EXHIBIT 8

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF [redacted]

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[redacted] as Administrator of the Estate of [redacted] Deceased, and [redacted] Individually,

Plaintiffs,

Index No. [redacted]

3101(D) – EXPERT WITNESS DISCLOSURE – EXPERT "A"

against

[redacted]

Defendants.

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PLEASE TAKE NOTICE, that pursuant to CPLR 3101(d), Plaintiff designates the following person as an expert witness expected to testify at the time of trial of this action:

A. IDENTITY

Plaintiffs have no duty to disclose the identity of this medical malpractice expert pursuant to CPLR section 3101(d)(1)(ii).

B. QUALIFICATIONS

Plaintiff expects to call at the time of trial a physician who is duly licensed to practice medicine in the States of [redacted] This expert is Board Certified in Emergency Medicine and Medical Toxicology. This expert attended and graduated from [redacted] The expert then attended and graduated from the [redacted]. This expert completed her postgraduate medical education as a Fellow in the Division of Medical Toxicology at [redacted] and served as a resident in the Department of Emergency Medicine [redacted] This Expert is a member of numerous

professional medical societies and has authored numerous publications. This expert is currently medical director at a Wound Healing and Hyperbaric Medicine Center.

C. **BASIS OF EXPERT'S TESTIMONY:**

Expert "A" will testify based upon her/his education, training, research and writings, and experience in Emergency Medicine and Wound Healing. S/he will rely upon her/his review of medical records and reports for plaintiff's decedent [redacted] including those from defendant [redacted] and [redacted] as well as the deposition transcripts of plaintiff and defendant's witness, as well as the pleadings, including the Bill of Particulars, and photographs. It is also anticipated that her/his testimony will address the reports and expert exchanges provided by defendant in this matter. All of this expert's conclusions will be to a reasonable degree of medical certainty.

D. **SCOPE AND SUBSTANCE OF TESTIMONY AND OPINIONS:**

Plaintiff's expert is expected to testify as to the quality and sufficiency of care given to plaintiff's decedent by defendant [redacted] The expert is expected to testify that the medical records reflect that plaintiff's decedent was a resident at and under the care of defendant [redacted] from May 22, 2010 through July 7, 2010. The expert is further expected to testify regarding the medical condition of plaintiff's decedent [redacted] om the time he came under defendant's care. The expert is also anticipated to testify that prior to his admission to defendant's facility, plaintiff's decedent lived independently and was able to ambulate using a walker, and was alert and verbally responsive upon his admission to defendant's facility.

Furthermore, it is anticipated that the expert will testify that plaintiff's decedent was admitted to defendant's facility for dialysis and with a stable and dry left fifth toe ulcer. The expert is expected to further testify that, according to plaintiff's decedent assessment of May 26, 2010, he was admitted to defendant's facility for short-term rehab and it was intended for him to return home once his health improved.

This expert is expected to discuss, among other related issues of the human anatomy, foot ulcers, vascular and pressure ulcers, nutritional issues, hydration, malnutrition, dehydration, weight loss, significant and unintended weight loss, incontinence care, infection, documentation, reporting, tracking, monitoring, and treating ulcers and comprehensive care plans.

The expert is expected to testify that, based upon review of the relevant New York State Public Health Law, Title 10 NYCRR and CFR sections, the treatment rendered to plaintiff's decedent during these periods of time was below acceptable standard of care and violated Public Health Law §2801(d) and §2803-c; 42 CFR §§483.10; 483.10(11); 415.3; 483.25(i)(1); 483.20; 483.20(k)(3)(i); 483.25(C)(2); 483.13; 483.15; 483.30; 483.65; and 10 NYCRR §§415.3; 415.4; 415.5; 415.11; 415.12; 415.13; 415.14; 415.15; 415.16; 415.19; and 415.20. The expert is anticipated to testify as to the standard of care, causation, and the damages caused thereby by defendant, [redacted], and defendant's overall neglect in the care of plaintiff's decedent. This expert is expected to testify that the medical malpractice and negligence of defendant [redacted] and its employees, servants, and agents occurred from May 22, 2010 through July 7, 2010.

The expert is expected to testify that the staff from defendant departed from the standards of care in the treatment rendered to plaintiff's decedent in that they failed to monitor plaintiff's decedent and take necessary precautionary measures to prevent the development and progression

of his leg and buttocks ulcers in violation of the aforesaid applicable statutes, rules and regulations.

The expert is expected to testify that defendant [redacted] was, throughout the periods of time alleged, neglectful, negligent, and departed from standards, practices, and customs in the field of medicine and nursing in that it failed to properly and completely assess plaintiff's decedent and update the plan the care for plaintiff's decedent as his condition changed. The expert is also anticipated to testify that defendant failed to properly evaluate and update such assessments and care plans, that the nursing staff failed to properly assess, document, and treat plaintiff's decedent's ulcers, and failed to perform appropriate investigation and work up of plaintiff's decedent in violation of Public Health Law § 2803-c(3)(e), §2801-d , and 10 NYCRR § 415.11.

