel spreadsheet is attached).

Please send back the Bioreference account form as soon as possible to Meaghan Abrego at meaghan.abrego@health.ny.gov and to me, the epidemiologist who sent you this email.

To prepare for the day of testing, please:

- Inform all of your facility's residents, and/or healthcare proxies that testing that will occur in your facility. Facilities can notify healthcare proxies when needed via email, letter, robocalls, or personal calls.
- Verbal declination is satisfactory. Written consent is not necessary.
- In the enclosed excel spread sheet, prepare a line list of all residents by unit according to room number who are to be swabbed with name, date of birth, room number, previous COVID-19 status (ever positive, only negative, never tested/unknown), whether or not the resident is on contact precautions (if yes, for which pathogen other than COVID-19).
- Prepare two sets of labels that include: name/date of birth/date of collection/NP. One label will be put on the lab form and the other on the test tube

- Your ordering clinician will have on-line access to all of these results and should work with Bioreference customer service to set up his/her on-line access.

After the results are available, NYSDOH Health Care Epidemiology and Infection Control will have a phone conversation with your facility to discuss infection control measures such as PPE use and cohorting given the results.

Best regards,
Marie
Mobile: 332 - 207 - 0766

The link to the CMS info: Reopening FAQ: https://www.cms.gov/files/document/covid-nursing-home-reopening-recommendation-faqs.pdf
FAQ **9. How often should a nursing home test its staff?** All staff should receive a baseline test, and continue to be tested weekly.

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Marie Ciacco Tsivitis, MPH, CIC, FAPIC
HAI Reporting Program Regional Representative – Metropolitan Area
New York State Department of Health
Bureau of Health Care Associated Infections
320 Carleton Ave, Suite 5000 Central Islip NY 11722
Mobile: 332 - 207 - 0766
Tele: 631 - 851 - 3652 Fax: 631 - 851 – 4593
Marie.Tsivitis@health.ny.gov

To: Tsivitis, Marie C (HEALTH)[marie.tsivitis@health.ny.gov]; Carol Frawley[cfrawley@bvnh.com]
From: Cathie Doyle[/O=MEX05/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=CATHIE.DOYLE5DC]
Sent: Thur 5/28/2020 3:34:30 PM (UTC-04:00)
Subject: RE: NYSDOH COVID swab team initiative- Fulton Commons

We did antibody testing on all residents…does this test count? And can you send me the regulation, EO or guidance pls? Thanks. Cathie

---

From: Tsivitis, Marie C (HEALTH)
Sent: Thursday, May 28, 2020 3:27 PM
To: Cathie Doyle <cathie.doyle@bvnh.com>; Carol Frawley <cfrawley@bvnh.com>
Subject: RE: NYSDOH COVID swab team initiative- Fulton Commons

Yes, testing of all residents who were never previously positive for COVID19 is required.
NYSDOH has a 14 day initiative to assist facilities in this effort which ends 6/7, described below.

Please call me at your earliest convenience to discuss how to arrange this or to decline if you will conduct this testing without the swab team from NYS.
Marie
332-207-0766

Marie Ciacco Tsivitis, MPH, CIC, FAPIC
HAI Reporting Program Regional Representative – Metropolitan Area
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NEW YORK STATE: ATTORNEY GENERAL'S OFFICE

----------X

In the Matter of

FULTON COMMONS CARE CENTER, INC.; an Investigation by the New York State Attorney General, made pursuant to the New York State Executive Law, et seq.

----------X

63(12) Examination under oath of CATHIE DOYLE, taken via WebEx video conference, held on January 26, 2020, commencing at 10:02 a.m.

Reported by

Nicole Lebovic

A P P E A R A N C E S:

NEW YORK STATE ATTORNEY GENERAL'S OFFICE
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
BY: PETER ZADEK,
Special Assistant
Attorney General

HAMBURGER, MAXSON, YAFFE & MCNALLY, LLP
Attorneys for Fulton Commons Care Center and Cathie Doyle
225 Broadhollow Road
Melville, New York 11747
BY: DAVID YEFFE, ESQ.

ALSO PRESENT:

Prabhjot Sekhon- Special Assistant Attorney General

Ben Smith- Special Assistant Attorney General

Anne Liptak- Paralegal, NYS AG

Mary E. Conway- Medical analyst, NYS AG

Robert Joyce- Investigator, NYS AG

Barbara Picone- Auditor investigator, NYS AG

Elysia Doherty- Special Agent, Department of Health & Human Services

1-27-2021 C. Doyle

(Documents were premarked as Exhibits 1 through 66 for identification; 1/26/21, N.L.)

C A T H I E D O Y L E, having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

MR. ZADEK: Ms. Doyle, what is your full name?

THE WITNESS: Cathie Doyle.

MR. YAFFE: Before you start, asking questions, would you please identify everybody who is participating in this deposition?

MR. ZADEK: You're moving ahead of us, momentarily we will.

Please state your full name for the record, Ms. Doyle.

THE WITNESS: Cathie Doyle.

MR. ZADEK: What is your address?

THE WITNESS: My home address is [redacted], New York.

MR. ZADEK: What city and county are you sitting in -- are you situated

at right now? Where are you located?

THE WITNESS: Nassau County, Fulton Commons Care Center.

MR. ZADEK: And the address there?

THE WITNESS: 60 Merrick Avenue, East Meadow, New York.

MR. ZADEK: As your counsel asked, my name is Peter Zadek. I'm a special assistant attorney in the Office of the Attorney General of the State of New York.

At this time I'm going to ask everyone who is present on this webcast to identify themselves, please.

MS. SEKHON: My name is Prabhjot Sekhon. I am also a special assistant attorney general at the New York State Attorney General's Office.

At this time, Ms. Doyle and Mr. Yaffe, I'm going to mute myself and I'm also going to stop my video in an effort to conserve bandwidth.

MR. SMITH: Good morning, Ms.

Doyle. My name is Ben Smith and I'm also a special assistant attorney general at the Attorney General's Office. I am based out of the New York City office.

And like my colleague, I'm also going to mute myself and turn off my video to conserve bandwidth.

Thank you.

MR. JOYCE: I am Investigator Robert Joyce with the Attorney General's Office, Medicaid Fraud Control Unit.

I'm also going to mute my audio and turn off my video.

MS. LIPTAK: Good morning, Ms. Doyle. My name is Anne Liptak. I'm the paralegal in the Office of the Attorney General.

I also will mute myself and I'm going to turn off my video.

MS. CONWAY: Good morning. My name is Mary Conway, medical analyst with the New York State Attorney

General's Office.

I'm going to also mute and turn off the camera.

MS. PICONE: Good morning. My name is Barbara Picone. I'm from the New York State Attorney General's Office.

I am also going to mute myself.

THE WITNESS: I couldn't hear who she was.

MR. YAFFE: Neither could I, I could not hear that.

MS. PICONE: Barbara Picone, investigator from the New York State Attorney General's Office. No?

MR. ZADEK: Her name is Barbara Picone -- P-I-C-O-N-E. She's an auditor investigator with the Attorney General's Office, Medicaid Fraud Control Unit.

THE WITNESS: Thank you.

MR. YAFFE: The first word was audit?

MR. ZADEK: Auditor.

MR. YAFFE: Audit?

MR. ZADEK: A-U-D-I-T-O-R, auditor investigator.

MR. YAFFE: Okay.

MR. ZADEK: All right.

MR. YAFFE: And my name is David Yaffe from the firm of Hamburger Maxon in Melville and I represent Ms. Doyle and Fulton Care Commons Care.

MR. ZADEK: Thank you, Mr. Yaffe.

MR. YAFFE: Excuse me, Fulton Commons Care Center.

MR. ZADEK: Thank you.

Elysia, did you note your appearance for the record?

MS. SEKHON: I see that Elysia is muted. I also see a low bandwidth in her corner, so she might be having technical difficulties.

MR. ZADEK: Okay. Then to move this along, I will note for the record that Elysia -- E-L-Y-S-I-A -- Doherty -- D-O-H-E-R-T-Y will also be present throughout the examination. And she is

an agent with the Department of Health & Human Services.

And I think everyone now is muted and audio is turned off.

MR. YAFFE: When you say she's an agent, what kind of an agent? What -- I mean, can you be more specific?

MR. ZADEK: I wouldn't speak for Miss Doherty, so she can identify her exact title.

Are you there, Ms. Doherty?

MS. DOHERTY: Hi, I apologize, I called in. I'm having a little bit of technical issues.

MR. ZADEK: Okay, can you identify for Mr. Yaffe, your official title?

MS. DOHERTY: Sure. My name's Elysia Doherty. I'm a Special Agent with the Department of Health & Human Services.

MR. ZADEK: Thank you.

THE WITNESS: Thank you.

MR. ZADEK: Ms. Doyle, we conduct

this examination remotely in order to ensure the health and safety for all participants that's due to the Coronavirus-related concerns we have.

The examination will be recorded by stenographic means by a court reporter certified to record the examination in the State of New York and any exhibits, will therefore be presented electronically.

Is David Yaffe your attorney?

THE WITNESS: Yes.

MR. ZADEK: Your testimony today is being taken pursuant to a subpoena that was issued by the Attorney General's Office pursuant to which I and Prabhjot Sekhon, as Special Assistant Attorneys General are authorized to take proof and make a determination of the relevant facts in connection with an investigation that pertains to the resident care provided by Fulton Commons Care Center.

You are an employee there,

correct, Ms. Doyle?

THE WITNESS: Yes.

MR. ZADEK: Ms. Liptak, can you exhibit for Ms. Doyle what has been premarked as Exhibit 1.

Ms. Doyle, I'm showing you what has been premarked as Exhibit 1, can you see that document?

THE WITNESS: I can.

M. ZADEK: The first page is a cover letter signed by Ms. Sekhon and the second page, if we stop there, indicates, "Subpoena Ad Testificandum," and it's addressed to you, correct?

THE WITNESS: Yes.

MR. ZADEK: And if we scroll down a little bit further, you'll see that there's a signature line -- a receipt signature line, which has your signature, dated December 29, 2020; is that correct?

THE WITNESS: Yes.

MR. ZADEK: Okay. This subpoena required and compelled you to virtually

appear for an interview today, correct?

THE WITNESS: Yes.

MR. ZADEK: And do you understand that your virtual appearance today is pursuant to that subpoena, which compels you to appear and give testimony?

THE WITNESS: Yes.

MR. ZADEK: Before we begin, I'd like to take a moment to discuss some of your rights.

Under the Fifth Amendment of the United States Constitution, as well as the New York State Constitution, you have the right to refuse to answer questions if your truthful answer to that question would tend to incriminate you.

Do you understand that?

THE WITNESS: I do.

MR. ZADEK: Please be aware, however, that should you choose to invoke your Fifth Amendment right, a negative inference can be drawn against

you in any future noncriminal proceedings.

Do you understand that?

THE WITNESS: Yes.

MR. ZADEK: You also have the right to consult an attorney and sitting -- I almost said sitting beside you, but sitting virtually at his office is David Yaffe, correct?

THE WITNESS: Correct.

MR. ZADEK: And you've already indicated that Mr. Yaffe is your attorney?

THE WITNESS: Yes.

MR. ZADEK: Is there any reason that you do not wish to proceed in this investigation with Mr. Yaffe representing you?

THE WITNESS: No.

MR. ZADEK: Do you understand that your attorney's firm, according to Mr. Yaffe, which he indicated to be Hamburger, Maxson, Yaffe & McNally, that they also represent Fulton Commons

Care Center?

THE WITNESS: Yes.

MR. ZADEK: Do you understand that it is possible that the interest of Fulton Commons Care Center do not align with yours?

THE WITNESS: Yes.

MR. ZADEK: Do you understand that you have the right to an attorney who also not does represent Fulton Commons Care Center?

THE WITNESS: Yes.

MR. ZADEK: Are you comfortable answering my questions in front of an attorney who also represents your employer?

THE WITNESS: I am.

MR. ZADEK: Okay, thank you.

And you still wish to proceed with David Yaffe representing you at this time?

THE WITNESS: Yes.

MR. ZADEK: You took an oath a moment ago to tell the truth, the whole

truth and nothing but the truth, should you intentionally make any false statement during this proceeding and by that I mean, a statement you do not believe to be true, you may be prosecuted for perjury.

Do you understand that?

THE WITNESS: Yes.

MR. ZADEK: I further advise you as has been indicated, that Elysia Doherty is present during this examination. She's a federal agent with the Department of Health & Human Services. Should you knowingly and willfully make any materially false statement or representation, you are subject to prosection pursuant to Section 1001 of Title 18 of the United States code.

Do you understand that?

MR. YAFFE: Objection, as to the extent your questions are calling for a legal conclusion. Ms. Doyle is not an attorney and I'm certain that she's not

familiar with the statute that you're referring to.

But -- so, a running objection to this line of questioning about her rights -- and the Fifth Amendment and her rights and all of that, but proceed.

MR. ZADEK: In the absence, Counsel, of a privileged -- the assertion of privilege, I would request that you not make any objection on the record. Your objection is noted and I think it's covered the area that you've referenced.

And if you need to explain to her Section 1001 of Title 18 of the United States code, you may do that, either now or subsequent to the examination.

But I want to know whether Ms. Doyle understands what I just indicated to her, that she is subject to prosection where if she makes a false statement to this federal agent -- in the presence of this federal agent.

Do you understand that, Ms. Doyle?

THE WITNESS: Yes.

MR. ZADEK: I'm going to ask you questions which are relevant to the Attorney General's Office investigation into the resident care provided by Fulton Commons Care Center.

I think it will be easier, Ms. Doyle, if I say, "Fulton Commons" or "Fulton" from this point forward, I am referring to Fulton Commons Care Center. Okay?

THE WITNESS: Noted.

MR. ZADEK: Thank you.

I'm going to try if I can as well to change my viewing.

I'm going to ask you questions relevant to the Attorney General's investigation of Fulton Commons. Some ground rules:

As you are aware, we have a stenographer here today. She's going to record this interview. It's

therefore, important that she hears everything we say. What that means is that we can't speak over one another. I can that you allow me to finish any question that I present to you before you begin to answer the question, otherwise she can't take us both down if we speak simultaneously.

It's also important that you give verbal responses to all of my questions. Nods of the head, either affirmatively or negatively, cannot be stenographically recorded.

If you do nod or shake your head, which is fine, I simply ask that you accompany that gesture with a verbal response. Okay?

THE WITNESS: Yes.

MR. ZADEK: If you do not understand my question, please let me know and I will do my best to rephrase it for you. I don't understand want you to answer questions that you don't understand. Okay?

THE WITNESS: Okay.

MR. ZADEK: If you do answer my question, I will assume that you understood it as I asked it. All right?

THE WITNESS: Okay.

MR. ZADEK: And if you do need to take a break for any reason, whether to consult with your attorney, Mr. Yaffe, or to use a restroom, that's fine. I just ask that if there's a pending question, the question before you, that you answer that question before leaving the camera frame.

Do you understand these questions -- these instructions that I have given to you?

THE WITNESS: Yes.

MR. ZADEK: Now sometimes you may provide an answer as completely as you can and later remember additional information. If that happens, please tell me that you'd like to add something to the earlier answer and

we'll do that while it's fresh in your memory. Okay?

THE WITNESS: Yes.

MR. ZADEK: In addition, it my occur to you at some point that a previous answer you gave was not completely accurate. If that happens, will you tell me and make any necessary corrections to that earlier answer?

THE WITNESS: Yes.

MR. ZADEK: This proceeding is confidential. Neither you nor your attorney are entitled to a copy of the transcript of this testimony or any exhibits that may be marked and shown to you today. Do you understand that?

THE WITNESS: Yes.

MR. ZADEK: And because this is a confidential proceeding, there shall be no recording during the taking of this testimony. Although, Webex does offer recording capabilities, I give you my assurance that this examination is not being recorded by the Attorney

General's Office.

Do you as well agree not to record this examination in any way?

THE WITNESS: Yes.

MR. ZADEK: Similarly, due to its confidentially, we request that you do not discuss this matter, your testimony here today or any documents that you may view or may produce in connection with today's testimony, with anyone else. All right?

THE WITNESS: I think we lost my attorney.

MR. ZADEK: Well, that's not good.

Are you there, Mr. Yaffe?

MR. YAFFE: I can hear you, can you not hear me?

MR. ZADEK: I can hear you.

MR. YAFFE: Cathie, can you hear me?

THE WITNESS: I can hear you, I can't see you.

MR. YAFFE: I can see Mr. Zadek

and Cathie and the stenographer.

THE WITNESS: Okay.

MR. YAFFE: Can you see me now?

THE WITNESS: You're back.

MR. ZADEK: Mr. Yaffe, why don't I give you my office phone number, if at any point you can no longer hear us, you could call my office and let me know.

MR. YAFFE: Yes.

THE WITNESS: Yes.

MR. ZADEK: Just to ensure that we don't lose you at any point.

My office number is [redacted] -- area code -- [redacted].

THE WITNESS: Got it.

MR. YAFFE: All right.

MR. ZADEK: Let me know if any issues should arise.

MR. YAFFE: I would like to make a comment before the meat of the questioning takes place. I didn't want to interrupt the flow of your instructions, but I just wanted to let

you know that I had a comment and I'm happy to make it now.

MR. ZADEK: The floor is yours.

MR. YAFFE: So, as agreed and understood, this is a remote deposition. I'm not in the same room as the witness or the questioner and neither can see everyone who spoke, I don't have exhibits in front of us. You're not presenting documents to me, rather having an assistant present documents on the screen. And when they're on the screen, you can only see the portion that's available on the screen. If it's a multipage document, the witness and I can only see the portion that your assistant is showing on the screen.

So, I just want to make sure that the stenographer is crystal clear in avoiding the misimpression that the witness has the entire document in front of her when they're asking her questions about it. And I'm not really

sure how to achieve that.

I noticed that when you presented the first document, the subpoena, that as you were talking, your assistant was scrolling and it is your assistant that is controlling the document and what the witness can see at any given moment in time.

And it may occur that you're asking her to look at a document, but the witness is only seeing one portion and that's not necessarily the portion that you're talking about.

And I just wanted to raise this issue because it's not like you're presenting the document by uploading it so that the witness can peruse it.

I'm not saying it's causing complications, I'm not saying that at all, but I'm concerned about it.

MR. ZADEK: To allay your concerns and it sort of dovetails with what I indicated earlier, if I do present a document to your client and

it relates to her not answering a question that she does not know the answer to -- that she does not understand. If I show her a document and I reference a portion of that document, such as that you referenced with the subpoena, her signature and hypothetically, if she does not see what I'm referring to, she should indicate to me that she does not see what I'm either reading or referring to.

So that if she's asked a question about a document and a particular portion of that document is identified and presented to her, as if it were presented to her across a table and here it's done virtually, she cannot see or does not -- cannot visualize what we're discussing, she should indicate that to me and we'll make certain that she can read it as I'm reading it and understands, therefore, what I'm asking. Okay?

MR. YAFFE: And I guess it might -- I'm not instructing you, of course, on how to conduct your deposition, but it might help when you're asking her about a multipage document, you indicate the page number of the document that you're referring to, "Drawing your attention -- I'm drawing your attention to the second page of the subpoena."

MR. ZADEK: Mr. Yaffe, like the expression, it's not our first rodeo here. Any substantive document beyond the subpoena, which she acknowledged receipt of, we will do our best to always identify the page.

And if by chance, I neglect to, I'm certain that you will remind me that I haven't identified the page. Okay?

MR. YAFFE: Okay. I'm trying to avoid interrupting during your deposition and that's why I had that upfront statement to make.

MR. ZADEK: And I appreciate that.

And just for the record, what Ms. Doyle and I discussed concerning audio and video recording of this examination, the same applies, Counsel, to you, not to record the audio or video. All right?

MR. YAFFE: Correct.

MR. ZADEK: Okay, thanks, Mr. Yaffe.

Unless we're on a break, Ms. Doyle, there shall not be any private communications with anyone. That includes phone calls, passing of notes, texting, e-mailing or other means of communication that may or may not be visible on camera.

Of course, we already indicated, should you wish to consult to your attorney, indicate it to us and you will be accorded time to speak with your counsel.

Please mute you phones and if

possible, turn off any electronic devices to prevent disruptions.

EXAMINATION BY

MR. ZADEK:

Q. And now let me ask you, Ms. Doyle, have you taken any drugs or alcohol within the past 24 hours that may have an impact on your ability to testify here today truthfully and to the best of your knowledge?

A. No.

Q. Are you aware of any physical or mental disability or defect that may interfere with your ability to understand my questions or your ability to respond truthfully and completely?

A. No.

Q. Other than your attorney, did you discuss the fact that you were subpoenaed here today with anyone else?

A. Yes.

Q. Whom did you speak with concerning that?

A. Steven Weiss and my daughter.

Q. What is your daughter's name?

A. [redacted].

Q. [redacted]?

A. [redacted] -- [redacted].

Q. Anyone else?

A. The director of nursing knows that I'm testifying this morning, as she's in charge.

Q. What is her name?

A. Carol Frawley.

Q. Anyone else?

A. No.

Q. And your daughter, is she employed in any capacity at Fulton Commons?

A. No, she's a high school senior. She was just wishing me luck.

Q. That's a good daughter.

A. Yes.

Q. You mentioned someone named Steven Weiss, is he employed at Fulton Commons?

A. He is the liaison between myself and the owner.

Q. Liaison, okay.

And what did you say to Mr. Weiss concerning this appearance today?

A. When I got the subpoena, I sent to him and I indicated that I needed to testify for two days and may be unavailable to him. And he suggested that I get in touch with Mr. Yaffe to handle that.

Q. Okay. Any other discussions with Mr. Weiss concerning your appearance today?

A. Other than him telling me to tell the truth? No.

Q. Okay. What about your conversations -- or conversation with Ms. Frawley, what discussion did you have with her other than she should run the ship today, anything else?

A. None.

Q. Did you speak to anyone else, again, other than your attorney in preparation for your appearance here today? What you would testify to?

A. I'm sorry, I didn't hear the first part of the question.

Q. Beyond the fact that you were

appearing here today, did you speak -- in order -- again other than your attorney, in order to prepare for your appearance today?

A. No.

Q. Did you review any documents to prepare for your testimony today?

A. I reviewed the timeline that I submitted to your office, that was it.

Q. You said a timeline that you submitted to the Attorney General's Office?

A. Correct.

Q. Is that a multipage document?

A. Yes.

Q. How many pages is that document?

A. I don't recall.

Q. Did you review anything else other than this timeline?

A. No.

Q. Do you have any documents -- are you at your office at Fulton Commons now?

A. I am.

Q. Do you have any documents in front of you on your desk?

A. No.

Q. You gave us your home address, correct?

A. Correct.

Q. Was that in [redacted], you said?

A. [redacted].

Q. [redacted], my apologies.

Do you have a cell phone that you use for work and a separate cell phone that you use for home?

A. No.

Q. You just have one cell phone?

A. Correct.

Q. What is your cell phone number?

A. [redacted].

Q. Do you have a home phone as well?

A. I do.

Q. What is the phone number there?

A. [redacted].

Q. Who are the providers? Two separate providers or the same provider for those phone numbers?

A. I believe they're both Verizon.

Q. Verizon?

A. No, I'm sorry, home it Verizon

and the cell is T-Mobile.

Q. Had you spoken to any current or former Fulton employees who stated to you that they were subpoenaed to gave sworn testimony in this investigation?

A. Former, no. Current, yes.

Q. So you've only spoken with currently employees who indicated to you that they've given testimony pursuant to this investigation?

A. Yes.

Q. Who did you speak with?

A. I spoke with Carol Frawley. I spoke with Kristin Hersher and I spoke with Larisa Ronayne.

Q. When did you speak with them? Let's start with Ms. Frawley, when did you speak with Ms. Frawley about giving testimony in this investigation?

MR. YAFFE: Objection to form.

MR. ZADEK: Again, Counsel, there's no need to, during this hearing, to make objection.

MR. YAFFE: I do understand that,

but you're asking her if she spoke with people who gave testimony, that was your question and she said yes. Of course, she's spoken with them, she works with them.

But not you're assuming that it's an implication that she spoke to them about their testimony, that's not your question.

MR. ZADEK: Unless it's a privilege that you're asserting, again, there's no reason for you to make an objection. This isn't forum such as an examination before trial where these objections would typically be part of the record. This is not such a forum that you're listening in on here.

But your objection is noted.

Q. Ms. Doyle, you indicated that you spoke to these current employees concerning the fact that they gave testimony, correct?

A. Yes, and I need to add one more name, please, I forgot, Mike Andrews.

Q. Mike Andrews?

A. Correct.

Q. So you spoke to Mr. Andrews, Ms. Ronayne, Ms. Hersher and Ms. Frawley?

A. Correct.

Q. What, if anything, was said between you and Ms. Frawley concerning her testimony?

A. It wasn't concerning her testimony. Those individuals report directly to me and needed to advise me they would not be in the facility.

Q. So the four individuals you named, was the conversation simply a matter of scheduling, that they will not be present at Fulton because they are providing testimony?

A. The first conversations with them, yes. There were several conversations with them after their examinations because they were insulted and upset and wanted to ensure that they were going to be okay.

Q. Okay. Did you discuss with any of these four individuals the substance of their testimony, what they testified to?

A. No, I did not.

Q. When did you speak with Mr. Andrews concerning his testimony? When was that, that you spoke to him? Was that before he gave testimony and then after he gave testimony?

A. That's correct. Before for scheduling circumstances and after to reassure him that he was going to be okay. They were all upset after that finished their testimony and I was seeking to reassure them that they were going to be okay.

Q. And this is true for Ms. Ronayne, Ms. Hersher and Ms. Frawley, that you spoke with them before they gave testimony and then after they gave testimony?

A. That's correct.

Q. And the discussions concerned again, as you said, the schedule aspect of it before they gave testimony and I think you indicated you provided some reassurance after they gave testimony?

A. That's correct.

Q. Do you know -- you mentioned that Ms. Frawley gave sworn testimony to the Attorney General's Office, correct?

A. Yes.

Q. Do you know when Ms. Frawley gave sworn testimony? Specifically when she gave sworn testimony to the Attorney General's Office?

A. I do not recall the date, I'm sorry.

Q. Okay. Did Ms. Frawley ever speak with you about the sworn testimony, the substance of the testimony she gave to the Attorney General?

A. No, she indicated she was told not to.

Q. Okay. When in relation to her providing testimony did you speak with her?

A. The next day, when she came back to work.

Q. When she physically returned to the office?

A. Correct.

Q. Did there come a time on

October 15, 2020, when you spoke with Ms. Frawley about her sworn testimony to the Attorney General?

A. I don't remember that date, I'm sorry.

Q. Well, do you recall if you spoke with Ms. Frawley at any time on the actual date when she gave her testimony to the Attorney General?

A. It's possible. She may have texted me or called me about a work-related issue, but I honestly don't recall.

Q. You don't recall?

A. No.

Q. When you said she might have contacted you concerning a work -- let me ask you this, do you know of Carol Frawley's cell phone number?

A. Yes.

Q. What is her cell phone number?

A. I don't know it off the top of my head, I can look in my phone if you'd like.

Q. No, it's not necessary at this time.

You don't recall if you spoke with her or you texted her on the day that she provided testimony to the Attorney General; is that correct?

A. I don't recall. I may have texted her that night to make sure that she was okay. I don't recall.

Q. Sometime later that evening just to see how she was doing?

A. That's possible, yes.

MR. ZADEK: Ms. Liptak, can you show and present to Ms. Doyle Exhibit 2, which has been premarked as Exhibit 2.

Q. Can you see what's been marked as Exhibit 2 on your screen?

A. I can see it, but I can't read the little writing.

Q. Okay, I will try to enlarge it, if we can in a moment. But you can see the document -- there's a document in front of you, correct?

A. There is, correct.

MR. ZADEK: This is, for the

record, a 97-page document.

Q. And I'm going to direct your attention to page 11 of this 97-page document.

So if we can scroll to page 11, which I think we're on. On the bottom of the page, line 163.

MR. ZADEK: I don't know if we can enlarge that I little more.

Thank you.

A. I see it.

MR. ZADEK: It's been highlighted.

Q. We see there on line 163 a date of October 15, 2020, correct?

A. Yes.

Q. And we see an indicated time of 17:48 and 45 seconds, that would be 1:48 daylight savings time, correct?

A. I don't know the daylight savings time, but I see 17:48.

Q. And there's a number -- an originating number of [redacted], do you recognize that number?

A. I do not.

Q. Okay. There's a terminating number next to it indicating the number [redacted], do you recognize that number?

A. Yes, that's my cell phone number.

Q. Okay. You indicated Ms. Frawley has a phone number that you didn't recall the number, you would need to check to see what her phone number was, her cell phone?

A. Yes.

Q. Do you know want to check and tell me if [redacted] is Ms. Frawley's cell phone number?

A. Sure, hold on.

Q. Thank you.

A. It is Ms. Frawley's cell phone number.

Q. Okay. Did you have a conversation with Ms. Frawley on October 15th at 1:48 in the afternoon?

A. 17:48 is not 1:00.

Q. Ms. Doyle, again, if you listen to my question, on the afternoon of October 15th at 1:48 p.m., did you have a

conversation with Ms. Frawley?

A. No.

Q. Okay. Did you have --

A. 17:48 is not 1:48 p.m.

Q. Are you speaking military time when you say, "17:48"?

A. Correct.

Q. Okay, listen again. I will ask you again. It's your testimony today that on the afternoon of October 15th at 1:48 p.m., it's your testimony that you did not speak with Ms. Frawley; is that correct?

A. Again, I do not recall that date specifically. She may have called me for a work-related incident. I don't recall.

Q. Did you speak with Ms. Frawley on October 15, 2020 during her -- at the time she was giving testimony to the Attorney General's Office?

MR. YAFFE: Objection.

A. Again, I don't recall specific telephone calls from that day.

Q. Okay.

A. I was still running a facility

here, so it's possible, yes.

Q. Okay. On October 15th -- on the afternoon of October 15, 2020, did Ms. Frawley call you and discuss her testimony with you, the testimony she was giving to the Attorney General's Office?

A. No, we did not discuss testimony.

Q. Did she discuss the subject matter of her testimony with you?

A. No.

Q. Did she discuss that it was concerning the COVID pandemic with you?

A. No.

Q. Do you recall what she said to you on October 15, 2020 or you don't recall the conversation at all?

A. I don't recall the conversation.

Q. You mentioned earlier that you may have texted her as well on the afternoon of October 15th; is that correct or did I misunderstand that?

A. No, that's certainly possible.

Q. Do you recall whether on October 15, 2020, while she was giving

testimony to the Attorney General's Office, you texted her?

A. Again, I don't recall specific times. I'm sure we were in contact because we were still running a facility.

Q. I'm not asking about a specific time. I'm asking whether during -- on the date she gave testimony to the Attorney General's Office, during the time fame when she gave such testimony, you and her engaged in text message?

A. "A," I don't know when her testimony was, what time it was. I don't know what time she was on break. I can't answer that question, honestly.

Q. Okay. Do you recall on October 15, 2020, speaking with Ms. Frawley about how the examination was going, the examination with the Attorney General's Office?

A. I don't recall that.

Q. So, you may have had discussion on the afternoon of October 15th with Ms. Frawley as to how the examination was going?

MR. YAFFE: Objection.

Q. You can answer, Ms. Doyle.

A. I'm going to assume that if we spoke, I said, "Are you okay?" But I don't recall.

Q. Do you recall any conversations -- withdrawn.

You might have had a conversation with Ms. Frawley on October 15th that beyond merely, "Are you okay?"

A. Again, I don't recall.

Q. Again, Ms. Doyle, this goes back --

A. I don't recall any conversation with her.

Q. This goes back to my initial instructions, let's try not to speak over each other. Let me finish my question so you and I don't talk over one another.

Might you have had a conversation with Ms. Frawley on October 15, 2020 in which you discussed with her how her examination with the Attorney General's Office was going?

A. Other than to ask her if she okay, I wouldn't have discussed anything else, no, not possible.

MR. ZADEK: Ms. Liptak, you can remove the exhibit, thank you.

Q. Have you ever testified under oath before today?

A. Yes.

Q. In what setting, when did you testify? How many times have you testified under oath in your life?

A. Oh, I'm going to be guessing. Several liability cases and one criminal case against a former CNA that stole from a resident.

Q. I didn't catch the last part about the CNA?

A. A CNA was stealing from -- a CNA was stealing from one of the residents in the facility and I testified against her.

Q. Let's talk about the liability case. You said several liability cases involving -- is that nursing home malpractice cases against Fulton?

MR. YAFFE: Objection.

Q. When you said liability cases, is that what you're referring to?

A. No, I'm not. I've never testified on a liability case against Fulton Commons.

Q. So when you said liability case, those cases are personal liability in which -- withdrawn.

Why don't you tell me, when you said you testified in several liability cases, please tell me what those cases were?

A. They were from my former employee, South Shore Healthcare.

Q. I'm not hearing, which employer?

A. South Shore Healthcare.

Q. How many cases did you say you testified in?

A. I'd be guessing quite frankly. I worked there for 20 years. I would say five or six. Don't hold me to that number.

Q. All the cases that you testified involved South Shore Healthcare?

A. Yes.

Q. Were those at trial? Were those at depositions? In what context did you give sworn testimony?

A. Both, trial and depositions.

Q. Why don't you go through them as best you can recall sequentially, when was the first case that you gave testimony and when was the last?

A. I don't recall. I know I gave a deposition when I was pregnant with my daughter, that one I recall clearly because the attorney was upset that I was pregnant. But I don't recall the other ones.

Q. Do you recall what county you testified in?

A. Nassau.

Q. So, in all the cases you had mentioned, South Shore Healthcare was the main defendant in those cases; is that correct?

A. Yes.

Q. And the other cases, besides the CNA case, any other cases that you testified in that you provided testimony in other than

those five or six cases involving South Shore Healthcare?

A. Not that I recall at this time.

Q. And did the case about the CNA, that was a criminal case, it went to trial?

A. Correct.

Q. Was that case prosecuted by the Attorney General's Office?

A. No, the District Attorney's Office.

Q. In Nassau County?

A. Correct.

Q. Did that involve Fulton Commons?

A. No.

Q. Did that also involve South Shore?

A. Correct.

Q. Have you given any sworn testimony in any matter that concerned Fulton Commons?

A. No.

Q. What -- did you attend college?

A. Yes.

Q. What college did you attend?

A. Undergraduate, I went to SUNY Cortland. For my master's, I attended Long Island University CW Post Campus.

Q. And you graduated, I take it, from both?

A. Yes.

Q. What was your master's degree in at CW Post?

A. I have a master's in public administration with a concentration in health.

Q. And when did you obtain your master's degree?

A. I can look at the certificate, it's right behind me, but I don't remember the date. I'm sorry, 1996 maybe, '94.

Q. Any other education or training besides the college and the master's program?

A. Yes, I'm a licensed nursing home administrator, which is required to taking an exam through New York Stat and I'm required to obtain 48 hours of continuing education credit every two years to maintain

that license.

Q. Any other licenses or certifications?

A. No.

Q. You mentioned, I believe, South Shore Healthcare as a prior employer, meaning prior to Fulton, correct?

A. Yes.

Q. Is that the only health care facility you worked at besides Fulton, South Shore?

A. No.

Q. Can you walk me through your work experience in the health care or nursing home arena chronologically from when your first job taking us up to Fulton Commons?

A. Sure.

Q. The position you held and when you worked there?

A. I did my administrator in training at Glengariff Healthcare Center in Glencove. After I completed that, I worked there for an additional four years as the assistant administrator.

In 1996, I was hired by South Shore Healthcare and remained there for 20 years, until I came to Fulton Commons in September of 2016.

Q. Okay. So you came to Fulton in September 2016?

A. Correct.

Q. Every skilled nursing facility in New York requires a licensed administrator, correct?

A. Correct.

Q. When was it that you obtained your nursing home administrator license?

A. I don't recall the year. I can look behind me on the certificate, if you'd like.

Q. You don't recall the approximate year?

A. I'm going to guess around 1996 when I got my first -- maybe 1995, I don't recall.

Q. You're teasing with me that offer, so why don't you turn around and look?

A. I really don't remember, so -- okay. So, I obtained my degree from LIU in 1992. I was licensed in January of 1994 and I graduated from SUNY Cortland in 1985.

Q. So now we got confirmation from that diploma hanging behind you?

A. They're right there.

Q. And as part of your course work to become a licensed administrator, did you become familiar with the New York State Medicaid program?

A. Yes.

Q. Did you become familiar with the New York Codes, Rules and Regulations that apply to skilled nursing facilities?

A. Yes.

Q. Did you become familiar with the New York State Department of Health rules and regulations that apply to skilled nursing facilities?

A. Yes.

Q. When I say, "DOH," do you understand that to mean the New York State Department of Health?

A. Yes.

Q. So moving forward, if at any point I use the initials DOH, I am referring to the New York State Department of Health. Okay?

A. Noted.

Q. When were you hired again as administrator of Fulton, was that September of 2016?

A. Correct.

Q. And who hired you?

A. Steven Weiss.

Q. The same gentleman that you characterizes as the liaison between you and the owner?

A. Correct.

Q. When he hired you in September of 2016, do you recall what your salary was when you were hired?

A. I believe it was $155,000 a year.

Q. And what is your current salary at Fulton?

A. 172,000.

Q. As Fulton's administrator, do you

receive any other benefits or compensation in addition to your salary?

A. Yes.

Q. What other benefits do you receive?

A. I receive health care insurance, dental insurance, vision insurance. I participate in a 401K, which has no match, but it's available for us to contribute to. And my vehicle and related expenses, up to repairs, as well are covered.

Q. Is the administrator of a nursing facility charged with or responsible for overseeing the day-to-day operations of the facility?

A. Yes.

Q. Can you briefly summarize what your job duties are at Fulton as the administrator, what do you do there?

A. Well, you just said it. I'm responsible for the daily operations of the entire facility that help maintain the welfare of the residents, as well as the staff and the building operations.

Q. Do you receive regular updates and reports from the medical director of the facility?

A. Yes.

Q. Similarly, do you receive such updates from the director of nursing?

A. Yes.

Q. As well as the assistant directors of nursing?

A. Yes.

Q. How about the unit managers, the RNs, do they provide you with updates?

A. Not directly, no.

Q. Do you know to whom they provide updates, if anyone?

A. To Ms. Frawley, the director of nursing.

Q. How about the director of admissions, do you receive updates from the director of admissions during your day?

A. Yes.

Q. How about the in-service coordinator?

A. No.

Q. How about the infection control nurse, do you receive updates from that individual?

A. Yes.

Q. How about the director of housekeeping?

A. Yes.

Q. As well as the director of social services?

A. Yes.

Q. Is there anyone else that I didn't list that you would receive regular updates from or is that pretty comprehensive?

A. The director of maintenance services, the director of food services, the registered dietician, the MDS coordinator, the rehab director, the discharge planner. I think that's everybody.

Q. Now, they all provide you with updates on what's going in the facility with respect to their departments?

A. Yes.

Q. And do you remain up to date on

any issues that arise on a particular unit? Are you notified of any issues that may occur during the day?

A. A significant issue, yes, but not all issues on every unit, no.

Q. Right. Do you make rounds in the facility? Do you go about visiting units during the day?

A. Pre-pandemic, yes, during the pandemic we limit or exposure as much as we can.

Q. Approximately how many people were employed at Fulton when you were first hired?

A. Maybe 270.

Q. Did you hire additional employees after you became the administrator in 2016?

A. Yes.

Q. Approximately how many employees are currently employed at Fulton?

A. 290.

Q. Who is your supervisor at Fulton?

A. Steven Weiss.

Q. Is that the individual that you

regularly report to concerning patient care issues and concerns at Fulton?

A. I'm not sure what you mean by patient care issues.

Q. Well, if an issue arises involving policies and protocols effecting patient care or decisions that need to be made concerning the patient care at Fulton, is that the individual who you would report to to discuss the issue?

A. I'm responsible for those decisions.

Q. So when you say Steven Weiss is your supervisor, what does he supervise? What aspects of your work did he supervisor?

A. I didn't use the word "supervisor." He's the gentleman that I report to.

Q. I'm sorry, what do you report to him about?

A. He'll have questions about -- you know, I do report to him about the specifications, the staffing, the -- you know, Medicare reports, the -- I mean,

depends on what's going on in the facility at the time. But the nitty gritty as to has an illness in a unit, that doesn't get discussed at that level.

Q. So again, what does get discussed with him, concerns what? What are the areas, the issues that you do report to Mr. Weiss about? You mentioned -- go ahead, I'll let you answer.

A. It's not a specific area. It's could be as simple as needing to buy a new snowblower, for example. It could be anything that comes up in the course of the day that I need him to okay or guidance on.

Q. Is it fair to say that he provides an authorization with respect to certain actions that you need to take?

A. Yes.

Q. Does Mr. Weiss own Fulton Commons?

A. I'm sorry?

Q. Does Mr. Weiss -- actually, when you say Mr. Weiss, that's Steven Weiss, correct? That's his first name? Steven?

A. Yes.

Q. Does Mr. Weiss own Fulton Commons?

A. Not to my knowledge, no.

Q. What owns Fulton Commons?

A. The owner that I'm aware of is Mr. Kalter.

Q. Kalter?

A. Yes, K-A-L-T-E-R.

Q. What's Mr. Kalter's name?

A. I believe it's M-O-S-H-E.

Q. M-O-S-H-E?

A. Correct.

Q. Moshe?

A. I think Moshe, I'm not sure.

Q. Okay.

A. He's Mr. Kalter do me.

Q. Is he the only owner of Fulton Commons, to your knowledge, this Mr. Kalter?

A. No, I believe his wife is part owner and I believe there is another couple whose last name is Fogel -- F-O-G-E-L.

Q. You said a couple with the last name F-O-G-E-L?

A. I believe it's a husband and wife. I'm not positive though.

Q. Do these individuals, Mr. Kalter and potentially his wife and the Fogels, do they have an ownership interest in any other skilled nursing facilities that you're aware of?

A. I'm unaware of the Fogels' extent of ownership, but Mr. Kalter, I know has ownership in several other facilities, yes.

Q. Which other facilities are you aware of his ownership interest in?

A. Bridge View Nursing Home, Mayfair Nursing Home and Midway Nursing Home.

Q. Any other nursing homes?

A. Those are the only ones I'm aware of.

Q. Is there any relationship that Fulton Commons had with Bridge View, Mayfair and Midway?

A. You just all disappeared from my screen -- oh, there you are.

Yes, we share a common business office.

Q. What common business office do you share?

A. We share -- we have an individual that does payroll, an individual that does purchasing, accounts payable, employee benefits.

Q. Is that office that is shared by all of these facilities, what is it called?

A. It's located in Bridge View Nursing Home and we call it the business office.

Q. The business office at Bridge View?

A. They're located in Bridge View, but it's the business office for all the facilities.

Q. Is that where Mr. Weiss works?

A. I don't know where he's located.

Q. How frequently -- withdrawn.

You said that you've had contact primarily with Mr. Kalter as opposed to his wife and the Fogels; is that correct or did I misunderstand that?

A. No, my contact is with Steven

Weiss.

Q. But you mentioned Mr. Kalter is the owner, how do you know that Mr. Kalter owns Fulton Commons and potentially these other nursing homes? How are you aware of that?

A. I looked it up on the website before I accepted the position and I have had conversations with Mr. Weiss.

Q. Have you ever spoken to Mr. Kalter?

A. No, I have not.

Q. Since you were hired in September 2016, you have never spoken to Mr. Kalter?

A. No.

Q. Have you spoken to any of the other individuals who you may believe who also have ownership interest in the facility?

A. No.

Q. How frequently has Mr. Kalter visited Fulton since you arrived in September of 2016?

A. I have not met him.

Q. To your knowledge, has he ever stepped foot in Fulton Commons since you arrived in September of 2016?

A. Not to my knowledge.

Q. What role, if any, does Mr. Kalter play in the operation of Fulton?

A. I know that Mr. Weiss speaks to with him frequently.

Q. How do you know that? How do you know that Mr. Weiss speaks to Mr. Kalter frequently?

A. Because if he asks me questions, sometimes he'll say, "Mr. Kalter wants to know."

Q. Okay. Do you know how -- withdrawn.

Do you know how Mr. Kalter remains updated on issues that arise at Fulton?

A. Through Mr. Weiss.

Q. To what extent do you keep Mr. Kalter apprised of issues that you have at Fulton?

A. As I said, I don't. I never speak with him directly.

Q. Okay. Have you ever -- you said you never -- you indicate that Mr. Kalter, since you've been there, never, to your knowledge, been in the facility, correct?

A. Yes.

Q. Have you ever spoken with Mr. Kalter, either in person or on the phone?

A. No.

Q. Have you ever e-mailed, share e-mails with Mr. Kalter since you arrived at Fulton?

A. No.

Q. Have you ever shared e-mails or had any communication with Mr. Kalter's wife or the Fogels?

A. No.

Q. Let's talk about Mr. Weiss. Mr. Weiss, you characterized as the liaison between you and Mr. Kalter, correct?

A. Yes.

Q. What is Mr. Weiss' position or

title, if you know?

A. I don't know.

Q. How would you describe what Mr. Weiss does in relation to the operation of Fulton Commons?

A. I would describe it as an overseeing manager perhaps.

Q. During the period that you have been at Fulton since September 2016, has Mr. Weiss been in the facility?

A. Yes.

Q. How often does Mr. Weiss come to Fulton Commons during any given year?

A. Depends on if there's something significant, maybe once or twice a year.

Q. So since you've been employed at Fulton Commons, how often has Mr. Weiss been in the facility, approximately?

A. I don't recall exactly. I can recall three or four off the top of my head.

Q. What were the circumstances that precipitated Mr. Weiss at Fulton?

A. The one I can recall clearly is that the facility lost power due to a LIPA

interruption of power. And he came that morning to make sure that all the residents were okay and see if we needed any assistance in getting things taken care of.

Q. How do you communicate with Mr. Weiss, do you visit him at Bridge View?

A. No, I don't visit Bridge View. We talk on the phone and we e-mail.

Q. How often do you generally speak with Mr. Weiss on the phone, how frequently?

A. Again, it depends on what's happening. It could be five times a day or once a week.

Q. Depending on what's going on?

A. Correct.

Q. Do you have regularly scheduled meetings with Mr. Weiss?

A. No.

Q. To what extent has the frequency of communication between you and Mr. Weiss changed during the pandemic?

A. It increased significantly during the pandemic.

Q. And again, your communications

with -- your communications with Mr. Weiss during the pandemic has been via e-mail and phone?

A. Voice and text on the phone, yes.

Q. What issues or concerns have you discussed with Mr. Weiss during the pandemic?

A. There's no way I could recall them all. We spoke frequently during the pandemic. The first one I recall was on a truck day when we were anticipating getting PPE when the pandemic just started.

After that it was -- I was getting updates, he was seeing if there were ways he could assist us. Just frequent communication back and forth.

Q. What kind of relationship, if any, does Mr. Weiss have with Mr. Kalter, do they have any relationship with one another?

A. I don't know.

Q. Is it your testimony that Mr. Weiss is the liaison between you and Mr. Kalter because Mr. Weiss indicates to you that Mr. Kalter has questions of you?

A. No, I believe Mr. Weiss is charged with overseeing the facilities. I believe he's hired by Mr. Kalter to do so.

Q. What forms the basis for that belief?

A. I answer to him. So, I assume he's in charge.

Q. What makes you believe that Mr. Weiss -- withdrawn.

You report essentially to Mr. Weiss, correct?

A. Yes.

Q. And it's your understanding that Mr. Weiss reports to Mr. Kalter, correct?

A. Yes.

Q. What is the basis for your belief that Mr. Weiss reports to Mr. Kalter?

A. Again, we'd have multiple conversations in which he had said that, Mr. Kalter is asking a question or he asked for information for Mr. Kalter or "Could you get back to me as soon as possible, Mr. Kalter is waiting for an answer?"

Q. So, is it your belief that Mr.

Weiss is a bridge or an intermediary between you and the owner?

A. I believe he's hired by Mr. Kalter to oversee his facilities.

Q. That wasn't my question. My question was, is it your belief that Mr. Weiss connects, if a bridge, between you and the owners in terms of what's transpiring in the facility?

A. Yes.

Q. Who has the final authority of Fulton Commons to make decisions which impact patient care?

A. I do.

Q. Do you know anyone by the name of Aaron Fogel?

A. That may be the first name of the other owner, I don't know.

Q. Do you know anyone by the name is Sheindy Saffer? First name S-H-E-I-N-D-Y, last name S-A-F-F-E-R?

A. No.

Q. Do you know anyone by the name of Aryeh Kalter? First name A-R-Y-E-H, last

name Kalter, as you spelled it?

A. I don't know his wife's first name. It could be his wife. I don't know.

Q. Do you know someone named Mindy Steger -- S-T-E-G-E-R?

A. No.

Q. Do you know anyone by the name of Chana -- C-H-A-N-A -- Kanarek -- K-A-N-A-R-E-K?

A. No.

Q. How about someone named Sheva Treff -- S-H-E-V-A, Treff -- T-R-E-F-F?

A. No.

Q. What is the facility census? What does that term mean? What is the facility census?

A. That refers to how many beds are occupied.

Q. Is it the number of residents that are in the facility at a particular time?

A. Yes. Let me correct that, the census can also include, not today because the regulations have changed, but previously

if people were on bed holds at a hospital, where they went to the hospital overnight, as the Medicaid regulations allow.

So, it's not necessarily the number of residents in the facility, but it's inclusive of who we are caring for.

Q. As the administrator, do keep track of Fulton's census?

A. I don't physically count the numbers, but I know what the census is daily, yes.

Q. I didn't ask whether you prepare or count the number, but whether you remain apprised of the numbers?

A. Yes.

Q. Does this include being aware of or keeping track of resident admissions to Fulton?

A. Yes.

Q. Are you kept aware of and remain apprised of resident discharges from Fulton?

A. Yes.

Q. And is this information contained in a daily report?

A. Yes.

Q. What's the name of that report?

A. I call it the census sheet. I don't know what's listed on top of it, but to me it's the daily census sheet.

Q. What information is contained on this daily census sheet? What information does it contain?

A. It outlines the number of residents on each unit by male and female. It outlines discharges from the previous day and it outlines admissions for the previous day.

Q. When do you receive -- it's a sheet, it's a physical report, a document?

A. Correct.

Q. When did you receive the daily census sheet during the day?

A. Well, it's now e-mailed to me. It used to be a piece of paper in my box, but now it's e-mailed and I get that first thing in the morning.

I need to correct myself, it also includes room changes.

Q. Okay. And you mentioned that it's now e-mailed to you, when did that conversion take place? When did it go from -- I think you said receiving a physical piece of paper to e-mail, when did that happen, that change?

A. I don't recall.

Q. Do you recall approximately when that happened? What year? What month?

A. I don't recall.

Q. Who compiled -- you said that you don't prepare the information that's on the sheet, correct?

A. Correct.

Q. Who compiles the census information?

A. The director of admissions is responsible for putting it on the sheet. She gathers that information from the other departments as necessary.

Q. And who is the director of admissions at Fulton?

A. Today it's Kristin Hersher.

Q. Who hired Kristin Hersher to work

at Fulton?

A. I did.

Q. When was Ms. Hersher hired to work at Fulton?

A. Again, I'm guessing, early 2017.

Q. In what capacity was she hired to work at Fulton, was she hired as the director of admissions?

A. No, she was hired as the assistant.

Q. And at some point she was promoted to admissions director?

A. Correct.

Q. When was that?

A. Again, I'm guessing, about a year ago, maybe a little longer.

Q. Who promoted Ms. Hersher from admissions assistant to the director of admissions?

A. I did.

Q. Would you agree that a nursing home should not accept a new admission unless the facility is capable of providing safe and adequate care to the incoming

resident?

A. Yes.

Q. Would agree that nursing homes should not add accept a new admission if that new admission would endanger the health and safety of other residents at the facility?

A. Yes.

Q. How many resident units are there at Fulton Commons?

A. Seven.

Q. Is that 1 East, 2 East, 2 West, 3 East, 3 West, 4 East and 4 West?

A. Correct.

Q. How many beds are in each unit?

A. 40.

Q. So, is it fair to say that the facility has a capacity of 280 residents?

A. Correct.

Q. And is Fulton a Medicare participating facility?

A. Yes.

Q. Do you, as the administrator, Ms. Doyle, have set hours at Fulton, hours you

report to work, check in, and hours that you leave?

A. No, I mean I'm in the facility normally Monday through Friday, 8:30 to 5:40ish, but I'm on-call 24/7.

Q. But is it fair to say you're physically in the facility typically during the daytime?

A. Yes.

Q. Where in the building is your office located, what floor are you on?

A. I'm on the first floor on the west side.

Q. So when you come in the building, would you make a left or a right?

A. Right.

Q. Now talking briefly about Ms. Frawley and you indicated initially that she was the director of nursing; is that correct?

A. Correct.

Q. As the administrator of Fulton, do you supervise Ms. Frawley?

A. Yes.

Q. When did Ms. Frawley begin working at Fulton?

A. October of 2016, as the assistant director of nursing.

Q. Who hired Ms. Frawley as the assistant director of nursing?

A. The director of nursing at the time, Cara Mangroo.

Q. I'm sorry, what's Tara's last name?

A. M-A-N-G-R-O-O.

Q. Ms. Mangroo is the one who hired Ms. Frawley?

A. Correct.

Q. Did you know Ms. Frawley prior to Ms. Mangroo hiring her as the assistant director of nursing?

A. No.

Q. When did Ms. Frawley become the director of nursing at Fulton?

A. January 2017.

Q. Who promoted Ms. Frawley from the assistant director of nursing to the director of nursing?

A. I did.

Q. Where is Ms. Frawley's office located at Fulton?

A. She's also on the first floor on the west side, directly next to my office.

Q. Generally, how often do you speak with Ms. Frawley during a typical workday?

A. A hundred.

Q. A hundred times a day?

A. Many, many times during a day.

Q. How often do you meet face to face with Ms. Frawley, again, during a typical workday?

A. Almost all of our conversations are face to face.

Q. Do you also have daily scheduled meetings with Ms. Frawley?

A. With just her? We meet every morning than we're both in the facility and we meet every afternoon before we go home, when we're both in the facility.

Q. Do you also have scheduled weekly meetings with Ms. Frawley to discuss patient care issues?

A. No, daily we meet.

Q. To what extent has the frequency of your communication with Ms. Frawley changed as a result of the pandemic?

A. During the heat of the pandemic, it was much more frequently than we would on a normal day.

Q. Okay.

A. Those conversations went into weekends, nights, much more frequently.

Q. Do you have a social services department at Fulton?

A. Yes.

Q. Is that department one that has social workers within it?

A. Yes.

Q. Who is the current director of social services at Fulton?

A. Luisa Esquivel.

Q. Luisa?

A. Correct.

Q. And what's the last name?

A. E-S-Q-U-I-V-E-L.

Q. How long has Ms. Esquivel been

the director of social services at Fulton?

A. Approximately six months.

Q. How many social workers currently work at Fulton?

A. 2.5.

Q. Who are the 2.5 individuals?

A. Luisa is one, Rachel Marx -- M-A-R-X -- is the second and Arlene Fisher is a part-timer that comes three days a week.

Q. You mentioned Ms. Fisher's part time?

A. Correct.

Q. How long has Ms. Marx been a social worker at the facility?

A. Approximately four, five months.

Q. So, is it fair to say Ms. Esquivel and Ms. Marx were not working as social workers at Fulton from, let's say, January of 2020 through May of 2020?

A. Luisa may have been here by May, but that's a fairly accurate statement, yes.

Q. Who were the social workers that are at Fulton from roughly January of 2020

until May of 2020?

A. The director was a woman by the name of Kameca Balan -- I don't recall her exact name. And the other one was Nina Topouria.

Q. Nina Topouria?

A. Yes.

Q. So there were two social workers?

A. And Arlene was here at the time as well.

Q. Did you have an intern working as well -- withdrawn.

Was there a social worker intern working there as well?

A. There may have been, I don't recall.

Q. What is the role of the social work in the lives of Fulton residents? What is their role at the facility?

A. They are the patient advocates.

Q. What does this mean, patient advocates?

A. That means they provide emotional support. They could do anything from

helping them get their cell phone turned on to discussing burials with the families.

Q. Do residents have what's called a designated representative in the context of a nursing home?

A. Most do, yes.

Q. What is a designated representative?

A. A designated representative is a person that the facility will reach out to to advise or to provide guidance in health and financial management matters.

Q. I'm sorry, health -- and I didn't get?

A. Health and financial matters.

MR. ZADEK: If we could show you what's been premarked as Exhibit 3.

Q. Ms. Doyle, this had been premarked as Exhibit 3 and it's Title 10 of the Codes, Rules and Regulations of the State of New York. Specifically, it's Article 3, Residential Care Facilities, Part 415 and it's specifically Section 415.2 that we're going to look at.

Do you see that on the screen?

A. Yes.

Q. And this is a three-page exhibit and if we scroll down under 415.2 -- are you familiar with this statutory section, Ms. Doyle?

A. Yes.

Q. If we scroll down on the first page, on page 1, under 415.2, we see under section F and I highlighted this just to make it easier to see what I'm referring to. Can you see the highlights?

A. Yes.

Q. It indicates under section F, "Designated representative shall mean the individual or individuals designated in accordance with this subdivision to receive information and to assist and/or act in behalf of a particular resident to the extent permitted by State law."

And below that, scroll down just a drop more, under heading 1 it says, "Such individual or individuals shall be designated, with such designation noted in

the clinical record."

And below that, under heading 2 it says, "by the resident if the resident has the capacity to make such designation" or 3, "by family members and other parties who have an interest in the well-being of the resident who, after discussion with the facility, identify the individual or individuals most personally involved in the resident's care if the resident lacks the capacity to make such designation."

So, is that what you were referring to when you said they're involved in -- was it health care decisions that you mentioned?

A. Health care and financials, yes.

Q. So is it fair to say that the designated representative plays a role in financial and health care decision-making?

A. Assuming the resident is alert and oriented times three and has designated the person, yes.

Q. And under heading 2 now it says, "The designated representative shall:"

Under 1, "receive any written and oral information required by this Part to be provided to the resident if such resident lacks the capacity to understand or make use of such information, and also receive any information required to be provided to both the resident and the designated representative."

And 2, "participate in the extent authorized by State law in decisions and choices regarding the care, treatment and well-being of the resident if such resident lacks the capacity to make such decisions and choices."

Do you see where I just read, Ms. Doyle?

A. Yes.

Q. So, first of all, the designated representative is generally noted in the clinical record, correct?

A. Yes.

Q. And do you social workers access that information by reviewing the resident's chart?

A. Yes, they also take the information -- the designated representative can be a health care proxy, it could be somebody other than a health care proxy. So, social work may be dealing with somebody on a health care issue. That's different from a financial issue, for example.

MR. ZADEK: You can take the exhibit off so I can see Ms. Doyle again.

Thank you.

Q. So is it fair to say that based on the section we just looked at, that the designated representative received information from the facility if the resident lacks capacity to make decisions?

A. Yes. Again, it depends on whether there's a health care proxy, a financial, yes, depending on the situation, yes.

Q. Right. And the fact you also referenced, correct, Ms. Doyle, that the designated representative will receive information if there's a requirement that

information be provided to both the resident and the designated representative, correct?

A. Yes.

Q. So there's circumstances where a resident might have capacity, but there's an additional requirement that both the resident and the representative participate in certain decisions, correct?

A. I believe what we read is if the resident did not have capacity, they both needed to be involved.

Q. Let's take another look then, just to Clarify.

A. Okay.

Q. Let's look at Exhibit 3 and if we bring up Exhibit 3 and we look at section 2 once it comes up.

Right there, looking at subsection 2, "The designated representative shall receive any written and oral information required by this Part to be provided to the resident if such resident lacks capacity to understand or make use of such information" -- that's what you just

mentioned, Ms. Doyle, correct?

A. Correct.

Q. "And also receive any information required to be provided to both the resident and the designated representative."

Do you see that?

A. Yes.

Q. So again, in situations where it is required to be provided to both the resident and the designated representative, then such information is shared with both, correct?

A. Correct.

Q. Thank you.

And of course, as you pointed out, the resident --

MR. ZADEK: You can take it down, Ms. Liptak.

Q. And of course the designated representative participates in decisions which concern the resident, if the resident lacks capacity to make such decisions, correct?

A. Correct.

Q. I'd like to now talk to you about the rights of each resident and the responsibility to communicate with the resident and his or her designated representative.

And if we can look now at Exhibit 4. Again, as your counsel correctly point out, let's identify that Exhibit 4 is an 11-page exhibit. We're only going to be looking at a small portion of it, but Exhibit 4 is an 11-page document.

Can you see that, Ms. Doyle?

A. Yes.

Q. And this is Title 10 of the Codes, Rules and Regulations of the State of New York, again, Article 3, Part 415. And specifically we're going to look at Section 415.3, "Residents' Rights," do you see that on page 1?

A. I do.

Q. And if we look at the first -- section A, "Residents' Rights, section A, I'm going to read the highlighted section and tell me if I'm reading it correctly.

"The facility shall ensure all residents are afforded their right to" -- among other things -- "self-determination."

And further done in the paragraph it says, "The facility shall also consult with residents in establishing and implementing facility policies regarding residents' rights and responsibilities."

Do you see that?

A. I do.

Q. So, what does that mean when it says that the facility shall ensure that all residents are afforded the right to self-determination? Who does that mean? What is self-determination?

MR. YAFFE: I'm just noting my objection. That question asks for a legal conclusion and you're asking the witness to opine on the document. But she can answer to the extent that's her full understanding.

Q. As an administrator with decades of experience, what is your understanding -- and your familiarity, as you already

indicated with the New York Codes, Rules and Regulations, what is your understanding of the right to self-determination?

A. My interpretation is that they're involved in the decisions concerning their care.

Q. That they participate in the decisions involving their own care?

A. Correct.

Q. And if we go to page 3 of the document, scrolling down now to page 3 and again, I highlighted it just to make it easier to read along with me.

There is a section titled on page 3, section 6D, "Protection of legal rights" -- withdrawn.

Not section 6D, section D, "Protection of legal rights," do you see that?

A. I do.

Q. And it says under 1, "Each resident shall have the right to:"

And if you go to section 8 at the bottom, "Each resident shall have the right

to exercise his or her" -- among other things -- "right to independent personal decisions and knowledge of available choices, which shall not be infringed."

Do you see?

A. Yes.

Q. So, if the facility is required to consult with the resident when implementing facility policies regarding resident rights, would that include consulting and discussing policies that Fulton created and implemented during the pandemic?

Does a resident have the right to know what policies have been created during the pandemic?

A. They have the right to know which ones were created, yes.

Q. Would that include discussing with the resident where he or she will be living during the pandemic?

A. Yes.

Q. Would that include discussing any potential health risks that the resident

might be exposed to based on where he or she was living in the facility during the pandemic?

A. That's not a simple yes-or-no question because if it infringes on the HIPAA rights of another resident, then the answer is no. If it's not a HIPAA violation, then the answer would be yes.

Q. Right. Just in terms of the right for every individual who lives in a nursing home to be made aware of risks that they may be exposed to, again, not concerning other patients, but their own potential exposure, ever resident has a right to that knowledge, correct?

A. Yes.

Q. And each resident, according to the section we just read, Ms. Doyle, "each resident shall have the right to exercise his or her right to independent personal decisions and knowledge of available choices, which shall not be infringed," do you recall we read that?

A. Yes.

Q. Do all residents have the right to make independent personal choices during the time that they live at a nursing home?

A. I'm sorry, I don't understand the question.

Q. Do all residents have the right to make independent personal decisions while living in a nursing home?

A. No, it would depend on their mental cognition, their decision-making abilities, whether they've been deemed competent to make decisions. In some cases those rights would refer to that designated rep we just said.

Q. Good point. Let me rephrase the question, Ms. Doyle.

If a resident is competent and has capacity, does that resident have the right to make independent personal decisions that concern their life while they are living at the nursing home?

A. I'm going to give you a general yes, but there are circumstance that the answer could be no.

Q. So when would a resident who has capacity, decision-making capacity and is cognizant of his or her surroundings or as you indicated, alerted and oriented times three, would not be afforded the right to make independent decisions?

A. There are circumstances that on occasion where a resident will not be told of something that involved him or her because it may do more damage than good.

And example off the top of my head is if a loved on the outside passes away, we may not tell them about it at the request of the other family members because they -- you know, would be deemed by the psychiatrist, the psychologist, that it would hamper their ability to heal or continue with their lives. So, it's not always black and white.

Q. Right, but that's not really what I was asking about. I was asking about independent personal decisions that effect the resident in the nursing home where they lived.

If the resident is competent, alert and oriented times three, does that individual have the right to make independent personal decisions about their own life within the nursing home?

A. Yes, I believe I answered yes previously.

Q. Okay. And in those situations where the individual does not -- where the individual lacks capacity, then is it fair to say as we discussed, it would be the designated representative who would participate in the decision-making concerning that resident's life in the nursing home?

A. Yes.

Q. Now let's add the pandemic to this inquiry. I'd like to discuss whether Fulton residents still had the right to make independent personal decisions during the pandemic.

Did a resident at Fulton Commons lose or relinquish his or her right to make independent personal decisions during the

pandemic?

A. Some, yes.

Q. What decisions would a resident -- withdrawn.

What decision-making rights of a resident as we discussed pursuant to the rules and regulations of New York State were lost because of the pandemic?

A. They lost their right to move freely throughout the facility. They lost their right to leave their room. They lost their right to have packages delivered. They lost their right to have their laundry done outside the facility. They lost the right to go to nonemergency appointments outside the facility. They lost their right to visitation outside the facility. They lost their right to visitors coming into the facility.

Those are the ones that I could think off the top of my head.

Q. And those were as a result of the pandemic, correct?

A. That's what you're asking me,

yes.

Q. Yes. Were the residents given the information or told that certain of these prior rights or decisions were no longer going to be available or were they just isolated and not told what was going on? Or were they informed they will not be able to engage in that activity?

A. Of course they were informed.

Q. Right. Within the context of certain restrictions as a result of the pandemic, did residents still have the right to make decisions with respect to further available choices concerning their lives?

A. I don't know how to answer that question. It would depend on what they were requesting. My goal in the pandemic was to keep them alive and safe.

Q. I'm not really talking about -- that's really not what I'm asking.

What I'm saying is residents were still made aware while at Fulton as to available choices, correct? They were still told what areas of their life they could

decide on, correct?

A. I didn't specifically go through and say you can still choose what clothes you want to where today. They were told which rights were not available to them anymore as a result of the pandemic, not which ones still existed.

Q. So why is it essential -- withdrawn.

Why is it necessary that every resident in a nursing home be made aware of available choices that he or she can make while living in the nursing home, why is that important?

MR. YAFFE: Objection, she just --

MR. ZADEK: Counsel.

MR. YAFFE: I'm still objecting here. I mean, you know, I object to this line of questioning.

Q. Ms. Doyle?

A. I'm sorry, you need to repeat the question, please.

Q. Let me rephrase it.

Did the pandemic preclude a resident be informed of the choices that were available to them while in the nursing home?

A. I'm sorry, I didn't hear the first part of your question.

Q. Were residents at Fulton still permitted to make choices in their lives, albeit with the exception of policies that concerned the safety issues you discussed?

A. Yes.

Q. And why was it important that, again, putting aside the safety issues that the pandemic raised -- presented, why was it important that residents still be permitted to make decisions in their lives?

A. Well, we still remained an obligation to maintain their quality of life during the pandemic.

Q. And pursuant to the rules and regulations of New York, does that include the ability to be apprised -- that residents be apprised of all available choices that existed for them?

A. Yes.

Q. I would like to talk -- because he you mentioned it, I think, earlier within the context of the daily census sheet, we talked about room transfers or room changes. I'd like to talk to you a little bit about room changes, specifically the rights of each resident and the designated representative to be notified of room changes. Okay?

So we'll look at Exhibit 4, again, which was up a moment ago.

MR. YAFFE: Cathie, while we're waiting for that exhibit to upload, I'm not suggesting it, but if you want to take a break now or at any time you need a break for anything, I just want to remind you that you can request that.

THE WITNESS: Thank you.

MR. ZADEK: Yes, my original instruction remains intact, any time you need to take a bathroom break, et cetera, don't hesitate to just say,

"Let's take a ten-minute break."

THE WITNESS: Okay, thank you.

MR. YAFFE: I just remind them because sometimes the witness forgets, that's all.

THE WITNESS: I'm a 57-year-old mother, when I have to go, you'll know.

Q. We are looking again at Exhibit 4, 11-page exhibit, Title 10 of the Codes, Rules and Regulations, Part 415 of Article 3, specifically Section 415.3, entitled, "Residents' Rights."

And if we go to page 4 of the document, we see I again highlighted just to make it easier for you to read, Ms. Doyle, number 2, "With respect to its responsibilities to the residents the facility shall:"

Under number 2, "properly notify the resident and the resident's designated representative when there is, A, a change in room. Except when the medical condition of the resident requires an immediate room change or an emergency situation has

developed, such change in room shall require prior notice and consultation with the resident as well as reasonable accommodation of any resident needs or preferences."

MR. ZADEK: Okay. You can take that off, Ms. Liptak.

Q. Are you familiar with that statutory requirement in New York, Ms. Doyle?

A. Yes.

Q. So is it fair to say that the facility has a responsibility to -- and this goes -- this relates back to what we talked about earlier, when a designated representative and a resident both are required to be informed of facility action, correct?

A. Yes.

Q. The facility has the responsibility to properly notify the resident and the resident's designated representative when there's a change in room, correct?

A. Yes.

Q. Now, again, the statute does provide exception of in a medical emergency, but other than that, the resident and the designated representative participate in that decision, correct?

A. I think it says they are required to be notified and take their preferences into account.

MR. YAFFE: I think the statute speaks for itself, but when you asked her that question, you don't have it up on the screen right now. If you want it up on the screen, you can do that, but you're asking her to rely on her memory, you're throwing in words, you're leaving words out.

MR. ZADEK: Counsel, I didn't think that the statute was particularly complicated and we can certainly at any time, if she doesn't recall what it said -- what's contained in the statute, we can certainly bring it. I didn't see the need to, but be that as it may --

Q. Why is it important to notify both the resident and the designated representative when a resident changes his or her room?

A. Well, obviously it's important to notify the resident because he or she is the one who is impact in the room. And it's important to notify the designated representative so that he or she can provide emotional support and be aware of the room change.

Q. And why -- again, pursuant to the statute, why is it important that both the resident and the designated representative receive prior notice and consultation before such bed transfer occurs? Why is there a specific requirement that there be prior notice given?

A. Because the statute also requires that we take into account preferences. So for example, if you're in a B bed and you move into another unit, they could still have a B bed, that would be your opportunity to request that.

Q. So is it fair to say that where it says between the facility, the resident and the designated representative, there's a period of discussion that can take place which takes into the account the preferences of the resident, correct?

A. Yes.

Q. And this regulation prohibits, except for an emergency, a sudden unannounced room change, correct?

A. Well, it could be a resident altercation. It could be something like a pandemic where we are required room changes. But yes, in general, we want to involve the resident and the designated representative.

Q. Well, you said in the pandemic, how does the pandemic alter the requirement in New York State that the resident and the designated representative participate in a decision?

A. Because there were designated areas in the facility that were identified, for example, suspected cases and positive case, and in that situation, you had no

choice where your loved one went.

Q. Right. But it goes back to what we discussed earlier, the resident and the designated representative are still informed of the policy change, they're not simply whisked out of their room without a discussion about it taking place, correct?

A. They may have been whisked out of their room and the discussion occurred afterwards if it was for the safety of the resident, yes.

Q. You mean if an emergency situation arose?

A. Correct.

Q. Again, excluding a medical emergency at a particular moment, excluding that, the resident and the designated representative are to be informed as to what's taking place, correct?

A. Yes, either before or after depending on the situation, correct.

Q. Well no, the statue doesn't say, "After," does it? I can bring it up to you, Ms. Doyle, if you don't recall?

A. It says in the case of a medical emergency, that the room changes can be done at that time, which is what happened during the pandemic. I assume that's what you're getting at, so.

Q. No, I'm not -- withdrawn.

I'm not talking about a medical emergency situation, I'm indicating in a situation within the confines of a pandemic or outside the confines of a pandemic, a resident and the designated representative are entitled to prior notice of what is going to take place?

A. Again, I'm going to answer that as a general yes. However, circumstances may dictate with the timing of all that.

Q. If there is some outbreak on a unit? Give me the context in which you would whisk a resident out of a room and not let the resident or the designated representative know that that transfer is occurring?

A. Well, the resident would obviously be advised because he or she would

be the one moving. But let's say your mother and my mother are both residents upstairs and they're roommates and your mother is throwing punches at your mother.

I'm going to move you before I call your designated rep.

Q. Again, let me clarify. I'm not talking about that scenario. I'm --

A. But that's what you asked me.

Q. No, I ask you in a situation where there's not an eminent immediate medical emergency? Where --

A. I don't consider that a medical emergency, so I wanted to give you another example of what could occur.

Q. Well, in a scenario where residents are not throwing punches at one another, where there's no acrimony in the room and where the resident, who is in the room who is being transferred has no medical emergency, in that context, pursuant to the statute, that resident and the designated representative are entitled to prior notice with respect to a room transfer, correct?

A. Yes, that's what I said all along, correct.

Q. And Fulton Commons has its own policies and procedures in place that address room transfers, correct?

A. Yes.

Q. If we can look at -- I'd like to discuss the role and responsibility of the social worker at Fulton when a resident transfers between units.

So, can we look at an exhibit which has been premarked. Do you recognize this document, Ms. Doyle?

A. I do.

Q. It's a four-page exhibit and it's entitled, "Fulton Commons Care Center Policy and Procedure". And again, I've highlighted some sections just so it's easier to read along.

But the title, "Transfer to hospital and room changes procedures," correct?

A. Yes.

Q. And it indicates that it had an

effective date of January 2014 and it was revised in October of 2014, correct?

A. That's what it says, yes.

Q. And if we go to page 3 of the document, there's a heading titled, "Room change protocol," correct?

A. Yes.

Q. And it says that the purpose -- under number 3 -- "to insure resident and family awareness of environmental changes that carry the potential or serious impact on the resident's physical or emotional well-being."

Do you see that?

A. Yes.

Q. And if we go under -- below that, under the heading of room change, if we go to the next page, page 4, we see between unit transfers and it says right there, "Social worker" -- go down to the fifth bullet point, "Social worker discusses team recommendation with family and resident documenting their response in the resident record."

Do you see that?

A. Yes.

MR. ZADEK: We can take it off the screen.

Q. Explain why -- this is Fulton's policy concerning room changes, correct?

A. Yes.

Q. Why -- explain why it's important for a social worker to speak with both the resident and the family prior to a bed transfer between units?

A. Well, it's important to involve the designated rep because he or she could have information that could impact the decision on where the room is they go to.

For example, if your mother was a Holocaust survivor, we may not put her with a person that they see fit. And that information is information that would impact where we move the resident to and that is something the resident may or may not relay to us.

Q. And explain providing detailed documentation in the chart as to how the

resident and the family responded to the proposed transfer to another unit?

A. Can we bring that document up again? Because I don't recall seeing detailed documentation in the policy, but I'll answer the question.

Q. No. No. Well, reading the language, "Social workers are subject to recommendation with family and resident documenting their response in the resident record"?

A. Correct.

Q. Is it your understanding that it need not be detailed?

A. No, it does not need to be detailed. It could be as simple as, "Resident and family agree to room transfer."

Q. So, separate communication in the chart that the resident and the family were consulted and discussed the issue; is that fair to say?

A. Yes.

Q. I'd like to talk about admissions

and readmission from the hospital?

A. Okay.

Q. Prior to the pandemic, who was responsible for deciding whether to admit a patient from the hospital to Fulton?

A. Admissions would do a basic screen of the resident and then director of nursing or her designee would review the clinical to admit the resident.

Q. So, are you saying it was the admissions department and the director of nursing?

A. That's correct.

Q. What role, if any, did you play in deciding -- again, this is prior to the pandemic, what role, if any, did you play in deciding whether to accept a patient from the hospital?

A. Not on a daily basis. If somebody had been here before and owed us money or if somebody had been here before and was very a difficult patient or a family that had been here before that was suing us, things that would impact our desire to admit

them would be brought to my attention.

Q. Prior to the pandemic, who decided on which unit and bed to place an incoming patient from the hospital?

A. Admissions and the director of nursing, if it was something that she needed her input on. For example, if somebody had an infection or liked a specific doctor, the director of nursing decided with her together.

Q. To what extend during the pandemic did you become involved in the admissions process of possible patients to Fulton?

A. I don't understand your question, at what point did I get involved?

Q. No, to what extent, if any, during -- did your involvement change in the admissions process of a hospital patient to Fulton?

A. Sure, it changed when the Department of Health mandated that we admit COVID-positive residents to the facility.

Q. Right. But my question to you is

to what extent did that change your involvement in the admissions process from a hospital?

You said earlier, if I understood correctly, it was Ms. Hersher and Ms. Doyle that largely participated in the admissions from the hospital, correct?

A. No, Ms. Frawley, I'm Ms. Doyle.

Q. I'm sorry, I meant Ms. Frawley. It was largely Ms. Hersher and Ms. Frawley, correct?

A. Correct, it remained that way throughout the pandemic. They understood what needed to be done based on the guidelines from the Department of Health and the Governor and they continued to make any admissions.

Q. To what extent did you get more involved in that process during the pandemic?

A. I was involved to the point of telling them the guidance that we were required to take. We designated an official COVID unit, I was involved in that decision,

of course. I was involved in making the necessary room changes to create that unit.

But the day-to-day reviewing of residents to admit remained with them.

Q. So during the pandemic, 1 East was designated as the COVID unit to receive admissions of COVID patients from the hospital?

A. That's correct.

Q. And how about bed transfers at Fulton, not incoming patients from the hospital, but generally bed transfers within the facility.

Prior to the pandemic what was the process by which a resident would transfer from one bed or unit to another bed or unit in the facility, how did that work?

A. Sometimes a unit manager would suggest it, that roommates weren't getting along or a resident -- very often a resident would request a room change.

In that case, they follow the protocol that we just saw up on a screen, where a conversation would be held. You

know, sometimes they want to be closer to a friend or a different unit or they didn't like their roommate.

Most of our room changes prior to the pandemic were at resident requests or because residents were not getting along.

Q. Prior to the pandemic, who had the authority at Fulton to approve and to authorize the transfer of a resident from one bed or unit to another bed or unit?

A. It's almost always a group decision. Sometimes a unit manager will come if my mom and your mom are not getting along. And social workers would get involved, counselors would get involved.

We would have discussions on where we thought we could place somebody to be a good roommate, what unit would be best suited. For example, if you were alert and oriented, they would put a resident that matched with another resident.

So, it was pretty much always a group discussion.

Q. Were there any individual or

individuals who had the final authority to make that bed transfer or could the unit manager on her own say, "I'm moving this resident from this unit to this unit"?

In other words, was there any individual who had to approve of the bed transfer?

A. No, it was a group -- they all -- it was a group discussion. The director or nursing, admissions and myself could say, "I saw on a report there was a resident -- I'd like to move Ms. Doyle to 3 East, to another bed on that unit." The unit manager might say, "That looks good on paper, but she stays up all night and the other one likes to sleep, I don't think that's a good pair."

So, it's always a conversation on where we should put people. That's not a decision you want to take lightly, you wanted to put them where they were best suited.

The ultimate decision with everything that happened in the building was mine, but I would never do anything by

myself without conversations with others.

Q. Right. But the final authorization comes from you?

A. Correct.

Q. Did that decision-making process which you just discussed with us, did that change during the pandemic as opposed to prior to the pandemic?

A. It sped up significantly in some cases where perhaps the conversations were not as lengthy, but no, the general process was the same for those transfers.

Q. I was going to ask you, Ms. Doyle, we were talking about hospital admissions and bed transfers, correct?

A. Yes.

Q. Is there any -- did you have any ability to visualize the residents that are in the facility at any given time? Was there any visual aid that the facility had to assist you in seeing where the residents are located in the building?

A. Yes, we use something called a bed board. It's a blackboard in the

admissions office that has all seven units identifies and the beds that are open and filled and with whom.

Q. Bed board -- B-E-D -- bed board?

A. Yes.

Q. And that bed board is located, you said in the admissions office?

A. That's correct.

Q. That's a physical board that contains each bed in the facility with the resident's name that's located in that bed?

A. Correct.

Q. Who has access and use of this bed board?

A. Well, admissions obviously, the director of nursing, myself, anybody that needs to know where a resident is located at that time.

Q. So, is it fair to say that you used the bed board as well in making decisions concerning bed transfers?

A. Yes.

Q. If we can look at Exhibit 6, again Title 10 of the Codes, Rules and

Regulations. This is Exhibit 6. Can you see that, Ms. Doyle?

A. I can.

Q. Title 10 of the Codes, Rules and Regulations of the State of New York, Article 3, "Organization and Administration," specifically Section 415.26. It's a 30-page exhibit.

And if we look at page 1, it indicates -- and again, I highlighted portions so that you can read along. "A nursing home shall" -- among other things -- "maintain the highest practicable physical, mental and psychosocial well-being of each resident."

And under "Administration," section A, it indicates, "No nursing home shall operate unless it is under the supervision of an administrator who holds a currently valid nursing home administrator's license and registration."

And it continues, you can scroll down a drop, "the administrator shall set an example for all staff members" -- and it

continues -- "which recognizes that the institution exists to serve the interests of and the needs of residents, which emphasizes the importance of a resident's right to independence regarding all aspects of institutional life."

Are you aware of this section, Ms. Doyle?

A. I am.

Q. Again, leaving it up on the screen, the statute emphasizes or recognizes rather, the importance of a resident's right to independence and is that -- does that independence include the ability to make decisions, either individually if they have the capacity, or as you discussed, they lack capacity, to have a designated representative participate in those decisions; is that correct?

A. Yes.

Q. And if we go to page 24 -- page 24 of the exhibit, we see -- I'm sorry -- yes, page 24, "Admission Policies and Practices" and it says, "The nursing homes

shall:"

And then if we go to page 25, under subsection 2, "The nursing home shall: accept and retain only nursing home residents for whom it can provide adequate care of."

Do you see that?

A. I see it.

Q. What is adequate care? When is a nursing home providing adequate care to an individual?

A. I'm sorry, I don't know how to answer that question. You admit residents that you have the capability of taking care of.

Q. That you can take care of?

A. Correct.

Q. And it continues under section 8, if we go to page 27, "The nursing home shall," under section 8, "apply the following restrictions to the admission and retention of residents."

And if we scroll down under section D, "a resident suffering from a

communicable disease shall not be admitted or retained unless" -- and it continues where I highlighted -- "the facility is staffed and equipped to manage such cases without endangering the health of other residents."

Do you see that?

A. I see it.

Q. So basically is it fair to say that the statute is indicating that a resident should not be admitted if so doing would endanger other residents, corrects?

A. Exactly why I disagreed with the directive from the Governor and the Department of Health to admit COVID-positive residents, which we were, of course, mandated to do.

Q. Can you please listen to my -- that isn't what I asked you. I asked you --

A. I answered your question.

Q. No, that wasn't what I asked you. I asked you -- we can read back the question. I wasn't talking about the Governor or the Governor's mandate, I was

asking about the statute.

A. And I answered yes, this is correct, except when it's overwritten by the Department of Health and the Governor's directive during the pandemic, that's my answer.

Q. Let me repeat the question.

A. Okay.

Q. The statute is indicating, correct, Ms. Doyle, that a resident who suffers from a communicable disease, should not be retained -- should not retained or admitted of so doing would endanger the health of other residents, that's what the statute says, correct?

A. That's what the statute says, yes.

Q. What is a communicable disease, what does that mean?

A. One that can be spread from one person to another.

Q. And is the Coronavirus a communicable disease?

A. Yes.

Q. Let's discuss a bit the protocols that were implemented during the pandemic to contain the spread of communicable diseases, including or specifically, COVID?

A. I would just like to make a comment, if I may? The interpretation --

Q. Actually --

A. I'm sorry?

Q. No, I cut you off, you can talk. I can see you're back because the exhibit's been removed.

A. I just wanted to comment that this provision in the code was overwritten by the Department of Health and Governor Cuomo's instructions that nursing homes must admit COVID-positive residents. So, we were given no choice in the matter to admit them and I would like that on the record.

Q. Actually, for purposes of this hearing, any questions I pose to you requires a response. Your opinion or your discussion or interpretation or feelings toward provisions is not relevant to the hearing. You made your record, but just

moving forward, just so we understand one another, the only requirement you have here is to answer my questions. Okay?

A. Noted.

Q. Okay. So, we talked a little about the protocols --

MR. YAFFE: I'm sorry, did you deem this to be hearing? I thought this was a subpoena to testify. You keep using the word hearing.

MR. ZADEK: We're not going to decipher the Executive Law.

Q. The protocols that were implemented during the pandemic, Ms. Doyle -- there were protocols implemented, correct, during the pandemic to address protocols, correct?

A. Correct.

Q. If we can look at Exhibit 7 and Exhibit 7, once we get it up here, Exhibit 7 is a three-page document. And I'm only going to reference a very small section of it, but it's a three-page document that has an issuance date of February 6, 2020.

Do you see that?

A. I do.

Q. And it's from the Department of Health & Human Services CMS, are you familiar with the Centers for Medicare & Medicaid services?

A. I am.

Q. Did you receive CMS updates during the pandemic?

A. Yes.

Q. And the subject of this three-page document is "Information of Health Care Facilities Concerning 2019 Novel Coronavirus Illness," do you see that?

A. I do.

Q. And it says on the next section under, "Memorandum Summary," if you scroll down just a bit. It says under, "Healthcare Facilities Expectations" in the middle of the page, "CMS strongly urges the review of CDC's guidance and encourages facilities to review their own infection prevention and control policies and practices to prevent the spread of infection."

And below that it says, "The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. Every Medicare participating facility in the Nation's healthcare system must adhere to standards for infection prevention and control."

Did Fulton Commons adhere to standards of infection prevention and control during the pandemic?

A. Yes, we did.

Q. If we go down a little further to the bottom of the paragraph, it says -- third line from the bottom of the second paragraph that's on the page, it says, "Facilities must take steps to prepare, including reviewing their infection control policies and practices to prevent the spread of infection."

And did Fulton --

A. Sorry, I don't see where you're reading. This is the first time I'm seeing

this document so I'm a little -- the other ones I'm familiar with, but one I've never seen before.

Q. Okay. You have not seen this before?

A. This is to the survey directors, not to administrators, I've never seen this before.

Q. You've never seen this?

A. Not to the best of my knowledge, so.

Q. So if we scroll down again towards the bottom middle of the page.

So, if you see -- I don't know if you see my cursor now, can you see my cursor on the screen?

A. No, I don't.

Q. You don't see this?

A. Oh, yeah, I see it now.

Q. It says, "Facilities must take steps to prepare, including reviewing their infection control policies and practices to prevent the spread of infection."

Do you see that?

A. No, I'm trying to find it, I'm sorry.

Q. There we go.

A. Okay, yep.

Q. Okay. Is it fair to say -- withdrawn.

Did Fulton -- withdrawn.

Did you take steps to prepare and did you review your potential policy with Fulton in order to stop the spread of infection?

A. Yes, before we were advised to do so by the New York State Department of Health.

Q. So, the answer is yes?

A. Yes.

Q. Again, if we go to page 2 of the document, right here at the top, the second paragraph in, it says, among other things, "CMS" -- I don't know if you see my cursor here -- "CMS also expects healthcare staff and surveyors to comply with basic infection control practices."

Do you see that?

A. I do, this is guidance from CMS to the survey team to follow infection control practices.

Q. Right. Did Fulton Commons follow basic infection control practices during the pandemic?

A. Yes.

Q. Okay.

A. Just for the record, that document was not sent to the administrators, just so you're aware.

Q. Have you ever seen that document before?

A. No, I have not. It was from CMS to state surveyor agencies.

Q. Hmm-hmm. Looking at Exhibit 8 -- what was premarked as Exhibit 8. Have you seen -- it's a -- have you seen this exhibits before?

A. I can't tell.

MR. YAFFE: You're only showing her the first quarter of the first page.

Q. You're not able to see the

heading on this document?

A. I can see a heading, but I can't tell you if I saw it or not based on heading. I haven't seen the context.

Q. Then let's do -- Exhibit 8 is dated March 4, 2020 and again, it's from the CMS, correct?

A. Yes.

Q. And the subject is entitled, "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes," correct?

A. Yes.

Q. And if we scroll down to the bottom of the first page of this four-page document, it says under, "Guidance," in the third line down, "Per CDC," do you see that right there?

A. Yes.

Q. "Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures amongst patients, healthcare personnel and visitors at the

facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals."

Have you seen that before?

A. I don't recall seeing that document.

Q. No?

A. No.

Q. Do you agree that facilities should and -- withdrawn.

Was Fulton vigilant in identifying possible infected individuals within the facility?

A. Yes.

Q. And if we go to page 2 of Exhibit 8. At the top of the page, second line down it says, "Facilities should maintain a person-centered approach to care. This includes communicating effectively with patients, patient representatives and/or their families."

Do you see that?

A. I see it.

Q. And do you agree with that

statement, that during the pandemic communication was critical in terms of patients, their representatives and their families?

A. Yes.

Q. If we go to page 3 of the document of Exhibit 8. Under the heading right there, "When should nursing homes accept a resident who is diagnosed with COVID-19 from a hospital"?

MR. YAFFE: That's not what it says.

MR. ZADEK: Are we on page 3? I think scroll down a drop. I noticed the exact same issue.

Q. Okay. "When should a nursing home" --

MR. ZADEK: No, let's go down.

Q. "When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital," do you see that?

A. I see it.

Q. "A nursing home can accept" -- it begins, "A nursing home can accept a patient

diagnosed with COVID-19 and still under transmission-based precautions for COVID-19 as long as it can follow the CDC guidance for transmission-based precautions."

Do you see that?

A. I see it.

Q. Did Fulton accept patients diagnosed with COVID-19 under circumstances when it was able to follow guidance for transmission-based precautions?

MR. YAFFE: Objection.

Q. You can answer.

A. Not until we were mandated to do so by the Department of Health.

Q. Hmm-hmm.

I'd like you to look at Exhibit 9, it's an additional guidance.

So, Exhibit 9 is a six-page document and it's dated March 13, 2020. It indicates that it's revised, do you see that?

A. I do.

Q. And the subject is "Guidance for Infection Control and Prevention ever

Coronavirus Disease 2019 in Nursing Homes (Revised)."

If we go to page 4 of the document and towards the bottom of the page of page 4, it says, "When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital," do you see that?

A. I do.

Q. If we turn to the next page, page 5, at the top under the note, do you see where it says, "Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was or is present. Also, if possible, dedicate a unit or wing exclusively for any residents coming or returning from the hospital. This can serve as a step down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original rooms)."

Do you see that?

A. I see it.

Q. And were you aware of this guidance?

A. No, we did not receive this guidance from the New York State Department of Health.

Q. Did Fulton dedicate a unit or a wing exclusively for residents coming or returning from the hospital?

A. Yes.

Q. And is it your understanding that that unit or wing at Fulton was designated or created as an infection control protocol during the pandemic?

A. Correct.

Q. And if we can now look at Exhibit 10, which is a three-page exhibit. And this is entitled, "COVID-19 Long-Term Care Facility Guidance" and it's from CMS, correct, and it's dated April 2, 2020, do you see that?

A. I see it.

Q. Do you know if you've seen this

document before?

A. I don't recall seeing this.

Q. Okay. If we go to the second page of this three-page document and we look at number five towards the bottom of the page, where it says, "To avoid transmission within long-term care facilities, facilities should use separate staffing teams for COVID-19-positive residents to the best of their ability and work with State and local leaders to designate separate facilities or units within a facility to separate COVID-19-negative residents from COVID-19-positive residents and individuals with unknown COVID-19 status."

Do you see that?

