EXHIBIT 11

MEDIATION MEMORANDUM

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

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[redacted] Attorney-in-fact of

Index No.: [redacted]

Plaintiff,

-against-

[redacted] M.D., "JOHN/JANE DOE, R.N." (said name being fictitious but intended to represent the Registered Nurse who examined and provided medical care to Plaintiff [redacted] on January 11, 2015 at [redacted] REHABILITATION AND NURSING), "JOHN/JANE DOE, NP" (said name being fictitious but intended to represent the Nurse Practitioner who examined, provided medical care and/or order x-rays to Plaintiff [redacted] January 11, 2015 at [redacted] REHABILITATION AND NURSING), and [redacted] REHABILITATION AND NURSING,

Defendants.

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EXHIBITS

Exhibit A	Bill of Particulars
Exhibit B	Relevant Progress Notes [redacted]
Exhibit C	Accident/Incident Report of January 11, 2015
Exhibit D	Relevant Records [redacted]
Exhibit E	Radiological Films at [redacted]
Exhibit F	Ambulance Report January 13, 2015
Exhibit G	Consultation and Operative Report [redacted]
Exhibit H	Radiological Films a[redacted]
Exhibit I	Relevant Records [redacted]
Exhibit J	Relevant Progress [redacted]
Exhibit K	Prior Accident/Incident Reports 2014
Exhibit L	Relevant pages Transcript [redacted]
Exhibit M	Relevant pages Transcript Defendant [redacted]
Exhibit N	Relevant pages Transcript o[redacted]
Exhibit O	Policies & Procedures
Exhibit P	Insurance Information
Exhibit Q	Lien Information/Outstanding Bills
Exhibit R	Verdict and Settlements with similar injuries

PRELIMARY STATEMENT

This case involves C[redacted] a then 83 year old woman (date of birth December 9, 1931), who sustained a fall while she was a resident of defendant [redacted] Rehabilitation and Nursing ("[redacted]") on or before January 11, 2015 that resulted in an intertrochanteric left hip fracture, which required intramedullary rodding[1].

Ms. [redacted] was admitted to [redacted] for long-term care on January 9, 2014 with a medical history that included Alzheimer, Dementia, unsteady gait, falls, need for total assistance with transfers and toileting, and was on antipsychotic medication, which placed her at a high risk for falls. She remained a resident at such facilty until January 13, 2015. During her one year residency, prior to the incident that caused her left hip fracture, Ms. [redacted] had sustained falls on April 8, 2014, June 1, 2014, and December 3, 2014.

Pursuant to the medical records, on January 11, 2015, Ms. [redacted] was complaining of severe left hip pain and the area was painful to touch. Her roommate advised the nursing staff that Ms. [redacted] fell "this past Sunday" and that she witnessed the staff picking her up from the floor and putting her back to bed. Ms. [redacted] was unable to communicate what had transpired due her mental condition and that a Spanish translator was not provided, as Spanish was her main language at the time. The nurse practitioner order stat x-rays to her left hip to rule out a fracture, which were reported as negative for fractures. According to the accident report, defendant [redacted] M.D. ("[redacted]"), her primary care physician, had ordered to transfer the resident to the ER for further evaluation. However, she was not transferred at that time. Ms.

[1] This surgical procedure stabilizes severe fractures of the femur by placing a metal rod into the center of the femur. See http://centralcoastortho.com/patient-education/femur-fracture-fixation-with-intramedullary-rod/

continued to complain of left hip pain, and the x-rays were repeated on January 13, 2015, which showed an acute intertrochanteric fracture on the left femur.

Dr. ordered her transfer to the ER after he became aware of the radiology reports for further evaluation. The x-rays results were received about 4:30 pm; however, the facility did not request a transfer to the ER until approximately 9:49pm.

On January 13, 2015 an ambulance pick her up at and transferred her to Hospital. Ms. presented to with significant left hip pain and swelling on her leg, which was painful to touch. After further x-rays were taken, she was diagnosed with a left intertrochanteric left hip fracture. On January 14, Dr. performed surgery on Ms. , during which an intramedullary rod was inserted. The type of injury indicates that the source was traumatic and the location of the fracture indicates that the same was a result of a fall.

As a result of her fracture and subsequent surgery with hardware, Ms. was confined to a wheelchair, continued to experience pain, and her functional level and ability to perform activities of daily living diminished. Prior to the fall that caused her left femur fracture, Ms. was able to walk up the stairs and transfer with assistance. Furthermore, since Ms. fall went unreported for days, there was a delay in treatment for her injury causing her severe conscious pain and suffering. Ms. was admitted to on January 19, 2015, where she remains to the present time.

I. STATEMENT OF FACTS

Prior to being admitted to Ms. lived at home (see Exhibit L pp. 37-38). Ms. and her daughter will see each other regularly and talk on the phone daily (see Exhibit L p. 38). Ms. was able to take care of her activities of daily

living until she started to experience the dementia in mid-2012 and required a home health aide in 2013 to assist her (see Exhibit L pp. 51-52, 58-59).

Due to her evolving dementia and safety concerns due to a fall, Ms. [redacted], was taken to [redacted] or long-term care with a history of prior falls, Alzheimer, Dementia, needed total assistance with toileting, bathing, dressing, and assistance with transfers (see Exhibit D and Exhibit L p. 79, 109-110). Upon admission, her Fall Risk Assessment Score was 15, which placed her at a high risk for falls and related injuries (see Exhibit D). By February 25, 2014, it was noted that Ms. [redacted] experienced unsteady gait, had a tendency to wander off, was unable to appreciate dangerous areas, and was on antipsychotic drugs, adding to her risk for falls (see Exhibit D).