Moreover, the expert is expected to testify that defendant negligently failed to assess plaintiff's decedent's wounds, including his left fifth toe ulcer, weekly and failed to adhere to its own internal policies and procedures that directed defendant's staff to conduct weekly assessment of all wounds. The expert is also anticipated to testify that the acceptable standard of care is to assess wounds at least on a weekly basis or more regularly upon a change of condition of the patient, particularly in patients who present comorbidities such as those suffered by plaintiff's decedent, including diabetes, peripheral vascular disease and stage renal disease. Defendant only assessed and measured the ulcers twice during his admission to its facility on June 17, 2010 and July 1, 2010.

The expert is further expected to testify that defendant failed to properly document and chart the development and progression of plaintiff's decedent's wounds and treatment against the standard of care in the medical and nursing field and in violation of Public Health Law §2801(d)

and §2803-c. The expert is also expected to testify regarding the importance of the nursing staff communicating changes in the plaintiff's decedent's condition to medical providers and documenting the same as medical practitioners rely on these nursing communications and/or notes when treating a resident and modifying the plan of care and treatment accordingly.

This expert is anticipated to testify that the left fifth toe wound was not measured upon his admission nor on June 17, 2010, and that there was no documentation of plaintiff's decedent's until June 17, 2010, and the wound were not documented again until July 1, 2010, when it was noted that the wounds on his right and left leg had worsened and exhibited bloody drainage and odor. The expert is expected to testify that it is noted that the administration of antibiotics was commenced on July 2, 2010 to treat plaintiff's decedent's foot infection.

The expert is further anticipated to testify that, while under the care of defendant [redacted] plaintiff's decedent's foot ulcers, were not documented or staged properly. The expert is expected to testify concerning the importance of proper documentation in the treatment of these type of ulcers in that such proper documentation ensures that the ulcers are met with the correct intervention to prevent them from worsening. The expert is also expected to testify that such documentation is imperative to assess the resident's risk of developing further ulcers. The expert is expected to testify that no resident treatment administration records existed from May 22, 2010 to June 16, 2010.

The expert is expected to testify that as a result of the insufficient documentation inadequate treatment for the wounds was rendered. This expert is further anticipated to testify that had defendant assessed and measured the wounds weekly, the wounds would have not deteriorated to the extent that they did.

The expert is anticipated to testify that defendant's charts were inadequate in preventative planning to meet the needs of plaintiff's decedent. The expert is expected to testify, within a reasonable degree of medical certainty, that defendant violated New York Public Health Law §2801-d by violating 10 NYCRR §415.11 and 42 CFR §483.20 for not having an adequate plan of care and not updating the plan of care as necessary.

The expert is expected to testify that, while being treated by defendant, plaintiff's decedent repeatedly complained about his foot ulcers and defendant failed to heed and consider his complaints of pain.

The expert is also expected to testify that defendant's staff failed to implement proper precautions and interventions to prevent, treat, and improve plaintiff's foot ulcers, including failing to administer topical wound care or debridement services.

The expert is expected to testify that, when a resident, such as plaintiff's decedent, presents with an increased susceptibility for the development of foot ulcers, nursing staff need to be more aggressive in their skin care and preventive measures, implement more vigilant interventions against their development, and promptly respond to and counter the first signs of skin breakdown.

This expert is anticipated to testify that defendant failed to timely refer plaintiff's decedent to a specialist, including a vascular surgeon, podiatrist, and/or wound care specialist and failed to timely asses plaintiff's decedent for any vascular abnormalities. The expert is further expected to testify that defendant did not order a vascular consult until on or about July 1, 2010 once the wound had significantly deteriorated. The expert is also anticipated to testify that as of July 7, 2010 a vascular consultation had not been performed.

The expert is expected to testify that defendant [redacted] failed to implement the more vigilant and aggressive prevention and treatment measures in a resident like plaintiff's decedent, who was at high risk for the development of ulcers. This expert is also anticipated to testify that aggressive medical and nursing interventions were essential to prevent the progression of plaintiff's decedent's ulcers.

The expert is expected to testify that defendant failed to implement aggressive medical and nursing interventions designed to prevent the development and progression of plaintiff's decedent's ulcers, such as offloading pressure from the foot, elevating his leg, applying topical wound care, optimize nutrition, and/or perform debridements or incisions of necrotic or infected tissue, revascularization.

The expert is expected to testify that defendant's staff failed to provide the necessary treatment and services to promote healing and prevent infection, and allowed the wounds to develop, progress and become infected in violation of 10 NYCRR § 415.12(c)(1) and 10 NYCRR § 415.12(c)(2). The expert is anticipated to testify that on July 7, 2010 plaintiff's decedent was transferred t[redacted]or an evaluation of his worsening foot ulcers and to treat the infection.

The expert is expected to testify that defendant was solely responsible for providing for the total care of plaintiff's decedent and that defendant had the responsibility to provide suitable nurses for his care. The expert is expected to further testify that defendant entrusted with the care of plaintiff's decedent those who were negligent and careless; that defendant was consciously indifferent to the negligence of those whom it entrusted with the care of plaintiff's decedent.