A. Yes.

Q. Do you agree with that, if you haven't seen this policy -- this guidance before, do you agree that from an infection control standpoint, do you believe in the value in separating -- having separate staffing teams to care for the COVID and nonCOVID patients?

MR. YAFFE: Objection.

Q. You can answer, Ms. Doyle.

A. The answer is yes, which is why I did it before the date on this memo.

Q. So, you were, if you will, ahead of the current on this?

A. Yes, I was.

Q. And you also, I believe you mentioned, you established a separate designated COVID unit within the facility, correct?

A. Correct.

MR. YAFFE: Can you just tell me the date of this document? I missed that. I'm sorry, it was on the first page.

MR. ZADEK: Yes, April 2, 2020.

MR. YAFFE: Thank you, sorry.

MR. ZADEK: That's quite all right.

Q. Looking to go to page 3 of Exhibit 10, page 3 at the top, it's the very first line on the top it says, "Also, staff as much as possible, should not work across

units or floors."

And then below that, the first bullet point, it says, "Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not or have unknown status."

And then number 2 it says -- going down right there under number 2 it says, "COVID-19-positive units and facilities must be capable of maintaining stringent infection control practices."

And under number 1 it says, "When possible, facilities should exercise consistent assignment or have separate staffing teams for COVID-19-positive and COVID-19-negative patients."

Do you see that, Ms. Doyle?

A. I see it.

Q. So what does that mean at the top of the page concerning staff should not work at best -- as feasible -- as much as possible, should not work across units or floors, what does that mean?

MR. YAFFE: Objection.

MR. ZADEK: Withdrawn.

Q. In the context of Fulton's operation, what -- to what extent, if any, was that implements?

A. That was implemented in the middle of March, right before the date of this memo, that staff should report to their unit and stay there, not go down for lunch, not to go from unit to unit.

And that as much as we were able to with the staffing to assign specific staff to specific units and not have them float between the units.

Q. If we look at Exhibit 11 -- before we look at Exhibit 11, did you also receive guidances from Department of Health?

A. I did.

MR. YAFFE: Well, when you said, "also," I just want it to be clear that you're suggesting that she received the other ones, but she did not.

MR. ZADEK: Counsel, you're recollect. Let me clarify that. Thank

you, Mr. Yaffe.

Q. Did you receive -- you indicated I think to the best of your recollection you had not seen the CMS guidance that I had just displayed, correct?

A. That's correct.

Q. Did you receive other guidances though from CMS?

A. I don't recall. The exhibits that you're showing me from CMS to the state surveyor, not to the administrator.

Q. No, you said that. But did you receive guidances and bulletins from either CMS or the CDC?

A. I don't recall receiving specific things from CMS. We certainly received recommendations from the CDC, but we took our direction from the Department of Health because the State guidance, if any came, overruled guidance from anywhere else.

Q. So let me just ask you whether you recognize the New York State Department of Health March 13th guidance which is now Exhibit 11?

A. Again, I'd have to see the contents. I don't know from a box.

Q. Well, let's go through it. It's dated March 13, 2020. It's from the New York State Department of Health Bureau of Healthcare Associated Infections and it's -- in the box it indicates, "Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities."

At the very bottom it says, "If there are confirmed cases of COVID-19 in an NH or ACF," is "NH" nursing home?

A. Yes.

Q. And "ACH" would be adult care facility?

A. Yes.

Q. So if there are confirmed cases of COVID-19 in a nursing home or adult care facility and if we turn the page, page 2 and look at number 5, it says, "Do not float staff between units. Cohort residents with COVID-19 with dedicated HCP and other direct care providers."

Do you see that?

A. I do.

Q. Do you recall now whether or not you had received and seen this bulletin?

A. Yes, I remember receiving it and saying, "Okay, we already did that."

Q. Right. And is that what you just mentioned to me a few moments ago when you said, "Do not float staff between units," is that what you were referring to?

A. Yes.

Q. And when it references dedicated HCP, do you know what HCP stands for?

A. Health care provider.

Q. So, this guidance or this bulletin is indicating that residents with COVID-19 should be cared for by separate health care providers on the unit; is that correct?

A. Consistent staffing, yes.

Q. That the staff not float -- as you said, float between the units?

A. Correct.

Q. Thank you.

So, we've looked at some CMS

guidances. We've also looked at the Department of Health guidance from March 13, 2020, which I believe you did recall seeing. And we talked a few minutes ago about Fulton's policy and procedures, I think we did that in the context of bed transfers.

I want to ask you in general about Fulton's policies and procedures. What are nursing home policies and procedures?

A. What are they?

Q. What are they?

MR. YAFFE: Objection.

Q. You can answer.

A. They are the written guidance to the staff on how the facility expects you to handle situations, care or how to mop the floor or -- depends on the situation.

Q. Are the Fulton caregivers expected to follow the nursing home's policies and procedures?

A. They are.

Q. Who creates the policies and procedures at Fulton?

A. It depends on what the policy is. If it's a housekeeping policy, then the housekeeping director would. If it's a nursing policy, then the director of nursing would. If it's an administrative policy, then I would.

Q. Who approves this policy and procedure before it's implemented at Fulton?

A. The Quality Assurance Performance Improvement Committee.

Q. And do you keep Fulton's owners or owner, Mr. Kalter, apprised of the facility's policies and procedures?

A. No, he doesn't see the individual policies.

Q. Do you keep Mr. Weiss apprised of Fulton's policies and procedures?

A. No, not each individual policy.

Q. Are the Fulton policies and procedures dated?

A. Generally, probably not all of them. But yeah, the practice is to have them dated, but it's not a requirement.

Q. Why is it good practice that

Fulton's policies and procedures be dated?

A. So you can see when you implemented something or changed -- revised something.

Q. So, there are occasions when the policies and procedures are revised or updated?

A. Yes, as situations change, the policies are updated.

Q. Let's talk in the context of the nursing policies and procedures, who's responsible for revising or updating those policies and procedures?

A. The director of nursing.

Q. Who approves of those updates or revisions to the nursing policies and procedures?

A. The Quality Assessment Performance Improvement Committee. I'll refer to that as "QAPI"; if that's okay?

Q. Yes, QAPI?

A. QAPI.

Q. Okay. Did the policy and procedures indicate the date of the

revision, if they are revised?

A. If general, again, that's good policy, but there's no requirement.

Q. And if you we look at Exhibit 12 and we will just use this as an example. Exhibit 12 is a one-page exhibit. It's entitled, "Hand Washing," correct?

A. Yes.

Q. And it has a date that it was issued as 2/29/08, correct?

A. Yes.

Q. And it has the date it was revised in January of 2019, correct?

A. Yes.

Q. And is that what you're to referring a good policy in that it indicated the creation and revision date?

A. Yes, it's a good practice to do that. I actually not date mine. People date them all, some people don't date them at all.

Q. I didn't ask you about that, but we'll get to that in a moment.

If we look at Exhibit 13, is that

another example and it will take another moment to come up. But Exhibit 13 is another policy exhibit and I think it's also involving hand washing, specifically hand cleanser, antiseptic, do you see that?

A. Yes.

Q. And again, here we see the issue date of 2/29/08 and that it was revised January 2019, correct?

A. Yes.

Q. And this would conform, as you said, good policy and good practice of including the issuance and revision date?

A. Yes.

Q. Thank you.

Does each nursing home develop policies and procedures which are tailored to the specific needs of its own residents?

A. Yes.

Q. Why is it important that each nursing home develop its own specific policies and procedures?

A. Because the facilities have their own ways of doing things, their own facility

needs, their own resident needs. You can never take a hand washing from here and implement it in another building because you may not have the same supplied. You just need to tailor it to your own facility.

Q. Is it fair to say that nursing homes, to some extent, have different patient populations as well?

A. Oh, definitely, yes.

Q. And you said it's important that caregivers adhere to the policies and procedures when they provide care to residents, correct?

A. Yes.

Q. Could the failure of caregivers to follow infection control policies and procedures endanger the well-being of Fulton residents?

A. Can you repeat that first half?

Q. Sure. Could the failure of caregivers to follow infection control policies and procedures endanger the well-being of Fulton residents?

A. Could it? Yes.

Q. Could the failure of caregivers to follow infection control policies and procedures result in the neglect of Fulton residents?

A. I don't believe it would be neglect, no.

Q. If staff -- withdrawn.

Could the failure of caregivers to follow infection control policies and procedures result in the death of Fulton residents?

A. I suppose, yes.

Q. Who is responsible for ensuring that the caregivers at Fulton properly carryout the facility's policies and procedures?

A. I am.

Q. I would like to discuss Fulton's policies and procedures relating to COVID-19 and infection control. As the administrator, Ms. Doyle, did you issue new protocols that were designed to reduce the risk of transmission of COVID in the facility?

A. Yes.

Q. And if we could look at Exhibit 14 for a moment. Ms. Doyle, do you see Exhibit 14 on the screen?

A. I do.

Q. It's a seven-page exhibit and it's -- this is a policy and procedure at Fulton, correct?

A. I don't know see the Fulton name on it. I'd have to read the whole thing to answer that. I don't see the facility name.

Q. Well, at the top it says, "Department: Administration," is that your department, administration?

A. Yes.

Q. And then it says, "Nursing," would that Ms. Frawley's department?

A. Yes.

Q. And then it says, "Medical, Dietary, Housekeeping, Maintenance, Social Service, Recreation, Admissions, Rehabilitation," correct?

A. Yes.

Q. And below that it says, "Policy

Name: COVID-19," correct?

A. Yes.

Q. And if we scroll down to the middle of the page under, "Policy," it says right there, "Fulton Commons Care Center will conduct," that's how it begins, do you see that?

A. Yes.

Q. So, does that refresh your recollection whether this is a Fulton Commons policy and procedure?

A. Well, it obviously is, it has our name in it.

Q. Do you recognize this document?

A. Not off the top of my head, no.

Q. It says, "Fulton Commons Care Center will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of the Novel Coronavirus."

And it says, "The facility will implement actions according to CDC, New York State DOH and World Health Organization recommendations, including identification,

isolation and information."

So you see that?

A. I do.

Q. You still do not recall seeing this policy and procedure before?

A. Yeah, it's ringing a bell.

Q. Okay.

A. I read a lot of policies during the pandemic, sir, so you will forgive me.

Q. So it does ring a bell now?

A. Yes, sir.

Q. Okay. Who prepared this policy and procedure?

A. If you scroll down to the bottom of the last page, I'm hoping it will be identified as to who wrote it. It may or it may not.

Q. It's a seven-page document. So let's go to page 7, the last page, which has the numbers 3, 4 and 5 at the top of the page. That's the last page, 7.

MR. ZADEK: Scroll down slowly so Ms. Doyle can see it. So that's the bottom of the page.

Q. So at the end of this document indicated who prepared it, correct?

A. Okay. It's an administrative policy, which means I wrote it.

Q. No, but there's nothing within Exhibit 14 that indicates who created this document, correct?

A. Correct.

Q. But you stated that you believe you created it?

A. Yes.

Q. Why is that? Why are you saying -- why do you believe that you created it?

A. Because the sentences start, "The Administrator/designee," which means it came from my office.

Q. When was it prepared?

A. I don't know.

Q. Does that go to your statement that it's good policy and practice to date policies and procedures because then you would know when it was prepared, correct?

A. Yes.

Q. Do you know if someone whited out

or redact the date of the policy from this document?

A. I'm sorry, what was the question?

Q. Do you know if someone at Fulton at any time redacted or whited out or removed the policy date?

A. Absolutely not.

Q. Do you know when this COVID-19 policy was implemented at Fulton?

A. I can give my best guess as to early March, but without my timeline or my documents, I can't answer that a hundred percent.

Q. Okay. If we look at page 2 of Exhibit 14, go to page 2, at the top it says, "Procedure" and it's "Nursing/Medical," correct?

A. Yes.

Q. And if you go down to the number 5, do you see where it says under number 5, the end of the first line of number 5, it says, "The facility will cohort confirmed positive residents in the same room or area of a unit as much as possible," do you see

that?

A. I do.

Q. Was that your policy that you implemented to I guess separate or isolate confirmed positives from others in the facility?

A. As possible, yes.

Q. And if you go to page 3 and we look at the bottom of the page, there's a heading on the bottom of the page, right there, it's entitled, "Confirmed COVID-19-Unit," correct?

A. Yes.

Q. And it says, "One floor of the facility has been designated to care for residents with confirmed COVID-19 admissions. It is the intent of this unit to ensure the safety of all residents and staff."

Do you see that?

A. I do.

Q. So, is it this case that there was a separate unit within the building designed to care for COVID-19 patients?

A. Correct. I'm going to correct myself on a previous answer, this couldn't have been written in March. It had to be late April. That's when the guidance came out to create units. So, prior to that guidance coming out from DOH, the policy wouldn't have existed.

Q. So you -- again, so you're saying you believe now it was created in April?

A. Yes.

Q. Okay. And if we look at the top of page 4 and I think you spoke to this before, number 3, it says -- at the end of the first sentence of number 3 it says, "Have separate staffing teams on a confirmed COVID-19-unit."

Do you see that?

A. Correct, as best as possible.

Q. That's what you referenced earlier and I think you used the word "not floating" between units?

A. Correct, yes.

Q. If you can look at Exhibit 15 for a moment. So, this is a Fulton policy and

procedure?

A. It is.

Q. And it says at the top, correct, "Fulton Commons Care Center"?

A. Yes.

Q. And it concerns the nursing department, correct?

A. Yes.

Q. And let me ask you, who prepared this policy and procedure?

A. Ms. Frawley.

Q. And can you tell me when it was prepared?

A. I don't know.

Q. Do you know the effective date of this policy and procedure?

A. I don't know.

Q. Is that because the date of the policy and procedure is not on the document?

A. Correct. And they were revised -- you know, protocols on admissions were revised numerous times. I don't know when this one -- this particular one was in place.

MR. YAFFE: Can we see the entire document? The witness is speculating as to what may or may not be on this document?

MR. ZADEK: I agree, Counsel.

Let's scroll down slowly. It's only a one-page document, so -- I failed to mention that.

Scroll down to the bottom slowly.

Q. Looking at the entirety of this one-page document, does that assist you in determining when it was created or revised?

A. No.

Q. Under policy -- well, this document is entitled, "Protocol for residents with suspected COVID, as well as residents admitted from hospital with confirmed COVID," correct?

A. Correct.

Q. And under policy it says, "It is the policy of Fulton Commons Care Center to ensure all residents are maintained in an isolated area once identified as a presumed COVID or is admitted to the facility from a

hospital setting with a confirmed diagnosis of COVID."

Do you see that?

A. I do.

Q. And under the first heading going down the first down, the heading, "Protocol for inhouse residents with a suspected COVID diagnosis."

Under heading number 1 the last sentence says, "The resident will be transferred to the designated unit, unless they are in a private room."

Do you see that?

A. I do.

Q. And under the next heading, which is "Protocol for admissions or readmissions from the hospital with confirmed COVID diagnosis." Heading number 1, it says, "Any resident that is being admitted or readmitted from a hospital setting, will be placed on the designated unit."

Do you see that?

A. I do.

Q. And is it fair to say that

according to this policy, both inhouse residents with suspected or presumed COVID and hospital admissions with confirmed COVID were separated from the other Fulton residents and they were housed on a separate unit in the building?

A. That's correct.

Q. And why was it necessary, from an infection control standpoint, to separate suspected COVID residents in the facility, as well as COVID patients from the hospital and nonCOVID residents at Fulton?

A. Again, the guidance changed multiple times. When this policy was written and adhered to it was determined by the Department of Health separating the residents all together because COVID was so vehement and spread so easy, unlike some other contagious diseases. They determined it would better to keep them completely separated as opposed to rooms up on the unit, with is what their first guidance was.

Q. Now, I'm not asking referencing you to a guidance now. I'm asking you from

an infection control standpoint, why was it necessary to separate suspected, as well as confirmed COVID patients from the hospital from the other nonCOVID residents at Fulton?

A. Right and what I'm answering to you is that because they learned that this virus was so other vehement and different from anything we ever dealt with before, they wanted to separate them completely because they realized how contagious it was.

Q. And you also said, When this was created," when was this policy created and implemented, the one we're looking at?

A. My best guess after reading this policy is that it had to be late April because that's when we were using the guidance to create units.

Q. And would you agree that housing COVID and nonCOVID residents on the same unit violates basic infection control protocols?

MR. YAFFE: Objection.

Q. You can answer.

A. From what I know today, yes.

From what I knew in March, no.

Q. No, I'm asking you now, today, would you agree that housing COVID and nonCOVID residents on the same units violates basic infection control protocols?

MR. YAFFE: Objection.

A. Yes, because I'm -- we're much better versed now on how this virus reacts and how to deal with it, that today I would say that's correct.

Q. That's what I'm asking about. As you're testifying here today.

A. But I don't want you to misunderstand that that's what I thought in February and March and the beginning of April because that was not the case at the time.

Q. So you're saying that in April or so, middle of April, end of April, I don't know what date you're demarcating your opinion, but then let's say from April forward until today --

A. April 29th.

Q. Would you agree that at the end

of April until today, that housing COVID and nonCOVID residents on the same unit potentially endangered the safety of nonCOVID residents in the unit?

A. No, I can't agree to the same unit because the guidance had been as long as they are behind closed doors -- for example, you can have one unit with a set of rooms. You might have had a closed door, which is perfectly acceptable.

So, I don't want to agree to them not being on the same unit, but they definitely need to be separated from each other.

Q. And I'm referencing guidance, I'm asking you based on your experience as a nurse and as the administrator of Fulton --

A. I'm not a nurse, sir.

Q. You don't have any nursing background?

A. Absolutely not.

Q. Based on your experience as an administrator then and your years of experience in the health care field, as you

sit here today, would you agree that housing COVID and nonCOVID residents on the same unit failed to provide safe and adequate care to nonCOVID residents on the unit?

MR. YAFFE: Objection.

A. No, I don't agree to that.

Q. Let me ask you, looking at Exhibit 15, if we look at the first heading again, scroll down, the heading entitled, "Protocol for inhouse residents with a suspected COVID diagnosis." If you look at number 3, do you see where it says there under number 3, "The same staff will be assigned to them on a daily basis for each shift"?

A. Yes.

Q. And under the next heading on the page, under, "Protocol for admissions or readmissions from the hospital with confirmed COVID diagnosis," again under number 3 it says the same thing, "The same staff will be assigned to them on a daily basis for each shift"?

A. Yes.

Q. Does that reference what you testified to earlier, that the staff should not float between the COVID and nonCOVID patients as best as possible?

A. Between the COVID and nonCOVID units, yes.

Q. I want to go back for a moment to Exhibit 14. It will take a moment to bring it up, but Exhibit 14 that -- if you recall -- was the COVID-19 policy and procedure, do you recall that?

A. You'd have to bring it up to me, we looked at one, yes.

Q. It's there now in front of you, if we scroll down the first page. We talked about it five minutes ago, do you remember that?

A. Yes.

Q. If we go to page 4 of the exhibit -- of this seven-page exhibit, which is again, Exhibit No. 14. If we look at page 4, do you see at the top of page 4 it says, "As best as possible, exercise consistent assignment or has separate staffing teams on

the confirmed COVID-19 unit."

Do you see that?

A. Yes.

Q. And this is a policy which you said you created, correct?

A. Yes.

Q. So, can you explain why, during the pandemic --

MR. ZADEK: You can remove it from the screen, Ms. Liptak.

Q. Can you explain why during the pandemic was it necessary, again from an infection control standpoint, that Fulton staff not provide care to both COVID and nonCOVID residents during their shifts?

A. That it reduces the risk of spread.

Q. Would you agree then that it would be a violation of basic infection control protocols if CNAs were providing care to both COVID and nonCOVID residents during their shifts?

A. No. Again, it depends on where we are in the COVID timeline. I can't agree

to that as a general statement, no.

Q. So even as you sit here today, you do not think that basic infection protocols are violated when CNAs on the same shift care for COVID and nonCOVID patients?

A. That's not what you're asking me sir.

Q. That's what I'm asking you.

A. Based on what we know today, yes.

Q. If you need that clarification, I'll be happy to provide it to you. If you need me to say to you, as you testify here today, would you agree that it would a violation of basic infection control protocols, if CNAs were providing care to both COVID and nonCOVID residents during their shifts?

MR. YAFFE: Objection. You're not focusing on a date and time.

MR. ZADEK: Counsel, you're not -- unfortunately you don't get that either inquiry or your understanding your inquiries as to what's being asked is, no offense, not relevant to this

hearing.

Q. Ms. Doyle, I will repeat the question. If you don't understand the question, ask me.

As you sit here today, would you agree that it would be a violation of basic infection control protocols if CNAs provided care to both COVID and nonCOVID residents during their shifts?

A. No.

Q. That would not violate infection control protocols?

A. No, it would not.

Q. Okay.

A. Assuming they were in proper PPE, the answer is no.

Q. Okay. Would you agree that if CNAs -- as you sit here today -- if CNAs were providing care to COVID and nonCOVID residents during their shift, they would not be not providing safe and adequate care to their nonCOVID residents?

A. Absolutely not, I don't agree with that.

Q. Do you agree --

A. That's why we have PPE.

Q. Okay. Do you agree that CNAs providing care to both COVID and nonCOVID residents during their shifts, they would potentially be endangering the nonCOVID residents?

A. No.

Q. As you sit here today, would you agree that it would be a potential act of neglect for CNAs to provide care to both COVID and nonCOVID residents during their shifts?

A. Absolutely not.

Q. I want to return for a moment to what you mentioned earlier. You talked about staff, I think you used the term floating between units?

A. Yes.

Q. What does that mean, what is a floater in the context of the nursing home -- in the context of Fulton?

A. You have full-time staff that only work five days a week, so the other two

shifts for that person's assignment need to be filled. So, you have part-time staff or full-time staff that floats through the building and fills in those shifts.

Q. What was the policy at Fulton during the pandemic as far as CNAs -- by the way, when I say, "CNA," you understand that I'm referring to a certified nurse aide, correct?

A. I do.

Q. What was the policy at Fulton during the pandemic as far as CNAs floating between the dedicated COVID unit and other units during their shifts?

A. We did everything operationally possible to make sure that didn't occur.

Q. Who created that policy that CNAs not float between units during their shifts?

A. The QAPI committee.

Q. When did that policy go into effect?

A. Again, I don't have my notes in front of me, but I believe we implemented that in early to mid March.

Q. Okay. Was it necessary from an infection control standpoint that CNAs not float between the designate COVID unit and other units during their sift?

A. It's best practice. It's not required because again, if you're wearing your PPE properly, you're not endangering anybody else. But to go above and beyond what was required, we did that, yes.

Q. So, it pertained to infection control standards to avoid the floating, correct?

A. Correct.

Q. And did that same policy about floating between units apply to other staff, such as nurses and social workers in the building?

A. Yes, it did, it applied to all departments.

Q. So are you saying that nurses remained on their units and did not go to other units during their shifts?

A. That's correct, same as housekeeper, maintenance, social worker,

they were all assigned specific units to stay on.

Q. So as an example you said social workers, if there was an social worker that was assigned to the designated COVID unit, they would not during their shift see a resident on another unit, correct?

A. No, they could, they had additional units. But again, the policy was you saved the COVID units for last. Do what you have to do, save the COVID units for last and do not go back on other units.

Although, they could, again, if they were wearing their PPE properly. There's no reason not to intermingle as long as you're following infection control and wearing your PPE properly.

For example, I can make rounds right now. I can go to four of the six units and not wear PPE if I went to a resident room. On two units, if I went into a room, I would don my proper PPE and be perfectly adequate and safe doing so.

Q. So then why did you this policy

-- this written policy in effect not to float between units of there was no danger to either the staff or the residents?

A. Because we were taking every possible precaution we could. The same way you wouldn't go to Target during the pandemic. Less exposure means heightened safety.

Q. Is it your assessment that going to Target -- the amount of scare going to Target is the same that is enforced in a nursing home?

A. Of course not.

Q. Okay.

A. That just seemed like a very silly question to me.

Q. No, I didn't mention Target, you did.

If you look at Exhibit 16 and this is an exhibit that will take a moment to bring up, it is a one-page exhibit.

And let's wait for it to come. It's a one-page document. It's entitled Fulton Commons Care Center at the very top,

correct?

A. Yes.

Q. And it's entitled, "Nursing Department COVID Surveillance and Tracking Method," do you see that?

A. I do.

Q. Are you familiar with this document?

A. I am.

Q. Who prepared this policy and procedure?

A. The director of nursing in conjunction with the medical director.

Q. So the director of nursing, that would be Ms. Frawley?

A. Correct.

Q. And who was the medical director?

A. Olaf Butchma.

Q. And when did they prepare this document?

A. I don't know.

Q. Is that because the policy is not dated?

A. I don't see a date, no.

Q. Was that the reason you don't know when it was created because there's no date on the document?

A. Yes.

Q. And under number 4 under this document it says, "Residents admitted from the hospital with a positive diagnosis will be housed on a designated COVID unit," correct?

A. Yes. It doesn't say, "COVID," but that's what it's referring to.

Q. Correct. It says, "Designated unit"?

A. You said, "COVID."

Q. Then I misspoke.

"Residents admitted from the hospital with a positive diagnosis will be housed on a designated unit," correct?

A. That's what it says, correct.

Q. Was the designated unit the designated COVID unit?

A. Yes.

Q. Okay. When did this policy go into effect?

A. I don't know. I assume when we started admitting them from the hospital.

Q. Do you know approximately when that was?

A. End of March, beginning of April.

MR. ZADEK: We can take it off the screen.

A. After the guidance from DOH to do so.

Q. So, again, your best recollection is mid March, end of March, somewhere in there?

A. Not mid March, it was -- I want to say March -- I believe the guidance that was from the Governor and the Department of Health to take COVID residents from the hospital was March 27th. But without my notes in front of me, I can't be positive about the date.

Q. So end of March?

A. Yes.

Q. Not middle of March, end of March?

A. Yes.

Q. So, this policy required that COVID patients from hospitals be housed only on the designated unit, correct?

A. Yes.

Q. And again, why it necessary to separate the COVID residents that were admitted from the hospital to the nonCOVID residents at Fulton?

A. So it didn't spread.

MR. YAFFE: What time do you want to take a break, Counsel?

MR. ZADEK: How about two questions and then we'll take a break?

MR. YAFFE: Okay.

Q. Would you agree that Fulton residents would potentially be endangered if COVID patients from the hospital were directly admitted on to nonCOVID units rather than the designated unit?

A. Again, my answer is no, as long you wore your PPE properly. It was best practice guideline. If you were able to create a unit, you created a unit, but lots of nursing homes, including us, didn't do

that immediately. So, the answer is no.

Q. So, admitting residents from the hospital with a COVID diagnosis and not placing them on the designated unit, as you sit here today, do not endanger nonCOVID residents on the units where they were placed?

A. I'm sorry, I didn't follow that question at all.

Q. If a resident from the hospital, a COVID resident, a patient from a hospital was not admitted to the designated unit, but instead was placed on a nonCOVID-unit, that would not potentially endanger residents on that unit?

A. No, not if you were wearing your PPE properly and following infection control protocol.

MR. ZADEK: How long of a break do you want to take? It's up to you. We can take five minutes. We can take 20 minutes. We can take half an hour. Totally up to you.

A. I would like to eat a little

lunch, so if we can have 20 minutes? That would be great.

MR. YAFFE: Let's take a half an hour.

MR. ZADEK: Okay. Shall we resume at ten to two, what do you think?

MR. YAFFE: It's up to you.

(A recess was taken.)

MR. ZADEK: Let's just note, it's 2:00, it's 2:04 actually. This is Peter Zadek. I just ask that everyone note their appearance for the record.

THE WITNESS: Cathie Doyle.

MR. YAFFE: David Yaffe.

MS. SEKHON: Prabhjot Sekhon.

MR. SMITH: Ben Smith.

MR. JOYCE: Robert Joyce.

MS. LIPTAK: Anne Liptak.

MS. PICONE: Barbara Picone.

MS. CONWAY: Mary Conway.

MS. DOHERTY: Elysia Doherty.

MR. ZADEK: Okay.

Q. Ms. Doyle, I'm going to remind

you that you remain under oath as we proceed. Okay?

A. Noted.

Before we get started, could I -- as I was eating my lunch I was thinking about your last question and I wanted to make sure I answered it correctly. Could we ask Nicole to read back that last question and answer, please.

(The requested portion was read.)

A. I wanted to clarify that the question was residents admitted to a specific unit and not in a specific room and my answer stands.

Q. I'm sorry. You're indicating that -- you're stating that if a resident from a hospital, a COVID-patient from a hospital was admitted to the nonCOVID unit, that would not endanger the other residents on that unit if they were admitted to separate rooms, is that what you're saying?

A. I wasn't sure if your question was asking whether residents were in the same room or the same unit. But your

question pertained to a resident being put into a specific unit with nonCOVID patients. So, my answer remains the same.

Q. That that would not endanger the other residents on that unit if they came from a hospital as a COVID patient?

A. Correct, as long as their PPE was worm properly.

Q. Right. Since you raised PPE, when did -- did Fulton have adequate PPE in March of 2020?

A. We had adequate PPE throughout the entire pandemic. We had to -- like everybody else -- get it from the Nassau County OEM and the State of New York, but yes, we had adequate PPE throughout the entire time.

Q. So Fulton never experienced a shortage of PPE during the pandemic?

A. No, we did not.

Q. And your statement concerning the wearing of PPE presupposes, correct, that the staff is properly wearing the PPE, correct?

A. Yes.

Q. If staff did not properly wear the PPE, then infection control issues would arise based on caring for nonCOVID patients on the same unit, correct?

A. They could potentially arise, yes.

Q. You mentioned that during the pandemic there was a unit at Fulton that was designated to house only COVID residents, correct?

A. Yes, not initially, but as we moved forward, yes.

Q. So at some point a unit was designated to house COVID patients?

A. That's correct.

Q. Which unit in the building was that?

A. 1 East.

Q. Where is 1 East located in the building?

A. On the first floor on the east side of the building.

Q. Okay. Does 1 East consist of two

wings, one that contains high numbered room and one wing that contained low numbered rooms?

A. It's the shape of a "Y." So when you walk onto the unit, it's a "Y." It's one small hallway with wings on both sides and then it veers out to a "Y" with the nursing unit in the middle.

Q. Right. So as I said, one unit or one side contains low numbered room and the other side contains high numbered rooms; is that fair to say?

A. Yes.

Q. And the low side -- the low wing, what numbered rooms are on that side?

A. I don't know.

Q. Would 101 to 111 refresh your recollection as to the numerical assignments?

A. It could be, if that's what you're looking at.

Q. No, I'm not looking at anything. I'm asking you if you recall that room 101 to 111 was the low side and then room 112 to

122 was the high side?

A. I don't know the breakdown.

Q. When was 1 East designated as the COVID unit?

A. Again, without my notes I don't recall the date.

Q. Approximately when?

A. I don't recall.

Q. Do you recall if it was in February?

A. It was not in February.

Q. Do you recall if it was in March?

A. I would be guessing, sir, I don't recall.

Q. Do you recall if it was in June? Do you have any sense of when this unit was designated as a COVID unit?

A. Somewhere in March or April.

Q. Who made the decision to designate 1 East as the COVID unit?

A. I did.

Q. Did you discuss whether to designate 1 East as the COVID unit with the owner or owners of the facility?

A. I discussed it with Mr. Weiss.

Q. And when did you discuss it with Mr. Weiss?

A. I don't recall.

Q. And tell me about that discussion that you, what did you say and what did he say with respect to converting 1 East to the COVID unit?

A. You're asking me to remember 10, 11 months ago. But to the best of my recollection and as I sit here today I believe it was, guidance has come out to create a separate unit and I wanted to do 1 East because it's right by the front door. People wouldn't have to get in the elevators. There's no co-mingling of residents or staff way and he agreed with that and I proceeded.

Q. And what discussion, if any, did you have with Mr. Weiss concerning his conveying that information to Mr. Kalter?

A. I did not discuss that with him.

Q. And did you discuss the designation of 1 East as a COVID unit with

Dr. Butchma?

A. Yes, it was through the QAPI committee.

Q. Can you explain what discussions were had with Dr. Butchma and the QAPI committee concerning designating 1 East as a COVID unit?

A. It was the same conversation that I had with Mr. Weiss. How we picked 1 East, why we picked 1 East and why we thought that was the safest choice.

Q. What, if any, input did Dr. Butchma provide as to converting 1 East to the COVID unit?

A. He agreed that not having residents admitted into the building where they had to go into the elevators and up into a common lobby that's shared by two units. That 1 East was the most safest to proceed with.

Q. Is 1 East still designated as a COVID unit at Fulton?

A. No, right now it's for new admissions.

Q. Right now 1 East is for new admissions?

A. That's correct.

Q. When was 1 East no longer being used as the designated COVID unit?

A. Again, I'm not going to remember specific dates, but at some point the census dropped where we were able -- not able, unfortunately we had to close two units and it's only a week or so ago that 1 East opened up for new admissions. Actually, it was last Friday.

Q. So again, my question is, when approximately was 1 East no longer being used as a designated COVID unit?

A. I don't remember when it got shut down.

Q. Do you recall --

A. If I had to guess, I would say June or July. We had no COVID cases from July -- so I'm going to guess that in July we shut it down, could be even sooner than that though.

Q. Who made the decision to no

longer use 1 East as a COVID unit?

A. It's not that it wasn't used as a COVID unit, it's that we had no COVID in the facility.

Q. So there was never a formal decision to no longer designate 1 East as a COVID unit?

A. I had no COVID residents or suspected in the facility and it was no longer needed.

Q. And you believe that was in what month, approximately?

A. Again, I'm totally guessing, it could be June or July, August, I don't recall.

Q. So it was the summer of 2020, is it fair to say that?

A. I think that's fair.

Q. In 2020, how many unit managers -- a unit manager is the nurse on the unit, correct?

A. It's the RN on the unit, yes.

Q. In 2020 how many unit managers were assigned to 1 East during the 7 to 3

shift?

A. Yes.

Q. Who was the unit manager during that period?

A. Ms. Weller.

Q. Latasha Weller?

A. Yes.

Q. Were you working at Fulton on Monday, May 4, 2020?

A. I have no idea.

Q. Do you recall if in early May 2020 the Department of Health, DOH, conducted an infection control survey at Fulton?

A. That spurs my memory. They were here on the 4th and the 5th, yes.

Q. Okay.

A. So yes, I was at work.

Q. And do you recall that DOH did conduct a survey and it was an infection control survey?

A. It was the first of our infection control surveys, yes.

Q. And that was -- do you recall

that it was on a Monday, May 4th?

A. I'm going to have to believe you on that one, I don't recall.

Q. Do you recall how many DOH surveyors were on-site on May 4th during the survey?

A. I do not recall. We've had four of them, so they're a little jumbled in my head.

Q. So the May 4th survey you recall because it was the first survey?

A. That's correct.

Q. So you don't recall the number of surveyors on-site, correct?

A. I do not recall.

Q. Do you recall any of the surveyors that were on-site on May 4th, meaning not necessarily the number, but do you remember any of the surveyors that participated from DOH?

A. I do not.

Q. Do you recall if the surveyors who participated on the May 4th infection control surveyors were individuals that you

had met during the prior surveys at Fulton?

A. Some of them I believe, yes. It was on-site and off-site, so I'm just answering to the ones that were on-site.

Q. Yes, I'm asking you concerning on-site?

A. Okay.

Q. But you don't recall who was on-site on May 4th; is that correct?

A. Yeah, I don't recall who was on the team.

Q. Okay. Did you speak with the DOH team members that were present at Fulton for the May 4th survey, did you have conversations with them on that day?

A. Sure, of course.

Q. Do you recall telling the Department of Health surveyors or the team that 1 East was the strictly COVID unit at Fulton?

A. I don't recall specific conversations from that day, I'm sorry.

Q. So the answer to that question, whether you recall telling the DOH surveyors

that 1 East was the strictly COVID unit at Fulton, the answer is you don't recall making that statement?

A. The answer is I don't recall.

Q. Do you recall telling the DOH surveyors that 24 COVID residents were housed on 1 East as of May 1st?

A. I do not recall specific conversations that I had with the team.

Q. Okay.

A. That's how many was in the facility, that's what I told them.

Q. My question was, do you recall telling the DOH surveyors that 24 COVID residents were housed on 1 East on May 1st?

A. Again, the answer is no, I don't recall that.

Q. Do you recall telling the DOH surveyors on May 1st, that the 24 residents on 1 East were from the hospital -- admitted from the hospital?

A. They weren't here on May 1st. They were here on May 4th and May 5th.

MR. ZADEK: Withdrawn.

Q. Do you recall telling the surveyors on May 4th, that the 24 COVID residents this were on 1 East on May 1st were admitted from the hospital?

A. I don't recall any conversations that I had with the Department of Health.

Q. Do you recall telling the Department of Health surveyors that there were no suspected COVID residents in the facility on May 1, 2020?

A. I don't recall any conversations with the Department of Health on those dates.

Q. Okay. Did the Department of Health request that you provide any documents for the May 4th infection control survey?

A. Yes.

Q. Generally, what documents were requested by the Department of Health for the May 4th survey?

A. To the best of my recollection and again, I keep files for this reason, they asked for pandemic policies and

procedures. Any policies that would be put into place because of COVID. They asked for admissions and discharge information. They asked for infection control blocking listings. They asked for how many COVID were in the facility at the time. That's what I recall.

Q. Are you referring to any documents or notes in front of you now?

A. No.

Q. Did you review any documents or records prior to testifying here today on this issue concerning the May 4th survey?

A. No.

Q. When did you receive the request for these documents from DOH?

A. When they entered on May 4th.

Q. So, when did you begin preparing documents to be given to DOH for the May 4th survey?

A. When they entered on May 4th.

Q. Did Fulton staff assist you in gathering or preparing documents for this May 4th DOH survey?

A. Yes.

Q. Who gathered or prepared documents to be given to DOH for the May 4th survey?

A. Carol Frawley, Kristin Hersher, Mike Andrews and anything that was downline in nursing, I would have gotten from Carol and she would have gotten from the other staff members.

Q. And these employees who gathered or assisted in gathering these documents, they were gathering these documents at your direction, correct?

A. Yes.

Q. Did you prepare or gather any documents for the May 4, 2020 infection control survey?

A. Yes, I had the pandemic policies and procedures, so that one I know I gathered myself. I don't recall -- I don't recall what they asked for, so I can't tell you who gathered them specifically.

Q. Okay. When were these documents given to the Department of Health in

conjunction with the May 4th survey?

A. On May 4th and May 5th, depending on what they asked for during the meeting. There was also somebody off-site asking for documents. It was during a two-day period.

Q. What gave these documents to the Department of Health? Who supplied them to the DOH?

A. Off-site they all went through me. On-site could have been my assistant, could have been DNS, could have been me. If it was MDS-related, the MDS coordinator would have handled them.

Q. Ms. Ronayne?

A. Yes.

Q. So, it depended on which documents you turned over with respect to who actually handed them over to DOH?

A. That's correct.

Q. Did you review all the documents prior to their being turned over to DOH for the May 4th survey?

A. Not all of them, no.

Q. Now, you mentioned an off-site

production of documents for the May 4th infection control survey?

A. Yes, there was.

Q. Which documents were produced off-site?

A. It was a pretty close replication of what was handed in person, but it was also sent electronically.

Q. When was it sent electronically off-site?

A. The day that the Department of Health was in the building.

Q. May 4th?

A. And 5th, they were here two days.

Q. I'm sorry, Monday, May 4th and Tuesday, May 5th, in the facility?

A. That's correct.

Q. So the production occurred physically in the facility on May 4th and May 5th, as well as off-site on May 4th and May 5th?

A. That's correct.

Q. Did you share any of the documents which you gave to the Department

of Health for the May 4, 2020 infection control survey with anyone else?

A. Our documents?

Q. Yes.

A. No.

Q. Did you have communications with any other nursing homes concerning documents that you had turned over to the Department of Health for the May 4th survey?

A. Yes.

Q. What communications did you have with other nursing homes concerning documents you disclosed to the Department of Health for the May 4th survey?

A. I prepared an e-mail advising other administrators what the infection control survey consisted of -- what documents they requested from admission.

Q. I'm sorry, can you repeat that? You broke up.

A. Sure. I prepared an e-mail that was sent to other administrators indicating that infection control surveys were occurring, what they were looking for when

they came in, what documents they requested and what they were focusing on.

Q. Who did you send that e-mail to?

A. I believe I sent it to Linda. I don't remember her last name, who was the chief administrator of the Intercounty Health Facilities Association.

Q. What is that?

A. It's an association of Long Island nursing homes.

Q. Okay. And then you were saying she distributed what?

A. I believe she then distributed it to all the association members.

Q. When you said she distributed "it," do you mean your e-mail?

A. My e-mail, correct.

Q. And again, did you share any documents with any other nursing homes that were also provided to the Department of Health for the infection control survey?

A. Not that I recall.

Q. Do you recall if you shared any policies and procedures that you disclosed

to the Department of Health with any other nursing homes pursuant to the May 4th infection control survey?

A. Yes, as a matter of fact, several facilities -- now that you bring it up -- requested -- when I sent out my e-mail saying they asked for this policy, this policy and this policy, the facilities asked of they could have the policies.

Q. So you did disclose to other nursing homes records that were turned over to the Department of Health for the May 4th survey?

A. Yes, I recall now.

Q. And did you offer any of Fulton's policies and procedures with other nursing homes?

A. Yes, I did.

Q. Relative to this infection control survey?

A. Yes.

Q. How many nursing homes did you share Fulton's policies and procedures with?

A. I don't know.

Q. Which policies and procedures did you share with other nursing homes?

A. I don't recall the specific policies.

Q. Do you recall approximately how many different policies and procedures you shared with other nursing homes?

A. I don't recall the exact number.

Q. Do you know approximately how many you shared with other nursing homes?

A. I don't recall.

Q. How did you decide which nursing homes would receive Fulton Commons policies and procedures?

A. They e-mailed me and requested copies of what they wanted to see. We compare policies very frequently, facilities.

Q. So when did you share Fulton's policies and procedures with other nursing homes?

A. I don't recall the exact date. It would have been after my first infection control survey.

Q. So some time after May 5th, is that what you're saying?

A. Yes, to the best of my recollection.

Q. Were these the same policies and procedures that you testified earlier to, which were developed for the specific needs of the residents at Fulton?

A. Yes.

Q. Why did you give documents that had been produced for Department of Health infection control survey to other nursing homes?

A. We like to not recreate the wheel. So if somebody has a good policy, we'll take it and build off of that and revise it to their own facility.

Q. But that wheel fits on different bicycles, i.e. different nursing homes, correct? No two nursing homes are the same, we already discussed that, correct?

A. That's why we revise them to fit our facility, yes.

Q. Would you agree that it would be

inappropriate for a nursing home to remove the creation and revision dates from its policies and procedures and then disseminate those policies and procedures to other nursing homes?

A. Again, there's no requirements for dates on policies, so no, I would not agree with that.

Q. Okay. Did you remove or redact the creation and revision dates from Fulton's policies and procedures prior to giving them to these nursing home administrators?

A. No, I did not.

Q. Do you know -- withdrawn.

The policies and procedures which you now recall sharing with other nursing homes, did you share it with the administrators at these nursing homes?

A. Yes.

Q. Do you know if these nursing homes shared Fulton's policies and procedures with other nursing homes in New York or other states?

A. I have no idea.

Q. Would you have any way of knowing whether a Fulton policy and procedure which you shared with another nursing home was then sent on to other nursing homes?

A. No.

Q. You mentioned several categories I believe of documents which you recall DOH requesting of you for the May 4th survey, correct?

A. Yes.

Q. I would like to take a look at what's been premarked as Exhibit 17A for identification. It's a one-page document.

Do you see Exhibit 17A?

A. I do.

Q. It's entitled on the top, "Fulton Commons Care Center" and it says, "Breakdown of residents from April 1st through May 1, 2020"?

A. Yes.

Q. Do you know who prepared this document?

A. Ms. Frawley.

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Q. Did you review this document -- withdrawn.

Do you know if you or Ms. Frawley gave this to the DOH team on May 4th?

A. Yes.

Q. Who gave it to the DOH team?

A. I believe Ms. Frawley handed it to them.

Q. Did you review this document before it was turned over to DOH?

A. No.

Q. Do you know, when it indicates, "COVID deaths 28" and next to that it says, "3 confirmed from hospital, 25 suspected," do you know what that means?

A. It means that of the 28 deaths, 3 were admitted to the hospital confirmed and 25 were suspected cases without positive tests.

Q. By the way, when was this document prepared?

A. I don't know.

Q. Do you know who the three confirmed COVID deaths were that are

mentioned here?

A. No, I do not.

Q. Well, it references three confirmed from the hospital, three confirmed deaths from the hospital and 25 suspected, what criteria was used to classify or identify a resident as being suspected COVID?

A. That changed throughout the pandemic. It included a temperature of greater than 100, that would trigger mainly. Anything who had temperature over 100 we suspected as COVID-positive and treated them accordingly.

Q. I would like you to look at 17B, if you would. 17B is a one-page document as well. Do you see 17B?

A. I do.

Q. Do you know who prepared this document?

A. I believe I did.

Q. What this document given to the Department of Health during the May 4th survey?

A. I don't know. I don't recall.

Q. And the document is one sentence, it says, "Please note: As of today Fulton Commons has no suspected cases of COVID in the facility," correct?

A. I can clear this up for you.

The documentation requests of off-site documents occurred before they entered the facility. I believe I submitted this to Emily at the Department of Health prior to the entrance.

Q. Well you said, "clear this up," what are you clearing up? I hadn't asked a question, but what are you clearing up?

A. Well, the survey team walked in on May 4th. This is dated May 1st. So, this was given to Emily off-site because she started requesting documents before the actual team walked into the building on May 4th.

Q. So Friday, May 1st, the DOH already requested the production of documents?

A. I can't swear that it was

May 1st, but I believe for this survey -- again, there were four of them, so forgive me. I believe for this survey they requested documents before they came on-site.

Q. So, would that request been made on Friday, May 1st, the date that's on the document?

A. I don't know if they requested it prior to that. I don't recall the date they requested it.

Q. Okay. And why does Exhibit 17A, which we just discussed, indicate that there were 25 suspected COVID deaths between April 1st and May 1st of 2020 and 17B states that there are no suspected cases of COVID in the facility?

MR. YAFFE: Objection.

A. One refers to past and one refers to current cases.

Q. So on May 1st, there were no suspected cases in the facility, is that what this is indicating?

A. That is correct.

Q. Okay. Can you take a look, if you would, at Exhibit 17C, which is also a one-page document.

MR. ZADEK: If you scroll down a bit. So, that captures all the written material on the document.

Q. Do you recognize exhibit 17C?

A. I do not.

Q. Do you know who prepared this?

A. I'm going to assume Ms. Frawley, given that it's relating to CNAs.

Q. Was this document turned over to DOH for the May 4th infection control survey?

A. It may have been.

Q. You don't know?

A. I don't recall all the documents that they requested.

Q. You didn't review all the documents that were turned over?

A. I did not review them all closely, no and I don't recall what I sent either.

Q. What you said?

A. Sent.

Q. Sent, okay. Are you familiar with this document, do you understand the document?

A. I understand it, but I'm not familiar with it, no.

Q. Do you understand on Exhibit 17C what the parenthesis with the plus sign and the COVID means?

A. That means that resident tested positive for COVID-19.

Q. Resident or employee?

A. I'm sorry, employee, sorry, thank you.

Q. That employee tested positive for COVID?

A. Correct.

Q. And then where it says the word, "COVID symptoms," do you see that?

A. I do.

Q. What does that indicate?

A. It means that that employee was exhibiting COVID-like symptoms.

Q. So, some of these employees had a

reason for absence that was based on a positive COVID test and others had a reason for absence that was based on observed COVID symptoms; is that correct?

A. Yes, and one due to exposure, I see.

Q. Right. Is testing more reliable than symptom observation in determining if an individual is infected with the COVID virus?

MR. YAFFE: Objection.

Q. You can answer.

A. I'm not a physician, I can't answer that for you and the way some of these tests run, my answer would be no. They are very unreliable, but.

Q. So, the answer to the question whether testing is more reliable than symptom observation in determining if an individual is infected with COVID is no?

A. I would say in general, yes, but there's always -- there's caveats to that, yes.

Q. So to be clear, in general, with

the exception of some caveats, testing is more reliable than symptom observation in determining a COVID patient's status, correct?

MR. YAFFE: Objection.

A. Yes.

Q. If you could look at Exhibit 17D and this is a two-page exhibit.

Now, Exhibit 17D it indicates at the top, "Fulton Commons Care Center, Nursing Department, Policy and Procedure" do you see it has a title, "Isolation"?

A. Yes.

Q. And it says it was revised in October of 2019. If you want to scroll down, we'll scroll down slowly on the first page to see what topics it covers.

It deals with isolation, correct?

A. Yes.

Q. I'm not going read the entire document, I just want to know if you're familiar with the document?

A. Yes.

Q. And if we look at the first page

under objectives -- going down a bit, under objectives, about halfway down it says -- it begins, "Isolation" -- in the middle of the page -- "Isolation equipment must be set up outside the resident's room with the proper instructions on donning off and on of PPE," do you see that?

A. I do.

Q. Were you familiar with that protocol?

A. Yes.

Q. Was this policy and procedure in effect during the pandemic?

A. At some point -- when it was its own unit, the PPE was set up outside the unit because the whole unit was in isolation, but this was in place.

Q. Okay. Was this document given to the Department of Health during the May 4th infection control survey?

A. I don't know.

Q. Can you explain to me why isolation equipment must be set up outside the resident's room with proper instructions

concerning PPE?

A. Well, first, it's a Department of Health recommendation. And secondly, from an infection point of view, you don't want to bring clean supplies into what we call a dirty room because that's when the supplies become dirty.

Q. And was there some signage or instructions that were placed outside the room of a resident who was in isolation? Was there something notifying staff that that room contained a resident that was in isolation?

A. When there was not a unit set up, it was outside the room. And when it was an entire unit, it was outside the unit.

Q. As far as outside the resident's room, during the pandemic, what signage or postings informed Fulton staff that a particular room housed a resident with suspected COVID who was on isolation precautions?

A. I don't know the exact wordage and quite frankly, it changed several times

during the pandemic given the Department of Health guidance and what they instructed us to have written.

Q. But was there some posting outside of a resident's room that was on isolation letting staff know that that particular room did contain a resident that was on isolation or they may have suspected COVID?

A. Yes.

Q. And was that to let the staff know to take precautions before entering the room?

A. That's correct.

Q. If you take a look at Exhibit 17E. It's a five-page exhibit and it's -- at the top it indicates, "Resident Listing." And it says under the first column, "ID" and then has the resident name and then to the right it has the bed listing, correct?

A. Yes.

Q. And the numbers are sequential and if we go down to the last page, page 5,

that's 196, you could see it's alphabetical as well. Are you familiar with this document?

A. Not this particular one, no, but I'm familiar with what it is.

Q. Is this a resident bed listing for the entire facility?

A. Yes.

Q. And it lists every resident in the facility by name, their ID and their particular room, correct, room and bed?

A. Yes.

Q. And if we go back to the first page, who prepared this document?

A. I don't know, either admissions or the business office.

Q. Did you prepare it?

A. Did I? No.

Q. Do you know when it was prepared?

A. I do not.

Q. It's printed out from the facility database?

A. I believe so, yes.

Q. Do you know when it was printed?

A. I do not.

Q. So, do you know what date this resident listing applies to, correct?

A. I do not know.

Q. Okay. I'm sorry, I don't recall if I asked, do you know if this document was given to DOH during the May 4th survey?

A. I don't know.

Q. Let's take a look at Exhibit 17F, this is a one-page exhibit. And it says at the top, "Fulton Commons," and then it says, "Bed listing." If we scroll down slowly, it goes from number 1 to number 24, do you see that?

A. I do.

Q. And if we go back up to the top, we see that all the beds begin with the number and letter 1E, correct?

A. Yes.

Q. So is the bed listing for 1 East, the designated COVID unit?

A. It appears to be the bed listing from Friday, May 1st for 1 East, yes.

Q. On the top left it has Friday,

May 1st, so this would be the bed listing for Friday, May 1st for the residents on 1 East, correct?

A. Yes.

Q. And that's a designated COVID unit, correct, or it was on May 1st, correct?

A. Yes.

Q. Who prepared this document?

A. I don't know.

Q. Do you know who printed it?

A. I don't.

Q. Was this -- was Exhibit 17F, this 1 East bed listing from May 1st, given to DOH?

A. I don't know.

Q. You have no recollection of this document being provided to DOH?

A. I have no recollection.

Q. Okay. All the listed beds correspond to rooms on 1 East, meaning room 103 at the top and all the way at the bottom, room 122, if we scroll down towards the very bottom, that encompasses the low

and high wings of the COVID unit, correct?

A. That encompasses the entire unit, yes.

Q. So this bed listing identifies 24 residents who are living on the COVID unit on the Friday before the May 4th survey, correct?

A. Yes.

Q. I would like to discuss, if we could, these 24 residents who lived on 1 East on May 1st. And I'd like to go through the residents because you indicated that 1 East was on May 1st, I believe or it would have been on May 1st, the COVID unit, correct?

A. Yes.

Q. So --

A. Let me clarify, because on April 29th, I believe, we got a directive from the Department of Health to create a unit if we could. It took us a couple of days to jog some things around. But was May 1st a Friday?

Q. I believe --

A. Whatever the Friday after April 29th was, we created a true COVID unit and removed suspected cases from within the building down to the COVID unit.

Q. Right.

A. At the close of business on May 1st, it that was a Friday, there were more than 24 residents on that unit.

Q. Right. But when you said that this document, if you scroll up, is dated May 1st and reflects the residents on 1 East on Friday, May 1st, what did you mean?

A. It's as of 1:22:54 p.m. On Friday, May 1st, we had number of room changes for suspected cases up on other units that we moved to the COVID unit based on guidance from DOH dated April 29th.

And I remember it clearly because my staff was not happy to have a dozen room changes on a Friday.

Q. When did you indicate earlier that the COVID unit was establish to house COVID patients?

A. I believe I said I didn't recall,

but I think I'm going to say it was May 1st.

Q. I thought you indicated that the COVID unit was set up towards the end of March, early April?

A. No, I misspoke because this jogged my memory as to when that occurred.

Q. So when was the designated COVID unit established?

A. I'm talking about two different things. The COVID unit for new admissions was established on May 27th. The moving of the residents that were suspected inhouse occurred on May 1st, based on guidance from the Department of Health on April 29th.

Q. I'm sorry, I wasn't asking -- I didn't ask you about movement of residents. I asked you when was the COVID unit established to house COVID patients?

A. And I'm answering that for residents from the hospital, it was, I believe, March 27th and for inhouse residents, it was May 1st.

Q. And the residents that are listed on Exhibit 17F, the Fulton Commons bed

listing, were all these residents COVID patients?

A. Yes, they were.

Q. Every one of the 24 residents were COVID-designated?

A. Yes.

Q. And how do you know that?

A. Because they were admitted to 1 East.

Q. Okay. And --

A. Pretty much all the admissions we were getting at that time.

Q. So according to Exhibit 17F, this 1 East bed listing, on May 1st, all the beds on 1 East were filled with COVID patients?

A. 24 of the 40, yes.

Q. So, according to this May 1st 1 East bed listing, Fulton had properly quarantined these 24 COVID residents on the designated COVID unit, correct?

A. That's correct.

Q. And based on Exhibit 17F, this May 1st 1 East bed listing, presumed COVID and nonCOVID residents were not living on

the same unit at Fulton, correct?

A. Positives were not, presumed may have been.

Q. My question was, according to this May 1st 1 East bed listing, presumed and nonCOVID -- or COVID and nonCOVID were not living on the same unit, correct?

A. These were new admissions. All new admissions that were COVID-positive went on 1 East. The rest of the facility still had some residents commingled until Friday May 1st when they were moved downstairs due to the April 29th Department of Health guidance.

Q. That actually wasn't my question though, Ms. Doyle. My question was, on this document, Exhibit 17F, these 24 residents that are listed were all COVID patients, correct?

A. That's correct.

Q. And if these -- these 24 patients living on 1 East indicated that there were no nonCOVID residents on 1 East on Friday, May 1st, correct?

A. That's my understanding, yes.

Q. There are no residents on this list who are nonCOVID, correct?

A. You're trying to have me say something that I can't say. Number 9 could have been admitted and then converted to a negative. I can't answer your question, sir, with all due respect.

Q. Well, all of these residents and we can go through any that you'd like, all of these residents came into the facility with a COVID-19 diagnosis, corrects?

A. They were admitted with it, yes.

Q. So there's no one on this list that was nonCOVID -- that was a resident who had never been diagnosed as COVID, correct?

A. That's corrects.

Q. And were you working at Fulton on that Friday, May 1st?

A. Yes, I was.

Q. And what time did you arrive at work on Friday, May 1, 2020?

A. I don't recall the exact time. It would have been somewhere between 8:30

and 9:00, I would assume.

Q. When you arrived at work on the morning of Friday, May 1, 2020, were the residents on 1 East, the same 24 residents that are listed on Exhibit 17F, the 1 East bed listing for May 1st?

A. I would assume so, yes.

Q. Were there any bed transfers in the days immediately before the May 4th infection control survey?

A. Yes.

Q. Approximately how many?

A. I want to say 15.

Q. Okay.

MR. ZADEK: We can take that off for now, the exhibit -- and I'd like to show -- Ms. Doyle to be shown Exhibit 34.

Q. And that is a two-page exhibit, when it comes up. And this is a document entitled, "Fulton Commons Care Center Patient Activity Log." Do you see that?

A. I do.

Q. Are you familiar with this

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document, the type of document, the patient activity log?

A. Yes.

Q. This patient activity log -- and we can scroll through it slowly, but it indicates that there were 18 residents at Fulton who transferred beds on May 1st?

A. Okay.

Q. So do you see here, this document indicates that 18 residents had their beds transferred on May 1st, correct?

A. I didn't count them, but I see the document.

Q. If you'd like, we can go through the document and count them?

A. No, I'll take your word for it. I'm just saying I can't attest to the 18.

Q. Okay, well, we can go through the document from the top and we'll do it quickly.

Resident Resident #12, Resident #13 , Resident #8 , Resident #7, Resident #14 , Resident #15 , Resident #16 , Resident #17 , Resident #18 , Resident #19 , Resident #20 , Resident #5 , Resident #21, Resident #22 , Resident #23

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#23 (cont) , Resident #24 , Resident #25 and Resident #26 , that's 18, okay?

A. Yes.

MR. ZADEK: Now, we can take that off for now.

Q. On June 11, 2020, Fulton Commons was served, electronically, pursuant to Section 504 of Title 18 of the New York Codes, Rules and Regulations with a request from the Attorney General's Office for specified documents, correct?

A. I don't recall the date, but we received subpoenas, yes.

Q. And pursuant to that request, you produced documents, including daily census sheets, do you recall that?

A. Yes.

Q. And if you take a look at Exhibit 35, I think we referenced these earlier, the daily census sheets, correct?

A. Yes.

Q. And these is the daily census sheet for Friday, May 1st, correct?

A. Yes.

Q. And do you recall producing this for the Attorney General's Office in a response for a June 1st request for records?

A. Not this specific document, no.

Q. When you said you do recall providing records in response to the demand?

A. Yes.

Q. And based -- according to Exhibit 35, the total census count on May 1, 2020 was 198, correct?

A. Yes.

Q. So, is it fair to say that based on the May 1st patient activity log, which we just looked at, and this daily census sheet for May 1st, almost 10 percent of Fulton's residents transferred beds on the Friday before the Department of Health survey?

A. Yes.

Q. And the Attorney General's June 11, 2020 document request specifically instructed Fulton Commons to produce all records which identify resident room changes

or transfers from March 1, 2020 through June 1, 2020.

MS. ZADEK: And can we show Ms. Doyle Exhibit 36.

Q. And this is as -- as it comes up -- this is a seven-page exhibit. And page 1 is a cover letter. It looks like it went to Fulton Commons to your attention, correct?

A. Yes.

Q. And this is a cover letter and the second page has my signature, do you see my name there? Correct?

A. I do.

Q. And then the third page is a schedule of documents that were requested for production, do you recall seeing these?

A. Yes.

Q. If you go to page 4, the next page, and look at number 11, do you see the request that Fulton provided all room changes/transfers within the facility from March 1, 2020 to June 1, 2020?

A. Yes.

Q. And if we go back to Exhibit 35,

which we looked at a moment ago, and if we look at Exhibit 35 and where you noted or you pointed out that the total census was 198 and if we scroll down to the section, which you mentioned earlier today where bed transfers are indicated, under the section on the bottom right, room transfers, there are no room transfers noted, correct?

A. This would have been for April 30th.

MR. ZADEK: Scroll up.

A. You'd have to look at the May 2nd document to see room changes that were done on May 1st.

Q. So they would not be indicated on May 1st?

A. Correct because the census is done at 10:00 in the morning. It's as of the midnight before.

Q. Right. Ms. Doyle, you did provide -- actually, you did provide us with the census, the daily census sheet from May 2nd as well, correct?

A. Again, I assume so.

MR. ZADEK: Ms. Sekhon, could you please provide to Ms. Liptak, the May 2, 2020 daily census sheet, which Ms. Doyle provided to the Attorney General in response to our demand?

MS. SEKHON: Sure.

MR. ZADEK: Thank you.

So, momentarily I'm going to ask that this document be deemed Exhibit 67.

(Daily Census Sheet 5/2/20 was marked as Exhibit 67 for identification; 1/26/21, N.L.)

Q. So, looking now, Ms. Doyle, at exhibit -- what's been deemed Exhibit 67, you produced the May 2, 2020 daily census sheet as well, correct?

A. Yes.

Q. And if we scroll down to where you said we would see the bed transfers from the day before, we see one bed transfer, correct?

A. Yes.

Q. We don't see 17 others, do we?

A. No, I'm guessing because they were so significant that they didn't get on until Monday. That's my best guess.

Q. We can produce Monday's as well, May 4th, if you would like?

A. That's the only thing I can think of why they're not on there.

Q. Well --

A. I know they're on there somewhere because I remember seeing them.

Q. Without doing that because my recollection -- withdrawn, my recollection is not relevant here.

On November 23, 2020, the Attorney General's Office served you with a subpoena rather than a request pursuant to Section 504. We served you with a subpoena for the production of records, including the product of "any handwritten addendums made to the daily census sheets," correct?

A. I don't recall the specific wording in the subpoena.

Q. If you look at Exhibit 37, Exhibit 37 is a six-page exhibit. And your

first page is the cover letter from me, correct? If you scroll down, you'll see it's a cover letter from me, correct?

A. Yes.

Q. And the second page is the production of records subpoena, do you see that?

A. I do.

Q. And if we go to page 4, you continue to the schedule on page 4, under number 5, do you see that a subpoena specifically requested handwritten addendums made to the daily census sheets, do you see that?

A. I do.

Q. And if you now look at Exhibit 38. Is this correct, Ms. Doyle, that five months after the Attorney General's initial request, you produced a document entitled, "Room Changes May 1, 2020"?

A. If you received it, then I guess we produced it. I was out on quarantine during your subpoena request. I didn't

gather these documents personally, but if you received it, I guess then we submitted it.

Q. Well, if you scroll down through this document, which identified 19 Fulton residents who changed rooms on May 1st, have you seen this document before today?

A. Not that I recall, no.

Q. Do you know who produced this document in compliance with the subpoena of November --

A. I don't.

Q. Do you know where this document was kept at Fulton?

A. I do not.

Q. Do you know who completed this May 1, 2020 bed transfer record?

A. I'm going to assume it was one of the ladies in admissions, but I don't know.

Q. Do you know when this document was prepared?

A. I do not.

Q. Do you know why this document wasn't produce to the Attorney General's

Office in response to the initial resident room change request?

A. I didn't know it wasn't submitted to you. I can't answer that.

Q. Do you know if this document, Exhibit 38, this listing of 19 Fulton residents who changed beds, do you know if it was disclosed and produced to the Department of Health during the May 4th survey?

A. I don't know. I don't recall.

There were room changes because we discussed them with them, but I don't know of this specific document was given to them.

MR. YAFFE: And she already testified that she hadn't seen this document before.

Q. Have you ever disclosed and produced, to your knowledge, Ms. Doyle, has this document ever been disclosed and produced to the Department of Health?

A. I don't know. I would assume in one of the four infection control surveys it

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would have been, but I didn't handle it myself.

MR. ZADEK: Thank you.

You can take the document off.

Q. Looking back at Exhibit 17F, the May 1st, 1 East bed listing, this document for May 1st, 1 East has Resident #7 -- Resident Resident #7 is was presumed COVID-positive in room [redacted] bed [redacted], correct?

A. Yes.

Q. Do you know who was actually in room [redacted] bed [redacted] on the morning of May 1, 2020?

A. I do not.

Q. If we can take a look at Exhibit 39. Exhibit 39 is a 94-page exhibit of 24 Hour Condition Reports, do you know what a 24 Hour Condition Report is, Ms. Doyle?

A. I do.

Q. What is it?

A. It's a report that the unit managers and nurses write on each resident on each shift. It has clinical information

that we may need to know.

Q. If we look at page 14 of this 94-page exhibit, this is a 24 Hour Condition Report for 1 East for May 1, 2020, correct?

A. Yes.

Q. And if we look at room [redacted], does looking at the 24 Hour Condition Report for 1 East indicate who was living on [redacted] on May 1, 2020?

A. It does.

Q. Does it indicate that Resident #26 was in room [redacted] on May 1st?

A. I can't really read it exactly, but I'll say yes.

Q. Do you recall Resident #26 who lived on [redacted] on 1 East?

A. I do not.

Q. Resident #26 was not a COVID patient, correct?

A. I do not know their clinical condition.

Q. Well, let's look then at Exhibit 40 for a moment. Exhibit is the 1 East bed listing for Friday, April 21st,

correct?

A. Yes.

Q. And it indicates in room [redacted] was Resident# 26 , correct?

A. It doesn't say Resident #26 , no.

Q. I think it says, " Resident #26 " -- it has her first name, part of her last name and the same room, [redacted], correct?

A. Yes.

Q. And it indicates that she had, among her presenting problems, hypertension, anemia, GERD, looks like diabetes, correct?

A. Yes.

Q. There's no mention of COVID, is there?

A. No.

Q. And if we go back now to Exhibit 39 and once again to page 14 of Exhibit 39, we see that Resident #26 had her -- are you familiar with the triangular sign indicative of the word "change"?

A. Yes.

Q. So Resident #26 in room [redacted] had a room change on May 1st from [redacted], the

COVID unit, to [redacted], correct?

A. Yes. You keep calling it the "COVID unit," it was the admission unit, but go ahead, yeah, she had a room change.

Q. I thought you had referred earlier and we went through the policies and procedures that 1 East was a designated COVID unit at Fulton?

A. Yes, and it's where new admissions went because they were presumed positive. All new admissions were presumed positive.

Q. So on May 1st, 1 East was a designated COVID unit, correct?

A. New admissions and COVID, yes.

Q. And the new admissions were COVID patients, correct?

A. Presumed positive.

Q. Okay. So Resident #26 , who was not a COVID patient, was transferred from room [redacted] to room [redacted], correct?

A. Yes.

Q. She was moved to unit 2 East, correct?

A. Correct.

Q. So is it fair to say that it was only after this nonCOVID resident, Resident #26 , was transferred out of room [redacted], that presumed COVID Resident , Resident #7 was transferred into her room?

A. That's correct.

MR. YAFFE: Objection.

Q. That's correct, Ms. Doyle?

A. That's correct.

Q. And in fact, if we look at page 16 of Exhibit 39, we will see that Resident #7 -- do you see where it says Resident #7 ?

A. I do.

Q. And it says under presenting problem, "Inhouse transfer," correct?

A. Yes.

Q. And under the 3 to 11 shift it says, "Inhouse transfer from 3W," is that from 3 West?

A. Correct.

Q. And if we look at page 27 of Exhibit 39, under Resident #7 we see under

presenting problem that he was COVID -- we see COVID-19, he was a COVID patient, correct?

A. Correct.

Q. And under the 3 to 11 shift, we see that he was transferred to 1 East, correct?

A. That's correct.

Q. Do you tell the DOH surveyors, the team, that on Monday, May 4th, that approximately 72 hours earlier, on Friday, May 1st, Resident #26 , who was not a suspected COVID resident was transferred from 1 East to 2 East?

A. We didn't specifically mention patients, no. But they were aware that based on the April 29th guidance from DOH, we had created a just COVID unit and had done room changes, yes. I can't say that we spoke about specific patients, no.

Q. Well, you said yes and no there, so let me repeat the question.

MR. YAFFE: Mischaracterizing her answer, she didn't say yes or no.

MR. ZADEK: Well, she said yes and no in the context of that response and I'm going to make it easier by repeating the question.

MR. YAFFE: But she already testified to that. And you know -- look, I know that my ability to object is limited and I'm obeying that to the extent I can, but I object to you mischaracterizing and changing the witness' testimony. That I cannot abide.

MR. ZADEK: I'm not changing her testimony. I'm going to repeat the question and let her answer it.

MR. YAFFE: Why? She already answered it.

MR. ZADEK: She did not answer it in a cogent matter.

MR. YAFFE: She did not answer it in a way that you wanted her to answer it for your own --

MR. ZADEK: Counsel, your objection's noted.

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Q. Ms. Doyle, let me repeat. Did you tell the DOH surveyors or team members on Monday, May 4, 2020, that approximately 72 hours earlier, on Friday, May 1, 2020, Resident #26 , who was not a suspected COVID resident was transferred from 1 East to 2 East?

A. I wouldn't have told them that at all. You're asking, so no, I did not tell them that.

Q. How long --

A. I can't tell you that another staff member didn't. And as I said, they were told that there are room changes in response to the April 29th guidance we received from the Department of Health.

Q. I'm not asking you about other individuals. I asked you whether you told the Department of Health concerning Resident #26 transfer?

A. And I believe I've answered you, sir.

Q. Yes. How long had Resident Resident #26 been living in room [redacted] in the

COVID unit before she was transferred up to 2 East?

A. I don't know.

Q. Why was Resident #26 moved off the COVID unit on May 1, 2020?

A. Because guidance was given to us by the Department of Health on April 29, 2020 to create a true just COVID unit. Not new admissions anymore, which was the previous guidance. The previous guidance said to take all new admissions to an isolated unit, that's how they ended up there.

The guidance on April 29th said that if you're able to, create a separate COVID unit for just positive and suspected COVID residents and that's what we did on May 1st.

Q. Who requested that Resident Resident #26 be transferred 1 East, the COVID unit, to 2 East on May 1, 2020?

A. The Department of Health by their April 29th memo.

Q. So, the Department of Health --

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it's your testimony, that the Department of Health contacted Fulton and said, "Move Resident #26 off the unit"?

A. No, of course not. They issued guidance on April 29th indicating to create a separate COVID unit. In order to facilitate that, we needed to move Resident #26 .

Q. Listen to my question, Ms. Doyle. Who at Fulton requested that Resident Resident #26 be transferred from 1 East, the COVID unit, to 2 East on May 1st?

A. I did.

Q. Who authorized that Resident Resident #26 be transferred from 1 East, the COVID unit, to 2 East on May 1st?

A. I did. And again, I object to you continuously calling it a COVID unit.

Q. What was Resident #26 told as to the reason why she was transferring rooms on May 1st?

A. I don't know. I did not speak to her personally.

Q. Do you know whether

Resident #26 family or designated representative was informed in advance as to the bed transfer?

A. I don't know, but I would say probably not, given that we were doing it for a medical emergency.

Q. Do you know when if -- withdrawn.

What emergency occurred on the morning of May 1st that required Resident #26 transfer without notification to her designated representative?

MR. YAFFE: Objection.

Q. What was the medical emergency?

A. Guidance from the Department of Health dated April 29th to create a separate COVID unit.

Q. And that was the medical emergency?

A. Yes, sir.

Q. When was Resident #26 designated representative told that she had been transferred from 1 East to 2 East?

A. I don't know the answer to that.

Q. Well, are you aware of the

family's response to being told that Resident #26 has being transferred?

A. No.

Q. Now Exhibit 17F, which we can take another quick look at, the May 1st, 1 East bed listing. Exhibit 17F has Resident #5 in room [redacted] bed [redacted], correct?

A. Yes.

Q. On the morning of May 1, 2020, correct?

A. Yes.

Q. Who was actually living in room [redacted] bed [redacted] on the morning of May 1, 2020?

A. Again, I don't know. You can go through all 26 of them, I don't know the answer.

Q. Let's look at Exhibit 39, which is the 24 Hour Condition Report and take a look at page 15. Again, this is 24 Hour Condition Report for May 1 for 1 East, in fact it says, "Friday," correct?

A. Yes.

Q. And does looking at the 24 Hour Condition Report for 1 East indicate that

Resident #51 was living in room [redacted]?

A. Yes.

Q. Do you recall Resident #51 who lived on room [redacted] on 1 East?

A. No.

Q. Resident #51 was not presumed to be a COVID resident; is that correct?

A. I don't know.

Q. Let's take a look then at Exhibit 41. Exhibit 41 is the daily census sheet for April 23, 2020, correct?

A. Yes.

Q. And it lists Resident #51 as an admission to room [redacted], correct?

A. Yes.

Q. And she is not listed as a COVID patient, her diagnosis, correct?

A. No.

Q. She is listed as COPD, is that chronic obstructive pulmonary disease?

A. It is.

Q. And diabetes correct?

A. Correct.

Q. And hypertension, correct?

A. Correct.

Q. And why was she admitted to room [redacted] as a nonCOVID residents?

A. Sir, I'm happy to explain it to you again. Prior to April 29th, the guidance was from Department of Health to admit all residents to one specific unit, not to spread them throughout the facility in case they were COVID positive.

On April 29th new guidance came out that said to create a specific COVID-positive unit if you were able to do so at the facility. That's what we did on May 1st.

Q. Were there beds available on all the other units in the building on the date that Resident #51 was admitted?

A. Yes.

Q. And it's your testimony that Resident #51, who was a nonCOVID patient was placed and housed on a designated COVID unit?

A. Again, I take objection to you calling it the designated COVID unit. That is incorrect terminology, sir.

Q. 1 East was not a designated COVID unit, is that what you're saying now?

A. It eventually became just for COVID residents, but I'm telling you for the third or fourth time now it was -- all the admissions went because the Department of Health told us to have admissions not be scattered throughout the building.

Q. Right. When --

A. All admissions went to 1 East and then the April 29th guidance came out saying create a COVID unit, which is what we did on May 1st.

So, I take objection to you calling it the COVID unit. That is an incorrect representation.

Q. The designated unit?

A. You can call it whatever you want, it's where our new admissions went.

MR. YAFFE: Could someone just tell me what exhibit this is, that's on the board, what's the number?

MR. ZADEK: Sure, 41.

Q. We talked earlier and I can bring

it up if you'd like again, but the policy and procedure, number Exhibit 14, which is a policy and procedure which you indicated, Ms. Doyle, that you created had the heading on page 3 and again, if you'd like, I can bring it up?

A. Yes, please.

Q. So, this is Exhibit 14. And on page 3 of Exhibit 14, you said you're offended on calling 1 East the COVID unit, but if we scroll down a little further on this page, which we've already discussed, the unit was characterized by you as the "confirmed COVID-19 unit," correct?

A. Correct, after May 1st, sir.

Q. So, prior to May 1st, this was not the COVID unit?

A. Correct.

Q. It was?

A. New admissions went to 1 East.

Q. Then what policy and procedure was created -- when was it did you say -- in March?

A. This policy was written on or

about May 1st when the dedicated unit was created. It was not a dedicated COVID unit prior to May 1st. On May 1st it became a dedicated COVID unit.

Q. So it was not the dedicated COVID unit prior to May 1st?

A. Correct, that's what I'm telling you. I've been saying it all day.

Q. Well, you haven't been, but --

MR. YAFFE: Note my objection.

A. Yes, I have, sir.

Q. But the unit, 1 East, was interspersed, was mixed, with COVID and nonCOVID patients?

A. They were separated on the units, but they were all on one, correct. All new admissions went to 1 East.

Q. Okay. And staff at Fulton Commons, nursing, director of nursing, nurses who worked in the building, they all -- to your understanding, they did not view 1 East as the COVID unit prior to May 1st?

A. That's my understanding, yes.

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Q. So, on May 1st, Resident #51 had a room change moving her off of the COVID unit and she changed room from [redacted] to room [redacted], correct?

A. Again, I don't have it in front of me, but if you say so.

Q. We can go to page 15 of Exhibit 39.

A. I just don't want to agree to specific room numbers because I can't without looking at it.

Q. That's why it's important that we show it to you, I agree.

A. Hmm-hmm.

Q. We will bring up Exhibit 39 and go to page 15. We see here, again, on page 15, Ms. Doyle, that Resident #51 had a room change, as I indicated, from room [redacted] to [redacted], correct?

A. Correct.

Q. And Resident #5 was transferred from 3 West into her bed, correct?

A. Again, it's not in front of me,

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but.

Q. Let's go to exhibit page 16 then, page 16 indicates that Resident #5 was an inhouse transfer. And on the 3 to 11 it says, "Inhouse transfer from 3 West," correct?

A. Correct.

Q. And in parenthesis it says, "[redacted]," correct?

A. Correct.

Q. And he was a COVID patient, correct?

A. Correct.

Q. So he came down and took Resident #51 bed on 1 East, correct?

A. Yes.

Q. I'm sorry, you indicated that this conversion to strictly COVID occurred on May 1st based on what protocol did you receive?

A. Department of Health guidance dated April 29th.

Q. So, the Department of Health survey team, they were aware -- withdrawn.

So, you told the Department of Health survey team that on May 1st you had moved 10 percent of the residents in the facility to comply with the Department of Health's requirement?

A. I didn't personally tell them that, no.

Q. Do you know who did tell them that?

A. I do not, but they get the same census documents when they come in. They also review charts. They also have the same report we're looking at here.

Q. Well, we just went over the daily census sheets and those daily census sheets did not indicate that 17, 18 or 19 residents changed their beds, correct?

A. Correct, but I can't tell you if the handwritten note was given to them or not. They didn't ask me for it and I didn't give it to them.

Q. So, they didn't ask for an indication of which residents changed rooms on May 1st and you didn't tell them,

correct?

A. I don't know if they asked somebody else for it. They did not ask me and I did not provide it. I can only speak for myself.

Q. How long had Resident #51 been living on [redacted] before she was transferred up to 2 East?

A. I don't know.

Q. Who authorized that Resident #51 be transferred from 1 East to 2 East on May 1st?

A. I did.

Q. Do you know if Resident #51 was told why she was transferring rooms on May 1st?

A. I wasn't present for the conversation.

Q. But do you know if someone explained to her why she was transferring rooms?

A. I would assume, yes.

Q. What do you assume she was told?

MR. YAFFE: Objection.

A. Again, sir, I wasn't there. I

can't speak for what somebody else told her.

Q. When was Resident #51 designated representatives informed that she was being moved off of 1 East to 2 East on May 1st?

A. Again, I don't know.

Q. Okay.

A. We can go through all 25, if you want, my answer's going to be the same.

Q. Resident #8 , according to the 1 East bed listing information from May 1st, was in room [redacted], bed [redacted], correct?

A. I don't know. I don't see it in front of me.

MR. ZADEK: Let's bring up for Ms. Doyle, Exhibit 17F, again so she can see who is listed in room [redacted] bed [redacted] on May 1st.

Q. So, if we scroll down, we see that in room [redacted] bed [redacted], Resident #8 was the listed resident in that bed on May 1st, correct?

A. Correct.

Q. Was he actually in room [redacted] bed [redacted] when you arrived at work?

A. I have no idea.

Q. Well, let's take a look at Exhibit 39 again and go to page 15 again.

If we look on the bottom of page 15 of Exhibit 39 for the May 1st -- for Friday, May 1st, on 1 East, we see that Resident #22 was in room [redacted], correct?

A. Yes.

Q. And she had a room change from room [redacted] to [redacted], correct?

A. Correct.

Q. And Resident #22 was not presumed to be a COVID patient, correct?

A. Correct.

Q. She was moved from 1 East to 3 West, correct?

A. Correct.

Q. So, after this nonCOVID resident, Resident #22, was transferred out of room [redacted] bed [redacted], that presumed COVID resident, Resident #8, was transferred into her room, correct?

A. Correct.

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Q. I have to ask you once again whether or not Resident #22 -- withdrawn.

Let me ask you as well, did you authorize that bed transfer of Resident #22 off of 1 East?

A. I did.

Q. Did you know if Resident #22 was told in advance as to the reason for a bed transfer?

A. Once again, I don't know.

Q. Do you know if and when Resident #22 designated representative was told of this bed transfer?

A. Her designated representative is her son and was in the same room with her.

Q. They were in the same room prior to the bed transfer?

A. That's correct and after. If you look two lines up you see his room transfer too.

Q. Right. I thought, Resident #23 , the son was in room [redacted]?

A. When they went upstairs, they

transferred together, you're correct.

Q. Right. They had not shared a room on 1 East?

A. Yes, you're correct. When we told them they were being moved, they requested they would be together.

Q. But they had not been sharing a room?

A. You're correct.

Q. Exhibit 17F, we'll take one more look at it and I'm going to ask you about room [redacted] bed [redacted] on [redacted].

Room [redacted] has Resident #6 in that bed, correct, on 1 East?

A. Yes.

Q. And on May 1st, Resident #6 was actually Resident #8 roommate in room [redacted], correct?

A. I don't know. I can't see that in front of me, sir.

MR. ZADEK: Let's show Ms. Doyle Exhibit 39 again.

Q. If we look at page 1 of Exhibit 39, we're looking now at -- this is

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a May 1st 24 Hour Condition Report for 3 West, correct?

A. Yes.

Q. And if we look, we see that Resident #6 was in room [redacted] bed [redacted], correct?

A. Yes.

Q. As was Resident #8, in bed [redacted], correct?

A. Correct, they were roommates.

Q. Right. And the 24 Hour Condition Report indicates under Resident #6 that he was -- under the 7 to 3 shift -- transferred to 1 East, room [redacted], do you see that?

A. I do.

Q. And it says under the 3 to 11, "Resident transferred to 1 East" as well, correct?

A. Yes.

Q. Now May 1, 2020, Resident #6 and Resident #8 were, again, roommates on 1 East in Room [redacted]?

A. Yes.

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Q. And Resident #6 , like Resident #8 , was presumed COVID-positive, correct?

A. Again, I don't know their diagnoses.

Q. Okay.

A. I see it on Resident #8 , but I don't see it for Resident #6. For Resident #8 , my answer is yes.

Q. Did you authorize that Resident #6 be transferred from 3 West to 1 East?

A. I did.

Q. Why was Resident #6 transferred from 3 West to 1 East?

A. Because we received guidance from the Department of Health on April 29th to put all COVID together if you had space in the facility to do so. So, on May 1st we moved all the COVID-positive to 1 East and moved those that were not positive off of 1 East.

Q. What condition was Resident #6 in when he was transferred down to 1 East?

A. I can't speak to his clinical condition, I don't know.

Q. Do you recall or did you learn what the family's response was when he was moved down from at 3 West to 1 East?

A. No, I did not.

Q. How long did Resident #6 live on 1 East?

A. I don't know.

Q. Can you know approximate how long he lived there?

A. I don't know.

Q. Let's look at page 8 of Exhibit 39, it says, "Resident #6, room [redacted]," correct?

A. Yes.

Q. And if you go to the far right column under the 11 to 7 shift, you see at [redacted] [redacted]. resident expired?

A. I do, may he rest piece.

Q. Were you aware that he died a few hours after being brought down?

A. No, I don't recall that, but.

Q. Was he moved down so when he

passed he would be on 1 East?

A. Excuse me?

Q. Was he brought down to the COVID unit so that when he passed he would be on 1 East, now the designated COVID unit?

A. No, absolutely not.

Q. Okay.

A. Let's go back to the previous page where it said he was in stable condition on the day shift.

Q. I want to ask you about nonCOVID residents that were moved off of 1 East on May 1st, how many resident rooms are there on 1 East?

A. Rooms or beds? There are 40 beds.

Q. I mean rooms?

A. 36 rooms, 40 beds.

Q. Would it refresh your recollection if I said there were 22 beds on 1 East?

A. There's not 22 beds on 1 East. There's 40 beds on 1 East. All the units that 40 beds.

Q. I meant rooms, how many rooms are there on 1 East?

A. You said, "beds," sir.

Q. Then that's my error, how many rooms are on 1 East?

A. There is 16 semi- privates and four privates, so 20.

Q. How about 22?

A. Okay, I'm not a math major.

Q. Sold for 22?

A. All right.

Q. Let me just touch on what you testified to as the reason for these bed transfers on May 1st, is it fair to say that these bed transfers that occurred on May 1st were as a result of the Department of Health directive, is that what you're saying?

A. That's correct.

Q. Which you received on April 30th?

A. Either the 29th or the 30th, I don't recall.

Q. But that's what it was based on?

A. Yes.

Q. That's why these residents

transferred rooms, correct?

A. That's correct.

Q. And you testified earlier that bed transfers, if I understood correctly, please correct me if I'm wrong, that was a discussion that typically was had between MS. Hersher, Ms. Frawley and yourself, correct?

A. Yes, in this case it probably involved the medical director and the unit managers, but yes.

Q. So, the discussion that was had between the unit managers, Dr. Butchma, Ms. Frawley, Ms. Hersher and yourself concerning these bed transfers, did that discussion involve the Department of Health directive as being the basis for the movement?

A. Yes.

Q. Is that what you all discussed as the reason for why they were making these bed transfers?

A. Yes.

Q. Did you provide staff in the facility with any other reason as to why you

were moving all these residents about?

A. No.

Q. Okay. So exhibits -- if you look at Exhibit 17F for a moment again, it lists the rooms 103 through 122, correct?

A. Yes.

Q. And if there were 22 resident rooms on 1 East, why were only 15 rooms occupied on May 1st according to the bed listing?

A. Because that's all the new admissions we had received.

Q. But why were there no residents listed for rooms 101, 102, 104, 106, 107, and 111, why were there no residents listed in those rooms?

A. Because I didn't have new admissions to put in there.

Q. But were these rooms empty?

A. Yes.

Q. When you arrived at work on Friday, May 1st?

A. They were, yes.

Q. Those rooms were empty on the

morning of May 1st?

A. That's correct.

Q. Well, let's look at page 14 again, of Exhibit 39. And those rooms that you indicated as being empty were, in fact, occupied by residents, correct?

A. It appears so, yes.

Q. Right. If you look at, again, page 14 of Exhibit 39 for May 1st on 1 East, we see that Resident #21 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And Resident #13 was living in room [redacted] [redacted] bed [redacted], correct?

A. Correct.

Q. And Resident #16 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And resident named Resident #12 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And a resident named Resident #17 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And a resident named Resident #14 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And if we go to the next page, page 15, we see a resident named Resident #25 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And a resident named Resident #15 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And a resident names Resident #19 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And a resident named Resident #23, as you pointed out, Resident #23 was living in room [redacted] bed [redacted], correct?

A. Correct.

Q. And a resident named Resident #18 was living in room [redacted] bed [redacted] on the morning of May 1st, correct?

A. Correct.

Q. So were these 11 residents and -- withdrawn.

Looking at page 14 and page 15, without going through them individually, we can see each of these residents were transferred off of 1 East, correct?

A. Correct.

Q. Were these 11 residents transferred on May 1, 2020 from 1 East to other units in the building?

A. I would have to count that it's 11, I can't confirm to that. But yeah, they were all from May 1st.

Q. You authorized these 11 residents be transferred from 1 East to other units?

A. Yes, I did.

Q. And what, if anything, did these 11 residents have in common with one another that necessitated their bed transfer on May 1st?

A. They were COVID-negative.

Q. They were all COVID-negative, correct?

A. That's my assumption if they were

being moved, yes. Again, I don't have their clinical information in front of me.

Q. Why were these 11 COVID-negative residents living on 1 East on the morning of May 1st?

A. Because they were new admissions.

Q. And when, meaning what time on May 1st were these 11 residents moved out of their rooms on 1 East and transferred to other units in the building?

A. I don't know what time each one was moved.

Q. So on the morning of May 1, 2020, prior to the Department of Health arrival at Fulton for the survey, nonCOVID and COVID residents were living on 1 East, correct?

A. I'm sorry, can you repeat the question?

Q. Sure. On the morning of May 1, 2020, this is 72 hours before DOH's survey, nonCOVID and COVID residents were living on 1 East, correct?

A. Again, I'd have to look at all their diagnosis to see if any of them were

positive. I don't know their clinical condition. But the new admissions were on 1 East as opposed to being a specific COVID unit, which we created on May 1st in response to the April 29th Department of Health guidance.

Q. But my question was, there were COVID and nonCOVID residents living on 1 East on the morning of May 1st, correct?

A. Again, I cannot answer that. I don't have their clinical information in front of me.

Q. Well, we can go through it if you'd like?

A. If they were positive they wouldn't have been moved off the unit.

Q. Right, but my question -- my question was, on the morning of May 1st, there were, by your own testimony, COVID-positive patients from hospitals and nonCOVID residents living on 1 East?

A. I cannot tell you how many or if any were COVID-positive versus nonCOVID. I can't answer this question without their

charts in front of me, sir.

Q. Didn't you testify --

A. They could have all been negative by then, I don't know.

Q. Right, but you testified that one of the things that these 11 residents you had in common, you believed, was that they were nonCOVID because they were moved off of the unit, correct?

A. Correct.

Q. So, if these 11 that were moved off of the unit were nonCOVID and there were hospital admissions who were COVID, then COVID and nonCOVID were living together on May 1st, correct?

A. Again, I'd have to see their medical information to answer that question.

Q. Well, let me ask you this, by the afternoon of May 1, 2020, all nonCOVID residents had been transferred off 1 East and placed on other units in the building, correct?

A. That is correct.

Q. Do you know what reason was given

to these residents who were moved -- all these residents who were moved off of 1 East on May 1st as to why they were being transferred off the unit?

A. My answer again is no.

Q. Okay. Were these 11 residents who were transferred off of 1 East on May 1st ever told that they had been living on a unit that also housed COVID patients?

A. I don't know.

Q. Do you know if the families or designated representatives of these 11 residents who were transferred off of 1 East on May 1st, were ever told that their loved ones were living on a unit that housed COVID patients?

A. I believe at least indirectly they were because my robocalls indicated that 1 East is where the new admissions came -- you know what, I can't say that, I'm going to say no. I'm going to say I don't know.

Q. So you don't know if the families of these 11 residents who were moved off of

unit 1 East on May 1st had known that their loved ones were sharing a unit with COVID patients, correct?

A. Yeah, I don't know the answer to that.

Q. Would you agree that if the designated representative of a nonCOVID resident had been told that their loved one was living on the same unit as COVID residents, they would have requested that their family member be transferred off of the unit?

A. I can't speak for the family members, sir.

Q. So you already testified, correct, that the residents were transferred off of 1 East to comply with the DOH directive; is that correct?

A. That is correct.

Q. I'd like then to look with you at the documentation as the reason -- that that was the reason for the transfer. If we can look at the 24 Hour Condition Report again, Exhibit 39, which I believe is on the screen

and go to page 11 of Exhibit 39.

MR. YAFFE: What are you calling that document? You just gave it a name, Mr. Zadek.

MR. ZADEK: I believe I called it the 24 Hour Condition Report.

MR. YAFFE: Okay, thank you.

MR. ZADEK: Which they all are, each page.

Q. So, we are now on page 11 of Exhibit 39 and do you see for Resident #13 , do you see that this is a 24 Hour Condition Report for May 1st, correct?

A. Yes.

Q. And under the 7 to 3 shift, towards the four, five lines up from the bottom, do you see where it says, "Room change [redacted] unit 2 East for facility necessity," do you see that?

A. I do.

Q. And then on the 3 to 11 shift it says, "Resident transferred to 2 East room [redacted], in stable condition, for facility necessity"?