The expert is expected to testify, within a reasonable degree of medical certainty, that defendant [redacted]ailed to assess, monitor, diagnose, and treat such changes

in plaintiff's decedent condition that ultimately caused his left foot ulcer to become infected and gangrenous, necessitating a transmetatarsal amputation on July 8, 2010 at [redacted]ue to the left foot gangrene. Plaintiff's decedent expired on July 13, 2010 after suffering a myocardial infraction.

The expert is expected to testify within a reasonable degree of medical certainty that defendant allowed ulcers to develop and failed to adequately treat the same once they developed and allowed them to progress.

The expert is expected to testify that within a reasonable degree of medical certainty that defendant violated New York Public Health Law §2801-d by violating 42 CFR §§483.15, 483.20 and 483.25 and 10 NYCRR §§415.3, 415.5, 415.11 and 415.12 by failing to ensure that the plaintiff's decedent was treated with dignity and that he had comprehensive assessments which addressed his physical condition.

The expert is anticipated to testify that within a reasonable degree of medical certainty that defendant violated New York Public Health Law §2801-d by violating 10 NYCRR §§415.5, 415.12 and 42 CFR §§483.15 and 483.25 in that it failed to ensure that the plaintiff's decedent received the necessary care and services to attain or maintain his highest practicable physical well-being in that defendant allowed his foot ulcers to progress.

This expert may also be asked to offer opinions as to any testimony proffered by the plaintiff's experts, defendant and its experts, as well as the testimony from anyone else elicited during the trial of this matter.

E. **SCOPE OF TESTIMONY REGARDING CAUSATION:**

This expert is expected to testify within a reasonable degree of medical certainty that the above deviations from the standards of accepted medical practice of defendant, and those under its supervision, were the competent producing cause of the plaintiff's decedent [redacted] sustaining injuries and wrongful death inclusive of:

- STAGE 2 LEFT LEG ULCER
- STAGE 2 RIGHT LEG ULCER
- RIGHT BUTTOCKS ULCER
- DEEP VEIN THROMBOSIS
- METATARSAL AMPUTATION
- HYPOTENSION
- MYOCARDIAL INFARCTION
- DEATH

The expert is also expected to testify that within a reasonable degree of medical certainty that defendant violated New York Public Health Law §2801-d by violating 42 CFR §483 et seq and 10 NYCRR §415 et seq and that all of the above departures from good and accepted medical practice and violations of statutes, codes and regulations were a substantial factor that led to plaintiff's decedent [redacted] sustain the above mentioned injuries. All of the above listed injuries and disabilities are claimed to be permanent, progressive and protracted, and were caused by the malpractice of defendant and those under its supervision.

F. **SUMMARY OF GROUNDS FOR OPINION:**

It is anticipated that all of the opinions expressed by this expert will be within a reasonable degree of certainty from the perspective of a physician board certified in Emergency Medicine and Medical Toxicology with a specialty in Wound Healing. Moreover, to the extent that defendant's experts express opinions that are contrary to those expressed by this expert, it is anticipated that this expert will refute those opinions of defendant's experts.

PLEASE TAKE NOTICE that plaintiff reserves the right to amend and/or supplement this disclosure up to the time of trial.

Dated: New York, New York
[redacted]

Yours etc.,
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By: WALTER OSUNA

TO: [redacted]

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF [redacted]

----------X

[redacted]

Index No. [redacted]

Plaintiff,

3101(D) – EXPERT WITNESS DISCLOSURE – EXPERT "B"

-against-

(GERIATRIC MEDICINE)

[redacted]

Defendants.

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PLEASE TAKE NOTICE, that pursuant to CPLR 3101(d), Plaintiff designates the following person as an expert witness expected to testify at the time of trial of this action:

A. IDENTITY

Plaintiff declines to disclose this expert physician's name pursuant to CPLR section 3101(d) (1)(i), but reserve their right to call at the time of trial a medical doctor board certified in Internal Medicine and Geriatric Medicine, which is identified herein as "Expert B"

B. QUALIFICATIONS

The Expert is a medical doctor duly licensed to practice medicine in the State of [redacted] and Board Certified in Internal Medicine and Geriatric Medicine by the American Board of Internal Medicine. The expert has engaged in the practice of Internal Medicine and Geriatric Medicine [redacted] This expert is board certified in internal medicine [redacted]; certified in Geriatric Medicine [redacted] certified in in Hospice and Palliative Care [redacted] and a certified Medical Director in Long Term Care [redacted] Expert "B" is a Medical Director of [redacted] This expert is also an Adjunct Clinical Assistant Professor of Medicine [redacted]

[redacted]f
[redacted]
[redacted]
[redacted] Expert "B" graduated from t[redacted]
[redacted]The expert's post-graduate training was [redacted]
[redacted]
[redacted]aintiff's expert also completed a fellowship in Geriatric Medicine [redacted]
[redacted]

C. **BASIS OF EXPERT'S TESTIMONY:**

Expert "B" is expected to testify based upon her/his education, training, research, writings, medical literature, and experience in the fields of medicine, nursing home care, geriatrics and geriatric administrative care, medical, nursing and individual attendant care. He/she will rely upon his/her review of medical records and reports for [redacted] including those from defendant [redacted]nd subsequent medical records, including [redacted] as well as the deposition transcripts of plaintiff [redacted], and defendants' and/or witnesses, as well as the pleadings, including the Bill of Particulars and Supplemental Bill of Particulars as well as Federal and State Regulations in existence for nursing home facilities, including New York State Public Health Law, NYCRR and the CFR. Plaintiff's expert may be asked to offer opinions as to any testimony, including from plaintiff's experts, defendants, and defendants' experts during the trial of this matter.

D. **SCOPE AND SUBSTANCE OF TESTIMONY AND OPINIONS:**

Expert "B" is expected to testify as to the quality and sufficiency of the medical and nursing care rendered to [redacted] by defendants [redacted] he expert is expected to testify that the medical records reflect that [redacted] was a resident at and under the care of Defendants from November 27, 2012 through December 4, 2012.

Plaintiff's Expert is expected to testify regarding the medical condition of [redacted] from the time she came under Defendants' care until her transfer to [redacted] on December 4, 2012. It is anticipated that the expert will testify that [redacted] was admitted to defendant [redacted] facility on November 27, 2012 from [redacted] for restorative rehabilitation and presented with confusion, dementia, decreased mobility, and was totally dependent for ambulation, transfer, eating, grooming, and toileting. She was also under anti-psychotic medication. Plaintiff's expert physician is further anticipated to testify that due to her medical history, [redacted] was assessed at a high fall risk, and consequently required the implementation of fall risk protocols, including bed and chair alarms, frequent monitoring and transfer assistance.

Expert "B" is expected to testify with respect to the medical and nursing care, procedures, standards and protocol as they relate to the care and treatment of residents at a high risk for falls in nursing home and home care settings.

Plaintiff's expert is expected to testify as to the standard of care while caring for a patient such as [redacted]. Expert "B" is expected to testify that defendant [redacted] through its agents, servants, and/or employees, including co-defendant [redacted] were

negligent in that they rendered medical and nursing care and treatment in deviation from accepted standards of care. The expert is expected to testify about the care and treatment rendered to the resident [redacted] or lack thereof, by defendant [redacted]. This expert is expected to testify that, based upon review of the relevant records and New York State Public Health Law, Title 10 NYCRR and CFR sections, the treatment rendered to [redacted] during these periods of time was below acceptable standard of care and violated Public Health Law §2801(d) and §2803-c. This expert is expected to testify that the medical malpractice and negligence of Defendants and its employees, servants, and agents occurred from November 27, 2012 through December 4, 2012, which caused her to sustain a fall on December 2, 2012 and suffer from serious injuries as a result.

The expert is expected to testify that Defendants were, throughout the periods of time alleged, neglectful, negligent, and departed from standards, practices, and customs in the field of geriatric medicine and nursing in that they failed to properly and completely assess [redacted] and update the plan of care for as her condition changed. This expert is anticipated to testify that Defendants failed to recognize the significance of the resident's past medical history, including her confusion, decreased mobility, unsteady gait, lack of safety awareness, ingestion of anti-psychotics/sedatives, and dementia. Expert "B" is expected to testify that [redacted] required that proper assessments of her fall risk be made so that CNAs on duty, including defendant [redacted] were properly aware of [redacted] condition.

The expert is also anticipated to testify that Defendants failed to properly evaluate and update the assessments and care plans, and failed to perform appropriate investigations and work ups of [redacted] in violation of Public Health Law § 2803-c(3)(e), §2801-d , and 10 NYCRR § 415.11. The care plan instituted for [redacted] had generic interventions for a fall risk

patient. The initial fall assessment did not include frequent observation or placing a mattress on floor despite [redacted]eing categorized as a high risk for falls. Additionally, Defendants failed to perform a necessary fall risk assessment for [redacted]on each shift or when there was a change in her medical or mental condition.

The expert is anticipated to testify that defendant [redacted] medical chart was inadequate in preventative planning to meet the needs of [redacted] The expert is expected to testify, within a reasonable degree of medical certainty, that Defendants violated New York Public Health Law §2801-d by violating 10 NYCRR §415.11 and 42 CFR §483.20 for not having an adequate plan of care and not updating the plan of care as necessary.

Plaintiff's expert is expected to testify that Defendants' failure to perform a necessary fall risk assessment for [redacted]n each shift or when there was a change in the resident's medical or mental condition, continually assessing and reassessing for risk of falling upon review of the resident's mental status, physical condition, age, and prior falls, or medication which may place the patient in jeopardy of falling, greatly contributed to [redacted]all and the resulting hip fracture. Furthermore, after the December 2, 2012 fall, Defendants further were negligent in failing to revise and reassess the plan of care to protect the resident from additional falls while she was still a resident at Defendants' facility.