A. Yes.

Q. Can you turn to page 12 now?

A. Can I interject that I also see documentation that this family was notified before the room change, just for record.

Q. Please show me where.

A. Right on the bottom. It says, "Family agree with same, given to charge nurse." This family agrees with same.

Q. Same meaning the transfer?

A. Correct.

Q. Okay. Thanks for pointing that out. Thank you.

Looking at page 12, the next page for Resident #23 , again, this is 1 East, if we scroll up we can see it's 1 East for May 1st?

A. Yes.

Q. Resident #23 , room [redacted], it says again, "Resident room change to [redacted], unit 3 West for facility necessity" and by the way I point out, as you noted, it says, "Resident agreed with same," correct?

A. Correct.

Q. And then if we go to the next column, 3 to 11, it also says, "Resident transferred to 3 West, room [redacted] for facility necessity," correct?

A. Correct.

Q. And if you looked at the next page, page 13, you see for Resident #17 for Friday, May 1st, as well under the 7 to 3 it says, "Resident transferred to room [redacted] for necessity" and as you correctly pointed out it says, "Family aware, agrees with same," correct?

A. Yes.

Q. And then under 3 to 11 it says, "Resident transferred to 2 East for facility necessity," correct?

A. Correct.

Q. So, what was -- do you know what was meant -- who wrote -- who made these entries, do you know that?

A. I do not know. It was probably the nursing supervisor or the LPN.

Q. Do you know what the facility necessity referred?

A. Yes, it was to create the COVID unit from the April 29th directive from the Department of Health.

Q. Okay. And there's no mention though anywhere within the chart that we looked at that it is to comply with any State regulation, correct?

A. No, that wouldn't be documented in an individual patient record.

Q. Well, there's nothing documented other than the words "facility necessity," correct?

A. Correct, that's what it is.

Q. And are you familiar with some of the documents that the social workers complete at Fulton?

A. Yes.

Q. So if we can look at Exhibit 51, which is a 12-page exhibit. Exhibit 51 says at the top, "Comprehensive Care Plan Room Change"?

A. Yes.

Q. Is this a social worker form?

A. It is.

Q. Are you familiar with it? Have you seen it before?

A. Yes, not that one, but the form, yes.

Q. But you're familiar with the form?

A. Yes.

Q. Who prepared these forms?

A. The social worker.

Q. So let's look at the May 1st of 2020 room change forms for six of the residents that we already discussed.

On page 1 is says, "Resident #23 ," correct and it's dates May 1st and it's completed by Nina Topouria, who I believe you mentioned was a social worker?

A. Yes.

Q. If we go to page 2 under the care plan update and evaluation, on the top line from May 1st it says, "Resident transferred from [redacted] to [redacted] due to psychosocial well-being," do you see that?

A. I do, but there's a line before

it that would be checked off if that was the reason. You see on the line before "due"?

Q. Right?

A. If it was due to psychosocial well-being, there would be a check mark there, I think.

Q. So it's based on the formality of the form, it's your belief that this resident was not transferred due to psychosocial well-being, is that what you're saying?

A. He definitely was not transferred due to psychosocial well-being. If that's what's documented by the social worker, it's incorrect.

Q. Because you stated -- you already provided us with the reason for the transfer, it did not have to do with the psychosocial well-being, correct?

A. Absolutely not. If that's the way that note was written, it's incorrect.

Q. Right. So the residents who were transferred from 1 East to other units on May 1 were transferred to comply with DOH

requirements and not for the psychosocial well-being of the resident, correct?

A. Correct.

MR. ZADEK: We can take that off the screen now.

Q. Had there been any other days in 2020 when as many residents were transferred from one unit to another prior to May 1st?

A. I don't recall if that was possible. If we were moving residents around for their safety, but I can't recall off the top of my head.

Q. And you don't recall whether this 1 East bed listing, the Exhibit 17A -- I'm sorry, 17F, you don't recall whether that document was given to the Department of Health team on May 4th?

A. I don't recall the specific documents that were given to any of the teams when they walked in.

Q. Okay. But the document -- the 1 East bed lists for Friday, May 1st, Exhibit 17F, that does not identify all the residents who were actually living on the

designated COVID unit on Friday, May 1st, correct?

A. Depends on what time it was done.

Q. Well, the document does not correctly indicate all the residents who were living on 1 East on the morning of Friday, May 1st, correct?

A. Again, it depends on what time. I don't know what time they started moving residents.

Q. When the residents on 1 East opened their eyes after their night's sleep, there were more residents on this unit than those that are listed on 1 East, correct?

A. I don't know.

Q. When you walked into the building on Friday, May 1st -- on the morning of Friday, May 1st --

A. Hmm-hmm.

Q. -- residents that are listed on the exhibit, the bed listing, were not the residents -- all the residents that were actually on that unit, correct?

A. Again, I cannot answer that.

It's not a snapshot in time, it's a rolling window of time in the facility. I give instructions to move 11 people, some are moved immediately, some are moved two hours later, some are moved at the end of the day.

I cannot answer who was in what bed specifically at what time. It would be impossible for me to tell you that.

Q. I'm not asking you that. You indicated to me earlier -- you testified that you are the one who authorized all of these bed transfers of May 1st, correct?

A. Yes.

Q. So, these residents, the 11 residents who were moved off of 1 East on May 1st, could not have been moved off of that unit before you arrived, correct?

A. That's not true, sir, I communicate by phone, text. I don't even remember, I could have given the orders the day before. I don't recall.

Q. So, you don't remember when you directed -- when you authorized that these residents be moved on and off of 1 East?

You don't recall if it was that morning? The night before? You don't recall?

A. I don't recall. It was a very hectic time, sir.

Q. This May 1st bed listing, Exhibit 17F, does not indicate that COVID and nonCOVID residents were living on 1 East, correct?

A. I don't think it asked for it.

Q. That wasn't my question. I didn't ask you what --

A. No bed listing lists the diagnosis of residents. So no, it wouldn't indicate a diagnosis ever.

Q. I'm not asking if it indicated a diagnosis, we've already gone through what it indicates.

A. Well, COVID is a diagnosis. You're asking me if COVID was listed on the bed listing and my answer is no, no bed listing does.

Q. I'm not asking you whether it's listing the diagnosis. I'm asking you if the residents who are listed on 1 East, the

11 residents, do not contain any residents who are nonCOVID, correct?

MR. YAFFE: Objection.

A. I don't understand your question, share.

Q. You don't?

A. No, I don't.

Q. When you testified earlier that the 24 residents that are listed on the bed listing are, to your knowledge, all COVID residents, what did you mean?

A. I did not say that. I said all along they were admissions from the hospital, with means we treated them as presumed positive per the DOH guidance.

Q. So all the residents listed on the bed listing for Friday, May 1st, were all presumed COVID patients, correct?

A. They had the potential to be positive based that they came from the hospital. We didn't know them well enough yet.

Q. There are no residents listed on the bed listing for 1 East that you

characterize as nonCOVID, correct?

A. Sir, you're trying to get me to say something that I can't say. Okay?

Q. If you don't know the answer, just indicate that you don't know.

A. The answer is I don't know.

Q. Okay.

If this document, Exhibit 17F, the 1 East bed listing from May 1st, which lists these 24 residents, if that document had been turned over to the DOH team on Monday, May 4th, that team would have no way of knowing who was living, actually living on 1 East on the morning of May 1st, correct?

MR. YAFFE: Objection.

A. Again, I don't understand your question.

Q. Okay. If this document, meaning -- which we've been discussing, Exhibit 17F, the Friday, May 1st bed listing had been termed over to the DOH surveyors on Monday, May 4th, those surveyors would have no way of knowing that there were additional

residents living on the unit on the morning of May 1st, correct?

MR. YAFFE: Objection.

A. They would have known when they came in on the 4th and asked for updated documents.

Q. Did they not ask for additional documents or handwritten addendums, they would not know who was actually living on the unit?

A. I can't give them what doesn't exist, sir. On May 1st, that's who was on the unit. When we pulled the census at midnight, that's when it would change.

Again, the census is based on midnight the day before. So, on May 1st, when they asked me who was on the unit, I gave them who was on the unit.

Q. So, it's your testimony now that these residents were moved off of 1 East, the 11 residents for instance that we just discussed, those 11 residents that were transferred off of 1 East, were transferred off of 1 East prior to midnight on May 1st?

A. No, they were moved during the day on May 1st.

Q. So how did the midnight hour impact your answer to the question?

A. On May 1st at 9:00 a.m., you're getting information from the day before at midnight. We do the bed count at midnight the day before. So on April 30th, what you're looking as is the information from May 30th. It's always a day behind.

Q. You meant April 30th?

A. Yes, sorry.

Q. Did you, at any time, discuss the May 1st bed transfers with Mr. Kalter at any time?

A. I have indicated that I have never spoke to Mr. Kalter, so that's a no.

Q. Did you at any time discuss these May 1st bed transfers with Steven Weiss?

A. I don't recall.

Q. You already said that you did discuss the May 1st bed transfers with Dr. Butchma, correct?

A. Dr. Butchma, Carol Frawley,

admissions, the unit managers, yes. Well, I didn't speak directly to the unit managers, Ms. Frawley did.

Q. So you spoke with Ms. Frawley, Dr. Butchma and would it be Ms. Hersher from admissions?

A. Correct and social work of course.

Q. And social work?

A. Hmm-hmm.

Q. Who would that be Ms. Topouria?

A. It would have been Kameca Balan a and Nina at the time, I believe. Again, we have changed social workers and I don't recall the dates when they left. So again, it's to the best of my memory.

Q. But to the best of your recollection, Ms. Frawley, Dr. Butchma, Miss Hersher and someone from social work was involved in the discussion surrounding the need to transfer all these residents in order to comply with the DOH directive; is that correct?

A. That's correct.

Q. And when did that conversation occur?

A. Again, I don't recall exactly when I got the memo. It would have been either the 29th or the 30th, depending on when I received it.

Sometimes they issue them the 29th, but they are not sent out until the 30th, for example. So, I'm not positive.

Q. But it was before May 1st?

A. Yes.

Q. So, within a day or two prior to May 1st is when there was a discussion about the need to make these transfers?

A. Yes, when we received the guidance from Department of Health.

Q. Was there any discussion with Dr. Butchma, Ms. Frawley, Ms. Hersher or social work on the morning of May 1st concerning the bed transfers?

A. Probably, yes. I don't recall exactly what, but I'm sure we discussed it.

Q. So there were multiple conversations with respect to the bed

transfers?

A. That's a big thing to do in a facility, move all those residents at once. It's not a pleasant task, to be quite honest with you. So, I'm sure we discussed it the morning of, as well as probably throughout the entire day.

Q. What time on May 1st did you have your first meeting with the individuals concerning the need to transfer these residents?

A. I don't recall.

Q. Did you have a meeting with -- withdrawn.

Do you recall having a meeting with Dr. Butchma, Ms. Hersher, Ms. Frawley and Ms. Topouria in the admissions office on Friday, May 1st?

A. No, I don't recall that specifically.

Q. Do you recall the location -- do you recall that on the morning of Friday, May 1st, you met with individuals in the admissions office to discuss this large

number of bed transfers?

A. I don't recall the location, sorry.

Q. Well, you mentioned earlier that you and others used this bed board to make decisions concerning where to move residents, correct?

A. Correct.

Q. Do you remember on May 1st, the day of the bed transfers, you utilized the bed board in discussions concerning moving the resident on May 1st?

A. Again, I do not recall.

Q. Do you recall talking -- withdrawn.

Do you recall at any time -- withdrawn.

Approximately how many meetings did you have with -- withdrawn.

Was Ms. Hersher, Ms. Frawley, someone from social work and Dr. Butchma present for all of the discussions you had concerning these bed transfers?

A. No, I don't believe Dr. Butchma

was even on-site that day. I believe when we needed him we reached him by phone. So, I don't think he was physically present. If he was in the facility that day, we spoke to him in person. Otherwise, it was by phone and sometimes by text.

But I can't recall who was specifically in this meeting.

Q. Approximately how many meetings did you have at the facility with Ms. Frawley, Ms. Hersher and a social worker concerning the bed transfers of May 1st, approximately how many meetings?

A. I have no idea. I don't know.

Q. Do you recall if it was more or less than five?

A. Listen, you have to define meeting for me. If I pass Ms. Frawley on the way to the ladies' room, we have a conversation, we're discussion room transfers, is that a meeting? It's constant all day long. This was not a normal time.

Q. Were these discussions concerning the bed transfers of May 1st occurring

constantly prior to the bed transfers taking place? Was there that amount of discussion?

A. Yes, we were strategizing as a team on who would -- there was two that went down together, for example. There was a conversation whether they got along well and should we keep them together or should we separate them, what would be in their best interest. They got along great and we decided to keep them together.

So, those conversations were constant as we got to each resident and each situation.

Q. Who was involved in that discussion?

A. That specific one? I don't recall.

Q. Do you recall using the bed board? Do you recall in the context of this very large bed transfer where, I believe, you indicated 10 percent of the residents transferred rooms, do you recall utilizing the bed board to guide you on where to make the transfers?

A. I do not.

Q. So you don't -- to what extent was Ms. Frawley, the director of nursing, involved in the discussions? To what extent did she play a role in deciding where residents would be moved?

A. She was integral. She knew the clinical condition of the residents and if she didn't know, she found out from her unit manager.

Q. So without testifying the exact location or the time of the meeting, tell me what Ms. Frawley stated to you in terms of the bed transfers?

A. She said, "Oh, the staff is going to love us, that's a lot of work."

Q. Okay.

A. Among other things. That's all I remember discussing, quite honestly. That's what stands out and I don't think it was on May 1st, I think it was the day before, that doing all those bed transfers on a Friday was going to be a significant amount of work. And I said, "This is the DOH

guidance, I don't care, get it done."

Q. But she was directly involved with you in those discussions and the need for the bed transfers?

A. Correct.

Q. And was Ms. Hersher equally involved in the discussions concerning the need for the bed transfers on May 1st?

A. I don't know that specific people were told why they were being transferred. I can't recall who we told it was because of the DOH guidance or otherwise. I really don't recall.

Q. That wasn't my question. My question was, was Ms. Hersher -- withdrawn.

You said that Ms. Frawley was very involved with you in the discussions and the need for the bed transfers of May 1st, correct?

A. Yes, we both get the DOH guidance.

Q. Say it again?

A. We both get the Department of Health guidance at the same time.

Q. So she was well aware of the need for the bed transfers?

A. Yes.

Q. Was Ms. Hersher equally involved in those discussions that you had with Ms. Frawley concerning the need for the bed transfers?

A. Again, I'll say I do not recall who we discussed specific reasons with. Not everybody would need to know why we were moving residents. I can't recall who I discussed the reasons with.

Q. Is it fair to say that it was primarily you and Ms. Frawley that had these discussions about, A, the need to move the residents and, B, the specific locations where the residents would move to?

A. It's fair to say the need for the move? Yes, primarily Ms. Frawley and myself. Where they went to would be a team approach.

Q. And the team approach would be who, who's on that team?

A. Again, myself, Ms. Frawley, Ms.

Hersher, social work, the unit managers.

Q. And what about Dr. Butchma, what role, if any, did he play in the discussion concerning the need to make the bed transfers and what role, if any, did he play in the rooms?

A. He played no role in what rooms people went to. And to be perfectly honest, when I got the guidance from DOH I called him up, I said, "Could you believe we have yet another directive from DOH, here's what they want me to do now."

He said, "Yes, I just got that from another facility. We're doing the same thing there." So he was in agreement with the need based on the DOH guidance to create a separate unit.

Q. This is, again, before the morning of May 1st?

A. Yes.

Q. So Dr. Butchma -- withdrawn.

Returning to Ms. Frawley, so Carol Frawley was aware that these bed transfers were going to take place, a

significant number of May 1st bed transfers that were going to take place before May 1st, correct?

A. We both knew prior to because we got the guidance from DOH, but we had to strategize on -- again, it's not as simple as saying, "Okay, move these 11 patients."

Q. Right. So she was well aware before the morning of May 1st that these bed transfers were going to occur?

A. Yeah, it could have been the night before. As I said multiple times, I do not recall when I got the guidance.

Q. But there was no surprise on the morning of May 1st that these bed transfers were taking place, Ms. Frawley was well aware of it, correct?

A. Yes.

Q. And was Dr. Butchma?

A. Correct -- well, let me clarify, I don't know that he new it on May 1st. But he was aware of the need to do them, that he had heard about the guidance from another facility.

Q. Okay. Was this May 4th infection control survey an announced or unannounced survey?

A. Unannounced, they all are.

Q. Were you aware of at the end of April that an infection control survey was going to be conducted at Fulton?

A. Specifically at Fulton? No, we were aware that infection control surveys were occurring on buildings across the State, I guess across the country at that time, but specifically at Fulton, no.

Q. But how were aware in advance of the May 4th survey that one was going to be conducted?

A. Again, you're twisting what I said, sir. There were apparent other facilities across Long Island -- the same way I wrote up my experience with my survey, we had gotten summaries from other facilities that had gone through it.

So, we knew they were occurring. We knew what they were about generally, but you have no idea when they're coming to your

facility.

Q. How were you informed then that the survey was going to take place? When did you first learn that there was going to be an infection control survey at Fulton?

A. May 4th at 8:45 a.m. when they walked in.

Q. You didn't have any advanced notice?

A. No, sir.

Q. So, when they walked through the doors on May 4th, that was the first you realized that Fulton was going to have an infection control survey done?

A. Yes.

Q. And because you mentioned -- I believe off-site production of records?

A. Yes.

Q. So, is the process one in which they walk through the door. They say, "We're conducting a survey. We need X, Y and Z." And you're also at the same time on May 4th, sending them electronically elsewhere?

A. I think the off-site record production started before they entered the facility, but they had never done that before. So, it didn't occur to me they would be coming shortly thereafter.

Q. When you say earlier, you mean earlier on May 4th?

A. No, I believe on the 1st they requested documents, as we discussed earlier.

Q. I wasn't clear on that. So, you believe on May 1st you had a request for documents from DOH?

A. Right. You pointed out the date May 1st on a document and I told you that they asked for that prior to the surveyors coming to the building.

Q. So prior to the -- you did not known when they were going to walk in the building, but you believed that possibly on May 1st you had receives a request for records from DOH?

A. I received a request for documents prior to them entering the

facility on May 4th. I don't recall the exact date.

Q. Okay. So is it fair to say that although you didn't know that they would be arriving on May 4th, based on that earlier document request, you were aware that there was an infection control survey -- an imminent infection control survey?

A. No, that's not fair to say.

Q. No?

A. No, they ask for documents all the time. It doesn't mean they're coming to the facility.

Q. Okay.

A. If you want to know the truth, I thought the production of the documents was in lieu of the on-site inspection.

Q. Just so you know, Ms. Frawley, during this entire examination I only want the truth?

A. I'm Doyle, not Frawley.

Q. I mean Ms. Doyle.

Take a look at Exhibit 52. Exhibit 52 is an exchange of e-mails, an

e-mail chain. We can scroll down to the bottom of the document because sequentially I believe that's where it begins. But do you see here on Exhibit 52 at the bottom that -- actually we need to -- yes, we see here, this is an e-mail from you, correct, Friday, May 1st at 11:57 a.m. and it's to Subrina Charles, Carlton Williams, Susan O'Connor, as well as Steven Weiss, do you see that?

A. Correct.

Q. And you write there in the e-mail -- this is your e-mail, correct, where you write, "Last evening a friend told me that DOH was calling facilities to get policies, census, et cetera the day before they are entering for the survey"?

A. Yes.

Q. "Today I got my call, so I expect they will be here tomorrow"?

A. That was my gut, but I had no specific information to confirm that.

Q. Right, but when you said a moment ago you had no expectation, you weren't even

sure they were going into your facility, it would suggest by this e-mail, Ms. Doyle, that you thought they were showing up the next day, correct?

A. No, it was just a supposition based on what another facility had gone through. I had no way of knowing if they were coming or not.

Q. But you're looking at the same document where you said, "I expect they will be here tomorrow," correct?

A. Well, if they came tomorrow it would have been Saturday. So, I was wrong.

Q. Do you come to work on that Saturday?

A. No.

Q. You weren't working on Saturday, May 2nd?

A. No, I was not.

Q. Did you ask staff to come in to work on Saturday, May 2nd?

A. Absolutely not.

Q. Because you had anticipated a DOH survey?

A. As I said, I didn't really anticipate them. It had occurred in another building. I was giving my co-workers, other administrators a heads up, but I didn't real except them, to be honest with you. If I did, I would have been there.

Q. My question was, did you ask staff members at Fulton to come into work -- any staff members to come into work on Saturday, May 2nd, because you anticipated the DOH survey?

A. I answered you no.

Q. Was it your intention to do everything in your power as administrator to ensure that DOH did not conclude findings or have findings against Fulton during the survey?

A. I don't run the building based on Department of Health is going to fine me. I run my building based on the regulation and anybody is invited to come in any time they want.

Q. Were you going to --

A. No, that's not how I run a

facility.

Q. Were you going to do everything in your power to ensure that DOH didn't have any findings against Fulton?

A. No, I do everything in my power to keep my residents safe.

Q. Can we scroll up to the very top of the document and look at an e-mail from later that day, Friday, May 1st, where, again, you're writing now to Steve Weiss directly and you write at 12:00, "Thank you, Mr. Weiss. We will do everything in our power to have them go with no findings"?

A. Yes because now they were fining facilities $2,000 per violation and we were concerned that there were going to be monetary penalties at this time.

You're taking my e-mails out of context, but that's why I don't like e-mails or texts.

Q. Okay. But you did write that to Mr. Weiss, correct?

A. I did.

Q. When you wrote initially -- again

at the bottom of the e-mail chain, "Today I got my call," do you see at the bottom --

MR. ZADEK: Scroll down a drop more.

Q. Do you see it says, "Today I got my call so I except they'll be here tomorrow"?

A. Yes.

Q. That was at 11:57 a.m., correct?

A. Yes.

Q. Who called you on Friday to let you know -- who called you from DOH?

A. I believer her name was Emily. I had never heard of her before.

Q. How soon after receiving this call from Emily at DOH that staff began moving the residents on and off of 1 East?

A. It had already happened by noon.

Q. It already occurred?

A. It had already begun.

MR. ZADEK: We can take that off the screen now.

Q. Were CNAs on 1 East providing care to both COVID and nonCOVID residents

during their shifts?

A. I don't know. You would have to ask Ms. Frawley that.

Q. You don't know?

A. I don't know.

Q. Were you told that CNAs within 1 East were providing care to both COVID and nonCOVID residents during their sifts?

A. No.

Q. Were you told that this behavior -- withdrawn.

Were you ever told that the behavior of CNAs providing care to both COVID and nonCOVID residents during their shifts violated basic infection control protocol?

A. No, that's not true.

Q. No, I'm just asking if you were told. If the answer's no, it's --

A. That's not true.

Q. Okay. Were you ever told, Ms. Doyle, that the behaviors of CNAs proving care to both COVID and nonCOVID residents during their shifts endangered the safety

and well-being of the nonCOVID residents on 1 East?

A. No.

Q. Were the families -- if you know the answer to this -- were the families of nonCOVID residents on 1 East told that their loved ones were on a daily basis receiving care from CNAs who were also caring for COVID residents?

A. I don't know the answer to that.

Q. We talked about -- we talked earlier about four residents who on May 1, 2020, transferred down to 1 East from 3 West, correct?

A. Yes.

Q. We talked about Resident #7 who was transferred from 3 West down to 1 East, Resident #5 transferred from 3 West into bed [redacted], correct?

A. Again, I don't have it in front of me, but if that's what you're saying.

Q. Without specifying the room, do you recall talking about Resident #7 , Resident #5 , Resident #8 and

Resident #6 all three were transferred from 3 West to 1 East on May 1st, correct?

A. Again, I don't know what unit they are on, but yes, they were transferred to 1 East.

Q. Were all these residents who were transferred on May 1st from another unit to 1 East, were they all residents who had arrived at Fulton from the hospital as COVID positive?

A. I don't know. I don't know if they were long term or short term.

Q. Well, if we can look at Exhibit 20. Looking at Exhibit 20, which is a daily census sheet dated Friday, April 17, 2020, correct?

A. Yes.

Q. And if we look at -- scroll down and look at the admission of Resident #5 and Resident #6 , is it correct that Resident #5 came in from Syosset, COVID positive and Resident #6 came from Winthrop as a COVID patient, correct?

A. Yes.

Q. And they both were housed on 3 West, correct?

A. Correct.

Q. Was 3 West ever designated at the COVID unit?

A. They were all COVID units, sir.

Q. I did not know that. All the units --

A. There was COVID on every unit.

Q. Let me just finish my question, please.

All the units at Fulton Commons were designated as COVID units?

A. They weren't specifically designated as COVID units. They all had COVID patients on them throughout the pandemic until we created this specific unit.

Q. And based on your understanding of infection control protocols, the placement of COVID patients throughout the building complied with fundamental infection control protocols?

A. The early guidances, yes, it did.

It wasn't until later guidances that they kept fine tuning them.

Q. Who made the decision to house Resident #5 and Resident #6 on this unit, on 3 West?

A. I don't know.

Q. Who authorized that these two COVID positive patients were placed directly from the hospital on to 3 West?

A. Again, they were just being admitted into the facility and at that point there was no dedicated COVID unit. So, who picked the rooms? I'm going to guess admissions.

Q. So it's your testimony that on April 17, 2020, 1 East was not the designated COVID unit, is that your testimony?

A. Yes, I said that all day.

Q. Why weren't these two COVID residents -- two COVID patients, Resident #5 and Resident #6 , housed on 1 East?

A. I don't know.

Q. Would it have been safer for

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other residents in the facility if Resident #6 and Resident #5 had gone to 1 East rather than 3 West?

MR. YAFFE: Objection.

Q. Based on your understanding of infection control and transmission?

A. Based on what I know today about COVID?

Q. Yes.

A. Which it is not your typical transmission-based disease, based on what I know today, not back then, the answer is yes.

Q. Resident #7 -- if we look at Exhibit 19, Exhibit 19 concerns Resident #7 and Resident #8 . Exhibit 19, which is an April -- the daily census sheet from April 21, 2020?

A. Yes.

Q. And do you see under the admissions and readmissions section that Resident #7 and Resident #8 both came from the hospital as COVID patients, correct?

A. Correct.

Q. Again, do you know why these COVID patients were housed on 3 West at that time?

A. I'll repeat myself again, because they were admitted into empty beds by the Department of Health guidance at the time.

Q. Is it your testimony, just again, compared to what you said a moment ago, did you consider 3 West to also be the designated COVID unit in the building as of April 21st?

A. Sir, there were no designated COVID units until May 1st when the guidance on April 29th came out from the Department of Health to create a designated unit if you could do so.

Q. Who made the decision to house these COVID patients on 3 West?

A. I don't know.

Q. Did you?

A. No.

Q. Were you involved -- withdrawn.

To what extent, if any, were you

involved in the placement of COVID patients from the hospital on to specific units?

A. I was not because there was no -- there was no guidance. We followed the Department of Health regulations throughout the pandemic. There was no guidance to not place them on these units and so, we did.

Q. So, who was responsible -- withdrawn.

Who was making the decision as to where to house these COVID patients from the hospital within the building? Who made the decision on where to put them?

A. I would assume admissions like they do on any other day.

Q. When you say you assume, so you assume that Ms. Hersher decided to place Resident #7 , Resident #8 , Resident #6 and Resident #5 on 3 West?

A. Correct, they were placed in empty beds.

Q. I didn't ask you that. I asked you who made the decision to place them into those beds?

A. You asked me if it was Kristin Hersher and I said, "Correct."

Q. Were the families of the residents who lived on 3 West told that there were COVID patients being admitted to that unit on those dates?

A. I don't know.

Q. Now, you discussed earlier, CNAs who I believe were characterized as floaters at Fulton, correct?

A. Yes.

Q. Just so I'm clear on the term, prior to the pandemic did these CNAs float as needed between residents on a single unit or did they float between units at Fulton?

A. Between units.

Q. Okay.

A. That's what floater refers to, floating between the units.

Q. So, they were moving from one unit to another as needed?

A. Correct.

Q. Not within the unit itself?

A. No.

Q. Okay. Do the CNA floaters work on all shifts throughout the day and night, meaning the 6 to 2, the 2 to 10, the 10 to 6, was there always a CNA who would do that between the units?

A. I can't speak to every shift because again, it was fulfilling for when people had their days off. So, if nobody had a day off on Thursday, we may not have needed a floater that night. I don't know.

Q. But it wasn't simply during the day time, there might be a CNA who needed to move to another unit in the middle of the night, correct?

A. When she came to work, yes, but not when she reported to work during the pandemic.

Q. During the pandemic, did CNAs continue to float between units or that ended?

A. That ended to the best of our ability from the beginning to the middle of March.

Q. So some time in either the

beginning or middle of March, all CNAs who were on a unit, would remain on that unit, correct?

A. To the best of our ability, yes.

Q. So, a CNA on 2 West would not, during the day, go down to, whatever, 3 East to give assistance?

A. No, they reported to their units and stayed there. Those were their instructions.

Q. Okay. If during the pandemic, let's say, after the middle of March, CNAs did float back and forth between, as an example, 1 East and other nonCOVID units during their shifts, then that would violate infection control protocols?

A. No because even the Department of Health will tell you that not floating CNAs is impossible to maintain a schedule. Every guidance we received said, "To the best of your ability."

Q. Okay. Would you agree that if during the pandemic -- again, after we'll say the middle of March -- CNAs floated back

and forth between 1 East and other units in the building during their shifts, they would be potentially endangering the safety of nonCOVID residents in the facility?

A. Not in they were wearing their PPE properly on 1 East when they were provided care there, no.

Q. Did you receive a letter or some statement from Department of Health concerning the findings of the May 4th infection control survey?

A. I did.

Q. We're going to take a look at Exhibit 55. And Exhibit 55 is a three-page document and this is a letter to you, is it not, Ms. Doyle, dated May 20th from the Department of Health?

A. Yes, it is.

Q. And if we scroll down under type of survey, we see that it refers to the COVID-19 focus infection control survey, correct?

A. Yes.

Q. And that's what we've been

talking about this afternoon, correct?

A. Yes.

Q. And if we scroll down to the second paragraph that begins, "The most serious," right there, do you see where it says, "The most serious deficiencies found during this survey were isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not Immediate Jeopardy whereby corrections are required."

Do you see that?

A. Yes, a D level deficiency.

Q. So is that significant in your mind or less significant, how do you characterize that?

A. No, that's a pretty insignificant deficiency in the world of deficiencies.

Q. Do you recall, in fact, what the isolated deficiencies that the DOH is referring to, do you recall what they might have pointed out to you or indicated as the minor deficiencies that they observed?

A. Yeah, there was a housekeeper on

a unit that was not wearing his PPE correctly.

Q. Right.

A. It was hot and unzipped his jumpsuit.

And there was a CNA that was pushing a resident in a wheelchair and then went directly to another resident and pushed that wheelchair.

Q. So as you said, in the world of deficiencies, not the most serious, correct?

A. Correct.

MR. YAFFE: I just note that we're past the 5:00 hour.

MR. ZADEK: I think I have maybe 10 minutes left, so can I try to finish now or -- you're call. I'm almost done.

MR. YAFFE: Completely or you're almost done with today?

MR. ZADEK: Good question. I'm almost done for today, to finish up this section, which is -- which will wind down today and get us on -- still

on schedule for tomorrow.

THE WITNESS: I'm good to keep going.

MR. ZADEK: Are you good for five minutes? If that okay with you, Counsel, if I wind this down today?

MR. YAFFE: That's fine me, is that fine with the stenographer?

THE COURT REPORTER: That's fine with me.

Q. So Ms. Doyle, what is the term Immediate Jeopardy or IJ, you're familiar with that term, right?

A. Yes.

Q. What is an IJ finding? What does that mean?

A. It means that you significantly put the residents -- resident, could be one resident, in that you actually caused harm to them or had more than little potential to cause harm to a resident based on a deficient practice.

Q. Can a nursing home's failure to follow basic infection control protocols in

a nursing home result in an IJ finding?

A. I don't know. I haven't heard of any. As I understand, it takes a large pattern of infection control violations to reach that level over the staff members. Over the course of two days, it did not rise to a high level of deficiency from what was observed.

Q. Right. So based on your infection control survey in May, there was no IJ finding whatsoever, correct?

A. That's correct.

Q. But in general, from your experience as an administrator for all these years, infection control is a serious issue within a nursing home, correct?

A. Correct.

Q. And a nursing home that is not providing infection control -- is not meeting infection control standards within New York State could lead to an IJ finding, correct?

A. It could be if you haven't in-serviced the staff properly or did

competencies or provided them with the correct PPE, then they would hold the facility much more accountable.

When they come in and they see an employee not wearing their PPE correctly, they want to make sure that they talk to that employee and it's just a stupid people trick as opposed to a system failure in the building.

Q. Would you agree that if the Department of Health compliance surveyors had known that 72 hours prior to the May 4th infection control survey that the designated COVID unit 1 East housed both COVID and nonCOVID residents, Fulton may have faced an Immediate Jeopardy finding?

A. Absolutely not.

Q. Do you agree that if the Department of Health compliance survey had known that there were COVID patients from hospitals what were not placed on the designated COVID unit, but then were housed on a nonCOVID unit, Fulton may have faced an Immediately Jeopardy finding?

A. Sir, I'm going to clarify it one more time before we end for the day, there was no designated COVID unit. There was no such thing. There was no guidance to have one until April 29th. So no, we would not have received an Immediate Jeopardy deficiency.

Q. So, you would not agree with that?

A. I do not agree with that.

Q. Would you agree that if CNAs on the designated COVID unit, by that I mean 1 East, if they had provided care to both COVID and nonCOVID residents on their shifts, Fulton could have faced an IJ finding?

A. Absolutely not. Again, every unit had COVID-positive residents on it throughout the pandemic until May 1st. So, I vehemently answer that question with a no.

Q. And finally, Ms. Doyle, would you agree that if caregivers and staff floated on and off the designated COVID unit, 1 East, during their shifts, Fulton may have

faced an Immediate Jeopardy finding?

A. Again, I object to you calling it a designated COVID unit. It did not exist prior to that survey, so that's number one and I'll keep saying it.

And number two, the answer is no because Department of Health acknowledges that for operational purposes you have to have set staff that goes to every unit.

Q. So I'll rephrase the question at your request.

Would you agree that if caregivers and staff floated on and off of 1 East during their shifts, Fulton may have faced an Immediate Jeopardy finding?

A. Same answer, no, for the same reason I just gave.

MR. ZADEK: Well, thank you for the courtesy of going a little past five, I appreciate that.

And I extend the same gratitude to you, Counsel. And what time are we resuming tomorrow?

THE WITNESS: 10:00?

MR. ZADEK: Okay, yes.

MS. SEKHON: It's at 10:00. I did send out the link to Ms. Doyle and Mr. Yaffe.

MR. YAFFE: Okay. Is the reporter still transcribing -- the stenographer?

THE COURT REPORTER: Yes.

MR. YAFFE: I just had something I wanted to state on the record, so I wanted to make sure you were there.

So your machinery is on?

THE COURT REPORTER: Yes.

MR. YAFFE: I just wanted to state my objection to what I would characterize as a bit of a shell game with several exhibits during questioning of the witness.

And I want to note for the record that you're not letting the witness completely review exhibits and it is only occasionally through her sharp eye and quick reading that sometimes the presumption and representation in the

question, it revealed to be belied and undermined by the words in the document itself.

For example -- and particularly with respect to Exhibit 39 -- there's a presumption or there was a presumption in several questions that residents were not advised to being moved, that families were not advised they were going to be moved and there were notes in the record that showed the complete opposite.

I also -- and the same goes for the CMS exhibits, which there was a presumption that CMS exhibits had been produced to the nursing home. And in fact, it was revealed that they were not sent to the nursing, that they were sent to the surveyors.

And finally I object and will object tomorrow to the method of continuing to ask the witness questions about an exhibit after you had taken it down from the screen. And, so you're

asking her questions for the documents that are not before her.

And I want the record to reflect that at any given moment during the questioning, when an exhibit is on the screen, the witness and I only can see about 15 to 20 lines of the exhibit and that's all that's visible to us at the time.

And so, it may lend itself to the appearance that the witness has the entire exhibit before her when, in fact, it is not because she can't flip around, back and forth to assist in the answering.

That's my statement and my objection.

MR. ZADEK: Your statement and objection is noted for the record.

Just for clarity and it should be noted, for instance, when you referenced that documents which your client was shown had not been seen by her, she had no difficulty indicated on

the record that she had not seen.

For instance, I think you gave the example of a CMS guidance or multiple guidances, she had no difficulty articulating that she had not seen those documents before.

She certainly had -- she had no difficulty explaining what she had seen or what she hadn't seen, what she was familiar with, what she wasn't familiar with.

As far as the issue of exhibits being displayed and removed from the screen out of her view, it should be noted and it's indicated in the record that many of the documents which she was shown, were shown repeatedly to her.

Many of the exhibits were brought up, removed, there was a discussion. Depending on the line of questions or your client's comments, the exhibit was returned to the screen for her to look at.

As far as the issue of the ability to view the entire document or read the document in its entirety, we are somewhat constrained by the virtual world we live in now. But the record should be clear and I think I made it clear that portions of a document, which your client was questioned on, were specifically highlighted to assist her and direct her into what -- to the areas in which she was being questioned.

So, your comments, your objections are noted for the record. It's almost -- it is just past 5:15. I think --

THE WITNESS: Can I just comment on what he said?

MR. ZADEK: I think you ought not to. There's no question before you, Ms. Doyle.

THE WITNESS: Okay.

MR. YAFFE: Ms. Doyle, do you have a comment that you wanted to make?

THE WITNESS: I do.

MR. YAFFE: Can you please make the comment.

MR. ZADEK: No, this is not -- we are not making comments during this examination. There's no question before the witness. I believe we're resuming at 10:00 a.m. tomorrow. This concludes today's testimony, have a pleasant evening.

MR. YAFFE: Well, I had a question for the witness. I'm not aware that I'm precluded and the witness is precluded from clarifying something that she expressed a desire to clarify.

But if you want to shut that down, Counselor, you do so at your own entitlement.

MR. ZADEK: You're not -- you're not to question the witness, Counsel. And if she needs to clarify a matter or a question that is presented to her, she will and she has clarified her

answers without difficultly.

So, we will resume tomorrow at 10:00. Have a good evening.

MR. YAFFE: She just indicated that she wanted to clarify something about --

MR. ZADEK: No, she indicated --

MR. YAFFE: Something about the exhibits.

MR. ZADEK: She indicated that she wanted to make a comment and this is not the forum for commentary. If she need to clarify an answer to a question, she can do that. That's not what she stated on the record.

MR. YAFFE: Her use of the word "comment" is a layperson term and I reject the notion that she has to be held to that fact, that she used the word "comment." It sounded to me like the witness wanted to clarify something.

Q. Ms. Doyle, do you wish to clarify an answer that you gave to a question that

was posed to you during today's examination?

A. No, I wanted to say that not seeing the whole document put me at a disadvantage.

MR. ZADEK: That opportunity to clarify an answer would warrant your testimony.

Beyond that, we'll result at 10:00.

MR. YAFFE: I believe her statement colored her answers to your questions and we can just leave it at that and agree to disagree about that. But it certainly colored her answers throughout the day.

MR. ZADEK: Well said, see you tomorrow at 10:00.

MR. YAFFE: Okay.

THE WITNESS: Good night.

(TIME NOTED: 5:18 P.M.)

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CERTIFICATION

I, NICOLE LEBOVIC, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 26th day of January 2020.

NICOLE LEBOVIC

NEW YORK STATE: ATTORNEY GENERAL'S OFFICE

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In the Matter of

FULTON COMMONS CARE CENTER, INC.; an Investigation by the New York State Attorney General, made pursuant to the New York State Executive Law, et seq.

VOL. II

----------X

63(12) Continued Examination Under Oath of CATHIE DOYLE, taken via WebEx video conference, held on January 27, 2021, commencing at 10:06 a.m.

Reported by

Stefanie Krut

A P P E A R A N C E S:

NEW YORK STATE ATTORNEY GENERAL'S OFFICE
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
BY: PRABHJOT SEKHON,Special Assistant Attorney General
PETER ZADEK, Special Assistant Attorney General
BENJAMIN SMITH, Special Assistant Attorney General
JANE ZWERN-TURKIN,
Regional Director

ALSO PRESENT

Elysia Doherty - Department of Health and Human Services
Robert Joyce - Investigator, NYS Attorney General
Barbara Picone - Auditor Investigator, NYS Attorney General
Anne Liptak - Paralegal, NYS Attorney General

C. Doyle

(Advisory dated 3/25/20 was deem marked as Exhibit 68, document as Exhibit 69; E-mail with attachment dated 5/2/20 as Exhibit 70.)

C A T H Y D O Y L E, having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

EXAMINATION BY

MS. SEKHON:

Q. Good morning, Ms. Doyle.

A. Good morning.

Q. My name is Prabhjot Sekhon. I am an Assistant Attorney General at the New York State Attorney General's Office, and we did meet yesterday. I am going to ask my colleagues to introduce themselves one by one and then mute themselves and turn off their videos so we can conserve bandwidth.

MR. ZADEK: Peter Zadek, Special Assistant Attorney General.

Good morning.

THE WITNESS: Good morning. How are you today.

C. Doyle

MR. SMITH: My name is Ben Smith I am a Special Assistant Attorney General with the New York State Attorney General's Office based out of New York City, and good morning, again. Thank you.

THE WITNESS: Good morning.

MR. JOYCE: Good morning, Ms. Doyle. Bob Joyce, Medicaid Fraud Control Unit, Hauppauge office.

THE WITNESS: Good morning, Bob.

MS. ZWERN-TURKIN: I'm Jane Zwern Turkin, I am the -- from the Hauppauge office.

THE WITNESS: I couldn't hear either one of them, I'm sorry.

MR. YAFFE: Neither could I. They were speaking at the same time.

MS. ZWERN-TURKIN: I'm Jane Zwern Turkin and I am the Regional Director of the Medicaid Fraud Control Unit Hauppauge office.

MS. LIPTAK: And my name is Anne Liptak, paralegal.

C. Doyle

THE WITNESS: Good morning, Anne.

MS. CONWAY: Good morning. This is Mary Conway, Medical Analyst from the New York State Attorney General's Office.

THE WITNESS: Good morning, Mary.

MS. CONWAY: Good morning.

MS. PICONE: Barbara Picone, the Medicaid Fraud Auditor Investigator.

THE WITNESS: Good morning, Barbara.

MS. DOHERTY: Good morning, this is Elysia Doherty, I am a Special Agent with the Department of Health and Human Services.

Good morning.

THE WITNESS: Good morning, Elysia.

MS. SEKHON: Okay, and counsel, would you please put your appearance on the record.

MR. YAFFE: Yes. My name is David Yaffe from the firm of Hamburger, Maxson, Yaffe and McNally, and we

C. Doyle

represent the witness and Fulton Commons Square Center.

MS. SEKHON: Thank you.

Q. And Ms. Doyle, this is a continuation of an examination that began yesterday morning, and you are still here pursuant to the subpoena that was shown to you as Exhibit 1 yesterday. Do you acknowledge that you are here pursuant to that subpoena?

A. I do.

Q. Mr. Zadek gave you a number of instructions yesterday morning before we began. Would you like me to repeat those instructions before we beginning our instructions today?

A. That's not necessary.

MR. YAFFE: Is Mr. Zadek not doing the questions today?

MS. SEKHON: I am going to be beginning the questions today.

MR. YAFFE: All right. I don't understand why Mr. Zadek is not continuing, but.

C. Doyle

MS. SEKHON: Okay. But that's not something that we need to address, so there are multiple attorneys on this matter and I will be continuing the questioning at this time.

MR. YAFFE: Well, if we were in a court of law you would not be able to do this, but go on.

MS. SEKHON: Your concern is noted.

MR. YAFFE: Over my objection go on.

MS. SEKHON: Noted.

Q. Ms. Doyle, I will remind you that did take an oath a moment ago to tell the truth, the whole truth and nothing but the truth, and should you intentionally make any false statements during this proceeding, and by that I mean a statement that you do not believe to be true, you may be prosecuted for perjury.

I will also remind you again that Special Agent Elysia Doherty is present during this examination and she is a federal

agent with the Department of Health and Human Services. Should you knowingly and willfully make any materially false statement or representation during this proceeding, you are subject to prosecution pursuant to Section 1001 of Title 18 of the United States Code.

And Ms. Doyle, just for clarification, Mr. Yaffe did indicate that he is your attorney. Do you still wish to proceed with Mr. Yaffe today?

A. Yes.

Q. Okay. Between close of examination yesterday or our session yesterday and this morning, other than Mr. Yaffe, have you spoken to anyone in preparation for your continued experience appearance here today?

A. No.

Q. Have you spoken to anyone other than Mr. Yaffe regarding the substance of your examination yesterday?

A. No.

Q. Have you reviewed any documents

in preparation for your continued testimony this morning?

A. No.

Q. Now, just a couple of things I would like to clarify. Yesterday you had mentioned that prior to your appearance yesterday morning that you had spoken to Carol Frawley, Kristen Hersher, Larisa Ronayne, and Michael Andrews, and that they had expressed concerns to you that they might be going to jail.

MR. YAFFE: That was not her testimony.

A. I don't believe that's what I said.

MR. YAFFE: That is a misrepresentation of her testimony.

Q. Actually, her exact testimony was that they were afraid they might go to jail verbatim.

So Ms. Doyle, did they express to you why they were concerned why they might go to jail?

A. Well, Larisa is the one who was

most distraught quite frankly. She is from Russia and has a healthy fear of all offices that oversee rules and regulations, including the police. She comes from a different culture and she was traumatized by the events of being questioned and insinuations that she was being dishonest.

Q. Was she the only individual who expressed to you that she was concerned she might be going to jail?

A. Yes.

Q. Did she express to you whether she was dishonest during her testimony?

A. No, we didn't discuss her testimony.

Q. Now, as the administrator for Fulton Commons, you had said that you are technically on call 24 hours a day and, I believe, seven days a week; is that right?

A. That is correct.

Q. And how can you be contacted after hours, and by that I mean when you are not in the office?

A. Either my home phone or my cell

phone.

Q. Does Fulton Commons or anyone else related to your employer pay for your home phone or your cell phone?

A. No.

Q. Do you have access to your e-mails when you are not in the office?

A. I do.

Q. In what way?

A. On my iPad and my phone.

Q. Is that an iPad that was provided to you by Fulton Commons or by your employer?

A. No.

Q. Were you compensated for that iPad by either Fulton Commons or anyone else related to your employer?

A. No.

Q. Is your iPad the only way that you can access your e-mails when you are not in the office?

A. My iPad and my phone.

Q. Okay, so your iPad or your phone?

A. Correct.

C. Doyle

Q. Are the those the only two ways you can access your e-mails when you are not in the office?

A. The only two ways I know how. If there are others, I don't know.

Q. And is your phone an iPhone?

A. It is.

Q. You also referenced a few times during yesterday's testimony QAPI?

A. Yes.

Q. And could you tell us just tell us again what that stands for?

A. Sure. It's Quality Assessment Performance Improvement.

Q. And that's a committee, correct?

A. That's correct.

Q. And who sits on that committee?

A. I do, Dr. Buchma, Carol Frawley, and whatever other department head the material we are discussing may apply to.

The entire committee is all the department heads, the resident counsel president, myself and Dr. Buchma, so when we have full meetings they're all present. If

we have an ad hoc meeting that applies to a specific topic, then we involve the people that that topic relates to.

Q. Is Steven Weiss a part of the QAPI committee?

A. No.

Q. Are any of the owners part of the QAPI committee?

A. No.

Q. Are there scheduled meetings for the QAPI committee?

A. Yes. Well, pre pandemic.

Q. Okay, pre pandemic, how often were those meetings held?

A. The in-person quarterly, but all reports were still -- the reports are done monthly and reported to me, and the committee actually physically meets quarterly, pre pandemic.

Q. And during the pandemic, how did that change?

A. The meetings in person have been suspended and remain suspended, but the reports are still -- the audits and

monitoring is still done, and the reports are submitted to me monthly.

Q. Does the committee meet in any other way other than in person?

A. No.

Q. Have there been any virtual meetings since the pandemic started?

A. No.

Q. Have there been any tele conferences since the pandemic started?

A. No.

Q. I believe you mentioned this yesterday, but who is the medical director at Fulton Commons?

A. Olaf Buchma.

Q. And how long has he been the medical director?

A. Under my administration, I believe he was here before and left and under my administration I brought him back, so maybe four years at this point.

Q. What are the qualifications for a medical director?

A. I don't know the specific

requirements. It's in the code, I believe.

Q. What are the duties and responsibilities of a medical director, generally?

A. Generally, they oversee the medical policies and procedures, they help with the nursing policy and procedures when requested, they -- medical director holds a medical staff meetings as necessary, he communicates with the doctors on changes in policy and issues that arise, oversees -- does chart audits and reviews to ensure quality care. He sits on the pharmacy committee and he is involved in the ethics committee meetings, as necessary.

Q. Is he involved in providing direct patient care?

A. Not in his role as medical director, but he is the attending physician on one unit in the facility.

Q. What unit is that?

A. He is on Unit 3 East.

Q. How many attending physicians are there at Fulton Commons?

A. Currently or pre pandemic?

Q. Pre pandemic.

A. Pre pandemic there were -- well, there is a partner of two, I am going to count them as one, so six total.

Q. And currently, how many are there?

A. Again, there is a partner of two, I will count them as one. Four. Four, I believe. Yeah.

Q. And why did that change?

A. Because there were two units that were shut down.

Q. So prior to the pandemic, pre pandemic, who were the attending physicians?

A. Dr. Johnson and Currin. Dr. Kim, Dr. Hasan, Dr. Buchma, Dr. Rahadke, Dr. -- oh, what the heck was his name. He's been gone a while. I can't recall his name at the moment. I'm sorry.

Q. Okay. If his name comes to you please let me know.

A. Okay.

Q. Currently, who are the attending

physicians?

A. Drs. Johnson and Currin, Dr. Hasan, Dr. Kim, Dr. Buchma, Dr. Rahadke.

Q. All right, and when did it change from the six total to four?

A. I don't recall when the units were closed.

Q. Okay, but it correlated when the units were closed, when the unit was closed then you got rid of a doctor, essentially?

A. Well, I didn't get rid of them, they were put on pause until the units could reopen.

Q. Got it. What are the duties and responsibilities of the attending physicians?

A. They are responsible for directly overseeing the care of the residents on their units.

Q. And do the attending physicians, do they report to Dr. Buchma?

A. Yes.

Q. And who does Dr. Buchma report to?

A. Me.

Q. How often, and let's say between March 1st and June 1st of 2020, how often were the attending physicians physically present in Fulton Commons?

A. I can't answer that. It was different for each one.

Q. Okay. How many days a week did Fulton Commons have an attending physician actually in the facility?

A. Again, I can't answer that. Their schedules, they're consultants, they don't work set hours, you know, they're -- I'm sorry, they are independent contractors, not consultants, and they, you know, set their own schedules.

Q. Do they sign in and out in any way when they do come into the facility?

A. They do.

Q. And how do they sign in and out?

A. We have an electronic system called, oh, I'm sorry, my brain is not working properly today. I forget the name of the system but it's an electronic system

when you come into the facility you log in.

Q. And do they log in and also log out?

A. Yes, I believe they do.

Q. So it would be fair to say then the system would actually reflect the number of hours that they were in the facility?

A. If they signed in and out, yes.

Q. Are they supposed to sign in and out?

A. Well, during the pandemic I can tell you that we took the iPads that they use to sign in to use for residents' Facetime calls, so there was a period of time during the pandemic they were not signing in and out.

We thought it more important to have the residents be in contact with their families than people signing in and out of the facility.

Q. And iPads weren't replaced by any sort of paper system?

A. No, I don't believe so.

Q. How long were those iPads being

used for patient communication as opposed to signing in and out for the doctors?

A. I would estimate approximately three or four months.

Q. Other than the doctors that you mentioned, are there any physician assistants who also work at Fulton Commons?

A. No.

Q. Did any of the doctors, the attendings physicians treat the patients via tele health?

A. Not as their sole method of caring for the residents, no. There may have been additional, I don't think it was tele health, I think they were, you know, communicating via phone with the nursing staff, but no.

Q. Who was the MDS coordinator at Fulton Commons?

A. Larisa Ronayne.

Q. What is her role?

A. She is the MDS coordinator of the facility. She is responsible for coordinating all the of the documentation

submission of the MDS books.

Q. What are MDS books?

A. Minimum data set books.

Q. And what is that exactly, what does that mean?

A. They capture the clinical care of the residents and they're utilized to determine the payments, the rate of pay for the facility, among other things. They're used for many other things other than rate of pay, but primarily that's what they're used for.

Q. And is that used for Medicare, Medicaid or both?

A. That is used for Medicare.

Q. Is part of Larisa's role to ensure that Fulton Commons gets back the maximum reimbursement for the care that it provides to a resident?

A. Her job is to make sure we receive the appropriate reimbursement for the facility. I take offense to the word "maximum."

Q. Okay. How does Ms. Ronayne

ensure that you are getting back the appropriate amount of reimbursements?

A. She reviews the medical records, she ensures that the information is submitted, captured and submitted in the MDS is accurate.

Q. How does she ensure the information is accurate?

A. Interviews with the staff, interviews with the residents when necessary, and reviews of the documentation in the clinical record.

Q. Is Ms. Ronayne permitted to diagnosis conditions?

A. I'm sorry, is who?

Q. Is Ms. Ronayne permitted to diagnosis medical conditions of residents?

A. No, the doctors are responsible for that.

Q. Okay, and Ms. Ronayne is not a physician; is that correct?

A. She is not.

Q. Does she hold a professional title?

A. She is a registered nurse.

Q. Should Ms. Ronayne ever tell a doctor what a diagnosis should be?

A. She could review a medical record and indicate to the physician that there is a diagnosis in the medical record that is there that is perhaps not in our documentation, and then the physician would review and agree or disagree that that diagnosis is still valid.

Q. Would it ever be appropriate for Ms. Ronayne to suggest to a physician that they change a diagnosis?

MR. YAFFE: Objection.

Q. You can answer.

A. Yes, it would be appropriate if she noticed that there was an error in the medical record or the doctor documented something incorrectly, by all means in her reviews she would have -- she would correct it, have the doctor correct it. For sure. We want them to be accurate.

Q. If she believes there is an error in the actual record, correct?

A. Or she identifies a diagnosis in the medical record that was not picked up by the physician or the admitting nurse.

Q. Would it ever be appropriate for Ms. Ronayne to suggest to a physician that they change a diagnosis to one for which the rate of pay would be higher for Fulton Commons?

A. Only if it was an accurate diagnosis.

Q. And would that be Ms. Ronayne's position as an RN to suggest to a doctor that she knows better an accurate diagnosis than he does?

MR. YAFFE: Objection.

A. Again, I take offense to your wording, counselor. Her job is to point out to the attending physician the accurate diagnoses in the medical record from the hospital.

Q. Okay.

A. If it happens to result in a higher rate of pay or a lower rate of pay speed it's a moot point.

C. Doyle

Q. Okay, so let me just make sure I understand then. If she sees something in the documentation that is different from what she sees a physician writing, then it would be appropriate for her to bring that to a physician's attention; is that correct?

A. Correct.

Q. If she does not see anything in the medical records from the hospital, would it be appropriate for her of her own volition go to a physician and tell them or suggest to them a different diagnosis than what the physician has documented?

MR. YAFFE: Objection.

Q. You can answer.

A. Yes, in certain circumstances the answer to that is yes.

Q. Under what circumstances, please.

A. For example, a resident may be on a psychiatric medication that has no diagnosis for the hospital. In that instance, Ms. Ronayne will tell the doctor that they are on a psychiatric medication but there is no corresponding diagnosis for

it, in which case you can't have a medication without a diagnosis, so when they come from the hospital and don't have complete diagnoses, then Ms. Ronayne would point out to the doctor that there is a medication, for example, that has no corresponding diagnosis, so yes, that would be entirely appropriate.

Q. Okay. In that situation would Ms. Ronayne be suggesting a specific diagnosis to the physician or would she be asking them for a diagnosis to explain the medication?

MR. YAFFE: Objection.

Q. You can answer.

A. I can't speak to that. I don't know.

Q. Would it be appropriate for Ms. Ronayne to suggest a diagnosis when she does not see one simply because a resident is receiving a certain medication?

A. Yes. She is a registered nurse with, you know, a dozen years experience and certainly understands what medications apply

to diagnoses, so I would say yes.

Q. Okay. So it is your belief and understanding that she can suggest to a doctor what a diagnosis should be for a resident if she sees that resident is on a particular medication?

A. And other reasons as well, I'm sure, yes.

Q. Okay. I would like to show you what's been pre marked Exhibit 57.

A. Okay.

Q. Ms. Doyle, do you see a document presenting on your screen currently?

A. I do.

Q. And I am just going to ask that we scroll down slowly so that you can scan the document.

A. Uh-huh.

MR. YAFFE: I just note for the record that this scrolling is too fast for me to read. I don't know if it's too fast for the witness to read, but it's impossible given the rate of the scroll to competently read this.

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MS. SEKHON: I am not asking her to read it, I am asking her to just quickly scan it. We will read it together.

A. I would like to read the documents that you put before me, please. It's very difficult for me to scroll and see parts of it.

Q. We will. We will them together. My question to you only at this point is whether this appears to be an e-mail chain?

A. Yes.

Q. So if we can go to the bottom of the first page. It's a two-page document.

A. Again, I would like to start at the beginning of the chain, please.

Q. We are, that's why we are starting at the bottom. Thank you. If we can go to the bottom of the page. Thank you?

A. That's the second page. I would like to read the entire document, please.

Q. We are, Ms. Doyle. Bear with me.

A. No, there's a second page. It's

in the middle.

Q. All right. Let's go ahead to the second page and let's see if that's starting in the middle of an e-mail.

A. Okay, so if we can scroll up slowly so I can read the document, it would be appreciated.

Q. Yes, that is what we are doing. Let's stop here at the top of the second page. Does this seem to be in the middle of an e-mail, correct?

A. Yes.

MS. SEKHON: So let's go up to the bottom of the first page.

MR. YAFFE: Stop.

MS. SEKHON: And we can stop right here.

MR. YAFFE: Go down a little.

MS. SEKHON: Counsel, I will direct the record. Thank you.

MR. YAFFE: But you are doing it in a way like your colleague did yesterday where you are only showing a portion of a particular e-mail or a

portion of a particular documents and frankly, it's not appropriate to do that with the witness when you are asking the witness questions about an e-mail communication.

MS. SEKHON: Counsel, you are assuming that you know what my question is going to be and where I am going with this. I am going to remind you what your role is here and your role is to object if there is a privilege asserted.

Q. Ms. Doyle, I am going to ask you to read this whole e-mail, so we can start at the bottom of page one where it says on April 9th, 2020 at 9:42 a.m. Does that indicate who wrote this e-mail?

A. I can't tell from this that that's where it starts.

Q. You can't tell that this is where the e-mail starts?

A. No, because there's more on the second page that I cannot see at this time.

Q. We just looked at the second page

together, Ms. Doyle, and you indicated that that second page looked like it was in the middle of an e-mail.

A. Yes, but I would like to ensure that it's a continuation of that e-mail.

It's very difficult to testify when I can't say the whole paper. If we were in person you would hand me the document. I can't see this whole thing, and yesterday I was asked to testify about things that were pieces of a documents, which is not really fair to me.

Q. Okay. Let's zoom out.

A. So we have the capability of doing this all day yesterday when I asked and nobody did this.

Q. Ms. Doyle, you never asked for this.

A. I asked multiple times to be able to see the entire document, so now all of a sudden we have the capability for me to see more. Okay, noted. Thank you.

Q. Does this address your concern?

A. It does, thank you. It would

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have yesterday, too.

Q. If you had brought it up yesterday, Ms. Doyle, we would have been happy to accommodate you.

A. Were you on the same call I was on, ma'am, because multiple times myself and my attorney asked to see the entire documents, multiple times. Now all of a sudden today magically I can see it.

MS. SEKHON: Let's zoom in, please.

A. Now why do we have to zoom in, I can see it perfectly fine the way it was.

Q. Okay, you are able to read all of it this?

A. I certainly am.

Q. Please.

A. You want me to read it?

Q. Yes, I would like you to read the e-mail into the record.

A. Okay, great. It says, "Good morning. Thanks for the advice about moving residents off 1 East to other units. I am suspending that as of today. I will fill

the last two open COVID beds and then suspend admission to Monday to see where we stand then. I know there's been some tension between you and Larisa, please try and do as she asked because with 34 empty beds, tons of overtime and all of the other COVID expenses, we are losing money by the day. She knows what she is doing to make sure we get paid the maximum amount and by code. Pretty please, Dr. B., I really need your help and cooperation."

Q. That was an e-mail that you sent, correct?

A. That's correct.

Q. Who did you send that to?

A. Dr. Buchma.

Q. With respect to the first line or the first two lines, rather, "thanks for the advice about moving residents off 1 East to the other units, I am suspending that as of today," could you please explain that?

A. I don't recall the specifics on what that applied to.

Q. What's the date of this e-mail?

A. April 9th, 2020.

Q. Do you recall Dr. Buchma recommending to you that residents be moved off of 1 East onto other units in early April late March?

A. I don't recall the timing of things and I don't remember who specifically recommended what.

Q. Is there a reason why you suspended moving residents off of 1 East on April 9th?

A. I am going to guess it was that at Dr. Buchma's advice being that that's what my e-mail says.

Q. So you believe that his advice was to stop moving residents off the units?

A. Well, it says, "thanks for the advice of moving residents off 1 East to other units" so I'm assuming that's what it means.

Q. Now at this point on April 9th, 2020, please just clarify for me, was 1 East a COVID unit or was it an admissions unit?

A. There was no specific COVID unit

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until May 1st, 2020.

Q. Okay, so what was unit 1 East on April 9th, 2020?

A. Again, it was a unit that we were admitting residents to.

Q. Was it the only unit that you were admitting residents to at that time?

A. No, as I stated yesterday.

Q. So you had referred to 1 East at several points throughout your testimony yesterday as an admissions unit, so what does that mean?

A. It means we were admitting new residents to that unit. There were no long-term residents on that unit.

Q. Was every unit an admissions unit in April of 2020?

A. Depended if there were available beds or not.

Q. Okay, so Ms. Doyle, you had talked about guidance that you received in the end of March 2020 from DOH and CMS, and you said that after that guidance that you had established 1 East as a designated unit,

so what does that mean?

A. I did not say the end of March I said the end of April. April 29th to be exact and that's when the unit was created, May 1st.

Q. Are you saying at this point, is your testimony now that you took no specific steps to designate 1 East as any sort of unit at the end of March and early April of 2020?

A. I'm telling you the same thing I testified yesterday throughout the entire day that there was no specific unit designated as a COVID unit until May 1st after we received guidance from the Department of Health on April 29th.

Q. I am not asking about a COVID unit right now, ma'am, what I'm asking you is if you took any steps to designated 1 East as any sort of particular unit at the end of March, early April 2020?

A. All of the units were designated as unit accepting residents, COVID or not.

Q. So what was special about 1 East

because you, yourself said yesterday that at the end of March and early April, 1 East was turned into an admissions unit, so what was the difference between that unit and the rest?

A. 1 East has been the admissions unit since I stepped foot into Fulton Commons when I created it as the sub acute admissions unit.

When a resident was coming for a short-term they went to 1 East. If they were coming for longer care, typically pre pandemic they went to other units.

There was nothing different when the pandemic struck about what 1 East was or was not.

Q. So it is your testimony now that up until the May 1st there were no special actions taken with respect to 1 East?

A. The same actions that were taken on the other units, they were given in-service, proper PPE and instructions on how to care for the residents properly.

Q. Going to the third line of that

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e-mail that you sent, "I will fill the last two open COVID beds and then to suspend admission until Monday to see where we stand then." Where were those two COVID beds located?

A. I don't recall.

Q. Did you have COVID beds throughout the facility in April of 2020?

A. Yes.

Q. Were there COVID beds on every unit or were there COVID beds on certain units?

A. I don't know that we had COVID residents on every units. As a resident testified positive then there was a COVID resident on that unit.

Q. Was an effort made to empty unit 1 East at the end of March and early April, 2020?

A. I don't recall the timing of when we were -- I don't recall. I'm sorry.

Q. Okay. Going to the second paragraph here where you write, "I know there has been some tension between you and

Larisa. Please try and do as she asks because with 34 empty beds, tons of overtime and all the other COVID expenses, we are losing money by the day." What are you referring to in that section?

A. I'm referring to that as the MDS coordinator, she was noting things in the medical record that he missed that she was pointing out to him and he can be a very stubborn man, if you will, and I was asking him to please listen to her.

Q. Okay, so let's scroll up just a little bit. That's fine. At the top of what we're looking at right now, do we see a response from Dr. Buchma to you?

A. I do.

Q. And what date and time was that response sent to you?

A. April 9th at 9:46 a.m.

Q. Could you please read his response into the record?

A. Sure. "Sounds good, no tension. I can give the best honest diagnosis I can, but change as more info is available. Just

that she cornered me at six a.m. in the lot. I said right now Resident #74 has UTI sepsis. She said how about acute bronchitis instead. I'm aggressive in assisting MDS everywhere so long as I am not writing fiction."

Q. Does that say sent from my iPhone?

A. Yes, it does.

Q. Okay, does that indicate that Dr. Buchma sent this e-mail back to you from his iPhone as opposed to from, say, an office computer?

A. I assume so, yes.

Q. UTI, that's a urinary tract infection, correct?

A. Correct.

Q. And acute bronchitis is a respiratory infection, correct?

A. Correct.

Q. So those are two completely separate different areas of the body; is that right?

A. Correct. He had both.

Q. He had both?

A. That's my understanding, yes.

Q. Okay, and what are you basing that understanding on?

A. Because I remember this resident well, he was one of my favorites.

Q. Why was it acute bronchitis instead of a UTI in sepsis?

A. She's indicating to please have him list the bronchitis as the primary diagnosis instead of the UTI.

Q. That's your recollection of this?

A. That's my understanding of how it's worded and what she would be requesting, yes.

Q. So just looking at the last line of that e-mail, "So long as I'm not writing fiction."

A. Yes.

Q. So would that indicate to you that Dr. Buchma did not believe that this resident had acute bronchitis?

MR. YAFFE: Objection.

A. Absolutely not.

Q. That does not indicate to you

that he didn't believe the resident had acute bronchitis?

A. No, and you see the first line it says, "I can change but as more info becomes available" that's what Larisa was giving him was more information.

Q. All right. Let's scroll up. Do you see a response that you then wrote to Dr. Buchma's e-mail?

A. I do.

Q. And what time and date was that?

A. April 9th at 9:47 a.m.

Q. And what did you write to Dr. Buchma?

A. I said, "How do we know he has a UTI?"

Q. And why were you questioning Dr. Buchma's diagnosis?

A. I often -- I am not questioning diagnosis, I often ask questions for my own interest.

Q. Why were you asking that question?

A. Because I was curious what

symptoms he was exhibiting that we knew it was a UTI. I frequently ask questions about diagnoses and symptoms for my own knowledge.

Q. So let's scroll up again. Did Dr. Buchma respond to your e-mail?

A. He did.

Q. And what day and time did he respond?

A. April 9th at 10:04 a.m.

Q. And what was his response?

A. "Status post catheter plus blood sediment clinical acumen."

Q. And just so that we can be clear, the e-mail itself says "SP" but that stands for "status post" correct?

A. Yes.

Q. And what does status post mean?

A. It means after.

Q. Okay, and by clinical acumen, what does that indicate to you?

A. I think it means his expertise.

Q. Okay, so Dr. Buchma is indicating to you that he believes the resident has a UTI based on specific symptoms that he is

seeing and his clinical expertise, correct?

A. Correct.

Q. Okay, and let's scroll up a little bit. Do you see a response that you then wrote?

A. I do.

Q. And what day and time was your response?

A. April 9th at 10:09.

Q. What did you write back to him?

A. "Okay, thanks. Larisa is the best MDS person I have ever worked with so if you can play nicer in the sandbox, it would be appreciated."

Q. What did you mean play nicer in the sandbox?

A. I mean not be nasty to her.

Q. Is it your understanding that he was nasty to her?

A. That's correct, that's what started this e-mail chain.

Q. So tell me what you know about that interaction in which he was nasty to her.

A. I don't recall the specifics. I remember Larisa coming to my office saying that he was rude to her in the morning.

Q. Did she explain to you what she was talking to him about that morning?

A. I don't recall, I'm sorry.

Q. Okay. Let's scroll up a little bit. Did Dr. Buchma respond to your e-mail?

A. He did.

Q. What did he say?

A. "I support you and Larisa a 100 percent. Want to not be quarantined three to five years, though."

Q. Do you know what he means when he says "Want to not be quarantined three to five years, though?

MR. YAFFE: Objection.

Q. You can answer.

A. I don't even recall seeing that. No, I don't know what he was referring to. I assume he was referring to not wanting to do anything dishonest.

MR. YAFFE: I think she was saying in the middle of her answer I

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said don't speculate.

Q. Let's scroll up. Did you respond to Dr. Buchma's e-mail that he didn't want to be quarantined for three to five years?

A. I did.

Q. And what was your response?

A. "Thank you and me either."

Q. Do you recall now seeing his response where he said he didn't want to be quarantined for three to five years?

A. No, I don't.

Q. So at this point you still don't recall seeing that response despite seeing that you, in turn, did respond to him?

A. No, I don't recall the specifics of this e-mail chain.

Q. Okay. Reading this e-mail chain does it seem to you that Larisa asked Dr. Buchma to do something dishonest?

MR. YAFFE: Objection.

A. Absolutely not.

Q. Would it have been appropriate for Ms. Ronayne to go and ask Dr. Buchma to change a diagnosis to something simply

because the reimbursement rate for a different diagnosis would have been higher?

A. She didn't ask him to change a diagnosis, she asked him to add a diagnosis of pneumonia which the resident legitimately had.

Q. Well, we didn't see pneumonia anywhere in this e-mail, correct. What we saw was UTI in sepsis or acute bronchitis. Those are the two different things.

A. I'm sorry, bronchitis, not pneumonia. You are correct. Thank you.

Q. Okay. What I am asking you, Ms. Doyle, is would it ever be appropriate for Ms. Ronayne to ask an attending physician to change a diagnosis to a different one simply because the other diagnosis has a higher rate of pay?

MR. YAFFE: Objection.

Q. You can answer.

A. That's her job, yes. Her job is to make sure that the documentation is appropriate. In some cases the reimbursements may go down, in some cases

the reimbursement may up. That is, in fact, her job.

Q. It is her job, so just to verify because my question was would it be appropriate for her to ask him to change it simply because a different diagnosis pays better?

A. Yes, the answer is yes, that's her job.

Q. Okay. Are you familiar with the initial CMI?

A. Yes, I am.

Q. What is CMI?

A. Case mix index.

Q. What does that refer to?

A. That is the method in which New York State determines the reimbursement rate for a facility for Medicaid residents.

Q. And what goes into a case mix index?

A. I don't know all the specifics that get captured for the case mix. I know that they take a snapshot of Medicaid residents on a particular day. They capture

the clinical acuity of those residents and it goes into a formula to determine the rate of pay for the next six months.

Q. Do you keep track of what Fulton's Commons CMI or case mix index is?

A. Not, not particularly, no.

Q. Were you ever asked by Steven Weiss for Fulton's CMI?

A. Yes.

Q. How frequently?

A. Probably three or four times a year, maybe. It depends on -- I really don't know, I'm sorry, I would be guessing.

Q. Are you familiar with the term patient driven payment model?

A. Yes.

Q. And what is a patient driven payment model?

A. That is what the federal government changed the payer source, the way we get paid for Medicare patients.

Q. So does that only relate to Medicare or does it also relate to Medicaid?

A. I'm not really sure. It may be

both.

MR. YAFFE: I'm sorry. Can we take a two-minute break?

MS. SEKHON: Yes, that's fine.

MR. YAFFE: Okay.

(A recess was taken.)

MR. YAFFE: Ms. Doyle, stop your video and mute yourself.

(A recess was taken.)

MS. SEKHON: So we can go back on the record, and if you can just let the record reflect that we just did a quick role call off the record and did ensure that all who were present when we began this examination are still present.

THE WITNESS: I would like to clarify a previous answer if I may before we move forward.

Q. Undoubtedly, go ahead, Ms. Doyle.

MR. YAFFE: Undoubtedly?

A. Yes. Your question involved would it be appropriate for Ms. Ronayne to have a doctor change a diagnosis if it resulted in an increase in reimbursement,

and my answer was yes that's her job. I would like to clarify, please, that I stated in previous statements that that is only if it is supported clinically and by documentation in the record.

Q. Okay, so when my question was would it be appropriate for her to do that solely if it results in a higher rate of reimbursement. Did you misunderstand that question?

A. I misunderstood that question and answered yes in instead of no.

Q. So would agree with them that it would not be appropriate for Ms. Ronayne to ask a physician for a diagnosis solely because it would pay more?

A. I would agree with you, yes, only if the clinical record and the documentation was in place to support it.

Q. And again, Ms. Ronayne is a registered nurse, correct?

A. She is.

Q. So legally she is not permitted to actually diagnosis residents, correct?

A. Correct.

Q. Thank you. Now, I believe we were talking about patient driven payment models prior to the break. So are you familiar with how PTPM, patient driven payment model works?

A. The basics, yes.

Q. Could you please tell us what you know about it?

A. I know that it is based on certain diagnoses and medical conditions that get captured in different categories and get all added together to determine the rate of pay.

Q. Would Fulton Commons receive a higher rate of pay for a residents if they were in isolation?

A. I don't know.

Q. Do you know if there were any specific requirements in order for a resident to be considered in isolation?

A. I don't know the specifics. For capture, for MDS purposes, I don't know.

Q. Did Fulton Commons receive a

higher rate of pay for its COVID residents?

A. I can't answer that because perhaps some of them. I don't know.

Q. Who would know the answer to that question?

A. I guess Ms. Ronayne.

Q. If Ms. Ronayne did not know the answer to that question, who else would know?

A. I don't know that anybody could answer that without analyzing all of the MDSs submitted for a month, for example, to see if you had COVID and your rate was higher than Mr. Yaffe's who didn't have COVID. There are so many different categories that go into determining the rate of pay. There could be some that were higher than the COVID rate and some that were lower and some that were the same. I don't know.

Q. As the MDS coordinator, would it be Ms. Ronayne's job to know which codes result in a higher reimbursement rate for the facility?

A. Again, I take offense to you indicating a higher rate for a code. She is responsible for putting the appropriate codes into and for the MDSs.

Q. I understand that that's her job. Her job is to put in the appropriate codes. My question is, is she responsible for also being aware of and knowing which codes pay more and which ones pay less?

A. She's responsible to know all the codes.

Q. So she should know what all codes are and what all the codes pay; is that correct?

A. If she doesn't know them, she is responsible for looking they up and inputting them in correctly based on the clinical records and the documentation in the chart.

Q. Now, we talked a lot yesterday regarding infection prevention and control. In your own words, Ms. Doyle, what is infection prevention control?

A. They are standards practices put

in place to prevent the spread of infection.

Q. And why is that important in a nursing home setting?

A. To safeguard the residents and the staff.

Q. Now, as the administrator, what is your role as the infection prevention and control?

A. I'm responsible to make sure the policies are appropriate and followed as written.

Q. Now, we did discuss yesterday that you personally do not have a medical background; is that right?

A. That's correct.

Q. And as someone who did not have a medical background and does not have a medical background, do you rely on others for their knowledge and expertise when it comes to determining proper infection control procedures and policies?

A. Yes.

Q. Who do you rely upon?

A. I rely upon the medical director,

the director of nursing, the infection control practitioner, the CDC, CMS, the New York State Department of Health, New York State Department of Epidemiology Department. A host of experts.

Q. And do you rely on others when considering and drawing up any policies that would implicate patient or residents' safety?

A. I'm sorry, I didn't understand your question.

Q. Sure. I will rephrase. As someone who has no medical background, do you rely on others within the Fulton Commons employees when coming up with policies and procedures that would have a bearing on residents' safety?

A. Yes. Inside and outside the facility experts.

Q. And are all those the same experts that you just listed for us?

A. Yes.

Q. Between March 1st 2016. Sorry --

A. Can I just ask a question. Could

we take this exhibit off. I have to keep my glasses on to see you.

Q. Oh, yes, my apologies. Please.

A. I don't have to wear my glasses if we're larger. Thank you. It's just hard for me to wear my glasses all the time.

Q. And please if I forget to do that let me know. My layout is different on my screen so I can still see you.

A. When we have it up here in a tiny little box in the top and I need my glasses on.

Q. Yes, I will try to be more mindful of that, I apologize.

A. Thank you.

Q. Between January 1st 2020 and June 1st, 2020 who was the infection preventionist, if anyone, at Fulton Commons?

A. It was Marie Jean-Baptist, RN, assistant director of nursing. Although I'm not sure she was there all the way through June 1st.

Q. Okay. Did there come a time when Ms. Jean-Baptiste left?

A. Yes.

Q. Under what circumstances?

A. I terminated her.

Q. Why did you terminate her?

A. Because her paperwork was sloppy.

Q. What paperwork was sloppy?

A. All of it. Any report that she wrote for me, her line listing, anything she was responsible for was just not up to my standards.

Q. You said she was also the assistant director of nursing?

A. She was.

Q. How many assistant directors of nursing did Fulton have between January 1st, 2020 and June 1st, 2020?

A. Two.

Q. And how were the duties and the responsibilities split up between the two of them?

A. The director of nursing decided who did what, but one was responsible for infection control, plus overseeing her units, and the other was responsible for a

multitude of things, including accident/incident reports and her units.

Q. So the units at Fulton were split up between the two assistant directors of nursing?

A. Correct.

Q. What are the qualifications for an infection preventionist?

A. They -- in my facility I don't believe there are any code regulations to be an infection control preventionist, but maybe for those initials you need to be.

In this facility they take the infection control classes and get certified in infection control prevention.

Q. Did Ms. Jean-Baptist meet those requirements?

A. She did.

Q. When did she become the infection preventionist at Fulton?

A. There was one prior to her. I don't remember the exact date. I'm sorry.

Q. And when she left, who took over for her?

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A. Janice Trnovski. Not as ADNS, strictly as full-time as the infection control preventionist.

Q. Was there a reason why you elected to have an individual strictly performing the infection control preventionist position?

A. Because we were in the middle of a global pandemic.

Q. And do you recall when Ms. Trnovski took over in that position?

A. I want to say early July, but again, that's a guess. I believe it was early July.

Q. So at that point --

A. Sorry.

Q. It's okay. So at that point did you feel it was important to have an individual focus solely on infection control and prevention?

A. I thought it was in the facility's best interest to have one person coordinating the entire program, yes.

Q. Did you consider implementing

that having a single person responsible for only infection control and prevention during March, April, and May, the earlier stages of the pandemic?

A. We considered it, but trying to find a registered nurse that would work in a nursing home during a global pandemic was near impossible. There were shortages across the country, across New York, across Long Island, so we reached out to our contacts and weren't able to find anybody that would be interested in taking that role at that time.

As a matter of fact, Ms. Trnovski worked in the facility at that time and worked was promoted into that role.

Q. Did you consider promoting someone into that role earlier than July 2020?

A. No.

Q. Why not?

A. Because I needed all hands-on deck to take care of my residents.

Q. What was Ms. Trnovski's role

prior to her promotion?

A. She was an RN supervisor.

Q. For what unit?

A. Three to eleven staff. Three to eleven shift, not a specific unit.

Q. As Ms. Trnovski was the infection preventionist at least in March, April and May, would you say of 2020?

A. I would need to check it.

Q. Did you have discussions with her regarding implementing infection prevention and control at Fulton in the midst of this pandemic?

A. Yes.

Q. How often did you speak to her?

A. Several times a day, sometimes. At least daily, sometimes several times a day.

Q. And did Ms. Jean-Baptist report directly to you?

A. No.

Q. Who did she report directly to?

A. Mrs. Frawley.

Q. Was Ms. Jean-Baptist the only

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individual working in infection prevention and control or were there others individuals within that department?

A. It's not a specific department, it's under the nursing department. The other ADNS was tracking the employee COVID tests, not the tests, the positives and who was out due to exposure, so one was tracking the employees, the other was dealing with the residents.

Q. Who would you say was responsible for ensuring that Fulton's policies and procedures regarding infection control were meeting industry standards from January 1st, 2020 through the end of May 2020?

MR. YAFFE: Objection.

Q. You can answer.

A. You mean from a day-to-day point of view or overall as administrator? Overall I am responsible that the policies be followed. During the pandemic, the infection control practitioner was responsible for inservicing and monitoring that PPE was being worn properly, and, you

know, that the policies were being followed.

Q. Was there anyone responsible for ensuring that Fulton's policies and procedures met industry standards and CMS and DOH guidelines?

A. Yes.

Q. Whose responsibility was that?

A. Mrs. Frawley.

Q. Did Ms. Frawley have any specialized training in infection prevention and control?

A. Thirty years as a DNS.

Q. Other than that, did she have any specialized training, individualized training in prevention infection and control?

A. Not that I'm aware of. You would have to ask her.

Q. When did Fulton first implement any policies and procedures related to COVID 19?

A. March 11th, I believe.

Q. And what policy was that, like what was the title?

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A. Well, I don't know that it was a specific policy, but there were things implemented as a result of the looming pandemic, for example, we stopped visitation or reduced visitation on March 10th. We stopped it entirely on the 11th. The protocol for the staff to remain on the units at all times was implemented that week. There were a bunch of things that we implemented during those early days that were either policies or protocols.

Q. When was Fulton's first written policy on COVID 19 put into effect?

A. I don't know.

Q. Let's take a look at what's been pre marked as Exhibit 58. Ms. Doyle, this is going to be a 19-page document. We can zoom out so you can see it page-by-page. We can quickly scan it and then we will go through them one page at a time.

MS. SEKHON: Can we zoom out a little bit, please.

A. Yeah, I'm familiar with this document. We don't need to scroll

C. Doyle

page-by-page on this one.

Q. Okay. So there are a few of them put together so let's just skip ahead then to, I believe to page six. It might be page four, actually, I apologize.

MR. YAFFE: Are you saying this exhibit is a composite of --

MS. SEKHON: It is.

MR. YAFFE: Okay, so --

MS. SEKHON: Various policies and procedures, and we will go through them one-by-one, but.

MR. YAFFE: So I am just stating that because the witness may have jumped the gun by saying she was familiar with this document, under a false assumption that it was a single document but rather it's a composite.

THE WITNESS: You are correct, David. Thank you.

Q. Yes, so skipping to page four, then we will continue scanning.

MS. SEKHON: So let the record reflect that we have just done a

cursory scan of approximately, almost every page in the 19 pages except for the first couple of pages that the witness indicated she was familiar with.

If we can just scroll up back to the top.

Q. So Ms. Doyle, looking at page one, you indicated that you are familiar with this policy; is that right?

A. I am.

Q. And what is the title of that policy?

A. Bio terrorism Pandemic Influenza/Virus.

Q. Is there a date on that policy?

A. 2/26/20.

Q. And does that appear to be initialed by someone?

A. Those are my initials.

Q. Is that the date that this policy was created or reviewed or something else?

A. That's the date it went through the QAPI Committee for review in response to

the COVID 19 pandemic.

Q. So is it fair to say then that this policy applied to COVID as well?

A. Yes, that's why it was reviewed.

Q. Okay. I would like to go down to the middle of the page. You can kind of see it where we are right now. Anyway, you will see in bold it says, "Monitoring residents for pandemic influence and instituting appropriate control measures."

A. Yes.

Q. Do you see where I am referring?

A. I do.

Q. Okay. In the first full paragraph, the last line reads, "Early detection of the presence of pandemic influenza in a facility is critical for ensuring timely implementation of infection control measures."

A. I'm sorry, I don't see where you are read that.

Q. Sure. So under that bold line there is the first full paragraph and the last sentence in that paragraph.

A. Okay, I'm with you now.

Q. I will read it again, and let me know if I am not reading it accurately. "Early detection in a facility is critical for ensuring timely implementation of infection control measures." Did that apply to COVID as well?

A. Yes.

Q. What were methods of early detection in a virus like COVID?

A. Monitoring them for -- monitoring their vital signs for fever, blood pressure, you know, normal monitoring. Well, listen, I don't know what other people did, I can tell you what I did here. We implemented taking vital signs on all three shifts.

Q. Okay. As we sit here today and understanding what we now about COVID has changed and evolved over the past year or so, but as we sit here today, can we agree that individuals can be infected with COVID and be completely asymptomatic?

A. Today, yes, but I don't believe that was the case in March, April, May.

C. Doyle

Q. Okay. But today we can agree that individuals can be completely asymptomatic but still have COVID, correct?

A. Yes, we know that today.

Q. And we know today that individuals who are asymptomatic can still spread COVID, correct?

A. We know that today, yes.

Q. And you said that you don't believe you knew that in March, April or May?

A. I don't believe anybody knew that in March, April and may.

Q. Okay. As we sit here today, what would be the best method of early detection for a virus like COVID that can be asymptomatic and still contagious?

A. For asymptomatic?

MR. YAFFE: Objection.

Q. Yes.

A. Today, it would be testing.

Q. Did Fulton take any attempts to procure any COVID 19 tests in February of 2020?

A. No, we were instructed by the Department of Health that testing was not to be done in the nursing homes, and that if somebody exhibited symptoms, they should be treated as if they were COVID positive, which is exactly what we did.

Q. Is it your understanding that the testing was not to be done or it was not necessary?

A. My interpretation was that it was not to be done because there were inadequate tests to do the thousands of people in the hospitals and nursing homes and assisted living facilities.

Q. So you are saying that was your interpretation. Do you remember receiving any sort of guidance that specifically directed you not to test?

A. Yes, we received guidance from the Department of Health that testing should not be done in the nursing home setting.

Q. When was that guidance given to you?

A. I don't recall the date.

Q. Okay. If we go to right where we were looking before just looking at the second bullet point.

So under the section monitoring residents, there is a second bullet point that says, "If symptoms of pandemic influenza are apparent, implement droplet precautions." So it says "Implement droplet precautions for the resident and roommate pending confirmation of pandemic influenza virus infection." Did I read that accurately?

A. Yes.

Q. And again, this applied to COVID, correct?

A. Correct.

Q. How would a facility obtain confirmation of infection for COVID?

A. We would not. We were not obtaining confirmation of COVID, we were presuming them positive based on their symptoms per the Department of Health guidance.

Q. Would you agree with me that the

only way to actually obtain confirmation of infection would be by having a positive test?

A. Yes.

Q. If we go to the next bullet point, it reads, "Cohort resident and staff on units with known or suspected cases of pandemic influenza."

Did Fulton, in March and April of 2020, cohort residents as known or suspected of having COVID?

A. I'm sorry, what was the question?

Q. Sure. Did Fulton in March and April of 2020 cohort residents and staff on units by known or suspected cases?

A. Well, if you go up the previous bullet, you will see that they should not be separated or moved out of their rooms unless medically necessary, so that bullet is prefaced by the earlier one, if you see what I am reading in the bullet above that.

Q. Yes, I do see that. So --

A. Yes.

Q. Can you explain, please explain

to me, if you would, how you would cohort residents if you're also not moving them out of their rooms?

A. We were not moving them out of their rooms in the beginning because the guidance from DOH, as well as our policy as you are reading right there was to not move them out of their rooms unless medically necessary, which by the way, was to stop the spread of the infection throughout the building. That however, was to the best of our ability of just taking care of their own residents, as I have said.

Q. So my question, Ms. Doyle, is the third bullet point does say cohort residents and staff on units, and I understand what you are saying is that that's not in line with the second bullet point, so my question for you is, doesn't this policy contradict each other, contradict itself?

A. No, it doesn't contradict, it reads in order, if you will. If it's medically safe to cohort them -- each disease process is different. For example,

if you have C.Diff, you are on isolation precautions, I can put you in with another C.Diff resident and not risk a third resident down the hallway.

Each disease process is different and needs to be handled differently.

Q. Yes, but this particular policy refers to COVID, right?

A. It refers to viruses and, I mean, if you go back to the top we can read the name of it again.

Q. Yes, I believe it said pandemic influenza.

A. Slash/virus.

Q. So it's your testimony that this was not a policy specific to COVID?

A. It was a policy reviewed in response to COVID to address the title of the policy. It doesn't say COVID anywhere in the policy.

Q. Agreed. So is it fair to say that if you are following the second bullet point and not moving residents out of their room it would be very difficult to follow

the third bullet point of cohorting residents?

A. Correct. It's an either or based on the situation. You see the next bullet says, "limit movement within the facility."

Q. As an example, cancel social and recreational activities, correct?

A. Correct or room changes, for example. Limiting movement within the facility would limit you from going from one room to the other.

The only time we did room changes is if it was medically necessary per the second bullet.

Q. Is there an indication between the second and third bullet point that it's an either or?

A. There is not.

Q. So for your staff members who are reading this, how would they know which part of this policy they should be following?

A. They don't read this policy, they are in-serviced in-person by my staff.

Q. So your staff aren't given

written policies?

A. Depends on the policy.

Q. Your staff were not given this particular written policy throughout the pandemic?

A. I don't recall if this one was given to them or not.

Q. Okay. Let's go to the second page, and you can stop where you are, so under the bullet point environmental cleaning and disinfection.

A. Uh-huh.

Q. It reads, "Cleaning and disinfection of environmental surfaces are important components in reaching infection control in healthcare facilities." Would you agree with that?

A. Yes.

Q. And if we go to the next bold bullet point it says, "Cleaning and disinfection after resident discharge or transfer" it read, "follow standard facility procedures for post-discharge cleaning of an isolation room." What did that entail, and

by that I mean standard facility procedures?

A. Well, I don't know the step by step procedures for cleaning a room. I'm sorry.

Q. Would those procedures need to be implemented before moving a new resident into a recently vacated room?

A. Yes.

Q. And should those procedures be implemented in the middle of room changes?

A. I don't understand your question the middle of a room change.

Q. Sure, and I will rephrase. So this heading specifically says after resident discharge or transfer. Does it also apply to if a resident's room is transferred?

A. Yes.

Q. So if we go to the third page and if we go towards the bottom of the page, okay, we see this is a chart and the third from the bottom indicates residents placement. Do you see where I'm looking?

A. I do.

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Q. And in the box next to it, it says, "Place residents with influenza in a private room or cohort with other residents with influenza."

A. Uh-huh.

Q. And again, did this apply to COVID?

A. No.

Q. So residents who had COVID were not being cohorted, correct?

A. Correct.

Q. The second paragraph further states, "During the early stages of a pandemic, infection with influenza should be laboratory confirmed if possible." Why is that part of this policy?

A. Because as we said earlier, the only way to confirm a positive test result, a positive diagnosis, is with a test.

Q. Would it have been helpful if Fulton had tested its resident in March and April of 2020 for COVID?

A. No.

MR. YAFFE: Objection.

C. Doyle

Q. It would not have been helpful for you if you knew which residents had COVID based on a test?

A. No.

Q. Why not?

A. If they exhibited symptoms they were all treated.

Q. Knowing what we know now and knowing that COVID had can be asymptomatic and contagious, do you think it could have saved lives if Fulton had tested residents for COVID in March and April of 2020?

A. No.

MR. YAFFE: Objection.

Q. So you don't think it would have had any impact at all on resident care if you had tested residents in March and April of 2020?

MR. YAFFE: Objection.

A. The only impact it would have had, it would have let family members know it was positive or negative and not presume is the only difference it would have made. Clinically, the treatment would not have

changed at all. And we wouldn't have tested asymptomatic residents, so if that was even a thing back in March, April we wouldn't have tested asymptomatic residents and it wouldn't have made a difference.

Q. So my question to you, Ms. Doyle, is whether, and I will rephrase. Knowing what we know now, knowing that you can have COVID and be asymptomatic and still spread it, would it have been helpful to prevent the spread of COVID within Fulton if you were to test a resident for it in March and April of 2020?

MR. YAFFE: Objection.