The expert is expected to testify that defendant [redacted]failed to implement proper precautions and interventions in a resident like [redacted], who was at high risk for falls, such as having a working bed alarm, placing floor mats and/or mattresses, lowering her bed, close supervision and assistance with ambulation and transfers, close monitoring for reactions to medications, placing the resident close to the nursing station, and close monitoring for disorientation or poor safety awareness due to inefficacy of psychotropic drugs.

Expert "B" is anticipated to testify that Defendants failed to ensure that the resident received adequate devices to prevent her fall on December 2, 2012, including working bed and/or chair alarms, secured bed rails, and/or floor mats. According to defendant [redacted] policies and procedures, to assure a safe environment for residents, the staff needed to provide assistive devices of bed/chair alarms for residents who were at risk for falls and injury. The expert is anticipated to testify that Defendants failed to have in place a functioning bed alarm. Expert "B" is expected to testify, that according to the progress note of December 2, 2012, the *"bed alarm was working buy [with] very low tone"* and that *"the bed alarm was replaced"* thereafter. The expert is further expected to testify that a bed alarm is not replaced if only the batteries need changing and thus, it is more likely than not, that the bed alarm was not functioning.

The expert is anticipated to testify that Defendants failed to ensure that any medical alert devices, including bed and/or chair alarms were properly in place and fully operational and consequently failed to follow its own safety and fall protocols. Defendant [redacted] failed to properly physically check the bed alarm and failed to ensure that the alarm was audible prior to leaving the resident unattended. The expert is expected to testify that defendant [redacted] protocols instruct the staff to ensure that the alarm is activated when resident is in bed, wheelchair, or Geri chair and to regularly conduct preventive maintenance of the alarm, including each shift for placement and functioning.

The expert is expected to testify that Defendants failed to adequately secure the resident in her bed. Pursuant to the medical records, at approximately 9:15am, the resident asked to lie down and defendant [redacted] put the resident to bed. It is expected that the expert will testify that had this defendant properly secure the resident in bed, it is likely that her fall could have been prevented. Defendant failed to ensure and check that the bed rails were secured upwards and that

the bed alarm was functioning properly prior to leaving the resident unattended.

Expert "B" is expected to testify that defendant [redacted] failed to place a mattress and/or mat on the resident's floor. Plaintiff's expert is expected to testify that floor mats and/or mattress, which are soft, cushioned mats placed beside a resident's bed, would have been effective in preventing the injury that resulted here. Plaintiff's expert is expected to testify that these mats and/or mattresses would have absorbed the impact of the fall preventing serious injury. Plaintiff's expert is expected to testify that it was negligent to fail to put in place said floor mats and/or mattress around the resident's bed and that such negligence led to the resident's injuries and defendant NEW VANDERBILT was in violation of CFR 483.20(k), 483.25(a)(1), 483.25(h)(2), 483.30(a) and 10 NYCRR 415.11(a), 415.12(a)(1) and 415.12(h)(2).

The expert is expected to testify that the staff from defendant [redacted] departed from the standards of care in the treatment rendered to [redacted] in that they failed to monitor and adequately supervise [redacted], and take necessary precautionary measures to prevent her fall on December 2, 2012 and subsequent injuries in violation of the aforesaid applicable statutes, rules and regulations. Expert "B" is expected to testify that Defendants negligent allowed the resident to leave her bed without adequate supervision. According to the medical chart, the resident was left in bed at approximately 9:15 am. The expert is expected to testify that at approximately 10:20 am, [redacted] was found lying on the floor on her right side in the East side hallway of the floor. Plaintiff's expert is anticipated to testify that had [redacted] been properly supervised and monitored at the time of the fall, the nursing staff could have intervened as to prevent her from falling. Plaintiff's expert is expected to testify that most likely [redacted] would not have suffered the December 2, 2012 fall had she been properly monitored.

The expert is expected to testify, within a reasonable degree of medical certainty, that defendant [redacted], failed to promptly assess, monitor, diagnose, and treat [redacted] injuries, including a hip fracture, which she sustained as a result of her fall.

Expert "B" is expected to testify that Defendants negligently failed to timely report the resident's fall to the attending physician and/or registered nurse. This expert is anticipated to testify that Defendants failed to timely refer [redacted] to a physician or registered nurse to examine her immediately after her fall on December 2, 2012 to confirm or rule out a fracture before putting her in a chair and back to bed. Defendant [redacted] departed from the standard of care by allowing a licensed practical nurse (LPN) and/or Certified Nursing Assistant (CNA) to assess the resident and pick her up the floor before she was examined by a physician or registered nurse.

The expert is expected to testify that defendant [redacted] failed to timely diagnose the resident's injuries, including her hip fracture, and failed to appreciate the inadequate results of the diagnostic tests performed at defendant's facility despite poor visualization. Defendant further failed to properly and timely order further diagnostic tests to assess the resident's complaints and condition.

[redacted] is expected to testify that defendant [redacted] failed to properly and timely treat the resident's right hip fracture and/or transfer her to an emergency room for medical treatment and evaluation. On December 3, 2012, a repeat x-ray was performed due to the resident continuous complaints of pain, which showed a displaced fracture of her right femoral neck.