A. Again, asymptomatic resident would not have been tested so your question is a hypothetical that I can't answer.

Q. Let's go to page four. And Ms. Doyle, I believe we looked at this policy yesterday with Mr. Zadek.

A. Yes.

Q. And to my recollection, you said you believe that this policy was implemented sometime in late April, is that right?

A. Again, I would have to read it to see why I gave that opinion at the time. I don't recall the exact wording.

Q. Okay, so let me refer you to a specific section of it in the first paragraph. If we go a little bit towards the bottom of it there is a sentence that starts the, "The incubation time is believed to be" do you see that sentence?

A. I do.

Q. So the incubation time is believed to be approximately two to 14 days and the virus may be transmitted from asymptomatic patients?

A. Correct.

Q. So when do you believe you were made aware of that?

A. The end of April.

Q. So then it's fair to say then in May of 2020 we did know that asymptomatic residents could still spread COVID if they were infected, correct?

A. I believe it was being discussed at as a possibility at that point, but had

not been confirmed, no.

Q. Okay, but you do believe it was a possibility?

A. Correct.

Q. And as a possibility then that is an issue that should be addressed, correct, by Fulton?

MR. YAFFE: Objection.

A. If it could be addressed, it should be addressed.

Q. Well, what would be a way to address an issue of asymptomatic residents potentially spreading COVID in the facility?

A. The only way would be testing.

Q. Did Fulton make any attempts to procure COVID 19 tests at the end of April and in May 2020?

A. Again, we were continuing to follow the Department of Health guidelines that testing was not necessary in the facility.

Q. So I just want to clarify something because you used a different phrase this time, you said not necessary so

is it your understanding that the guideline is that it was not necessary or that it should not be done?

A. Both.

Q. So it's not necessary and also should not be done, that's your understanding?

A. Yes, that's my understanding.

Q. Can you explain why a test would not be necessary if someone could be asymptomatic and still spread the disease?

A. Because there was no guidance to test asymptomatic residents at all.

Q. So is it your testimony that absent guidance from DOH or CMS directing you to test, you would not have tested any resident for COVID?

A. That's correct.

Q. Why?

A. Because I was following their guidance. They knew the overall picture of COVID where they needed tests more desperately, where they didn't need tests. I followed the Department of Health

C. Doyle

guidelines every step of the way with testing.

Q. Okay, so it's your testimony that?

A. Are you laughing at me?

Q. No, no, no, just want to make sure I understand.

A. You appear to be laughing at me.

MR. YAFFE: Yes.

Q. I am not laughing, I am confused so I am trying to make sure I understand. It's your testimony --

MR. YAFFE: You can characterize your behavior that way, but it's clear from the record what your behavior is.

A. Yeah, no kidding.

Q. I would like to clarify with you, Ms. Doyle, are you saying that if you did not get a specific directive from DOH or CMS telling you to affirmatively test residents in your facility, you would not have done it?

A. That is correct, I was following the Department of Health guidance to not

test.

Q. Did the guidance specifically say do not test, did it say testing is not necessary?

A. I don't recall the exact language without the document. To me, it's one and the same.

Q. If --

A. If the Department of Health tells you it's not necessary, it means don't do it.

Q. Did anyone in your facility ever recommend to you that you should be testing residents?

MR. YAFFE: Objection.

Q. You can answer.

A. Other than several family members, no.

Q. Did Marie Jean-Baptist ever recommend to you that you should be testing residents in order to have a baseline to know who was infected and who wasn't?

A. No.

Q. Did any of your employees ever

ask you why Fulton was not testing its residents because they believed that it would be helpful?

A. No.

MR. YAFFE: Objection.

THE WITNESS: Again, can we take the document off the screen, I am having trouble --

Q. I have more questions for you regarding the document.

A. Well, can you let me know when?

Q. Let's go to page two of this particular policy, so it's page five of the overall documents item number four. So towards the bottom of number four after the underlined section it reads, "In the case that roommates are tested and one has a positive result and one has a negative result, the facility will separate the roommates if strategically feasible without putting residents or staff at risk for exposure." What does that mean?

A. I'm sorry, I have to read it again. It means that if and when the

facility was directed to do testing that we would follow that protocol.

Q. And so that was only if the facility was ever affirmatively told to test this resident?

A. Oh, well, in this case it probably referred to admissions that were coming in with positive test results because at this point we were accepting residents from the hospital that were tested.

Q. So just going back for a second, if these residents were tested in a hospital, why would somebody with a positive result be placed with somebody with a negative result?

A. I didn't say that they were.

Q. This specifically says roommate. They were talking about people placed together in this section. "In the case that roommates are tested and one has a positive result and one has a negative result the facility will separate the roommates."

A. Correct.

Q. So do you still believe this

refers to hospital admission?

A. No, probably not. I believe it refers to in the event that we were able to start testing that this protocol would kick in, if you will.

Q. Why would that be the protocol?

A. Why would it be the protocol, which part?

Q. Yes, why would it be necessary to separate roommate if one is positive and one is negative?

A. Because as the guidance as we became aware more of how the transmission of COVID, you know, how it came about things were changing consistently. In the beginning the guidance was not to move them, as they learned more about the virus and the disease process the guidance changed as the knowledge increased based, you know, what they knew about the disease, and so I'm assuming that guidance came out before this was written that we were now aware that having them in the same room might not be in their best interest. Thus, the room changes

on April 29th to create a separate unit.

Q. So would you agree with me, Ms. Doyle, that this suggests that if a resident is negative for COVID and they are roomed with someone who is positive, that could put their safety at risk?

MR. YAFFE: Objection.

A. Sitting here today, I know that back --

Q. No, I am asking about when this policy was written.

A. I don't know when this policy was written, I have said that multiple times.

Q. Why would the policy be to separate a positive resident from a negative resident?

A. Is that the end of your question?

Q. Yes, what would be the point of such a policy, why would that be a policy?

A. It's a policy because, obviously, we became aware at the time this policy was written that having them together -- having them separated was safer for the resident.

Q. Thank you. So it would have been

safer for a negative person to not be housed with a positive person, correct?

A. As I sit here today, I know that to be true.

Q. And at the time this policy was written it was known to be true, correct?

A. I don't know that because, once again, I do not know when this policy was written.

Q. Why would that be included in a policy if it wasn't known at the time the policy was written?

A. It could have been in anticipation, other facilities share information with us, we update our policies, it could have been in anticipating of new guidance coming out. I don't know. There's multiple reasons why that would be in there ahead of the guidance from DOH to separate them.

Q. If the policy is to separate residents if one has a positive test and one has a negative test, wouldn't you agree that it would be helpful to actually test the

resident to know who is positive and who is negative?

A. You are asking me the same questions over and over and my answer is again there was no guidance to test. If they had symptoms they were positive and were treated accordingly.

Q. My question isn't whether there was guidance to test. My question to you, Ms. Doyle, is at the time that this policy was written where it indicates that if roommates are tested and one is positive and one is negative that they should be separated, wouldn't it have been helpful if Fulton was testing its residents at that time so that it could implement that policy?

A. I can't answer the question. You are trying to ask me something that I cannot answer.

Q. Okay, so you don't know if it would have been helpful or not.

A. It's easy to ask those questions today when we know much more about the disease than we did then.

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Q. Well, if we go back up one page to the first part of this policy to the line that we looked at before in the first paragraph, it's the second, well, the third to last line, "The incubation time is believed to be approximately two to 14 days and the virus may be transmitted from asymptomatic patients."

A. Yes?

Q. Would that suggest to you at the time this policy is written, and I believe you indicated yesterday that you wrote this policy, so would it suggest to you that at the time you wrote this policy you were aware that asymptomatic residents could transmit the virus?

A. I believe it says may but I would need to read it again so if we can find that line, I'm happy to read it.

Q. I believe it's being highlighted for you.

A. It says may be transmitted. There was no definitive awareness that it was transmitted from asymptomatic patients,

it says may be transmitted.

Q. Yes.

A. It doesn't say -- it is -- it says it may be.

Q. Yes, it may be --

A. Because we didn't know.

Q. -- it could be transmitted?

A. We couldn't know yet because nobody knew yet, counselor.

Q. But at that point people did know that it could be a possibility?

A. It says --

MR. YAFFE: Objection.

A. Again, I can answer it 15 different ways, my answer isn't going to change.

Q. So just to make it clear, it's your it testimony that --

MR. YAFFE: We have been over this several times already.

Q. At the time of this policy when you wrote this policy and you were aware that it may be transmitted from asymptomatic patients, it would not have been helpful to

you to test the residents of your facility to determine who was positive and who was negative, that's your testimony; is that right?

A. That's absolutely putting words in my mouth, counselor. You are trying to combine two answers into one and it can not be done.

Q. So please explain to me, would it be helpful to you knowing what you wrote in this policy that the virus may be transmitted from asymptomatic patients, would it have been helpful for the facility to test its residents?

A. Yes, I believe I answered yes before and I will answer yes again.

Q. I don't believe you said yes before, but I am happy to know that you do believe it would have been helpful.

MS. SEKHON: So I need to go to page I believe it's going to be page eight. Can we go to the next page please, I'm sorry. Can we go down one more. I'm sorry. Let's actually go

back up to seven.

Q. Okay. So under number six on this page of this policy it reads, "If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control protocol precautions, the resident should be transferred to another facility that is capable of implementation." Was that, in fact, the policy at Fulton Commons?

A. Yes.

Q. In early April, May of 2020?

A. Yes.

Q. Were any residents transferred to another facility as a result of this policy?

A. As a result of number six, no.

Q. Correct. Okay. Were any residents transferred to the hospital as a result of number six?

A. No, they were transferred because of clinical condition perhaps but not because of number six. It's a two-prong bullet, number six. It says if a resident requires a higher level of care or the

facility, so you are asking me to answer yes or no on a two-piece question.

Q. So I will direct you more specifically to the section of if the facility cannot implement all recommended infection control precautions. Pursuant to that part of number six, were any transferred to a hospital or another facility?

A. No.

Q. Let's go to page 11 of this packet. Ms. Doyle, yesterday you talked about that you believed this was created by Ms. Frawley and then you also believe that this policy was created in late April. Do you recall that testimony?

A. I do.

MR. YAFFE: That was not this document, though.

MS. SEKHON: It was not this -- correct, so let me go back.

Q. This particular policy on page 11, did we take a look at the same policy yesterday?

A. I don't recall.

Q. Okay.

A. We looked at a lot of stuff.

Q. We did look at a lot of stuff yesterday, so let's look at the title of this "We have protocol for residents with respect to COVID as well as residents admitted with from hospital with confirmed COVID." Do you recall seeing this policy yesterday?

A. Not specifically, no.

Q. Do you recall seeing this policy ever?

A. Yes.

Q. And who do you believe created this policy?

A. Mrs. Frawley.

Q. Do you have any recollection of when it was created?

A. I do not.

Q. So under the section, the first section protocol for in-house residents with a suspected COVID diagnosis, would you please read the first sentence?

A. "Any resident residing in the facility that has a fever of 100 will be assumed a suspected case of COVID and will be placed on isolation precautions immediately. The resident will be transferred to the designated unit unless they are in a private room."

Q. What was a designated unit?

A. There was no designated unit until May 1st and that was 1 East.

Q. So do you believe that this policy was created after May 1st?

A. It would appear that way, yes, that would be my best guess.

Q. With respect to the first sentence that any residents residing in the facility, I am paraphrasing, with a fever of 100 will be assumed a suspected case of COVID, when was that policy put into place?

A. March, mid March.

Q. So as of mid March, is it fair to say that any residents that had a fever of 100 or more was deemed a suspected case of COVID?

A. Yes.

Q. Was it required that they exhibit any other symptoms in order to --

A. Again, I won't say suspected. We deemed that they it could possibly be COVID and we treated them accordingly.

In some cases tests came back and, you know, proved that it was a UTI, in which case the protocol would change for their treatment, obviously.

Q. So then is it fair to say as of mid March any individual who was considered a fever of 100 was treated as if they had COVID unless a test proved otherwise?

A. Yes.

Q. Were there any other symptoms that would also prompt a resident to be treated as if they had COVID?

A. The temperature was the big one at the time when first COVID first came out, that what they were basing all of the diagnoses on, as it progressed we became aware of other symptoms, but the fever was the one that was the trigger.

Q. Did that remain the symptom throughout and up until now throughout the pandemic?

A. No, this thing has morphed several times now and we are well aware of that as I sit here today, but back then the main guidance was to look for a fever, respiratory distress, you know, everything you saw in the news in the hospital, it was respiratory distress and a fever.

Q. So you already indicated that that was put into place in mid March. In April of 2020, was that particular part of the policy still in place?

A. Yes, but the medical treatment probably had morphed a few times by then as well as what we were monitoring residents for.

Q. Okay.

A. And again, that's my best guess. I don't have it in front of me.

Q. Understandable. So in March and April, is it fair to say that any residents who spiked a temperature of more was deemed

as likely having COVID and treated to have COVID unless a test approved otherwise?

A. Yes.

MR. YAFFE: Objection.

Q. Did that remain the case in May of 2020?

A. I don't recall when protocols changed specifically.

Q. Looking at the second section here where it says protocol for admission re admissions from the hospital with confirmed COVID diagnoses. Number one reads, "Any resident who is being admitted or readmitted from a hospital setting will be placed on the designated unit." And I just want to verify, does that apply only to those residents being admitted with a confirmed COVID diagnosis or did that pertain to all residents being admitted from the hospital?

A. At that time we were only admitting residents that had COVID, so it says with a confirmed COVID diagnosis right in the title.

Q. So it's your understanding that

when this policy was drafted which it seems according to you to be after May 1st of 2020, that all the residents that were being admitted were COVID had positive residents?

A. That's my recollection, yes.

Q. And again, that designated unit at that point then is unit 1 East, correct?

A. From May 1st forward.

Q. Let's go to the following page, page 123. Ms. Doyle, have you ever seen this policy before?

A. I have.

Q. And do you know who created this policy?

A. It was created by Mike Andrews.

Q. And who is he?

A. The director of housekeeping.

Q. At Fulton Commons, correct?

A. Correct.

Q. What's the title of this policy?

A. Terminal Cleaning COVID 19. With a typo.

Q. Do you know when this policy was created?

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A. I do not. I don't recall. I typed it for him, but I don't recall when.

Q. This is a one-page policy.

MS. SEKHON: If we can just zoom out a little bit so we can see the whole page.

Q. Is there a date anywhere on this policy?

A. No.

Q. Now, you mentioned yesterday that it would be best practice to have dates on policies; is that correct?

A. Yes.

Q. And is it also correct that I believe we testified that you generally did not put dates on your policies; is that right?

A. Correct.

Q. Why don't you generally date your policies?

A. I just don't see a need for it. There is no requirement for it and I don't see a need.

Q. Would it be helpful for you

looking back if a policy had a date on it to determine when it went into effect?

A. Not particularly.

Q. It would not be helpful to see that this policy was implemented, for example, March 1st, that wouldn't help you remember now when it was put into effect?

A. Well, of course it would tell me exactly when it was put into effect.

Q. So would you agree that it would be helpful if policies were dated?

A. Again, my answer is going to be the same, it depends on the circumstance. For this purpose today, you asking me when this policy was developed, I would be able to answer you.

Q. After yesterday and today where you have been questioned about a number of policies and procedures and when they were put into effect, do you now see any reason to date policies?

A. Yes, the next time I'm questioned by you I would be able to answer your questions.

C. Doyle

MR. YAFFE: Or you wouldn't be questioned to begin with.

THE WITNESS: Are you laughing at me again?

MS. SEKHON: No, I was not laughing. I was simply smiling at your attorney's comments.

MR. YAFFE: I think it would have obviated a lot of the false assumptions being made by the Attorney General, but here we are.

Q. Ms. Doyle, reading under the line under the top where it says Policy it reads, "It is the policy of FCC that all rooms will be terminally cleaned so that new residents may be admitted." Was that the policy at Fulton Commons?

A. Yes.

Q. Was that always the policy at Fulton Commons?

A. Yes.

Q. Did that specifically pertain only to COVID 19 or was that across the board?

A. No, it's across the board. The Department of Health requested specific COVID 19 policies and procedures and that's why this policy was created. They wanted to see specific policies that had COVID 19 so that they were aware the facility was aware that COVID 19 was present and had it cleaned. Did not change the procedures, though.

Q. When did you know the Department of Health wanted to see specific COVID 19 procedures?

A. During one of the infection control surveys, the four that we've had.

Q. So is that what prompted the creation of this particular policy and procedure?

A. The addition of the COVID 19 on it, yes.

Q. Did learning that the Department of Health wanted specific COVID 19 procedures warrant the previous COVID 19 procedures that we looked at?

A. Yes.

C. Doyle

Q. Ms. Doyle, should a resident ever be moved into a room that was not terminally cleaned?

A. No.

Q. Can you explain what terminally cleaned means?

A. I can read the policy if you would like. My understanding is that there is specific procedures that gets followed for a terminal clean. I don't know all the facts. I can read them if you would like.

Q. No, that's okay, but let me ask you generally. Is terminal cleaning different, is the procedure different from a regular room clean where a resident isn't being moved?

A. Yes.

Q. Okay, so is it fair to say that to your understanding there are additional steps that are taken when a room is terminally cleaned?

A. That's correct.

Q. So I would like to go to the next page, page 13. Ms. Doyle, have you seen

this policy and procedure before?

A. Yes.

Q. Do you know who created this policy and procedure?

A. Mrs. Frawley.

Q. Do you know when it was created?

A. I do not.

Q. If we look under number five, the first numbered section under number five it reads, "Residents that have displayed no symptoms and remain afebrile will remain in their rooms and temperatures will be monitored every shift." Can you just explain that policy a little bit more, please?

A. I need a minute to read the whole thing so I have confidence.

Q. Sure, absolutely. Do you need it zoomed in or can you read it?

A. No, I can read it, thank you.

Okay, so what it's saying that residents that were asymptomatic will remain in their rooms and have their temperatures monitored every shift. Exactly as it says.

Q. Does that refer to residents who have a confirmed laboratory test for COVID 19 as well?

A. I don't understand your question. I'm sorry.

Q. Sure. So if we just go up to the top of the policy under Surveillance it says confirmed case and also a suspected case.

A. Correct.

Q. So my question to you is number five where it says, "Residents with no symptoms who afebrile will stay in their rooms" did that comply as well to confirmed positive COVID residents or was it only for suspected COVID positive or COVID residents?

A. The policy says for confirmed and suspected, so it would imply it's for both.

Q. Okay.

A. For the record, they all remain in their rooms at all times. To this day they still do unless they have a behavior and can't.

Q. Let me ask you this, is this particular policy still in effect?

A. I don't know if this is the most current version.

Q. Okay. Would a resident who is asymptomatic and afebrile with a confirmed positive test stay in their room on their unit today or would they get moved to a designated COVID unit?

A. I'm sorry, ask the question again.

Q. Sure. And let me go back. After if the COVID unit was established, I believe you said on May 1st, the day of all the room transfers, as of that date would residents who displayed no symptoms and remained afebrile still remain in their rooms on non COVID units or would they have been moved to 1 East at that point?

A. If they had no symptoms but had a positive test result you mean?

Q. Yes.

A. If they had a positive test result, they were moved.

Q. And that's irrespective of symptoms then, correct?

A. That's correct.

Q. If the resident had a roommate, what would have been done regarding the roommate?

A. The roommate would stay where they were and be monitored for signs and symptoms, they would be put on isolation and monitored for signs and symptoms.

Q. Okay, let's go to the following page. Ms. Doyle, have you seen this policy and procedure before?

A. Yes.

Q. Who created this policy?

A. Mrs. Frawley.

Q. When was it created?

A. I don't know.

Q. Was this also created following your understanding that DOH wanted specific COVID 19 policies and procedures?

A. No, this was put in place by our own accord because we started screening the employees.

Q. Okay. So if we look at number four, it reads, "Essential personnel with a

confirmed or suspected case of COVID can be permitted to work if the following is met: A; personnel has maintained isolation for at least seven days after illness onset and have been afebrile for at least 72 hours without using any fever reducing medication and with other symptoms improving. B: Personnel whoever coving must wear a face mask and the proper PPE for 14 days following the onset of the virus."

Has that remained Fulton's policy up until today?

A. No.

Q. When did it change?

A. When the guidance from the Department of Health came out. I don't recall the date. This was written based on president guidance from the Department of Health and the CDC at the time, which was has changed numerous, numerous times, as you know, over the months.

Q. So it is your testimony that when the DOH guidance and CDC guidance evolved, then this also evolved; is that correct?

A. That's correct.

Q. So it's fair to say this policy is no longer in effect?

A. That's correct.

Q. Do you know or do you believe there is an updated version of this policy?

A. I believe there is, yes.

Q. And who would have a copy of that?

A. Mrs. Frawley. Anybody with a suspected, positive, suspected or even exposure to somebody with a positive case is out automatically 14 days and has to have a negative test to run return. That's the current policy.

Q. Just looking at the following page. Ms. Doyle, are you familiar with this policy and procedure?

A. I am.

Q. And what is the title of this one?

A. Communication Notification of COVID 19 Pandemic Protocol.

Q. And who created this policy?

A. I did.

Q. And does this policy have a date on it?

A. Yes.

Q. And what date was it in effect?

A. April 24th, 2020.

Q. So if we look at number two, letter D, it states, and please let me know if you can't see it, we can zoom in but it states, "Administration will continue to take family designated representative calls as well as utilize a robo call system to update families representatives on COVID 19 status in the facility. Said calls will be make at least weekly or more often as necessary and/or as mandated."

Who was responsible for making those calls?

A. I am.

Q. And where would you obtain the information that you would convey on those calls?

A. What information. It depended on what information we were referring to. Some

was the DOH guidance. Some was the executive Governor's executives orders, some from how many positives cases we had it, some were from the ADNS on how many employee case we had. Depends on what you're asking me.

Q. Okay, so let's break it down. You said that one thing you might provide on those calls was the number of cases; is that right?

A. Yes.

Q. Would you also provide a number of suspected cases?

A. Yes, as well as deaths.

Q. As well as deaths. And how would you obtain that information prior to the robo call?

A. From Mrs. Frawley.

Q. And how recent would be the information that you would be conveying?

A. I'm sorry, how what?

Q. Sure. How recent was the information that you would convey?

A. Oh, as of that day. I remember I

had to report to HERDS everyday as well, so in the morning I would get the information and complete the HERDS survey and then later in the day I would make my robo call.

Q. We talked yesterday about being some information being current as of midnight the night before?

A. Yes.

Q. Or midnight that morning, so could you be more specific as to how current the information would be that you would then convey on the robo calls?

A. It was at least through the midnight census the day before, but if I was made aware in the morning that another positive case came in or unfortunately there was a death, I would include that current in my robo call, so it may not have always refer referred back to the midnight census, it may have been more current to the time I was making that call.

Q. Did anyone else play any role in making those calls other than yourself?

A. No. You mean physically making

the call? No, it was me. Seventy-seven of them to date.

Q. If we scroll to the bottom of this page, Ms. Doyle, we see in little print at the bottom it here, it looks like it says REV 420420 CD -- can you explain what that means?

A. Yes. Those are the dates I revised the policy. 3/12 is the date I initially wrote it. It was revised on 4/10 by me and again on 4/24 by me.

Q. Was there a particular reason that you included dates on this particular policy?

A. No.

Q. So if we go to page 16, does this appear to be an earlier version of that policy?

A. Yes.

Q. And if we go to page 17, does this appear to be the original version of that policy?

A. Yes.

Q. And again, this policy, all three

versions we looked at have dates on them, correct?

A. Yes.

Q. So let's go to page 18. Ms. Doyle, are you familiar with this particular policy we are looking at?

A. I am.

Q. And do you know who created this policy?

A. Mrs. Frawley.

Q. Is there a date on this policy?

A. There is.

Q. And what is that date?

A. March 10th, 2020 when we were well ahead of the curve.

Q. And going down to number six on this policy it reads, "Ms. Baptist, RN ADNS infection control, per the RN unit manager must evaluate any staff displaying signs symptoms of illness. Any employee ill will be sent home immediately." Was that, in fact, Fulton's policy --

A. No.

Q. -- throughout the pandemic?

A. Yes.

Q. Were you made aware of any staff who became ill during the course of their shift?

A. Yes.

Q. Were those staff, in fact, sent home?

A. Absolutely.

Q. How many staff or how often were staff sent home because they developed signs or symptoms?

A. I don't recall.

Q. Is there a list anywhere that would keep track of staff members who were sent home in the middle of their shift?

A. It may be on the line list that we maintained for staff, but I'm not sure.

Q. Were any staff members to remain at work after developing symptoms of illness?

A. I'm sorry, were they permitted to stay?

Q. Were any staff ever permitted to stay?

A. No, not if we were aware they were ill, no.

Q. Who was responsible for in-servicing the staff on the COVID and other infection control policies from January 1st, 2020 to June 1st, 2020?

A. Marie Baptist.

Q. Was anyone else responsible for providing those in-services?

A. The unit managers assisted her.

Q. And how do those in-services take place?

A. Because we weren't taking people off their units, they were done up on the units.

Q. Were they done in person?

A. Yes, oh well, I shouldn't say that. Some were in person and some may have been by memo attached to paychecks. I don't want to give you any wrong information.

Q. I appreciate that. So some in-services were done via memorandum?

A. Some may have, I'm not sure if they were or weren't, but I don't want to

C. Doyle

rule out that possibility.

Q. Okay. Were there any documents that staff members were required to sign when they attended or received potentially by memo an in-service?

A. Just the ones by memo?

Q. No, in general.

A. Oh yes, yes, yeah, we all signed for in-services.

Q. And did that apply to both types of in-services, in-services in person and as well as in-services by memo or was it only for in-services attended in person?

A. Again, we would have to ask Mrs. Frawley, I am not sure if she has them signed for memos.

Q. Ms. Frawley or Ms. Baptist?

A. Well, now Mrs. Frawley.

Q. Okay.

A. Ms. Baptist isn't here so we can't ask her.

Q. Okay. When Ms. Baptist left, who took over in-services servicing the staff members?

C. Doyle

A. Janice Trnovski, and I believe at that point Joan Dublin also began to assist with in-services.

Q. Who was responsible for creating the lesson plans that the staff were in-serviced on?

A. Sometimes Mrs. Frawley would create them, sometimes Mrs. Trnovski would create them, sometimes Joan Dublin would create them.

Q. And when Ms. Baptist was still employed there, was she also responsible for creating them at times?

A. I think Mrs. Frawley created them at that time.

Q. Did you play any role in drafting any of the lesson plans for the in-services between January 1st 2020 through June 1st, 2020?

A. Not to my recollection.

Q. Did you review --

A. I may have had input by way of QAPI meeting, an ad hoc QAPI meeting in terms of, you know, I will go in and say

listen, we need to stress this but physically writing the lesson plans, no.

Q. Did you review any of the lesson plans prior to them being implemented?

A. No, not that I recall. Again, I don't want to back myself in a corner. It was six months of chaos, and if I reviewed a document I don't want to tell you no and I did. Not that I recall.

Q. Okay. Were the lesson plans maintained for the in-services that were given from January 1st, 2020 to June 1st, 2020?

A. Yes.

Q. Who maintained those records?

A. Mrs. Frawley or Ms. Baptist or Joan Dublin or Janice Trnovski depending on the timing and the in-service.

Q. Did you personally ever direct your attention staff to sign an in-service sheet for a lesson that they did not receive?

A. No.

Q. Did you ever request that your

staff sign an in-service sheet for a lesson they did not receive?

A. No.

Q. To your knowledge, were any of your staff ever asked to sign an in-service sheet for a lesson they did not receive?

A. No. They make me sign for in-services I wrote that, you know, that are my policies, so no.

Q. Did anyone ever bring to your attention that they were asked to sign an in-service sheet for a lesson that they did not receive?

A. No.

Q. Did you ever hear any rumors that your staff were being asked to sign in-service sheets for lessons they did not receive?

A. No, never.

Q. What would you have done if it had been brought to your attention for lessons that they were not receiving?

MR. YAFFE: Objection.

Q. You can answer.

C. Doyle

A. What would I have done?

MR. YAFFE: I mean, it's a hypothetical. It's just not relevant.

MS. SEKHON: Counsel, she can answer the question.

Q. What would you do if it was brought to your attention. What would you do if it was brought to your attention that staff were signing in-service sheets for a lesson they didn't receive?

A. Per our corporate compliance program that employee would have severely disciplined up to and including possible termination. The in-services would then have been re given to the entire staff to ensure that they actually received the in-service.

Q. And which staff in particular would be disciplined up to and including termination?

A. Whoever asked them to sign a sheet without giving them the in-service.

Q. Would the staff member who actually signed the sheet also be

disciplined up to and including termination?

A. They would. If you were aware of that I would love to be advised so I can handle that situation.

Q. So Ms. Doyle --

MR. YAFFE: We would actually request that information be provided to the facility.

THE WITNESS: I need to address that. That's a corporate compliance violation and a very serious one. If someone is saying that happened, I'm not a happy girl.

MS. SEKHON: That is noted.

Q. Ms. Doyle, we have spoken a lot about some of the changes in the policies and procedures as a result of the pandemic, so I just wanted to ask you, in January and February, 2020, did Fulton take any steps in order to stockpile PPE in preparation for the pandemic?

A. Yeah, I don't remember the exact dates. Again, can we take this document off?

Q. Yes, I'm sorry, we can take this down.

A. I am just going getting a headache from my glasses.

Q. I'm sorry.

A. I have to wear them for reading on the computer but not seeing you so I am getting a headache.

Q. I apologize.

A. Can you ask the question again, I'm sorry.

Q. Yes. In January and February of 2020, did Fulton take any steps in order to stockpile PPE, by that I mean personal protective equipment in preparation for the pandemic?

A. Again, I don't remember the exact dates. I know I had conversations with the purchasing agent and I know I was actually on my own personal Amazon procuring PPE throughout the pandemic, but I don't recall when we first started getting them.

Q. Did you have any discussions, to your recollection, in January and February,

2020, with Steven Weiss regarding preparing for the possibility of a pandemic?

A. Yes, I'm sure I did.

Q. Do you recall the substance of any of those conversations?

A. I'm getting that I, you know, discussed overall the pandemic in the industry, you know, what was occurring, and I believe at one point, again, I don't recall that it was in January or February but it was a Sunday where I discussed with him the need to procure some PPE. I don't know if that was January or February or March, I can't recall.

Q. Was there specific PPE that you needed at that point?

A. Again, I don't recall.

Q. To your knowledge, was there any DOH and CMS guidance regarding the use, and by that I mean the extended use of PPE in February and March, April and M of 2020?

A. Yes, there was.

Q. And what --

A. Which also changed throughout

that four-month period, by the way.

Q. So let's talk about that a little bit. What did that guidance entail and how did it change?

A. When there was a shortage on some of the PPE, the guidance would come out on how to use the limited PPE that you might have in the facility at that time to extend, for example, the life of an N95 that you would normally change daily at the end of the shift to continue to use it for an additional six days, and I am suing that as an example, I don't remember the timeframe.

Q. Sure.

A. To, you know, how to properly clean a reusable gown that by manufacturer's recommendations that you could reuse those gowns and store them properly on the unit. So guidance was changing throughout that four-month period, but those are the type of things that guidance came out on.

Q. So if fair to say that in March, April an, M of 2020, PPE was being used differently than it would have been used pre

pandemic?

A. Yes, when it wasn't really available, yes.

Q. Right.

A. I mean when it was readily available.

Q. Yes. So when PPE was readily available, is it fair to say that the guidelines from DOH and CMS required that it be changed more frequently than they required that it be changed in the midst of the pandemic?

A. You mean were the guidelines changing more frequently prior to the pandemic?

Q. Yes.

A. Yeah, the recommendations would have been more rigid.

Q. Okay, and would the recommendations have been more rigid because it would be safer to change it more frequently?

A. Yes.

Q. If possible?

C. Doyle

MR. YAFFE: Hold on. Objection. I mean, you are asking her to opine on recommendations made by another agency or are you asking her to opine on the facility's recommendations? If you are asking her to opine on -- it sounded like you were asking her to opine on recommendations regarding PPE made by the government.

MS. SEKHON: Okay, I will rephrase.

Q. Ms. Doyle, would you agree that generally, if possible, it would be safer to change PPE more frequently than DOH and CMS required in the midst of the pandemic?

A. If you had the supplies to be able to do so, yes.

Q. Thank you.

MS. SEKHON: I am just going to suggest a quick five minute break right now. I am going to apologize, I am pregnant so I just need a few more breaks than Mr. Zadek needed yesterday so it will be very quick, just a quick

C. Doyle

five minutes. Thank you.

(A recess was taken.)

MS. SEKHON: So we can go back on the record, and just let the record reflect that we did do a quick role call and everyone who was present this morning is still present at this time.

Q. All right, so Ms. Doyle, aside from the attempts you made to procure additional PPE, what other steps, if any, did Fulton take in order to prepare for the potential of a pandemic? And at this point let's talk more about March of 2020, so what steps were taken in March?

A. Okay. So in March, I believe it was the 10th of March, don't hold me to these exact dates, on or about March 10th we I am going to lump together what we did in a three-day span 10, 11 and 12 because I don't remember which was on what day, if that's okay.

Q. That's fine.

A. So we obviously hung up all the signage indicating at that point if you were

ill to not come in because visitation was not restricted yet. We implemented staff to check off -- staff and visitors to check off a sheet if they had any symptoms. We began taking, I don't think we started temperatures yet, I don't want to -- again, if I have my timeline in front of me I can tell you exactly, but I'm guessing at this point.

We restricted staff to go to their units and stay there for the entirety of their shift. We reduced visiting hours significantly, and then the next day restricted them entirely well before we were guided to do so, by the way, by DOH.

We began taking, I think we began taking temperatures of the residents, all three shifts. Those are the ones that come to the top of my head.

Q. Okay. With respect to the halting of in-person visitation, how was that communicated to residents and their families?

A. Telephone calls were made to each

individual designated rep by the social worker and the discharge planner.

Q. So was that before you implemented the robo call system?

A. Yes, I implemented the robo call on March 13th. I wish I had done it on the 10th.

Q. It would have saved them a lot of calls, probably?

A. Yeah, they weren't happy with me. They made them two days in a row, once to let them know that we were reducing visiting and then the next day when I made the decision to stop visiting all together, they called again.

Q. Okay. And I know you mentioned that the iPads that were initially used for the physicians to sign in and out, that those iPads were used instead at that point for resident communications?

A. That's correct.

Q. How many iPads in total were being used to assist in resident communications with their families?

A. Four. We took the two from the front desk and Steve Weiss sent in two additional iPads.

Q. Did you feel that that was sufficient or did you need more?

A. No, that was adequate. Anybody who wanted a telephone call or Facetime call received it.

Q. And how frequently were residents permitted to communicate with their family members through Facetime?

A. Whenever it was requested by a family member, recreation went and did the call.

Q. And it was recreation that was responsible for assisting in those calls?

A. That's correct. There was a period of time, again, I don't want to mislead you, there was a period of time where when the COVID -- when there were a high number of COVID residents in the facility that I did not let them go up on the unit so they were speaking by phone through the unit managers.

C. Doyle

Q. Okay, and so just to be clear, when you say they were speaking by phone to the unit managers, do you mean that the units managers were assisting with phone calls instead?

A. Yes.

Q. So in lieu of the Facetime calls, there were phone calls being placed at that time between the residents and their families?

A. Correct.

Q. Do you recall when that was precisely or what month or anything like that?

A. I don't recall, I'm sorry.

Q. Do you know how long that lasted for?

A. Maybe 10 days, as a guess. I was trying to keep everybody off the unit unless it was medically necessary for them to be there.

Q. And was that before or after you started admitting residents from the hospital who were COVID positive?

A. Before.

Q. Okay, so this is based on a large number of suspected or presumed COVID resident in the facility then; is that correct?

A. Correct, and good common sense.

Q. Other than phone calls and the Facetime calls, were there any other methods of communication that Fulton utilized for residents and their families?

A. Yes. Some family members would come here and we would bring the residents to the window and assist them to stand up and/or, you know, talk cell phone to cell phone from the room downstairs. Whatever they asked we basically tried to accommodate. It's difficult because it's a four-story building but there is parking and driveway around the entire building, so if they came to the building, we would try to assist them so they could see their loved ones, you know, eyeball them at least.

Q. Who was responsible for assisting with that?

A. They would either call recreation or call the nursing unit directly.

We had one family member who came every single day, for example, so at 10 o'clock we knew they would be coming and we would have the resident ready with their cell phone on and looking out the window.

Q. Okay. I am going to refer your attention now to what was pre marked as Exhibit 8.

Ms. Doyle, in the March 4th 2020 CMS guidance that we looked at yesterday, and correct me if I'm wrong but my recollection is that you had indicated that you had not seen this before and that looking at it we can see it was not addressed to the nursing home, it was addressed to State survey agency directors.

A. That's correct.

Q. So understanding that you have not seen this before, I am still just going to ask that you be directed to page three of this document, and if we can just scroll down to the section, the bullet section when

C. Doyle

should a nursing home accept a resident who was diagnosed with COVID 19 from a hospital. And again, Ms. Doyle, I understand this was not guidance that was directed to you and that you had not seen this prior to yesterday. I am just going to read the first line that says --

MR. YAFFE: Before you ask your question because I don't want to interrupt while there is a question pending, but I object to your use of this document which we don't even know if this is a true and correct copy of a documents. It's not properly in evidence. This witness has not seen this document before. It was not addressed to her, and if you are going to ask her to opine on the meaning of the author of this document, I submit that that's entirely improper and inappropriate.

MS. SEKHON: Okay, counsel.

MR. YAFFE: I object to this line of questioning.

C. Doyle

MS. SEKHON: Okay, counsel, and your objection is noted.

I am going to remind you that the proper objections for you in this forum are objections to privilege.

THE WITNESS: Can I just have a date on this document again please.

Q. Sure. So if we just go to page one.

A. Okay, thank you.

Q. Okay, so it was March 4th. And then going back to the third page, so under when should a nursing home accept a resident who was diagnosed with COVID 19 from a hospital, it reads, "A nursing home can accept a patient diagnosed with COVID 19 and still under transmission based precautions for COVID 19 as long as it can follow CDC guidance for transmission based precautions." Ms. Doyle, was that your understanding of the guidance? And again, I understand you have never seen this before, my only question is did you understand that to be the guidance, the CMS guidance on

March 4th, 2020?

MR. YAFFE: Objection.

A. There was no guidance. The only guidance we received -- the first guidance we received about accepting COVID 19 residents was the Governor's executive order and the DOH memo on March 27th when he indicated we should accept COVID positive resident into the nursing homes.

Q. So prior to March 27th, you were never made aware of any guidance of when a facility should and should not accept a COVID 19 resident, is that your testimony?

A. That's correct.

Q. If we go up on this page to the bullet section "When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID 19 to a hospital" if we look at the second line, it reads, "Residents infected with COVID 19 m vary in severity from lack of symptoms to mild or severe symptoms or fatality."

Ms. Doyle, in March of 2020, were

C. Doyle

you aware that residents infected with COVID 19 could be asymptomatic?

A. No.

Q. So is it fair to say then that you were not aware of this particular CMS guidance or any CMS or DOH guidance that indicated to you in March of 2020 that those infected with COVID 19 could be asymptomatic?

MR. YAFFE: Objection.

A. I can tell you that I did not see this document.

Q. Okay. So let's take this document down. Ms. Doyle, until March of 2020, were you aware that there could be residents who had COVID 19 but did not exhibit any symptoms?

A. No.

Q. Okay, so I would like to show you Exhibit 11, Ms. Doyle. This is an exhibit that we looked at yesterday and the date on this is March 13th, 2020 and this was addressed to nursing homes and adult care facilities. If we can just scroll down

slowly.

A. Could you just slow down a little bit, I can't read that fast. Okay.

Q. Do you recall looking at this guidance with Mr. Zadek yesterday?

A. I do.

Q. If we look at the second page.

MS. SEKHON: You can scroll up a little bit. Actually, let's go up a little bit further. Let's go to the bottom of the first page. Actually, let's go up even a little bit more, I'm sorry?

Q. All right, so looking at the first full paragraph, the second to last line in that paragraph reads, "At this time nursing homes and adult care facilities and NHs and ACFs statewide are required to take the following actions." Did I read that correctly?

A. You did.

Q. Then there is a section in bold that's at the bottom that says, "If there are confirmed cases of COVID 19 in a nursing

home or ACF" so understanding that this deals with instances of confirmed cases. If we can continue to scroll down, the second page, number five, reads, "Do not float staff between units. Cohort residents with COVID 19 with dedicated healthcare personnel HCP and other direct care providers. Minimize the number of HCP and other direct care providers entering rooms."

Were you aware of this requirement on March 13th, 2020?

A. Yes, I implemented it prior to getting this memo.

Q. Did any of your staff continue to float from one unit to another after March 13th, 2020?

A. Yes, as I have indicated, we needed to -- you have slots you have to fill in, so based on operational needs, the answer is yes. Every facility had to, I would guess.

Q. And this particular guidance indicates cohort residents with COVID 19 with dedicated HCP and other direct care

providers. Were residents who were suspected or presumed of having COVID 19 at Fulton Commons as of March 13th, 2020 cohorted with direct care and healthcare personnel?

A. Yes.

Q. How was that implemented?

A. Again, the staff would, excuse me, the staff would report to their unit, stay that there for the entire day. Anybody that was suspected positive was taken care of last in the rotation, if you will, and then the CNAs would go in only when necessary.

Q. Were there specific CNAs on each unit caring for those residents that were presumed or suspected of having COVID and other CNAs caring for residents who were not suspected of having COVID?

A. I believe so, yes, but you would to have to ask Mrs. Frawley specifically that question.

Q. When you read number five on this guidance, does it indicate to you that DOH

is directing that there be separate staff members caring for COVID presumed versus separate staff members caring for non COVID residents?

A. It says to have the COVID 19 residents with a dedicated healthcare provider.

Q. And what does that mean to you?

A. It means that the same healthcare provider should take care of that resident each day.

Q. Does it does that indicate to you that that same healthcare provider should be caring for all of the COVID residents on that unit, if possible?

A. I don't read it that way, no.

Q. Okay, so it's your understanding that that means they just need to have the same person caring day in and day out?

A. That's my interpretation, yes.

Q. And do you believe --

A. Again, this would have fallen to Mrs. Frawley, so I, you know, I didn't direct policy on this number five bullet,

just for the record.

Q. Okay.

A. You would have to ask Mrs. Frawley what was implemented based on that.

Q. So it would have been Mrs. Frawley, the director of nurse's responsibility to implement this policy?

A. That's correct.

Q. Did you take any role in ensuring that Mrs. Frawley was aware of this guidance from DOH?

A. We reviewed every guidance that came out together as soon as we received it.

Q. So if we can just scroll down a little bit. Going to number seven, it reads, "The residents who initially test negative, retesting should be performed immediately if they have develop symptoms consistent with COVID 19."

So up until this point, Mrs. Doyle, up until March 13th of 2020, had Fulton Commons made any attempts to procure COVID tests?

A. No.

Q. And is that because you were not specifically directed to test the residents for COVID 19?

A. That, and according to the medical director, testing would not change the course of treatment for any resident in the facility. If you presume they're positive and treat them for COVID anyway, what difference does a positive result make anyway.

Q. So that's per Dr. Buchma?

A. That's correct.

Q. Did you have conversations with Dr. Buchma regarding whether or not Fulton should test the residents for COVID 19?

A. Yes.

Q. When did those conversations take place?

A. I don't recall.

Q. How many of those conversations did you have?

A. Oh, I don't recall specifically on that topic, I have no idea. We spoke

frequently.

Q. Did you believe that testing would be helpful in terms of providing resident care at Fulton in March and April of 2020?

A. No. Again, if you are treating them all as if they're positive, what difference does a test result make.

Q. Okay.

MS. SEKHON: I am going to ask that the witness be shown Exhibit 59.

Q. Ms. Doyle, this is a 28-page exhibit.

MS. SEKHON: And if we could zoom out a little bit and then scan the document.

A. I don't need to read this whole thing because I've never seen this before and it was never given to me so this is guidance to the survey teams.

Q. So let's go to the first page.

A. There's language and initials I don't even recognize.

Q. So I will go back up to the first

page, and I understand so you said you have never seen this before, correct?

A. Correct.

Q. Is there a date on this document?

A. March 20th, 2020.

Q. So if we look just at the first page in the gray box. If you scroll down just a little bit we see the second bullet point from the bottom, Targeted Infection Control Surveys.

A. Yes.

Q. It reads, "Federal CMS and State surveyors will conduct targeted infection control surveys of providers, identify the collaboration with the Centers for Disease Control Intervention, CDC, and the HHS, Office Assistance Secretary for Preparedness and Response ASPR."

Ms. Doyle, were you aware of that announcement in March on March 20, 2020?

A. I can't say definitely that I knew on March 20th.

Q. Okay. Did there come a time that you became aware of that announcement from

CMS?

A. Yes.

Q. The following bullet point which is underlined Self-Assessment reads, "The infection control checklist referenced above will also be shared with all providers and suppliers to allow for voluntary self-assessment of their infection control plan and protection."

Did there ever come a time that you received an infection control checklist from CMS?

A. Yes.

Q. Do you recall when you received it?

A. I don't recall the date, no, but I still continue to use it. We do it every month.

Q. So when you first began to utilize that checklist, who was responsible for utilizing it?

A. I don't know. We would have to ask Mrs. Frawley. I don't know who she assigned.

C. Doyle

Q. And currently who is responsible for utilizing it?

A. I do it in conjunction with the director of nursing and the infection control nurse.

Q. Have you kept copies of the monthly checklists that have been completed?

A. I believe so, yes.

Q. And just to be clear, have you personally kept them or has somebody else at Fulton been responsible for maintaining them?

A. Well, there is no requirement to maintain them, so I don't want to speak out of turn and say they have been maintained.

Q. Okay. I understand that there is no requirement that they have to be maintained, but you said you believe so?

A. They may be retained. We would have to ask Mrs. Frawley.

Q. Okay. So is it fair to say that you personally did not keep copies of the monthly checklist, is that fair?

A. That's correct.

C. Doyle

Q. But it's possible that Mrs. Frawley might have?

A. She might.

Q. So if we can go to page 14.

A. They may also be on the unit QAPI unit minutes, I don't recall what we did with them, but.

Q. Okay. And let's go up a couple of more pages to page 11. Ms. Doyle, do you recognize what's displayed right now on the screen?

A. No. Could we go to the top of this because I think this was or surveyors, not administrators, but can I see the top.

Q. We can, and this was not sent to you, this was --

A. Well, how would I recognize it if it wasn't given to me.

Q. My question to you, Ms. Doyle, is you said you utilized an infection control checklist.

A. You asked me about the writing in the gray box. How would I recognize it if I didn't see this. That's why I'm requesting

to see the entire document because you are asking me questions on things that were not given to me, and it's a little unsettling.

Q. My question for you, Mrs. Doyle, with respect to the infection control checklist that we were just talking about that you said you received one from CMS and used monthly, I am going to direct you to a specific page in this document, so at this point it was page 11?

MR. YAFFE: I apologize. I made an objection but I was muted.

MS. SEKHON: Counsel, is there an objection as to privilege?

MR. YAFFE: My objection is to the use of CMS documents, as I stated before.

MS. SEKHON: Your objection has been noted for the record. Thank you.

MR. YAFFE: Thank you. Okay.

Q. Okay, so Ms. Doyle, you indicated that there is an infection control checklist that has been utilized by Fulton on a monthly basis. I am going to ask you to

take a look at what's in front of you, and we can scroll down slowly, and if you can tell me if this is the infection control checklist that was --

A. I would have to compare to what we currently use. I can't answer that without seeing what I'm currently using.

Q. Okay. Can you look at what is on the screen in front of you and just tell me if any of that looks familiar to you.

A. Again, these are instructions to the surveyor to conduct their infection control survey, this is not the checklist that was given to facilities.

Q. Okay, so this was not the checklist that was utilized by Fulton then, is that fair to say?

A. I don't believe so, no. I don't ask my staff about PPE shortages and, so, no, these are questions for the survey team when they do their infection control surveys, this is not what was distributed to us.

Q. Okay. So let's move on then.

C. Doyle

MS. SEKHON: And I ask that you be shown Exhibit 60.

Q. This is a one-page document, Ms. Doyle, do you recognize Exhibit 60?

A. Vaguely.

Q. Is this guidance from the Department of Health that was sent to nursing homes and adult care facilities?

A. Yes.

Q. And the date on this is March 21st, 2020, correct?

A. Correct.

Q. Have you seen this document before?

A. Yes.

Q. Under what circumstances did you see it?

A. It was sent to me by the Department of Health.

Q. It was sent directly to you?

A. Yes, I believe so.

Q. So looking at the second paragraph on this page, it reads, "As the result, any febrile acute respiratory

illness or clusters of acute respiratory illness whether febrile or not in nursing homes, NHs, adult care facilities, ACFs, New York City, Long Island, Westchester County or Rockland County, should be presumed to be COVID 19 unless diagnostic testing reveals otherwise. Testing of residents and HCWs healthcare workers with suspect COVID 19 is no longer necessary and should not delay additional infection control actions." Did I read that correctly?

A. You did.

Q. Ms. Doyle, is this the DOH guidance that you had been referring to that indicated that testing is not necessary?

A. There may have been an additional one I had a different date in my head because, I don't recall. I don't recall exact.

Q. What date did you have in your head?

A. I had March 27th in my head but I could be wrong. A lot of dates rattling around in there.

C. Doyle

Q. Okay. So please take your time and take a look at this guidance, let me know if there's anyplace where it says that nursing homes should not test residents for COVID 19.

MR. YAFFE: The document speaks for itself.

A. Well, we can play semantics with words all day long, counselor, but it clearly says no longer necessary.

Q. No longer necessary, so we can agree that's what DOH says, no longer necessary to test, that any residents exhibiting certain symptoms should be presumed to have COVID, correct?

A. They should be presumed to be positive and treated accordingly and that testing is not necessary. That's what it says.

Q. That is what it says?

A. Correct.

Q. Would you agree with me that this does not say that you are not permitted to or you should not test residents?

C. Doyle

A. No. I interpreted it as I should test.

Q. Okay, that was your interpretation, that you should not test?

A. That's what it says. It says it's no longer necessary.

Q. So Ms. Doyle, do you believe that no longer necessary and should not do something are synonymous?

A. In this case, absolutely.

MR. YAFFE: Objection.

Q. Why in this case?

A. Because it's crystal clear what the intention of the memo was and it was to not do testing in nursing homes.

Q. You don't think the intention of the memo was to implement necessary infection control protocols prior to having to wait for a test results?

MR. YAFFE: Objection. Why don't you ask the author?

Q. You can answer. You can answer.

A. I can't speak to the intent of the memo. I can speak to how it was

interpreted by the industry and myself and my medical director.

Q. Okay, so when before you said it's crystal clear what the intent of the memo said, it's really, is it fair to say it's really your interpretation of it?

A. No, I am reading it in black and white with suspect COVID 19 is no longer necessary. That's pretty clear.

Q. And it continues to say "And should not delay further infection control actions." Is that correct?

A. That's correct.

Q. If we go to the next paragraph, it reads, "All facilities in areas of the state with the same community transmission of COVID 19 including New York City, Long Island, Westchester and Rockland with residents who have febrile acute respiratory or with clusters of acute respiratory illness should follow the guidance from the New York State Department of Health advisory issued on March 13th, 2020 for COVID 19 cases in nursing homes and adult care

C. Doyle

facilities in the section entitled If There Are Confirmed Cases Of COVID 19 In Nursing Homes Or Adult Care Facilities." Did I read that correctly?

A. You did.

Q. Is that the guidance that we were looking at just a few moments ago?

A. Yes.

Q. With respect to the second paragraph where it states that, "Certain cases as they enumerate should be presumed to be COVID 19 unless diagnostic testing reveals otherwise." What diagnostic testing do you believe that refers to?

MR. YAFFE: Objection.

A. Again, I didn't write this and I am not a physician.

Q. What diagnostic testing would reveal that an individual does not have COVID 19?

MR. YAFFE: Objection.

Q. You can answer.

A. I'm sorry, could you rephrase the question.

C. Doyle

Q. Is there any particular diagnostic testing that would reveal that a resident showing symptoms does not have COVID?

A. Today, yes.

Q. And what would that diagnostic testing be?

A. A COVID 19 test.

Q. And there were COVID 19 tests in March, 2020, correct?

A. Not readily available to facilities, no. As a matter of fact, you can see in their last line even their language says that those facilities should continue to pursue testing, meaning that getting tests was difficult at best, impossible, and they only advised facilities outside of those areas to pursue testing, not us. You can read through the document in entirety, counselor, you are picking and choosing a sentence and trying to make sense out of it.

Q. All right, Ms. Doyle --

A. That says outside, you see this

line, correct?

Q. Yes, Ms. Doyle, I am very familiar with this guidance. My question for you is whether you are.

A. I certainly am.

Q. With respect to the section where it say, "Someone should be presumed to have COVID 19 unless diagnostic testing reveals otherwise", what diagnostic testing would reveal otherwise?

A. Simply a COVID test. It then goes on to say that testing is not necessary and it goes on further to say outside of New York, Long Island, and Westchester and Rockland are the only ones who should pursue testing of residents.

Q. Does it say only ones?

A. It says, "Nursing homes outside of these areas should continue to pursue testing of residents and healthcare workers."

Q. Does it say nursing homes and adult care facilities outside these areas are the only ones that should pursue

testing?

A. No, this is the guidance from the Department of Health. Above it says it's no longer necessary, and then it further clarifies which ones should pursue testing. This memo is crystal clear to an administrator, with all due respect. I am not an attorney, but I can read.

Q. So in the section where it specifically addresses New York City, Long Island, Westchester County or Rockland where it stays tells you, "Presume certain residents are COVID 19 unless diagnostic testing reveals otherwise" how would nursing homes in Long Island determine whether a resident is negative for COVID without a test?

A. We wouldn't, which is why they're suspected positive and treated accordingly per the Department of Health guidance.

It says it right there. It goes on further to say which counties should pursue testing, of which Long Island was not one of them.

C. Doyle

Q. Yes. Instead you were to presume that any resident exhibiting symptoms was COVID positive?

A. And treat them accordingly, yes.

Q. And at that point you were also to implement the specific guidance issued on March 3th that refers to nursing homes that had confirmed cases, correct?

A. I would have to review that document again. You are asking me to go back and forth again.

Q. Nope, I am asking you to go right down here to the third paragraph where it says, "All facilities in areas of the state which the state's community transition of COVID 19, including New York City, Long Island, Westchester, Rockland with residents who have febrile acute respiratory illness or with clusters of acute respiratory illness should follow the guidance from the New York State Department of Health advisory issued on March 13th, 2020 for COVID 19 cases in nursing homes and adult care facilities in a section entitled "If there

C. Doyle

are confirmed cases of COVID 19 in a nursing home or nursing adult care facilities."

A. Correct.

Q. Now, you had mentioned guidance that was received from DOH on March 27th.

A. Again, I believe I said don't quote me on dates.

Q. Understood.

MS. SEKHON: At this point I would just like to ask that the witness be shown what I am going to deem Exhibit 68. This is a one-page document. If we can zoom out a little bit.

Q. Ms. Doyle, do you recognize this document?

A. I do.

Q. And what is this document?

A. This is that an advisory from the Department of Health concerning hospital discharges to nursing homes.

Q. What's the date of this document?

A. March 25th.

Q. And have you seen this document

before?

A. I have.

Q. Under what circumstances?

A. When it was delivered to me by the Department of Health.

Q. And you believe it came directly to you?

A. Yes, it did.

Q. I want to direct you to the section towards the middle of the page that is underlined.

A. Uh-huh.

Q. And it reads, "No resident shall be denied re admission or admission into the nursing home NH solely based on a confirmed or suspected diagnosis of COVID 19." Is this it the guidance that you had spoken about yesterday that required that Fulton Commons accept COVID 19 residents?

A. That's correct.

Q. Did you believe that Fulton was mandated to admit COVID 19 residents even if Fulton did not have the capability of properly caring for them?

C. Doyle

MR. YAFFE: Objection.

A. Yeah, that -- again, you are trying to put words in a memo. This memo clearly indicates that we cannot deny them based on a COVID diagnosis.

Q. Okay.

A. It doesn't say.

Q. And that's how --

A. It does not say if you can take care of them properly, it says you shall not deny them based on a COVID diagnosis.

Q. I understand that's what it says. My question for you is did you take this guidance and believe that it meant that you could not deny them if you did not have proper infection control procedures in place?

MR. YAFFE: Objection.

A. Again, you are asking a question that has nothing to do with this memo. Can you read -- -

Q. I am not trying --

A. "Cannot deny admissions based on COVID." This was a directive from the

Department of Health to admit COVID residents into the facility. Period.

Q. Did you believe that Fulton Commons had proper infection protocols in place such that it could safely admit COVID 19 residents?

A. Yes. I still thought it was a jackass idea, but yes.

Q. Why did you think it was a jackass idea?

A. What governor or of the State of New York would mandate facilities to take residents that they didn't want to take?

Q. Did you not want to accept COVID 19 patients at Fulton?

A. I did not.

Q. Why not?

A. I did not until this memo came out.

Q. Why is that?

A. Because I didn't want to deal with the hassle, quite frankly. It was a very scary disease. My staff were not going to be pleased with that decision. Families

weren't going to be pleased with that decision. I, myself have an auto immune disease. I wasn't thrilled with the decision, but when I was given instructions to admit them I admitted them and not before this.

Q. Did you have concerns about Fulton's ability to implement proper infection control protocols in order to contain the virus?

A. No.

Q. Did you have any concerns about the fact that Fulton was utilizing PPE pursuant to the extended wear guidelines when it came to admitting residents with COVID 19?

A. No, CDC indicated that was safe, we followed their guidance. They deem it safe, it must be safe, right?

Q. Ms. Doyle, do you believe that you could have refused admission to COVID 19 residents?

MR. YAFFE: Objection.

A. Not until the further guidance

came out and rescinded this approximately a months later.

Q. So did you believe pursuant to this guidance that it was a mandate that you had to take to have COVID 19 residents no matter what?

A. Yes, that's the interpretation of this memo. It's pretty crystal clear what it says in black and white.

Q. So I am just going to direct your attention again to Exhibit 10, so this is a three-page document and we can zoom out and scroll down.

Ms. Doyle, this was shown to you yesterday with Mr. Zadek. Do you recall reviewing this guidance with him yesterday?

A. Not specifically, no. Again, I looked at a lot of documents.

Q. Do you recognize this particular guidance at all?

A. Possibly.

MS. SEKHON: We can go back up to the top.

Q. Did you receive this guidance

from CMS in April 2020?

A. I believe so, I can't say definitively.

Q. What is the date on this guidance?

A. April 2nd, 2020. Just for the record, the Department of Health guidance comes directly through their healthcare system, their communication system. I don't know how these are distributed so I can't definitively say yes or no to the CMS memos.

Q. Okay. Who was responsible from Fulton to make sure the facility is taking up-to-date on the most recent CMS guidance?

A. I am.

Q. And how do you ensure that?

A. Normally, the Department of Health -- because New York Department of Health supersedes is usually more strict than CMS, we rely on the Department of Health to give us guidance.

Q. Do you ever check CMS's website?

A. Yes.

Q. How often do you check it?

A. Periodically.

Q. Are you signed up for CMS's list serve where they will send you guidance directly to your e-mail?

A. No.

Q. Are you aware that you could sign up for CMS's list serve where they will send you documents directly to your e-mail?

A. No. I mean, I get something from them on occasion that has like a bunch -- if what you are referring to you are using language I don't know, but I will get an e-mail from them that has a list of a bunch of things, changes in billing, you know, so if that's what you are referring to then I do get those.

Q. Okay. So looking at this particular guidance and I believe we established that the date on this is April 2nd of 2020. If we go to the middle of the page number one, it reads, "Nursing homes should immediately ensure that they are complying with all CMS and CDC guidance related to infection control." Were you

aware of that guidance in April 2020?

A. It wouldn't matter. We adhered to infection control guidelines at all times.

Q. The second bullet point under that guidance says, "CMS has already issued extensive infection control guidance including a self-assessment checklist that long-term care facilities can use to determine their compliance with these crucial infection control actions," and I believe you indicated that there was a checklist provided to the facility by CMS, not the checklist we looked at but there was some other checklist that was provided to for these infection control compliance purposes?

A. Right.

Q. Correct?

A. Yes.

Q. And if we go to the last page, so towards the top of the page, the first bullet point reads, "Long-term care facilities should separate patients and

residents who have COVID 19 from patients and residents who do not or have an unknown status." Were you aware of that guidance in early April 2020?

A. No. This contradicts the Department of Health guidance that we received.

Q. What was the Department of Health guidance that you received?

A. Well, when they were here on our survey and when we speak with them, and I believe it's in writing as well that the initial guidance and specifically from the medical director was to not move residents, and we read it in an earlier bulletin, you recall, I don't remember which one, was to not move residents throughout the facility because at that time they were afraid it would spread throughout the facility.

This is what I say to you when we were getting conflicting guidance throughout the pandemic, it's a perfect example, so thank you for bringing this up.

Q. Just so I'm clear, so you were

not aware of this CMS guidance in April of 2020?

A. No.

Q. If we look at the section two, the little ii, it says, "COVID 19 positive units in facilities must be capable of maintaining strict infection control practices and testing protocols as required by regulation. When possible, facilities should exercise consistent assignments or have separate staffing teams for COVID 19 positive and COVID 19 negative patients."

Were you aware of that guidance in early April of 2020?

A. We were already doing that. I didn't need he guidance for that.

Q. Did Fulton have separate staffing teams for COVID 19 positive and COVID 19 negative residents?

A. Well, again, I think it says when possible facilities should exercise consistent assignment, which is what we did, we had consistent assignments within the facility.

Q. Okay. So the second part that have where it says, "Or have separate staffing teams for COVID 19 positives and COVID 19 negative patients," was that implemented by Fulton?

A. Well, it was an either or and the first part was implemented.

Q. So the first part was implemented but not the second?

A. And again, I will repeat my answer you asked me a little while ago, you have to ask Mrs. Frawley that question.

Q. Okay, so it's possible that they did but you're just not aware of it, is that fair?

A. Correct, you would have to ask the director of nursing.

Q. Okay. I would like to show you what else been pre marked as Exhibit 61. This is a two-page document.

Ms. Doyle, do you recognize Exhibit 61?

A. I do.

Q. What is this exhibit?

A. This is a letter to nursing home administrators from the Department of Health.

Q. What's the date on this letter?

A. April 29th, 2020.

Q. Did you, in fact, receive this letter on April 29th, 2020?

A. As I testified yesterday, I don't know if it was the 29th or the next day.

Q. Is this the April 29th guidance that you testified about yesterday that you indicated prompted establishing units 1 East as the COVID unit?

A. That's correct.

Q. Okay, so I am just going to read the top of the letter under Dear Nursing Home Administrator. "This letter is intended to serve as a reminder of your facility's obligations under public health law and regulations to ensure that all the residents receive the care they need. Specifically, pursuant to 10 NYCRR Section 415.26, nursing homes must only accept and retain those residents form whom the

facility can provide adequate care."

Did I read that correctly?

A. You did.

Q. So is this indicating that this letter is trying to serve as a reminder of certain actions that the facility should have implemented?

A. Well, this was a tricky memo, quite frankly because the governor was trying to backtrack on his initial order to accept COVID residents and he was trying to cover his patootie with this one in my opinion, so you know, so that's why he threw it there to only accept and retain those residents. That wasn't in the first one when he told me to take COVID residents.

Q. Ms. Doyle, let me ask you this and please take your time to look at this memo. What part of this guidance was new to you when you received it in at the end of April?

A. Sure. I believe on bullet number three, the .2 check them every 12 hours while on duty was new.

Q. Okay.

A. And the fifth bullet was new.

Q. Okay.

A. Can you scroll down, though? I can't see the whole thing. Thank you.

Q. What part of the fifth bullet was new?

A. Successfully separating where they -- well, let me read it as it says. Having protocols to separate -- well, it's the whole bullet. You want me to read it for you?

Q. Sure.

A. Okay. "Having protocols to separate residents into cohorts of positive negative and unknown, as well as separate staffing teams to deal with COVID positive residents and non positive residents. The staffing teams we were aware of the cohorting, the separation was new guidance. In order to effectuate this policy, nursing homes facilities should transfer residents within a facility to another long-term care facility or to another non certified

location if they are unable to" there is a typo. Should be successfully "separate patients within the facility."

Q. So is it your testimony that the first part of that memo, the part that reads having protocols to separate residents into cohorts of positive negative and unknown, that was new to you?

A. What was new to me was to transfer them within the facility to separate them. Prior to that, the guidance was to leave them where they were.

This is the first time in the last line where they indicated that if you couldn't, you know, suspend admissions to the facility, that was new as well.

Q. And Ms. Doyle, the guidance that we saw on CMS on April 2nd, and that was almost a month earlier, and we can go back to that if you would like, do you recall that that guidance says that there should -- the facility should designate separate facilities or units within a facility to separate COVID 19 negative residents from

COVID 19 positive residents and individuals of unknown status?

A. Again, I was taking my direction from the Department of Health.

Q. As a nursing home that receives money from Medicare and Medicaid, you are required to comply with the regulations of CMS and the Department of Health, correct?

A. Yes. As interpreted -- well, DOH is the designee of CMS so CMS tells the State what to do and then the State tells us what to do.

MR. YAFFE: Counselor, could you can you give us an indication of when we're going to take a break?

MS. SEKHON: Yes.

MR. YAFFE: I am needing one, and I don't know --

MS. SEKHON: Sure.

MR. YAFFE: I didn't know what your intention was, but I wanted to discuss that.

MS. SEKHON: Just a couple of minutes, I am just going to wrap up

this section and then we will take a short lunch break.

MR. YAFFE: Okay.

Q. So Ms. Doyle, just so I'm clear, it's your testimony that CMS issues guidance, then DOH issues guidance, but you get your marching orders, for lack of a better term, from DOH; is that right?

A. Yes.

Q. And you would agree with me that you are required, by you I mean Fulton is required to comply with both DOH and CMS regulations, correct?

A. Again, you are asking me a question that is not a yes or no answer. I think I was pretty clear when I said that CMS issues its guidance to the State and the State issues it to the facility.

Q. Yes, but as a Medicare and Medicaid provider, the facility is required to stay up-to-date on CMS guidance as well, correct?

A. We are required to follow guidance issued to us by the Department of

Health, yes.

Q. Is it your testimony that you are not required to follow guidance issued by CMS unless and until it comes through the Department of Health?

A. We do not normally get guidance from CMS directly.

Q. I believe you indicated earlier that it would be your responsibility nonetheless to maintain, I shouldn't say to maintain, but to stay up-to-date on guidance from CMS; is that right?

A. The way I stay up-to-date is by monitoring what the Department of Health has me do.

Q. And occasionally you will check CMS's website, right?

A. Correct.

MS. SEKHON: Okay, we can take a break now. It is 1:38, should we do half an hour, is that okay for everyone?

THE WITNESS: That's fine.

MS. SEKHON: Mr. Yaffe, does that

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work for you.

MR. YAFFE: Yes.

MS. SEKHON: And Stefanie, does that work for you?

THE COURT REPORTER: Yes.

MS. SEKHON: Okay, we can take this exhibit down.

And just to verify also for scheduling purposes, it is my understanding that we need to complete today by 3:45 p.m., is that right?

THE WITNESS: Actually, I cancelled my appointment so I would rather just get done. You are more on fun than the dentist anyway.

MS. SEKHON: I don't know that I hear that too often, so.

THE WITNESS: I hate the dentist.

MS. SEKHON: All right.

(A recess was taken.)

MS. SEKHON: So we can go back on the record, and let the record reflect the time now is 2:12 p.m. we took an approximately 35 minute break, we did a

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role call off the record and ensured that all participants who were present this morning are still currently present, and Ms. Doyle, I will remind you that you are still under oath.

THE WITNESS: Before we get started, can I clarify something that was from previous testimony?

MS. SEKHON: Sure.

THE WITNESS: We ended up with you asking me if I follow CM S guidance. I would like to clarify that my answers were in respect to the COVID pandemic. I wasn't trying to imply that we don't follow CMS guidance, but during the pandemic we took our direction from the Department of Health, particularly because the governor was on his daily phone calls indicating that he was running the pandemic in his state and not the federal government, so I just wanted to clarify that for you.

MS. SEKHON: Thank you for that

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clarification.

Q. So would you acknowledge then, Ms. Doyle, that it is the facility's responsibilities generally speaking to follow CMS guidance an as well?

A. Yes.

Q. Are any of your staff unionized?

A. I'm sorry?

Q. Sorry. Are any of your staff unionized?

A. Yes. I thought you said immunized. I hope many of them. Yes.

Q. And what unions do your staff belong to?

A. SEIU 1199.

Q. And which staff belong to that union?

A. Dietary, housekeeping, CNAs, LPNs, maintenance, recreation, I think that's everybody.

Q. Did any of your staff complain to you between March 1st, 2020 and June 1st, 2020 that they did not believe they had sufficient PPE?

A. No.

Q. Did any of your staff complain to you that between January 1st 2020 and June 1st 2020 that they did not believe they had sufficient PPE?

A. No.

Q. Was it ever brought to your attention that any of your staff were making those complaints to their immediate supervisors?

A. No.

Q. I know you mentioned before that you had conversations with Steven Weiss and that you personally were on Amazon trying to obtain PPE, and yesterday you also mentioned going through the Office of Emergency Management OEM. Were there any other methods utilized by Fulton in order to prepare PPE?

A. We did receive some from the federal government as well, although it was all defective. No, it was through our purchasing agent we borrowed between facility at times when a facility needed

something and the other one was running low.

At no point did I ever run out of any type of PPE thankfully. We were able to secure whatever we needed throughout the entire pandemic using CD C guidelines on reusing PPE.

I just want to backtrack to your question. It was brought to my attention that somebody was under the impression that we didn't have the proper PPE because we did get a call from OSHA, although they didn't indicate who made the call, somebody called them to indicate that we didn't have proper PPE. I responded to their inquiry and they dropped, you know, they didn't have any findings.

Q. Okay, and OSHA, is that the Office of Safety and Health Administration, I think?

A. I think that's the title. It's the organization that protects the welfare and safety of employees as opposed to residents.

Q. Okay. Did you also receive any

complaints from the union, from 1199 that some of your staff were alleging that they did not have sufficient PPE?

A. I think at one point the union inquired as to whether we have proper PPE, I am not sure they worded it in terms of a complaint. I don't recall exactly, but the union did inquire about the PPE.

Q. And what was the result of that inquiry?

A. Again, I think I showed them photos of the stockpile of PPE that I had at that time and they were satisfied. Same as my response to OSHA. I still have the photos.

Q. You mentioned that the PPE that you received from the federal government was defective?

A. Yes.

Q. In what way was it defective?

A. Well, it depends on PPE, which by the way, I didn't request it from them. It just started showing up in the facility. For example, the masks were defective. They

were so old that the straps were would break if you try to put it on your head. Things of that nature.

Q. What other PPE did the federal government provide to Fulton?

A. Oh, I really don't recall exactly what came from where and when.

Q. Were you able to utilize any of the PPE that was provided by the federal government?

A. I don't recall.

Q. Did there come a time when Fulton made gowns out of garbage bags?

A. We used those as a second layer of protection. It was never the only gown protection provided to them. I actually paid a CNA to come in for two days and make them just in case we ran out. We never had to utilize them as the primary source of PPE.

Q. How long were they used utilized as a secondary source?

A. I may have misspoke. I am not even positive they were used as a secondary

source. I don't really recall. I actually think they're still in the infection control room at this point, but.

Q. So they may have been used as secondary source but you're not sure?

A. Yeah, I'm not positive if they were ever rotated into use or not. I don't believe we had to but I don't want to speak, which, by the way, was the CDC guidance if you couldn't score gowns to use ponchos and plastic bags.

Q. In your efforts to obtain PPE for Fulton Commons, did you ever receive any sort of pushback from Mr. Weiss or from the owners relating --

A. No.

Q. -- to where you could go to obtain it?

A. Absolutely not. The exact opposite. If I needed it, I was to get it.

Q. Did they ever direct you --

A. -- by any means possible.

Q. Did they ever direct you on specific vendors that you should be

utilizing to obtain PPE?

A. Never.

Q. Did you ever have any discussions with Mr. Weiss regarding testing the residents?

A. I don't recall specifically discussing that. I may have, but I don't recall.

Q. Now, are you familiar with the term PUI or person under investigation?

A. I think I always interpreted it to mean similar to a suspected case, but.

Q. So it's a suspected case for COVID?

A. Yes.

Q. If I use the term PUI, will you understand that I am referring to a person suspected of having COVID?

A. I will.

Q. So I know we talked about the criteria that was used from about mid March, I think we agree that it was used most likely through May where it was if the individual had a fever over 100 degrees. At

the beginning of March, was it required that that fever be in conjunction with any other symptoms in order for a resident to be considered under suspicion of COVID?

A. I would have to refer to the clinical protocols that were ever changing. I don't recall specifically what was in place at what time.

Q. Okay. When did Fulton have its first PUI?

A. I don't remember the date. It was one that was suspected and actually came back as a UTI, but I don't recall the date. In March, but I don't remember the exact day. Again, that's why I took notes.

Q. Do you recall if it was early March or mid March or late March?

A. I am going to say mid March after we implemented our first round of safety protocols stopping visiting and that kind of stuff. I believe it was after that.

Q. Do you recall what unit that individual was housed on?

A. I do not.

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Q. What was the first protocol that was utilized to treat residents who were under suspicion for COVID?

A. I do not recall. It changed multiple times as the hospitals changed protocols the facility tried to change protocols as well. Sometimes we changed and couldn't get what the hospitals were using and had to change it again. It changed multiple times.

Q. And who was responsible for determining what protocol should be utilized?

A. Dr. Buchma, the medical director.

Q. When Fulton had its first suspected case of COVID to the first PUI, who was notified about that?

A. I'm sorry, what do you mean who was notified?

Q. Within the facility?

A. Oh, within the facility?

Q. Who was notified? Yes.

A. I would believe that -- well, the staff would have had to start wearing PPE

so, you know, appropriate to suspected positive case, so the staff on that unit, the unit manager, myself, I was notified because I didn't get the results, you know, I didn't determine that, and any other staff that would have gone on the unit so that they would be protected.

Q. What other staff would have gone on the unit?

A. At that time, recreation, social work, rehab, dietary, maintenance, housekeeping. It think that's it.

Q. Was the room the resident who was suspected of having COVID designated or identified in any way?

A. I don't know. I'm going to assume that the proper infection control sign was on but I didn't visualize it myself so I can't answer that.

Q. Why would it be important to tell other individuals so, you know, you mentioned recreation, dietary, social work, housekeeping, why would it be important to inform them if there was a resident who was

under suspicion of COVID on a particular unit?

A. It would be twofold. Number one, to protect the staff that would be entering the room, and number two, so that they would wear the appropriate PPE so to prevent the spread through the facility.

Q. Would you agree with me that if certain individuals such as recreation, housekeeping and dietary were not notified, then it would have been difficult to ensure that they were following the proper infection protocols when encountering a resident who was under suspicion for COVID?

MR. YAFFE: Objection.

A. Yeah, they're notified by signage on the door so before they could enter a resident's room, that signage would alert them to the fact and they are in-serviced to watch for that signage on the door.

In some cases of the pandemic it was on the outside of the unit when that unit was established, but prior to that the infection protocol would be that the

necessary PPE would be outside the room and a sign would be hung, that's how the staff are informed that that resident is on isolation. So there's no form that goes through the building or an e-mail or anything like that, it's that signage determines, you know, determines the fact that that resident is on isolation. Sometimes it will say, "Stop, see the nurse before entering the room." You know, that convened of thing.

Q. Okay. So that signage seems like it's very important; is that right?

A. Yes, it is.

Q. And absent that signage, someone who is entering the room would not have known that they need to implement certain safety infection protocols; is that right?

A. They may have known from other methods, I don't believe I said that.

Q. So it's possible they might have known otherwise, but that signage is really the way that the facility was ensuring that someone who went into that room would know

they had to implement certain infection protocols, is that fair to say?

A. That's fair.

Q. The first individual who was deemed a PUI or suspected case of COVID, did that individual have a roommate?

A. I don't recall who it was, so I can't answer that question.

Q. Okay. Ms. Doyle, did there come a time that DOH reached out to you regarding testing residents for COVID 19?

A. Not that I recall.

Q. Do you recall ever receiving an e-mail that was forwarded to you from other staff members with respect to a DOH request to come in and test the residents for COVID?

A. Well, yeah, they did. I don't think they tested the staff, they tested the residents. Correct. And then we started weekly testing right after.

Q. Do you recall when you were contacted by DOH?

A. I want to say the end of May, but again, without my notes in front of me, I'm

guessing.

Q. So I would like to show you what's been pre marked as Exhibit 62. This is a five-page document, and we can scroll down slowly. If you would, like we can zoom out.

A. I can't read this as the scrolling so fast.

Q. All right, we are going to read it.

A. Okay.

Q. E-mail by e-mail together, I just wanted to scan it right now so you can kind of just take a look at what it is and then we will go through each e-mail individually.

A. Okay.

Q. So Ms. Doyle, does this five-page document appear to be an e-mail chain?

A. It does.

Q. And as we were scrolling through, did you see that your name appeared on some of those e-mails?

A. Yes.

Q. So we are going to start from the

bottom. This is in reverse order, so starting from page five we will just scroll up slowly, and before we go to the next page, can we agree that this appears to be a continuation of an e-mail at the top of page five?

A. Yes.

Q. Okay, so if we scroll up now to page four, and if we stop towards the top of page four, does this appear to be the first e-mail that was sent in this chain?

A. Yes. I mean, I can't really tell but from what you are showing me it's the first e-mail.

Q. Okay, and it does say towards the top of page four original message; is that right?

A. Yes.

Q. Okay, and who is that e-mail sent from?

A. Marie Tsivitis.

Q. And based on the e-mail address, does that appear to be someone who works for the Department of Health?

A. Yeah, I believe she is with the epidemiology office or the infection control office, not the regulatory branch but a different division of the Department of Health.

Q. And who is this e-mail that we're looking at, who was it sent to?

A. Marie Baptist.

Q. The infection preventionist at Fulton, is that right?

A. At the time, yes.

Q. And what's the date on this e-mail?

A. May 26th.

Q. So we can agree then that at least as of May 26th, Ms. Baptist was still employed by Fulton; is that right?

A. Yes. Well, if she answered this. You know, I can't really speak to that. If she answered it, she was still here. If she didn't, I don't know.

Q. So let's scroll up just a little bit then to the bottom of page three. Okay. And just from what we're looking at between

the bottom of page three and top of page four, does it appear that Ms. Baptist forwarded this message to someone?

A. Yes.

Q. Who did she forward this message to?

A. To the director of nursing two days later.

Q. And that's Carol Frawley; is that right?

A. Correct.

Q. So if Ms. Jean-Baptist was able to forward that this message two days later, would that indicate that she was still working for Fulton Commons?

A. Yes.

Q. On May 28th?

A. Yes, it would.

Q. If we go gown back down to the original message. Can you please read the first two paragraphs out loud.

A. "Hi Marie. As discussed, there is a pressing need to completed the COVID testing of all nursing home residents. As

promised, I have included the CMS links at the bottom of this e-mail. Thank you for reviewing this with your leadership today. Please review the information below and if you wish to have New York State Department of Health perform the swabbing, please contact me and begin as per these instructions. If you decline, please advise how your facility will meet the requirement of CMS, example, testing all residents by facility hiring a service to perform testing, etcetera."

Q. And if we look towards at the bottom of the screen right now, do you see an area where it says, "Benefits of testing residents may include."

A. I do.

Q. Would you please read what's listed as benefits of testing the residents?

A. "Benefits may include CMS has the expectation that facilities will test all residents for COVID. No cost to facility, nurse swabbing team comes by June 7th. The ability to accurately cohort residents

according to their COVID 19 status. Improved and more efficient use of your facility's PPE. The ability to perform enhanced monitoring of residents who are newly identified as COVID 19 positive."

Q. So Ms. Doyle, does this indicate that the Department of Health would have come in and tested all of the residents of Fulton Commons at no cost to the facility?

A. It does and they did.

Q. Would there be any downside to the Department of Health coming in to test the residents?

MR. YAFFE: Objection.

A. I couldn't think of any at the time, but I believe that's why I reached out to my medical director to inquire if he had seen it in other facilities and, you know, what his thoughts were on it. This would be a medical decision, which is why I would have reached out to him, I believe.

Q. So let's scroll up a bit. So we did see together that this was forwarded from Ms. Baptist to Ms. Frawley. If you can

continue controlling up. Towards the bottom of the page, do we see it was also forwarded by Ms. Frawley to you?

A. I see it.

Q. And then if we look up now to what's displayed at the top of our screen, is that an e-mail sent by you?

A. It is.

Q. And who was that sent to?

A. To Mrs. Frawley and Marie Tsivitis.

Q. Could you please read your e-mail?

A. Sure. It says, "Hi, Marie. My name is Cathie Doyle, administrator at Fulton Commons. Can you please advise as to whether testing of residents in New York State is required at this point. Thank you, Cathie Doyle."

Q. Is there a reason why you asked that question?

A. Because prior to this information from Department of Health testing was not required nor recommended, so I wanted to see

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if the guidance had changed.

Q. Is there a reason you were asking whether it was required?

A. Because I wanted to see if the guidance had changed.

Q. How did you feel when you got this e-mail from Ms. Frawley?

MR. YAFFE: Objection.

Q. You can answer.

A. I felt confused because our guidance had been not to test residents and now the Department of Health was saying they want to come in and test the residents, so I was seeking clarification as to whether the regulation had required -- had changed. Sorry.

Q. Did you think at that time since this is May 28th of 2020, did you personally think that testing the residents would be a good thing?

MR. YAFFE: Objection.

Q. You can answer.

A. Again, I saw no reason for it, quite frankly. If somebody was presumed

positive they were treated, so what would the result of a positive test do for us. That's what the director, that's what the medical director advised me and that's what I went by.

Q. At the time that this e-mail chain occurred, so May 26th and 28th of 2020, were you aware that residents could be infected by COVID 19 but be asymptomatic?

A. It's probably -- again, I'm guessing it's probably around the same timeframe that they were becoming more sure that there could be asymptomatic people that had COVID. I am going to guess it was hand-in-hand which resulted in them wanting to test every resident.

MS. SEKHON: So let's scroll up a little bit. You can stop right there.

MR. YAFFE: Could you tell me what exhibit number this is, I sort of missed that.

MS. SEKHON: Sure. This is Exhibit 62.

MR. YAFFE: Okay. Thank you.

C. Doyle

MS. SEKHON: Sure.

Q. And Ms. Doyle, do we see at the top of the screen that we're looking at right now and, again, we are still on page three, a response from Ms. Tsivitis to you?

A. Yes.

Q. And what was her response?

A. "Yes, testing of all residents who were never previously positive for COVID 19 is required. New York State Department of Health has a 14-day initiative to assist facilities in this effort, which ends 6/7 described below. Please call me at your earliest convenience to discuss how to arrange this or to decline if you will conduct this testing without the swab team from New York State. Marie." And then her number.

MS. SEKHON: Let's scroll up a bit more. If you can scroll up a little bit more probably to the bottom of page two.

Q. Okay, Ms. Doyle --

A. You skipped, you skipped some

e-mails there.

Q. Oh, you're right. No, going to the bottom of page two, I think that's the top of the e-mail.

A. From me to Marie.

Q. Yes.

A. Uh-huh.

Q. That's the response that you wrote to Ms. Tsivitis?

A. Yes, correct.

Q. The e-mail that we just read?

A. Yes.

Q. What did you write back to her?

A. Again, I wanted clarification because we had done antibody testing so I wrote, "We did antibody testing for all residents. Does this test count. And can you send me the regulation, executive order or guidance, please. Thanks, Cathie."

My phone is ringing, my apologies.

Q. Do you need to take it?

A. No, they're calling about my car warranty 3,000 times a day.

C. Doyle

MR. YAFFE: She is going to start asking you questions about that if you --

THE WITNESS: She can ask about my car warranty, I'll forward the calls to her.

Q. Ms. Doyle, what's the difference between an antibody test versus COVID 19 PCR test?

A. I'm not a physician, nor an expert, but my layperson understanding based on having gone through this for 10 months or 11 months is that an antibody is a blood test that alerts you to the fact whether a residence has antibodies built up and a test tests whether you currently have COVID or not.

Q. So would it be fair to say that an antibody test is more likely to show that a resident previously had COVID 19 and has recovered, while a test will show the presence of a current infection?

A. Again, I'm not a medical person but my understanding is that an antibody

test could also show if you currently have COVID. But again, I'm not a medical person.

Q. Okay. So let's scroll up a little bit more then. And at the top of the screen that we're looking at now and, again, right now we're on page two of this exhibit, is there a response from Ms. Tsivitis to you?

A. Yes. She said, "It's great that you test for antibody status, but no, this is not acceptable. Please call when you have a moment, thank you, Marie."

Q. Let's scroll up again. Towards the top of the screen that we are looking at now and, again, we are still on page two, did you respond to Ms. Tsivitis' e-mail?

A. I did.

Q. And could you please read your response?

A. I said, "With all due respect I do not have a moment right now. I have to complete surveys for DOH. Can you send me the regulation or executive order, please."

MS. SEKHON: Please scroll up a

C. Doyle

little bit more.

Q. Going now to it seems the about the middle of page one, did Ms. Tsivitis respond to your e-mail?

A. She did.

Q. And I am just going to ask you to read the first three lines.

A. "I understand background cohorting of COVID infected residents including asymptomatic or pre symptomatic infected reduces transmission of COVID 19. See attached reference NMWR publication which supports the CMS directive to have a baseline test of all residents."

Q. And I am not going to have you read everything else, but could we agree she gave further information in her e-mail to you?

A. Yes.

MS. SEKHON: So we will scroll up a little bit.

Q. And if we just starting from what we see at the top of the page now which it starts the lines on May 28th 2020, does it

appear that you sent another e-mail?

A. Yes, but I can't see to whom. I don't know if you have to scroll up a little more.

Q. Okay, yeah, we probably have to scroll up a little more.

A. It doesn't say who it's to. That's very odd. It shows that I sent it but it doesn't say who it went to.

Q. Okay. So it does indicate that you wrote an e-mail at that point?

A. Yes.

Q. At 6:37 p.m., and could you please read your e-mail?

A. I said, "This woman is telling me that this is required, please advise."

Q. Do you recall sending that e-mail?

A. I do.

Q. Do you recall who you sent that e-mail to?

A. Dr. Buchma.

Q. And just underneath the please advise, it reads sent from my iPad?

A. Yes.

Q. Does that mean that this was an e-mail that you sent from home, potentially?

A. Likely, yes. Although I'm not usually home by 6:07, but.

Q. Well, then let me rephrase. Would you typically use your iPad in the facility to send or receive e-mails?

A. Not typically, no.

Q. So based on this e-mail which says that it was sent from your iPad, that would suggest that you were not in the facility, is that fair to say?

A. I can't answer that. I could have used one of the iPads that we were using for recreation. I don't recall. I'm just not usually home by 6:07, that's what's getting me so I don't really want to answer you. I don't recall.

Q. Okay, that's fine. Would that suggest that you did not use your office computer to send that particular e-mail?

A. Yes.

Q. And if we scroll down a little

bit again to the e-mails that you had sent earlier in the day, so looking, for example, in the middle of page two, the e-mail it's from you to Ms. Tsivitis where you indicated with all due respect, I do not have a moment right now. Do we see any notations on the bottom of that e-mail that would indicate it was sent from your iPad?

A. No.

Q. So would that indicate to you that that e-mail was sent while you were in the office?

A. Yes, it was also four p.m., so likely I was still here, yes.

MS. SEKHON: So we can scroll back up.

Q. Okay, so after the e-mail that you sent at 6:07 p.m., did you receive a response from someone?

A. I did.

Q. And who did you receive a response from?

A. Dr. Buchma.

Q. And do you see that response on

the screen right now?

A. I do.

Q. And what did Dr. Buchma say?

A. "This is what I'm hearing but I have not seen documentation. I know they had four or five people come into Carillon and test the patients from DOH."

MS. SEKHON: And if we scroll up.

Q. So now we are at the top of the exhibit the top of page one. Is there a one-word e-mail in this chain?

A. There is.

Q. And who is that e-mail from?

A. Dr. Buchma.

Q. And who was it sent to?

A. Sent to me and copied Mrs. Frawley.

Q. And what did Dr. Buchma say in that e-mail?

A. He said "In Flushing and Westhampton they are going to test. Quantum tested them all anyway."

Q. Were you reluctant to have Fulton's residents tested for COVID 19?

C. Doyle

MR. YAFFE: Objection.

MS. SEKHON: Counselor, is there a privilege attached to that question?

MR. YAFFE: No.

MS. SEKHON: Okay.

Q. Ms. Doyle, please go ahead and answer the question.

A. I'm sorry, could you repeat the question?

Q. Sure. Were you reluctant to have Fulton's residents tested for COVID 19?

A. Reluctant is the wrong word. I wanted to ensure that I was not following one piece of department -- one department within DOH and not following what the original DOH guidance was. So I wanted to make sure that it's not infrequent that one department in DOH isn't aware what the other department is doing, and my intention was to make sure that we weren't violating the original DOH guidance to not test by now testing.

Q. Okay. And again, when you say the original DOH guidance to not test, you

are referring to the guidance that says testing is no longer necessary; is that correct?

A. Yes, where it went further on to tell counties which ones to pursue testing and which ones not to.

Q. So that's the guidance we looked at earlier today?

A. That's correct.

Q. Ms. Doyle, did you tell your staff members that because Fulton wasn't testing for COVID that there was no COVID in the building?

A. Absolutely not.

Q. Did you tell your staff members that because Fulton was not testing its residents, that if family members asked they were supposed to tell the families there was no COVID in the building?

A. Of course not. Families were told on my robo calls that there were suspected cases and that's what they were told when their loved ones were involved. There was no guidance to reveal any other

information to any other family members at the time, if you recall. Other peoples' diagnoses were not other family members businesses until the Governor mandated we release that information.

Q. Ms. Doyle, how many COVID presumed or COVID confirmed Fulton residents passed away?

A. I don't recall that number off the top of my head, I'm sorry.

Q. Were any of those residents transferred to a hospital prior to their passing?

A. Yes.

Q. How many?

A. I don't recall.

Q. Was it more than five or less than five?

A. I don't recall.

Q. Did you ever direct that residents should be discouraged from being transferred to the hospital?

A. Did I discourage, no, the hospitals did, the EMTs did, but not me, no.

C. Doyle

Q. Did Steven Weiss ever direct you to discourage residents from being transferred to the hospital?

A. Absolutely not.

Q. Did Dr. Buchma ever direct you to discourage residents from being transferred to the hospital?

A. You are using the word discouraged. We discussed that sending them to the hospital meant that an elderly resident would be sitting on a stretcher alone to die of COVID in unfamiliar surroundings and the physicians when they reached out to the family members would describe this to them and ask if they wanted them to stay or go. As a matter of quality of life and quality of death, quite frankly, but there was no directive not to send residents to the hospital, no.

I do recall one that we sent was in the ER for about an hour and then discharged to another long-term care facility with no further treatment other than what we provided. She's still alive

and well in another facility.

Q. With respect to the residents who passed away at Fulton Commons between March 1st, 2020 to July 1st, 2020 were COVID presumed or COVID confirmed, were any of the once who were COVID confirmed tested at Fulton as opposed to being tested at the hospital?

A. No, not to the best of my recollection.

Can we take this exhibit off an make you bigger?

Q. Yes, and again, I apologize.

A. I will remind you, don't worry.

Q. Please do.

A. Yeah thanks.

Q. Are you familiar with the HERDS system?

A. I am.

Q. And what is the HERDS system?

A. HERDS is a communication system between facilities and the Department of Health.

Q. Is it still utilized as a result

of the COVID 19 pandemic?

A. Every day.

Q. And are you required to report certain information through the HERD system to the Department of Health?

A. I am.

Q. And what information are you required to report?

A. That change throughout the pandemic, you would have to be more specific.

Q. Sure. Between March 1st, 2020 and June 1st, 2020, what information were you required to report?

A. Again, I won't recall every question off the top of my head, but it was seeking information concerning the number of positive COVID cases, suspected COVID cases, suspected COVID deaths, positive COVID deaths, number of hospitalizations, names and demographic information including diagnoses of residents that had expired, and I can't recall if in the early days it wanted information concerning the employees

or not. I don't recall when that was added.

Q. Who at Fulton was responsible for submitting this information through the HERDS system?

A. Me.

Q. Was anyone --

A. With the exception of a couple of days where Mrs. Frawley did it on my behalf if I was off.

Q. Was there anyone at Fulton who was responsible for compiling or providing you with the documentation needed in order to submit this information to DOH?

A. Yes.

Q. And who was responsible for helping you in that regard?

A. Mrs. Frawley.

Q. Was she the only one responsible for assisting you in that regard?

A. Yes. She would gather the information where she got it from you would have to ask her but she would relay it to me, yes.

Q. Did you report any suspected

cases of COVID to DOH in March of 2020?

A. I'd have to see the reports. I'm sorry. I want to say yes, but again, I don't want to answer without being -- I don't have anything in front of me.

Q. Okay, so I would like to show you what's been pre marked as Exhibit 64. And this is a two-page document.

MS. SEKHON: If you can scroll down slowly, so you can scan it and we will go through each of the e-mails that are here individually.

Q. Ms. Doyle, does this peer to be an e-mail chain?

A. Yes.

Q. And were you listed on some of these e-mails, if not all of them?

A. Yes.

Q. So I just wanted to start with the first e-mail chronologically which begins on the bottom of page one. So at the bottom of page one, do you see where it's written on April 29th, 2020, at 10:48 a.m.?

A. I do.

Q. And does that indicate who wrote this e-mail that's below?

A. Yes, I wrote it.

Q. And just so that we're clear, in this particular section that we are looking at, it does not indicate who this e-mail was sent to; is that correct?

A. It does not again, no.

Q. Okay. Could you read your e-mail, please?

A. Sure. It says, "In light of Resident #57 positive COVID result in the hospital before her death, should I now be reporting our fevers, etcetera, as suspected cases to DOH?"

Q. Do you recall sending that e-mail?

A. I do.

Q. Do you recall who you sent that e-mail to?

A. I believe it was Dr. Buchma and possibly Carol Frawley.

Q. Why did you ask that question?

A. Because I didn't recall. I am

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going to assume that I didn't recall reporting COVID deaths, positive COVID before and I was asking for clarification from the medical director.

Q. So prior to that, is it your recollection at this point that you did not report any suspected cases to DOH?

A. I don't recall, as I said.

Q. Okay.

A. But I would have to look at the HERDS.

Q. What effect did Resident #57 , who, by the way, was that a resident at Fulton Commons?

A. It was.

Q. What effect did Resident #57 positive COVID result in the hospital have on Fulton?

A. Other than us being incredibly sad she passed, I don't know what you mean.

Q. Prior to Resident #57 death, was Fulton treating residents as being suspected of having COVID?

A. Yes.

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Q. Prior to Resident #57 death, had Fulton implemented certain treatment protocols for residents that would be consistent with treating a resident for COVID?

A. Yes.

Q. Prior to Resident #57 death, did Fulton have residents within the facility that were suspected of having COVID?

A. Again, I don't recall dates. I would have to look at documents. I would have to look at my notes. I know there was one that we presumed positive and then it turned out to be a UTI, so I can't answer that fully.

Q. Prior to Resident #57 positive COVID result, did Fulton have an increased number of residents who passed away in the months leading up to this, so from March 9th to April 9th as compared to in previous years?

A. I don't recall how many passed away in what months, but I mean, we

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definitely had a high number of deaths, yes.

MS. SEKHON: If we scroll up just a bit.

Q. Do we see that somebody responded to your e-mail?

A. I do.

Q. And who responded?

A. Dr. Buchma.

Q. And does that indicate other than yourself if that e-mail went to anyone else?

A. Carol Frawley.

Q. And what was Dr. Buchma's response?

A. "Unless there is a really obvious diagnosis like a big cellulitis leg."

MS. SEKHON: And if we scroll up again, please.

Q. Does it say indicate that you responded to Dr. Buchma's e-mail?

A. It does. Well, I don't know. I responded to somebody.

Q. That's fair. This does show a response; is that correct?

A. It does, but it doesn't show to

whom it went.

Q. Okay. Could you please read your e-mail response?

A. Okay. "So can you and Carol please review all residents and advise how many I should be reporting as in-house suspected cases, please."

Q. Would this e-mail suggest to you, Ms. Doyle, that prior to this date no suspected cases had been reported to DOH?

A. I don't know if I was trying to clarify how many or that -- I can't answer that. It could just as well be that I wanted to make sure we reported the correct number as a medical director. I may have been asking him to review the count. I don't know.

Q. Okay.

A. But definitely possible that I was asking him to review the count at that point.

MS. SEKHON: Let's scroll up then.

Q. Do we a see a response to your

e-mail requesting that information?

A. I do.

Q. And who was that response from?

A. Dr. Buchma.

Q. Was that sent to you and to Ms. Frawley?

A. It was.

Q. And what was his response?

A. "Of course."

MS. SEKHON: And if we scroll up again.

Q. Did you respond thereafter?

A. I did.

Q. And what was your e-mail response?

A. Again, it doesn't indicate who it went to but it says, "Thank you, guys. I revised my reporting today to include 21 perspective cases and one COVID death in hospital."

Q. So would this e-mail indicate to you that the numbers that you reported to DOH were different on April 9th as compared to what they were the day before?

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A. I don't know what I reported the day before, so I can't answer that question.

Q. But you used the term "revised the reporting" is that right?

A. I could have revised it by adding the death. I don't know. I don't recall. It's a two-part sentence. I don't know if I revised the suspected cases or added the deaths in the hospital is what I'm saying.

Q. Okay, but one of those things was different; is that right?

A. That's the inference from this e-mail, yes.

Q. Okay, all right.

MS. SEKHON: And we can scroll up.

Q. And did someone respond to your e-mail?

A. Yes.

Q. Who responded?

A. Dr. Buchma.

Q. And who did his response go to?

A. To myself and Mrs. Frawley.

Q. And what was his response?

A. "Okay, let's conference daily until this is over."

Q. And if we just go all the way to the top to the final e-mail. Did you respond thereafter?

A. I did.

Q. And your response was?

A. "Thank you."

MS. SEKHON: Now we can take this exhibit down.

Q. Ms. Doyle, do you recall if you reported any of those 21 residents who were suspected of having COVID to DOH prior to Resident #57 death?

A. I don't recall.

Q. Okay. I would like to take a look at what's been pre marked as Exhibit 65.

MS. SEKHON: Let the record reflect that this is a four-page document. We can slowly scan through, scroll through the rest of the pages on this. So we can scroll back up to the top.

Q. Ms. Doyle, is Exhibit 65 a single e-mail that was sent along with an attachment to that e-mail?

A. Yes.

Q. And who sent this e-mail?

A. I did.

Q. Who was it sent to?

A. Steven Weiss.

Q. Could you please read this e-mail?

A. "The 23 and 34 were in-house residents that were suspected COVID."

Q. What was the date of this e-mail?

A. June 16th.

Q. And that's in 2020, correct?

A. Correct.

Q. If we go to the second page, do you recognize this particular document?

A. I don't recall it, specifically.

Q. If we look at it together it has Fulton Commons Care Center listed at the top; is that right?

A. Yes.

Q. And then beneath that it says

Residents with COVID 19?

A. Yes.

Q. And it looks like we can scroll down just a little bit so you can get a better look at this page, but it looks like there are at least a couple of different lists; is that correct?

A. Yes.

Q. So if you look at the first list. What is the title of that list?

A. "Residents treated for virus without Plaquenil first protocol."

Q. Are you familiar with the common name for Plaquenil?

A. No, I'm not.

Q. Do you know if Plaquenil is Hydroxychlorquine?

A. Yes, that's it.

Q. So underneath that section we have a number of names listed. Are those residents of Fulton Commons?

A. They were, yes.

Q. So were those residents who were suspected of having COVID 19?

A. I assume so, that's why -- well, again, let me be clear. They had a fever. Whether the doctor suspected them of COVID or not, I can't answer that, you would have to ask the doctor, but if they were treated with the protocol, they had a fever.

Q. Okay. Going back to your e-mail, it says "The 23 and 34" we can go up to the first page just so we're reading along. It says the 23 and 34. I see it froze a little bit.

A. Yeah, I can't see it.

MS. LIPTAK: I am trying to unfreeze it on my end. I'm actually going to close the document and then reopen it.

MS. SEKHON: You know what, before you do that.

Q. Ms. Doyle, do you recall that your e-mail said the 23 and 34 were in-house residents that were suspected COVID?

A. I do.

MS. SEKHON: So we can just go back to the down to the second page.

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Q. So in light of your e-mail, is it fair to say that this first list of residents were individuals suspected of having COVID 19?

A. No, I should have reworded my e-mail to Steven Weiss to indicate that they were treated with the protocol and could have been suspected. My e-mail is incorrect. I am not a physician and I can't diagnosis and I shouldn't have.

Q. Okay. So then is it fair to say that these residents on this list were treated as if they had COVID 19?

A. They were treated that they had a fever and were treated with the protocol in case they were suspected COVID.

Q. And I think what we established throughout the day and a little bit yesterday also, 100 or higher were suspected of having COVID; is that right?

A. They were treated as if they were suspected of having COVID.

Q. And pursuant to DOH guidance, they were presumed of having COVID; is that

right?

A. Again, you would have to ask the physicians that question.

Q. Well, Ms. Doyle, my question is for you because the guidance says you no long have to test also indicated that they should be presumed as having COVID, isn't that the guidance we had gone over?

A. I would have to see that document again. I am not going to answer without seeing the documents. I'm sorry.

Q. Sure. Let's get that document back up. Just bear me with me because I don't want to ask my assistant to put up the wrong exhibit, but I believe that was Exhibit 11.

MS. SEKHON: No, that's not the right one. Okay. Exhibit, 60 let's put that back up.

Q. So locking again at Exhibit 60, I am going to direct your attention to the second full paragraph, so "As a result, any febrile, acute respiratory illness or clusters of acute respiratory illness

whether people are not in nursing homes and adult care facilities in New York City, Long Island, Westchester County and Rockland Counties, should be presumed to be COVID unless diagnostic testing results otherwise." Did I read that correctly?

A. You did. This includes respiratory illness, not just fever.

Q. Okay, so Ms. Doyle, according to the process and procedures at Fulton Commons were residents who ran a fever of 100 and higher deemed a suspected case of as of mid March?

A. I would have to review the protocols. I don't recall all the symptoms that were outlined to define a suspected COVID resident. I believe I said that earlier.

Q. Okay.

MR. YAFFE: I am going to need like a three to five minute break at some point in the near future without interfering with your questioning, counselor.

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MS. SEKHON: Thank you. If we can get Exhibit 58 back up on the screen. And if we can go back to page 11.

Q. Ms. Doyle, we looked at this exhibit earlier today this is the protocol for residents with suspected COVID, as well as residents admitted from hospital with confirmed COVID?

A. Uh-huh.

Q. And under the protocol for in-house residents with suspected COVID diagnosis it says, "Any resident residing in the facility that has a fever of 100 will be assumed as a suspected case of COVID and will be placed on isolation precautions immediately." Did I read this correctly?

A. You did, but this document is undated, and I have no idea before or after, you know, these protocols changed.

Q. Okay, I believe you testified earlier that you thought that was the protocol in mid March, is that no longer your testimony?

A. I believe I said I don't recall but it appears as if it's from them.

Q. It appears as it this was done mid March then, correct?

A. That's my best guess.

Q. So going back to Exhibit 65, so according to your e-mail and according to this document that's titled Residents with COVID 19, the first list of residents that we see on here were residents that were suspected of having COVID in-house; is that correct?

A. I am going to assume. Again, you would have to ask the physician that, I am not a physician, but based on them being -- saying that they were treated as if they had the virus, I would say yes.

Q. Okay. Could you read their names please out loud, just the first list?

A. Sure. You want the first name too?

Q. Yes, please?

A. Resident #47 , Resident #53 , Resident #54 , Resident # 55 , Resident #58 ,

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Resident # 59 , Resident #60 , Resident #61 , Resident #2 , Resident #62 , Resident V.T. , Resident #63 , Resident #64 , Resident #65 , Resident #66 , Resident #67 , Resident #68 , Resident #69 , Resident #70 , Resident H.G. , Resident #71 , Resident #72 , and Resident #73 .

Q. Thank you.

MS. SEKHON: Counselor, before we move on to the next exhibit, I will accommodate your break request, so we can take five minutes now. It's 3:14, we will reconvene at 3:20.

And Ms. Liptak, you can take the exhibit down. Thank you.

MR. YAFFE: Thank you.

(A recess was taken.)

MS. SEKHON: Let the record reflect we will did a quick role call off the record and all individuals present this morning continue to be present at this time. Ms. Doyle, I remind you that you are still under

oath.

So at this time I am going to ask the witness what's been pre marked Exhibit 66.

Q. Ms. Doyle, what we have in front of us is a 23-page document. I am just going to ask my colleague to scroll down very quickly just to see what the nature of each of these pages is and then we will talk more specifically about each one.

So going back up to the top to page one, Ms. Doyle, do these all appear to be death certificates?

A. Yes.

Q. I am just going to take a look at page one with you. Who does that certificate pertain to?

A. Resident #55 .

Q. Was that a resident of Fulton Commons?

A. Yes.

Q. Was she on the list of residents that we just read who was treated as if they were expected of having COVID 19?

A. I don't recall, but if you say so.

Q. We can go back to that list, if you would like.

MS. SEKHON: That was Exhibit 65.

A. Yes.

Q. Do you see Resident #55 name?

A. Yes, I do.

Q. Great. Going back to Exhibit 66, does that indicate on the death certificate what her death of death was?

A. I am not overly familiar with these, so give me one second.

Q. So I will direct your attention to the top right-hand side corner.

A. Yes, [redacted], 2020.

Q. So you mentioned you are not overly familiar with these, do you review death certificates at all in the course of your job as the administrator of Fulton Commons?

A. No.

Q. Do you play any role of preparing death certificates as an administrator of

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Fulton Commons?

A. No.

Q. Do you have any discussions with attending physicians regarding the information that's put on death certificates?

A. No.

Q. So according to this document, Resident #55 passed away on [redacted], 2020, correct?

A. Yes.

Q. And according to Exhibit 56 that we looked at, she was a suspected case of COVID; is that right?

A. Again, I am not a physician, I cannot answer that question. She is on a list that, you know, indicates she was treated as if she was suspected, but I can't answer your clinical questions.

Q. Okay, so to be clear, Resident #55 was treated as if she had COVID; is that right?

A. If the list we just looked at was correct, yes, but again, I didn't prepare

that list. I can't -- I can't answer to the accuracy of the list, I didn't prepare it.

Q. Do you know who did prepare that list?

A. Carol Frawley.

Q. Do you generally have confidence in the information that Ms. Frawley provides to you?

A. In general, yes, it's a very hectic time, though, and keeping track of information was, you know, a little more difficult than usual.

Q. Is it fair to say you don't have any specific reasons to doubt the information provided to you by Mrs. Frawley?

A. No, generally, no.

Q. So let's go back to page two and, Ms. Doyle, who does this death certificate pertain to?

A. Resident #73 .

Q. And is this also an individual whose name appeared on the list that we just looked at as having been treated as if she

had COVID?

A. Yes.

Q. What was her date of death?

A. [redacted], 2020.

Q. If we go to the third page, who does this death certificate pertain to?

A. Resident #62 .

Q. And when was her date of death?

A. [redacted], 2020.

Q. Was she also a resident whose name appeared on the list we just looked at as having been treated for COVID 19?

A. Yes.

Q. If we go onto page four, who does this death certificate pertain to?

A. Resident #68 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Did her name also appear on the list of the residents who was treated for COVID 19?

A. I don't recall.

Q. Let's go back to Exhibit 65, who does this pertain to?

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A. Resident #66 .

Q. What was his date of death?

A. [redacted], 2020.

Q. Did his name also appear on the list we just looked at as a resident who was treated for COVID 19?

A. Yes.

Q. If we can go onto page six. Who does this death certificate pertain to it?

A. Resident #69 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Does her name also appear on the list we just looked at as a resident who was treated for COVID 19?

A. Yes.

Q. If we go onto page seven, who does this death certificate pertain to?

A. Resident #72 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Does her name also appear on the list we just looked at as a resident who was treated for COVID 19?

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A. Yes.

Q. We can go to the next page. Who does this pertain to?

A. Resident H.G. .

Q. What was Resident H.G. date of death?

A. [redacted], 2020.

Q. Does his name also appear on the list that we just looked as a resident who was treated for COVID 19?

A. Yes.

MS. SEKHON: Can we go to page nine?

MR. YAFFE: Can you scroll slowly. You are not showing the entire document, in other words, who signed all these documents. I mean, these are not the witness's documents and if you can just scroll a little more slowly so we can see the whole thing.

MS. SEKHON: Mr. Yaffe, we established that this is not the witness's documents and she did not prepare these or sign them, I am just

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asking her to read the information on them.

MR. YAFFE: For what purpose? These are not her documents.

MS. SEKHON: That's not a question you are entitled to ask.

MR. YAFFE: I think I am.

MS. SEKHON: Unfortunately, what you think is not of a concern right now.

Q. Ms. Doyle, looking at page nine, who does if the death certificate pertain to?

A. Resident #53 .

Q. What is her date of death down here?

A. [redacted], 2020.

Q. Did her name also appear on the list of residents that we just looked at as someone who was treated for COVID 19?

A. Yes.

Q. If we go to page 10, who does this pertain to?

A. Resident #63 .

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MR. YAFFE: I don't see a signature on any of these documents, I mean, you are scrolling them very quickly.

MS. SEKHON: I am not asking her about any signatures, Mr. Yaffe.

MR. YAFFE: You are asking her to read from a document that appears to be unsigned, so if it's not signed it's not a proper certificate of death. You can do what you want, I am entitled to distinguish --

Q. Ms. Doyle --

MR. YAFFE: Give my opinion which it seems very irrelevant to you, but I can't see a single signature on any of these alleged, maybe they're draft certificates of death, I don't know what they are.

Q. Ms. Doyle, did there come a time when our office asked you for copies of death certificates for the residents at Fulton Commons who passed away?

A. Yes.

Q. And did you provide those death certificates to our office?

A. Yes.

Q. And are these some of the death certificates that you provided to our office?

A. I don't recall.

Q. To the best of your recollection?

A. To the best of my recollection, yes.

Q. Okay, thank you.

MR. YAFFE: I note the language on the left-hand side of every one of these which says -- I mean, it speaks for itself but it does say "This certificate is not valid unless it has been signed by the registrar of vital statistics."

MS. SEKHON: You have made your point, counselor.

Q. Ms. Doyle, looking at page 10, who does this pertain to?

A. Resident #63 , [redacted] [redacted], 2020.

Q. And that was her death of death

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[redacted]?

A. Yes.

Q. And did her name also appear on the list of residents we just looked at as someone who was treated for COVID 19?

A. Yes.

Q. Going to page 11, who does this pertain to?

A. Resident #59 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Did her name also appear on the list of resident that we just looked who were treated for COVID 19?

A. Yes.

Q. Going to page 12, who does this pertain to?

A. Resident #64 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Did her name also appear on the list of residents that we just looked at as having been treated for COVID 19?

A. I believe so, yes.

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Q. Before we move on from Resident #64, did there come a time when her daughter and son came to the facility in March, 2020, and asked to have her removed?

A. No.

Q. You do not recall having any discussions with Resident #64 daughter or son regarding removing Resident #64 from the facility?

A. No. They came and requested to visit with her, which we had obliged. They never requested her to be moved.

Q. You do not recall telling them that they could not take Resident #64 out of the facility?

A. Of course not. It's not a prison.

Q. Okay.

A. They never questioned to take her out or move her elsewhere. They asked to visit her which we permitted twice, actually.

Q. So if they had requested to remove her from the facility, is that a

request that would have been obliged by?

A. Absolutely.

Q. Okay. Let's go onto page 13. Who does this pertain to?

A. Resident #2 .

Q. What was his date of death?

A. [redacted], 2020.

Q. Does his name also appear on the list of residents that we just looked at treated for COVID 19?

A. Yes, in further answer regarding your previous question, that family also called the police while they were they were there. For what reason I am not sure, but if they wanted her removed, that certainly would have been their opportunity to bring it up further at that time. It was never discussed.

Q. What happened when they had the police called to the facility?

A. They were asking to go up and see their mother, which had already been granted. We were gearing them up with PPE. The daughter was distraught that her mother

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was ill and dying. Her brother was much more level-headed and appreciative of what we were doing for them.

Q. Were you ever told that her mother was under suspicion of having COVID?

A. I can't answer that, you would have to ask the physician.

Q. Would they be entitled to that information as her next of kin?

A. You would have to ask the physician.

Q. Do family members have the right to know how their loved ones are being treated at a nursing home in order for them to make informed decisions regarding their healthcare?

A. Depends on the individual circumstances. We went over this yesterday at length. If they are alert and oriented, if they have a guardian. Sometimes family members aren't entitled to information.

Q. So if there is an individual who is not alert and oriented and has a designated representative, would the

designated representative be entitled to information regarding whether their loved one was under suspicion for COVID?

A. If there is not a guardian that's making those decisions in lieu of the family member, yes.

Q. Now, would you agree with me that that would be important information for a family member to know so they can make an informed decision regarding their loved one's healthcare?

A. Yes, every family was aware that there was suspected COVID in the facility at some point.

Q. So just to make sure I didn't lose my train of thought here. So going on to the next page, page 13, who does this pertain to?

A. Resident #67 .

Q. And what was her date of death?

A. [redacted], 2020.

Q. Did her name also appear on the list of residents who was treated as being under suspicion of COVID 19?

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A. Yes.

Q. Go on to the following page. Who does this pertain to?

A. Resident #65 .

Q. What was this individual's date of death?

A. [redacted], 2020.

Q. Does her name also appear on the list of residents that we just looked at who were treated for COVID 19?

A. Yes.

Q. Going to page 16, the following page.

A. I would like to clarify I believe they were suspected cases, not confirmed.

Q. Yes, if I said --

A. Being treated for COVID.

Q. Yes, and understood and noted throughout our review of people, they are all suspected. Understood. Who does this death certificate pertain to?

A. Resident #60 .

Q. What was her date of death?

A. [redacted], 2020.

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Q. Did her name also appear on that list of residents who were suspected of and treated as if they had COVID?

A. Yes.

Q. Go to the following page. Who does this pertain to?

A. Resident #70 .

Q. What was his date of death?

A. [redacted], 2020.

Q. Does his name also appear on the list of residents that we just looked at who were treated for as if they were suspected cases of COVID?

A. Yes.

Q. Let's go to the next page. Who does this pertain to?

A. Resident #61 .

Q. What was his date of death?

A. [redacted], 2020.

Q. Did his name also appear on the list of residents suspected and treated as if they had COVID?

A. Yes.

Q. If we go to the following page,

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who does this pertain to?

A. Resident #54 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Did her name also appear on the list of residents that we just looked at who were suspected of and treated as if they had COVID?

A. Yes.

Q. Going to the following page, who does this pertain to?

A. Resident #58 .

Q. What was her date of death?

A. [redacted], 2020.

Q. Did her name also appear on the list of residents that we just looked at who were suspected of and treated as if they had COVID?

A. Yes.

Q. Go to the next page. Who does this pertain to?

A. To Resident V.T. .

Q. What was his date of death?

A. [redacted], 2020.

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Q. Does his name also appear on the list of residents that we just looked at who were suspected of and treated as if they had COVID?

A. Yes.

Q. We can go to the next page, who does this per taken to?

A. Resident #71 .

Q. What was his date of death?

A. [redacted], 2020.

Q. Does his name appear on the list that we just looked at who were suspected of and treated as if they had COVID?

A. Yes.

Q. If we go to the last page on this list, who does this pertain to?

A. Resident #47 .

Q. What was her date of death?

A. [redacted] 2020.

Q. And did her name also appear on the list of residents that we just looked at who were suspected of and treated as if they had COVID?

A. Yes.

C. Doyle

Q. Ms. Doyle, almost all of these individuals passed away prior to [redacted], which is the date that you were notified of Resident #57 positive COVID test; is that right?

A. Yes.

Q. Now, you talked about the robo owe calls.

MS. SEKHON: We can take this down. Thank you.

Q. Now, we talked about the robo calls and that you placed to family members and the information you gave them. Is it your testimony that you informed family members the fact that there were suspected cases of COVID in the building?

A. I would have to look at the dates and the contents of those robo calls how frequently that occurred prior to the Governor's executive order.

Q. So Resident #47 who was on that list of individuals who was treated as if she had COVID and had passed away according to the death certificate that we just looked at on

C. Doyle

[redacted], 2020, did you tell family members on [redacted], the following day, "We continue to have no Coronavirus cases amongst our residents, staff members or their families?"

A. I don't recall the specific dates or contents of my calls at this time.

Q. Would that have been accurate to tell family members after Resident #47 passed away the day before?

A. If she passed away she wouldn't be an active case so, yes. Two different things. Active cases and a death as outlined by the executive order that came down weeks later on how to make the calls.

MS. SEKHON: Let's put Exhibit 66 back on the screen. Can we go to page eight, please. Okay, can we go to the next page.

Q. So looking at page nine of this exhibit, and this refers to Resident #53 , what does it have her date of death as?

A. [redacted], 2020.

Q. So [redacted], 2020, Resident #53 passes away and she was on the list that we just looked at as a resident who was suspected of and treated as if she had COVID 19. In light of that, would it be accurate if on [redacted], the day before, you placed a robo call to family members telling them, "We continue to have no Coronavirus cases amongst our residents, staff members or their families."

A. That would be correct statement. We had no confirmed cases of COVID because we didn't test. There was no way to confirm whether we had confirmed cases or not.

Q. So you added a word in there that I did not say, so I understand you didn't test, and I am going to read it again. In light of her death on [redacted] would it have been accurate if on [redacted] you told family members "We continue to have no Coronavirus cases amongst our residents, staff members or their families."

A. Yes, at the time that's the information I had.

C. Doyle

Q. And why was that the information that you had?

A. Well, if you scroll down to the cause of death, we will see that it likely does not say anything about COVID.

Q. We can scroll down there, that's fine. Let's scroll down. And you are right, it does not say anything about COVID, so can you explain to me why she appears on a separate list that you provided to your supervisor Steven Weiss indicating that she was a COVID resident?

A. I believe the list was compiled because he had asked who had been treated with Plaquenil as opposed to those who had not been treated by Plaquenil and, you know, I don't determine cause of death, obviously, so I can't comment on death certificates and their contents, I don't have anything to do with them.

Q. Okay. And actually, Ms. Doyle, that's why I originally didn't ask you regarding the cause of death because I understand you don't complete that part of

it.

None-the-less, irrespective of what the bottom of this dead certificate says, you'll acknowledge that this resident appears on a list that you provided to your supervisor indicating that she was suspected of and treated as if she had COVID, correct?

A. Well, after the fact, yes.

Q. So --

A. That may very well be why there were corrected numbers submitted to the Department of Health concerning confirming positive suspected cases.

Q. Well, she was treated with Plaquenil, right?

A. Counselor, this is very early on in the game. You have the advantage of 11 months of experience with COVID, we didn't have at the time.

Q. Ms. Doyle, my question for you is not about what we know now versus what we knew then. My question for you is this resident appears on a list of residents what you testified to today were suspected of

having COVID?

A. Which in June we indicated were suspected of having COVID, not at the time of her death.

Q. Okay, but she was treated as if she had COVID?

A. Yes.

Q. So that treatment took place before her death?

A. Correct.

Q. So that treatment was taking place at the very least on [redacted], the day she died?

A. Correct.

Q. Would that probably have taken place on the day before [redacted]?

A. I can't speak to that, I don't know.

Q. Would it have been accurate on [redacted] to tell members family members that you have no Coronavirus cases?

A. Yes. I had no confirmed COVID had cases.

Q. Ms. Doyle, isn't it true that the

C. Doyle

reason you didn't want to test residents at Fulton was so that you could continue to say that you had no cases?

A. No, I was following Department of Health guidance.

Q. And the Department of Health guidance that we looked at also indicated that residents should be presumed in the absence of a test if she exhibit certain symptoms, correct?

A. Correct. Including febrile and respiratory distress. I don't see any respiratory distress on here as her cause of death, do you?

Q. What can cause cardiopulmonary arrest?

A. I am not a physician.

Q. All right, then. So we saw that Resident #47 , according to the death certificate, passed away on [redacted], 2020. We saw that, I should say we see that Resident #53 passed away on [redacted], 2020.

MS. SEKHON: Can we go to, I

C. Doyle

think it's going to be page 17.

Actually, it's 19, my apologies.

Q. So this death certificate pertains to Resident #54 , correct?

A. Yes.

Q. And her date of death on here is [redacted], 2020, correct?

A. Yes.

Q. Did you tell families on March [redacted], "There remains no Coronavirus in the facility."

A. I do not believe that was my wording. I never used that wording. I believed there were no COVID cases in the facility, and I don't know what I specifically said on [redacted].

Q. Would it have been accurate to say there remained no Coronavirus in the facility?

A. Yes. There was also no requirements for me to be making those calls by the way, just for the record.

Q. Ms. Doyle, I just want to go to looking at what's in front of you, this

death certificate, does that have an hour of her death?

A. It does.

Q. And what is that time?

A. [redacted]

Q. So she died the night of [redacted]; is that right?

A. Correct.

Q. And it's still your testimony that it would be accurate to tell families earlier in the day that there remains no Coronavirus in the facility?

A. Again, counselor, I am not a physician. I cannot diagnose. I went by what the attending physicians were giving me as information.

Q. Ms. Doyle, on [redacted], did you send out a robo call and did you state on that robo call, "We continue to have no cases of Coronavirus amongst our residents in the facility."

A. I don't have my robo call log in front of me. I don't recall -- are you going to keep asking me about dates of my

calls, I don't have it in front of me, counselor.

Q. Okay, I won't keep asking you about dates on your calls. On [redacted], did you issue a robo call in which you stated, "At this time we have no suspected or confirmed cases of COVID 19 in the facility?"

A. I don't have my timeline in front of me, counselor.

Q. On March 30th did you say, "As of today we have no confirmed cases of COVID 19 in the facility?"

A. I don't have my timeline in front of me. I can't answer any of these questions. If you give me my paperwork, I will answer you.

Q. Ms. Doyle, when you have residents who were being treated as if they have COVID 19 and residents who are on COVID 19 protocols, do you think it is still accurate information to tell families that there are no cases of Coronavirus in the facility?

A. Yes, there were no confirmed cases. I cannot -- I did not diagnosis and I can't say somebody has it if there wasn't a test, and I was told not to test by the Department of Health. You can see the riddle here we are in?

Q. Ms. Doyle, just for clarification, you were told that a test is not necessary, right? We haven't looked and you haven't mentioned any guidance that specifically said do not test; is that correct?

A. If you pull the document back up, I am happy to read it again with you.

Q. Do you recall whether that guidance said do not test?

A. It says said it's not necessary and it went on further to point out that counties that should pursue testing and those that should not. I was in the county that was advised not to pursue testing.

Q. Other than that guidance, Ms. Doyle, was there any other guidance that you can recall that you believe told you that

you should not test a resident for COVID 19?

A. I think that was the only one that addressed it one way or the other. I don't recall seeing others that addressed testing to test or not test other than that one guidance and the information a month later or so from the State saying they were going to come in and do the testing the baseline.

Q. Ms. Doyle, I believe you said yesterday that you are part of a group of nursing homes and that you share information they share information with you, etcetera, etcetera; is that right?

A. I am actually not in that association, no.

Q. Okay. Do you have friends who work at other nursing homes?

A. Yes.

Q. Okay, was it ever brought to your attention that other nursing homes were testing residents for COVID 19?

A. No.

Q. So nobody ever brought to your

attention that other nursing homes on Long Island or New York City were testing residents for COVID 19?

A. No, not until the Department of Health went in to do their baseline testing.

Q. Okay. So Ms. Doyle, we talked a little bit about room changes yesterday or I should say a lot of room changes that occurred on May 1st, 2020.

A. Can we take the document down now or no.

Q. Yes, we can take it down.

A. Thanks.

Q. Should those rooms that were vacated been terminally cleaned before a new resident was put in?

A. I'm sorry, what timeframe are we in now?

Q. Sure. We talked yesterday about room changes that occurred on May 1st, 2020?

A. Yes.

Q. Should those shows rooms that were vacated that day have been terminally cleaned before a new resident was put in?

A. Yes.

Q. Was there a log maintained by Fulton Commons that would show which rooms were terminally cleaned and which ones were not?

A. You would have to ask the doctor director of housekeeping Mike Andrews. I don't know.

Q. Have you ever asked Mr. Andrews if he was keeping a log of what which rooms were terminally cleaned and which ones were not?

A. No, I have not.

Q. Have you ever seen a log that would indicate that a room was terminally cleaned?

A. No, I have not.

Q. Would you agree with me that it would be a pretty major violation of infection control if a resident vacated a room and a new resident was moved into that room prior to the room being terminally cleaned?

A. It would be a violation of

C. Doyle

infection control protocols.

Q. So when in the documents you looked at with Mr. Zadek yesterday, there were two rooms in particular we talked about, rooms 105 and 122 were where residents were moved out on that were day and residents were moved in. Do you recall that?

A. I do.

Q. To your knowledge, is there any documentation anywhere at Fulton Commons that would show that those rooms were terminally cleaned before new residents were moved in?

A. Again, you would have to ask Mike Andrews as the director of housekeeping.

Q. Do you ever do spot checks with Mr. Andrews to make sure that he's implementing proper policies and procedures?

A. Yes.

Q. How often do you do them?

A. Ah, once every couple of months or so but he's responsible for submitting hits audits to me monthly.

C. Doyle

Q. What do those audit consist of?

A. Well, just to be clear, I don't want to misrepresent again, I have not made room rounds specifically since the pandemic began. Again, I have an auto immune and I try not to go to the units. That being said, pre pandemic it would include checking room cleanliness and the overall appearance of the units.

Q. So just so I'm clear, what you just referred to the checking the room cleanliness, would that be the spot check that you would typically do prior to the pandemic?

A. Yes.

Q. Through the pandemic, did you continue to do any sort of spot checks with Mr. Andrews in the housekeeping department?

A. No, not on the units.

Q. The audit report that Mr. Andrew submits to you on a monthly basis, what do those consist of?

A. Depends on the month. There is a comprehensive QAPI program in the facility

and each month departments are responsible for auditing and monitoring different aspects of their job requirements.

Q. Ms. Doyle, when you are doing this spot check for a room to determine cleanliness, can you tell from looking at it whether the room was terminally cleaned?

A. Only if I'm doing a check with them at the time where we, you know, watch the procedure together.

Q. Okay. So is it fair to say that after a room is cleaned it would be impossible for a layperson to walk in and know whether that room was simply tidied up versus terminally cleaned?

A. I guess it would depend on the layperson, but yes.

Q. Would you be able to tell after the fact if a room was terminally cleaned as opposed to just tidied up?

A. Probably not.

Q. Now, I do want to go back to one thing we talked about a little yesterday about the room transfers made on May 1st.

You said that those were the result of the guidance you received on April 29th, 2020; is that right?

A. Correct.

Q. Did those room changes have anything to do with the fact that you got a call from DOH asking you for certain documents?

A. I believe I was asked this yesterday and answered it. The answer is no.

Q. And just so I'm clear, is it your testimony that you did not believe that DOH was going to be coming in after you received their call on May 1st?

A. That was not my testimony, counselor.

Q. So please clarify that.

A. Ask a question.

MR. YAFFE: (Inaudible.)

Q. When you received a call on May 1st, 2020, did you form any opinion as to whether DOH may or may not be coming to Fulton Commons within the next couple of

days?

A. No, what I was told is that in other facilities when document requests occurred, they entered the next day.

Q. Did you expect them to appear in Fulton Commons on May 2nd, 2020?

A. No or I would have been in the facility.

Q. I would like to show you what I am going to deem marked as Exhibit 70, and we can scroll down slowly just so you can familiarize yourself with this document. Going back to the top, this is a four-page document. Ms. Doyle, does this appear to be an e-mail with an attachment?

A. Yes.

Q. Who sent this e-mail?

A. I did.

Q. Who did you send it to?

A. Mrs. Frawley.

Q. What's the dated on this e-mail?

A. May 2nd.

Q. Is that a Saturday May 2nd?

A. Yes.

Q. What time was it sent?

A. 8:55 a.m.

Q. And was this an e-mail that you forwarded?

A. It appears that way.

Q. Can you read your portion?

A. Sure. It says, "Here is the CYA letter. Wasn't sure if you got it, too."

Q. Is there anything underneath that before we get to the forwarded message?

A. No.

Q. So that doesn't say sent from my iPad, correct?

A. No, it does not.

Q. So that doesn't say sent from my iPhone, correct?

A. No.

Q. So this would imply that you were actually in the facility sending this from your office computer on Saturday, May 2nd; is that right?

A. No, I was not in the facility on Saturday, May 2nd at 8:55 a.m.

Q. How would you have sent this

e-mail?

A. I can't answer that, I am not a computer expert, but I was not in the facility on May 2nd.

Q. Well, we established your other e-mails that we looked at when you sent it from you iPad that it said sent from my iPad, right?

A. Some of them we saw that, yes. I haven't examined every e-mail I ever sent, no.

Q. And we saw that the ones that you sent during office hours when you believed you might have been or were in the office did not include that language; is that right?

A. Again, the ones we looked at, yes, certainly not all of my e-mails.

Q. This particular e-mail has no indication that that was sent from your iPad; is that right?

A. It does not indicate where it was sent from at all.

Q. Correct. It doesn't indicate it

C. Doyle

was sent from your iPad and it doesn't indicate it was sent from your iPhone either; is that right?

A. It's silent on where it was sent from.

Q. That's fine, Ms. Doyle, I am asking you a yes or no question.

Does this e-mail indicate whether -- I will rephrase. Does this e-mail state that this was sent from your iPad?

A. No.

Q. Does this state that it was sent from your iPhone?

A. No.

Q. And if we scroll down to the attachment to this e-mail starting on page three, what was the attachment that you sent to Ms. Frawley?

A. A letter from Howard Zucker err to the nursing home administrator.

Q. Is this the April 29th letter that we looked at earlier today?

A. It is.

Q. Is this the April 29th letter

that you have testified was the basis for the room transfers that occurred on May 1st?

A. Yes.

Q. And if we can scroll up, if we look at the forwarded section, the part where it indicates it was sent to you, does it indicate when you received that letter?

A. It indicates when it was sent, it doesn't indicate when I received it.

Q. What is the sent time on that?

A. April 29th at 7:36 p.m.

Q. Ms. Doyle, with respect to what you wrote to Ms. Frawley here is the CYA letter.

A. Uh-huh.

Q. What does that stand for?

A. "Cover your ass."

Q. And in what way was this letter intended to cover Ms. Frawley's ass?

A. No, no, not Mrs. Frawley, the Governor's.

Q. Please elaborate on that.

A. Sure. If you go down to the letter we discussed it earlier where I got a

little inappropriate with my comments in a the April 29th the letter was covering his ass from his March 21st letter when he directed us to take in residents that were COVID positive.

It had nothing to do with Mrs. Frawley.

Q. It had nothing to do with you?

A. Absolutely not.

Q. It had nothing to do with the room changes that you instituted on May 1st, 2020?

A. Absolutely not. It refers to the Governor's issuing new guidance covering his ass telling us to accept COVID residents.

Q. Ms. Doyle, isn't it true that you sent this over to Ms. Frawley expecting DOH to show up that morning so that if she had to explain why 18 residents were transferred to different rooms the day before, she could point to something and say this is what the impetus is?

A. No, that is not correct.

Q. All right.

C. Doyle

MS. SEKHON: Let's take a five minute break.

(A recess was taken.)

MS. SEKHON: We can go back on the record. And let the record reflect that we just go a quick role call off the record and confirmed that everyone who was present this morning still continues to be present at this time.

And at this time, Ms. Doyle, we are all set. I am going to thank you for your time the last couple of days.

Mr. Yaffe, I extend that thanks to you as well and we will talk to you all soon.

MR. YAFFE: So just to be clear, you will not be sending a transcript of this subpoenaed deposition to the witness for her review and signature?

MS. SEKHON: That is correct.

MR. YAFFE: And you will not be sending a certified transcript to my office for review?

MS. SEKHON: That is correct.

C. Doyle

MR. YAFFE: You are keeping this to yourself.

MS. SEKHON: This is a confidential proceeding, and at this point neither you nor the witness are entitled to a copy of the transcript.

RQ:

THE WITNESS: I would like to circle back to my request that if you have information that staff signed in-services without being given in-services, that you provide that to me for immediate correction in the facility.

MS. SEKHON: Your request is noted, Ms. Doyle.

MR. YAFFE: And I reiterate that request on behalf of the facility.

MS. SEKHON: We will take it under advisement. Thank you. Have a good evening.

(TIME NOTED: 4:16 p.m.)

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CERTIFICATION

I, Stefanie Krut, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 31st day of January, 2021.

Stefanie Krut

DOH-1961 (8/2011)

RECORDED DISTRICT 2950
REGISTER NUMBER 01416

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

131-2020-00031523
STATE FILE NUMBER

NOTE: This certificate is NOT VALID unless it has been signed by the Registrar of Vital Statistics.

DECEDENT

1. NAME: FIRST H.G. MIDDLE LAST
2. SEX: MALE ☒ 1 FEMALE ☐ 2
3A. DATE OF DEATH: MONTH 04 DAY 07 YEAR 2020
3B. HOUR: 11:30 PM
4A. PLACE OF DEATH (Check one): HOSPITAL DOA ☐ ER ☐ HOSPITAL OUTPATIENT ☐ HOSPITAL INPATIENT ☐ NURSING HOME ☒ PRIVATE RESIDENCE ☐ HOSPICE FACILITY ☐ OTHER (Specify) ☐
4B. IF FACILITY, DATE ADMITTED: MONTH [redacted] DAY [redacted] YEAR [redacted]
4C. NAME OF FACILITY: (If not facility, give address) Fulton Commons Care Center, Inc.
4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐ Hempstead Town
4E. COUNTY OF DEATH: Nassau
4F. MEDICAL RECORD NO.
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☒ YES ☐
5. DATE OF BIRTH: MONTH [redacted] DAY [redacted] YEAR [redacted]
6A. AGE IN YEARS: [redacted] yrs.
6B. IF UNDER 1 YEAR ENTER: months days
6C. IF UNDER 1 DAY ENTER: hours minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) [redacted]
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:
8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☐ 0 YES ☒ 1
9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.
A ☒ No, not Spanish/Hispanic/Latino B ☐ Yes, Mexican, Mexican American, Chicano C ☐ Yes, Puerto Rican D ☐ Yes, Cuban E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be:
A ☒ White/Caucasian B ☐ Black or African American C ☐ Asian Indian D ☐ Chinese E ☐ Filipino F ☐ Japanese G ☐ Korean H ☐ Vietnamese J ☐ Native Hawaiian K ☐ Guamanian or Chamorro M ☐ Samoan N ☐ American Indian or Alaska Native (specify) P ☐ Other Asian (specify) R ☐ Other Pacific Islander (specify) S ☐ Other (specify)
11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death.
1 ☐ ≤ 8th grade 2 ☐ 9th-12th grade; no diploma 3 ☐ High school graduate or GED 4 ☒ Some college credit, but no degree 5 ☐ Associate's degree 6 ☐ Bachelor's degree 7 ☐ Master's degree 8 ☐ Doctorate/Professional degree
12. SOCIAL SECURITY NUMBER: [redacted]
13. MARITAL STATUS: NEVER MARRIED ☐ 1 MARRIED ☐ 2 WIDOWED ☒ 3 DIVORCED ☐ 4 SEPARATED ☐ 5
14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.
15A. USUAL OCCUPATION: (Do not enter retired) [redacted]
15B. KIND OF BUSINESS OR INDUSTRY: [redacted]
15C. NAME AND LOCALITY OF COMPANY OR FIRM:
16A. RESIDENCE: (State or Country if not USA) NY
16B. County or Region/Province if not USA: [redacted]
16C. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☐ [redacted]
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐ YES ☐ NO IF NO, SPECIFY TOWN:
16D. STREET AND NUMBER OF RESIDENCE: [redacted]
16E. ZIP CODE: [redacted]

PARENTS

17. BIRTH NAME OF FATHER / PARENT: FIRST MI LAST [redacted]
18. BIRTH NAME OF MOTHER / PARENT: FIRST MI LAST [redacted]

DISPOSITION

19A. NAME OF INFORMANT: [redacted]
19B. MAILING ADDRESS: (include zip code) [redacted]
20A. 1 ☒ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT MONTH [redacted] DAY [redacted] YEAR [redacted]
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: [redacted]
20C. LOCATION: (City or town and state) [redacted]
21A. NAME AND ADDRESS OF FUNERAL HOME: [redacted]
21B. REGISTRATION NUMBER: [redacted]
22A. NAME OF FUNERAL DIRECTOR: [redacted]
22B. SIGNATURE OF FUNERAL DIRECTOR: [redacted]
22C. REGISTRATION NUMBER: [redacted]
23A. SIGNATURE OF REGISTRAR:
23B. DATE FILED: MONTH DAY YEAR
24A. BURIAL OR REMOVAL PERMIT ISSUED BY:
24B. DATE ISSUED: MONTH DAY YEAR

CERTIFIER

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: Robert Curran, MD
License No.: 176137
Signature: Robert Curran, MD Electronically Signed
Month 04 Day 08 Year 2020
Certifier's Title: 0 ☒ Attending Physician 0 ☐ Physician acting on behalf of Attending Physician 1 ☐ Coroner 2 ☐ Medical Examiner / Deputy Medical Examiner
Address: 60 Merrick Ave, Hempstead Town, NY 11554
25B. If coroner is not a physician, enter Coroner's Physician's name & title:
License No.:
Signature:
Month Day Year
25C. If certifier is not attending physician, enter Attending Physician's name & title:
License No.:
Address:
26A. Attending physician attended deceased: FROM Month 04 Day 17 Year 2019 TO Month 04 Day 07 Year 2020
26B. Deceased last seen alive by attending physician: Month 04 Day 01 Year 2020
26C. Pronounced Dead ON Month 04 Day 07 Year 2020 AT Time 11:30 PM
27. MANNER OF DEATH: NATURAL CAUSE ☒ 1 ACCIDENT ☐ 2 HOMICIDE ☐ 3 SUICIDE ☐ 4 UNDETERMINED CIRCUMSTANCES ☐ 5 PENDING INVESTIGATION ☐ 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☒ NO 1 ☐ YES
29A. AUTOPSY? NO ☒ 0 YES ☐ 1 REFUSED ☐ 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☐ YES

CONFIDENTIAL **SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH** **CONFIDENTIAL**

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. IMMEDIATE CAUSE:
(A) Cardiac Arrest — immediate
DUE TO OR AS A CONSEQUENCE OF:
(B) Atherosclerotic Heart Disease — years
DUE TO OR AS A CONSEQUENCE OF:
(C) Arteriosclerosis — years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): Renal Failure
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☒ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN
31A. IF INJURY, DATE: MONTH DAY YEAR
HOUR:
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☐ 0 YES ☐ 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☒ 0 YES ☐ 1
33A. IF FEMALE: 0 ☐ Not pregnant within last year 1 ☐ Pregnant at time of death 2 ☐ Not pregnant, but pregnant within 42 days of death 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death 4 ☐ Unknown if pregnant within past year
33B. DATE OF DELIVERY: MONTH DAY YEAR

NEW YORK STATE: ATTORNEY GENERAL'S OFFICE.

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In the Matter of

FULTON COMMONS CARE CENTER, INC.; an Investigation by the New York State Attorney General, made pursuant to the New York State Executive Law, et seq.

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63(12) Examination under oath of DR. OLAF BUTCHMA, taken via WebEx video conference, held on February 25, 2021, commencing at 10:04 a.m.

Reported by

Stefanie Krut

A P P E A R A N C E S:

NEW YORK STATE ATTORNEY GENERAL'S OFFICE
Medicaid Fraud Control Unit
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BY: PETER ZADEK, Special Assistant Attorney General
PRABHJOT SEKHAN, Special Assistant Attorney General
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Attorneys for Olaf Butchma, D.O.
One MetroTech Center, Suite 1701
Brooklyn, New York 11201
BY: GLENN JONES, ESQ.

ALSO PRESENT
John Tarpey - Investigator, NYS Attorney General
Khristian Diaz - Auditor Investigator, NYS Attorney General
Anne Liptak - Paralegal, NYS Attorney General

2-25-21 O. Butchma

O L A F B U T C H M A, having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

EXAMINATION BY

MR. SMITH:

Q. Sir, please state your name for the record.

A. Olaf Butchma.

Q. And can you spell that please?

A. O-L-A-F and the last name is B, as in boy, U-T-C-H-M-A.

Q. And what is your address?

A. My address is [redacted], [redacted], [redacted] in [redacted], New York [redacted].

Q. And what city and county are you sitting in right now?

A. What county? I am in Nassau County currently.

Q. In what city?

A. This is Lake Success, I believe.

Q. And am I correct in assuming that you are at your attorney's office right now?

A. Correct.

MR. SMITH: Okay. So just really quickly, I am going to introduce myself and then everybody on this call, so we get everybody's name for the record. So my name is Benjamin Smith. I am a Special Assistant Attorney General at the New York Attorney General's Office. I work out of the New York City office. If we go around the room, digital room, I guess, and introduce everybody else.

MR. ZADEK: My name is Peter Zadek. I am, as well, a Special Assistant Attorney General. Good morning.

MS. SEKHON: My name is Praghjot Sekhon. I also am a Special Assistant Attorney General out of the Medicaid Fraud Control Unit based in the Hauppauge office. And just so that you're all aware, I am going to turn off my video and mute myself so as to conserve bandwidth.

MS. LIPTAK: Hi. Good morning.

My name is Anne Liptak. I am a paralegal with the office.

MR. DIAZ: My name is Khristian Diaz. I am an auditor/investigator.

MR. TARPEY: I am a detective assigned to the New York State Attorney General's Office.

MR. SMITH: And, Mr. Jones, if we could just get your appearance for the record.

MR. JONES: Sure. Glenn Jones, Abrams and Fensterman, One MetroTech Center, Brooklyn, New York 10001. I'm sorry, the zip is 11201.

MR. SMITH: We won't hold you to the zip code. Don't stress that. So at this point I think I am going to leave my camera on. I will ask, you know, Mr. Jones and Dr. Butchma to leave theirs on. Stefanie, totally up to you. If everybody else could turn theirs off, it looks like everybody has their cameras off just for the purposes of bandwidth.

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Before we get started, I want to run through some ground rules. So this is going to be just me sort of speaking sort of in paragraph form here for a bit before we get into the actual questioning. So as you can tell, obviously, we are conducting this examination remotely in order to ensure the health and safety of all participants due to the Coronavirus related concerns in play at this time. The examination will be recorded by stenographic means by a court reporter certified to record the examination in the State of New York, and any exhibits will be presented to you electronically.

Q. Is Mr. Jones your attorney for the purposes of this hearing today?

A. Yes.

MR. SMITH: So your testimony today is being taken pursuant to a subpoena that was issued by the Attorney General's Office pursuant to

which I and Ms. Sekhon and Mr. Zadek, Special Assistant Attorneys General are authorized to take proof and make a determination of the relevant facts in connection with an investigation that deals with the resident care provided by Fulton Commons Care Center.

Q. I'm going to show you now what will be marked as State's Exhibit-1. And this is a copy of the subpoena that was issued and served on you directly. And we can just sort of slowly scroll down. Have you seen a copy of this subpoena before?

A. Yes.

Q. And as far as you understand, does this subpoena require you and compel you to virtually appear for this hearing today?

A. Yes.

Q. And you understand that you are here today pursuant to the subpoena?

A. Yes.

Q. And, again, just to confirm, that's your signature down at the bottom of

the page, correct?

A. Yes.

Q. So I would like to run through a few of your rights today that will apply during this hearing. So as you may know, pursuant to the Fifth Amendment of the United States Constitution, as well as the New York Constitution, you have the right to refuse to answer questions if your truthful answer to that question would tend to incriminate you. Do you understand that?

A. Yes.

Q. Please be also aware, though, that if you choose to invoke your Fifth Amendment right, a negative inference can be drawn against you in any future noncriminal proceedings. Do you understand that?

A. Yes.

Q. You also have the right to consult an attorney, and you have Mr. Jones with you today, correct?

A. Yes.

Q. And is there any reason at all that you would not wish to proceed in this

hearing with Mr. Jones representing you?

A. No.

Q. So you took an oath a moment ago to tell the truth, the whole truth and nothing but the truth. Should you intentionally make any false statement during this proceeding, and by that I mean a statement that you do not believe to be true, you may be prosecuted for perjury. Do you understand that?

A. Yes.

Q. So I am going to ask you questions today that are relevant to the Attorney General's investigation into general resident care provided by the Fulton Commons Care Center. If I say Fulton Commons or Fulton from here on out, would you understand that I am referring to Fulton Commons Care Center?

A. Yes.

MR. SMITH: And just a few more ground rules and then we will get started, so thank you for bearing with me. As you see, we have the court

reporter here today, that is Mrs. Krut. She will be recording a written transcript of this interview. It is, therefore, very important that she hears everything we say. I know that can be difficult with the virtual setup that we have going. Primarily what that means is we want to avoid speaking over each other. So if I'm asking you a question, I please ask you to allow me to finish that. Even if you can anticipate what I'm going to ask, please let me conclude that so we can get that on the record, and then you will have a full chance to respond, obviously.

It's also important that you give verbal responses to my questions. So any nonverbal responses, like a nod of the head, shrug of the shoulder, you know, any sort of gesticulating with your hands, that obviously will not make it onto the record and we want to get your full response. So please

accompany any sort of nonverbal response with a verbal response.

If you don't understand my question, if I ask a convoluted question or something that just doesn't make sense, please just ask me to rephrase that. That's perfectly fine. If you do answer the question, we will assume that you understood it.

Along those same lines, if you need to take a break at any point -- this is not going to be just a grind all day through with no breaks, so if you need to use the restroom, make a call, get some water, just let us know. We will try to finish the question we were on at the time, but we will definitely give you breaks as needed. So don't hesitate to ask us for that.

There will be times today, I'm assuming, where you will give an answer as fully as you can, and because of the way memory works, you may, later on in the day, want to revise that answer.

That's perfectly fine. Just raise that to our attention and we will let you go back and revise that answer. So, again, if you answer something this morning and by this afternoon your recollection changes, you can definitely bring that up to us and change that, change that answer.

Q. Does that sound fair?

A. Yes.

MR. SMITH: So as sort of a final point about confidentiality. So this proceeding is, as I said before, under the auspices of an Attorney General investigation, so it is absolutely confidential. Neither you nor your attorney are entitled to a copy of the transcript of the testimony or any of the exhibits that will be marked today. So we will show you exhibits and a transcript will be taken, but those will be kept confidentially by our office.

Along those same lines, because

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this is a confidential proceeding, we will not make any recordings of this testimony. WebEx does allow recording capabilities. We will not be using those. There will be no video recording made and we ask that you do the same and make no video recording.

Q. Do you understand that?

A. Yes.

Q. And do you agree not to record this proceeding?

A. Yes.

MR. SMITH: Along those same lines, we also request that you do not discuss this matter or your testimony here today or any of the documents you see today with anyone outside of your attorney.

Q. Do you understand that?

A. Yes.

MR. SMITH: Along those same lines, if we do take a break during the course of your testimony today, we are asking you not to make any private

communications to anyone, aside from your attorney. So that includes phone calls, texts, e-mailing, anything of that nature.

Q. Does that make sense?

A. Yes.

MR. SMITH: We also ask you to mute your phone. It's a typical consideration. So please just make sure all your electronic devices are muted or turned off or on airplane mode or anything so we don't have disturbances during the course of your testimony.

Q. I want to ask a couple of quick background questions before we get into the majority of the questions here for you today. So have you taken any drugs or alcohol within the past 24 hours that may impair or have an impact on your ability to testify truthfully and to the best of your knowledge?

A. No.

Q. Okay. Are you aware of any

physical or mental disability or defect that may interfere with your ability to understand any of my questions or respond truthfully or fully?

A. No.

Q. Prior to coming to the hearing today, did you speak with any current or former Fulton employees about your testimony today?

A. No.

Q. Did you tell anyone at Fulton that you had been subpoenaed for this testimony today?

A. No.

Q. Okay. Other than your attorney, Mr. Jones, did you discuss the fact that you were subpoenaed with anyone?

A. Yes.

Q. And who was that?

A. My girlfriend.

Q. What did you discuss?

A. I was going to give testimony today and that I wouldn't be able to respond to texts or calls.

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Q. Did you discuss the substance of the subpoena, as far as you understood it?

A. I told her that it was regarding Fulton Commons, but that was it.

Q. Anything else beyond that?

A. No.

Q. Did you discuss the subpoena with anyone outside of your girlfriend?

A. Outside of my girlfriend, no.

Q. Did you review any documents in preparation for today's testimony?

A. No.

Q. Have you ever testified under oath before?

A. Yes.

Q. In what setting?

A. Medical malpractice depositions and as a factual witness for product liability cases.

Q. Would I be correct in assuming that those were as an expert witness or a fact witness or a combination of both?

A. A fact witness.

Q. Were you ever an expert witness

in any of those cases?

A. No.

Q. When you were a fact witness, were you a party to the litigation, or a nonparty?

A. Sometimes a party, sometimes a nonparty.

Q. How many times, if you could guess, would you say you were a party to a litigation?

A. Oh, probably 12 to 15 times.

Q. Were those all in the context of medical malpractice?

A. Yes.

Q. What was the most recent case, if you can recall?

A. Most recent case was a case at [redacted] in Freeport.

Q. Is that still an active, an ongoing case?

A. It is still pending.

Q. How many currently pending cases are you a party to?

A. That's the only one, thankfully.

Q. And as a fact witness, were those also in the context of medical malpractice?

A. Yes.

Q. Have you ever had a verdict or a settlement against you in those cases?

A. No verdicts, two settlements.

Q. Outside of the medical malpractice context, any other involvement in lawsuits or legal proceedings?

A. A product liability lawsuit where I was a factual witness, nonparty, for so-called Fen Phen weight loss drug.

Q. And what was the context for your testimony in that case?

A. General prescribing information, having worked for NutraSystem some 25 years ago.

Q. And is it fair to say that this is an old case, it sounds like?

A. Yes.

Q. So outside of medical malpractice, product liability, any other involvement in lawsuits or legal proceedings?

A. Recently, no, nothing like that.

Q. In the last 10 years?

A. No.

Q. What about in the last 20 years?

A. No.

Q. What is your cell phone number?

A. [redacted].

Q. And do you just keep one cell phone or do you have multiple cell phones?

A. Just the one.

Q. Do you have a business cell phone?

A. I didn't hear your question.

Q. Sorry. Do you have a business cell phone, a cell phone issued by a practice group or a nursing home that you work for, anything along those lines?

A. A cell phone, no.

Q. Is there another device that you are issued from a work --

A. You are breaking up a little bit there.

Q. Oh, sorry. Can you hear me now?

A. Yes.

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Q. Do you have any other devices issued by a work association?

A. No.

Q. So the number you just gave us, who is the carrier for that phone number?

A. AT&T.

Q. And how long have you had that number?

A. More than 20 years.

Q. And is it your name on the account or someone else's?

A. My name.

Q. And just day-to-day, do you wear any sort of fitness tracking device, like a FitBit or Apple Watch, or anything along those lines?

A. No.

Q. So I want to talk a bit about your education and training. Where did you go to college?

A. Adelphi University, Garden City, New York.

Q. And when did you graduate from Adelphi?

A. 1984.

Q. And was that followed by medical school?

A. Yes.

Q. And where did you go to medical school?

A. New York Institute of Technology, College of Osteopathic Medicine.

Q. And when did you graduate from the Institute?

A. 1988.

Q. And then was the next sort of step residency, I assume?

A. My residency and internship were at New York Medical College at Metropolitan Hospital, New York, New York.

Q. And you did a residency and an internship, you said, at the same location?

A. Correct.

Q. Was there a specialty associated with that residency?

A. Internal medicine.

Q. Any other training aside from the internship and the residency?

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A. I did a one-year fellowship in liver diseases.

Q. And where was that?

A. Mount Sinai Medical Center, New York.

Q. Was that immediately after completion of your residency or at a later date?

A. Immediately following.

Q. Are you licensed in New York?

A. Yes.

Q. And when did you obtain that license?

A. I was licensed, I believe it was, 19 -- 1990.

Q. Has any disciplinary action ever been taken against your license?

A. No.

Q. So it's never been suspended, revoked or limited in any way?

A. No.

Q. Are you licensed in any other states?

A. No.

Q. Have you ever done a specialized board certification?

A. I didn't understand the question.

Q. I'm sorry. Have you ever completed a board certification?

A. Yes.

Q. What was that in?

A. Internal medicine.

Q. Any other certifications?

A. No.

Q. Have you ever taught or lectured?

A. No. Or, actually --

Q. Sorry?

A. I was a faculty attending in Our Lady of Mercy Medical Center in the Bronx from 1991 to 1992. So I was essentially a faculty teacher.

Q. Anything -- any teaching or lecturing outside of that?

A. No.

Q. And I think we have answered this, but just to be clear on the record, have you ever testified as an expert?

A. No.

Q. So obviously we are going to talk a good bit about Fulton Commons today, but I want to get a bit of background about your employment before you came to Fulton Commons. So describe for me, if you can, your employment history after your training but before you got to Fulton Commons.

A. I was faculty attending for one year at Our Lady of Mercy Medical Center, ending in 1992. From 1992 until 1996 I worked for Park Avenue Healthcare in White Plains, New York, as a nursing home attending and medical director. And from 1996 to present time I have been in private practice as a medical director and as a attending physician in nursing homes.

Q. Let's drill down a bit on that. So you mentioned Park Avenue, correct?

A. Correct.

Q. Have you served -- let's go through the other nursing homes that you served at, if you could list those for me, to the best of your recollection.

A. Currently I'm the medical

director and attending physician at Fulton Commons in East Meadow. I am medical director -- administrative medical director at Nassau Extended Care. That's in Hempstead, New York. I'm the administrative medical director and attending physician at Quantum Rehabilitation. That is in Middle Island, New York. I am medical director and attending physician at Massapequa Healthcare and Rehabilitation. That's in Amityville, New York. I am administrative medical director at Berkshire Healthcare. That's in West Babylon, New York. And I am medical director at Pavilion Rehabilitation and Nursing at -- that's in Flushing, New York. As well I am an attending physician at Westhampton Care Center in Westhampton, New York.

Q. So I know these are multiple facilities. Let's work through those and just try to get a timeline set out for each. So Park Avenue, when did your association with Park Avenue start?

A. I worked for Park Avenue

Healthcare from 1992 until 1996 full-time.

Q. And then was there a part-time employment following that?

A. With them, no. I resigned from them and, as I stated, went into private practice.

Q. What about Nassau Extended Care, when did your association begin with them?

A. That was from from 2015 to present.

Q. And if I'm correct, you said you were the administrative medical director at Nassau Extended Care?

A. I am the administrative medical director there.

Q. What about Quantum Rehab?

A. Quantum Rehab was from 2017 to present.

Q. And Quantum Rehab, you are also the administrative medical director, correct?

A. Administrative medical director and I am an attending physician.

Q. And then what about Massapequa

Healthcare, what's your timeline there?

A. That was from April of 2020 to present.

Q. And at Massapequa you also are administrative medical director?

A. Administrative medical director and just started -- just took over some patients this week, actually.

Q. And then what about Berkshire Healthcare, what's your timeline there?

A. Berkshire I took over in June -- July of 2020 and until present. And I am an administrative medical director.

Q. And Pavilion, what's your timeline with Pavilion?

A. Pavilion was April of 2016, and I'm administrative medical director.

Q. And that's April 2016 until the present, correct?

A. Correct.

Q. And just for my own clarity, is there a difference between administrative medical director and medical director or is that just a semantic difference?

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A. Medical director is an administrative position. The mention was if I'm attending physician, that's a clinical post, as opposed to administrative post as a medical director.

Q. So just for my own clarity, they are almost interchangeable, saying administrative medical director would be no different than saying medical director, in substance?

A. Correct.

Q. Any nursing home related positions, aside from the ones we just walked through?

A. Westhampton Care Center. Other than that, no.

Q. Were you ever associated with another Long Island facility called Cold Spring Hills Center for Nursing and Rehab?

A. I was.

Q. Describe the nature of that relationship.

A. I was the medical director from July of 2007 until February 14, 2020.

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Q. And what sort of caused or led to you leaving Cold Spring Hills?

A. They no longer wished to pay me my salary.

Q. That seems like a good reason for leaving. Is there more detail there, was it a dispute or a disagreement of your payment or something else?

A. No. They were cutting costs and they wished to have the services for a significantly lower amount of money.

Q. So had you been medical director at Cold Spring Hills for those entire 13 years?

A. Yeah. Just shy of 13 years.

Q. Had administration changed at all during that time?

A. Several times.

Q. From your perspective, did changes in administration or leadership precipitate your leaving Cold Spring Hills?

A. Quite possibly.

Q. Did you have disputes with Cold Spring Hills' leadership?

A. No.

Q. So you mentioned private practice. Let's walk through that briefly. Were you a member of a practice group? How was that organized?

A. So my -- the current structure of my practice is that I'm -- my practice is medical direction and attending physician services in nursing homes.

Q. And what is the name of the practice group?

A. Olaf Butchma D.O. of Great Neck PC.

Q. So you mentioned before, you entered private practice sometime around 1996; is that correct?

A. I had a -- I worked in a private office, solo practice, from two -- from 1996 until I closed it in 2002.

Q. And then did you join or open a new practice group at that time?

A. I limited my practice after 2002 to medical direction services and attending physician services in nursing homes.

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Q. And just for my own clarity, is your private group, the Olaf Butchma Group, is that specific to those attending services you were describing?

A. Correct.

Q. Are you the attending at any hospital?

A. I have attending privileges at North Shore University in Manhasset since 1996.

Q. Any other hospitals?

A. No.

Q. And to jump back to the practice group, are you a member of any other practice group, aside from the Olaf Butchma Group?

A. No.

Q. Are you familiar with something called the Titan Medical Group?

A. Yes.

Q. What is that?

A. That is -- that was a practice, and I was the -- I was actually -- the chief medical officer was a friend and colleague

of mine who provides medical services to nursing facilities.

Q. And when did you start your association with Titan Medical Group?

A. I believe in 2017.

Q. Are you still associated with them?

A. Titan no longer exists.

Q. When did that come to pass?

A. The owner, Dr. Santucci, decided to give up her license and enter the seminary in Florida in -- at some point last year, so Titan, in its form, does not exist anymore.

Q. Is it correct to say that you were associated with Titan from 2017 up until it was dissolved?

A. Yes.

Q. Any other affiliations we haven't discussed?

A. Not that I can think of, no.

Q. So to get into the Fulton Commons zone, what brought you to Fulton Commons?

A. I was hired prior to Fulton

Commons opening. So they opened officially in -- just after 9/11/2001. So I was hired at some point in, I think, in June or July of the same year. To be medical director.

Q. How did you get the job, if you recall?

A. A nurse consultant who I knew well had recommended me for the job.

Q. Do you remember her name?

A. Pat Brown.

Q. Do you still work with Pat brown?

A. Pat Brown works for Zimmet.

Q. And what is Zimmet?

A. I believe they are -- they provide auditing services for nursing homes.

Q. So is it fair to say it was not -- Pat Brown is not a recruiter, it was just sort of a word-of-mouth reference to Fulton Commons?

A. She was the nurse consultant at that time for Fulton Commons, and we had worked together in a couple of nursing homes, and she recommended me.

Q. Who ultimately hired you at

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Fulton Commons?

A. The responsibility was the executive director. His name was -- don't remember his name, but he no longer works in the industry. But he hired me.

Q. And just for my clarity, you were hired on -- right out of the gate as medical director of Fulton Commons, correct?

A. Yes, I was.

Q. And when you took the job at Fulton Commons, is it correct to say that the only other sort of medical work was the private practice endeavors you had going on?

A. At that time, it was 2001, so my -- all my work was limited to medical direction and providing medical services in nursing homes.

Q. I know this is going back a ways, but what was your starting salary at Fulton?

A. Easy to remember. It's the same exact amount of money I still make. $5,400 per month.

Q. So that has not changed since 2002?

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A. It went down at one point to 4,333 for about two years, I think it was from 2004 to 2006, and then it went back to 5,400.

Q. So because you have got a few other similar positions to compare to, is that sort of market rate or how does Fulton compare to your other experiences?

A. I would say it's currently -- it's about -- it's about the going rate for medical directors, more or less.

Q. During your time at Fulton, did you receive any bonuses or incentives or profit sharing, anything like that?

A. You broke up a little bit.

MR. JONES: The whole question was jumbled.

Q. No, I'm sorry. And let me know -- I think my bandwidth might be a little dodgy, so let me know if it comes through unclear. So during your time at Fulton, Dr. Butchma, did you receive any other form of compensation, like bonuses, incentives, performance related pay,

anything like that?

A. Never.

Q. And what is your technical or tax status at Fulton, are you an independent contract or W-2 employee?

A. I am an independent contractor. I receive a 1099.

Q. Is that consistent across your other medical director positions?

A. Yes.

Q. I want to see -- there's a few names I want to see if you recognize. Do you recognize the name Barry Breskin?

A. Yes.

Q. Who is Barry Breskin?

A. Barry is the executive administrator for Kennedy Healthcare, which is the ownership group of Pavilion, Berkshire and Massapequa Center.

Q. What about Richard Sherman?

A. Richard Sherman is the administrator at Massapequa Center.

Q. What about Avi Goldstein?

A. Avi Goldstein was the

administrator at The Hamlet in Nesconset, where I worked for several years as a medical director.

Q. The Hamlet in Nesconset, I don't think we covered that. I don't believe we covered The Hamlet in Nesconset. When did you serve as medical director at that facility?

A. From December of '96 -- I mean 2016, rather, until the end of December of 2020.

Q. And so Mr. Goldstein was the administrator of that facility, correct?

A. I didn't hear you. I'm sorry.

Q. I'm sorry. Mr. Goldstein was the administrator of that facility?

A. For about a year while I was there, yes.

Q. And what about Valerie Barba?

A. Valerie Barba is the director of nursing at Westhampton Care Center.

Q. So are you familiar with Cathie Doyle?

A. Yes.

Q. Who is she?

A. She is the administrator at Fulton Healthcare -- Fulton Commons.

Q. And describe for me, if you can, your relationship with Mrs. Doyle.

A. I worked with Cathie as -- while she was administrator at South Shore Healthcare from, from 1997 until -- I believe she was there until 2016, and then subsequently at Fulton Commons.

Q. When you were at South Shore Healthcare, what was your position at the facility?

A. I was medical director and I was an attending physician.

Q. Is it fair to say that you worked closely with Ms. Doyle during that time?

A. Yes. She was administrator and I was medical director. We worked closely as well with the director of nursing.

Q. And is it fair to say that that sort of close interaction would continue at Fulton Commons?

A. Yes.

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Q. So during your time at Fulton Commons, how often would you meet with Mrs. Doyle?

A. Prior to the pandemic, we'd probably have a face-to-face meeting in her office twice a week.

Q. And since the pandemic has that changed?

A. Yes.

Q. Describe that change for me.

A. I didn't hear your question.

Q. I'm sorry. Describe that change for me.

A. I think it's typical in all of the facilities I work, that the vast majority of all of our meetings have changed to either conference calls or phone conversations.

Q. Is it fair to say that the frequency has remained the same or has that increased or decreased?

A. I would say it's changed, but off -- off-site and phone-wise, it's probably about the same amount of time, more

or less.

Q. And you mentioned before that you met with Mrs. Doyle previously about twice a week face-to-face; is that correct?

A. Twice a week face-to-face in the past.

Q. When you had those face-to-face meetings, were those for a set purpose or what did you discuss during those meetings?

A. It is my practice with all my administrators to try to have sit-down -- brief sit-down meetings with them once or twice a week to discuss any issues or concerns in the facility regarding the medical staff or regarding medical services in general.

Q. So is it fair to say you would be giving her updates on maybe issues you had noticed or updates in patient care, status reports, those sorts of things?

A. Typically I would say she did the vast majority of the talking, but anything that came up from my side I would present to her. My tendency with Cathie was to -- if

it was anything of significance, to, to call her prior to that, prior to those sit-downs. So I would call her if I was outside of the facility if it was something significant as she preferred to be informed right away.

Q. I understand. So is it fair to say that -- let's use the pandemic period. So from March 2020 until the end of 2020, could you call her sort of as needed?

A. Any time.

Q. Was that common for you, to pick up the phone and give her a call?

A. I would say prior to the pandemic I might have called -- had reason to call her a couple of times a month.

Q. And during the pandemic I'm assuming that increased?

MR. JONES: You're frozen.

Q. I'm frozen? I can hear you. Can you hear me?

MR. JONES: No.

Q. Can you hear me now?

MR. JONES: Yes.

MR. SMITH: Okay. I can give you

the question again. Did you miss the question?

MR. JONES: Yes.

Q. Okay. So I'm assuming during the pandemic the frequency of your interactions with Mrs. Doyle increased?

A. As I said, they changed. So the vast majority of them were, as I said, very similar to all my other facilities, conference calls involving the director of nursing, the administrator and myself. Also Cathie likes to forward me the -- any and all the directives from the CDC, from the Department of Health of New York State, from the Governor's office, which I actually receive on my own anyway. She'll put a comment or a question on top of it sometimes.

Q. So would you say that during the pandemic, would you speak to her daily or multiple times a day or something different?

A. Speaking, we tend -- we typically would speak, I would say, either once a week by phone but conference with the director of

nursing. It was pretty consistent throughout all my buildings that as soon as we received a directive from Albany or a new information regarding the Coronavirus, then my administrators would schedule a time to have a 10, 15 minute conference call, often on a Friday.

Q. And when you would communicate with Mrs. Doyle, what was the most common method of communication, would that be phone, e-mail, texting?

A. We would -- the most typical -- the most frequent was via e-mail and, as I said, that was really mostly Cathie forwarding me the, the manifestos sent from from Albany. So frequency wise, those were coming fast and furious, particularly in the beginning. So that was most common frequency wise. The calls were less often, but, as I said, whenever there was any major dictum, we would end up on a 10 or 15 minute conference call. The director -- she would set it up, the director of nursing, Cathie and myself, and we would discuss the

features of those, those notations and how we would be implementing them.

Q. So is it fair to say that the majority of your interactions with Mrs. Doyle during the pandemic were related to complying with state directives or federal directives?

A. I would say more than 95 percent of the time, yes.

Q. And is Ms. Doyle your boss, do you report to her?

A. She is most definitely my boss.

Q. So is it fair to say that she has final say on decisionmaking at Fulton Commons?

A. Cathie, in the 25 plus years I have known her, she has the final say in policy and implementation. She does give me a fair amount of leeway with my practice of medicine, however, most of the time.

Q. So to drill down on that, if -- well, describe that for me in more detail. When you say "my practice of medicine," does that mean the actual day-to-day practice or

could that be a larger application to the facility?

A. No. My general practice and medical policies and procedures. She does like to read Google a lot.

Q. So for clarity, she would give you leeway in developing policies and procedures at Fulton Commons?

A. She would -- anything -- anything that was directly a medical policy, she would give me her, her internet input and then she would hear me out and, and, in general, I would present to her medical literature or textbook information, and then we'd make our -- the final decision on policy that way.

Q. Could she overrule you on those medical policies and procedures?

A. I would say in 25 years she has never overruled me in regard to strictly a medical, medical policy or procedure, no.

Q. So in your interactions on those specific items, she is deferential to your medical judgment?

A. She tends to be very respectful of it, yes.

Q. What is the chain of command at Fulton, as far as you understand?

A. Cathie is in charge of 100 percent of the building. I know she has a boss, who I've never met. His name is Steve Weiss. And he has a boss, Moshe Kalter, who is the owner, who I have also never met.

Q. Any other individuals aside from Mr. Weiss and Mr. Kalter?

A. Not that I know of.

Q. And just for clarity, you said you never met Mr. Weiss?

A. Never.

Q. Have you ever spoken -- I'm sorry?

A. He signs my checks, though, so I appreciate it.

Q. Aside from that, have you ever spoken to him on the phone or via e-mail, any communication with Mr. Weiss?

A. Never.

Q. Mr. Kalter, you said, you never

met as well, correct?

A. Never.

Q. Have you ever communicated with Mr. Kalter, whether by phone or e-mail?

A. Never.

Q. As far as you know, are Mr. Weiss or Mr. Kalter ever physically at Fulton Commons?

A. I have never seen them there. Wouldn't know either of them, but as far as I know, I have never known that they were there.

Q. Would Mr. Weiss or Mr. Kalter ever join any of the conference calls you have been describing for me?

A. No.

Q. Is there a governing body at Fulton, as far as you understand?

A. I believe the governing body is the owner, the executive director, which I believe is Mr. Weiss' title, and then the administrator, Cathie Doyle.

Q. Is anyone else involved in the governing body, as far as you know?

A. Not that I know of.

Q. And from your understanding, what is their role at the facility?

A. The governing body?

Q. Correct.

A. In nursing facilities, the governing body is generally, for my purposes, makes final decisions regarding personnel and general operations of the building.

Q. Do you have any role or participation in that process?

A. Didn't hear your question.

Q. I'm sorry. Do you have any role or function in that process?

A. In the process of personnel? Only in regard to credentialing medical staff members.

Q. And you mentioned Mr. Weiss briefly, and I know it sounds like you have limited interaction with him, but from your understanding, what does he do at Fulton Commons?

A. Mr. Weiss?

Q. Correct.

A. Mr. Weiss operates, I know from Bridgeview, from another -- from the other facility, I think that's their main -- it's the main place they operate, and I believe he's in charge of all of Mr. Kalter's facilities. So I believe the administrators answer to him.

Q. And do you know if Mr. Weiss has office space at Fulton?

A. If he does, I've never seen it.

Q. So from your understanding, most of his work is done out of Bridgeview?

A. As far as I know, yes.

Q. Have you ever reported to Mr. Weiss in any way? I know you mentioned you don't communicate with him, but have you ever forwarded something to him or a written report or sent a report or some written document to Mr. Weiss for review?

A. I have only ever sent, in the past, my invoices, if there was any -- if the main office lost them. So I would fax it to his attention, but that was it.

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Q. Do you know Carol Frawley?

A. I do.

Q. And who is she?

A. She is the director of nursing at Fulton.

Q. Describe your professional interactions with Mrs. Frawley, how the two of you interact.

A. I would say professionally we have a very solid relationship. I typically -- pre-pandemic I would go into her office at least three of the days of the week when I was -- after I finished on the units and talked to her for 10 or 15 minutes, sign-off on -- review and sign-off on accident and incident forms, pharmacy -- pharmacy related form. Currently I still go in her office, about 12 feet away, and we meet for about, I would say, for about 10 or 15 minutes. Maybe it's twice a week now. We have more phone conversations now.

Q. That was my next question. So during the pandemic period, how often would you say you communicated with Mrs. Frawley,

was that daily or something else?

A. After the pandemic started, it went from three days to once or twice a week, but we would -- our phone conversations, she would -- she would -- she would ask me if she could call me and we'd speak for 10 or 15 minutes, typically, regarding any specific issues or concerns that she had, clinical ones.

Q. And describe for me that interaction with Mrs. Frawley. Were you discussing specific patient issues or larger issues at the facility? How did that play out usually?

A. During the -- during the pandemic, a lot of things are business as usual, so patients still have falls with injuries, transfers to the hospital or, or a fall with a concussion. So a lot of our interactions were still the same, mostly related to hospital transfers, accident/incident, patients who had lost weight unusually. It was pretty much any, any specific clinical concerns that Carol

had, and then in addition, of course, was all the ever changing Whac-A-Mole of COVID during the past year.

Q. So just to boil that down, it sounds like it could have been specific patient issues developing day-to-day as well as larger issues in regards to the pandemic?

A. Correct. Anything clinical.

Q. Did you also communicate with Mrs. Frawley by text or e-mail or was it mostly in-person conversations?

A. Not -- e-mail, I don't recall her e-mailing me very much. She's -- I am not a young guy, she is a little older than me, and our -- most of our interactions are either in person or phone conversations. If she texts me, it was generally to say "can I call you".

Q. And from your perspective as the medical director, how did Mrs. Doyle and Ms. Frawley operate?

A. I didn't -- I missed your question.

Q. No worries. I can regive it,

give it again. From your perspective as medical director, did Mrs. Doyle and Mrs. Frawley have a functional relationship?

A. From what I've seen over the past few years that they've been together, they have a very solid working relationship.

Q. Did it ever cause difficulties or friction for you in completing your roles and duties as medical director?

A. As I said, they have a very good relationship, and pre-pandemic we would have conversations, the three of us. A lot of times if I went to see Carol, Cathie would be in her office talking. It was always very civil and I would -- they would bring me into the conversation, if it concerned me, as far as patient issues or anything specific to the facility. So there was never -- that I ever witnessed, there was never any -- anything -- any major friction beyond what you would normally expect between administrators and directors of nursing.

Q. Who is the infection

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preventionist at Fulton Commons?

A. I believe currently it's the assistant director of nursing.

Q. And do you know that person's name?

A. Lisa Peterson.

Q. Did Ms. Peterson have a predecessor in that role?

A. I don't recall who the previous person was.

Q. Did you have interactions with that previous person, as far as you can recall?

A. So there was a time period for about a year and a half where I was not the medical director at Fulton Commons. I would say probably about -- probably about a year after Cathie joined there, she brought me back or asked me to come back to the facility. So there was a predecessor to Lisa, just like there was a predecessor to Carol. I didn't -- I don't recall who they were because I think it was partly during the time I wasn't there.

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Q. And just for clarity of the record, when did you come back to Fulton Commons? When did Cathie bring you back?

A. It was just after the new year in 2016 or '17.

Q. So that's January or February of 2016, correct?

A. I think it was 2016, yeah.

Q. And you have been at Fulton Commons continuously since that time, correct?

A. Yes, I have been.

Q. From your understanding as a medical director, what is an infection preventionist?

A. Infection -- the infection control person at the facility?

Q. Are you asking or -- sorry.

A. Are you saying the infection control person at the facility?

Q. Is that your understanding of what the infection preventionist does, is run the infection control program?

A. Yes. There is -- in every one of

my nursing facilities, and I believe it's required by code, there is an infection control person responsible for reviewing policies and procedures of infection control in the building, of securing appropriate in-services for the staff, making sure that, that any required things such as tuberculosis testing, antibody testing for measles, mumps, rubella, the flu vaccine program, any -- any unusual infections, resistant infections, isolation procedures, that pretty much comes under their responsibility. They report to the quality improvement committee and present their data, rate of infection in the facility, types of infections, urinary tract infections, pneumonias, skin infections, eye infections. That's all under their responsibility typically.

Q. And from your expertise and experience, why would infection control be important in the nursing home context?

A. Well, most -- number one, it's -- it is required by code, for good reason,

because the -- quite a bit of the risk of morbidity and mortality to patients in nursing homes involves secondary infections.

Q. And would that importance for centrality be any different in a pandemic setting?

A. It would be enhanced certainly.

Q. Describe for me your interactions with the infection control person or the infection preventionist at Fulton.

A. I -- my interaction with the infection control person typically in facilities is, is during the quality improvement meetings, medical staff meetings. I deal directly with the director of nursing and so generally the infection control person takes up their concern to the director of nursing and it's usually brought to my attention by the director of nursing. However, the infection control person in all my buildings, I have a pretty friendly relationship with all of them, and they ask me -- they tend to ask me specific questions in regard to -- in regard to policy and

procedure, what other facilities might be doing. When there was -- for example, when there was a shortage of tuberculosis testing material, how would we handle that and, you know, how would we address the, the associated risk without having the proper materials to test.

Q. And would you say that's consistent with Mrs. Peterson, is your relationship with her along these same lines you have been describing?

A. I would say it's about the same as with most of my infection control people.

Q. And Mrs. Peterson's predecessor, if you can't recall who that is, would you assume you had a similar relationship with that individual?

A. It has been my practice for the last -- as long as I can remember, during the last 20, 25 years that I have been doing this, that I tend to have pretty good interaction with the infection control people in the building.

Q. And what is your role in the

infection control space as the medical director?

A. So as I said, I am a member, in all buildings, of the quality improvement committee or so-called QAPI, the vernacular now. So they -- so ultimately I sit in those meetings, but of course go through the data ahead of time, either with the infection control person or the director of nursing, for validity. I typically go through the lab reports of infections, of culture results that have been taken for the building. If the building triggers, for instance, for frequent urinary tract infections, then I will work with the infection control person to review and see if the physicians are overtreating, under-treating or treating appropriately, if the cultures are colonization and not actual infections. And then -- and of course if there were any infection control issues, such as peroneal care by the nursing staff, then I might suggest that they -- that they re-in-service the nursing staff from the

in-service coordinator and infection control person, for example.

Q. How many beds does Fulton Commons have?

A. Fulton Commons at capacity has seven units, 40 beds each. So 280 beds is their, their operating capacity, I believe.

Q. And you mentioned the units. How many units are there again?

A. There are seven.

Q. And how are those configured?

A. There's four floors. The first floor has one east. That's typically been the rehabilitation, short-term rehabilitation unit. Then each floor has east and west sides, so two east, two west, three east, three west and four east and four west. The units are individually contained and the -- there is a elevator bank and closed doors in-between them. And the unit is kind of shaped like a, like a tripod. There is a long corridor with rooms on either left or right side, and then that splits into a fork, a left fork and a right

fork, again with, with rooms on either side and a dining area behind the nursing station, which is in the middle of that configuration.

Q. Pre-pandemic, so pre March 2020, let's say, how many residents would Fulton have at any given time?

A. I couldn't say specifically, but I believe they would run over 90 percent capacity.

Q. So census was usually towards capacity?

A. I believe so, yes.

Q. With the onset of the pandemic, so March 2020 and after, how did that change?

A. Well, I think similar to all my buildings in New York, they -- we became census challenged because of the ceasing of elective surgeries in the New York area. So there was certainly a smaller pool of the typical patients, which oftentimes is orthopedic cases, hip replacements. Obviously the hospitals weren't doing that

for several months, so everybody had trouble achieving reasonable census.

Q. And at Fulton Commons specifically, would you become involved in discussions or conversations about census and census issues?

A. The only time I became involved in census issues, it's similar to every building, which is either a formal or informal meeting about reasons for specific hospital transfers where I would review charts and see if, if the hospital transfer was warranted or it could have been something that could have been treated specifically in the facility. So that's typically my involvement with census.

Q. And, again, pre-pandemic, so pre March 2020, what was your typical schedule at Fulton Commons?

A. I would round there from -- I would round there Sunday mornings, typically, Monday mornings, Wednesday mornings and Friday mornings.

Q. And did that change at all with

the onset of the COVID pandemic?

A. As I said, most of my medical director duties became, as in most facilities became more virtual, more computer -- they're -- they have an app based electronic health record, so I can do a lot of chart reviews from my laptop, and that became more convenient and more, more encouraged, shall we say.

Q. Did you still come into Fulton Commons in person --

A. Yes.

Q. -- post March 2020?

A. Yes.

Q. Did you have a set schedule or was that sort of as needed?

A. Well, I tend to have a set schedule everywhere. I am a creature of habit. So, again, Sunday -- Sunday mornings I tend to take care of my own unit, which is three east. During the pandemic, my census was significantly lower, so my rounds on Sunday were -- became as needed, if I had patients to see. If I didn't, I wasn't in

on Sunday and I would work from my computer regarding medical director issues. But the rest of my schedule pretty much stayed the same; Monday, Wednesday and Friday mornings. I would meet with Carol, typically, those days and drop by the office. Still things to sign, still things to review, weight losses to review, so I would do all that stuff.

Q. So at least roughly you would be at Fulton Commons Monday, Wednesday, Friday and Sunday?

A. Yup, pretty much.

Q. And, again, we mentioned Mr. Kalter briefly a bit ago. Are you aware of any other owners of Fulton Commons or is it just Mr. Kalter, from your understanding?

A. Not that I know of.

Q. Did you ever discuss the owners with Mrs. Doyle or Mrs. Frawley?

A. No.

Q. You mentioned a bit ago the QAPI board. And that's Q-A-P-I; is that correct?

A. Correct.

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Q. And what does QAPI stand for, just the acronym itself?

A. That's quality -- quality assessment performance initiatives, I believe.

Q. And you are a member of the QAPI at Fulton Commons, correct?

A. Yes. It was previously known as the quality assurance committee or the quality improvement committee, so now the acronym is changed but the basic features are the same. And we at Fulton, as at South Shore, Cathie would typically have a monthly meeting. Of course that's certainly changed to where, to where it's become a more virtual meeting.

Q. And is it common practice for a medical director to be a member of the quality assurance board?

A. They are -- we are required by code to be a member of that committee.

Q. And you mentioned the regularity of the meetings, at least pre-COVID. From March 2020 to the end of 2020, how often

would the quality assurance board meet?

A. All the meetings now are virtual, so it entails, for the most part, the committee members submitting their reports, their quality improvement reports to Cathie. Cathie putting together the -- all the data, the statistics and then disseminating that to the members for input, for correction, and I believe she meets individual -- more individually with, with each member of the committee as opposed to -- it became logistically challenging for us to have meetings in most of the facilities because of the number of the committee members and social distancing issues.

Q. So what was the schedule for the QAPI meetings post March 2020, was it once a month or was it a different level?

A. The data, she -- Cathie still disseminates the data monthly.

Q. But there weren't meetings as such?

A. No. They became more ad hoc meetings.

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Q. Was there ever sort of a joint full-scale meeting of the QAPI between March 2020 and the end of 2020?

A. I believe there was. I attended -- I would have attended virtually, though.

Q. Would it be fair to say there was just one meeting or were there other meetings like this?

A. To be perfectly honest, there were so many ad hoc meetings regarding the implementation of directives that those became my -- most of my quality meeting involvement with Cathie and Carol. So those -- as I said, those, those became more frequent. Sometimes weekly, sometimes more often than that, but no less than a couple of times a month.

Q. Who are the other members of the quality assurance committee?

A. By code it's the director of nursing, the infection control director, the administrator, medical director, housekeeping director, director of building

services, the head dietician. During regular times, the resident council president, which is one of the patients in the facility, would be invited. Sometimes they don't attend because they're watching a movie or doing Bingo, but they are invited. And then the director of rehab and the, I think, the MDS coordinator as well.

Q. And from your understanding, do each of those individuals contribute sort of on their own specialty or how does that typically work? What is each individual's contribution, from your understanding?

A. So each -- each member of the committee is responsible for, for -- and usually at the beginning of the calendar year Cathie will send out a schedule that delineates the audits that everybody is doing. So for instance, the director of rehab has an audit for the cleaning and maintenance of wheelchairs and they're required to report that every month, every two months, every three months, depending. The directors of nursing typically collect

data on pressure injuries, wounds, as I said, infection control issues. The dietician would be regarding weight losses, weight gains. The director of housekeeping would be regarding, you know, particular housekeeping issues, building type issues, and they -- they would present -- depending on the schedule, they would present it at specific meetings, the results of their audits, their data and their plans for going forward for the future to ensure quality improvement on their projects.