Expert "B" is expected to testify that Defendants failed to promptly transfer the resident to a hospital, despite her persistent complaints of right hip pain and inadequacy of the x-rays

performed. [redacted] is expected to testify that, while under the care of [redacted] repeatedly complained about pain on her hip post-fall and Defendants failed to promptly heed and consider her complaints of pain and discomfort. The expert is expected to testify that the resident was not transferred to [redacted] for right knee and hip x-rays until December 4, 2012. It is further anticipated that the expert will testify that on December 5, 2012, [redacted] underwent a right hip replacement as a result of her injury caused by the fall on December 2, 2012.

Furthermore, the expert is anticipated to testify that on December 3, 2012, Defendants allowed [redacted] to go out on a pass after her fall and a suspicion of a fracture. Defendants should have placed the resident in bed rest after the incident.

It is also anticipated that plaintiff's expert will testify regarding the resident's complaints, progression of her injury and course of treatment at [redacted] based on his/her review of the medical records. Expert "B" is further expected to testify that [redacted] remained hospitalized at [redacted] until December 13, 2012, at which time she was transferred to [redacted] with a cast boot on both legs, where she remains a resident to the present time.

The expert is expected to testify that defendant [redacted] through its agents, servants, and employees, including defendant [redacted], was solely responsible for providing total care to [redacted] and that defendant had the responsibility to provide suitable nurses for her care. The expert is expected to further testify that defendant [redacted] entrusted with the care of [redacted] those who were negligent and careless, including co-defendant [redacted] and that defendant [redacted]

was consciously indifferent to the negligence of those whom it entrusted with the care of resident [redacted]

Plaintiff's expert is anticipated to testify that defendant [redacted] failed to have available adequate personnel, including co-defendant [redacted] who were properly and adequately trained in the subject of fall prevention and treatment, in order to properly treat [redacted] and failing to exercise proper and effective supervisory control over its personnel. Expert "B" is further expected to testify that defendant [redacted] negligently hired nurses, nurses' aides, and other medical professionals who were unqualified, poorly qualified and lacked the requisite qualifications and skills to perform diagnosis and treatment and properly assess the resident for safety risks according to protocols and in conformity with standards of good medical practice. Defendant [redacted] the CNA on duty at the time of the resident's fall, testified that she did not have knowledge of [redacted] medical history, fall risk or previous falls, and that the fall risk documentation was inadequate and incomplete. Expert "B" is expected to testify that a CNA on duty must know whether that patient has a history for falls or is at a risk for falls. Plaintiff's expert is expected to testify that this was a deviation from the standard of care as well as the facility's own protocols.

The expert is expected to testify that within a reasonable degree of medical certainty that defendant violated New York Public Health Law §2801-d by violating 42 CFR §§483.15, 483.20 and 483.25 and 10 NYCRR §§415.3, 415.5, 415.11 and 415.12 by failing to ensure that the resident [redacted] was treated with dignity and that she had comprehensive assessments to address her physical condition.

The expert is anticipated to testify that within a reasonable degree of medical certainty that defendant violated New York Public Health Law §2801-d by violating 10 NYCRR §§415.5,

415.12 and 42 CFR §§483.15 and 483.25 in that it failed to ensure tha[redacted]eceived the necessary care and services to attain or maintain her highest practicable physical well-being in that Defendants allowed her to fall and sustain a hip fracture that impaired her mobility.

Expert "B" is expected to testify that the treatment rendered to[redacted] at defendant [redacted]s facility was below the acceptable medical standard of care and in violation of New York State Public Health Law, NYCRR and the CFR, including 10 NYCRR § 415.12 (h)(2), which places a duty on nursing home facilities to maintain an environment as free from hazards as possible and to ensure that "[e]ach resident receives adequate supervision …to prevent accidents."

Additionally, Plaintiff's expert is expected to testify that the standards fell below those required by the Federal Code that govern and oversee care in skilled nursing facilities set forth by the Centers for Medicare and Medicaid including 42 CFR §483.20(d) (3) & § 493.20(d)(3)(i) in that the services must meet professional standards of quality and §483.25(1)(1) in that [redacted] as required to have proper monitoring for her medications.

The expert is further expected to testify that Defendants failed to properly document and chart the treatment against the standard of care in the nursing field and in violation of Public Health Law §2801(d) and §2803-c. Defendant further failed to properly complete the MDS. The expert is also expected to testify that Defendants failed to properly investigate the incident. The expert is expected to further testify that there are inconsistencies between the Incident Report and the Progress notes prepared soon after the incident occurred as to the cause of resident's fall. The Incident Report documents that the resident fell out of her wheelchair despite the progress note stating that the resident was placed in bed prior to being left unattended and the resident needing assistance to transfer to a wheelchair. The expert is also expected to testify regarding the

importance of the nursing staff communicating changes in the plaintiff's [redacted] condition to medical providers and documenting the same as medical practitioners rely on these nursing communications and/or notes when treating a resident and modifying the plan of care and treatment accordingly.