Q. And along those same lines, what role do you, as medical director, play on the quality assurance committee?

A. I typically interject towards more clinical issues. So we have a subcommittee of weight loss and weight gain with the dietician, for instance, so I will -- I'll make suggestions before, during and after the meeting regarding, regarding that, those issues. Pressure injuries, if there is an increase in them, looking at ways to prevent that, to, to reduce the

amount of injuries. And, again, as I said before, infection, similarly.

Q. And what role, from your perspective, does Cathie Doyle play on the QA committee?

A. Cathie is the boss. She -- you don't want to go into that meeting not prepared or not having done something that you were supposed to do. Let's say that.

Q. So is she sort of the MC, is that a way to describe what she does there?

A. I would say that's a gentle way of saying it. She makes sure that every, every report is submitted in a timely fashion, and if it doesn't make sense, for whatever reason, she will take that member to task. Oftentimes -- she's softened up a little bit over the years, as have I, but she will ride you a bit during the meeting if you didn't do what you were supposed to do.

Q. And who makes the final decision on items discussed during QA meetings?

A. The final decision on?

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Q. Any number of items. If you have an agenda of five items and five recommendations are made, who would have the final decision on each of those items?

A. So if's there's any -- so as I said, there is an agenda, but there's always open forum. So if any particular issue comes up, which it often does, there will be a discussion amongst the relevant members for that particular issue, and then Cathie would typically say, you know, okay, we are going to do a -- we will do a subcommittee, it will be you, you and you and you're going to work on that today and I want a report in my office in three days of what we're going to do to make that improvement.

Q. So if you made a recommendation during that committee meeting, could that theoretically be overruled?

A. I missed the first part of your question.

Q. If you made a recommendation at a QA meeting, could that, theoretically, be overruled?

A. I never recalled, in any of my QA meetings, anybody overruling me on a suggestion or a clinical issue. If it -- if it was outside of my lane, which I typically try to stay inside of my lane, then it's possible it could be overruled, but I don't recall a time, in any of my buildings, where anybody's discounted my suggestions.

Q. And as far as you know, has Steven Weiss ever attended a QA meeting?

A. I missed the first part of your question.

Q. Sorry. As far as you know, has Steven Weiss ever attended a QA meeting?

A. In all the years that I have been there, I have never -- I have never met him and I've never seen him there. I do know, from previous administrators at Fulton, that they did typically report to Mr. Weiss anything relevant going on. They would mention that to me on occasion. So any Department of Health issues, any Department of Health survey. So I would imagine that they report anything relevant to him in the

privacy of their own office.

Q. What about Mr. Kalter, did he ever appear at a QA meeting or play any role in the QA process, as far as you know?

A. I've never seen him, never met him, so I have never seen him at a committee meeting.

Q. Are minutes taken at the QA meetings, if you know?

A. Yes. So as I said, Cathie coordinates the minutes before the meeting, based upon the materials that are submitted to her, and then during the meeting she will, she will make notations based upon what's reported and discussed, and then you will get another set of -- you will get a set of minutes, a final set of minutes within the -- usually within that day or two with a request to review them and make any comments or errors or corrections. There's typically no errors and no corrections, from my perspective.

Q. And do you know where they're kept, the minutes?

A. I believe everything is kept in Cathie's office.

Q. And as far as you know, you may have already answered this so my apologizes, but your work on the QA committee, the QA committee's work, does that get sent up the chain to Mr. Weiss or Mr. Kalter, as far as you know?

A. You broke up during that.

Q. Sorry. So this is a bit of a followup on a prior answer you gave, but as far as you know, does the QA committee's work get forwarded up the chain to Mr. Weiss or Mr. Kalter?

A. I could not say for sure, with surety what is sent up to them.

Q. So I know we have been sort of discussing this peripherally, but if you could, please describe your responsibilities as a medical director of Fulton Commons.

A. So medical director is responsible for coordinating, credentialing of medical staff, so physicians, NPs, PAs. Consulting staff, such as psychiatrists,

psychologists, even eye doctors and audiologists, podiatrists. I'm responsible for overseeing, again, participating in infection control, accidents/incidents, any clinical issues, weight losses, weight gains -- unplanned weight losses and weight gains, pressure ulcers, wounds, as I said, infections. Any issues with the medical staff, medical director is liaison between the medical staff and the administrator and nursing staff, and that's pretty -- in a nutshell, that's what the medical director does. Also review -- very importantly, typically is to prepare, which we do daily, for Department of Health surveys, which obviously a regular survey has been suspended but replaced with infection control surveys. So typically when Department of Health survey's there or infection control surveys, I'm either in the building or proximal. They'll typically -- the surveyors typically like to ask the medical director questions regarding policy, procedures or individual patients. That's

been the main role last year.

Q. And is it correct to say that part of your role as medical director is to keep up-to-date on applicable standards in the nursing home context?

A. Yes. I am a -- I'm a certified medical director through AMDA, so I receive any regulatory updates regularly through their literature, which has been daily for the last year, and, and then, again, I'm on the receiving end of, in a usual time, influenza reports from New York State, CDC reports, nurse State Department of Health reports, physician disciplinary actions in New York State to make sure that, you know, nobody is in -- in my building is operating that shouldn't be operating there. So, so that's -- all those -- those are the typical -- those are the typical items that, that I review. It is my practice and habit to keep up with general medical literature as well.

Q. And is part of your role or responsibility as medical director to ensure

that those guidances or directives are disseminated out to staff at Fulton?

A. Yes. To the medical staff. It's my practice in all my facilities to interact directly with, with my attending physicians and providers, either by phone call -- if it's something that applies to one of them, then a direct phone call or message. If it's to everybody, sometimes a written memo or a, you know, a group -- at Fulton it would tend to be a group discussion on a conference call amongst them. So I tend to talk to everybody either in person, when I saw see them on the units, or, or I call them directly.

Q. And does this apply to, you know, doctors, nurse practitioners, sort of the whole spectrum of clinical staff at Fulton Commons?

A. I missed part OF your question.

Q. Sorry. Does this approach you are describing, does that apply to the full spectrum of clinical staff at Fulton Commons, including doctors, nurses, PAs,

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NPs?

A. Yes. The -- a lot of my interaction these days is with the two PAs that round in the building, but otherwise the -- with all the medical staff. So it's generally -- it's generally the specific attending physicians for the units. Not so often with the consultants. So I may have a monthly or every three month conversation with the specific psychiatrist, but -- so it's mostly just the general attending physicians.

Q. And we've been talking about the QA committee. Aside from the QA committee, does Fulton Commons have any compliance program in place, that you're aware of?

A. Every building I'm in has a corporate compliance program.

Q. And describe Fulton Commons' program for me.

A. So there's -- so typically, as I said, very similar to other buildings, there is a posted number in the building that if any staff member has a issue or concern,

potential concern regarding corporate compliance that they can call. They can call usually -- usually it's a hotline number. They'll -- we'll have a -- so corporate compliance is a subcommittee of QAPI, of QA, and, and generally -- in normal times we will have compliance meetings -- I think it's typically a couple of times a year, it might be quarterly -- to discuss the overall program as a compliance program typically kept in Cathie's office in a binder.

Q. And you had mentioned earlier that you would be involved in the drafting or preparing of policies and procedures for Fulton Commons, correct?

A. Policies -- clinical policies and procedures I generally sign-off on in every building.

Q. As far as you know, would any of those policies and procedures at Fulton Commons be used at any of Fulton's sister facility?

A. So years ago when I was first

medical director in 2001, Fulton was brand new and a lot of the policies and procedures that were written, I was involved with Pat Brown at that time, and we'd often, at that point in time, would disseminate them to, to the four or five buildings that he had at that time. I have not done that in recent years, though.

Q. And you mentioned earlier that you are still providing patient care, correct?

A. I have one unit of patients, which is three east.

Q. How many residents are you caring for on three east currently?

A. I have -- well, the census varies depending on the day, but there is a capacity for 40. Typically in the low to mid 30s these days.

Q. Backtracking to early in the pandemic, so we will say from March 2020 until June 2020, how many residents do you think you were providing direct care to?

A. Well, at one point -- so early

on, my census was in the 20s, and then about -- it's about six months ago, the unit was split in two, and it was utilized -- so half of the unit was my long-term care patients, down one of those forks in the road, and the other half was patients being cared for by Dr. Johnson and Curran, and those were short-term -- the short-term admissions and they were being -- having their 14 day hospital quarantine, which is typical of what's done in every facility now. That has since stopped and now the unit is -- as I said, about three to four months ago it became my unit completely again, and now the census tended to run anywhere from 22 to about 32 patients.

Q. Would you see any residents outside of three east or was it exclusive just to three east?

A. If I am in the building and they need a physician on any of the units, everybody is pretty -- staff is pretty comfortable to call me or ask me to come and see a patient. It doesn't happen often.

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Q. And it sounds like you still go in person, but during the pandemic did you ever use telehealth to conduct patient care?

A. No. I'm 58 and I still haven't really adapted to that technology completely.

Q. So most, if not all, of your patient care is delivered face-to-face --

A. 100 percent is face-to-face.

Q. -- in person? At Fulton Commons, when you are providing direct care, do you specialize in any types of patients or do you sort of see the whole spectrum?

A. They're anywhere from -- at any given moment in these buildings, they're from age 18 or 20 with a motor vehicle accident all the way up to 108 years old. You know, typically older patients, but there's nothing -- there's no specific patients that I don't see or -- and there's no specific that I see out of the ordinary. So any medical issue.

Q. And how do you document your care at Fulton Commons? What platforms does

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Fulton use for medical record keeping?

A. I missed the first part of your question.

Q. Sorry. When you're documenting your medical care at Fulton Commons, what platforms do you use to document that, is it digital, handwritten, a mix of both?

A. So we were completely paper for many years. Then I would say about five years ago, four or five years ago we became electronic, but only for -- only for orders, only for pharmacy orders and treatment orders, and then maybe within the last year and change where it became progress notes as well. So currently everything is on the computer, but for the previous 18 or so years it was all paper.

Q. And how is your clinical work at Fulton evaluated? Does somebody review your work or are you sort of the top of the chain there?

A. I didn't catch your question.

Q. Sorry. How is your clinical work at Fulton evaluated? Does anybody go to

review your work or does it sort of stop there?

A. Well, my ultimate boss is Cathie, so if something did arise that was brought into question by nursing and presented to Carol, Carol would go to Cathie and Cathie likely would call and yell at me, but it generally doesn't occur very often. I review the physician's -- the other physicians I review based upon -- as I said, I tend to review admitting orders, everybody's admitting orders, looking for antipsychotic medication used or excessive use of antibiotic, for instance, and then I will typically speak to that physician if there is an issue. And if an issue is brought to my attention by the nursing staff, similarly, I would go directly to the physician.

Q. And just specific to your patients that you are providing direct care to, were you responsible for communicating with your patients' family members and healthcare proxies or was that done by

somebody else?

A. I tend to -- if there's any specific changes, any, any significant changes of my patients, I will pick up the phone, call the healthcare agent or the next of kin, if that patient does not -- if the patient has capacity, then I speak directly to the patient and I'll speak to their next of kin only with specific consent from the patient.

Q. Did the nature of those communications change at all over the course of the pandemic?

A. I would say initially my patients had -- there was a short period of time where my patients became, became ill early on. There was a fair amount of communication because there were significant changes in those patients that were sick. Some of those patients died and, and after the fact I know that at least three or four prolonged conversations with family members, trying to help them better understand what may or may not have happened. They were

very cordial conversations, I recall, and I had -- generally I have -- I try to have a good relationship with my family members. So they increased by virtue of the fact that the patients did get sicker at that time.

Q. So you mentioned as medical director you were responsible for providing educational support to your staff. Did you receive any training at Fulton Commons? Did Fulton Commons provide you with any training or practice guidance over the course of 2020?

A. So as I said, I'm a certified medical director through AMDA and I pay for all my CME credits usually. They used to be in person, but they've become primarily webinars and live webinars and virtual through, primarily through AMDA. Nobody pays for that, if that's the question, besides me but...

Q. So that's sort of pursued through your own auspices as a medical director educating yourself?

A. Correct.

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Q. Did anyone or could anyone at Fulton Commons have any input into your medical decisionmaking for your patients that you are providing direct care to?

A. I try to have -- I have a good working relationship with my nurse manager, Ms. Henry. We have known each other for the better part of 20 years. She is a drill sergeant and expresses her opinions to me. She -- if she feels that I need to see a patient or address something or maybe she has a question, she's, I believe, fairly comfortable to be able to approach me, as are, as are many of the supervisors there that I have known for years. They're pretty comfortable to -- they generally question me if they don't understand something, but it doesn't become argumentative. But they always have input and I try to value -- I try to value their input and see if it's something valid. And if it's not, I explain to them why medically it doesn't -- might not make sense.

Q. But is there anyone at Fulton

Commons who can overrule your medical judgment?

A. They would have to -- they would have to go to Cathie, and, again, that would have to be a -- that would be a sit-down or a phone conversation, why are you doing this. Something like that might be more from a family member who, who calls administration and says the doctor doesn't want to do -- for instance, doesn't want to do a mammogram on my hundred year old mother and I think my mother should have a mammogram. So that's something that would trickle down to me. And if it was something valid, I'd have a discussion with the attending physician. If it was my patient, then either Cathie and/or Carol would have a discussion with me and say why, what is your thinking in this clinically and, you know, why do you disagree with the family member.

Q. Outside of the context of that exchange, if you took a position and it was your medical judgment that that was the correct decision, could that be overruled by

anyone at Fulton Commons?

A. Not that I've ever -- I've never been overruled on a clinical decision that I can remember anywhere, unless I had a boss -- unless there was a chief medical officer or a medical director over me who was entitled to overrule me medically.

Q. And you had mentioned, I think, a Dr. Johnson just a few moments ago. Who were the other physicians at Fulton Commons during March through, say, June of 2020?

A. We have had a pretty consistent medical staff over the recent years. Dr. Johnson and Curran -- Dr. Johnson and Dr. Curran are hospitalists from Mercy Medical Center. They have three west and one east. Three west is a mix, primarily, long-term care patients. One east, as I said, is a rehabilitation unit. Then Dr. Kim, Anthony Kim has one of the units in the facility. He's been there close to 20 years. He is an emergency room internal medicine trained physician. Dr. Rohatgi has one of the units. She's also on staff at, I

believe, at Mercy Medical Center. Dr. -- Dr. Rana Hassan. Dr. Hassan I have known for 10 years. He has one of the units there. I think that's pretty much it.

Q. And -- I'm sorry, go ahead.

A. And myself.

Q. And how are these doctors hired? Do you hire them, does Cathie hire them or is there some other process?

A. In general the attendings come from a variety of -- variety of ways. Most of the time at Fulton, over the years, has been through the administrator. I know Dr. Rohatgi was -- had worked with -- a couple of administrators ago, he brought her in. Then Dr. Kim, as I said, has been there for years. I don't even remember how he ended up in the facility. Doctors Curran and Johnson, most facilities like to have a hospitalist group as part of the -- as part of the team. There's coordination -- because we use Mercy Medical Center a lot, so it's a nice conduit or continuity to have a couple of hospitalists on the unit or in

the facility. So I would say a variety of -- typically in nursing homes it's personal relationships between the facility administrators, maybe the medical director. None of them -- as I say, I know Dr. Hassan, but pretty much none of them -- none of them came in based upon my, my say so. So they're all -- I have no issues with them, but they were -- they were brought in mostly from the administrators I believe.

Q. And are they paid by Fulton Commons or by some other entity?

A. No. We are all independent physicians, essentially, private practice. We do our own -- we do our own billing, and it's similar to, you know, having a private office, except it just happens to be a nursing home.

Q. And I guess to backtrack just a bit, when you would receive the guidances or directives or updates through your certified medical director link, would you disseminate those to staff at Fulton Commons?

A. So if there was anything -- so

during -- so let's say recently, get daily updates regarding -- daily and weekly updates from AMDA regarding COVID. If there was anything interesting or relevant, I would share that directly with, with Carol -- at Fulton, with Carol and Cathie. If it was anything specific to add -- for instance, treatment protocols were making their way around AMDA and, and the medical literature. As I said, it was playing Whac-A-Mole because they changed from month to month. The current one is vitamin D, vitamin C, etcetera. And I would be -- if something was recommended or something changed or a building was doing something that another building wasn't, I tended to share that with the administrator or the director of nursing, infection control person. And then if we put it in place, typically I run a conference call or individual calls or meeting with the physicians telling them this is what we're putting in as a protocol, you know, and they're allowed to give input and comments

on it, if they disagree with something as well.

Q. And I assume there's overlap, but aside from AMDA, did you go to the websites or use resources provided by the New York State Department of Health, the Centers for Disease Control or the Offices for Medicaid Services?

A. Yes. So those -- as I said, they were coming, sometimes coming fast and furious. I try to weed out the ones that have minimal amount to do with direct medical practice and the -- the other ones -- the other ones I focus in on, I focus in on a bit more, but yes, I received them all. And then, of course, building to building we tend to have either brief or longer meetings about -- if it's something significant. For instance, when the HERDS reporting started, that became a Saturday long debacle for all of us to try to decipher it, and, yeah, I was on the phone all day with all the administrators and directors of nursing trying to, trying to

get the data reported properly.

Q. And just a minor logistical item, as far as you know, during the pandemic did the providers on staff, and that's doctors, NPs, PAs, did they sign in when they arrived at the facility?

A. So there is a -- there is a sign-in. It's not uncommon and a lot of facilities use it. I don't know the name of the software. And visitors and staff -- visitors and staff that doesn't punch the time clock, so medical staff, consultants could sign in there and -- and sign in and sign out. Unfortunately, during this time, and it's been in all the buildings, I don't know why, maybe it's a sensory overload, but the software hasn't always cooperated, similar to all the Zoom-ing. So when it works, you sign in. We also sign in and out -- we also sign in because when you get your temperature taken on a daily basis there, you put in the time, the -- the time, sign your name and the temperature. So that's been for the last year or so.

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Q. So technical glitches to the side and to the extent the system was working, you would use this digital sign-in apparatus to sign in and sign out at Fulton Commons?

A. If it's working, I sign in and out. Otherwise, I get a phone call.

Q. When did that platform for signing in and signing out get instituted at Fulton Commons?

A. I am going to say at least three or four years ago.

Q. And am I correct in stating that that applies -- the need to sign in and sign out applies to all the providers at Fulton Commons? And by that I mean doctors, nurse practitioners, PAs.

A. Yes. Any -- so any -- any visitors, so it could be a vendor or a family member, when they were allowed in, and then certainly any medical staff or, as I said, anybody that doesn't fingerprint their way in through the other system would sign in on that system.

Q. And so to backup all the way sort

of to the beginning of COVID, when did you first become aware of COVID-19?

A. Well, I think pretty much like everybody else, at the end of the previous year we started hearing that there was a Novel Coronavirus in China, you know, in a providence of China, and we were initially assured, I believe it was in December, that everything was fine and it was likely not going to be a major issue for us. So that was the first time, like everybody else, when I used to watch the news. That was -- that was when -- my first interaction with it.

Q. And what was your understanding of the disease during that early stage? So January, February, March of 2020.

A. I missed the first half of your question.

Q. Sure. So during the early stage of the pandemic, so we will say January 2020 to March of 2020, what was your understanding of the disease itself?

A. So I -- I actually had a patient

that had a sputum culture and it came back Corona. It was the old Coronavirus, the usual Coronavirus. So a friend of mine, a colleague of mine is an infectious disease attending, I called him up and I said what do you know about this, and so he said -- he gave me the short course, which was basically that it's similar to an influenza virus and that patients that are infected with the Novel Coronavirus are at higher risk to have pneumonia and other complications and it was more -- potentially more effect to immunocompromised people. I think that was -- there was a minimal amount medically really known at that time since we were working from foreign medical information which was a bit sketchy. So that was kind of the -- kind of my first memory of, of the understanding of the clinical aspects of it.

Q. And I'm assuming you familiarized yourself with the common symptoms of COVID-19 around that time?

A. Yes. As much as we -- we were

assured that -- we were assured that fever was in almost every patient with Corona. Of course subsequently we realized that that's certainly not the case. But we still -- similar to taking off shoes at the airport for exploding shoes, we dutifully take temperatures. With every patient that I have had recently with Corona, including my girlfriend, they never had a fever.

Q. What are the other primary symptoms?

A. Well, what we found out later was in the elderly anorexia. So they would just stop eating and, and sometimes that would -- they -- they -- after that point they wouldn't survive for a very long period of time. Sometimes within 24 hours, patients would stop eating and demise. And then, you know, within the next month we got the, the update from the CDC that if you have -- if you have geriatric patients and they stop eating, that's, that's a primary clinical sign of COVID infection. Also hypoxemia, which initially was thought to be the

pulmonary involvement, we later found out that the -- that thrombotic events, or pulmonary embolism, was a significant concern. We learned from trial and error. And, again, a little late in the game we got informed that we should consider anticoagulating some patients for that. Then they were putting hypoxemic patients on ventilator support, those hundred thousand ventilators that were ordered, and found out that ventilators were not so good. So hypoxemia, tachypnea, mental status changes, anorexia. I'd say the most common I saw in my patients was anorexia and hypoxemia.

Q. And just as a layperson and kind of for the record, fever also -- you mentioned beyond fever. Is it fair to say cough, shortness of breath, lethargy were also common symptoms?

A. Mental status changes, as I said, so lethargy. Some patients that I had would stop -- just stop talking as if they had had a stroke, yet they hadn't. Cough was certainly a very common -- dry cough was a

very common symptom. More so I would say in the outpatients that I had interactions with, the friends and acquaintances that had it, most of my patients, only a few actually had a cough.

Q. And what were, again, this obviously -- I will restart that question again. So clearly things changed and developed over the course of the pandemic, but what was your understanding of the common or best medical treatments for COVID-19?

A. Well, unfortunately in the beginning we were told -- and I did an AMDA conference, webinar conference with AMDA and, as I said, I was working for The Hamlet at that time, and that was a Care Right building, so we had three point clinical meetings from the chief medical officer there, and basically it was the same kind of treatment. We were hoping that if your patient had fever or got sick, you better hope they have something else, something treatable. So if they had an infiltrate or

pneumonia, IV antibiotics. Some of the initial protocols in buildings, we would throw antibiotics at the patient, whether they had a source or not, because the thinking was that maybe there was some -- you know, even though it's a virus, there was some benefit that some of the antibiotics provided. So an antiinflammatory, which probably is still the case, effect from some such medications as doxycycline and, to a lesser degree, Zithromax, IV fluids, supplemental oxygen, Tylenol. In some cases, patients with refractory fevers, we were using or advocating intravenous Tylenol infusions. But there wasn't anything specific early on, as everybody who watched TV knows, that there was -- there was nothing -- there were no antivirals -- no significant antivirals available to patients and there were no monoclonal antibodies, as there are now, and there was no hint of a vaccine, so we were just giving basically supportive care.

Q. And so starting from February

2020 and March 2020, what did Fulton do to prepare for the arrival of COVID?

A. So early on, because my mother-in-law was actually my patient at the time, Cathie -- Cathie stopped visitors being allowed in the building about a week earlier than it was dictated from Albany, much to the unhappiness of family members, but wisely decided to shut things off to the outside world. And there's only one way in and out of Fulton, for the most part, which is through the front door with a guard there. So nobody was allowed in. You weren't even allowed to bring packages. They had to be left -- they had to be left in another location, as a lot of other places were doing. Again, initially there wasn't a lot of recommendation in any of the buildings or coming from the CDC. Masks were not recommended until, I would say, maybe a few weeks after the buildings all, you know, were shut down where we were told wear a surgical mask if you are within six feet of a patient. Never the mind the fact

that you were around staff members who were circulating behind. So that was the first -- that was the first recommendation that I recall coming from the CDC and New York State Department of Health, was to wear a surgical mask. Not exactly sure when that was, but I know it was probably late March, early April.

Q. On that front, did Fulton Commons engage in efforts to obtain PPE in February of 2020?

A. I didn't hear the first part.

Q. Sorry. Along the same lines as what you are describing, when did Fulton Commons begin efforts to obtain PPE, as far as you know?

A. Well, as I said, initially the only PPE that buildings were using was the usual, gloves. They were -- we were ensured to have antiseptic, you know, the antibacterial hand sanitizers on the walls, and then gradually surgical masks. I do remember once surgical masks were recommended and then put into place, as

policy in all the buildings, they -- I remember them being available, as they are now, on a table in the front at Fulton. Full disclosure, I do bring my own N95s goggles to buildings. That's been my practice since the beginning. So I don't recall seeking out equipment in, specifically, in buildings. I know that at Fulton there were always gloves available when I was examining patients, and there was always the antibacterials available to me, so I don't remember ever not being able to find them.

Q. Do you know if Fulton Commons undertook a review or revision of policies and procedures in those early days of the pandemic?

A. I missed the first part of your question.

Q. Sorry. Do you know if Fulton Commons undertook a review or revision of its policies and procedures in the early days of the pandemic?

A. So as I said, a while ago we had

ad hoc meetings, so whenever we were directed to, to do anything differently, from the CDC and New York State Department of Health, have a discussion, typically, again, in every building but definitely at Fulton where we would -- we'd add something, you know, something would be added to our policy and procedure, so like temperature, temperature screening, more frequent vital signs on patients, you know, as it -- as it became that we were, that we were -- as I said, it was kind of chasing tail in the beginning, but the different directives as far as, you know, what to do, what the recommendations for isolation were or, or quarantining, or even even staff members, how to deal with that, those were all discussed in every building and put into place.

Q. And these discussions, I assume, involved leaders like Mrs. Doyle and Mrs. Frawley?

A. Anything specifically clinical, if it was only clinical, I would have -- I'd

often have a discussion with Carol, the director of nursing, in person, and she and I are both there early in the mornings, and then when Cathie got there, Carol would discuss that with Cathie. If there was any clarifications, Cathie would call and we would -- the three of us would be on the phone.

Q. Did you have any discussions with the infection control person at this time?

A. I was -- as I said before, during the pandemic, specific for COVID, I typically deal directly with the director of nursing for the infection control issues, and there were discussions with the infection control person between them.

Q. And between January 2020 and June 2020, who managed resident admissions at Fulton?

A. Who is the director of admissions? I do not know.

Q. Are you involved at all in that process, resident admissions?

A. No.

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Q. If a potential admission came across your radar, could you provide input on that admission?

A. If admission -- I didn't hear the first part.

Q. Sorry. If an admission -- if a potential admission came to your attention, could you provide input on that admission?

A. Well, I brought -- I brought two friends and my mother-in-law there, but other than that, I have no interactions with the director of admissions nor the screening process there. The only time I get involved, in most buildings, would be if there is a question about a medication that the patient is on or a diagnosis, whether the facility or a particular -- for instance, a biliary catheter, if the facility is able to handle that from a nursing perspective. They would ask me that question. It doesn't happen very often in most places.

Q. Was there ever a time, during the entire pandemic, so, you know, from February

2020 until the end of 2020, when you thought Fulton was not prepared or equipped to admit residents?

A. No.

Q. Would you agree with the proposition that a nursing home should not accept a new admission unless the facility is capable of providing safe and adequate care?

A. That is correct.

Q. Would you also agree with the proposition that a nursing home should not accept a new admission if that resident's health and safety would be endangered or would endanger the health and safety of other residents in the facility?

A. That is generally how we try to operate, yes.

Q. I want to talk a bit about policies and procedures again with a little more detail. What is your understanding, in the most general sense, of what nursing home policies and procedures do and are meant to do?

A. So as I said before, there is a nice big book of regulations from the Department of Health, New York State, and the policies -- in a nutshell, the policies and procedures of every nursing facility in New York is meant to address and reflect each and every one of those regulations so that we can -- we can fulfill, have good patient care, you know, good patient care and, and follow the rules accordingly.

Q. And who approves policies and procedures at Fulton before they're put into implementation?

A. So as I said before, clinical -- the clinical ones, those are, you know -- if there's any new ones or updated ones, they're brought to me to review, clinical ones. If they're nonclinical, typically I believe through the department head and then everything ends up with the administrator.

Q. And in your experience, are Fulton Commons' policies and procedures dated?

A. That I've ever seen or asked for

one, they all have dates. And as I said, when the building opened its doors in 2001, a lot of those -- a lot of those policies and procedures, clinical ones, I'm pretty sure, still are in effect and just, you know, probably been updated over the years as things change. But -- so when they're changed, they typically put an addendum date on them as to when they were revised or updated.

Q. So a revised P&P should have a revision date or at least the date reflecting when it was revised?

A. Should.

Q. So, again, on a very general level and based on your medical, you know, experience as a medical director or an attending physician, why is it important that caregivers adhere to facility policies and procedures when they're providing care to residents?

MR. JONES: Hey, Ben, I'm sorry but that question totally broke up on us.

Q. Sorry. I will do it again. No worries. So based on your experience as a medical director, as an attending physician, someone with a lot of experience in this world, why is it important that caregivers at all levels adhere to facility's policies and procedures when providing care to residents?

A. Well, as I said, the -- so the clinical procedures, policy and procedures, for instance even something basic like hand washing, which becomes, becomes a major concern in healthcare, to the point that hospitals spend millions of dollars to make sure that their doctors are washing their hands in an appropriate fashion. So if -- it's a very basic premise. A lot of time is spent in-servicing staff on that to make sure everybody is washing their hands properly because it has a direct impact, potentially, on patient care, morbidity, mortality. There have been infections, certainly in the newspaper and in medical literature, that all started because there

was inadequate hand hygiene. So most -- I would say the clinical policy and procedures in buildings are based upon clinical data and relevant medical facts, for the most part, and, and there's, there's sound clinical reason behind them. So, for instance, this -- the use of hand sanitizer, we were told never to use hand sanitizer more than two or three times in a row and then you had to wash hands. Now, in the last 24 months, that recommendation changed from the CDC. So, you know, as I said, these things are constantly evolving, but they're clinically based in fact and utility. It's important for staff because it has direct impact on patients, patients' lives.

Q. And along those same lines, and based on your experience, if a caregiver failed to follow infection control policies and procedures, could that endanger the wellbeing of a nursing home resident?

A. Potentially, yes.

Q. And similar to that, if a

caregiver failed to follow infection control policies and procedures, could that result in the neglect of a nursing home resident?

A. Potentially, yes.

Q. And based on your experience, you know, doing this work for many years, has a breakdown of infection control policies and procedures resulted in the death of a nursing home resident?

A. I can't remember a specific instance, but there have been -- there certainly have been, you know, documented outbreaks of influenza that ended up in nursing home deaths and hypothetically or most likely start with, with somebody not following things as well as they could have.

Q. From your perspective as medical director and based on your understanding, who at Fulton Commons is responsible for ensuring that staff follows facility policies and procedures? And I mean staff from top to bottom. Is there someone who carries that role at the facility?

A. Well, Cathie is pretty specific

that every -- and this goes back to when we were together at South Shore -- that every department head and every staff member from the top down is responsible for reporting anybody on any level that they see not following facility policy.

Q. And is that -- from your understanding and just for my clarity, is that Ms. Doyle putting the onus on staff department heads to ensure that P&Ps are followed, or something else?

A. I think, you know, following, so for instance infection control policies, if you -- it requires a lot of eyes and ears to be able to enforce those things. There is a lot of personnel throughout the facility, and I think reasonably her expectation has been -- she screamed at me once because she thought I didn't wash my hands. I had, but she didn't see it. So she -- she certainly expects that everybody is going to follow policy and procedure and expects to see disciplinary reports. If she doesn't see a lot -- if she doesn't see disciplinary

reports from nursing, for instance, she will think that everybody is just not watching as closely, rather than that everybody is maybe doing all the right things. It's probably some mixture of both those things. So for instance, in nursing homes, you see a call bell on. The expectation is anybody walking down the hall, including somebody mopping the floor, should put their head in the room and ask if there is an issue or if somebody needs help. If she -- if Cathie sees that you didn't do that, she will be quite unhappy with your performance. So as I said, it does require a lot of, a lot of staff members keeping an eye out for each other.

Q. So is it fair to say that Cathie almost views the staff at Fulton Commons as something along the lines of a mandatory reporter in this context?

A. The higher -- yes. The higher -- you know, from especially the department heads and the, you know, the RNs more than the LPNs more than the CNAs, you know, kind

of in order. The more title and responsibility you have, the more expectation she has for you.

Q. And just from your own perspective, did you ever see anything happen during the course of the pandemic that you felt obligated to report?

A. I would say that particularly on three east, Ms. Henry is, as I said, a drill sergeant. She says "even in hell the devil has rules" and she tends to run a very tight ship so -- and those ladies are -- CNAs and LPNs are hand selected pretty much to be up there. So I would say the staff up there, in all the times I've seen them, are pretty strict, and if anybody was out of line and didn't follow something, they'd probably not be up on three east for very long.

Q. Okay. So is it fair to say you didn't see any behavior or activity that you can recall at this time that would have triggered your --

A. No. I would say that -- I would say that everybody became, like everywhere

else, became very cautious, more cautious than they had ever been in the past, and, you know, as far as masks, gloves, hand sanitizer, everybody's pretty -- I've never seen anything outside of everyone following what they're supposed to be doing.

Q. As medical director at Fulton, did you issue any protocols yourself that were intended to reduce the risk of transmission of COVID at the facility?

A. Everything was done in conjunction. As I said, all the buildings the same. It was all done in concert with, with ad hoc meetings for, for QA or QI. So it was director of nursing, myself and the administrator and being in agreement based upon recommendations and putting those recommendations into effect and disseminating that information to the relevant staff as quickly as possible. So I didn't specifically -- let's say if I had thought about doing that, I would have gone through Cathie and Carol to do it.

Q. That makes sense. So right now I

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would like to direct your attention to what will be marked as State's Exhibit-2.

MR. SMITH: We are going to get into a different set of questions, so we can take a break now if that works for everybody.

MR. JONES: Great. So what time should we come back?

MR. SMITH: Does everybody just want to do a quick restroom break? And I would be open to lunch too, obviously, and not grind all day. So you want to do a quick restroom break and lunch in an hour or so?

MR. JONES: Yeah. That sounds good. Why don't we take a 10 minute break.

MR. SMITH: So come back at 12:35.

MR. JONES: 12:35 is good.

MR. SMITH: That's good? 12:35 it is. I am going to mute everybody, especially so, Glenn and Mr. Butchma, we can't hear you speaking.

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MS. SEKHON: I think it's all me, so I will mute everyone.

MR. SMITH: All right. Thank you.

(A recess was taken.)

MR. SMITH: So we are returning from a brief break. We did a check, everyone is returned. So we have the full complement with us.

Q. Dr. Butchma, I am going to return to the exhibit we were bringing up before we broke, which is State's Exhibit-2. And do you recognize this document?

A. Yes.

Q. Do you see a policy name?

A. It says COVID-19.

Q. Do you know who prepared this policy and procedure?

A. Not specifically, no.

Q. Do you know if you assisted with the preparation of this policy and procedure?

A. As I said, I have seen a lot of policies and procedures over the last year,

so I don't have a specific recollection, without it being a title of where it's from.

Q. Can you tell when this P&P was created?

A. Not from the part you are showing me, no.

Q. Let's, Anne, if you would, let's just slowly scroll through. It's a seven page document, but let's scroll through and see if we can find a date. Okay. So we just scrolled through the seven page document titled "COVID policy and procedure". Dr. Butchma, did you see a date on that document?

A. I did not.

Q. And going back to what we discussed before, is it odd that this document is not dated, from your perspective?

A. Not specifically, but typically there is a date on most policies and procedures.

Q. So let's look at page one of the document, and we will just scroll down a bit

to where the document reads -- maybe just a bit down further. So under the policy section, the document reads: "The facility will implement actions according to CDC, NYS DOH and World Health Organization recommendations including identification, isolation and informing the health department of any suspected cases of COVID-19. The facility will screen residents, visitors and staff for symptoms of acute respiratory illness (eg fever, cough, difficulty breathing) before entering the healthcare facility."

Do you know, from your perspective, if Fulton Commons implemented a plan to identify potential presumed or suspected COVID cases in the facility?

A. So early on we were advised by the CDC and New York State to presume that anybody who had suspicious symptoms should be considered a POI, or person of interest, or patient of interest, and presumed to have it; that testing was not mandatory or at that time was not very feasible for any of

the facilities since we virtually had little, if any, testing material available in the first few months of the pandemic.

Q. So is it fair to say that identifying or classifying somebody as a presumed or suspected case was based on clinical assessment?

A. Yes. I think basically across the board what all the facilities were doing at that time was increasing vital sign monitoring because, as I stated before, the information available was everybody's going to have a fever who has this so we kind of picked an arbitrary number in every facility. You know, clinically speaking a fever is typically 100.6 degrees. Some facilities based it upon an amount of -- a number of degrees over your baseline. So two degrees over baseline I think is what Care Right did, and then other facilities just picked 99 and are still using that as their number. So we put into effect increased vital signs, oxygen saturation levels and, you know -- in the early part.

And then as we got to understand, as I said, about anorexia and changes in appetite and mental status, then we added those in. So anybody who was clinically suspected of being possibly having it was treated as if they did. Unfortunately, there was little, if any, testing supplies made available to nursing homes, and there was -- there was, as I said before, no real concrete treatment at that time.

Q. And you would have noticed, in the section of the policy and procedure I just read, there was a reference to isolation or isolating residents. How did Fulton Commons go about isolating potential or presumed or suspected COVID cases?

A. I don't have a specific memory of every month, but we basically followed -- as I said, all the facilities, we tried to follow the directives. So depending on -- depending on the logistics in the individual facility. So there were seven -- there were seven nursing units in Fulton, and, as I said, for example, as of late we used, you

know, one fork of one -- one of the forks in three east was used for the 14 day recommended isolation type quarantine post hospital, even for negative patients. Of course -- you know, so as we -- as we got more information and more directives, then Fulton put into place whatever the recommendations were, and that was done -- that was actually done, as far as moving patients around, was coordinated by, as always, the social service admission administration and nursing primarily.

Q. And there's also a final reference to, in this P&P, to keeping the State Health Department updated as to COVID specific developments. What was Fulton Commons' approach to reporting COVID specific developments to the state?

A. Well, we were all -- and, again, this has evolved over the last 12 months. You know, the first -- the first shot across the bow is the HERDS reporting, which was chaotic, to say the least at the end of -- from the State's end. They -- the system

was overloaded and it was difficult to -- for the people who were responsible to report to HERDS. I don't directly do the HERDS report, but I know it contains staff members that are, that are suspected or tested positive or people that -- you know, any COVID deaths during particular days or weeks and any positive tests, you know, in the facility. Of course early on, as I said, we didn't have testing supplies in any of the facilities, so it was how many POIs we had, person of interest, or patient of interest, and possible or suspected deaths, was the primary thing we were doing. My understanding is they were called -- they would call in if there were any questions or any aberration. If you don't report to HERDS, they call you up and then they would then -- at some point they started focused infection control surveys, which is basically the usual Department of Health survey teams with infection -- infectious disease or infection control experts as part of their survey team coming in and reviewing

those items in some detail, walking around, to some degree, on the units, seeing how isolation or quarantining was being accomplished, and then making recommendations or expressing any concerns that they -- that the surveyors would have.

Q. So let's quickly jump down to page two of this policy and procedure. So we will go down just a bit more. So if you look at, I'm sorry, bullet five there, I will read it for you: "If logistically feasible and will not put other residents or staff at risk of exposure, the facility will cohort confirmed positive residents in the same room or area of a unit as much as possible."

How did Fulton Commons go about cohorting confirmed positive residents?

A. So I would say based upon the verbiage in that policy and procedure, it would seem to be a little bit -- wouldn't have been something that was written in March or -- February or March or April because it's referring to positive tests and

we didn't have that capability. So I am assuming it would have probably said symptomatic or patients of, you know, patients of interest. So by that time, I am going to imagine it was, you know, a little bit later in the game when there was more testing available. Again, it was -- like most facilities, they, they cohorted on -- there's been different units that were used. As I said, three east was used at one point for one purpose. The other units were used, depending on what the census was and, you know -- it kind -- it tended -- so three east -- to go backwards, three east got sick sort of early on before there was testing availability, before we had a lot of knowledge, and I -- I had a -- I had a few -- several patients that died in the March time period and then it, as is typical in a lot of facilities, it kind of moved its way around the facility. So if a unit became infected, similar to the flu, that unit was pretty easy to shut down. And, again, we've resumed that. Since there were

five febrile patients that pretty much there had been some level of exposure and, you know, everybody was contained in their room. In any event, you know, diets -- community dining had been stopped when Cathie closed the building. There wasn't much movement around the units. So for all intents and purposes, patients -- there's only one bedded and two bedded rooms in Fulton, so those patients had -- were pretty much contained. Nobody really left their room very much. It mentions masks in there so, again, that's not an early -- that's not an early policy and procedure. Probably more a couple of months down the road.

Q. And based on your answer there, would it be safe to assume that an earlier iteration of this policy and procedure would have applied the same idea about cohorting to suspected or presumed residents?

A. I would think so, yeah.

Q. And, again, just to be clear for the record, when you say confirmed positive, you are reading that to mean via testing?

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A. What this is referring to is positive tests.

Q. Positive tests. To back up a bit, you said you had residents pass away of COVID on three east in March of 2020; is that correct?

A. I said I had patients -- so I lost a number of patients within a short period of time. I would say about 10 or 12 patients died within about three or four days, where several of those patients were -- had been on palliative care or dying of other causes. They were not suspected COVID. And some of them had been treated for other infections successfully and deemed to be doing well and probably had some sort of embolic or thrombotic event, which may or may not have been COVID related, but, you know -- and of course those, all those deaths were reviewed, hashed and rehashed with the Department of Health -- with the Department of Health people, specifically. The one patient I had that I know tested positive, it was only because the family

came to visit her when she was dying, and as family dynamics sometimes are, one of them decided to call 911 and send -- and send mom to the hospital, which they were testing everybody in the ER at that point, and she tested positive. Whether it was just a coincidental positive, which sometimes happened, or it was actually her cause, I don't know. But as I said, I did not have any -- on three east I did not have any confirmed positives except for that one patient.

Q. Aside from that patient -- and do you recall her name offhand?

A. Not off the top of my head.

Q. Aside from that patient who was confirmed at the hospital, within the group of patients that passed away during that period of time in March on three east, were any of them what you would call COVID suspected or presumed or suspected COVID cases?

A. At the time -- at the time, no, because, as I said, there was a 96 year old

patient with three end stage conditions who, you know, as I said, that was expected. I had patients that I was treating with IV antibiotics who had a confirmed infection. And, again, sometimes it was better to have something to be able to treat with intravenous antibiotics and IV fluids. There was no mysterious fevers -- on my service anyway, there was no mysterious fevers and mysterious deaths. But in the, as they say, the retro-spectascope, looking back a year, knowing what we know, it's possible that somebody would have had an infiltrate, you know, pneumonia, been treated successfully, but also had COVID and had a pulmonary embolism, which we didn't even know to think of or look for at that time because the medical information just wasn't there for us.

Q. So just to make it perfectly, perfectly clear, at that time, in March of 2020, none of those individuals who passed away, to you, indicated potential or suspected COVID infection?

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A. Correct.

Q. So let's scroll down to page three of the same document, and we're going to go down to, right there, to confirmed COVID-19 unit. So I am specifically looking at the section that reads: "One floor of the facility has been designated to care for residents with confirmed COVID-19 admissions. It is the intent of this unit to ensure the safety of all residents and staff."

When, approximately, and this is to the best of your recollection, was this confirmed COVID-19 unit created at Fulton?

A. I don't remember exactly. I can say that, you know, a range of times. So probably, you know, all the facilities were doing it about the same time, so I am going to say sometime in the summer probably that we had -- which turned out, when we were admitting COVID patients, those were probably the very best and safest patients to have, in retrospect, because they probably had some immunity already. They

weren't going to get sick themselves beyond what they had. And they probably, after 14 days, weren't infectious to anybody else. But, again, based upon the verbiage, I would say sometime in the summer months that would have been.

Q. Beyond the verbiage, just to your recollection about the idea about of a designated COVID unit, to your recollection did that also transpire, the designation of that unit, in the summer or sometime before that?

A. I think be -- as I said before, so the, you know -- in -- in some of my other buildings, we had red, yellow and yellow number two zones, and that was based upon structure of the building. So Fulton, the -- the way I remember it clinically, and again this happens for gastrointestinal illnesses, when we've had -- when we've had things like communicable diseases go through Fulton Commons over the years, it's been very -- pretty straightforward to be able to shut down that particular unit because

it's -- you know, it's a contained unit. Most of the time the staff stays -- there is not a lot of floating staff. Typically the same staff members. I mean, I can't speak to the evening or the nights or all the weekend shifts, but -- so when you have, you know, diarrhea and vomiting and 14 patients, you shut that whole unit down, you have all the hand washing and hand sanitizing supplies, you -- you're using whatever, paper plates, Styrofoam, throw-away things. So the facility lends itself to, to fairly straightforward infection control, and unit by unit we were dealing with febrile and illness and, you know, symptoms that were consistent with COVID and we were presuming COVID. So, you know, the individual units, you know, four west is -- four west has 14 febrile patients, four west was closed, and there would have been no medical sense to move eight febrile patients to two west or the febrile patients from two west to four west, if you know what I'm saying. So the way the building is setup, it's pretty

friendly to infection control procedure.

Q. So just to clarify for my purposes, it sounds like it until this confirmed COVID-19 unit was created, residents were sort of treated in place, they were treated on the unit that they happened to reside on at the time, or something else?

A. Well, I'm reading the confirmed COVID was confirmed COVID admissions. Different things. So initially we were ordered to accept patients without benefit of knowledge whether they had been tested and whether they had tested positive or not. What this policy is referring to is admissions that are already have -- already had COVID, which we were -- you know, which individual facilities deal with very differently now than eight months ago, but that's not talking about in-house patients that are sick. That's talking about COVID admissions.

Q. So this would be individuals admitted directly from the hospital --

A. So you had COVID, you had pneumonia related to COVID, tested positive, and now you're going for rehab, you're going to end up on that, on that COVID unit.

Q. Okay.

A. Most buildings -- most facilities don't even do that now because, as I said, those are -- you can put a whole facility full of those if you want. That would be great. Because medically speaking they've already had it. There is no -- they're -- there is really no danger to anybody that we know of and there is no reason to -- you're not going to test them again because they can be positive for three months. So, so the COVID -- so as I said, that would have been kind of in the -- that would have been kind of in the third or fourth inning of the nine inning game, which we're are now in extra innings.

Q. To that end, is there still a confirmed COVID unit for hospital admissions at Fulton Commons?

A. As I said, nobody's really --

nobody's doing that. So it's not recommended to do. So you're admitting -- you already have -- you are a COVID positive patient in the hospital who's tested negative and you're accepting them for admission. So you are putting them in -- either in an individual room, or you can cohort them -- from infectious disease policy, you can cohort them with another similar patient that you took in that day. So I got two admissions in Westhampton the other week. They both had had COVID pneumonia, they were both admitted the same day and they're both in the same room. They are just quarantined, which is the standard 14 day quarantine, but there is no reason to test them and there is no specific -- you don't have to go crazy with protective equipment, per se, because they have already -- they have been sick, it passed. They are of no danger to you and you're really of no danger to them, COVID wise. So nobody is really -- that I know of, nobody really has a specific unit setup for

hospital COVID patients. It would be a small unit at this point and there is no medical reason to do it.

Q. Because I am looking at -- you see the first line of that policy section, it says "one floor of the facility has been designated." So is it safe to assume that at some point that designation of that floor was dissolved or changed in some other way?

A. I think it probably evolved into what I said was, which is that -- so -- so right now, for instance, I believe one east is back to being the new admission, the new admission unit for the 14 day quarantine. A lot of those 14 day quarantine patients, whether they had COVID or not, when they graduate, then they may end up on three east or one of the other units because they've cleared their quarantine. So those units everywhere have evolved into something different.

Q. So it's safe to say that efforts at Fulton Commons to cohort confirmed COVID cases has evolved over the course of the

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pandemic?

A. Yes.

Q. So I would like to direct your attention now to what will be marked as State's Exhibit-3. And do you recognize this document, Dr. Butchma?

A. Yes.

Q. Can you read the title there?

A. It says "Fulton Commons Care Center nursing department protocol for residents with suspected COVID as well as residents admitted from hospital with confirmed COVID."

Q. And do you recall if you assisted with the preparation or revision of this P&P?

A. Again, all the policies and procedures from the pandemic were, you know, discussed as far as directives that we were receiving from New York State and from the CDC via conference call. So it wasn't a visual thing. We would discuss different features or changes and then, like, if it's a nursing department, then Carol and Cathie

would have, would have navigated and revised that policy and procedure, and then they would have asked any specific input from my perspective.

Q. But just from your recollection, does this particular P&P seem familiar as one you might have worked on?

A. Yes.

Q. Can you tell, from looking at the document here on the screen, when this P&P was created or revised?

A. Again, not specifically, but this -- it's not -- it's not a recent document. So it would have been somewhere, again, somewhere last, you know, somewhere last year, middle of the year probably.

Q. But, again, as with other P&Ps we have looked at, it's unusual that it is not dated, correct?

A. Unusual, but, to be honest, from, you know, from my other facilities where they're doing COVID policies and these things are constantly changing, I don't recall that I have seen a lot of date

specific, date specific things. Sometimes nursing home policies -- so, for instance, the dietary policy, they will make a new face sheet for it and a signature sheet and a new date, but I haven't seen a lot of that with the -- as I said, because of the ever changing nature of the game with this, it's not that unusual that I haven't seen a lot of date notations on them.

Q. So I am going to read the first block of text there. It's under the section policy. So I am reading the policy. "It is the policy of FCCC to ensure all residents are maintained in an isolated area once identified as a presumed COVID or as admitted to the facility from the hospital setting with a confirmed diagnosis of COVID." Did I read that correctly?

A. Yes.

Q. So the P&P goes onto provide -- and this is a bit further down on the page -- protocol for inhouse residents with a suspected COVID diagnosis. The policy and procedure goes on to state that "the

resident will be transferred to the designated unit unless they are in a private room." And did I read that portion correctly?

A. Yes.

Q. From your recollection, is this designated unit that this P&P is referring to the same unit referenced in Exhibit-2 that we just looked at, or something else?

A. I think this is -- again, it's -- it seems to be something else. The other policy and procedure seems to be specific to the hospital -- patients admitted from the hospital who actually were diagnosed. This is discussing -- and as I said, this would be fairly early because they're -- we were advised to cohort as if they were similar and they're really not. So there is no -- there would be no reason to keep confirmed COVID patients from the hospital, who I assume have already recovered, along with patients who have fevers and were symptomatic and potentially had something else as well. But that was initially what

we were, you know -- what they were recommending -- what they were recommended to do, you know, by the epidemiologists.

Q. And so would I be misconstruing anything or misstating anything if I said that -- or if I took this policy and procedure to indicate that there potentially could be two designated COVID units in operation at Fulton Commons?

A. No. This seems to be -- no. What I said was this was at a time when they were putting -- they were putting -- these are dissimilar patients. There would be no reason -- so as I just said before, there is no reason to move me from three east with 101 fever over to two west. And so a lot of movement is not necessarily the ideal thing right now. We did a lot -- all the facilities did more movement back at that time. So these appear -- this appears to be one unit where they're cohorting suspected COVID and confirmed COVID cases. It's not wrong. From a medical point of view, it's fine, but it's -- it's -- it was something

they were doing, you know -- we were all doing earlier -- more earlier on.

Q. And from your recollection, when did this effort start, this effort to cohort the type of residents described in this section of the P&P?

A. Again, everything -- I can tell you for certainty -- I'd have a weekly conference call from, from Care Right. Pretty much everybody's heard of Care Right. They have 35 facilities. It was from my chief medical officer with 35 facilities on the eastern seaboard. And that I remember every Friday at 4:00 because it was very inconvenient for my life, and they -- what Care Right was doing was taking the directives from New York State and utilizing those and implementing them throughout the east, even though it wasn't required in those states. So New York was kind of the more aggressive state, as far as putting in policy, you know -- demanding policy change from nursing homes, and then everybody was following suit, all my seven or eight

facilities at the time. We got a directive, as I said, typically on a Friday and those directives can be traced back to when we all put our policies into effect. So if we got it on Friday, we had a conference call in the individual facilities, we had the discussion with the administrative director of nursing, we put the policy into effect, the procedure. Social service and admitting were advised whatever room changes there were going to be, if that was necessitated, and it was done. So I don't remember the specific time periods because, as I said, it's Whac-A-Mole, medically speaking. We were moving along and changing week to week and month to month at the very least with the recommendations, you know, being the mask wearing, etcetera, and so these all corresponded -- so I have the general idea, as I said, based upon the verbiage of specific policies of any facility where they were, you know, in the time periods that we've been dealing with COVID. So if it doesn't mention testing, I know that was

generally February, March, April of 2020, you know. Once it starts mentioning testing and staff testing, when staff was required to test in New York State, twice a week initially then once, now twice again, I can tell you that was more towards the late spring and early summer. So, you know, as I said, the time framing is based upon the demands from -- that we all received, you know, via e-mail from the state and the CDC.

Q. Right, and I definitely, you know -- I'm not -- you know, I don't want to give you a hard time about recalling specific details of things that happened, you know, nearly a year ago at a stressful time. So to that end, if we could just try to ballpark this. Like looking at this protocol now, the idea of a designated unit for suspected or presumed, would you -- based on your recollection, could this have happened as early as February 2020 or sometime afterwards?

A. I would say -- oh, definitely not in February.

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Q. Okay.

A. You know, as I said, we -- because in March -- I believe in late March it was that, that the Governor told us we had to go blind as far as not, not even asking for a positive test, that it could be considered -- you could be -- you could be penalized for that as a facility, if you are going to ask if the person had had a COVID test, COVID swab. You weren't allowed to ask. So conceivably you could have a sick patient or a febrile patient who was still contagious and that would have been -- again, that would have been early. That would have been early on, so that was -- that was March in and of itself. When it doesn't mention testing, it's usually -- it's usually probably late March. Most everything, all this started where we got directives was late March into April and May. There wasn't a lot coming down, up until the time that the Governor ordered closure of the facility to visitors, etcetera, which, again, was sometime after

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Good Friday, I know, and during the Easter season. Up until then, there wasn't much recommendations coming down, so there wasn't much policy change to be doing, you know.

Q. Right. So maybe an easier way to do it, do you recall Fulton Commons having a designated COVID unit as early as, say, early March 2020?

A. I would say more towards -- probably either late, late March or maybe early April. That would have been -- as I said, Easter time is kind of the range where I remember everybody, everybody putting that into effect.

Q. So that's at least the time you can have some memory of a designated unit coming into existence at Fulton Commons?

A. Yes.

Q. So I want to scroll down just a bit more towards the bottom of this page to the next section that reads "protocol for admissions slash readmissions from the hospital with confirmed COVID diagnosis." There is a section just below that that

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reads: "Any resident who is being admitted or readmitted from a hospital setting will be placed on the designated unit."

Did I read that correctly? I'm sorry, did you lose me for a second maybe?

A. No. I'm reading.

Q. Oh, sorry. Take your time.

A. Yes. That's what it says, yes.

Q. So according to this policy, is it accurate to say that both inhouse residents with suspected or presumed COVID and hospital admissions with confirmed COVID were to be separated from other Fulton residents and housed on a separate unit in the building?

A. Based on that policy and procedure, yes.

Q. So was it necessary, from an infection control standpoint, to separate suspected COVID residents in the facility as well as the COVID patients from the hospital from non-COVID residents at Fulton?

A. At that time, that's what everybody was doing. At the current time

it's being -- it's done differently. So, you know, at that time that's what we were instructed to do. That was what the epidemiologists were saying, and CDC and New York State, so that's what we were doing.

Q. So based on, you know, the advice you were getting at the time, the guidance that you were getting at the time, would it be correct to say that housing COVID and non-COVID residents on the same unit potentially violated infection control guidelines and policies?

A. No.

Q. And why is that?

A. What I'm saying is that there is no medical reason or infectious disease reason to create COVID land like that. So what Care Right was doing was a version of it, which was they had a red zone, they had a yellow zone number one and yellow zone number two. One of the yellow zones was for hospital admissions who had had COVID, and then the red zone was for sick people. But a sick COVID patient, even being in the same

room as a patient who's had COVID two weeks ago and is recovered, there is no particular -- there is no particular adverse thing medically for it, but there is also no medical reason to move somebody around and do that. And also aesthetically, you know, you wouldn't -- it wouldn't be necessary. So for instance, right now what most places are doing that patients that tested -- that have an outbreak, so you have 12 patients that have COVID, you are putting them in a tented zone, basically, with a zippered enclosure and they're all kind of cohabitating together because they're -- medically speaking they're similar patients. You could bring a hospitalized patient who had COVID in there, and some facilities test the patient who had COVID and if they're positive they put them in that zone. You can do it but there is no specific medical reason that you have to do it, you know, other than your own -- keeping with your own policy and procedure. That, what you have up there, that's what was recommended at the

time. That's what we were doing.

Q. And at the time, you know, based on your understanding of the disease in February, March, April of 2020, what was the point of creating these designated units and cohorting the residents?

A. Well, again, nobody knew -- so early on, for example, if I had tested positive, I could go back and work in the nursing home in 72 hours, as long as I isolated at home, which, in retrospect to you and me, makes no sense whatsoever. But that's what the rules were back then. So as it became some understanding about the disease which, again, changed from day-to-day and week to week, you know, is how it was transmitted and for how long it was transmitted that, you know, that -- things certainly changed. Now we know that if you had it, probably -- you're probably a pretty safe person in seven to 10 days and, you know, definitely by 14 days you are probably not shedding the virus. But there was a belief for a time that you can shed

the virus until you were negative. Now we don't do that anymore. So as I said, the recommendations, they were -- this wasn't guidance so much as it was demands of us to put into effect, and that's what we did, based upon what was sent out on that particular Friday in March. And then at the end of April, something entirely different, probably, was published and sent out based upon the nonpracticing epidemiologists and infectious disease experts for the CDC that came up with something different. So that's what we were all acting upon from week to week and month to month.

Q. So I want to just direct your attention down to page -- the same page, down to bullet three, and that bullet reads: "The same staff will be assigned to them on a daily basis for each shift." And by "them" I think it's safe to assume, correct me if I'm wrong, that that is referring to residents.

Did I read that bullet three correctly?

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A. Yes.

Q. So I want to direct your attention back to State's Exhibit-2, and that's the policy and procedure titled COVID-19, and so let's just scroll down to page four. So I want to look specifically at the line that says "Fulton shall have separate staff -- just go up just a bit. Just a bit more. Sorry. Scroll down for me, just -- ah. Oh, sorry. There you go. You directed me to it Anne. So bullet three, top of page four, it reads: "As best as possible, exercise consistent assignment or have separate staffing teams on the confirmed COVID-19 unit."

Did I read that correctly?

A. Yes.

Q. So why, during the pandemic, was it necessary from specifically an infection control standpoint that Fulton staff did not provide care to both COVID and non-COVID residents during their shifts?

A. Well, I think, as I said, I think early on, and I don't -- I am not involved

with staffing, except that I tend to see the same staff on the same units. I think that the belief was that it was better to have, to have staff, similar staff, rather than having paid people that have potentially been exposed on those units moving to other units. However, what wasn't taken into account in a lot of these recommendations was -- which now we understand -- a lot of the risk with staff comes from being at home or being in various places when they're outside of the building. So it's a very nice idea, in general, to keep the same staff on the same units. So if you had a -- so, for instance, like I said before, you have a diarrheal illness or you have an influenza outbreak, that's what they do typically, at Fulton and other places, which is they don't let -- they don't even want staff visiting other units, if there's diarrhea and vomiting in one of those units. Unfortunately, we know that people have lunch together or car pool together or do things, and so while, conceptually, it's a

good idea to practice, in practice it's more important to follow general infection control policies and procedures; hand washing, disinfectant, and in the case of COVID, as we now are using N95s and surgical masks on top of that in a lot of situations, you know, to, to take every precaution as much as possible. Now goggles have been commonplace, and certainly in the beginning they weren't recommended, required or otherwise. So as I said, that was an earlier recommendation that probably came from epidemiologists, but as I said, in practice it probably doesn't make a heck of a lot of bearing on overall infection control.

Q. So would you agree with the idea that if, say, a COVID positive resident was in room one and a non-COVID resident was in room two and the same staff was caring for both residents, that would not be a breach of infection control protocols?

A. No. That's a different thing. This is talking -- this is unit specific.

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So you're having -- so I have got a unit of 40 people that I need to, let's say for sake of argument, it's a COVID zone, like I just discussed, you are behind a tent, like my girlfriend was a month ago. So everybody in that unit has tested positive and have varying degrees of symptoms of having COVID. The protective equipment is all the same and the patients are all the same. It's a homogeneous population. This is talking about a homogeneous population of COVID people. The -- as I said, there is no real reason to risk -- not to risk. There is no real reason to put people that are recovered in with people that are at some degree of active shedding. It's not harmful to either one of them. What you wouldn't want to have, and what you are referencing, is a COVID positive or suspected patient in one bed and move another patient that you are pretty sure doesn't have it. If they're there at the same time, however, if I get a fever of 102 and you have been my roommate for a week, well, guess what, you have been

exposed and there is no point whatsoever in moving you out, and there is no point in moving me out. We're kind of like Felix and Oscar at that point, we're living together. So -- but what you're describing, yeah, you wouldn't want to bring in somebody into a, you know -- in most cases anyway, somebody has an infection or potential infection, you don't want to start moving somebody in who's not sick. But that's not what that -- that's not what that was talking about.

Q. So if you have a section of COVID rooms, you have staff assigned to those COVID rooms, that's perfectly safe, but you just would not want to float that staffer who is caring for those COVID patients to a section of rooms that are non-COVID patients?

A. Yeah. So -- so in that, as I said, the extraneous factors that we can't control is, for staff or for me to be at home with my college sons, you know. They're bringing in all manner of friends or whoever. So that we can't control. But

inside the building, it's a fine idea to have the same staff on the same unit and, and if you have a designated COVID unit, say four west, you would prefer not to send your four west nurses and CNAs down to two east where you have nobody sick, for instance, because you kind of know there's been at least the potential for exposure, even though they're wearing protective equipment and they're taking all precautions, it's a better idea not to start moving them, you know, if you can help it to another unit. However, as I said, I go from COVID unit to see my patients, I put protective equipment, then I go see my little old nursing home patients who have nothing, they're fine, and I am not wearing the same protective equipment. And if I take reasonable precautions, it should be a safe interaction in either event.

Q. I understand everything you are saying, but the baseline it leaves for nursing staff would be to keep them cohorted with a status patient, so COVID, non-COVID

and to not float them between those two statuses; is that correct?

A. Based upon that nursing policy, that's what that's stating, is that their preference is to keep the same staff, the same staff assigned to those units.

Q. And are you familiar with the term "floater" in the staffing context?

A. I've heard it.

Q. Is that usually in the nursing or nurse aide context that that term is used?

A. Most of the time it's -- it's nursing assistants, CNAs. As much as I know about it, that's generally where I hear -- when I'm at the computer, that's the conversation I hear amongst the CNAs.

Q. Do you know or did you observe at any time staffers being floated between units at Fulton Commons?

A. I wouldn't have noticed and I wouldn't have paid attention to it. It's not something that comes under -- on my radar, to be honest.

Q. So now I would like to direct

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your attention to what's going to be marked as State's Exhibit-4. And this is a one page document and it is entitled "COVID surveillance and tracking method." Is that correct?

A. Yes.

Q. And do you recognize this document?

A. It looks familiar, yes.

Q. And I know you are going to get tired of hearing this, but do you recall being involved in the drafting of this or revising of this document?

A. Again, it would have been -- any of my involvement would have been over the phone.

Q. But does this one in particular refresh you at all about specific conversations about the specific P&P?

A. Not initially, no.

Q. So let's scroll down a bit to section four, and the document reads: "Residents admitted from the hospital with a positive diagnosis will be housed on the

designated unit." Is this the designated unit, from your understanding, that we have been talking about this whole time or something else?

A. Just go back up for me.

Q. Sure, we can scroll back up.

A. So this is -- this is talking about -- so this isn't talking about hospital patients. This is talking, specifically, about inhouse patients.

Q. So then there could be a discrepancy here because I am noticing section four, bullet four says "residents admitted from the hospital."

A. Yeah, it's an odd -- it's an odd placement because -- and I am talking about isolation for seven days. Once they've completed their first seven days in the hospital. So that was -- again, that was an earlier on thing where -- so that's the -- that's the same form of the 14 day. So now, as I said, now we're doing a 14 day from the time you leave the hospital. You are quarantined for 14 days. So that was back,

I would say, mid to maybe -- mid to late summer, that -- maybe later than that even where they said well, if your patient's in the hospital for seven days, then you only have to quarantine them for seven more days in the facility, which -- and that hasn't been for a while.

Q. So is it -- and I will note again, and correct me if I'm wrong, but this policy and procedure does not appear to be dated, correct?

A. No.

Q. From your knowledge of guidance and directives, are you thinking this would be potentially from the summer of 2020?

A. As I said, it's all a blur, but as much as I can remember -- because like I said, those days and timeframes were constantly changing and that's why there's, you know, there's different policies and procedures. You know, some places they were revised, you know, six, eight times, however many times the -- one or more details of the recommendations changed. So the seven --

seven and seven day thing, it definitely -- it's definitely not this year and it's definitely not the latter half of last year, so it has to be, I would say, late summer.

Q. And just separating all of that contextual aspect of it, when you see the reference to the, quote, designated unit in section four, is that the designated unit we have been discussing or something else?

A. It seems to be the same designated unit, yeah.

Q. Do you think there's any chance that this policy and procedure could have come into effect before the summer of 2020?

A. Again, I don't know because, as I said, everything -- a lot of everything is a blur. My best recollections, to be perfectly honest, is what Care Right was doing because it's just the conference calls lasted 45 minutes and so a lot of it -- a lot of the language and verbiage sticks out in my mind, and I remember the weather, so most -- a lot of the policies and procedures I just remember from -- a lot of the changes

happened during the summertime. Can't tell you from week to week or month to month which one, but I remember the seven day and seven day didn't last that long, maybe a month, because the idea then later on was it doesn't matter how long the patient was in the hospital, you have to quarantine them for 14 days out.

Q. And when did that change?

A. As I said, that has -- that's been from -- I know from my facility where I have patients and I am not the medical director in Westhampton, they have been doing a 14 day hospital quarantine for at least the past five months.

Q. So sometime in the fall of 2020? Sorry, I don't know if I might have dropped there for a second. Did you catch the question? Or I can say it again.

MR. JONES: No.

A. I didn't hear a question.

Q. I'm sorry. So would you say sometime in the fall of 2020 was when that change transpired?

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A. For sure from the fall of 2020, I remember there being a 14 day quarantine out of the hospital.

Q. So would you say, based on a review of this particular policy and procedure, is it fair to say this policy required COVID patients from the hospital to be housed only on this designated unit we have been discussing?

A. Looks like it, yes.

Q. And again, based on the knowledge of the disease at the time, was that to facilitate infection control and/or reduce the spread of the infection?

A. Yes. Both. Most everything was, you know -- most everything of these recommendations in theme is to try and control spread to the staff and, and to the rest -- and to the residents that are not infected. I mean, that's been the general theme, you know, throughout, and that's kind of the focus, is to isolate out people that either potentially you don't -- you don't know their risks so you are doing a 14 day

quarantine from the hospital because God only knows or you have a confirmation or a suspicion and you -- again, you are trying to protect the outside world from, from those patients.

Q. But would it be fair to say that if, you know, under the understanding of the disease at the time, if a resident had been transferred in from the hospital and not placed on a COVID unit, on a designated unit, that that could endanger the other residents at Fulton who were not COVID presumed or suspected or positive?

A. So in the event that you put -- that you -- if you admitted a patient from the hospital that did not have COVID, excuse me, you wouldn't have put them on -- you wouldn't have put them on a designated COVID unit. What they would have done, like I said, is typically, and my best recollection is Care Right, is they were on a yellow zone, so they were what is now the 14 day post hospital quarantine. So some places have -- so now Fulton has a designated, I

think it's one east as I said, where you're going to cool your heels there for 14 days regardless of what your diagnosis was from the hospital, and you are confined in that area and you are essentially quarantined. And once you finish that, you will move to another area, another unit that's convenient for you and for the facility. And, you know, since the 14 days, you are -- the risk of you having undiagnosed COVID is, is gone. And, again, you only cohort -- so you and I would have to be admitted the same day from the hospital for us to be roommates on that quarantine unit because then our risk is kind of similar and if anything happens, you know, we're basically in the same boat.

Q. Do you know if Fulton Commons has a policy and procedure specific to the roles and duties of the medical director?

A. Every facility does, yes.

Q. Have you seen that P&P or reviewed that P&P?

A. Probably -- I probably had a hand in writing it years ago.

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Q. Do you recall the last time you might have seen or revised that document?

A. Not specifically.

Q. And do you recall what it directs or dictates?

A. Well, pretty much as I discussed before what medical directors' responsibilities are, who I answer to, which is the administrator, what -- which committees I am a member of; ethics committee, quality improvement, weight loss committee. You know, my general -- my general responsibilities over the medical staff, my right to reassign patient visits, if a physician doesn't see this patient. It's pretty general stuff. I think a lot of the buildings now use the -- use some sort of version of AMDA's medical director version of description.

MR. SMITH: So I know I promised you guys a break, and I have gotten a request for a lunch break. We are kind of at a good breaking point, if that works for the two of you, or how do you

stand?

THE WITNESS: You have the wrong guy because I don't eat, and ultimately I do have patients, so the sooner we finish, the better.

MR. JONES: I mean, we can break now. Certainly we don't need a whole hour for lunch. Whatever is the shortest duration. Do you have any sense of when we might be finishing today?

MR. SMITH: Yes, I think it's a good time too. I agree with doing a quick break. That works for me too. I do want to try to not keep you guys super, super late, so we will try to get through, but I think a full day would probably be realistic, going until 5:00. We can -- of course if you have patient issues, Dr. Butchma, we can come back tomorrow or however you want to work it out, but I do see at least another few hours.

THE WITNESS: It's better to

forge ahead because I work seven days a week and my life doesn't get any easier tomorrow so...

MR. SMITH: That's what I assumed. If it works for you all, we can stay and sort of finish this today, but I am going to try to, you know, be reasonable about the time. So we will try to move along as quickly as possible. Would you want to take a quick, just do a 20 minute lunch break?

MR. JONES: That's good.

THE WITNESS: That's good.

MR. SMITH: So maybe come back at -- how about 2:10? Does that work for everybody?

MR. JONES: 2:10 is fine, yes.

MR. SMITH: So we will brake now and we will return at 2:10.

(A luncheon recess was taken.)

MR. SMITH: So after a taking a short lunch break, we are returning on the record. We have done a roll call and everybody is present so we will

begin questioning again.

Q. So Dr. Butchma, I know we have been talking about and reading policies and procedures specific to what has been called a designated COVID unit or COVID unit. I want to get into more detail on that. I believe you had testified earlier that you recall a COVID unit maybe being designated as early as late March or early April; is that correct?

A. At the earliest.

Q. And at the time of that designation in late March or early April, what was the purpose of that COVID unit? What purpose did it serve?

A. So as I said before, early on we were trying to -- when we were isolating patients or quarantining them, we were trying to keep them out of the general population and to prevent any potential spread through the rest of the building. Unfortunately, because of our, you know -- because of the minimal knowledge that we had and the constantly moving recommendations,

it was, it was rather difficult at that time.

Q. So the unit that was designated as a COVID unit that received hospital admissions that had tested positive for COVID; is that correct?

A. No. As I said before, we were told from the Governor that we had to accept patients regardless -- we could not even ask for their status. It would be considered a potential offense. We would be penalized for even requesting that information from the hospitals. So the presumption inside the building was that anybody who was sick or had any signs and symptoms of COVID actually had it because we didn't have testing material and we kind of had to presume that potentially anybody who was coming from the hospital may have been tested and tested positive and we didn't have that information. So we were trying to -- we were trying to do our best to keep, to keep those patients, you know -- to keep those patients away from everybody else. Of

course, as I said before, the dining rooms were closed down, recreation was closed down. There's only one and two bedded rooms. And really, for the most part, nobody was wandering up and down the hallways. Rehab was closed. So for all intents and purposes -- and they're seven units that are kind of isolated on their own. So structurally Fulton lended itself pretty well to contain whatever unit we were on, to contain infection. Of course there's, you know -- again, there is staff wandering through the building because to get from -- even to get from your -- the time clock to your post, you do have to pass by people and there was always the potential for spread. But as far as patients were concerned, the idea was to try to keep spread from the rest of the population, yes.

Q. So let's break that down a bit. So there was a COVID unit that received hospital admissions. And did that same unit also house inhouse COVID suspected residents?

A. So according to the policy and procedure, you could put COVID patients from the hospital and have them on the same unit, same designated unit as a -- as patients of -- POIs, let's say, patients of interest, suspected COVID patients because we didn't have testing material. So yes. And again, as I said before, from an infection control point of view there was -- whilst you don't have to do that, it was certainly not harmful, not harmful specifically to do that.

Q. And is it your recollection that both hospital admissions that have tested positive for COVID and inhouse residents that were persons of interest or presumed or suspected COVID were housed on the same unit?

A. So again, we didn't have -- early on we had no knowledge if those patients were tested positive because the Governor would not allow to us have that information and Dr. Zucker, I believe his name is. So we didn't have that information. So if it's

talking about COVID positive patients from the hospital, that policy would have been revised a bit later when we actually were allowed to know. So if it mentions in the policy and procedure about COVID positive patients in the hospital, that would not have been early on. That would have been revised at some point because we didn't have that information. But as I said, COVID positive patients from the hospital, it was whenever it was, late April, May, June, whenever we were allowed to have that information, cohorting them with POIs on the same unit, you wouldn't have to. You could have two different units if it structurally worked, but putting them in the same place would have been -- from an infection control point of view would have been okay.

Q. And I guess -- so going back to March 2020, I understand that COVID status would not be a grounds for refusing admission, but correct me if I'm wrong, if a patient was admitted to Fulton Commons, you as a physician or their care team would be

able to ascertain whether that person tested positive for COVID, correct?

A. Well, after the fact, once they came in, we might have that information, but getting that information would have been likely not possible. So no -- we don't get -- so the hospitals are not required to send us the entire medical record. They only have to send us the PRI, the patient information sheet, which is often questionably accurate. It may be incomplete. And they're not required to send us anything more than a discharge summary. So the hospitals at that time were not necessarily very forthcoming about whether that patient had been tested at all or tested positive or hadn't. If they had pneumonia, you could say well, maybe they had COVID and we just don't have that test. If you called the hospital and asked, it would be very unlikely that anybody was going to give you that information because, number one, they don't didn't have to. If they don't -- they certainly wouldn't want

you sending the patient back, which you can do within 24 to 48 hours. So no, we didn't -- we couldn't obtain that information. That -- the Governor and Dr. Zucker fixed that for us.

Q. So then is that why -- to backup to the policy and procedure we were just reviewing -- that document says "any resident who is being admitted or readmitted from a hospital will be placed on the designated unit," was to that avoid confusion that everyone who came in from the hospital would be put in on the COVID unit?

A. Right. So -- so early -- again, there was -- once -- once the smoke cleared from that initial debacle, we were, we were quarantining, as it mentioned in the last thing, there was a seven day quarantine plus the seven in the hospital made 14 and now it's a straight 14 from the time you leave. So once that -- once that initial issue, we were quarantining all new, you know, all new patients from the hospital. In fact, if you go out for a blood transfusion and you

stayed past, most facilities it's 48 hours, you come back and you do a 14 day quarantine because you have been in the hospital for a period of time. So the quarantine rules changed, as everything changed, but -- and the so-called guidelines which were demands. But, you know, once we were -- once we were taking admissions -- so you didn't have to take an admission at all, but you wouldn't have any admissions then. So once you were taking admissions to the facility, once they were available and everybody needed them, then we were quarantining as soon as that was recommended or demanded, we were quarantining those patients, yes.

Q. Right. So just to clarify for purposes of the record, any patient that was admitted under the policies and procedures of Fulton Commons that was admitted from the hospital would go into the COVID designated unit for quarantine?

A. Right. So they had a -- so what most places did, and we did the same, I believe, if I remember correctly, is there

was one -- there was one, one designated side of a unit, which was fine, which was, which was, you know, hospital patients who had been in the hospital. Now I believe it is an entire -- because hospital admissions have decreased and there is availability, I believe it's one east, and there is enough flow of patients so that you can use that unit just for, just for brand new admissions and then cohort them based upon their day of admission.

Q. And just for the purposes of clarity too, because we had discussed this a bit earlier in the day, there were not multiple COVID units at Fulton Commons at any time, correct?

A. I do not recall their ever having multiple units. As I said, as things evolved, then, then at one point -- at one point -- for example, so on three east, I know for sure, because I remember that for sure, there were -- the new hospital -- the newly asymptomatic hospitalized patients were quarantining on the, on the right fork

of the road and then my long-term patients were on the left side of the, of the unit. You know, they're asymptomatic, we know they have tested negative and we are quarantining for them for 14 days and they are quarantined in their rooms and they're waring masks. So that unit would be separate. If there was an outbreak on a particular -- if there was an outbreak in the facility, then what we used to do is move the symptomatic patients, try to have them in one area. Unfortunately, as I said before, once you start doing that, then you're -- you don't know who you're moving and where you're moving to, so it's kind of better to leave them staying put, and what I was saying before, similar to the flu or diarrhea, leave them on the unit and just close the unit, essentially, and just designate it and say we have an outbreak on three west and leaving it like that, rather than trying to move people around, which at one point all the facilities tried to move patients.

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Q. And did Fulton Commons move patients with the same intent as far as moving them?

A. I don't remember specifically, but everybody was at one point, so I am pretty sure -- I am pretty sure, you know, we did it on occasion too.

Q. Do you have any specific recollection of moves like that happening at Fulton Commons?

A. So the only moves that I know for sure that -- so we test -- so we test, on a regular basis, all our patients now, which not every -- which most facilities don't do, but we test them regularly. And if we have a patient that came in from the hospital and 10 days in tests positive, then we'll, we'll whisk them and their roommate to another location, to another unit designated for COVID. Because now, we're -- you know, now we know -- now we know -- excuse me. We know who's negative and who's positive and it's a lot easier contained, you know, as far as keep them isolated. When you are

just kind of guessing, you know, you're moving a patient with a 99 temp and then, you know, now you got to move their roommate without knowledge of a test, it's a lot trickier.

Q. In the scenario you described a minute ago where you had people quarantining on one side of the hall, it sounded like, and then other individuals moving on the other side of the hall, when was that happening?

A. I would say that was -- that was when I was sharing the unit with Dr. Johnson, as I mentioned. I would say that was around six months ago where the -- where asymptomatic patients, new admissions -- because my unit was only half full, so the left side of the unit, you know -- the left side of the unit was my long-term patients and then the right side of the unit was new hospital admissions. Now that's -- I think that's now, as I said, now that's one east that's done that. Now one east is new admissions. But there

weren't enough -- there weren't really a lot of new admissions at that time, so you could have four two bedded rooms in the back of three east and they were pretty isolated from everybody else, you know, and nobody -- as I said, nobody was walking around.

Q. So rewinding back to March of 2020, sort of at the outset of all this, you do recall at some point, and correct me if I'm wrong, but it sounds like you recall at some point in late March or early April that some level of a designated COVID unit was created at Fulton Commons?

A. As I said, I would say more -- it was definitely -- it was definitely after -- like around Easter time or after that. Early -- late March nobody -- late March nobody was really doing that because things had just shut down, and as I said, we didn't even have a -- you know, we didn't even have a grip on how everything was working. We hadn't been ordered to put full PPE in place. We weren't wearing masks. So based on that, I would say the individual units

started happening -- you know, started happening more in April and after.

Q. And am I correct in understanding that in the, say, late March, early April when this designated unit was created, it could have housed both hospital admissions and inhouse residents who had been designated as presumed of suspected COVID cases?

A. Could have because, again, at that time there wasn't -- there weren't -- like right now there is elective surgical cases in the hospital. Back when, when there was nobody driving on the roads, there was nothing going on in the hospital but COVID in New York. So the presumption, as I said, somebody had pneumonia or hypoxemia or, you know, had respiratory failure, even if they wouldn't tell you the test -- whether the test was positive, negative or otherwise, there was a certain assumption made, just like there was an assumption that might -- that, you know, our febrile patients probably had it. So putting them

together in the same vicinity, as I said, down one sleeve of the unit and then the other half on the other sleeve or however you are doing it, would not have been a breach of infection control protocol.

Q. And I think what I want to drill down on is that idea of certain individuals being on one side of a unit and other individuals being on the other side of a unit. Would that be a quote/unquote designated unit or would that be something else?

A. It could be a designated unit. So as I said, for a while when there was only -- so, you know, you may get four or five new admissions a day, typically, in a facility that size, so when you're getting six admissions a week, you can setup just one side in the back of that unit and designate it, because remembering that our censuses in all these buildings was -- were abysmal, you know, we were -- most facilities were below or at 70 percent, between 70 and 75 percent, if they were

lucky, so there was plenty of room to move around and, you know, some facilities closed units. One east was closed for a while because there just wasn't a need and there was plenty of room for the rest of the building. So there was plenty of room, from an infection control point of view, to have a designated area on a unit and, and isolate people, just like you do for any other infection; C Dif colitis or MRSA, they can be on an individual unit. You just have -- you have a setup with the room and with equipment. In smaller facilities you can't do -- you don't have seven units, so you have to deal with the structure you have and you have to either close off with a tent -- you tent off now. They put up those white tents with the zippers and you close off an individual side. So there is a way to do it, if you have to. You don't have to have one whole unit as a designated unit. It can be half a unit. Whatever they were designating, then they were adhering to the infection control, you know, mandates that

were down at that time.

Q. So then theoretically -- just so I understand, theoretically, if you had five units at Fulton Commons, there could theoretically be five COVID units within those five units; is that correct? You could have five separate COVID units within the five units at Fulton Commons?

A. Yeah, but you wouldn't do that, and they didn't do that. As I said, what I do remember early on -- so you are talking about March or April. What I do remember in March, for sure, was that -- because it wasn't my unit. I think it was four west or three west. And the entire unit was closed off because there was enough febrile patients. They were long-standing patients. They hadn't come from the hospital and they were all considered patients of interest, so the entire unit was shut down, as I discussed before, like you would for diarrhea or influenza. It was just easy to close down to the entire unit. You could -- yeah, theoretically you could start doing

that on every unit and making -- but the presumption at that point, once you have 13 or 14 febrile patients or symptomatic patients is that, you know, potentially 35 or 40 or whatever your census is on that unit are at risk, so you have got to presume they've all been exposed so there is no -- there is no good reason to start moving them around to another unit.

Q. So to drill further into that development, so am I correct in understanding that in March of 2020 three west was closed down, and by that I mean it was quarantined or cohorted?

A. So once -- as I said, we didn't have testing material. So my recollection is sometime -- it was either late March or early April -- there were enough patients that were febrile on one particular unit -- I don't recall if it was three west or four west, it's inconsequential the discussion, but it was -- it was the -- everybody was informed that it was, you know -- that there were patients of interest on that side, that

the presumption should be that these patients might or could or have COVID and to take associated precautions. So I remember accessibility to whatever the PPE that was recommended at the time, I remember Carol having, having protective gowns and etcetera and, you know, handing them out to the nurses accordingly. But the unit -- as I said, like for any infectious disease, the unit was -- it was easier to just shut the unit off. You can call it a designated COVID unit if you want at that point, but it's just something that morphed into it, rather than to be created. It just kind of happened organically, if that makes sense.

Q. It does. And do you recall when that transpired in that unit? Did non-COVID residents -- were they moved off the unit or was everyone on the unit at that point deemed COVID suspected or presumed?

A. So as I said, so if you have a unit of -- if you have a unit of -- what we're doing now, if you have a unit of 40 patients and you have got, even one is now

considered an outbreak, but let's say you have got 12 patients that have fever, cough, you are closing the whole unit. If you move off an asymptomatic patient and you don't have testing availability, or even if you do, you move that patient off, now you are potentially moving an asymptomatic positive or somebody that's converting to another unit so they can start infecting everybody else. So once you have got really even one case on a unit, now what happens is the signs all go up, droplet precautions, the unit is designated as having even one COVID patient, and potentially you could have a Domino effect where all of a sudden in three to seven days, where the -- isolation period for the virus, now you have got half the unit is symptomatic. So you don't want to start -- you don't want to move them around. In fact, as I said, ideally the structure of Fulton was once they were symptomatic and we weren't moving -- if we weren't moving them, that was highly advisable because the unit was contained and, and as I said, the

patients weren't leaving their rooms ostensibly.

Q. And do you know if any other similar shutdown of the units occurred like that in March, April or May of 2020?

A. I don't remember. I just remember that one -- that particular instance because, as I said, you know, we had a -- we had kind of a hit of deaths, and I know because I reviewed each and every death in the facility on my own and then, you know, gave my findings to Carol to double-check and review what we had -- what had been reported to HERDS. So I was reviewing the paper charts at that time for, for suspicion or where the physician had said I think this is COVID or I think it might be COVID. So I reviewed all those deaths. I remember there being about 50 -- somewhere between 40 or 50 charts that I reviewed, and I know it was between, you know, between March and -- pretty sure March, April and May that I was reviewing that many deaths. So I can remember --

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Q. So in this unit shutdown -- sorry. I didn't mean to interrupt. Say that again.

A. I said so I just remember -- from my memory, I remember that one unit, and I couldn't say if it was three west or four west, that it was -- ostensibly it was closed in the sense that they said there's enough patients of interest there, the physicians are treating with antibiotics, fluids and so there is enough suspicion that, that everybody was, you know -- staff was -- is always forewarned that there's infectious disease up there.

Q. So moving sort of a little beyond that discussion of units shutting down in response to a potential outbreak, from reading the P&Ps and our discussion, it sounds like there was actually an official unit at some point created at Fulton Commons; is that correct?

A. Yes.

Q. And what unit was that?

A. As I said, it's been different --

different units have been assigned different things based upon what was going on at the time. So as I said, when the censuses -- so I couldn't tell you at any particular time which unit was a designated unit. Just could be based upon -- based upon that time period, I don't know.

Q. Was there ever a time in March 2020 when you knew that there was a designated COVID unit at Fulton Commons?

A. Not in March, no.

Q. What about in April of 2020?

A. As I said, it wouldn't have been March because we didn't, you know, we didn't have -- there was only -- there was only febrile illnesses and the, the directive to assume that anybody who had any signs or symptoms. So as I said, again, it would have probably been in -- more towards -- more in the April time period.

Q. So going there, going to April 2020, do you remember a specific unit at Fulton Commons being officially designated as the COVID unit?

A. Yes, but I don't remember which unit was.

Q. But you do recall one unit was --

A. Yes.

Q. -- designated as such? Okay. Going on down the road, May of 2020, was there a unit, that you were aware of, having been designated the official COVID unit?

A. Again, you know, there was -- once there was a designation -- so like in every building, sometimes the entire building is shut down, so the entire building is ostensibly a COVID unit. But I do remember, based upon our conference calls, Cathie, Carol and myself, they would update me and tell me, you know, we're using, you know, unit X, Y or Z and this is what we're doing. And then, as I said, as time went on, it would change. Then it was quarantining for new admissions, and that would move around depending on how many admissions were coming in and which unit had the best availability to, to take care of those patients. So as I said, it was kind

of a moving target, but they did -- and it was always discussed in a, you know, in a brief conference call, that kind of thing.

Q. So is it fair to say that the designated COVID unit, you know, being the unit we have discussed in the P&P was a fluid thing, it could move from unit to unit?

A. If need be. As I said, I don't think it was -- I don't think it was always the same unit for the entire -- and it certainly hasn't been the same unit for the entire 12 months. If you don't have any -- when you don't have any POIs, you don't need to have a designated unit. It's empty. You are not going to staff -- you are not going to staff a unit that -- when you have -- eventually -- so, you know, eventually in -- I forget which month, again it's a blur, but I know it was the summertime when everything -- because it started cranking up in Florida, from my Care Right calls. In the March and April calls they didn't have a case, they hadn't seen it yet, and we had a

ton of it and it kind of -- it quaiesced [sic] here, so that was probably June. And then by summer everything was, was very quiet, so you wouldn't have a designated unit because you didn't have any patients to put in the designated unit.

Q. And do you recall, going back to the March, April 2020 timeframe, so toward the beginning of the pandemic in New York, who made the decision at Fulton Commons to create a designated COVID unit?

A. That -- again, that would have been Cathie and Carol and acting upon the the guidelines slash, you know, demands from the CDC and department -- New York State Department of Health.

Q. Were you involved at all in that discussion, as far as you recall?

A. Every -- every -- like I said in the beginning, every dictum that came down from Albany, if it involved -- if it involved changing what we were doing, which oftentimes it did, I had a flurry of conference calls from eight different

facilities usually on the same day, Friday, whenever those came down and they came down typically the end of the week. Sometimes they came down on Saturday, which was tricky because some of the staff, some of the administrators are orthodox, so that was always -- that became Saturday evenings and Saturday nights. So any changes that happened warranted a conference call at Fulton between Cathie, Carol and myself.

Q. Do you recall -- just drilling down specifically to conversations that were creating a designated COVID unit, do you recall any conversations specifically about that?

A. No. Not over there, no.

Q. And by "over there," you mean Fulton Commons?

A. Yes. As I said, the one specific place that I remember, and that's because -- that's just because of the duration of the calls and, and the sheer volume of the people on the calls, so that sticks out in my mind, and they actually named their zones

red, yellow and yellow so catchy, and so that I remember specifically. But -- and that I remember, I think, in April, if I remember correctly.

Q. Now, when you reference red, yellow, the color coding, was that Fulton Commons or somewhere else?

A. No. That was somewhere else. That's why why I specifically remember out of eight calls, I remember that one call because it was 45 minutes long, it was always on Friday. But I remember talking to Carol and Cathie, but I don't remember specifically when the, when the unit -- I just know that all those calls happened basically the same time, the same day because everybody got the same e-mail from, from Mount Olympus and, you know, we all, we all acted upon it so...

Q. Now, I know you --

A. And novel --

Q. Go ahead, sorry.

A. I said there was nothing novel or exotic from facility to facility. It was

all pretty repetitive because we were pretty much given a list, a cookbook and told to make it happen in short order, so that's what everybody was doing or trying to do.

Q. And do you know -- I know you don't deal with him directly, but do you know if Mr. Weiss was involved in the decision to create a designated COVID unit?

A. I would not know specifically, but I know, as I said, Cathie reports directly to Mr. Weiss and I'm sure he's -- my presumption is he's apprised of anything major that happens in the facility.

Q. And would it refresh your recollection or do you know if one east was ever designated as a COVID unit?

A. I don't remember.

Q. Where is one east located in Fulton Commons, just geographically?

A. On the east side of the building. It's --

Q. Is it the first floor, I assume?

A. If you come in the main doors, right ahead of you is a security desk, and

if you throw your arm out to the left, that's one east.

Q. And how many beds are on one east?

A. All the units have 40 beds each.

Q. And again, to your recollection, one east was never designated a COVID unit or you just can't recall?

A. I don't recall that it ever was. And as I said before, there were a fair amount of months when one east was closed.

Q. And when was that time?

A. I want to say it reopened at the beginning of this year, and it was probably closed since late summer, early fall. So it was closed for about a solid three month period.

Q. And we discussed, you know, the idea of a unit being shut down in response to a potential exposure of COVID, appearance of COVID. Did that happen over the course of time in any other units in Fulton Commons?

A. Well, as I said, I'm not sure if

it was three west or four west and I don't remember -- I don't remember any other units. So as I was saying, there was kind of a -- it was kind of a flurry of infectious activity over a short period of time. I lost 12 patients. I wrote 12 death certificates in a 72 hour period for a variety of causes, some of which may or may not have been related to COVID. So that's how fast things went down. So it was -- it was not a -- it was a quick period of time which we lost, as I said, probably around 50 patients throughout the facility, and so I would say that was -- that probably all transpired in about a four week period, so there wasn't much -- except to react to it, it wasn't a slow moving activity, you know, like from -- it just kind of banged out all at one time.

Q. And was your sense that there was COVID in multiple different units in the building, at least suspected or presumed COVID, say, between March 2020 and June 2020?

A. Well, we -- we presumed -- again, early on when we had no testing apparatus or, you know, beyond suspicion, we presumed anybody that was sick, as I said, falsely or inaccurately hoped, thinking that well, everybody is going to have a fever so as long as you don't have a fever, you don't have COVID, and that was pretty much the belief early on. But, again, going through the illness it became, as the facility was experiencing illness and then death in succession, the presumption was that at least some of them would have been -- were COVID related or potentially. And, again, those are reported accordingly through the HERDS system through VICAP being Carol and then the Department of Health. That I remember distinctly coming in on an infection control survey, I know most of the surveyors over 25 years, and asking me about every patient and going over each and every case to see if there was a possibility that it was a COVID patient and that it hadn't been reported as such. I spent many phone

calls going over it with, with the Department of Health, sometimes two or three different times, sometimes the same patient two or three different times.

Q. But is it safe to -- am I correct in understanding that, in March 2020, April 2020, May 2020, the suspected or presumed COVID cases were located on multiple units rather than just one unit at Fulton Commons?

A. I remember -- as I said, my unit was -- my unit was, was -- had illness but it was kind of, as I said, it was kind of a hybrid of different things and the only one patient I knew went to the hospital and then tested positive. I know that there were a couple of other units, in my recollection, that had, that had multiple patients and interests, and I seem to remember that mostly illness and deaths were, were the two or three different units, but I can't -- couldn't swear to that for sure right now.

Q. And just based on your recollection, when you say the two or three different units, what units were those?

A. My unit had a fair amount, so if there were 50 deaths and I did 13 death certificates, you know, so it was somewhere, somewhere more than a quarter of those belonged to me. I think three west. I don't remember what the other unit was.

Q. So I want to go to a specific weekend in 2020. So this is the first weekend in May of 2020. I know it's difficult to recall these things offhand, but do you know if you were working at Fulton on Monday, May 4th, 2020?

A. Well, since I've only had two days off in the past 14 months, I can say with surety I was at work as my usual schedule, Sunday, Monday, Wednesday, Friday through most of the pandemic.

Q. So do I understand that you would have worked that prior Friday, May 1st?

A. I didn't hear your question.

Q. Sorry. So is it safe to assume that you would have worked the prior Friday, May 1st?

A. Still don't hear you.

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Q. I'm sorry. Can you hear me now? Is that better?

A. Yup.

Q. Is it safe to assume -- based on what you've said about your schedule, is it safe to assume you would have worked the prior Friday, which is May 1st?

A. So I can -- based on my schedule, which is repetitive, I can say that May 1st I would have been there until about -- from about 6:30 in the morning until about 9:00.

Q. And by 9:00 you mean 9:00 p.m. or 9:00 a.m.?

A. 9:00 a.m.

Q. 6:00 a.m. to 9:00 a.m.?

A. 6:30 a.m. to 9:00 a.m.

Q. And, Dr. Butchma, do you keep a calendar or journal to keep all these days straight? Is there some sort of document that you track your days working?

A. No. I'm so anal retentive I have the same schedule. I used to have a Care Right meeting the second Friday of every month. I know exactly where I'm supposed to

be every day. I keep the same schedule so that everybody knows exactly when I will be in. So Fulton, I had a clandestine gym that I was working out, and it would have been Monday, Wednesday, Friday. So Friday, my shower was over at 6:15, I bought coffee and I was at Fulton at 6:30. That's how I know.

Q. Okay. Then I think this is consistent with what we discussed about your schedule. Is there a good chance you would have also been there Sunday, May 3rd?

A. More than likely, yes.

Q. At what time of the day would you usually come on Sundays?

A. Whatever time my dogs finished walking, which was probably about 7:30 in the morning until about 9 o'clock.

Q. A.m. again, correct?

A. Yes.

Q. Okay. Now, zooming into May 3rd, that's the Sunday, May 3rd, 2020, do you recall seeing anyone from Fulton management there, that's Carol Frawley, Cathie Doyle, anyone else?

A. The only interaction I would have with anybody on a Sunday would be, would be with the nursing supervisor. Otherwise, I don't go to the administrative offices, so I wouldn't know -- excuse me -- I wouldn't know who comes -- it could very well be -- so the structure of the facility is you have to go through a set of doors to the right, so directly opposite to one east, and I have no business in there on a Sunday. I don't go into looking for mail or anything like that, so I just go up -- I would just go up to three east and use the computer up there for my business. So I would never -- whether somebody was in or not, except for the nursing supervisor, I would have had no interaction with them or known if they were there.

Q. And by "nursing supervisor," do you mean Ms. Frawley or somebody else?

A. No. The nursing supervisor is an RN who is in charge of, of all the units, essentially, of all the nursing activity. So each, each nurse on each unit reports up

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to the supervisor.

Q. And do you recall if you had any conversations or discussions with the nurse supervisor on that Sunday, May 3rd?

A. I have no idea, but typically if there's any problems, they always know where I am, and anything specific with a patient, and then, you know, some of them I've known for so many years that they just come and say hello. So I usually run into them.

Q. Do you know if DOH, the Department of Health, conducted a survey at Fulton on Monday, May 4th, 2020?

A. No recollection. They were -- they were around a lot during that time. I am in multiple buildings. Sometimes they were in two of my buildings at one time. So I don't have -- I don't remember specific dates. But I remember the infection control surveys probably started, you know, right around that time and have continued ever since.

Q. Do you have any recollection of participating in a DOH infection control

survey from around that time, May of 2020?

A. Yes. As I said, the -- regarding -- regarding the causes of death and the designation of death on the HERDS. Didn't go over each and every patient with me, but I remember it was -- I think it was Usha, she is a dietician, I don't know her last name, known her for at least 10 years, and we were on the phone for about, you know, 35, 45 minutes going over different patients. It could have been that time.

Q. Beyond that, what about an in-person infection control survey conducted by DOH, does that refresh your recollection at all?

A. I didn't hear the first part of that.

Q. I am wondering if you have a recollection of an in-person DOH infection control survey where surveyors would come to the actual facility and walk around and talk to staff, does that refresh your recollection?

A. Yeah. No. That's what it was,

but I'm not in the building all the time so they contact me by phone. So I know they were doing that because that's what they were doing everywhere, but I don't remember the specific days. But it was around that time period, yeah.

Q. Did you talk to anyone from DOH in conjunction with that specific infection control survey?

A. If it's the same survey, then it would have been, as I said, Usha and most, most of the questions from infection control survey that I dealt with and have dealt with for the past, the past whatever, nine months that they started doing them, it's always regarding a specific patient or specific patients and the clinical scenario and whether they, you know -- when they got COVID or if they had COVID or could they have had COVID. That's usually what they want to talk to me about. They don't usually ask me questions or discuss specifics of, you know, of infection control policy, unless -- again, unless it's a

clinical question, and so then they'll ask me. But most of the questions I remember and still -- and still they're doing it is about particular patients and the scenario of their death.

Q. Do you recall any discussions with Cathie Doyle or Carol Frawley leading up to this DOH infection control survey that was specifically about the upcoming survey?

A. Every fa -- in every facility, we were well aware, administration, myself and infection control and the director of nursing, we were all aware that these surveys were going to happen. I remember early on at The Hamlet, my director of nursing at the time, she, she said she had -- it was a Friday and she said she had sent up -- they had requested a ton of paperwork from her and she said well, they're probably going to show up on Monday or Tuesday. So the formula seemed to be they would ask for documents and information from the facility and then there was usually -- they were usually going to show

up within the week. So that's --

Q. So were you -- sorry. Go ahead.

A. That was my conversation with anybody I had a conversation with. It was usually kind of well, they're going to show up. It was the fait accompli, and it was just a matter of -- it was just a matter of when and -- but we, we kind of always had an idea that, that they were -- you know, within X number of days they were going to come to the facility and check things out.

Q. Do you remember if there were conversations about documents being requested by DOH leading into this particular survey?

A. No, but I -- as I said, I know for sure that every -- it was the same in every facility, they asked for the same documents. I couldn't tell you what they all were. I didn't see the documents, but I know that the various DNSs -- there is always a DNS in the building that states the DOH asked for different documentation regarding our -- you know, what we were

doing, how we were doing things and asked them to submit, and then we all -- we always knew that an infection survey was probably imminent.

Q. And I guess what I'm driving at is: Do you recall any specific discussions with Cathie Doyle or Carol Frawley about DOH document requests or impending DOH investigation or survey around May of 2020?

A. Cathie and I never would have had, you know, that kind of discussion. We were all on, you know, a particular level of preparedness so I think the general theme for all -- you know, the general theme for everybody was, you know, be ready, that -- as a medical director, that they might want to ask me questions, which is typical. I've done -- I've done over 110 full Department of Health surveys over the past 25 years, so it's nothing that I'm not used to. So it wouldn't set-off any particular -- it wouldn't be memorable in my world, let's say that, based on what was happening.

Q. So I guess maybe that answers my

next question, which is: Do you recall specifically having discussions with Cathie about this particular investigation or survey?

A. I can -- I can say, again, that, you know, Cathie and I have worked together for so long, I -- we would never -- it's typical not that we would remember -- she would say -- she's always said, over the past 25 or so years, that you always have to be prepared and ready, act as if the Department of Health is going to show up today, tomorrow, the next day, always be prepared, don't slack off. So that's -- that's -- and as I said, I work in different buildings, so for me, they're in and out of my buildings all the time so I can't -- I can't relax and downshift, so I wouldn't -- it's not the kind of conversation I would have had with Cathie. And as I said, most of my conversations at that point were with Carol. I didn't -- I didn't run into Cathie very much because we didn't have our usual sit-down meetings anymore, so most of my

interactions with her would have been over the phone with Carol in attendance.

Q. And do you recall having any conversations with Carol about this specific May DOH survey?

A. No. As I said, I spoke to all my, you know, directors of nursing in all the buildings and it was just a matter of -- you know, so many -- so many things were being requested of us besides the HERDS and everything else, it was a little daunting -- I don't -- to be honest, I don't have to provide those documents. I don't have to do that kind of leg work, so, you know, I felt bad for them that they spent quite a bit of their time and day trying to collect things and have to submit them and, and be so preoccupied with one particular aspect of care. So that would have -- that was my only conversation with all my directors of nursing, just kind of lament that on Fridays or Friday afternoon or Friday morning having to put all these things together, you know, and submit, submit documents all the time.

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Q. And did you assist -- I think you got into this a bit, but did you -- did you assist in any way in preparing for the DOH surveys?

A. No. They -- so unlike annual Department of Health surveys, these were pretty much, you know, they -- they asked for particular materials. They already had the HERDS information. They already knew how many deaths you had. You know, once -- once testing came into effect, they knew how many positives you had. So they came in, they already knew what they wanted to ask or look for. I know they would typically walk around to the different, you know -- to the units, if there was a designated COVID unit in action, you know, they would usually ask to see the, you know, couple of other things in the building. And then they'd sit in the conference room and go through medical records and ask questions of the relevant staff. And, again, they tended to call me on the phone, because by the time they finished I was usually not in any particular

place. So preparation -- there was no specific preparation necessary on my part except to be ready for their phone call.

Q. So I would like to direct your attention now to what will be marked as State's Exhibit-5. Okay. So this document is titled "breakdown of residents from 4/1/20 to 5/1/20;" is that correct?

A. Yes.

Q. And do you recognize this document?

A. I've never seen it before.

Q. Can you tell us -- Anne, if we can scroll down a bit. Can you tell us what this document is?

A. Yeah. So the numbers that I was discussing from -- that I said, which is fairly good memory on my part, which is I said other deaths 36, COVID deaths 28, so that comes around 60 and change so I was saying about 50, right. So I remember reviewing -- so those, those are the deaths that I reviewed the charts for.

Q. Do you know who prepared or

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created this document?

A. No.

Q. Do you know if it was produced to DOH in conjunction with their May 2020 survey?

A. No, but I do know, as I said before, that one of the topics of conversation in the -- in that survey was, was the deaths and who died from what, and those were the charts I reviewed, in fact, twice.

Q. And aside from the charts you reviewed, did you review any other documents that were produced to DOH?

A. Not that I recall, no.

Q. So going back to this document, would I be correct in stating that this document shows a total of 28 COVID deaths at Fulton between April 1st and May 1st with three confirmed from the hospital and 25 noted as, quote, suspected, closed quote?

A. That's what it says.

Q. Can you tell us which of the three confirmed COVID deaths were residents

from the hospital?

A. I would have -- without seeing the specifics, no.

Q. And at this stage, in May 2020, what criteria was Fulton using to classify or identify residents as being suspected or presumed COVID?

A. So if there was -- so backing up, other deaths, so those -- if a patient had an end stage illness and there was no clinical signs or symptoms of COVID, from what we knew at that time, then we -- I was -- at least I was -- on my review, I would say they were non-COVID deaths. So my patient with an end stage heart, end stage dementia was -- who had, who had no fever and was 96 years old would have been under other. Those charts -- if I reviewed a chart and it says -- and the physician said "likely COVID," "suspected COVID" and was treating accordingly and we were counting it -- I was counting it as a COVID, and I imagine that that's what they were putting on that, and that would have been the --

what they were reporting on HERDS, I would presume.

Q. So next we are going to take a look at what will be marked as State's Exhibit-6. Okay. Dr. Butchma, have you seen this document before? I might have broken up there. Did you hear me?

A. Yes, I heard you. I am squinting at the print. I don't remember that particular document, but most -- but all my facilities had -- if they were -- they would have that usually under like a laminate board somewhere prominent in the front of the facility, so at the security desk or the reception area. That became a commonplace -- that became a commonplace, even now, a notation that's kept in full view, so if there's one case, two cases, three cases, that's usually what's posted. I don't remember seeing it at Fulton, though.

Q. My apologies.

A. I don't recall seeing it specifically at Fulton, but it's probably

there and I just don't pay attention to it.

Q. So from your experience during the pandemic at other homes, this was a common thing to see at the front of the facility, sort of notifying people what the status at the facility was?

A. Yes. I mean, since there's nobody in the building but all of us, for the most part, it was really -- it was really for the -- more information for the staff at that point because, as I said, we have no visitors. But it is pretty common, even now, in, in most of my facilities that they post something like that.

Q. And do you know who at Fulton Commons would have been responsible for creating this document or posting this document?

A. No.

Q. Okay. Do you know if this document was given to the Department of Health in conjunction with their May 2020 survey?

A. I don't, but they would -- as

part of their infection control surveys, they were asking for a number of suspected, number of confirmed and any staff that were, that were, you know, suspected or confirmed as well. So I would assume that they had that information in some form or another.

Q. Okay. So looking at Exhibit-5 and Exhibit-6 together, Exhibit-5 that we just looked at showed 25 suspected COVID deaths at Fulton Commons between April 1st and May 1st, but Exhibit-6 here states that there are, as of May 1st, quote, no suspected cases of COVID in the facility, closed quote. How do those two documents make sense together?

A. So I don't know what they're reporting -- I don't know specifically -- that was a timeframe they were showing, so this is as of -- as of that day there are no cases, on May 1st. The other document, as I recall, has a range from X number of months. That was a total number and review including deaths, suspected and otherwise. This is one day in time. So as of that day, they're

saying that on May 1st, not -- you know, April 30th could have been five suspected cases, you know, and they're not -- and on May 1st they are no longer suspected. But the other document was a range of dates with total deaths, suspected COVID deaths, not suspected, and then probably my patient which tested positive in the hospital and expired.

Q. Based on your perspective as the medical director, which of these two documents, Exhibit-5 and Exhibit-6, more accurately represent the status of Fulton Commons on May 1st?

A. Well, this would -- as I said, this is a snapshot in time. So on May 1st, as of today, May 1st. So if in the evening of May 1st five patients had tested positive, if you had swabs, then on May 2nd you'd have, as of today Fulton has five cases. So it's a snapshot in time. Remembering that the Department of Health has -- it's an open book test. The Department of Health has all your

information. There's nothing -- it's all in the HERDS. It's all in the HERDS report. So it's -- whatever is on the HERDS is what they're looking at. So if you have -- if you have five staff members that are tested positive, that's on the HERDS. That's always been, since they started requiring that, the amount of -- the number of deaths and, as I said, we painstakingly, all the facilities, go through and try to report, as requested, as best as possible. Now of course we have more testing supplies, so we kind of got a better idea, but it all goes in black and white on the computer report in the HERDS and it goes up to Albany, and any Department of Health surveyor has access to that data so...

Q. So would it be your testimony that these two documents could go coexist and accurately reflect the status at Fulton Commons on May 1st?

A. Sure. And Department of Health is only -- as I said, Department of Health, it doesn't matter what you write on a legal

pad or any pad. Department of Health is going by what their HERDS data is.

Q. And based on your experience as a medical director, does it seem likely that 25 suspected COVID deaths occurred between April 1st and May 1st but on May 1st there were no COVID cases in the facility?

A. Sure.

Q. Do you recall if one east had any occupants on May 1st, 2020?

A. No idea. To be honest, I don't -- I don't have a lot of business to, to veer over there, and during that time period, we weren't exactly -- as physicians, we weren't exactly looking to, to go on any treasure hunts, going from floors to floors. You tried to kind of limit your, your destination. So I didn't -- I haven't been on one east in -- probably in quite sometime because everything I can operate is from the computer, unless they ask me to see a patient.

Q. So it's fair to say, just for clarity of the record, that you were not

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providing care to any patients on one east in at least March 2020 to June 2020?

A. I do not have any -- I have not ever had any patients on one east.

Q. So let's look next at what will be marked as State's Exhibit-7.

MS. SEKHON: It's Praby. To let you know, Anne is frozen. She is just working on unfreezing.

MR. SMITH: I thought it might have just been me. I thought I had a lag. I might be able to just throw that up. One second. Let me see if I can share this.

Q. Okay, Dr. Butchma, I am going to try and share this with you now. This is a document that will be marked as State's Exhibit-7. Can you see that document?

A. Yes.

Q. Have you seen this document before?

A. It's a roster of patients.

Q. And would it be fair to describe this -- you call it a roster. Would it be

fair to call it a resident listing as well?

A. I didn't hear what you said.

Q. Sorry. You described it as a roster, which makes complete sense. For me, for clarity of the record, because the exhibit is titled "resident listing," would it also be accurate to call it a resident listing?

A. Sure. Yes.

Q. Do you know who prepares this or how these sorts of listings are prepared?

A. I imagine that you can print it out of Reliable nowadays. I am not sure how they generated it back then.

Q. Can you tell from looking at it when it was prepared?

A. No idea, except one of them is my patient and she was discharged home at least six months ago, so I would say it's older than six months.

Q. So I am going to take this down and I am going to next direct your attention to what will be marked as State's Exhibit-8. And can you see this document now?

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A. Yes.

Q. Okay. Do you recognize this document?

A. Again, it's a -- it's a roster of patients from either part or all the facilities.

Q. Similar to Exhibit-8 that we just looked at, does this appear to be a resident bed listing?

A. It is from -- because I know a couple of those patients are now mine so...

Q. And it does list, at least at the date this was created, it lists the residents' location, their room number, correct?

A. Yes.

Q. Now, this document has a time stamp on it in the upper left-hand corner?

A. Yes. Yes.

Q. And am I correct in saying that's May 1st, 2020?

A. Yeah. Yes, May 1st.

Q. And take your time to look, if you'd like to, and I can scroll down if

you'd like, but all the residents in this document also share something, and correct me if I'm wrong, but that is a location on one east?

A. It looks like it, yes.

Q. And again, as with Exhibit-7, do you know who would be responsible for creating this sort of document?

A. No, but I -- that -- that's printed out of Reliable, so I could print that out myself and anybody -- anybody who knows how to work the computer and can log in and out can print the same document.

Q. And is it fair to describe this as a bed listing identifying residents who were residing on one east on May 1st, 2020?

A. Yes.

Q. And just for clarity of the record, on May 1st did one east serve a specific purpose at Fulton Commons?

A. So as I said before, one east has traditionally been the short-term rehab unit. I cannot tell you specifically on May 1st what it was because I don't remember,

but it has typically been the short-term or new admissions from the hospital up until, you know, two or three months, whenever they go home.

Q. And as far as you know, I know you weren't treating patients on one east during this time, but were the 24 residents that we are looking at right now, as far as you know were they on one east on the morning of May 1st, 2020?

A. I couldn't tell from that because that's a roster printed in the afternoon, so if they moved -- if somebody moved from another unit or was admitted that morning or, you know, an hour after that was printed, it would be different. So in that snapshot of time, that's who there was.

Q. So at least as of 1:22 p.m. on May 1st these 24 individuals were on one east?

A. Yes.

Q. Okay. If any of these residents had been a patient of yours, would you have been notified of a move to a different room?

A. Yes. Ms. Henry would have been sure to notify me.

Q. And at what stage in the process were you notified of a room change, was it after it happened, before it happened?

A. If -- if one of my patients was moving from my unit, was either being discharged or moving to another unit for preference or other reasons, as I said, Ms. Henry would typically give me a call because I don't like surprises.

Q. Could you overrule a room change plan?

A. Again, it depends. So -- so there's preference. So I have a right to request to be moved to another unit, as a patient. I have a right to ask for another physician if I wish. I can -- I can always be moved for the purpose of the facility. So if I am in a single room and I no longer need a single room and there is a reason to put a patient in a single room, they can inform me and move me out of that room. So you can protest, but so long as there is a

valid reason to move someone from one place to another, nobody usually -- there is not too much discussion. There is a lot of reasons to move patients around from one floor to another or one unit to another.

Q. And were you ever consulted on room transfers during the pandemic period? So from March 2020 until June 2020, let's say, were you consulted on any room transfers during that period of time?

A. If they're -- you know, if they're just movement kind of things, they typically don't involve me in that. If it was a case -- as I said, if it was a case where we were -- where a facility which, again, happened in all my facilities, or most of them, where moving, moving patients from one place to another -- for instance, in Westhampton they created a COVID unit, as I said, behind the zippered tent and, and anybody -- when they were testing, whoever was testing positive, they were all moving to the COVID unit. So you were told your patient's being relocated to a COVID unit.

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So movement wasn't overly unusual during the past, say, 12 months or so.

Q. Do you recall, during the period of April and May 2020, if you were consulted on room transfers for people who were not your patients?

A. Didn't hear your question.

Q. Sorry. So in April 2020 and May 2020, do you recall ever being consulted on potential room transfers for residents that were not your patients?

A. Again, unless it was -- unless it was a specific medical concern or wholesale change, so if it was a designation like I just gave for example where you are creating a COVID unit and you decided to relocate, or you're closing the entire unit, I would have probably -- I would have been included in that and apprised in a conference call and said, you know, we're closing -- when they closed one east, they let me know. It didn't really effect my life, professionally or otherwise, but I was -- Cathie generally keeps me informed of things.

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Q. So on that note, let's drill into, you know, April of 2020 and May of 2020. Do you recall any specific consultations --

A. We lost you there.

Q. Any specific interactions that you recall? So just drilling into April 2020 and May 2020, do you recall any specific interactions between you and Ms. Doyle and Ms. Frawley, any combination, about room transfers of residents that were not your patients?

A. I don't remember anything specific.

Q. Was there ever a time when you suggested a transfer and it was rejected or overruled by anyone else at Fulton Commons?

A. That I suggested a room transfer for a specific patient?

Q. Correct.

A. No. If I -- if I had a reason that a patient, for medical reason, needs to be transferred, I would -- I don't recall ever suggesting it, but I think they would

respect my opinion.

Q. And as far as you can recall, during the pandemic period, March 2020, again, to June 2020, was there any conflict between you and any other staff at Fulton Commons about where to place residents on certain units or in certain rooms?

A. Where to place them, no.

MR. SMITH: Anne, are you still frozen? Or I can share documents.

MS. LIPTAK: No. I'm back. I just didn't want to interrupt. I am ready to go.

MS. SEKHON: Ben, before you get to the next document, can I ask for a quick five minute break?

MR. SMITH: Sure. Sure. Sounds good. So we will break -- you want to come back at 3:40?

MS. SEKHON: That would be great. Thank you.

MR. SMITH: Okay. We will break until 3:40. Thanks.

(A recess was taken.)

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MR. SMITH: So I just wanted to discuss scheduling. So we are now almost at 4:00. We have got a bit more ground to cover. Can you hear me? Is that better at all? Okay. So, you know, we are coming up on 4 o'clock, we have got a bit more ground to cover. I wanted to talk, before we get too close to 5 o'clock, to you guys about either trying to stay long to finish or just going ahead and setting up a -- I think we can do -- if we wanted to go until 5:00 or 5:30 today, we'd probably have a couple of more hours to do at a different time. So I think we can either try to go later on and just finish today, maybe go a little bit late in the evening, or come back for a small session on a second day.

MR. JONES: Give us a second. Let's keep on going and see where it goes.

MR. SMITH: So we can keep going, I'm fine with that if everybody else

is, and then maybe we can reassess if there is a point when we need to stop, but I do think we have got a bit more to go. But we will try to go and --

MR. ZADEK: Hey, Ben? Hey, Ben. It's Peter. Just getting a sense of the timing, you are probably thinking what, 8 o'clock, somewhere in that range?

MR. SMITH: If we can keep up at a good clip, it probably would be in that zone, maybe a little bit before. And, Dr. Butchma, just before we go back into questioning, I think to the goal of finishing in one day and not going super late into the evening is, you know, just tampering responses specific to Fulton Commons. I know you've got a lot of work going on at a lot of different places. I think if we zero in on Fulton Commons and just keep things strictly to that, I think we can probably streamline this a little bit. With that said, if everybody is good, I

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can start back in.

MS. SEKHON: Thank you for the few minute break. And just a heads up, I did already pass the presenter privilege to Anne, so she is good to go.

Q. So Dr. Butchma, I want to circle back really quickly to the days right around that first weekend in May 2020, so that's Friday, May 1st. Am I correct in understanding that you were not aware of an impending Department of Health inspection or were you?

A. As I answered before, specifically we were all prepared at any time for infection control surveys.

Q. So to sort of elucidate that, though, were you more prepared, were you given warning, were you aware of an actually impending inspection at any time around the first weekend in May?

A. As I answered before, once paperwork was sent in, every facility knew to anticipate a likely infection control

survey within days to a week.

Q. So in the context of May 2020, you referenced paperwork getting sent. Were paperwork sent out around the first week in May?

A. As I answered before, I was not the one submitting paperwork so -- the facility did that.

Q. But were you aware of efforts to prepare a paperwork submission to DOH or the fact that others at Fulton Commons were submitting paperwork to DOH?

A. Every facility was.

Q. Right. But I think we all would assume that not all facilities are continuously submitting paperwork to DOH every day. So I would assume that would ebb and flow over time, especially leading up to inspections such as the one that happened the first week in May. Is that the case here?

A. As I said, I wasn't the one submitting the paperwork.

Q. Okay.

A. I don't know the timing of it, when it was done, if it was done, how it was done.

Q. So would it be your testimony that you were not aware of an impending Department of Health inspection on the first weekend in May?

A. I think I answered that.

Q. For my own clarity and for the clarity of the record, were you not aware of an impending DOH inspection the first weekend in May 2020?

A. Nobody had -- nobody had confirmation that -- when the Department of Health was coming. So nobody knew when -- nobody had inside information, that I know of, to know whether a Department of Health survey was coming in a particular day or in a particular week.

Q. So then I guess just to kind of drill it down to a yes or no answer, were you aware that DOH was planning an inspection on the first weekend of May?

A. Not specifically, no.

Q. And by "not specifically," what do you mean?

A. Again, they could come at any time. So I'm always prepared for myself, for my professional purposes.

Q. So it's your testimony that the days leading into the first weekend in May were no different than any other days at Fulton Commons?

MR. JONES: I think he answered the question and the testimony stands for itself, Ben. I mean, you've asked it 10 times.

MR. SMITH: That's duly noted, Counsel, but I think you also can't argue with the fact that there's not been a direct answer to my question. So I will --

MR. JONES: We can certainly --

MR. SMITH: So we will make it very clear.

Q. Just yes or no, were you aware of DOH's impending investigation on the first weekend in May?

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A. No.

Q. As far as you know, was anyone else at Fulton Commons aware of an impending DOH inspection in the first weekend in May?

A. No.

Q. So I would like to direct your attention now to what will be marked as State's Exhibit-9. And do you recognize this e-mail?

A. Not specifically, no.

Q. Do you see who sent this e-mail?

A. Cathie Doyle.

Q. And who is the recipient?

A. Me.

Q. And is the date April 9th, 2020?

A. April 9th, 2020.

Q. So just for clarity, I am going to read this e-mail into the record. "Good morning. Thanks for the advice about moving residents off one east to the other units. I am suspending that as of today. I will fill the last two open COVID beds and then suspend admissions until Monday to see where we stand then. I know there's been some

tension between you and Larisa. Please try and do as she asks because with 34 empty beds, tons of overtime and all the other COVID expenses, we are losing money by the day. Pretty please, Dr. B, I really need your help and cooperation."

Do you recall receiving this from Mrs. Doyle?

A. I -- I recall the second part of the e-mail. Two different subjects.

Q. So we will take the second part first. What is the tension between you and Larisa?

A. Larisa is the MDS coordinator, who I have known for 20 years.

Q. And that's Larisa Ronayne, correct?

A. I don't know what her last name is.

Q. So what is the tension referenced here between you and Ms. Ronayne?

A. Larisa came to me when I was in the parking lot going somewhere, trying to discuss a patient -- a patient's diagnosis

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and I reported her to her boss, who is Carol Frawley.

Q. And what was the interaction between you and Ms. Ronayne about?

A. She was speaking to me about a patient's diagnosis on the unit.

Q. And what was the diagnosis?

A. A patient was on antibiotics and she wanted to discuss it in the parking lot and I did not want to.

Q. And what did she want to discuss?

A. The patient's clinical -- clinical case.

Q. Was she challenging your diagnosis or something else?

A. No. She was trying to have a discussion about a patient in a busy parking lot, which I felt was inappropriate and not professional, so I reported her to her boss.

Q. Do you know why she came and talked to you about it, was it, like I said, to challenge the diagnosis or to just discuss the diagnosis?

A. My recollection is to discuss the

diagnosis and I found it, the behavior, to be aggressive so I reported her to her boss.

Q. And how was she aggressive?

A. By confronting me in a parking lot and trying to have a discussion in a public area about a patient.

Q. So it wasn't based on tone?

A. Larisa is very aggressive. She's from Russia. And so her tone is generally the same, not unlike my father from eastern Europe. It's always the same tone. It sounds angry, whether it is or not.

Q. So if her tone is similar and it's a discussion about a patient, what was your grounds for sort of raising this up the chain and complaining to her supervisor?

A. I answered that. She was in a public area in a parking lot, I was going to an appointment and she wanted to have a conversation, a confidential conversation about a patient in a public area, which I felt was unprofessional and inappropriate, so I reported her to her boss.

Q. So is it your testimony that the

discussion and the resulting tension had nothing to do with the substance of your diagnosis?

A. Correct.

Q. Jumping up to the first paragraph of this e-mail from Mrs. Doyle to yourself, what was your advice about moving residents off of one east?

A. No recollection of that at all.

Q. Do you recall recommending movement of patients off of any unit at Fulton Commons around this time?

A. It's possible, but as I said, there was a lot of movement and that's it. No specific recollection about it.

Q. Looking at this e-mail, what would you think would be your rationale for recommending moving residents off an entire unit?

A. Could have been that they -- she said she's suspending admissions until Monday, so it could have could have been a census issue and -- again, as I said, they did close one east at one point, at an

eventual point so...

Q. And by "closed" what do you mean?

A. Eventually they -- as I stated before, they closed the entire unit. They shut it down, turned the lights off and there were no patients at that time.

Q. And when was that, to your best recollection?

A. I answered that before. As I said, at least -- at least more than three or four months ago, probably for a three month period.

Q. And then here again in the first paragraph, Ms. Doyle references filling the last two open COVID beds and then suspending admissions. Do you recall what she was referring to there, the, quote, last two COVID beds?

A. No.

Q. Is she referring to COVID beds on one east or somewhere else?

A. I can't tell from the e-mail so... it doesn't say.

Q. Do you recall what the resolution

of this exchange was, specific to Ms. Ronayne?

A. Yes. I spoke to Carol and I asked her to please ask Larisa, given the tension they were all having with COVID and sick patients, that she didn't need to have conversations with with me in parking lots.

Q. Did you ever end up having a conversation with Ms. Ronayne about this specific issue?

A. That one, no, but we subsequently maintained a professional relationship.

Q. And do you recall any other details, aside from what we talked about, about this specific exchange referenced in this e-mail?

A. No, nothing specific. She is the MDS nurse, so she asks questions of the physicians about diagnosis or clarification of what their diagnosis is and we try our best to, to document accordingly, appropriately.

Q. So I would like to direct your attention now to what's going to be marked

as State's Exhibit-19. So, Dr. Butchma, the format is a little different, but can you see that this is, what we're looking at now, the e-mail that we just went through?

A. All right.

Q. And if we scroll up a little bit, we can see that there is a continuation of this exchange. Can you read the highlighted portion right there towards the top of the screen?

MR. SMITH: And maybe, Anne, if you can scroll up just a bit. Yeah.

Q. So if you can just read the highlighted portion.

A. "I said I give the best diagnosis I can but change is more information available. So she cornered me 6:00 a.m. in the lot and said right now Resident #74 has UTI sepsis. She said how about acute bronchitis instead, period. I am aggressive in assessing and assisting MDS everywhere so long as I'm not writing fiction."

Q. Does that refresh your recollection at all about the substance of

the disagreement?

A. The disagreement, as I said, was that she was confronting me in a parking lot and trying to ask me about a diagnosis. In the second one I said I am very happy to help MDS, which I said before, they can tend to be aggressive and they are looking for clarification to a specific diagnosis. So I was going to document what the patient had specifically and that was my diagnosis.

Q. The reason I ask, Dr. Butchma, is it looks like Mrs. Ronayne had quite a different approach here. You identified Resident #74 as having a UTI, a urinary tract infection, and sepsis. Mrs. Ronayne offered acute bronchitis instead. Those are substantially different diagnoses, correct?

A. Correct. So MDS coordinators read charts. Physicians see patients. So she is seeing a fever and some congestion. She's seeing acute bronchitis. I am the clinician, I am examining a patient. He had a suprapubic catheter, permanently indwelling catheter, so that was my

diagnosis as being the cause of his fever and that's what I was treating him for. They are reading paper and doing paper reviews.

MR. SMITH: And let's scroll up just a bit more, Anne, if you don't mind.

Q. And, Dr. Butchma, if you can read the highlighted section there at the top of the page.

A. I said -- it says "I support you and Larisa 100 percent. Wanna not be quarantined one to five."

Q. And just for clarity, I think it says "wanna not be quarantined three to five years, though;" is that correct?

A. Three to five. I thought it said one to five.

Q. What are you referring to there?

A. So Cathie and I have had a running joke for 30 years where she says I don't look good in orange and so that was a personal exchange, joking around.

Q. Referring to what, incarceration

for what reason?

A. It means whatever I do, whatever I document, I am going to document it 100 percent according to what it is clinically and I am not taking any risk or any chances of it being inaccurate.

Q. Okay. So --

A. I tried to say it in a joking manner to her, though.

Q. Understood. Back to May 1st. As far as you know, were any room transfers made on that day, on May 1st, 2020?

A. I would have no knowledge of that.

Q. And when you say "no knowledge," do you mean you are not aware, you don't recall that happening or you wouldn't have known about it at the time?

A. I wouldn't have known about it specifically, unless it was my -- unless it was my patient.

Q. Do you recall if any of your patients were transferred on May 1st?

A. Not that I recall, no.

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Q. Do you recall anything else about May 1st? Did you have any other meetings with Ms. Doyle, Ms. Frawley, Ms. Ronayne?

A. Not -- not that I recall, no.

Q. Just for my own clarity, did you have discussions with Ms. Doyle and Ms. Frawley on May 1st, that Friday?

A. My only discussion on May 1st -- May 1st or on April? Are you talking about --

Q. May 1st. Friday, May 1st.

A. Unless Cathie called me on a conference call, I didn't have any -- I wouldn't have had any discussion after my usual morning visit to, to Carol.

Q. Do you recall, during your usual morning visit to Carol on May 1st, anything specific about an impending DOH survey?

A. No.

Q. Do you recall discussion on May 1st with Carol about impending room transfers?

A. No.

Q. And again, is it accurate to say

you probably worked May 3rd, which is a Sunday, based on your schedule?

A. Yes.

Q. Do you recall specifically working May 3rd?

A. No.

Q. Do you recall any room transfers being made on that Sunday? Did you notice that at all on May 3rd?

A. No.

Q. And again, it's safe to assume you were back at work on that Monday, May 4th, according to your schedule?

A. Yes.

Q. And when you got there on May 4th, it sounds like you typically arrived in the morning; is that correct?

A. Yes.

Q. Do you recall seeing any non-Fulton staff, non-Fulton personnel at Fulton Commons on the morning of May 4th?

A. No.

Q. As far as you knew, were there any DOH staff or surveyors at Fulton on the

morning of May 4th?

A. No.

Q. When did you eventually learn about the DOH infection control survey from May of 2020?

A. I believe Carol apprised me that they were in the building.

Q. And when did she tell you about that?

A. It would have been right after they got in.

Q. So Carol let you know the DOH surveyors were there when they were actually onsite?

A. Yes.

Q. And would that have been Monday, May 4th?

A. I don't recall specifically.

Q. And you had mentioned speaking on the phone to DOH surveyors around that time; is that correct?

A. Yes.

Q. Did you have any in-person interactions with DOH surveyors?

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A. No.

MR. ZADEK: Hey, Ben. I'm sorry to interrupt, but I think there may be a scheduling issue that needs to be addressed. We can go off the record for a moment and have a discussion, but I think a scheduling issue may have arisen.

MR. SMITH: Okay. We can go off the record.

(A discussion was held off the record.)

Q. So, Dr. Butchma, I would like to direct your attention now to what's going to be marked as State's Exhibit-10. Do you recognize this document?

A. No.

Q. So it's safe to say you would not use a document like this in your practice?

A. No.

Q. Am I correct in noting that the title of this document is "patient activity log"?

A. Yes.

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Q. And it's dated, in the upper left-hand corner, June 11, 2020, correct?

A. Yes.

Q. But if we look down the page, it is clearly pertaining to activity taking place on May 1st of 2020; is that correct?

A. Yes.

Q. And even though you haven't seen this document or this sort of document before, can you tell what kind of activity this document tracks?

A. Room transfers.

Q. Okay. And scrolling down, how many transfers does this document reflect on May 1st?

A. Maybe about 16. 20.

Q. So you are very close. It's a total of 18. So this document reflects 18 bed transfers occurring on May 1st, 2020, and you note all transfers occurring on the same day? Am I correct in those statements?

A. That's what it says, yes.

Q. Reviewing this document, does that refresh your recollection about room

transfers occurring around that first weekend in May of 2020?

A. No.

Q. So let's go next to what we marked as State's Exhibit-11. Do you recognize this document?

A. It's a census report.

Q. So it's a daily census sheet; is that correct?

A. Correct.

Q. And does it appear to be for Friday, May 1st, 2020?

A. That's what it says.

Q. And according to this document, was the total census count on May 1st 198?

A. That's what it says, yes.

Q. So based on the patient activity log we just looked at, Exhibit-10, comparing that against this document, the daily census showing the total census count for May 1st, it would appear that nearly 10 percent of Fulton's residents were transferred between and amongst beds on May 1st; is that correct?

A. That's what it says, yes.

Q. And am I correct in understanding that you were not aware of these movements of residents on or around May 1st?

A. No recollection of it.

Q. Does it seem unusual to you that the medical director would not be aware of roughly 10 percent of the facility's residents being moved in such a short period of time?

A. Not necessarily, no.

Q. And expand on that for me.

A. I said -- first of all, I said that I have no recollection of it, so that doesn't mean I wasn't informed. I just don't remember. As I said, there was a lot of movement of beds in a lot of different places. It's not unusual during that time to change patients' beds around, to move units around, to consolidate. So I may have been informed. I have no independent recollection of it. And as I stated before, admissions, social service and nursing generally handled bed transfers.

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Q. And I understand that movement was common during this time. Would it be your testimony that a movement of roughly 10 percent of the residents in the facility in one day would be common or uncommon?

A. During that time period, not unusual.

Q. Were there any other days that roughly 10 percent of the facility's residents were moved in one day?

A. In that specific facility, I couldn't say. There's -- it's not unusual -- it's not unusual now for -- I got 10 patients moved to my unit from the hospital unit in a day period. It's not un -- it's not that noteworthy of an event to me.

Q. Typically would you be notified if around 10 percent of a facility's residents were being moved in one day?

A. Not necessarily. Just in the context of -- as I said, in the context of a pandemic, patients were moved in different facilities. That's why I don't have an

independent recollection. Not that unusual of an activity.

Q. And what would be your educated -- as a medical director, what would be your educated assumption as to why this many residents were moved on one day?

A. There could be a lot of reasons. As I said, consolidating a unit, moving patients from hospitalized to coming off quarantine. There could be a lot of reasons. There was -- the censuses were relatively low in comparison, except for one or two units, so moving patients around wouldn't surprise me, even just consolidating them.

Q. And just to return to an issue we've talked about a bit, am I correct in understanding that you were not aware of any of your residents being moved on May 1st, correct? You can --

A. Not necessarily. If you show me a list, I can tell you if any of them were mine.

Q. We'll do that. Let's go back to

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Exhibit-10 quickly. So we will go to the top, and we can slowly scroll down, and just let me know if you recognize any of these names as your patients. And we can slow it down if you need to.

A. Didn't see any three east.

Q. Okay. So just for my own clarity, let's go back to the daily census sheet for May 1st. That's Exhibit-11. So if we scroll down a little bit -- it's a one-page document. If we scroll down that page a bit, we will see there is a section for intra facility transfers. Do you see that?

A. Yes.

Q. How many transfers are noted on this document as occurring on May 1st?

A. Discharges/transfers, one patient.

Q. And when you compare this document showing one transfer and that is an expiration, as you'll note there, Resident #82 , expired in the facility. So actually removing Resident #82 from

consideration, zero transfers in the facility on May 1st, as noted in this document, and we compare that against the bed activity log we just looked at, how does that make sense?

A. It makes perfect sense.

Q. Explain.

A. Because the daily census when it's printed. When is the daily census printed?

Q. So let's --

A. Generally 7:00 in the morning, which I'm sure you know. So the other -- if somebody moves after 7 o'clock in the morning or whenever they decide to print the daily census, which is first thing in the morning, then those wouldn't be recorded on it. It would be recorded on the next daily census.

Q. So the timing of the printing of the documents?

A. Ah, yes.

Q. If the documents were not printed, if printing was removed, would

there be another explanation for the recording of zero transfers happening at the facility on this day as reflected in the daily census sheet when compared against the patient activity log?

A. I don't understand the -- a hypothetical question?

Q. Your explanation for this document showing no transfers is that it was printed before the bed activity log?

A. Correct.

MR. SMITH: Anne, if we can just go back to Exhibit-10 please.

Q. Can you tell from this document when this was printed?

A. It says June 11th.

Q. So just for my clarity, the patient activity log was printed a number of weeks, five to six weeks, after that daily census sheet?

A. Yes.

Q. So the daily census sheet would not reflect transfers based on the timing of the printing, that's your testimony?

A. Daily census sheets, as I said, it's printed first thing in the morning on that day. So if that was printed on May 1st at 7 o'clock in the morning, generally early because it's printed before morning meeting, which is usually 9 o'clock in the morning, most facilities, anybody that's transferred or expires or goes to the hospital after that's printed is going to go on the next day's sheet to be printed May 2nd.

Q. So based on this approach to these two documents that you are advocating for, these transfers would have happened after the printing of the daily census sheet for May 1st, correct?

A. I said it already, yes.

Q. So who at Fulton would be responsible for maintaining records like these?

A. No idea.

Q. So is it safe to assume you don't play a role in that process?

A. No. I'm not a clerk.

Q. Do you rely on the daily census

sheets in your practice as medical director?

A. No.

Q. Do you ever consult with them as medical director?

A. Generally not, no.

Q. What would be the circumstances where you would consult a daily census sheet?

A. Virtually never any reason.

Q. What would be -- if there was one reason, what would that be?

A. If I wanted to know if there was a hospital transfer.

Q. Especially during the pandemic, that was a relatively regular occurrence, though, correct?

A. I received that information from -- it wasn't, no. Hospital transfers were not that usual because New York State was telling us not to transfer patients out of the hospital. Inhouse deaths, as I stated before, were not uncommon, and I was informed from that and received listing of that from Carol Frawley directly.

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Q. And my apologies for being unclear. I was referring to -- I understand what you said and I appreciate that clarification. I was referring to transfers from the hospital to Fulton Commons. That would also appear on a daily census sheet, correct?

A. Right, but I wouldn't be interested in that information.

Q. So you would not consult this sheet to determine whether individuals had been transferred into the facility?

A. Correct.

Q. So I want to move back to Exhibit-8 briefly. And, again, this is the resident listing printed May 1st showing residents' locations on May 1st. So do you see the bed listing for Resident #7 ? That's the second from the top.

A. Yes.

Q. And does that identify him as residing in [redacted] bed [redacted]?

A. That's what it says.

Q. Do you have any idea if Resident #7

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was a COVID positive or presumed resident at this time?

A. No idea.

Q. So I would like to direct your attention to what will be marked as State's Exhibit-12. So this is the daily census sheet for [redacted], 2020, correct? Sorry, I may have missed you there. I am just confirming, this is the daily census sheet for [redacted], 2020, correct?

A. That's what it says, yes.

Q. Do you see the section down the page a bit for admissions, if you scroll down a little bit?

A. Yes.

Q. And do you see Resident #7 name in that section?

A. Yes.

Q. And does that section define his status?

A. It defines his diagnosis.

Q. As what?

A. His diagnosis from the hospital was COVID-19.

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Q. Okay. And I want to jump back to an item we discussed a bit earlier which was Fulton Commons being aware of incoming residents, transfers from the hospitals, COVID status. I want to revisit that because I believe at the time you stated that you would not know an incoming resident's COVID status. Do you still maintain that?

A. I didn't say that. I said there was a time --

Q. What did you say?

A. That there was a time period where we were not allowed to ask about a patient's COVID status.

Q. Okay. Was there ever a time when you would --

A. I said what the period of time was and I didn't say that time period. I said there was a time period where the Governor and the Health Commissioner did not allow us to ask and we were not informed. But clearly this -- this census sheet, when that patient -- those three patients were

admitted, that was not the case because there's the diagnosis.

Q. Do you know when that period of time ended where you would not know a patient's status upon transfer?

A. I said no, I don't know.

Q. And just for refreshing, this is April 21st, 2020 so that issue had been resolved by this time, correct?

A. As of -- as I said, as of that date, the facility was aware of those three patients being COVID positive, yes, from the hospital.

Q. Okay. So I want to go now to what will be marked as State's Exhibit-13. And this is a 94-page document. We won't go through the whole thing. I just want you to know that you will see that it is a large document. This is a compilation of all of Fulton Commons' 24-hour condition reports from the period of May 1st to May 5th, 2020. We can get to the edge so you can see it. And, Dr. Butchma, are you familiar with 24-hour condition reports?

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A. It's a nursing document.

Q. Do you utilize them at all in practice?

A. I didn't hear your question.

Q. Do you utilize them at all in your clinical practice?

A. It's a nursing document, so no.

Q. What about in the context of your work as a medical director?

A. It's a nursing document. I don't utilize it.

Q. Do you ever find a reason to consult these documents?

A. No.

Q. So let's jump down to page 14 of this document. Let's scroll down just a bit. And, Dr. Butchma, who does this document identify as --

MR. SMITH: We will go down just a bit more, if you don't mind, Anne.

Q. The last line on the bottom, who does this document identify as residing, as of [redacted], in [redacted], bed [redacted]? If you can't read that, I can give you the name --

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A. I can't read it.

Q. It's a resident Resident #26 . Is that familiar?

A. No.

Q. Am I correct in saying this document, the 24-hour condition report, shows resident Resident #26 as living in room [redacted] on [redacted], 2020?

A. Can't read the name but..

Q. But trusting me -- if you trust my representation that it is Resident #26 , does it show her residing in room [redacted]?

A. It says [redacted].

Q. And Resident #26 was not a patient of yours, correct?

A. Correct.

Q. Can you tell from this document if she was a COVID patient?

A. I cannot.

Q. So let's look at what will be marked as State's Exhibit-14. And this is the 24-hour condition report for Resident #26 on [redacted], 2020. Is

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Resident #26 identified as a COVID patient in this document?

A. It says parietal resection.

Q. Okay. So there is nothing in this document that indicates to you that she was a COVID patient, correct?

A. Not that I can read, no.

Q. So if we jump back to page 14 of Exhibit-13, we can see here, this document is reflecting a room change for Resident #26 from [redacted] to room [redacted] on [redacted]; is that correct? Do you see that in the central column, bottom of the page?

A. That's what it says, yes.

Q. So it would appear that Resident #26 moved off of one east on May 1st onto the second floor; is that correct?

A. From one east to two east.

Q. And, again, your understanding -- under your understanding, as far as you recall, as of May 1st was one east the designated COVID unit of Fulton Commons?

A. I have no independent recollection of that.

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Q. Were you aware of any unit at Fulton Commons at this time being a designated COVID unit?

A. As I said before, there was designated COVID areas in the facility. I don't remember which units it was and I don't remember the dates when they became units for COVID patients.

Q. Okay. But it is fair to say, based on these documents, that Resident #26 was residing on one east on May 1st and was moved to two east on that day?

A. That's what it says, yes.

Q. So based on the records we've just looked at, can we also agree that it was only after this non-COVID resident Resident #26 was transferred out of one east that a COVID resident Resident #7 was transferred into that same room?

A. That would appear to be the timing, yes.

Q. Do you have any understanding as to why Resident #26 was moved on May 1st?

A. No idea whatsoever.

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Q. Let's go back to Exhibit-8 again. That's the one east bed listing. We are going to take a look at another resident. So I would like you to look at Resident #8 . He is a bit down the page, second from the bottom. Is it correct that he is listed as residing in room [redacted] bed [redacted]?

A. Yes.

Q. And was he a patient of yours?

A. No.

Q. Are you aware of what his COVID status was at this time?

A. No.

Q. So let's take a quick look back at Exhibit-12. That's the daily census sheet from April 21, 2020. And do you see Resident #8 there, the third of three?

A. Yes.

Q. And what is his diagnosis upon entry to Fulton Commons?

A. That he had had COVID-19.

Q. So if we go back to Exhibit-8, and this document identifies Resident #8 as the occupant of room [redacted] bed [redacted] on the

morning of May 1st, correct?

A. Yes.

Q. And then if we jump to page 15 of Exhibit-13, so this is, again, the 24-hour condition report, who on this document is identified as residing in room [redacted] bed [redacted] as of May 1st?

A. I can't really read the name, but it starts with an [redacted].

Q. So the handwriting is not great, but it's Resident #22 . Is that familiar, that name?

A. No.

Q. She was not a patient of yours?

A. No.

Q. Do you know what her COVID status was at this time?

A. No.

Q. So I would like you to take a look at what will be marked as State's Exhibit-15, and this is the daily census sheet for April 27th. And if we scroll down a bit, do you see Resident #22 admission diagnosis?

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A. It says COPD hypertension.

Q. So let's go to what will be marked as State's Exhibit-16, and this is the 24-hour condition report for one east on May 1st. Does this document indicate that Resident #22 was transferred on May 1st?

A. I can't hear you.

Q. Does this document indicate that Resident #22 was transferred on May 1st?

A. It says from one east to three west.

Q. Okay. Stable condition; is that correct?

A. Yes.

Q. So she was transferred from room [redacted] to room [redacted], correct?

A. Correct.

Q. So in other words, out of one east and onto, would that be three west?

A. Three west.

Q. Three west. And just to return briefly to Resident #23 , it was only after non-COVID resident Resident #22 was transferred out of one east that

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Resident #23 , a COVID resident, was transferred into one east; is that correct?

A. Correct. It would appear that as the initial policy that you pointed out much long time ago that the COVID -- cohorting COVID hospital patients onto a unit, that's where the transfers were appearing.

Q. So even though you don't recall these movements happening, is it your testimony that you think these were done in an effort to cohort residents?

A. That's what it appears to be, yes.

Q. And would it appear to be an effort to cohort residents on one east?

A. That's what it looks like, yes.

Q. Okay. So in other words, moving residents out of one east that were not COVID suspected or confirmed or presumed and replacing them with COVID suspected, presumed or confirmed residents, correct?

A. That's what it looks like, yes.

Q. So let's look at one more resident transferred on that day. So we are

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going to go back to Exhibit-8. That's the one east bed listing. If we can, we are going to look at Resident #6 . He's at the very bottom, 24 of 24. Am i correct in stating that this document shows Resident #6 in room [redacted] bed [redacted]?

A. Yes.

Q. And was Resident #6 a patient of yours?

A. No.

Q. Are you aware of his COVID status at this time?

A. No.

Q. So we are going to move now to State's Exhibit-17, what will be marked as State's Exhibit-17, and that is the daily census sheet for April 17th, 2020. You can scroll down just a bit. And you can see Resident #6 in the admissions section, third of three. What is his diagnosis there upon admission?

A. He had had COVID-19.

Q. So we are going to go back to Exhibit-8 briefly. So this exhibit, as we

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discussed, shows Resident #6 in room [redacted] bed [redacted] on the morning of May 1st; is that correct?

A. Correct.

Q. Now, if we go to Exhibit-13, the first page of Exhibit-13, you can see Resident #6 is there, at the very top of that exhibit, but this indicates that Resident #6, as of May 1st, was in room [redacted]; is that correct?

A. That's what it says, yes.

Q. And do you see, immediately below Resident #6, who was his roommate in [redacted]?

A. [redacted] somebody.

Q. I think it's misspelled, but that's Resident #8, who we were discussing earlier. So on May 1st Resident #6 --

A. They have been cohorted in the same room, two patients with a COVID history, correct?

Q. Maybe you can answer that better than I could. Would that be your understanding of this document here, is that

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Resident #6 and Resident #8 were being cohorted in room [redacted] together?

A. That's what it appears to be, sure.

Q. And, again, neither of them were your patients, correct?

A. No.

Q. And I apologize for the confusion. This was not your unit, though, was it, three west?

A. No.

Q. So this document shows Resident #6 , Resident #8 as roommates Friday, May 1st. Why do you think Resident #6 was moved that day to a different room?

A. It would appear that they decided to cohort on a different unit. As I said, you know, a lot of suggestions, guidances and things changed and overtime, particularly early on. So to get a different directive or to change where people were doing things is not so unusual. So what you're presenting, I understand it, but it's -- it's not -- medically it's not

unusual and it's not inconsistent with, with regular infection control practices, as long as the room was -- the rooms are always terminally cleaned when you change one patient to another patient. So cohorting on a different unit would not have been particularly unusual.

Q. So two sort of quick questions there. So when Resident #6 and Resident #8 would have been transferred. There would have necessarily been a terminal clean of their room, correct, before somebody else came in?

A. Always.

Q. Sorry, say that again.

A. The rooms are always terminally cleaned after a patient is moved out, discharged, expires, goes to the hospital, goes home before the next patient comes in. It's like a good hotel.

Q. So that's independent of the prior resident's COVID status, there is going to be a terminal cleaning regardless of the person's status?

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A. That's my understanding.

Q. And it's also your testimony that, you know, although you were not directly involved in this, per your testimony, that you would read this as these two individuals being cohorted together and being transferred for further cohorting together?

A. Yes.

Q. Are you aware -- sorry, did I hear somebody?

A. No.

Q. Are you aware at all of the course of Resident #6 illness after he was transferred on May 1st?

A. Wasn't my patient, so no independent recollection if I ever heard anything about him, no.

Q. So let's jump back to -- let's go to page eight of Exhibit-13. And what does this document show? I know the handwriting is not great but --

MS. LIPTAK: I will zoom in a little bit.

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Q. And, Dr. Butchma, to save you time, I am looking particularly at the bottom right-hand side -- the bottom of the right column.

A. This resident expired.

Q. [redacted] a.m.?

A. That's what it says, yes.

Q. Am I correct in understanding Resident #6 died within hours of being transferred to one east?

A. That's what it looks like, yes.

Q. Can you identify a medical reason for transferring Resident #6 at this time?

A. A medical reason?

Q. Correct.

A. Transferring him from one unit to another?

Q. Correct.

A. As I said, there is no medical reason, but cohorting can be considered a medical and nursing reason to move a patient.

Q. Okay.

A. It's not unusual. And, by the

way, it's not unusual for -- during that time for patients to expire, independent of whatever their condition, stable condition was, you know, hours before.

Q. So aside from the individuals we just discussed, are you aware of any other non-COVID residents on one east prior to the moves on or around May 1st?

A. You were asking me to remember the 1st -- as I stated multiple times, one east was not my unit so I wouldn't have had any specific knowledge of patients except whenever I looked in a medical record for a particular reason. I don't have any independent recollection of any of these patients because they weren't my patients.

Q. What I'm getting at is I wonder if going through these residents in detail refreshes your recollection at all. If not not, that's fine, but --

A. They weren't my patients.

Q. More generally, though, as medical director, were you aware of any other non-COVID residents on one east around

the time of these moves?

A. I don't remember the specifics of any of that time anywhere, to be perfectly honest. We -- as I said, moving units, cohorting on different units, moving patients around was pretty commonplace at the time. Most of it was based upon the orders of, of the Governor and of the Health Commissioner, and we tried to keep up as best we could with whatever their guidance was. So that's -- it came fast and furious and that's what we were doing. We were responding mostly to that. As I said before numerous times, those recommendations changed on an ongoing basis. They're very different today than they were 12 months ago. So for me to remember exactly what the logistic was back then, it probably was very logical at the time to move patients. Now everybody is doing things differently based upon the new knowledge that we have.

Q. And based upon the knowledge you had at that time in April, May of 2020, if you had known about non-COVID residents

being on one east, would that have concerned you?

A. As I said before, not necessarily now, because -- so based upon what we had back then, we didn't know how long patients were infectious. Now we know how long -- generally how long they're infectious. But it wouldn't have -- if we had knowledge -- so if you have a patient who is COVID positive in the hospital, that doesn't mean they're infectious now. We were accepting COVID patients when we knew that they had had COVID and the presumption was either they had negative tests coming in and/or we knew they were asymptomatic. So the presumption was they were likely not shedding virus anymore and they were safer to take. It's a difference from taking patients that are pig in a poke, that you don't know if they were tested or not, and they have pneumonia and they were treated for three days and now they're transferring them out. Very different clinical scenarios. If those patients were in the

hospital for a prolonged period of time that were -- those three residents that have a history of COVID positive, that doesn't mean they're infectious or they're dangerous to anybody else. You can still cohort them, and we do it now for 14 days, as I said numerous times, for quarantining. But, again, the rules changed and the guidance has changed on an almost daily basis, definitely on a weekly basis. So those things that you are presenting are not shocking or unusual medically. The fact that patients were transferred from one unit to another, not unusual. The fact that they moved from -- they were COVID patients cohorted on -- in the same rooms on three west and they decided to move them to one east to try to move things around or vice-versa, it's not unusual for the time. Typical of what I saw.

Q. And was it common to shift cohorted residents around to other parts of the facility in April and May of 2020?

A. As I just said, it wasn't

unusual -- movement was not unusual back then. It's not unusual now. It's a little bit more sustained now because we try not to move people, but back then there was more movement going on early on. We had less of an understanding and we tended to move patients around to try to play Whac-A-Mole.

Q. So would it be correct in understanding that to be more of an ad hoc response to patients becoming presumed or suspected COVID?

A. Correct. So we're less likely to -- we're less likely to do those things now. But back in that time we did. And as I said, it was all done in -- just because I don't have recollection of it, was informed of it. You know, if there was a medical reason and we were moving suspected patients from one unit to another, that wouldn't have been unusual in any facility, and Fulton was no exception. So all this movement around, medically, is not -- is not particularly unusual for what was going on at that time.

Q. Are you familiar with the term

"psychosocial well-being"?

A. Oh, yes.

Q. And what does that mean in the nursing home context?

A. Well, it's like -- so the Governor ordered no family members being allowed in under any circumstances, and making the requirements to have visitation now so onerous that it's almost impossible, that's particularly bad for a patient's psychosocial well-being, that they can't have -- they can't have visitors, they can't have family members in, they can't dine in a communal area and have interaction with some of their peers. So yes, psychosocial -- I am painfully aware that they have all -- that all of my patients and all those under my charge have suffered from the orders from New York State, particularly, for psychosocial well-being.

Q. And would psychosocial well-being be a reason for the patient resident moves that we just walked through?

A. To enhance their psychosocial

well-being? We try not to move patients excessively, but in this given time, we are following orders and directives, so movement has been -- has been necessitated by that. What's effecting my patients' psychosocial well-being and all these patients, and Fulton Commons particularly, is the extraneous things that we have no control over as a facility, which is that basically our patients are all captive in quarantine. Whether they put a sign on the door or not, they're all stuck in their rooms for the last 12 months that they've been there without family members. So yeah, it's been terrible for psychosocial well-being, if that's your question.

Q. Maybe to approach it from a different angle -- I appreciate the answere. That answer is a good part of my question. But from a bit of a different approach, you had testified just now that several of these moves appeared to be efforts to cohort residents. Would cohorting a resident be related to their psychosocial well-being?

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A. Would it improve their psychosocial well-being, or relevant to it?

Q. Would it be relevant to it?

A. I just answered that. I said we try never to move patients from one place to another. We try to keep them -- ideally we like to keep them in the room that they were admitted to initially. It doesn't always work out that way. So just like you don't want to check in and out of a hotel room and move down the hallway every day you are in a hotel for two weeks. You want to be in the same room. They kind of like to be in the same room. They get to know their roommate a little bit. So they get to know the staff a little. We try to keep -- we try to keep residents in the same general area. If they like a particular unit, we want to keep them there. That's good for their psychosocial well-being. Moving them, particularly, would not necessarily be. It depends.

MR. SMITH: So I'm at a bit of -- I know we are not quite at 5:15. I'm at a good stopping point to sort of

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keep things contained somatically and to make more sense maybe when we get restarted. I did -- while we still have Stefanie and what looks like we're going to go into a second session, Dr. Butchma, I just want to remind you that whether we take this back up tomorrow or Monday or a later date further out, to remind you that this is a confidential proceeding. So aside from your conversation with Mr. Jones, you know, we ask you to not discuss this with anyone, including your girlfriend, friends or family, anyone at Fulton Commons. So it remains confidential throughout, of course, but between now and the next time we meet we want to reiterate that this is confidential.

Q. And also I want to just revisit some discussions we had earlier and I want to make sure, while we are on the record, can you confirm again to me that you did not discuss any prior subpoenas, deposition

testimony related to the Attorney General's investigation of Fulton Commons with any Fulton Commons staff?

A. With any Fulton Commons staff, no.

Q. So just for my own clarity --

A. I'm aware that they were subpoenaed.

Q. Right. And so without revealing too much, we have deposed several Fulton Commons staff. Did you discuss their testimony at all afterwards or at any time between when they gave testimony and today?

A. The only people that I know were subpoenaed from Fulton were the director of nursing and the administrator.

Q. Okay. So specifical to Mrs. Frawley, did you ever have discussion with Mrs. Frawley about her testimony?

A. No. She told me she had been subpoenaed.

Q. Did you have discussions with her after her testimony about what we had spoken about?

A. No.

Q. Same for Mrs. Doyle; aside from, obviously, knowing that Mrs. Doyle was subpoenaed, did you ever discuss Mrs. Doyle's testimony?

A. I became aware that she had been subpoenaed. She did not discuss -- Cathie is very close to the vest. She did not discuss her testimony with me. And Carol said she had been subpoenaed and did not discuss her testimony with me.

Q. Okay. After the deposition itself, did you discuss with Mrs. Doyle the content of her deposition?

A. I didn't hear what you said.

Q. Sorry. So after Mrs. Doyle was deposed by our office, did you discuss with her any of the subject matter or content of her deposition?

A. Cathie, no.

Q. Sorry. You broke up a bit for me. Can you say that one more time?

A. I said Cathie, no. Cathie is very close to the vest. As I said, I didn't

even know -- until I was subpoenaed, I didn't even know any of this was going on at all.

Q. So you didn't learn about Ms. Frawley's and Mrs. Doyle's subpoenas until you got your own subpoena?

A. That's correct. I actually heard that from the two elderly gentlemen that accosted me after my run at 6 o'clock in the morning to serve me with a subpoena and then informed me that didn't I know this was all going on, that the director of nursing and the administrator had been subpoenaed.

Q. Up until that morning that you were served with a subpoena, did you know that we were investigating Fulton Commons?

A. No idea.

Q. There had been no discussions amongst Fulton Commons staff about our investigation?

A. I didn't hear anything from anybody until those two, two guys that morning.

Q. Okay. And between that morning

and today, there were no discussions with Fulton Commons staff about any of our investigation?

A. To my recollection, I have not had any discussions with anybody about this, except for -- as I said, except for knowing from Carol that she was subpoenaed, she did not volunteer any information and I didn't ask.

MR. SMITH: So I would just ask that you continue on that course.

A. I know she took it -- she said it took -- she spent a day. That's all she said.

Q. Okay. And nothing else beyond that?

A. Nothing else.

MR. SMITH: Okay. So, again, I would just ask that you continue on that course, just keep this confidential. Don't discuss with anyone -- you can obviously discuss with your attorney, but no one else. Before we lose Stefanie, Glenn, do you

have potential dates or we can just touch base later today or tomorrow?

MR. JONES: Let's touch base tomorrow. I want sometime to talk to Dr. Butchma and look at my own schedule.

MR. SMITH: Okay. We will be in contact tomorrow. I will reach out by e-mail.

MR. JONES: Okay. Sounds good.

MR. SMITH: Okay. So we are going to close the record. Dr. Butchma, I appreciate it. I know it's a long day. Like I said, we've made good progress in the last couple of hours, so the second chapter will be much briefer. I can promise you that. It will be a small portion of the day. So I appreciate your patience today. We will wrap this up quickly next time. Okay. Stefanie, we can go off the record.

(TIME NOTED: 5:03 P.M.)

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CERTIFICATION

I, STEFANIE KRUT, a Notary Public in and for the State of New York, do hereby certify:

THAT the witness(es) whose testimony is herein before set forth, was duly sworn by me; and

THAT the within transcript is a true and accurate record of the testimony given by said witness(es).

I further certify that I am not related either by blood or marriage, to any of the parties to this action; and

THAT I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 1st day of March 2021.

STEFANIE KRUT

NEW YORK STATE: ATTORNEY GENERAL'S OFFICE

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In the Matter of

FULTON COMMONS CARE CENTER, INC.; an Investigation by the New York State Attorney General, made pursuant to the New York State Executive Law, et seq.

VOL. II

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63(12) Examination under oath of DR. OLAF BUTCHMA, taken via WebEx video conference, held on March 10, 2021, commencing at 10:02 a.m.

Reported by

Nicole Lebovic

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BY: GLENN JONES, ESQ.

ALSO PRESENT:

Prabhjot Sekhon- Special Assistant Attorney General

Peter Zadek- Special Assistant Attorney General

Anne Liptak- Paralegal, NYS AG

Khristian Diaz- Auditor Investigator, NYS AG

John Tarpey- Detective, NYS AG

03-10-21

(Documents were marked as Exhibits 1 through 29 for identification; 3/10/21, N.L.)

O L A F B U T C H M A, M.D., having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

MR. SMITH: Can you state your full name for the record, please.

THE WITNESS: Olaf Butchma.

MR. SMITH: Where are you located today?

THE WITNESS: In Lake Success, in my attorney's office.

MR. SMITH: So, I'm going to introduce myself and everybody on this call very quickly before we get started. So, it's the same crew from last time, but just to make sure we're all clear, my name is Benjamin Smith. I'm a Special Assistant Attorney General with New York Attorney General's Office and I work out of the New York City office.

And if everybody else could introduce themselves and then maybe, please, once you've done that, discontinue your video so we can preserve the bandwidth a little bit.

MS. SEKHON: My name is Prabhjot Sekhon. I'm a Special Assistant Attorney General with the Medicaid Fraud Control Unit with the Attorney General's Office. I work out of the Hauppauge office.

Good morning, Dr. Butchma and good morning, Mr. Jones.

MR. JONES: Good morning.

MR. ZADEK: Good morning, this is Peter Zadek. I am as well a Special Assistant Attorney General. I work out of the Hauppauge office.

Good morning, Dr. Butchma.

Good morning, Glenn.

MR. JONES: Good morning.

MR. TARPEY: Good morning. My name is John Tarpey. I'm a detective assigned to the New York State Attorney

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General's Office.

Good morning, Mr. Jones.

Good morning, Dr. Butchma.

MS. LIPTAK: Good morning, Dr. Butchma.

Good morning, Mr. Jones.

My name is Anne Liptak. I'm a paralegal with the Hauppauge office.

MR. JONES: Good morning.

MR. DIAZ: Good morning, everyone. I'm Khristian Diaz, auditor investigator with the New York City office.

MR. SMITH: Okay, Dr. Butchma, as you know, obviously this is day two of your 63(12) hearing that we commenced back in February. As with our first meeting, all the same rules that we went through that first time still applies today.

I will go through a couple of quick ones. Again, primarily, I notice we have Nicole with us, the court reporter, same as the last time, we

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want to keep all our responses verbal, no nonverbal gesture or shrug, that sort of thing, if you can make all your answers verbal.

Again, you're under oath, so we wan to remind you the importance of truthfulness, answering to the best of your ability.

Again, if you give me an answer one point this morning and think about it over the course of the day and you want o adjust or change an answer, just let me know. That's perfectly fine, we'll do that.

Again, as we discussed last time, the importance of confidentiality in these proceedings is paramount. I just want to confirm with you today, have you discussed anything about your subpoena or your testimony with anyone since we last met?

THE WITNESS: I have not.

MR. SMITH: And that includes no discussions with any Fulton Commons

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employees?

THE WITNESS: No discussions.

MR. SMITH: And no discussions with anyone other --

THE WITNESS: No discussions with anyone.

MR. SMITH: And I'll remind you that that confidentiality mandate still applies today.

THE WITNESS: Yes.

MR. SMITH: So that --

THE COURT REPORTER: Mr. Smith, I'm having trouble hearing you.

MR. SMITH: Let's take a quick five-minute recess and so I can get on a different network. So let's just take a quick five-minute pause.

(A brief recess was taken.)

MR. SMITH: So Dr. Butchma, I apologize for the technical issue there.

I'm going to restart our discussion of confidentiality. So just to revisit, I want to confirm with you

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that you have not discussed your subpoena or your testimony last time you were with us with anyone that works at Fulton Commons, correct?

THE WITNESS: Correct.

MR. SMITH: Did you discuss your testimony or your subpoena with anyone aside from Fulton Commons employees?

THE WITNESS: No.

MR. SMITH: I want to remind you, again, the confidentiality applies today, tomorrow and through the duration of our investigation. So, after we are finished today, after we leave, please do not discuss your testimony or your deposition or this investigation with anyone aside from your attorney, do you understand that?

THE WITNESS: Yes.

MR. SMITH: Finally, last time, we walked through all of your rights and of course, if you have questions about those, you can ask me, but primarily, as you know, you're entitled

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to have an attorney with you to consult with an attorney.

And is Mr. Jones your attorney for the purposes of this hearing today?

THE WITNESS: Yes.

EXAMINATION BY

MR. SMITH:

Q. So, during our last meeting, we discussed that you served as medical director at a number of other nursing homes during the pandemic; is that correct?

A. Correct.

Q. Just roughly, how many nursing homes was that?

A. Total approximately six.

Q. As far as you know, did any of these other facilities create a designated COVID unit during the pandemic?

A. Yes.

Q. Was it all the facilities or just a few of the facilities? How does that work out?

A. All.

Q. So it's your testimony that all

six of your facilities at some point during the pandemic created a designated COVID unit?

A. Yes.

Q. And that includes Fulton Commons?

A. Yes.

Q. Do you recall the earliest of your facilities to create a designated COVID unit?

A. No.

Q. When is the first time you recall one of your facilities having a designated COVID unit?

A. I believe in April and it was all of them simultaneously.

Q. When you say simultaneously, do you mean it was within days of each other?

A. Upon receiving the New York State order, all of my facilities which I am medical director prior to COVID had a dedicated COVID unit.

Q. What directive are you referring to?

A. From the Governor of New York

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State, Department of Health.

Q. And do you recall when that directive came down?

A. No.

Q. Do you recall -- you mentioned April, do you recall a specific time in April when your facilities instituted a designated COVID unit?

A. No.

Q. During our last meeting we also discussed the move of roughly 10 percent of Fulton's resident population on or around May 1st, do you recall that?

A. Yes.

Q. As far as you recall, as far you know, were there similarly large transfers of residents in a short period of time in any of your other facilities?

A. I don't specifically recall.

Q. When you say specifically, do you have any recollection of a similarly large transfer of patients in a short amount of time?

A. There were transfers in every

facility that I worked, but I couldn't state specifically how many.

Q. Was there any transfer of patients in a short amount of time that approached a similar percentage of the patient population?

A. I don't recall.

Q. I want to talk briefly about staffing at Fulton Commons, do you notice any staffing -- if any staff at the facility were ever disciplined during the pandemic for any reason?

A. I wouldn't be privy to that information unless it was medical staff.

Q. Would you ever be called in to deal with any disciplinary action?

A. I didn't hear the question.

Q. Would you ever be called in or involved with any disciplinary action against a Fulton Commons staffer?

A. Only medical staff.

Q. When you say, "Medical staff," you mean like doctors, nurse practitioners, CNAs?

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A. And consulting physicians, yes.

Q. So you would not be involved in disciplinary actions taken against nurses or nurse's aides; is that correct?

A. Correct.

Q. Do you recall any disciplinary action being taken during the pandemic against the MDs, DOs, NPs or PAs at Fulton Commons?

A. None.

Q. As far as you know, in the earlier weeks of the pandemic, did Fulton Commons prohibit staffers who had recently traveled abroad from reporting to work?

A. I don't recall specifically when -- so the screening tool in all the facilities came based upon the directive from New York State. And as I stated before, those changed on a weekly basis, which countries were included, which states were included. It was a moving target, even now.

So, there was a screening process instituted in the front entrance to Fulton,

as I stated before. Staff members were and are required to attest to any travel that's been done. If they have traveled, then they are -- they're instructed to report to administration and their boss for further review as to whether they can work or not.

Q. Do you recall what Fulton's approach was to staff who had recently traveled abroad?

A. No.

Q. What is the earliest recollection you have a regime being put in place at Fulton to deal with staff who have traveled abroad recently?

A. As I said, my recollection is once the building -- once all the buildings were shut down, it was towards -- it was one week earlier at Fulton Commons and then the other buildings that I dealt with.

There was a screening process in taking temperature and a brief questionnaire as to travel and any potential exposure. That was put in place and which -- as I said, they were constantly changing.

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Could have been the end of March, could have been the beginning of April. Whenever New York State gave directives, that's when all the buildings did it.

Q. And when you say, "All the buildings," is that all the buildings that you serve as medical director at or something else?

A. All the buildings I served.

Q. So, I believe it was your prior testimony that part of your duties as medical director at Fulton involved keeping up to date on state and federal guidances and directives, does that sound correct?

A. Correct.

Q. Are you familiar with the Department of Health directive if there are confirmed COVID cases in a facility?

A. As I said before, I don't recall specific directives. I receive them once or twice via e-mail, I review them and then each facility that I worked in as medical director put into place what the directives indicated.

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As to specific dates of specific directives, there have been so many over the past 12 months, no, I don't.

Q. Okay, that makes sense.

I want to show you what's been marked as State's Exhibit 18.

Dr. Butchma, are you familiar with this guidance?

A. Again, as I said, I read them all, but this is a year ago, almost exactly a year ago, so specifically no, I don't remember it, but I know I read them.

Q. Okay. Let's scroll down to bullet number five on the second page, "Do not float staff between units. Cohort residents with COVID-19 with dedicated HCP and other direct care providers. Minimize the number of HCP and other direct care providers entering rooms."

Do you recall that directive coming down from the Department of Health?

A. Again, specifically, no.

Q. So let's scroll down to the last line of the next section and that's also

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highlighted.

So, I'll read that as well, "Facilities should bundle care and minimize the number of HCP and other staff who enter rooms to reduce the number of personnel requiring face masks."

Bases on these two sections that we just read, would it be fair to say this guidance directed nurses across the state to isolate and cohort all suspected COVID cases?

A. It indicated suspected, so as I stated before, POIs or patients of interest or persons of interest, suspected cases, should be cohorted, yes.

Q. Is it fair to say it states to assign and cohort staff specifically for the care of those COVID positive or suspected residents?

A. It does state that, yes.

Q. From your perspective as the medical director and as a physician, why is this sort of resident and staff cohorting important?

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A. As I stated before, the concept is to be able to try to isolate any type of infection to a specific location if possible. So, if it's in seven units, basically close the doors in all seven units, would be -- the idea would be to try to keep any infection, whatever type of communicable disease at bay by keeping them isolated, keeping patients isolated in their rooms and try to diminish the movement of staff.

Q. From a function perspective, how does this cohorting of staff and residents minimize the risk of spreading a contagious disease?

A. As I said in theory, if you're isolating patients that potentially or do have particular infectious disease, then you should be able to close the spread or diminish the spread.

Unfortunately, it's a small directive in its concept and delivery because there was no testing material and they diminished the amount -- it reduced the

personal requiring face masks. And as I stated last time, the face masks were only required within 6 feet of patients and that was the earliest and it was surgical masks.

We now know that all of that is inadequate in containing any part of the spread, that it didn't -- it certainly didn't contain spread between staff members and staff members. And in practice, to keep staff members on one unit is great, but then they go home.

So, it's incredible -- logistically, it's almost impossible.

Q. Our understanding of the disease has changed over the past year, would it be fair to say that our understanding of the importance of cohorting and quarantining remains consistent or something else?

A. The important of cohorting and quarantine, yes, but certainly has changed and evolved way past the point when that directive came.

Q. Specifically to your concept of cohorting and quarantining, how has those

ideas changed over the course of the pandemic?

A. Well, as I stated, moving to -- moving patients -- now we're quarantining patients for 14 days even if they testified negative in the hospital. They are using face masks, all patients are using face masks. The doors in those areas are closed.

If a patient tests positive, we're not moving -- we're not doing a lot of movement of rooms. There was more movement in the beginning, so now we try to limit the movement of this patient.

And of course, our understanding is that suspected cases in March of 2020 was people with fevers because we believed everybody had a fever and of course, we know that's certainly not the case. There were far different signs and symptoms in our patient population. So, that was kind of a useless directive, as well as the surgical face mask provided much of any -- so now N95, goggles, double masks, have become much more mainstream. Whereas, back then, nobody

was directing that from the CDC.

Q. Just for my own clarity, knowing your understanding of protective equipment and the use of protective equipment has changed over time, the importance of cohorting staff with staff and residents with residents is perhaps different?

A. Well, it certainly has evolved and changes as to how we're able to carry it out with a lot. It's a lot more streamlined now in my facilities.

Q. Looking back at the very beginning of the pandemic, so we'll say March of 2020, would you agree that's the beginning of the pandemic?

A. To my recollection, yes, but I specifically couldn't tell what date that was that. As I said it all coincided. In all facilities, it all coincided with the directive coming out from New York State.

Q. Just from your perspective just walking the halls at Fulton Commons, what is your earliest memory of residents being cohorted based on COVID status?

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A. I don't recall specifically and most of my -- as I stated last time, most of my interactions in the interest of limiting provider movement, was 3 East, which was my patient unit.

So, specifically, I indicated to the other physicians -- we're each assigned one physician per unit, do not cross over typically. So, the physicians were encouraged and instructed by me not to go to other units.

So 3 East, I don't specifically recall when it was, but I did state that I had a fair amount of deaths some time in mid March, which may or may not have had some relation to COVID. But after that my unit was stable.

So, I don't recall when 3 East started to have residents being moved there.

Q. What about staff specifically caring for residents with a COVID suspected or presumed status during the pandemic?

A. As I stated last time, in my experience most of the staff at Fulton

Commons is fairly stable to each unit. However, because of sick calls or staff members out for a variety of reasons, I couldn't say specifically if one staff member moved from one unit to another on a particular day.

Q. Did you ever become aware or were you ever aware of staff floating between a COVID unit and a nonCOVID unit?

A. Not to my knowledge.

Q. Did you ever become aware or hearing of cohorting COVID residents with nonCOVID residents at Fulton?

A. Not to my knowledge.

Q. Along that same lines, do you know if any staff at Fulton were ever providing care to both COVID and nonCOVID residents on that same shift?

A. Not to my knowledge, but that wouldn't be unusual. In that time period of time that wouldn't be particularly unusual.

Q. Going back to March and April of 2020, would that have been unusual at that time?

A. As I said, I don't recall any specific instances that would stick out in my mind.

Q. If during March and April 2020 you learned of staff were caring for a COVID resident and a nonCOVID resident on the same shift, would that have raised alarms for you?

A. Again, would depend on the circumstances and as I said, I don't recall that coming to my attention.

Q. When you say, "Depends on the circumstances," what would that be?

A. For instance, if there was a code or CPR was required.

Q. Assuming standard day-to-day care, no like in nonemergent situations, would you find it troubling if a staffer was providing care to a COVID resident and a nonCOVID resident on the same shift?

A. Again, it would depend on the circumstances and what was the protective equipment being used.

Again, as I said, our knowledge

at that time protective equipment was very different from now. So, there was much less protective equipment recommended in the beginning from the CDC and New York State.

Q. So just, you know, purely looking at a staffing scenario, would there have been a scenario that would have created an alarm for you in March of 2020 or April of 2020 involving a staffer providing care to a COVID resident and nonCOVID resident at Fulton?

A. As I said again, it's possible, it depends on the circumstances.

Q. Is there any circumstance, and again, this is assuming what we knew about the disease in March or April of 2020, is there any circumstance where you would have seen a staffer providing care to a COVID resident and a nonCOVID resident on the same shift that would have caused alarm to you?

A. Again, at Fulton Commons, I don't recall -- I can recall on 3 East I did not see that happen. There were no -- in March and in April, there were no diagnosed known

case COVID on 3 East and that would have been the only unit I would have been walking on, touring and rounds.

Q. As a physician and as a medical director with a lot of experience, I'm wondering if there is a circumstance where the same staffer caring for COVID residents and nonCOVID residents on the same shift would have raised concern for you?

A. Again, possibly.

Q. Let's explore that possible scenario, what would that have looked like?

A. Well, in a hypothetical, if there was COVID positive patient in one room and a staff member or nurse or nursing assistant took care of the patient in that room and then, even washing their hands, walking into the next room without regard to equipment, then that would be a reason for concern.

Following infection protocol, then -- whatever infection protocols were used at the specific time, it wouldn't have necessarily raised alarm, no.

Q. At our last meeting we discussed

the creation of a COVID unit at Fulton Commons, as far as you know, was staff ever floated between that COVID designated unit and any other units during their sift?

A. Again, as I stated before, I have no knowledge of nurse staffing and I have no recollection of who floated or if anybody floated between the units.

Q. Would you agree that if staff had floated within the designated COVID units during their shift, they would be violating infection control protocol?

A. Somebody floating during their shift?

Q. During their same shift?

A. I'm not the nursing director, nor a nurse, but in general, to my knowledge, that's a highly unusual occasion to float somebody during a shift to another unit.

If from unit to unit at the beginning of a shift, likely happened on occasion, but not during a shift, no.

Q. As a physician and as a medical director, if you had heard about a staff

member being floated between a COVID unit and a nonCOVID unit, would you believe that was a potential violation of infection control protocol?

A. Again, depends on the circumstances. What we know now is we could certainly have a COVID unit and a nonCOVID unit in proximity with the same registered nurse or LPN taking care of those patients without significant risk because the utilization of infection protocol and proper equipment makes it safe.

Q. So -- and I want to just get your testimony clear here for the record, would it be your testimony that a staffer could in fact staff a COVID and nonCOVID unit on the same shift?

A. In this place and time and what we know, yes.

Q. Going back to March or April of 2020, would the same concept apply?

A. Again, depends how the units -- how the isolation would be set up. It's recommending in that directive not to. So

again, I'm not the nursing director, nor the staffing director, but I hadn't seen floating and I may or may not have even noticed.

Q. As a medical director and an experienced physician, if you were asked whether a nursing staffer could float between a designated COVID unit and a nonCOVID unit on the same shift, would that be something you would approve of or recommend against?

A. If I was asked that question in March, at that time, I would -- depending on the circumstances, I would have, as the directive said, say that it was best to avoid it.

Q. So, let me ask you about hospital admissions. I know we discussed it last time and just to sort of refresh all of our memories. Were you involved at all in the decision to admit patients from the hospital to Fulton Commons during the pandemic?

A. As I stated before, the only time I ever become involved in any of my

facilities for specific patients approval for admissions, is if I'm asked directly by admissions specific medical questions.

I don't recall them ever asking in any facility whether a particular patient could be admitted at that point.

Q. So, it's not every possible hospital admission into Fulton Commons?

A. Certainly not every one, no.

Q. Just for clarity, do you recall being consulted on any specific admissions decision at Fulton Commons during the pandemic?

A. I do not recall specific cases of being asked in Fulton Commons, no.

Q. If you were consulted on an admissions decision, who at Fulton Commons would you consult with?

A. Whoever asked me the question, so that would either be nursing, administration, the admission director or a combination of all.

Q. So that would be either Carol Frawley, Cathie Doyle or Larisa Ronayne?

A. Larisa is not the admissions director.

Q. So that would include Cathie Doyle or Carol Frawley?

A. Correct.

Q. Anyone else?

A. The director of admissions, whoever it was at the time.

Q. Anyone beyond that?

A. Not that I know, no.

Q. As far as you know, who at Fulton Commons made the decision about what floor or unit a new resident would be sent to after admission?

A. Admission and the destination of a particular patient is typically handled between the director of nursing and the admission director.

Q. Is that a process you would be involved in at all?

A. Generally, no.

Q. Do you remember any specific instances at Fulton Commons during the pandemic when you were consulted on the

resident placement?

A. Specific resident placement, no.

Q. So, during the pandemic and after Fulton had designated the COVID unit, were all suspected and presumed COVID hospital admissions sent to the designated unit upon admission?

A. Again, I didn't have specific knowledge of each and every patient that comes in. So, if there was a designated unit, my assumption would be that a particular patient would be sent to that unit.

Q. Do you have recollection of any discussions with anyone at Fulton Commons about admissions to the designated COVID unit?

A. Not specifically.

Q. Do you have any recollection of any sort of those discussions?

A. Generally, as I stated before, when each of these directives came down, it would trigger a conference call of relevant facts of department heads and how that was

going to be instituted based on the directives.

So, my recollection is remembering different conference calls and that would have been discussed during that time.

Q. So any calls you were involved in, would have been turned to more high-level discussions, not on specific granular admission discussions?

A. Correct.

Q. Let's take a quick look at a couple of residents that we discussed in our last meeting. Do you recall -- I know it's been a couple of weeks, but do you recall our discussion last time concerning Resident #7 , he was a hospital admission that ended up being transferred to 1 East on May 1st?

A. Yes.

Q. What about Resident #8 ? He was another hospital admission that ultimately ended up being transferred on to 1 East on May 1st?

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A. I remember the name, yes.

Q. Do you recall from our discussion last time what their COVID statuses were upon admission to Fulton?

A. I believe that they had a history of COVID.

Q. Do you have a good memory? I was going to ask Anne to bring up Exhibit 12 just to refresh, but you are correct. But we will still take a look at Exhibit 12 quickly.

So let's scroll down just a bit, you see Resident #7 on the middle of the first page. And where are they noted on this document as being placed at Fulton --

A. One --

Q. --upon admission?

A. Resident #7 was on 3 West, Resident #8 was on 3 West.

Q. And Resident #7 was in Room [redacted]?

A. Yes.

Q. And Resident #8 was in Room [redacted]?

A. Correct.

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Q. On April 21st, from your recollection -- withdrawn.

From our recollection, on April 21st, did Fulton Commons have a designated COVID unit?

A. I have no specific recollection where their COVID unit was at that time.

Q. From your recollection, would that essentially have been 3 West?

A. Based upon the two patients seen there, it looks like they were admitting patients with COVID history to 3 West.

Again, having COVID-19, whether three weeks ago, three months ago or three days ago, there's a difference as to where you would put them now. So, where they went then, I don't know.

Q. From this document, can you tell what Resident #7 and Resident #8 's course of COVID-19 was at that time?

A. No.

Q. If you had seen this document and had been aware of Resident #7 and Resident #8 's placement at Fulton

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Commons, would this have raised concern for you?

A. Not necessarily, no.

Q. Does this admission of Resident #7 and Resident #8 to 3 West violate infection control guidance?

A. Not specifically, no.

Q. What are you basing that conclusion on?

A. Because on this, I have -- again, I have no knowledge as to when those patients had COVID-19. So again, our understanding now is different than our understanding then.

Cohorting asymptomatic hospital admissions who had COVID in the past and had no more known symptoms in an area would be very different from potentially cohorting patients that were POI, febrile, pneumonia, hypoxemia on a unit. It's a very different population of patients.

Q. If 3 West was not the designated COVID unit at this time, would admitting Resident #7 and Resident #8 to 3 West violate

Fulton's infection protocols and procedures?

A. Not necessarily, as long as they were following their own specific policy. So if their policy was to admit COVID-19 patient who are asymptomatic from the hospital, in theory testing negative, to a specific unit, that as long as they did to that unit, that would be keeping within their infection control because it's their policy.

Q. Let's look back to Exhibit 2 and we're going to look at page 2, bullet five.

Dr. Butchma, if you need us to scroll back up. This is the COVID-19 policy and procedure we discussed last time, but we can absolutely go back and review if you need to do that.

We're going to go to bullet five and I'll read that, "If logistically feasible and will not put other residents and staff at risk of exposure, the facility will cohort confirmed positive residents in the same room or area of a unit as much as possible."

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Does the admission that we're discussion of Resident #8 and Resident #7 , is that consistent with bullet five here?

A. Yes because as I stated before, you're talking about two different populations of patients. A patient that was in the hospital, had COVID, now asymptomatic and potentially -- as I said, I don't recall when facilities were allowed by the Governor to keep COVID status, that would be -- that's very different from the patients you're talking about there.

The patients that had confirmed positive cases, we're talking about POIs and patients that are testing positive and are symptomatic. It's not talking about patients who have a history of it.

You don't have to cohort patients who have the disease. We know now probably 10 days, maybe 7, but certainly you don't have to cohort a patient who has the disease, is asymptomatic, tested negative, there's no medical reason or infection control reason to cohort them specific.

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Q. Let's scroll down, I think, to page 3, to the section that's entitled, "Confirmed COVID unit."

So, I'm going to read that quickly. "One floor of the facility has been designated to care for residents with confirmed COVID-19 admissions. It is the intent of this unit to ensure the safety of all residents and staff."

I guess my question again is, do you find the admission of Resident #7 and Resident #8 to 3 West to be consistent with that policy?

A. It could be, as I said. I can say it again, so a patient who had COVID, was in the hospital, if they're cohorting those patients, with many facilities did, we all do now, if you're cohorting patients what have had known COVID, now asymptomatic, in a particular area for whatever reason, it's different than patients who are actively ill, who are COVID positive and sick.

I can't tell from the paper what

categories they fell in and 3 West could have certainly been used specifically for new hospital admissions who had COVID history or another area could have been used for patients who are symptomatic or patients of suspected cases.

Q. If Resident #7 and Resident #8 had not exhibited the full course of quarantine as we understood it to be at that time, in April of 2020, would their placement on of 3 West concern you?

A. Again, not necessarily. I don't know what 3 West was being used for at that time. If there was -- I said it before, at one point half of 3 East was being used as a possible quarantine area, it's not being used like that anymore.