Plaintiff's expert is anticipated to testify as to the damages caused by Defendants as well as the exacerbation of injuries caused thereby, and Defendants' overall neglect in the care of [redacted] while she was a resident at their facility. Plaintiff's expert is expected to testify that the above noted medical malpractice, negligence and violations of Statute and Code were the proximate cause of the resident's fall on December 2, 2012, which resulted in a fracture of the right hip, need for surgical intervention and hip replacement, diminished mobility, and conscious pain and suffering.

This expert may also be asked to offer opinions as to any testimony proffered by the plaintiff's experts, Defendants and their experts, as well as the testimony from anyone else elicited during the trial of this matter.

E. <u>SCOPE OF TESTIMONY REGARDING CAUSATION</u>:

This expert is expected to testify within a reasonable degree of medical certainty that the above deviations from the standards of accepted medical and nursing practice of Defendants, and those under their supervision, were the competent producing cause of the injuries sustained by [redacted] including:

- FRACTURE OF THE RIGHT FEMORAL NECK
- NEED FOR SURGERY
- RIGHT HIP REPLACEMENT
- NEED FOR CAST BOOTS

- EXTENSIVE HOSPITALIZATION
- DIFFICULTY AMBULATING
- CONFINEMENT TO WHEELCHAIR
- NEED FOR ADDITIONAL/INCREASED PHYSICAL THERAPY
- DECREASE IN ACTIVITIES OF DAILY LIVING
- INCREASED NEED FOR ASSISTANCE
- ACUTE AND EXTENSIVE PAIN
- PAIN IN LEFT HAND AND RIGHT HIP
- SWELLING
- BRUISING
- EMBARASSMENT
- EMOTIONAL DISTRESS
- FEAR, ANXIETY, DEPRESSION
- MENTAL ANGUISH
- LOSS OF ENJOYMENT OF LIFE

The expert is also expected to testify that within a reasonable degree of medical certainty that defendant violated New York Public Health Law §2801-d by violating 42 CFR §483 et seq and 10 NYCRR §415 et seq and that all of the above departures from good and accepted medical practice and violations of statutes, codes and regulations were a substantial factor that led [redacted] to sustain the above mentioned injuries. All of the above listed injuries and disabilities are claimed to be permanent, progressive and protracted, and were caused by the negligence and malpractice of Defendants and those under their supervision

F. SUMMARY OF GROUNDS FOR OPINION:

It is anticipated that all of the opinions expressed by this expert will be within a reasonable degree of certainty from the perspective of physician board certified in Internal and Geriatric Medicine. Moreover, to the extent that Defendants' experts express opinions that are contrary to those expressed by this expert, it is anticipated that this expert will refute those opinions of Defendants' experts.

PLEASE TAKE NOTICE that plaintiff reserves the right to amend and/or supplement this disclosure up to the time of trial.

Dated: New York, New York
[redacted]

Yours etc.,
The Jacob D. Fuchsberg Law Firm, LLP
Attorneys for Plaintiffs
500 Fifth Avenue
New York, NY 10110
Tel: (212) 869-3500
Fax: (212) 398-1532

By: WALTER OSUNA

TO: [redacted]

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF [redacted]

----------X

[redacted]

Index No: [redacted]

Plaintiff,

-against-

[redacted]

Defendants.

----------X

3101(D) – EXPERT WITNESS DISCLOSURE – EXPERT "C"

(Physical Medicine and Rehabilitation)

PLEASE TAKE NOTICE, that pursuant to CPLR 3101(d), plaintiff designates the following individual as an expert witness expected to testify at the time of trial of this action:

A. **IDENTITY**:

[redacted] M.D.
[redacted]

B. **QUALIFICATIONS**:

Plaintiffs expect to call at the time of trial a medical doctor whose primary specialty in Physical Medicine and Rehabilitation. This expert obtained his/her medical degree from the [redacted]e. This expert is board certified in Physical Medicine and Rehabilitation and has been affiliated with several nationally known medical centers. This expert is a member of numerous professional medical societies and has taught at several nationally known medical schools and teaching hospitals in the areas of physical medicine.

C. BASIS/SUBJECT MATTER AND SUBSTANCE OF TESTIMONY AND OPINIONS

The Subject Matter of [redacted] expected testimony will be regarding his review and analysis of the medical records and medical history, and his findings, analyses, projections, conclusions, and opinions that are contained in his report, attached as Exhibit A. [redacted] is expected to testify regarding [redacted], her injuries, including a fracture of the right femoral neck, hip replacement, necessity for long-term rehabilitation, decreased mobility, and the injuries and conditions listed in Plaintiff's Bill of Particulars and Supplemental Bill of Particulars, his review of the current literature and science regarding Physical Medicine and Rehabilitation, his review of all deposition testimony in the case, and all other items that are discussed in his report, which is attached as Exhibit A. [redacted] will testify based upon his education, training, research, writings, and experience and expertise as a physician that is Board Certified in Physical Medicine and Rehabilitation.