So, if at that time, 3 West was being used for patients who had had COVID, were asymptomatic and coming from a hospital and admitted, they could have potentially been on 3 West and as long as they was their policy, that would be fine.

Q. And that answer aside, if we just

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look purely at this section of the policy and procedure, would you find the admission of Resident #8 and Resident #7 purely identified on their admission sheet of having a COVID history, would there admission to a unit that was not the COVID-designated unit be problematic, just for this policy and procedure?

A. Again, if there were two different COVID areas, where are they designated? And they were put into a third area, which was not designated for any of those purposes, then yes, you would be outside your policy and procedure.

Q. So, we've been discussion policies and procedures for the last time today. I want to quickly walk through something that we have not discussed yet.

MR. SMITH: I'm going to ask Anne to pull up what will be marked as State's Exhibit 20.

Q. And while that comes up, Dr. Butchma, I will just note that this is a 19-page document. It's compiling several

policies and procedures. So, these are going to be different policies and procedures. We can scroll through, if you'd like or just go specifically to what I was going to discuss.

A. Specific questions are appreciated.

Q. Okay. If we do get into these and you want to see the whole policy and procedure, just let me know and we'll scroll through it and let you read it.

I do want to look at the first -- as you can see it's entitled, "Bioterrorism Pandemic Influenza/Virus," with the "slash virus" being handwritten.

Is this document dates?

A. There is a date on top, it says, "2/26/20."

Q. Do you know who created this document?

A. No.

Q. Do you recall having any role in its creation and revision?

A. Not specifically, but.

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Q. As far as you can tell, did this policy and procedure also apply to COVID-19?

A. It says, "Pandemic Influenza/Virus" and then a notation on the side, somebody initialled and put a date where they added the word "Virus" on 2/26/20, that would apply to the beginning of the Coronavirus pandemic, yes.

Q. Do you recognize by any chance that initial under the date?

A. No.

Q. Let's jump down to the first bullet point. So that's the third bullet point towards the bottom of the page, I'll read it.

It says, "Cohort residents and staff on units with known or suspected cases of pandemic influenza."

Dr. Butchma, does this third bullet point that we just read apply to COVID-19?

A. Globally, yes.

Q. Let's scroll down to the third page, third section from the bottom, it's

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identified as "Resident placement."

So, I will read this as well, "Place residents with influenza in a private or cohort with other residents with influenza."

And again, Dr. Butchma, do you know if this specific directive would apply to COVID-19?

A. As I said before last time, any communicable disease, influenza, another viral pandemic such as this, norovirus, it's a general recommendation, yes.

Q. To drill down on this particular directive, so the idea is either put a resident with suspected or confirmed influenza or virus in a private room or cohort with other residents with that same illness, is that the correct understanding?

A. Right. As I said, Fulton is all either one or two0bedded rooms. So, it would -- it certainly lends itself to cohorting two residents with the same or suspected diagnosis.

Q. And going back to March 2020 and

April 2020, if you were going to cohort a resident with another resident "with influenza", as we see here in the policy and procedure, what stage should those roommates be at in the course of the disease?

A. Going back then?

Q. Correct.

A. As I said, it's very different now and my specific recollection of then would be hazy at best. So, I don't know what would be considered being done. Remember that testing ability was very poor for all facilities, except tertiary hospitals. And so, that specific stage, we didn't have those tools at that time. It was depending upon symptomology, which is erratic and flawed, at best.

Q. At that time, so March 2020, April 2020, if two residents were sharing a room and one resident began displaying symptomology consistent with the understanding of COVID at the time, would the second roommate then also be considered a suspected case?

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A. So back then to the best of my recollection, the roommate would be considered exposed, but facilities were moving patients out of that room that were symptomatic. Whereas, nowadays we would likely leave them together because the exposure risk had already occurred and there's very little point medically to move those patients around.

Q. Would it be fair and accurate to say that at the beginning of the Pandemic, there would have been an effort to separate those two individuals if one of them was starting to present with COVID-19 symptoms?

A. Certainly, there would be -- one patient was asymptomatic and one was symptomatic, you would treat one as an exposure and observe them. Testing supplies weren't there and often times if the other patient was symptomatic, we moved them to another location.

Q. So jumping down to page 11 of this exhibit, this is a policy and procedure titled, "Protocol for Residents with

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Suspected COVID as well as Residents Admitted from Hospital with Confirmed COVID."

Dr. Butchma, as best you can tell, is this document dated?

A. I see no date.

Q. And I know we discussed this last time, but from your experience as a medical director and as a physician, is it best practice to leave policies and procedures undated?

A. As I said, policies and procedures -- when changes are made, such as the previous one, the previous notation of virus with the date and initial. When they're updated, it is general practice to change the date or when it's updated to put a date or initial at the top of the page or by the page, but not specifically. Not all policy and procedures are dated.

Q. As you noted, this policy and procedure we looked at had actually been dated by hand, so that would be sufficient from your experience?

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A. Stating a change, yes.

Q. Do you know who created this specific document we're looking at?

A. No.

Q. Do you recall if you had any role in the creation of this specific document?

A. I don't recall specifically.

Q. We'll scroll down to the second section on this page and this section is titled, "Protocol for Admissions/Readmissions from the Hospital with Confirmed COVID Diagnosis."

So, we'll go down to bullet point, I'll read that, "Any resident who is being admitted or readmitted from a hospital setting will be placed on the designated unit. They are allowed to be cohorted together in the same room and will be placed on isolation precautions. If they are a readmission, they will be transferred back to their unit upon completion of their isolation period."

Do you recall or have any recollection of when this particular

protocol was implemented at Fulton Commons?

A. That specific one? No because, as I said, some form of it has existed in nursing homes for years. The number of days and specifics of it changed from week and month to month. So, specifics to that, no, I don't remember.

Q. So going down to page 13 of this same document. This is the policy and procedure entitled, "COVID Surveillance and Tracking Method."

Again Dr. Butchma, can you tell us if this document is dated?

A. No date there.

Q. And again, do you recall having any involvement in the creation of this document?

A. Not specifically. But again, all the COVID policies and procedures specifically at Fulton Commons were based upon directives from the State and were discussed generally on conference calls. So as far as me seeing something in writing, most of our meetings -- all of our meetings,

in fact, occurred on conference calls. So, I wouldn't have specifically remembered that.

Q. So just looking at this period, from March 2020 until June 2020, what was Fulton's process for tracking COVID in the facility on a more macro level?

A. Tracking in what way?

Q. So, to see COVID appearing or popping up in a unit, COVID moving through the facility, fluctuations in numbers of residents of suspected or confirmed COVID cases, those kinds of fluctuations in COVID cases at Fulton Commons itself?

A. Well, every facility reports on something called the HERDS, which is on the health commerce system. And we've been doing that in every single facility, my recollection, since the end of March, whenever the Governor demanded it.

I do recall the first time was on a Saturday and each facility -- I do not enter the data on that, each facility is required to report that on, I believe, on a

weekly basis on a specific day. And if they don't report their data, they get a friendly phone call, a not so friendly phone call as a reminder that they have to report. And I believe they can get penalized for that.

My only involvement with reporting virtually from the beginning has been if there were a question regarding a patient having expired from COVID because I believe that's one of the -- I know for a fact that's one of the questions on the HERDS report.

Q. So --

A. We were reporting -- everybody's reporting on HERDS.

Q. And my apologies for interrupting there.

Aside from HERDS and your reporting to DOH, did Fulton utilize any internal process for tracking purposes specifically?

A. The internal process at Fulton was conducted to reflect what was going to be reported in HERDS. So, on any daily

basis, the known cases, the suspected cases, staff members that were confirmed or out on furlough, patients that they penalized, staff, those are all -- all the reportable data was kept in each and every facility, including Fulton.

Q. Do you know from your perspective as medical director or a clinical physician at the facility, was there a master tracking tool at Fulton or any sort of master document that collected all that data or were these things kept independently of each other?

A. I would presume that there was, to be able to enter that data into HERDS, but I'm not privy to that in any building.

Q. So, it's accurate to say that you have not seen what could be a cluster tracking tool or a tracking tool specific to COVID at Fulton Commons?

A. No.

Q. So, jumping into the discussion of PPE. From your perspective in your position as the medical director at Fulton,

did Fulton have enough or sufficient PPE in March of 2020?

A. As I stated last time, with full disclosure, I supplied and still supply my own N95s, my own goggles and protective equipment, except for gloves.

And as I stated last time, whenever I needed gloves to go and examine a patient, I did find them on a unit and they were proximal. And when I needed alcohol -- hand sanitizer, it was available on multiple wall units. There was soap and water available.

And when surgical masks were the initial adequate recommendation from the CDC, my recollection is they were available at the front lobby where the staff members were signing in.

Q. I recall you stated you sort of supplied your own PPE, am I correct in understanding that that was not out of necessity, but out of some other reason?

A. That was a good friend that was supplying it to me. It was easier for me to

carry my equipment -- my own equipment from facility to facility and being responsible for myself and also not depending on the facilities to supply me. I'm an independent employee.

Q. If you had needed PPE at Fulton Commons in March of 2020, could you have gotten it?

A. My recollection, anything -- as I said, anything I needed was there. If I had needed something specific, such as a gown, I recall gowns being available on the units and otherwise, I would have gone to the director of nursing and asked her.

Q. Did you ever have to do that, go to the director of nursing and ask for PPE?

A. No.

Q. Do you know who was responsible at Fulton for procuring PPE?

A. No.

Q. How did Fulton's supply of PPE in March of 2020 compare to the other facilities that you work at?

A. I have no knowledge of that. But

I do know on the HERDS report currently, but I don't know when that started, every facility is required to report how many days supply of PPE they have, gowns, masks, et cetera and they're required a certain amount of days supply. Although, I don't know off the top of my head what those are and I don't know when it started.

Q. Based on your own -- go ahead, sorry.

Based on your own experiences at Fulton Commons in March of 2020, did you notice Fulton having less PPE than the other facilities that you worked at? More? The same? Something else?

A. I would say the same.

Q. Did this change at all as the pandemic intensified from March into April?

A. I can't say the specific date, but Fulton, as well as other facilities, Fulton had -- as the recommendations evolved and the availability of protective equipment changed, so when surgical masks became required and the norm, then there were more

surgical masks around. For practicality, that they were required, we always had to wear them, so there had to be more availability.

So, it reflected the CDC recommendations for protective equipment, that was universal.

Q. Was there ever a time during the pandemic, especially in the pandemic, they were low on PPE supply?

A. I would have had no knowledge as to what their supply was. And as I said, my only knowledge would have been if somebody had indicated that to me, which I don't recall anybody doing. Or if I sought out some equipment and it wasn't there, which I know that didn't happen during the pandemic.

Q. Let's take that approach. So, just as a physician practicing on the unit, did you ever notice a time when you saw from that perspective that Fulton was running low on PPE?

A. Again, anything I was looking for was there. So, my perspective it was

available on the unit. I never saw that there wasn't -- that there wasn't gloves or masks.

Q. From your perspective, both as medical director and a physician at Fulton, did any Fulton staff, where nurses, doctors, anyone, ever complain to you at any point during the pandemic that they did not have sufficient PPE to do their jobs?

A. Physicians and medical staff definitely, no. I do not recall any staff member coming up to me and complaining specifically.

Q. So, is it fair to say that none of the doctors, nurses, nurse practitioners or PAs that you supervise ever came to you and complained to you about not having sufficient PPE?

A. I don't supervise the nursing staff. But as far as the medical staff, they never complained to me or indicated that there was inadequate equipment.

And as far as the nursing staff, nobody came up to me as I recall and said

there was inadequate PPE.

Q. In March of 2020, did Fulton test any residents that were presumed to be COVID positive to determine if they were?

A. As I stated last time, in March, I don't recall any of our facilities having any testing equipment available. That evolved with time and it was a very, very limited -- when it did occur, it was a very limited supply that the buildings were given.

Q. And just for my own clarity, was Fulton testing residents in March of 2020?

A. Again, nobody had testing supplies. As I said last time, the only way we knew if a patient tested positive was if they went out to the hospital or a 911 call for another reason and then they were tested in the hospital.

We had no testing supplies. None of my nursing facilities were given testing supplies or had testing abilities from outside laboratories from New York State or from the CDC, specifically only in

hospitals. And we were told at all costs, do not transfer patients to the hospital unless it was extreme.

Q. You might have preempted my next question there, but the lack of testing at Fulton was consistent across the other facilities that you worked at during the pandemic, correct?

A. Hundred percent.

Q. As far as you know, was Fulton making any efforts in March to acquire testing kits?

A. To my knowledge, they were attempting to get testing supplies. But again, from a practical level, nobody had testing supplies available and more importantly, the laboratories, to be able to process the testing, even if you could swab a patient, you would need the transport material, which was -- everybody saw on the news was in tremendous shortage and you needed a lab to process it. But the labs weren't available and they were specifically processing primarily for the hospitals.

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So, I'm sure there was an attempt to get that testing supplies, but that didn't happen until down the road.

Q. Were you involved at all in any attempts in March of 2020 by Fulton Commons to acquire testing supplies?

A. That wouldn't have been something that I would have been involved in.

Q. Do you know who would have been involved with that at Fulton Commons?

A. I would assume administration.

Q. By that you mean Cathie Doyle?

A. Cathie Doyle.

Q. Or Cathie Dole and Steve Weiss?

A. Cathie would have been involved.

Q. Did the approach to testing at Fulton change at all in April of 2020?

A. Nobody's testing and specific Fulton, we didn't have testing material that I recall until probably until May, in May. So again, testing supplies, not only the ability to test or having a nasal swab, et cetera, but having somewhere to send it.

Fulton did not have the ability,

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I don't know how many months later, until where simultaneously in other buildings became more available to the different laboratories.

Q. So would it be fair, as far as you know, no Fulton residents were tested in April?

A. To my knowledge -- again, in the facility, no. If they were tested if would have been for some reason they went out to the hospital for a different reason or for respiratory distress and they're tested in the ER, which was fairly commonplace, which was my understanding back then.

Q. Is it fair to say in April of 2020 in regards to testing, it was consistent across your facilities?

A. Yes, we were told to presume that any symptomatic patient had COVID, to conduct ourselves as such and that there was no specific reason to seek out testing if they had symptomology.

Q. Do you know if any of your facilities were testing residents?

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A. I don't believe so.

Q. Do you know if anyone from administration at Fulton Commons was making efforts to acquire testing?

A. Specifically, I don't remember. And I wouldn't likely be included on that.

Q. In regards to testing, did things change at all at Fulton Commons in May of 2020?

A. As I said, I don't recall the specific month or date, but ultimately testing supplies became more available. I don't remember exactly when staff or myself were required to get tested, first twice weekly and then once weekly and now twice weekly to the current day.

Once that was occurring, that was roughly about the time that we had -- there was an increase in testing supplies.

Q. Do you have any specific recollection of residents at Fulton Commons being tested in May of 2020?

A. Specifically? No.

Q. Do you have any recollection,

even generally, of residents at Fulton Commons being tested in May?

A. No.

Q. Do you know if any of your other facilities were testing their residents in May of 2020?

A. If they were, it was just starting up. As I said, I can't swear to the date, the month or the date. I know by early summer, like June, it was more available, but February, definitely no, March, no, April, no. It may have been late May, but I don't remember that testing policy.

But right around that same vicinity that the State put out what the preferred labs were. Again, it was taking five to seven days, it still does in some cases and it was about that same time that there was testing supplies, carrier supplies and then the testing, the labs that were able to test.

Q. From your perspective as a physician and a medical director, would

testing during the pandemic have helped you do your job?

A. Well, if we had had testing materials and the ability to get tests back quickly, which we do in some fashion now, it would have made our job a bit easier because we were relying upon the fact of symptoms that really didn't -- weren't consistent. We were told that everybody's going to have a fever and it turned out that wasn't exactly the case.

So, would it have made our lives easier? Hypothetically, yes. Were we supplied with that? No.

Q. How would it have furthered your efforts as a physician and medical director to protect your residents?

A. It would have helped in the sense -- like we know, an asymptomatic carrier to try to contain outbreaks. It's much more -- at Fulton we test -- everybody's tested routinely. I believe it's weekly. So you can pick up the asymptomatic carrier and then isolate them.

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Again, we didn't have that ability a year ago and if we'd had it, it would have allowed -- it wouldn't have helped us with treatment or survival because there was no treatment. But it would have certainly helped in being able to identify and contain.

Q. From March 2020 to June 2020, do you recall having discussions with anyone at Fulton Commons about testing?

A. Yes.

Q. Who did you discuss testing with during that time?

A. Early on with Cathie and Carol on a conference Call.

Q. Do you remember what that conference call was that?

A. Yes, it was when we were basically told from the CDC and New York State that even if we had testing supplies, that rather than seek out testing for patients, to presume that anybody that had symptomology, primarily a fever, actually had COVID and should be considered as such

and conduct ourselves as far as isolating them.

Q. Do you recall when that conversation happened?

A. No, specifically no, but it would have corresponded with the directive with the recommendation from New York State, probably in late March.

Q. And you had said just now that Cathie and Carol were involved, correct?

A. That was on the conference call with Cathie and Carol, yes.

Q. So, aside from the conversation we just discussed, were there any other discussions with anyone else at Fulton Commons about testing?

A. Not that I recall, no, not at that point.

Q. By that what do you mean in the early stage or something else?

A. Early stage.

Q. So were there later conversations about testing at Fulton?

A. As I said, once it became more

ubiquitous throughout the nursing homes, nursing homes to be able to have testing supplies, then we had discussions later on about testing staff and based on the requirements and which patients to test, don't recall what month or date that was.

Q. Would it be safe to assume that it was April of 2020?

A. Definitely after April.

Q. Would it have been potentially May of 2020 or sometime after?

A. I don't recall.

Q. Was anyone else present for those conversations, that you recall, aside from Cathie Doyle and Carol Frawley?

A. All of our meetings typically were by phone, so many discussions would have involved Carol Frawley and myself and would have done by phone. And I don't recall their being more than the three of us ever being on a call.

Q. So it's safe to assume that neither Steve Weiss or Fulton ownership was present on those calls?

O. Butchma, M.D.

A. Not that I was ever told.

Q. Did you ever suggest to anyone at Fulton Commons that residents should be tested?

A. I think as soon as the testing supplies became more available. Then again, that discussion was -- not that somebody should specifically be tested, but which patients were we going to use the testing supplies for. Those discussions I remember.

Q. Were those discussions with Cathie Doyle and Carol Frawley?

A. If I had specific discussions there, it would have been with the two of them, yeah.

Q. Would you have had these discussions with anyone at Fulton?

A. No.

Q. In these discussions, do you recall what Cathie or Carol's response was to your suggestion?

A. No.

Q. Outside of your own facilities, the facilities that you serve as medical

director, do you know if those facilities, if any of them were testing in April of 2020?

A. I don't recall that any of them -- the nursing homes had testing supplies, certainly not any volume of them. So, I don't know. If there was anybody testing that early, I don't know that.

Q. When is the earliest time that you became aware of other facilities on Long Island testing?

A. I believe at some point in May, Care Right was discussing which patients to test based on the limited testing supplies they had.

Q. Are those calls you were involved or this is something you sort of heard through the grapevine?

A. As I said last time, I was in a weekly conference call when I was working for Care Right and it usually on a Friday.

Q. Did you ever speak with anyone at the Department of Health about testing Fulton's residents?

A. No.

Q. Do you know if DOH ever offered to assist with testing Fulton's residents?

A. That came -- that didn't come -- that came to all facilities at one point, but I don't know what month that was, where the Department of Health availed themselves to facilities and came in and actually brought in personnel and swabbed.

I don't know what month that was, but that was every facility, not just Fulton Commons.

Q. Let's take a look at what will be marked as State's Exhibit 22.

Dr. Butchma, do you recognize this e-mail? We can scroll to the bottom of this exchange to the first e-mail.

Does this look to you like an e-mail chain?

A. It looks like an e-mail chain.

Q. We will go to the bottom and we'll work our way through and see if this refreshes your recollection at all.

This appears to be an e-mail from

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a Department of Health representative, correct?

A. Correct.

Q. And if we slowly scroll up, can you tell what this Department of Health representative is referring to?

And you can tell us to stop and go somewhere else if you need to read a different portion.

A. So, this was about the time at some point where the Department of Health was offering a swab team and testing for residents in the facility.

Q. Do you remember seeing this e-mail?

A. I don't recall it.

Q. But you remember this offer from DOH?

A. I remember it, as I stated, for each and every building.

Q. Okay, let's scroll a little bit more. So, I want to read this section here. So, this an e-mail from Cathie Doyle to Carol Frawley on May 28th, correct?

O. Butchma, M.D.

A. Yes.

Q. And the e-mail says, "Hi Marie - my name is Cathie Doyle, administrator at Fulton Commons. Can you please advise as to whether testing of residents in New York State is required at this time?"

If you can scroll up just a bit. So, as you can see here Marie, the Department of Health representative responds to Cathie Doyle, "Yes, testing of all residents who were never previously positive for COVID-19 is required."

MR. SMITH: If we can scroll up a bit more.

Keep scrolling.

Q. So we just scrolled to where Cathie Doyle responded to Marie from the Department of Health where Mrs. Doyle asked of antibody testing is sufficient to satisfy this testing requirement, does that represent what you saw, Dr. Butchma?

A. Yes.

MR. SMITH: So we can keep scrolling up, Anne.

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And we can keep going.

Q. So, towards the bottom of this page, we see an e-mail where Cathie Doyle writes, "This woman is telling me that this is 'required,' please advise."

And Dr. Butchma, it would appear that you respond to that e-mail with, "That is what I'm hearing."

Do you understand why Mrs. Doyle appeared to have been pushing back against the Department of Health's requirement for testing or do you understand it differently?

A. Cathie will always require to see the regulation or the Department directive. So, that's not unusual in 25 years for her to ask, "Where's the order?" I don't take it as her pushing back. She was trying to clarify if it was a recommendation or a requirement. That's how I read it.

Q. Do you recall how -- in the e-mail, towards the end, it appears the last response is from you and you appear to be referring to other facilities testing, correct?

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A. Correct.

Q. Do you remember how this exchange resolved with Mrs. Doyle?

A. I don't recall -- as I said, I recall facilities having teams came in over a period of time. As I stated, following early summer or the spring and that appears to be correct. They obviously didn't do every facility in one day, they were stretched over a period of time.

So, I don't remember when they came into Fulton or for that matter, any other facility.

Q. Along that lines, do you have any recollection of DOH coming to Fulton to test residents around this time?

A. Specifically, no. But as I said, I don't remember them specifically coming into any facility, but I know they did.

Q. And they came to Fulton?

A. Correct.

Q. From your perspective, would there have been any downside to having DOH test Fulton's residents?

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A. Well, the first test we had available was the antibody test and I knew once that became available through our facility lab, Cathie had everybody -- that I know of, anybody that agreed, to have them have an antibody test.

We are all -- I think we were all hopeful in the building that the antibody test would be worthwhile clinically, but as the DOH person pointed out, they were looking to do a PCR test. So again, our knowledge of the testing supply and what was available was -- wasn't so -- was kind of limited.

And in retrospect, going into every facility, testing every resident, it just a snapshot in time. So, you can potentially catch asymptomatic positive patients, but of course, that didn't help you a week later when you would have 20 more patients with it.

Q. You sort of hinted at my next question, were Fulton staff ever tested? Were the staff at Fulton Commons ever

tested?

A. Staff -- as I said before, when staff testing was mandated by New York State. We had -- I forget how many days to institute it. I gave an inservice to the staff, the nursing staff, upper nursing staff at Fulton, supervisors and Cathie and Carol were there, as to how to technically swab somebody with a swab up their nose.

So, we started it the same as every other building because it had to be reported on the HERDS or there was a financial penalty.

Q. Do you recall when testing staffers began at Fulton?

A. No.

Q. Would it be safe to assume this was May 2020 or was it some time after?

A. When the Governor ordered it, that's when we all started.

Q. Would it about accurate to say that Fulton Commons instituted resident testing within days of that directive or something else?

O. Butchma, M.D.

A. Resident or staff?

Q. Sorry, staff testing within days of that directive?

A. We had "X" number of days. I remember you had to start the next week. You had four, five days to have a policy and basically procedure, something set up with a lab to handle the specimen. You had about three to five days to start.

And everybody, in New York State, as far as I know didn't get any leeway as to when to start. So, the same day.

Q. Was that consistent across your other facilities?

A. Again, yes.

Q. Did testing of residents at Fulton Commons start around the same time?

A. That I don't recall.

Q. If staff were being tested, would it not make sense to also test residents if the testing kits were available?

A. Potentially, yes.

Q. Are you aware of the vaccination status of Fulton's residents as you sit here

today?

A. Vaccination status? I don't know what that means.

Q. Correct. Are residents be vaccinated?

A. They had -- anecdotally, I know they had a tremendous turnout for both staff and residents when it was -- I believe it was -- I think it was in the beginning of January.

Q. From your perspective as medical director, do you know if all residents at Fulton had been vaccinated or some other percentage?

A. I would have no idea and certainly, there were -- there's always those that refuse. So I would say it likely would not have been a hundred percent.

Q. Okay. Just taking your patients that you deal with directly, what would you estimate is their vaccination percentage?

A. I would say on my unit, probably over 90 percent.

Q. I know we're only dealing with

estimates, but the 10 percent that are not vaccinated, is that a result of them refusing the vaccination or something else?

A. Either family refusing, they can't make decisions or the patient them self.

Q. Do you know what vaccines are being provided at Fulton Commons?

A. I believe -- at that time I believe everything was Pfizer, from December to January.

Q. Has that changed since January?

A. I have no idea when the next date are or -- that would have been handled through nursing.

Q. And this vaccination percentage, you had mentioned 90 percent among your residents, as a rough estimate of course, is that consistent with you experience at your other facilities?

A. Probably as good or better.

Q. Do you know how Fulton procured its dosages of the vaccine?

A. I think the same as everybody

else. When the applications came out, I think pretty much in September, I know that the facilities all asked for my identification numbers because they need the medical director to send in the application.

And then we were assigned on whether it was going to be CVS or Walgreens or whatever, who was going to coordinate and come in. What specific date, the earliest was a couple of days before I was vaccinated. So, that was 12/23, so the earlier part of that week was when the first time it started after being approved the previous week.

And then three weeks later they would come back and give the second vaccine.

Q. Dr. Butchma, does Fulton Commons offer the vaccine to everyone inhouse or is it certain residents? I mean, long term residents versus a short term rehab admission, what is your understanding of that protocol, if there is one?

A. I think everybody -- it's tricky, logistically, but what I believe they do

consistent with other facilities, which is if you were a short term patient and you are leaving, you are given a date and time when the next shot would be given and to return to the facility to do that.

Now things have changed a little bit as it's more available, but that was pretty much how everybody was doing it back in December and January.

So, every resident and every staff member was offered.

Q. If you were a short term admission at Fulton Commons, you would at least receive the first dose while you were on-site and that would be available to you?

A. Correct.

Q. Is that consistent across your other facilities?

A. Yes.

Q. So last time we spoke we talked about the concept of a person under investigation. I believe you also referred to as person of interest. So, if it works for you, I will use "PUI" or "POI"

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interchangeably, is that okay?

A. Correct.

Q. As the pandemic arrived in March of 2020, what criteria was used at Fulton to determine if a resident was a PUI or POI or designates them as a PUI or POI?

A. As we were recommended that anybody with a fever and kind of however you determine that some facilities change in temperature or baseline temperature was pretty much, I think if you had a temperature of hundred or more, you were potentially a PUI and again, not having another source for that fever.

So, if you had a urinary tract infection and a fever and it's diagnosed, you weren't a POI.

Q. Aside from a fever, were there any other criteria used to designate someone as a PUI or POI?

A. Just respiratory symptoms and a fever.

Q. And by respiratory symptoms, are you referring to cough, shortness of breath,

that sort of thing?

A. Yes.

Q. Anything beyond cough or shortness of breath?

A. Early on, no.

Q. Did the criteria for the PUI or POI change over time?

A. Yes.

Q. Can you describe that?

A. As I said last time, we learned later on that a lot of our population in nursing facilities presented atypically. So, gastrointestinal symptoms, diarrhea, vomiting, anorexia. So, if they stopped -- they would just abruptly stop eating.

That was kind of more of a typical -- a more common presentation we found out after the fact.

Q. Just to expand on that, when did that happen? When were the symptoms list expanded?

A. That changed -- that was fluid and a little less so now, but it continues to be fluid as more information came out.

So, I would say in March it was fever, congestion, hypoxemia. And then as April, May and June progressed, anorexia, diarrhea and gastrointestinal symptoms.

Q. And how at Fulton Commons, how did you and any other clinicians identify somebody as a PUI or POI?

A. So, the facility ramped up their vital signs checks on the units and they would report anybody that had a low grade or a whole grade temperature with cough and congestion or other symptoms to their specific attending physician.

Q. And would that designation had been reported or recorded in the resident's medical record?

A. Typically any fever or change in condition, the nurse would usually put a notation in the nursing note and then once the physician is told that their patient has an acute change, typically they would go and examine and then write a progress note.

Q. In March of 2020, as far as you recall, did Fulton have a specific protocol

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for treatment of PUIs or POIs?

A. In March? No.

Q. What about in April?

A. As time progressed, as I said before, there were no known treatments for COVID, even now it's limited. So, I don't recall exactly when, but some treatment protocols started making the rounds.

And as I said, the American Medical Directors Association circulated one such. They were typically very similar to now, vitamins, IV fluids and antibiotics, particularly antibiotics if the patient had pneumonia.

Q. Do you recall when Fulton had its first PUI or POI?

A. No.

Q. What is the first time -- withdrawn.

When is your earliest recollection of dealing with a PUI or POI at Fulton Commons?

A. Well, as I stated, on my unit I had an early patient that expired from one

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cause or another within a 72-hour period.

After that time, which was probably mid March or late March, I don't recall having a PUI on my unit.

Q. Do you recall your first resident that was a PUI?

A. Not specifically, no.

Q. Who was the first resident you treated that you recall being designated as a PUI?

A. As I said, I don't recall any. I had acute illness on my unit, most of which were explained from a variety of either urinary tract infections or pneumonia and they were treated as such. So again, we didn't have testing supplies for patients. Some of them improved, some of them rapidly declined and expired very quickly.

So again, with the lack of information and knowledge we had at that time, it was so rapid. You didn't even have time to consider them as being a PUI.

Q. So is it your testimony that those residents, those deaths that you had

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on your unit, those individuals were not identified as PUI?

A. I don't recall them being identified as such. But as I said, they had -- they had -- they typically had a reason -- a diagnosis of a urinary tract infection, which again, they wouldn't have been a PUI.

Q. So is it fair to say that if there was any other potentially contributing factor or underlying condition would disqualify someone as being a PUI?

A. Correct. If you have a fever and you have a cough and it's not related, we know now you can have pneumonia and still have COVID, it's just a COVID-related pneumonia, secondary bacterial pneumonia.

But if you have a patient with pus in their urine and you're giving them IV antibiotics for it, that's the source of their fever, that wouldn't be consistent. With COVID patients could still get fevers.

Again, in retrospect, the patients that we didn't know about, that the symptomatology was not eating, stopped

eating and then 24 hours later I died, in retrospect, yes, that was most likely a COVID patient, but we didn't have that knowledge back then.

So, if I had a couple of those, which I did have, they wouldn't have been considered a COVID patient. They would have gotten IV fluids and treated accordingly and I'd think maybe they had something else going on.

Q. Just to make sure I understand, I want to give you a hypothetical. If you had a patient who did have a urinary tract infection and a fever, but was also simultaneously deoxygenating or appeared to have hypoxia, would those two factors be enough to keep them off the PUI list?

A. Well, in a narrow spectrum they could coincidentally have COVID and have a urinary tract infection. So, they'd be septic and have hypoxemia related to the urinary tract infection, that's possible too.

Q. So is it fair to say that for

someone to qualify as a PUI, they would be to be a contained -- or I guess, an uncomplicated diagnosis of COVID -- suspected COVID?

A. At that time, there has to be -- it was basically a fever with or without -- without congestion, hypoxemia, but without another source -- without another known source.

Q. Dr. Butchma, if a resident in a double room was identified as a PUI or POI, was the protocol to immediately remove that person from that room or something else?

A. I don't specifically remember. I know, as I stated before, it was not uncommon at that time if you had a symptomatic and an asymptomatic to move the symptomatic person out and then observe the asymptomatic person to see if they develop the symptomology. We don't generally do that anymore.

Q. As far as you know, was a tracking tool created at Fulton to keep track and monitor?

A. I don't specifically remember. I know most places were.

Q. Did your other facilities, did they have a tracking tool?

A. Well, as I said before, everybody had to report on HERDS. So, as soon as that happened, there was generally some sort of a list being kept. Again, of who died, who died of death of COVID, who died of something else, staff members and also PUIs.

Q. I guess what I'm trying driving at, are you familiar with the concept or the idea of a line listing?

A. Yes.

Q. Would any of your facilities track something like a PUI?

A. They could.

Q. Do you know if something like a line listing was utilized at Fulton Commons during the pandemic?

A. Not specifically, no.

Q. When you say, "Not specifically," what do you mean?

A. It means I didn't see a line

listing that I recall, so I couldn't say that it was used in that form. Some did, but it wasn't an essential tool that we used.

Q. So then is it fair to say that you had never seen a line listing at Fulton Commons used for COVID purposes?

A. For that purpose, no.

Q. Do you know if any of your other facilities used line listings to track COVID or PUIs during the pandemic?

A. A couple did, but it became so fast moving with reporting to HERDS, I think a lot of facilities chose another path.

Q. If you had come into Fulton Commons in May of 2020, let's say, would there have been a single document you could have accessed to see the PUIs in the building at that time? A realtime snapshot of PUIs at Fulton Commons?

A. Not that I recall. If there was, not that I recall.

Q. Would a took like that, like the one I'm describing, have been helpful to you

for your practice at Fulton Commons?

A. For me specifically, no.

Q. Do you think it could have been helpful to staff or other clinical staff at Fulton Commons?

A. I think potentially it could be beneficial.

Q. It would appear, from my perspective, to allow a quick snapshot of where COVID is in the building or where PUIs are in the building and the status of those individuals, would that be your correct understanding?

A. Yes, each individual unit would have a 24-Hour Report, the nursing report. Likely they would have a list of febrile patients or a list of similar symptomatic patients.

Q. Do you know if any facilities -- the facilities that you worked for as a medical director, used a line listing at any point during the pandemic?

A. Again, not that I recall specifically. Line listings are very useful

in a short term infection. So, you have an outbreak of norovirus or influenza. It's useful.

In a long term pandemic, we're all operating in a different thing. I think line listings kind of became a little clumsy, probably that's why they weren't specifically used in some places.

Q. When you say, "Clumsy," expand on that idea for me?

A. Again, for a short term infection and an isolated area for a week or two, is very different from tracking something wreak to week, reporting it on a central location like HERDS and trying to keep up with all that data. Probably a line listing --

A line list is best for infection control data, if you want to keep statistics. But the reporting that we were required to do, probably didn't lend itself very well.

Q. So specifically to your internal sort of recordkeeping, then keeping a realtime snapshot available of the disease's

presence or progression in a facility, a line listing would assist on that front?

A. If there's an outbreak, that's when you use a line listing. Like I said before, if there's the norovirus and diarrhea and vomiting and then there's a line listing.

And then if it's designated as an outbreak, then that's reported to the Department of Health that we have an outbreak of a diarrhea illness. And typically one of their infectious disease people or epidemiologist will get back to you to make recommendations on how to conduct that.

So, a lot of times, that's how a line listing is used in a facility.

Q. At any time during the pandemic, was testing of PUIs ever discussed?

A. At any time?

Q. Correct.

A. As I said, early on there was no testing supplies. So, when we had the discussion, which I mentioned before, it was

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-- I do specifically remember that conversation with Cathie and Carol that the directive came down and said there's really -- you know, there's a flaw to these supplies and in any event, if you have a patient that has symptoms and suspecting COVID, then treat them as such and testing is not something that you necessarily have to seek out.

And again, on a practical level, it wasn't available. So, at least through that period where we saw in the end of May, early June, where the Department of Health decided they were going to come and offer and provide swabbing and PCR, that was probably about the time that there was significant availability.

We talked about end of March, April, May, at least two months.

Q. So is it fair to say PUIs came online around the same time as the widespread testing of other residents?

A. That's correct.

Q. So, it sounds like from our

conversations today and last time, that you are at least relatively familiar with Department of Health's HERDS system?

A. Yes.

Q. And just for the record, that's the Health Emergency Response Data System, correct?

A. Correct.

Q. Have you ever had training on HERDS reporting or usage?

A. As I said before, I'm not responsible for doing the reporting in any facility, that's data entry and generally either by the director of nursing or the administrator.

Q. So, it's safe to assume that you are do not participate in the HERDS reporting at Fulton?

A. Correct.

Q. As far as you know, what kind of information does HERDS collect via -- withdrawn.

As far as you know, what kind of information does DOH collect through the

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HERDS interface?

A. As I said a few times before, the staff -- the number of staff positives, whose been furloughed because they're positive, how many patients are positive, that's and deaths. Total -- I believe total deaths and deaths related to COVID.

Q. Do you know if the HERDS interface requests information on presumed -- number of presumed cases?

A. Patients of interest or infected cases, yes, I believe so.

Q. So HERDS would be for both confirmed and presumed COVID, correct?

A. Suspected -- or early on it was suspected, I believe, because we didn't have testing. Time has gone and we have testing, so now I believe it's confirmed tests.

On a practical level now, if you have a suspected COVID patient, you swab them and they're negative, there would be very little to report. There would be no reason to report them as suspected because you have the negative testing confirmed.

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So it's change -- I believe it's changed. But I don't specifically do the data entry for it and I only get involved if I'm asked a specific question about a specific patient.

Q. Did HERDS also report on the number of COVID deaths that occurred outside of the facility?

A. I know that that has changed over time. I don't know specifically what the rules are, if the hospital's reporting it versus the nursing facility, how many days they had to have been out, I don't know what the protocol is to that.

Q. And from your perspective as a medical director, why does DOH collect outbreak data like this?

A. Why? Because we're in a pandemic and the collection of data, it should be to assist the epidemiologist and the CDC is collecting data knowing more about the outbreak, which region and to try to contain those in a better fashion.

Q. I believe you may have answered

this for me, but just for my own clarity, who at Fulton has primary responsibility for managing reporting to HERDS?

A. I don't know specifically. Typically either the director of nursing, the administrator, either one or the other or both.

Q. So, we've made clear that you did you not actually submit a report or do reporting to HERDS for Fulton Commons, but did you assist in the compilation of data, preparation of data or report for any of that sort of prefatory work?

A. As I said last time, I did -- during that time period where we had multiple deaths at Fulton. So ranging between March until June, I was doing a blind chart review of every death in the facility and then noting on each one whether it was a nonCOVID, a possible COVID or a definite COVID based on the medical chart review.

And then I give that data to Carol Frawley and they had -- they had the

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information to compare it to that they had reported to her. That would correspond to the infection control surveys.

And then I would discuss, depending on how many patients -- the deaths that the Department of Health had a question on, I had several discussions with surveyors as to why a patient -- a death had been reported as or typically not as a COVID death and why.

Q. From your perspective and as far as you know, did Fulton's approach to reporting data or information to DOH change at all over the course of the pandemic?

A. To my knowledge, it's always been the same. But again, I don't know -- I'm assuming that the questions HERDS asked has changed somewhat over time. So, it's always based upon what would be required to be reported.

Q. And you mentioned before, I believe, that you were approached by DOH to review pertinent resident deaths at Fulton; is that correct?

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A. I was called, at least on two occasions, by a surveyor, who had come in for an infection control survey to review the deaths at that time and they wanted to review selected amounts of deaths to determine if they had not been reported as COVID death related and what was my professional opinion regarding that.

Q. Let me show you what will be marked as State's Exhibit 23.

Do you recall receiving this e-mail from Mrs. Doyle?

A. Yes.

Q. Just for the record, this is an e-mail dated May 14, 2020 from Mrs. Doyle to yourself, correct?

A. Yes.

Q. And it's titled, "DOH Record Review Request"?

A. Yes.

Q. Is this the request that you were just describing?

A. Yes.

Q. What is your recollection of the

context of this request?

A. The context? It's not an usual request that the Department of Health wants to speak to the medical director about -- could be a myriad of topics. Surveyors come in for all different reasons. So, it's a regular day at the office. It's just a different topic.

I know Usha. She's a surveyor. She's a dietician by training. I've dealt with her over the past 10/15 years. We had a phone conversation. We discussed the patients that she had question on. I gave her my opinion professionally and I don't know specifically if there was any outcome from that, but as long as she was satisfied with that discussion.

Q. Is it your recollection that this request from DOH was to reevaluate whether these deaths had been reported as a COVID death or should have been reported as a COVID death?

A. That's what I said before, several times.

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Q. Okay.

A. All those infection control surveys, the questions would come out and they would say, "Why is this reported as a nonCOVID, why isn't this reported as a COVID death?"

Q. Did you undertake this specific review requested by DOH?

A. I had -- since -- when I had those requests, they would give me the names of the patients. I would re-review the chart for the second, third, sometimes fourth time, make any notations or ideally sit and return the phone call with the chart in front of me.

Q. Would you get information aside from the chart to complete this review?

A. No, I never had any knowledge from -- as I said, reviewing death originally, I never had any knowledge of how it was reported on HERDS. I was never told by either Cathie or Carol how it was actually reported. I was only asked to review typically of other physician's

patients and make a notation of what my opinion was.

Q. And I know I'm asking you to remember back to May, so it's been a while, but do you remember what your determination was specific to this request? And by that I mean, was there any COVID statuses changed for any of the residents from that request?

A. I don't believe so. I know one of those patients was mine and she was 96 years old with three terminal conditions. So, that was a very, very short conversation regarding that patient, but I don't remember the details.

Q. If I'm understanding correctly, your patient's death was not changed after that conversation?

A. That is correct.

Q. It sounds like there were other reviews like this one or is this a single sort of solitary review of this type?

A. As the deaths were occurring in the facility I was reviewing monthly. So March, April, May, I believe June also and

then I remember going back to that particular -- to those particular ones, going back and re-reviewing about 45 or 50 charts during one particular date.

So, it was on several occasions that I did chart review.

Q. After this particular DOH survey in 2020, did your approach to reporting deaths at Fulton change at all?

A. My approach of reporting deaths? I don't report deaths.

Q. Did your approach to handling death reporting at Fulton chance at all after this exchange?

A. So, as a physician I'm responsible for the death certificates on my patients or if another physician requests, as a courtesy, I fill out a death certificate for them. But I don't have specific responsibilities in determining or reporting causes of death.

But I was, like I said, several times asked to review and re-review those charts of other physicians and give my

opinion professionally.

Q. With respect to death certification, did your approach to that change at all after your May 2020 review?

A. What's the first part of your question?

Q. With respect to death certification, did your approach to that function of your job change after this May 2020 review?

A. No because I always report as accurately as possible the patient's cause of death in the death certificate. It's a legal document. I have always reported what I determined professionally was the cause of death.

Q. As far as you know, and this is a general question about recordkeeping, was anyone at Fulton ever asked or directed to change or alter medical records?

A. To my knowledge, no.

Q. Did anyone ever come to you and explain or relay to you that they had been asked to alter or change medical recorded?

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A. In my experience there, no.

Q. Do you know how many, off the top of your head -- Dr. Butchma, to the best of your recollection, do you recall how many COVID presumed or COVID confirmed Fulton residents died over the course of the pandemic?

A. No, I don't know specifics, no.

Q. Without getting into a specific number, do you know if any of the individuals -- the residents at Fulton who died were transferred to the hospital prior to their death?

A. As I said, the one patient who I treated early on, she had a urinary tract infection or pneumonia and then she stopped eating. I relayed to it last time.

The family came in. One of the sons came in on a compassionate visit. I spoke to the son three times. He was a former New York City police officer. I told him that there was nothing more I could really do for her. We spoke about a transfer to the hospital. I said there's

only very little that could be done for her.

In any event, we spoke about the possibility of COVID as a diagnosis. We did not have testing ability at that time. Family came to visit for -- to be with her when she died. One of the family members opted to call 911. Patient was transferred to the hospital.

Was swabbed in the emergency room, typical by that time, swab tested positive for COVID. She expired, I don't know specifically, but within a short period of time after that.

So, I don't know if she had COVID early on or if she was just a swab positive by then.

Q. How long had this resident specifically had the UTI?

A. She was sick over about a two-week period. She was not in great health. She had multiple comorbid conditions and treated with IV antibiotics, IV fluids and she -- as I told her son, she improved a bit, but basically never ever

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resumed eating and drinking. And all I could really offer was IV fluids by that time.

Q. Aside from this resident that we're discussing, were any other residents transferred to the hospital where they died?

A. Not that I recall, not on my unit. I don't have a specific recollection of others.

Q. Do you recall ever hearing from any of the other doctors or nurse practitioners or PAs about any of their residents being transferred out to the hospital before they died?

A. Not specifically, no. It was a very business time though.

Q. Did you ever discourage the transfer of residents -- as the medical director of many facilities, did you ever discourage the transfer of residents out to the hospital?

A. No, because as I said, we were told from the Department of Health directive that we were encouraged not to transfer

patients to the hospital for a variety of reasons. The underlying theme was that the hospitals were or anticipated to become very crowded and overloaded and we were encouraged not to transfer nursing home patients.

Q. Do you recall having conversations about not transferring residents out?

A. With physicians or --

Q. Physicians or residents or families?

A. With family members? As I stated before, they -- that particular patient, I remember, that I said there wasn't much at that point. It was very a elderly patient with a lot of comorbid conditions. Aside from putting in a feeding tube and drastic matters like that, her stomach was not interested in that and there wasn't much that would be offered at the hospital setting.

We discussed COVID. I said it's possible, that they could test her there.

But at that point, there was no specific treatment available for COVID.

As I said last time, I had multiple conversations with my family members -- my patients' family members and as is usual of my practice, I discuss the possibility of the transfer to the hospital, if it's something that we can handle in that setting. But the caveat for everyone at that point was that at that point COVID was rampant in the hospital. So, most -- my situation with the families, which they were pretty much agreeing, that the hospital was not where they wanted their loved one to be.

Q. So am I correct in understanding, it sounds like you had multiple conversations with family members about the decision whether or not to transfer their family member to the hospital?

A. Yes.

Q. Do you recall any specific instances where there's a disagreement between you and a family member about the decision, aside from the one we just

discussed?

A. No and that wasn't a disagreement. They opted to call -- somebody decided to call 911. I don't recall anybody disagreeing. They do as it is practiced and posed, the final decision rests with the patient if they have capacity or with the health care agent or the next of kin. If they insist upon transfer to the hospital, we have to do that.

Q. We've been discussing the family that called 911, that the family was not disagreeing with you about transferring, they just decided to transfer unilaterally?

A. Yes, my only contact was with the primary health care agent, the son, the former police officer, he did not ask me to transfer her to the hospital on the three different conversations.

My last conversation was not with him, but rather the family was either bedside or a FaceTime setting, I don't know how many were bedside, which was allowed for her end of life or compassionate visit and

somebody made the decision -- one of the siblings, I believe there were four or five siblings, one of them made the decision to call 911.

Q. Were there any times when a resident or family specifically asked for transfer out to the hospital and that's something you refused or discouraged?

A. In my patient population?

Q. Correct.

A. I don't recall. As I said, I didn't refuse because I'm not in a position to refuse. They can certainly call 911 or ask the facility to call 911. We don't have to agree with them. They have to do what they want.

As far as discouraging people, as I said, I explained the risks and benefits, if hospital transfer was even being considered, which I don't recall lot of instance.

But one specific instance where I offered transfer on a Sunday to a patient and the daughter actually refused

hospitalization and the patient died a few hours later. But I don't recall somebody pressing it.

But I did paint a picture where there was -- there was certainly quite a bit of COVID in the hospital and it was something that we were handling, such as IV antibiotics, IV fluids, the patient was stable and there wasn't much more the hospital could do.

But again, the final decision rests with them.

Q. And were you discouraged by anyone at Fulton Commons from transferring your own residents to the hospital?

A. No.

Q. By that, that may include Cathie Doyle, Carol Frawley, did either of those individuals discourage you from transferring any of your residents?

A. No, in all my years there I don't recall anybody discouraging me or telling me not to transfer a patient to the hospital.

Q. I know we just discussed this,

but it sounds like you have been a clinician responsible for certifying deaths on a death certificate, correct?

A. On my patients, yes.

Q. What did you base your decisionmaking process on when completing that function?

A. My clinical skills as a physician.

Q. Have you read or do you keep up with reference material with instructions to physicians on certifying deaths on death certificates?

A. Yes, I do.

Q. Describe that for me?

A. Well, for instance, if COVID is suspected, there's a -- in Nassau County there's a nice big printed in capital letters where to enter that if it's a primary consideration. The general guidelines you get from EDRS, that's the reporting on the Health Commerce System, it's just kind of how to fill in the blanks rather than specifically what to put in the

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blanks.

Q. As a practicing physician, what is your understanding of why deaths are registered in New York State?

A. Well, death registry was vital at one time because it actually gave an accurate portrayal of patient morbidity and great for data collection.

Of course now, there are more literature articles than a few years, the vast majority of death reporting becomes the same atherosclerotic heart disease, cardiopulmonary arrest, kind of general cause of death as opposed to autopsies are significantly lower percentage than they were years ago.

So is death reporting ac accurate as it was? Probably not, but again, it's another way of finding comorbidities, mortalities and how and why people were dieing in particularly.

Q. To build on that, would you agree that accurate death certifying would be critical to the State's response to a

pandemic?

A. Yes.

Q. Whose responsibility is it typically to certify a patient's cause of death on the death certificate, is it the treating physician or somebody else?

A. At I said before, the attending physician is responsible for completing the death certificate. On some occasions, particularly now because it's done on a computer so it could be done remotely, a physician will ask another physician to do a death certificate.

Q. You're familiar with the New York State standard death certificate form?

A. Well, New York State has two different death certificates. There's the City death certificate and the rest of the state, for somebody who has a franchise on it.

So I deal typically with the rest of the state, which is Nassau County, Suffolk County and I am extremely familiar since I treat a high patient population that

typically doesn't go home, but ultimately does expire.

Q. From your experience and expertise, what is the purpose or purposes of the medical portions of the death certificate?

A. The clinical portion?

Q. The medical or clinical portion, correct?

A. So, again, it's data collection ultimately. That's been what it is and that's still what it is.

Q. Is it fair -- would it also be fair to characterize it as a basic description of the sequence or process leading to an individual's death?

A. As I said, it's four parts and there's an other. So the first part is generally cardiopulmonary arrest because that's how most people die. Your heart and lungs stop working as a result of an acute myocardial infraction or heart attack as a result of coronary artery disease.

And then there's a section for

whether cigarette smoking has contributed. And then at the bottom, so if the patient had COVID four months ago or if they had advanced dementia, there's an "other" section, it's not the direct cause of death, but it certainly didn't help them any.

So, advanced dementia or a history of COVID would go in that box after the description of the sequence.

Q. So, you sort of lead me into my next question which is does a death certificate in its standard format limit the certifying doctor to a certain number of diseases or contributing factors that comprise the chain of events that lead to the individual's death?

A. No, not really.

Q. Okay. And by "not really," expand on that for me?

A. As I said, there's A, B, C and D, which usually will give you a more than adequate opportunity to explain the cause of death and then you have a nice big box below that. You could put 15 different other

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conditions if you'd like.

Q. In the event the causal pathway is uncertain, how should the certifying physician report the cause of death?

A. Well, I never experienced that as I recall, but they could always ask somebody else to review or they could try to encourage an autopsy.

Q. Would it be acceptable when a causal pathway is unknown for the certifier to use words such as probably, presumed or suspected?

A. Well, you're allowed to do that in the course of things. So, if you have -- if there is lung cancer, but you don't know what type it is, you'd say, "Unknown cell type." So, there is that leeway.

Of course, if you put "Probable" something, ultimately the EDRS people, they can question it and reject the certificate. As I said, it never happened to me in Nassau and Suffolk County, but they ultimately -- somebody is reviewing those causes and if it's not clear, not clear enough, then they

would reject the certificate and ask the physician for more clarity.

Q. And you had said that that never happened to you in your career though?

A. Not happened -- as I said, not in Nassau and Suffolk County. I had it happen 20 years ago in Queens.

Q. Did you ever review the CDC's guidance for certifying deaths that was issued during the pandemic?

A. I'm sure I did.

Q. I can refresh your recollection. Let me direct your attention to what will be marked as State's Exhibit 24.

Dr. Butchma, do you recognize this document?

A. It looks familiar.

Q. And am I correct in stating or identifying for the record this is March 4, 2020 version of the CDC's guidance?

A. Yes.

Q. Certifying death -- certifying COVID-19 deaths?

A. Yes.

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Q. So, on the page there's a graphic and is this the standard cause of death section that we've been discussing?

A. Similar.

Q. And you'll note there are several lines available there for identifying causes of death, correct?

A. As I stated.

Q. And in this simple list in this guidance, COVID is listed as one of the three causes of death, correct?

A. That's how they did it, yes.

Q. So based on this guidance that was issued by the CDC in March of 2020, the certifier could list COVID as one of several causes of death, correct?

A. As I said, yes.

Q. Next let me direct your attention to what will be marked as State's Exhibit 25 and this is a very similar looking document.

But do you recognize this document?

A. Again, looks familiar.

Q. Okay. Am I accurately

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representing this as the April 2020 edition to the CDC's guidance on certifying deaths?

A. Yes.

Q. And that's specific again to certifying COVID-19 deaths, correct?

A. Yes.

Q. Let's go down to page 2 of this document, do you see the highlighted section towards the bottom of the page.

I will read that, "In cases where a definite diagnosis of COVID-19 cannot be made, but it is suspected or likely (e.g. the circumstances are compelling within a reasonable degree of certainty), it is acceptable to report COVID-19 on a death certificate as 'probable' or 'presumed.'"

So Dr. Butchma, it appears that if a resident with suspected or presumed to have been COVID positive, the death certificate should reflect that status?

A. Right, that's what I said before.

Q. Okay.

MR. SMITH: Anne, we can take that down, thank you.

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Q. Dr. Butchma, what does the due to or in consequence of indicator on a standard death certificate mean?

A. As I said, I'm repeating myself, the first cause of death, that example was if it was pulmonary distress or cardiopulmonary arrest, basically the same thing.

And then again, basically whatever progression that physician or clinician determined was the progression event, the cause of death. So if the patient had COVID and just died suddenly, you'd put cardiopulmonary arrest and the second cause would be COVID-19 and that would be all you would have to put.

You can put all four modalities and as I said, unrelated, but a risk factor for the death of COVID, you could put that. They don't have the box -- they don't show you the little box below, but you could put it in other, as I stated before.

Q. And there's another indicator called, "Significant conditions contributing

to death, but not related to immediate cause," is that an indicator that you're familiar with on a standard death certificate?

A. I lost you on the end.

Q. Sorry. On the standard death certificate called -- and I'll read it -- "Significant conditions contributing to death, but not related to immediate cause," is that a different indication than the one we just discussed or something else?

A. As I said, if the patient had advanced dementia, a bout of pneumonia, the dementia is still a significant cause, then that's something that would go in that box below, as I stated multiple times.

Q. So is it fair to say that these two indicators that we've discussed are not mutually exclusive or are they mutually exclusive?

A. So, the primary cause of death -- the acute cause of death, if you can determine it, is in questions A, B, C and D, starting with cardiopulmonary arrest, the

final cause of everybody's death.

Then once you've filled out A, B, C, and D, if you feel like there's other causes that are significant to that patient, like I said, advanced dementia, but they didn't specifically die of that, but they did have it and it was significant, then you put it in that box.

Q. So is it fair to say -- I think your answer is that you could use multiple indicators on the same death certificate?

A. They are for the physician to use, yes.

Q. And correct me if I'm wrong, you did certify death certificates, correct?

A. As I stated, approximately 12 or 13 within a few days.

Q. I will show you next what will be marked as State's Exhibit 26.

Do you recognize this document, Dr. Butchma?

A. Yes, it's an antiquated death certificate. Somebody printed out a working copy. That's not a -- that's a working copy

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off of the EDRS.

Q. Do you see in the upper left-hand corner where it indicates that this death certificate was filed for Resident #53 ?

A. That's what it says, yes.

Q. If we scroll down a bit, did you certify her death?

A. Yes.

Q. What are the causes of her death as identified on this death certificate?

MR. SMITH: Please scroll down a lit.

A. Cardiopulmonary, atherosclerotic heart disease and hypertension.

Q. And for the clarity of the record, COVID does not appear on this death certificate?

A. No, dementia is another significant cause.

Q. So let's go now to what will be marked as State's Exhibit 27.

Do you recognize this document?

A. Yes.

Q. Is this a death certificate?

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A. Yes.

Q. Do you recall certifying this death certificate?

A. Yes.

Q. And if we scroll down, what are the conditions listed at causing his death?

A. Cardiopulmonary arrest, atherosclerotic heart disease, diabetes mellitus and then another cause, peripheral vascular disease.

Q. And again, COVID does not appear on this document, correct?

A. No, the patient did have a urinary tract infection though prior to his death.

Q. Okay. So let's go next to what we will mark as State's Exhibit 28.

Again, Dr. Butchma, do you recognize this document?

A. Death certificate, I don't recall the name.

Q. For the record, this is the death certificate od Resident #83 , do you recall certifying this death certificate?

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A. Not hers, no.

Q. Do you see the cause of death in the middle of the page?

A. Cardiopulmonary arrest, lobar pneumonia-unknown type.

Q. I will direct you to top center of the page, Section 25A, is your signature block?

A. Yes.

Q. You certified this document, correct?

A. Yes.

Q. And again, just for clarity of the record, COVID does not appear as the cause of death on this document, correct?

A. Correct.

Q. So I would like to next direct your attention to what will be marked as Exhibit 29.

Dr. Butchma, do you recognize this document?

A. No.

Q. For clarity of the record, I will read the titled. It is, "Fulton Commons

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Care Center Residents with COVID-19."

I'm going to direct you to the second name from the top, is that Resident #53 ?

A. That's what it says, yeah.

Q. So at least, per this document, Resident #53 was a resident with COVID, correct?

A. No.

Q. Can you explain that to me?

A. This is from April and as I stated, we did not have testing, correct.

So at that time, once we had a protocol written with a multivitamin, at one point we started using Plaaquenil, we were doing that, as I said, for anyone who had possible symptoms.

So sometimes, put that into effect, again as I stated before, looking for a cause that would explain their symptoms. So, in Resident #84's case, I see a urinary tract infection. In Resident #53 's case, lobar pneumonia.

So, these are patients not with

COVID-19, but they were put on a protocol without Plaaquenil, the first protocol, a non-Plaaquenil protocol.

So, you always can put in effect, as I said, facilities -- most facilities had a protocol by that time using Doxycycline, Zithromax, IV antibiotics, IV fluids and vitamins and at one point, Plaaquenil, which fell out of favor as everybody knows because it was in the newspaper.

But none of those patients, to my knowledge, had a test done. So, we were -- that's a misnomer to say, "Residents with COVID-19." They may have had a suspicion if it at certain times it they had a temperature or some congestion. It doesn't mean they were diagnosed because we didn't have testing, but none of those patients, to my knowledge, had a test.

Q. So at that time, based on this document, which is reflective of treatment protocols, Resident #53 was presumably suspected of COVID, correct?

A. As I stated before, anybody with

cough, congestion, low grade or mid grade fever, high grade fever, was -- we were told to presume they have COVID. The cause of death as I stated and signed off on that she had lobar pneumonia.

If she had COVID, I don't know that, but based upon that she had arterial lobar pneumonia and I'm assuming she was treated for that. I don't have the medical record in front of me.

Q. When you say, "I don't know that," in reference to her COVID status, that's predicated on the lack of testing at that time, correct?

A. You had lack of testing and in her case, a bacterial -- on the chest x-ray, a bacterial lobar pneumonia, which I recorded as her cause of death. But she did not have a swab positive and she had another -- whatever her symptoms were, I assume cough, fever, congestion, which is explained by a lobar pneumonia.

Like Resident #84 was explained that a urinary tract infection and then

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subsequently to come to his other comorbidities.

Q. Let's scroll down to the second page of this same document. So about two-thirds of the way down the page we see Resident #84 , correct?

A. Right.

Q. And right below Resident #84 you see Resident #83 , correct?

A. Okay.

Q. As with Resident #53 , you see that Resident #84 and Resident #83 also appear on the Fulton Commons list, residents with COVID, correct?

A. So, as I said, we did not have testing materials at that time. We were told and instructed to presume that anybody who had a fever, cough, congestion, hypoxemia, symptoms such as that, is presumed to have COVID unless there's another cause.

So, at one point those patients had been put on a protocol, one of the protocols that we had. So, IV fluids or

vitamins or whatever else it was.

Resident #84 was subsequently diagnosed, as I stated, with a urinary tract infection. He had a suprapubic catheter as I think I stated two weeks ago and an indifferent vein.

And I don't recall Resident #83 , what she ended up being diagnosed with. But these were patients that were put on a protocol. Not necessarily finishing that protocol and not necessarily all being treated in the same fashion.

But like I said, we were told to presume that they may or may not have it, give them what we could, try to protect and isolate as best we could and look for another source. Which in those specific patients, which were mine, two of them at least, I do remember, that they had another cause.

Q. So to parse through this document because the title is pretty unequivocal, it does state, "Residents with COVID," is it your testimony that not all of these

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residents were presumed to have COVID or something else?

A. I think I was pretty clear. I said that we did not have testing. We were told that any patient with cough, congestion, low grade fever, fever, had it until proven otherwise.

So, on day number one -- on Thursday, I start you on IV fluids, put you on a protocol, maybe give you Plaaquenil depending on what day of the week it was or what month it was, whatever was in fashion and you could tolerate Plaaquenil based on your EKG, did lab work.

By day number three, after being on the protocol, it may have been determined that you have a different infection all together and still being treated with IV antibiotics for urinary tract infection.

I would think that the title for this is incorrect and cases admitted from hospital with COVID is probably accurate. They're presuming -- this looks like something to report to HERDS. They're

presuming that these are patients of interest, the same patients with COVID or possible COVID or presumed COVID. It doesn't mean that that's the final diagnosis. The death certificate would bear that out and it's been my determination that that was not their final diagnosis.

Q. We can agree that Resident #83 , Resident #84 and Resident #53 , they are, at the very least, presumed or suspected COVID patients at this time, correct?

A. At one point in time, they can't tell from that document. It could have been for 24 hours. It could have been for 72 hours. It could have been for four days, but at one point in time. So therefore, whoever is creating that document is including them as being a patient of interest at a point in time, yes.

Q. And also at this point in time, is it accurate to say that testing was not available at Fulton Commons?

A. That's what I stated numerous times, it wasn't available, except in the

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acute care setting.

Q. So, these three individuals -- Resident #83 , Resident #84 and Resident #53 -- ended up being suspected or presumed until what point, they received a test or something else?

A. Nobody had testing, but let's get that straight. There was no testing available. So, unless you went to the hospital, which two out of three I know didn't go to the hospital. I don't remember if Resident #83 did.

So, unless -- once those patients -- at that time, once those patients had another cause for their symptomology, they were not considered -- at least medically not considered to be POIs. They were probably still reported as that generously on the HERDS and again, I don't know until what day and time that document was created. It was probably used to report to HERDS to give to the Department of Health.

Q. Because testing was not available at Fulton, these three individuals we're

looking at would have remained on the suspected or presumed COVID list until they were either transferred out of the hospital or they expired, correct?

A. No, that's not what I said.

Q. So, clarify?

A. I just specifically said, I said until such time, at that time there was -- first of all, there was no testing at Fulton. There was no testing at any skilled nursing facility.

So with that being said, until such time -- at that juncture in time, which was probably in March, beginning of April, end of March, until such time there was another cause, so a patient with blood and pus coming out of their suprapubic catheter, has a urinary tract infection.

So, is it simultaneous they had COVID? It's possible, but we had a cause -- another cause of infection. So, they would have remained as a patient of interest or person of interest for whatever period of time until they had a clear diagnosis.

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Once that diagnosis was a UTI, which was a day or two later, he would not have been considered a COVID risk at that juncture in time.

Q. To clarify for me, I do want to distinguish person of interest, POI/PUI from certification of death certificates because, would you agree, that those are two slightly different things?

A. One has nothing to do with the other.

Q. Correct. So what I'm asking here is, even if Resident #84 had a UTI, if Resident #84 was also at this time presumed or suspected COVID and remained presumed or suspected COVID up until the time of his death, would it not follow that should have been included at some point somewhere on the death certificate?

A. Honestly, I keep saying the same thing and we keep going back around and saying something completely different and asking me to clarify, I don't how medically I could be more clear.

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I stated that Resident #84 , in whatever juncture of time, was included on a list of being a patient of interest based on the fact that he had a fever and whatever symptomatology, mostly a fever at that time that I recall, change in medical status.

But at the time period that I diagnosed him with a urinary tract infection and urosepsis he was no longer a patient of interest for COVID. He would not have stayed on the list until he died. He was diagnosed with another condition. He had UTI and urosepsis and was treated for such.

And ultimately, though he improved, the comorbidities is what's reflected on his death certificate. So, I don't have a swab positive for him and I don't have, in this particular case, a high index of suspicion that a patient who had diabetes, was obese, had one leg and other comorbidities and then got urosepsis should also have an honorable mention for having COVID because there was no indication that he had it as far as --

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At a moment in time, yes, he had a fever. Until such time as you can diagnose with something else, which what looks like the patient started having happen. He had lobar pneumonia, that was his cause of death. I didn't have a swab positive and I treated with IV antibiotics and oral antibiotics and again, decided the comorbidities along with the lobar pneumonia as an indicator of death.

I don't know who made this form or created it or who decided which names to put on it, but I can say there was no testing available and it would only be a patient of interest or person of interest at that time until such time that they were diagnosed with something else.

Nowadays, you are POI until you are swabbed negative or positive within several days within each other. And after seven days, two negative swabs, you're no longer a person of interest. If you died a week later, you wouldn't be included on a list because you swabbed negative twice.

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But we didn't have that. So once you had another cause of your symptoms, your infection, are being treated for something else, that was seemingly unrelated to COVID, you were no longer a POI.

Q. So I think that's what I'm asking, Dr. Butchma, is from your description of POI, it seems like as soon as another potential intervening cause or symptomology appears, that can cause that person to be removed from the POI list.

However, in death certification, that does not need to be an exclusive reason for death. There can be multiple causes of death, that's why we walk through the CDC guidance.

So, my question is, is that certification context exclusive of POI if someone had previously been identified as someone that was COVID and had been treated with COVID protocols, would it not follow that that should be reflected on their death certificate?

A. Yeah, but that's not the case

here.

Q. And why is that?

A. As I stated before, these are not patients who are diagnosed with COVID. There is no list of POIs, patients that had symptoms. None of these patients were tested for COVID. Once they were diagnosed with something else, they were no longer of interest as far as COVID was concerned. So, it wouldn't be included on the death certificate, no. I can keep saying it as many times as you'd like, but that's the answer.

I have a determination of the death of Resident #53 , who was never tested for COVID because there was no testing and had a lobar pneumonia and was treated with antibiotics and demised. My cause of death is based upon what my knowledge is, that she had an infiltrate on her x-ray and she was treated accordingly and that's what she died from and that's what's reflected on this death certificate.

Q. And what I want to make clear is

that in this context you are not limited to a positive COVID test to identify somebody as having a COVID cause of death are their death certificate. We just discussed how suspected or presumed would be sufficient to include COVID on someone's death certificate per CDC, correct?

A. I, as a physician, if I determine that it's possible or probably, I may put that. The fact that I didn't put it meant that it was neither probable or possible.

Q. Do you recall ever identifying COVID as an immediate cause of death on a death certificate?

A. Numerous times.

Q. Do you recall at which facilities?

A. West Hampton Care Center.

Q. And again, for clarity, I'm asking about identifying COVID as an immediate cause of death, not as a secondary?

A. It's secondary because it's not -- cardiopulmonary arrest or respiratory

arrest is also going to be the first cause. The second cause could be COVID or pneumonia and then COVID as a tertiary cause.

Q. And again, it's your testimony that you did identify COVID as an immediate cause of death at some point during the pandemic?

A. Between the last nine months, dozens of patient.

Q. Do you remember when the first resident was that you identified as COVID being an immediate cause of death?

A. No.

Q. Would you -- I would guess that it was after the availability of testing or before that?

A. Probably after.

Q. Is there any way that you identified COVID as an immediate cause of death before the advent of available testing?

A. It's possible.

Q. Do you have any recollection of doing that?

A. No because, as I stated, the deaths that I certified at Fulton were all within a 75 -- a 72-hour period. They all kind of died around the same time of various ones, pulmonary hypertension, end stage dementia, chronic obstructive pulmonary disease.

So, if we had the ability to swab and three of them had been positive swabs and he died of congestive heart failure, it would have been listed as one of the causes in the lower box, but that wasn't the case.

So, if I suspected it clinically and after that point my unit was rather stable, virtually every one of those patients tested positive for antibodies. So, they had had some sort of exposure possibly, as many people did. But I had a pretty stable medical unit and I don't recall certifying very many deaths at Fulton throughout the summer. For other facilities, yes.

Q. At least at Fulton, am I correct in understanding, that you may have

certified COVID as an immediate cause of death in the absence of the positive COVID death?

A. I said I would have, I didn't say I did.

Q. Okay. So that would have been something that you would have considered at that time, you think?

A. I was analyzing all those charts and trying to weigh out when the patient -- and having a secondary discussion with the Department of Health because them questioning some of my patients and other parents. So yes, I defended all this going back to that list of patients that the Department of Health surveyor wished to discuss. That's not the first time that I had the discussion.

It was considered. I reviewed and re-reviewed charts, medical records, including my own, to determine if there was a possible -- a possibility of whether a patient had COVID. It wasn't not considered.

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Q. So what I'm driving at here, Dr. Butchma, in March 2020, April 2020, May 2020, when certifying a death, you would have at least entertained the possibility of someone being a presumes or suspected COVID when certifying their death certificates, correct?

A. When doing the death certificates, and as I stated again, about 12 of them within a short period of time, if I look back a year ago, we now know that patients have a deep pulmonary embolisms from COVID and I have several patients that I'm taking care of now in that situation.

But we didn't know that then. So, were there a couple of patients that might have died of acute pulmonary embolism, which would have made suspicions for COVID nowadays very really. At the beginning of it, no, it wasn't really a consideration because we didn't have that knowledge.

So, at that time, it wouldn't have been a consideration to put on a death certificate because that one isolated

clinical sign and symptom or diagnosis wasn't associated with it yet. So at that moment in time, considering that anybody had to have a fever and congestion and hypoxemia, that was basically what we all entertained until we all learned more.

So again, death reporting, despite from what other brochures were coming out from the CDC or guidelines, we had the knowledge we had. And again, as a physician for over 30 years, trying to report -- I'm trying to fill out those death certificates as accurately as possible. So, all things come into consideration.

Q. Dr. Butchma, backing up to the earlier time of the pandemic, losing a number of residents on one unit, I believe you mentioned 10 to 12, correct, in a 72-hour period?

A. 12 or 13.

Q. 12 or 13, at that time, did that strike you as an unusual thing?

A. Well, as I said, we were always concerned about COVID. The only one patient

that for sure I know had a positive test was my patient that I had transferred to the emergency room.

The other patients were at various levels of acuity. So, a couple of patients had been successfully treated for pneumonia and were doing actually pretty well and passed away quickly. Two patients were end stage. One was 96, one was in her 80s. So again, that was more of a progression of their diseased state. There was no fever, there was nothing, except they died in their sleep.

So, is it unusual? It's not unusual. Is it impossible now to have -- pre-pandemic, years ago, that a patient didn't necessarily die at that time, they died of other causes to, pneumonia or they stopped eating. So there's always a consideration, but specifically for those patients they had other causes of death, which were reported on HERDS based upon whatever I had written in the chart.

And then we reviewed and reviewed

again by the Department of Health surveyor who asked and who interviewed me and asked me again the same question, was it taken into consideration and I answered the question then and now.

Q. Just to understand the scale of that development over those 72 hours, there were 40 patients on a unit, correct, at Fulton?

A. I probably had about 35, 36 patients.

Q. So, we're talking about losing roughly one-third of your residents on that unit within three days. Is that something you'd experienced in the past, a loss of residents in that scale -- in that speed?

A. Over 25 years of doing this, I've where I've done numerous death certificates in a short period of time. Again, you're dealing with a patient population -- my oldest patient at that time was close to a hundred.

I had another patient die at that time, he was HIV positive and was sick on

and off for -- since January. One of my best friends was 92 and he died there. His girlfriend died during that time, she had advanced Alzheimer's, it wasn't COVID related.

It's a large comorbid elderly population with complicated disease states and sometimes you get a run of patients where they get sick and die, particularly in late autumn and in the winter.

Q. Just to sort of revisit the actual scale, is this just something in your years of doing this work, where you've experienced a loss of roughly one-third of your residents in a three-day period, is that a common or an uncommon thing?

A. I wouldn't say common, like it happens, but it has happened before, yes.

Q. And by saying it's happened before, have you lost one-third of your residents in a three-day period before?

A. Proportions and fractions are deceiving, but if I had 20 patients, to lose six patients in a short period of time, it

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happens, yes.

Q. So going back to this specific loss of these residents over this period of time in March of 2020, at the time, did it strike you as suspicious or alarming?

A. And as I stated -- I mean, I could go through, the once I remember, each and every one, you know.

One had end stage pulmonary hypertension and dementia, she was on the list that the Department of Health wanted know about. Her name was Resident #85 , 96 years old, end stage dementia, pulmonary hypertension, very fatal and congestive heart failure, all causes of death. Was it suspicious to me? No, she died of her disease.

One patient died of her -- as the one I mentioned that had a few complications. She had acute hypoxemia. She was an asthma/COPD patient and declined rapidly on a Sunday. Offered hospitalization, she needed ventilator support. She had advanced disease process

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of COPD.

My one patient died after having two patients die after I successfully treated them for pneumonia. They cleared up. They were eating. They were sitting in front of me at the nursing station and they were eating their whole meals and --

MR. SMITH: I apologize for interrupting, Nicole and Dr. Butchma, I lost both if you.

Anne, would you mind dropping the exhibit to help my bandwidth a little bit.

A. As I was saying, you could go through each and every one of those 12 deaths or so and I can tell you even now, for the most part, what they died of and what my considerations were.

If I look back a year and said, "Well, somebody that had pneumonia, was treated successfully, was doing well, all of sudden died suddenly, died of a pulmonary embolism, might have been related to COVID." Did I know that in March or April? No, none

of us did.

So when I look at those -- each and every death, was it a bit discerning, to do that many death certificates in that short period of time? Sure, these are human lives we're dealing with. But by the same token, there were a lot of different comorbidities and illnesses and I had different reasons for them. There were all different reasons why they expired.

As you can see, one died of pneumonia. One died of complications from his urinary tract infection with complications of other things, having longstanding diabetes mellitus complications.

So, does it happen? Yeah, it happens. Does it happen often? No, not that often. Was COVID a consideration at the time? Resident #84 , early on, yes, but then he had an urinary track infection. So, the answer is no, I wouldn't have put "probable" or "possible" COVID because there hadn't been more than a reasonable

consideration about it.

Q. Going back to the patient who was sent out to the hospital and subsequently tested positive at the hospital, when that transpired, did that cause you to reconsider the effects of COVID potentially in the facility?

A. Well, we were considering, as I stated before, that every patient who had a fever, a low grade temperature or congestion, as either had or was presumed to have COVID. That particular patient had none of those things. So, she had anorexia. She had a urinary tract infection. She was triple diabetic. She was obese.

And as I spoke with the son before, it was three times in one day when she transferred, did she have COVID? I said, "She could, I can't rule it out. I don't have ability to test at this point." But I believe that the complications from having the acute illness that she had, she stopped eating.

Now again, in retrospect, we

didn't know that anorexia was a possible -- was a clinical sign of patients with COVID. We didn't have that knowledge then. So, when she was sent out, was it considered? No because we were presuming that everybody -- anybody and everybody who had symptoms had COVID.

So, we were -- we had a level of an index if suspicion and a level of concern for anybody that had an unexplained fever, cough, congestion, COVID symptoms.

Q. And I wonder, related to your answer, if you don't have testing, people are displaying symptomology, another diagnosis comes along that could explain some of the symptomology, maybe not all of it, would it not be reasonable to include COVID as a potential presumed or suspected contributing factor in that individual's ultimate death?

A. No because I'm an internist. So, internists, we don't give you five -- nurses will give you five different conditions at once. So for every symptom, there's a

disease and that's what you have.

Internists, we're determined to most likely cause of somebody's clinical signs and symptoms. We don't give you pneumonia, UTI, cellulitis and possible botulism. It doesn't -- there's no reason to do that, it's not done. It's not appropriate. So, we determine one cause of death.

If a patient has had cough, congestion and fever, was put on fluid antibiotics, had no other source. Chest x-ray was normal, labs were normal, the urine was fine and expires, none of my patients were in that circumstance.

And yes, you could say, "Okay, I was suspecting them to be COVID, they're on the list." We certainly did count patients in the facility that were in that situation, where the physicians wrote "possible" or "probable" COVID. I assume they put that on their death certificate. I don't read their certificates generally.

But it's not required to put four

or five causes of death -- come in and put four or five causes of death. And if I wasn't suspecting it, no, I wouldn't put it on there.

Q. Dr. Butchma, from your perspective, who ultimately is responsible for ensuring that government directives, guidelines requiring patient health and wellbeing are carried out effectively at Fulton Commons?

A. Well, ultimately the administrator is the final person in charge and the administrator coordinates -- there's been some practice during the last year with the department heads, generally there are clinical things, the director of nursing, the medical director, maybe the director of infection control depending on the facility and sitting down and saying, "This is the directive. This is what we've been told to do and this is how we're going to strategically do it."

Then the final delivery of that goes to the general administrator.

O. Butchma, M.D.

Q. And along those same lines, where does the buck stop on ensuring that Department of Health directives on infection control are followed at Fulton Commons?

A. Essentially, the administrator, yeah. The administrator is responsible for all of that, but certainly anything clinical, is the director of nursing and medical director is certainly consulted.

For the directives, we weren't given a tremendous amount of leeway for the most part. "You're swabbing staff twice a week, this is the days it has to be done, three days in between, not two, not one."

We were told what dates to start and if you didn't, you got slapped with whatever thousands of dollars of fines, that was the penalty. That was the penalty that was available for New York State.

So, that's what we dealt with. There wasn't a lot of wiggle room. We had testing available, yeah, sure, we could have tested as much as we wanted, there was nobody processing that. But again, from a

practical level though, without testing available, there's not much you could do with it.

We weren't given much leeway in those directives except to review them on a conference call generally and then put them into effect. And generally, Cathie would coordinate that with Carol.

Q. Who ultimately at Fulton Commons was responsible for ensuring that those P&Ps are being followed by staff?

A. Well, there's policies and procedures for everything in the building. So, generally the department heads. If it's a building thing or a kitchen thing, then the director of that department is responsible. They all answer to the administrator, as do I.

So, I'm responsible to make sure that the medical staff is getting swabbed. If they're not getting swabbed, I tell them they can't come back in the building until they have a negative swab and they need to provide that information.

O. Butchma, M.D.

So, I'm responsible for my staff, Cathie is in charge of me. So ultimately, all the individual department heads control the policies of -- the implementation of the policies for their department. Ultimately, the administrator is responsible.

Q. Would you agree with the proposition that the quality of resident care at Fulton Commons would be dependant on the nursing staff at the facility following infection control guidelines and mandates?

A. Well, quality of care is a lot more things than just infection control. But certainly, part of quality of care is infection and making sure that -- basic things like handwashing would be -- with bacterial gel, wearing gloves and changing gloves, that's certainly part of quality of care, as well as a lot of other things.

Q. As a physician and medical director, I assume that during your career you have been in-serviced on resident abuse, neglect and mistreatment?

A. I have taken courses, as I stated

last time, through AMDA. The last convention was virtual in March or April and that is part of that their inservice, is the webinars.

Q. So you're aware that neglect as defined by the laws of the State is "failure to render timely, consistent, safe, adequate appropriate services, treatment or care for a resident," correct?

A. That's correct.

Q. Would you agree that failing or a failure to properly cohort COVID and nonCOVID residents with any nonCOVID residents at a risk for contracting COVID?

A. Again, as I said before, the directives had changed numerous times. So, if indeed a facility -- or Fulton Commons specifically, failed to follow the directives that were given by the CDC and New York State and were not implemented properly, then that potentially could be considered neglect.

Q. Along those same lines, would you agree that the failure or failing to cohort

staff, so that's allowing staff members to care for both COVID and nonCOVID residents on the same shift, puts any nonCOVID residents at risk for contracting the disease?

A. Well, as I said before, so the recommendations have certainly changed from when initially talking about staff being allowed and not allowed to come to work. We were all -- we're essential. So 72 hours are you were diagnosed, as long as you feel okay, you just got out of quarantine and that's it. So, certainly that's changed.

So medically speaking, infection control-wise, can a nurse take care of -- my girlfriend's a nurse. She took care of COVID patients and nonCOVID patients. If COVID patients were in like a Ziplocked tent and the nonCOVID were outside, she crocked and uncrocked inside the tent. She came out, disinfected and took care of those patients.

So, in the narrow scope of the question, it's possible because that's what

we're doing to some degree now. If you're walking in and out of a room, without taking precautions and without having knowledge of that, then that's very different.

Q. In March, April, May of 2020, at that time, cohorting staff and then allowing staff to treat COVID and nonCOVID residents, would have been a breach of infection control guidelines at that time, correct?

A. Based upon that policy -- that undated policy that's up there and -- then that would have been -- if they were overlapping and the policy said not to do that, then that would be a breach of policy.

MR. SMITH: So Dr. Butchma, I think we are very, very, very close to the end here. I might propose a quick five-minute break, so I can confer with the team and then we'll get back and hopefully get you out of here in a second.

THE WITNESS: Okay.

MR. SMITH: You want to say 1:50? That's about eight minutes.

O. Butchma, M.D.

MR. JONES: 15:0 is nine.

(A brief recess was taken.)

MR. SMITH: Back on the record.

Dr. Butchma, that is all the questions we have for you today. We really appreciate the time. I know it's been two long days, so we appreciate you coming and talking to us.

Again, just to reinforce, confidential proceeding. So as I mentioned at the beginning today, it remains confidential for the duration. So, obviously you can talk to your attorney about what was discussed today, but absolutely nobody else and we ask you to keep that throughout the duration of the investigation.

I will then release you for the day. You are good to go and again, we appreciate your time and thank you very much.

And thank you, Glenn, I appreciate it.

O. Butchma, M.D.

MR. JONES: You're welcome.

(TIME NOTED: 2:00 P.M.)

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CERTIFICATION

I, Nicole Lebovic, a Notary Public in and for the State of New York do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 10th day of March, 2021.

NICOLE LEBOVIC

Sophia L.

3 years ago

This place is HORRIBLE the administration is never there when you need information. The staff are overwhelmed with work. They would have one nurse caring for over 10 patients on one floor, it's even worse at night. At night I'd have to leave my job early to go over there and clean my mother up and put her to bed. The night staff would lined up the patients outside their room waiting to be cleaned. And there are times when I'm there; The hallway are cold and patients are freezing, patient are trying to escape, and crying for help. That place is dreadful PLEASE I URGE ANYONE TO NOT PUT YOUR LOVE ONES AT THAT PLACE!!! THIS PLACE NEED TO BE SUED AND SHUT DOWN!!! It was too hard to witness this everyday. I had to transferred my mother out of there. As update to the Owners response! 10-16-18 My mother didn't have alzheimer or put in a screaming unit (TLC). She was there because she suffered a heart attack and was disabled on her right side. So please stop acting like you care because when I tried to reach out to the manager about my mother's care. I came to the facility during business hours, he wouldn't give me the time to explain what was going on. He (manager) walked out on our meeting. And just to add on to the madness when my mother was being transferred that case worker(with the dreads hairstyle) didn't leave any proper documents to bring to the new facility. What you aren't understanding is I CAN sue this facility have documents from the nursing home that my mother is at. That she had bed sores and wrist fractures from neglect of a patient. Because my mother is kind hearted and didn't want people to lose their jobs, I didn't go through with it. So stop giving false accusations of my mother's health to betray that she was the problem.

L

Lia Rodriquez

3 years ago

IF I COULD GIVE 0 STARS I WOULD. Let me start off by saying, my grandmother has UNFORTUNATELY been a resident here for almost a year now. The facility is so disgusting, there has been blood spots on my grandmas floor since she was moved to this room which shows the floors are never mopped. My family brings in cleaning products to clean her bathroom ourselves. And we also do her laundry because her clothes went missing went Fulton commons was doing it. -Next, the nurses on the floor DO NOT CARE about the residents. My grandma will hit her call button to use the bathroom, and no one will show up until an hour later or they don't show at all.I've seen this with my own eyes multiple times. They take so long to the point that she has to get herself out of bed and she fell and got hurt - she had to drag herself across the DIRTY floor to get to her call button.. she laid there until someone finally showed up. The nurses put the residents to bed at 7 at night so they can sit in the break room and hangout. My grandma likes to stay up to watch the rangers games or her shows, and everyday they try and force her to bed right after dinner so she is one less resident to worry about. -Next, the food served is terrible. My grandma has lost over 40 pounds since being here, and so has multiple of her friends who are residents. Everyday my family needs to bring either dinner or lunch to make sure she is eating. Her friend eats a pb&j everyday for every meal because it's she will eat. -Next and finally, the icing on top of the cake! She was given an Easter basket, which every item including (bath and body works perfumes and lotions, toiletries, room sprays) were stolen besides the candy. My grandma is sharp as a tack and is FULLY AWARE to her surroundings she did not misplace any of these items which is what administrators told us. Her friend who is also a resident, said a ring and bracelet were taken from her nightstand draw. -in conclusion, my grandma has called my family crying far too many times. And all I really want is for SOMEONE,ANYONE TO CARE. my family and I feel as if we are badgering the staff to just do their damn job and do it correctly. Our questions are answered with attitude and rudeness. DO NOT SEND YOUR LOVED ONES HERE !!!!!!!!!!!!!!!

14
Share

Response from the owner 3 years ago

Lia - I am so sorry to read that you are unhappy with Fulton Commons. As the Administrator, I take your concerns VERY seriously and would love to discuss them with you in person. I do not believe we have met so please fell free to call me directly at 516-222-9300 to see how I can help address your concerns. Thank you for your feedback, Cathie Doyle

T

Tom Ferguson

a year ago

1 star would still be giving Fulton Commons Care Center more credit then it deserves. This facility is poorly run from the top down. I had a loved one who was admitted for Rehabilitation and stayed for just under 2 weeks. In that time I was constantly being the middle man between my loved one and the facility for simple things like ringing the bell because they could not get out of bed themselves to use the lavatory. I was told they were waiting for close to 15 minutes for someone to help them to the point they picked up their cell to call me so that I could call the facility to let them know they had to go to the bathroom. And then I was placed on hold for 20 minutes until someone from that unit could pick up the phone to even listen to my request! I am not a healthcare professional but that seems a bit excessive for a place that claims to be in the upper echelon of care facilties. The administrator will have you fooled on these review responses making it sound like they truly care when in reality, when you call to speak to them on certain matters, they cannot handle confrentation and will immediatly put up a wall of defense of their facility. If you catch them on a good day, they might even give a condescending chuckle at you as you try to describe an incident from your perceieved point of view. I am not on here to sway anyone against using this facility, but I would truly do your research before deciding on this place. I am not even a person to post reviews, but I am so regretful of choosing this place and I do not want anyone to be in the same position looking back on it.

5 Share

Response from the owner a year ago

Tom - thank you for your feedback - I will be discussing your concerns with my team. I understand how difficult it is to have a loved one in a facility during this pandemic - not being able to visit or get to know the staff at all not to mention the residents not feeling well, being confined to their units with time going by very slowly for them. Please feel free to call me at 516-222-9300 to discuss your thoughts if you would like...Cathie Doyle, Administrator

Rose M.
San Francisco, CA
290 2

4/23/2019

DO NOT LEAVE YOUR FAMILY MEMBER HERE!
my husband was in rehab for 1-1/2 months last summer
It is disgusting! I myself had to bring cleaning products to clean the bathroom and his area. Every night i would go and change his bed and blankets myself because the aids would disappear and not change his bedding.
I brought in a cooler so he would have food to eat. Yogurt, pb&j, etc... along w snacks.

There were a couple of nurses that would go above and beyond to help and make sure he was taken care of but those handful that were there when they were off were the worst! My husband was afraid to sleep at night because if something were to happen, the night staff would not know what to do.
He actually witnessed the man in the next bed, in distress.. the nurse aids had no idea what to do nor could they find a nurse. A couple hours later the morning nurse came in and went into panic.. first thing she said is 'did anyone check his sugar'? His sugar was so low, he may have gone into diabetic coma.. we are not sure as he was rushed to the hospital. We did find out a day or two later he did have a stroke. and why my husband was afraid to sleep. The Management are a bunch of bullies and look at the Insurance $$..had many a run-ins with them.
A total disgrace!!

Useful **2** Funny Cool

Lisa P.
Erdenheim, PA
0 friends
1 review

3/17/2020

This facility is horrible! Do not send your loved one here. My father couldn't get into the rehab we were hoping for and we placed him here. He declined so rapidly there. He lost tons of weight. He was so drugged up he couldn't have a telephone conversation at night . He sat in his own pee for quite a while before being helped and developed awful rashes . He was ignored when he asked several times for extra blankets at night while he laid there cold . The smell in the place was horrid . They didn't want to release him because they wanted the money . His doctor had demand he be released because he couldn't believe his rapid decline in the three weeks he was there. Horrible!!!!!!

Ruth B.

Piedmont, CA

0 5

6/5/2020

This place should have negative stars. Please, even if you do not like your loved one, do not put them here. It is a slow torture of death. The state must get involved to shut this place down. Do not be fooled by the outside. It is beautiful. Then once your loved one is there..(My mother.) it is an endless torture room. You sit in your own feces for hours. There was even a point where they pushed my mother and kicked her. They do not answer their phones, and the room phones do not work. So when you leave, it is as if you will never be able to get in touch with them again unless you go back in person to see your loved one. The stereotype of being pushed in a corner to drool all day is really happening at Fulton Commons. I could not be happier when she got out of there.

Useful **7** Funny Cool

Rip Bryan Y.
San Francisco, CA
0 friends
1 review

3/31/2021

Although all clothing are labeled, don't expect to get all of them back. Two nightgowns, a bathrobe, 2 tops, and slacks went missing. We received other peoples clothing, with their names labeled in them. One item was torn. Good thing we didn't send a pair of good earrings, because her cheep pair went missing along with her denture cup. Very disappointment in their efforts to try to find my mother's belongings.

October 02, 2020

By ridiculou

I am a friend or relative of a current/past resident

My mom had a horrible experience in this place. Many of the people were unkind and mean. If you needed assistance, it would take hours for a response. My mom went 6 days without heat and hot water. The food was awful. All, in all, this place should loose it's license. There were a couple of people who were caring and did a good job, but they were few and far between.

November 15, 2021

By RB61

I am/was a resident of this facility

Just awful, should be investigated. I was in for rehab after knee replacement surgery and they ignored a chronic condition in my legs that the hospital had been treating, causing me to be bedridden for 4 days before they finally took action. With a few exceptions, the staff is rude and unresponsive. One aide actually tried to make me sit on a feces-smeared toilet seat, when I asked her to clean it she made a half-hearted attempt and left me to finish the job myself. And they'll lose your clothing in the laundry -- one time, several articles of women's clothing were sent to me (I'm male). They also ignore their own Covid mask rules; one woman who I took to be a dementia patient wandered into my room unauthorized and maskless a total of 16 times in one week, my attempts to complain were met with chuckles or a "she's out of her mind, you know," as if I should just accept it. The best thing I can say about this place is I got out alive.