[redacted] is expected to testify concerning associated costs for [redacted] s home health aide (HHA) services and nursing home care as a result of her injuries. [redacted] is expected to testify that at [redacted] n, her current residency, the annual per diem costs are calculated at $140,525.00. The expert is expected to testify that assuming [redacted] was able to return home instead of requiring permanent resident at a nursing care facility, as a result of her injuries, she would require 24 hours HHA assistance, which cost would total approximately $174,148.80 ($19.88 per hour). This expert is further anticipated to testify that discounting the 8 hours HHA care provided to [redacted] prior to her admission to Defendant [redacted] the net

increase in cost for a HHA based on her current condition would amount to $116,099.20 annually.

In addition, the expert may be asked to address or offer his analysis and opinions as to any testimony proffered by Plaintiff, Defendant and its employees, agents, servants, Defendants' experts, and any other trial witnesses. All of the opinions of [redacted] will be testified to within a reasonable degree of medical certainty for a physician who is Board Certified in Physical Medicine and Rehabilitation. It is also anticipated the testimony of [redacted] will address the reports, expert exchanges, and testimony provided by Defendants and/or its experts in this matter. Moreover, to the extent that Defendant's experts express opinions, or other witness opinions, that are contrary to those expressed by this expert, it is anticipated that this expert will refute those opinions of Defendant's experts.

PLEASE TAKE NOTICE that Plaintiff reserves the right to supplement and or amend this CPLR §3101(d) expert disclosure up to and during the trial of this action, in accordance with the CPLR and applicable case law.

Dated: New York, New York
[redacted]

Yours etc.,

THE JACOB D. FUCHSBERG LAW FIRM, LLP

By: WALTER OSUNA, ESQ.
Attorneys for Plaintiff
500 Fifth Avenue 45th Floor
NEW YORK, NEW YORK 10110
(212) 869-3500

[redacted]

[redacted] M.D.
Physical Medicine & Rehabilitation
[redacted]

[redacted]

Walter Osuna
The Jacob D. Fuchsberg Law Firm LLP
500 Fifth Avenue
New York, NY 10011

RE: [redacted]

Dear Mr. Osuna:

The following narrative is based upon medical records reviewed from [redacted] and the EBT Plantiff's notes re: [redacted]

A discharge summary is available from [redacted] indicating an admission date of 11/20/12 through discharge 11/27/12. This noted that [redacted] was admitted to the hospital with a urinary tract infection and confusion. The past medical history included Alzheimer's disease. A Patient Review Instrument (PRI) completed on 11/26/12 indicated that she required help/encouragement to complete a meal, walk with constant one-on-one supervision or physical assistance, assistance with transfers, and incontinent of bowel and bladder.

[redacted] was admitted to [redacted] on 11/27/12. Diagnoses included urinary tract infection, confusion, dementia, hypertension, and decreased mobility. The falls assessment of 11/28/12 noted that she had fallen within the prior 30 days. She needed assistance with transfers and ambulation. She had an unsteady gait and decreased safety awareness, among other issues. Preventive measures included a medication review/adjustment, low bed, allow adjustment to facility, mechanical alert device on bed and chair, and a rehabilitation evaluation. The nursing note of 12/02/12 described that the patient had been placed back to bed and subsequently found by the CNA laying on the floor on her right side in the hallway. An x-ray was ordered, 12/02/12, of the left hand describing severe degenerative joint disease and a chronic deformity of the distal radius and carpal bones without acute fracture. The right

[redacted]

knee x-ray indicated the prosthesis to be intact. Another falls assessment dated 12/03/12 was very similar noting that she was at risk for falls. The right hip x-ray dated 12/03/12 found a displaced fracture of the right femoral neck with severe osteoporosis. She was discharged on 12/04/12 to the acute care hospital emergency room for evaluation due to a displaced fracture of the right femoral neck.

Records have been provided from [redacted] The patient was admitted on 12/13/12 and reportedly remains to date with available records through 10/08/14. Overall, there appeared to be a decline in mobility status, as well as notations of agitated behavior.

An Examination Before Trial Plaintiff's notes is dated [redacted] The notes indicate that there was a home health aide 8 hours per day until admission to [redacted] She was able to leave the house with the aide to go shopping, events at the [redacted] and such. She used a walker for walking and did not use a wheelchair prior to the admission to [redacted] She was able to go to the bathroom on her own with the aide assisting her with bathing. Both knees had been previously replaced. The events surrounding the fall and subsequent treatments were reviewed. She eventually underwent a hip replacement per the testimony.

CONCLUSION:

As requested I am providing costs for home health aide (HHA) services and nursing home care. [redacted]s currently at [redacted] where the per diem is $385.00, annualizing to $140,525.00. Should she be able to return home, 24 hours of HHA at $19.88/hr annualizes to $174,148.80. Discounting for the previous need of 8 hours/day of HHA service at $19.88/hr, annualizing to $58,049.60, the net increase in cost would be $116,099.20.

Very truly yours,

[redacted]

Electronically signed and approved

[redacted]

[redacted]

RESOURCES:

[redacted]