Furthermore, during her one year residency, Ms. [redacted] sustained falls on **April 8, 2014** (resident noted sitting on buttocks near bedroom door after sensor alarm sounded at 11:30 pm, she was transported to the ER to rule out a right hip fracture), **June 1, 2014** (staff observed resident sliding out of the wheelchair to the floor on her left side and hitting the left side of her face on the floor, sustaining redness to left side of her face 0.1 x 0.1 cm), and **December 3, 2014** (resident found at 3:05 am sitting on the floor before the front of her bed, no visible injuries found) (see Exhibits B and K).

On or before January 11, 2015, Ms. [redacted] made complaints of pain to the left hip site, which was painful to touch and appeared to be the result of a fall (see Exhibits B – C, and N pp. 94, 98, 101, 103-106). Ms. [redacted] was unable to explain the occurrence, due to her compromised mental condition and that no Spanish speaking staff made inquiries about the incident (see Exhibits B, C, and N pp. 63, 103). However, her roommate blurted out to [redacted] LPN, that Ms. [redacted] "fell this past Sunday" (see Exhibit N p. 102). The roommate thereafter advised the nursing staff that Ms. [redacted] was picked up from the floor, she "went out in the hall and called for

help" and Ms. [redacted] was put back to bed[2] (see Exhibits B-C). Furthermore, according to the statement of Nurse [redacted] she had noticed Ms. [redacted] in pain after she placed on her on a wheelchair on January 8, 2015 and had asked a CNA to put her back to bed (see Exhibit C). Based on the records and accident report, there is no indication that there was a working bed or chair alarm in place at the time (see Exhibits C, B, M p. 81, and N p. 51, 60-61, 106). Ms. [redacted] had previously complained about the chair and bed alarms not working (see Exhibit L p.122,). Ms. [redacted] was sent for x-rays of the left hip to rule out a fracture as she was screaming and crying when the left leg was touched (see Exhibits B). No visible fractures or dislocation were noted; however it was noted that some percentage of hip fractures were occult radiographically (see Exhibit E). According to the accident report, Dr. [redacted] had ordered to transfer the resident to the ER for further evaluation; however, she was not transferred at that time (see Exhibit C). No other studies were performed at such time.

Ms. [redacted] continued to cry from pain to her left femur on January 12, 2015 and continued doing the same on January 13, 2015 when weight bearing (see Exhibits B-C). Further x-rays were requested on her left knee and femur (see Exhibit E). The x-ray report of the left femur obtained at around 4:39 pm demonstrated an acute intertrochanteric fracture with varus angulation (see Exhibit E).

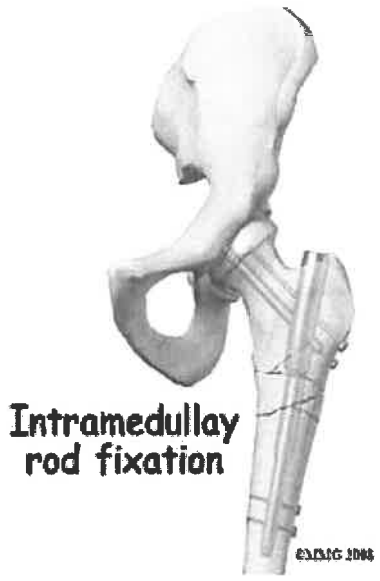
On January 13, 2015 an ambulance picked her up at around 10:02pm to transfer her to [redacted] Hospital for further evaluation due to a possible left femur fracture (see Exhibits F). Dr. [redacted] ordered the transfer of the resident to the ER for further evaluation and treatment after

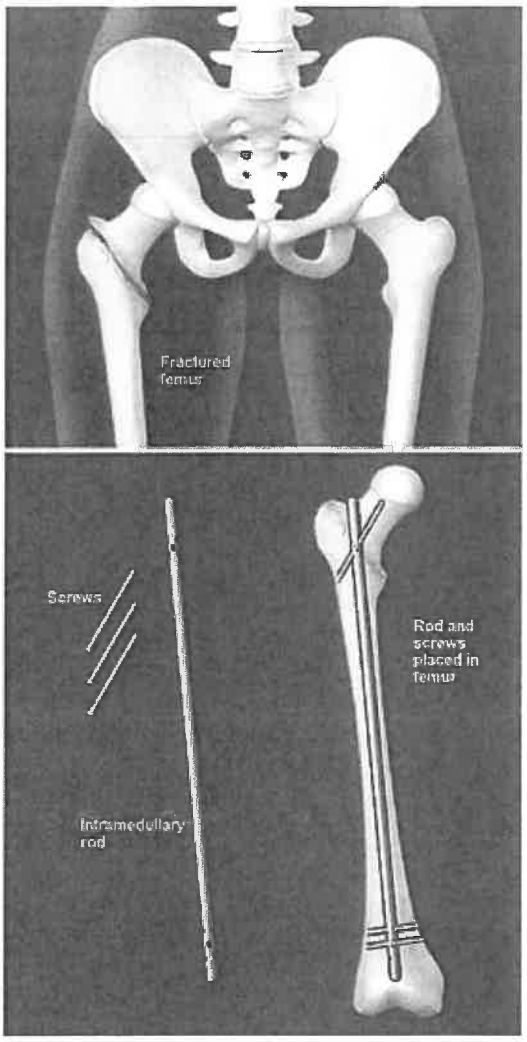
[2] Per the accident report, the resident's report was spoken to on January 14, 2015, and she reported that the resident fell "the other night and was picked up by two women and a male photographer". Although the resident experienced confusion, as noticed by [redacted]'s staff, it is likely that she referred to the x-ray technician as a male photographer (see Exhibit C).

reviewing the x-ray reports (see Exhibits B, D, and F). The x-rays results were received about 4:30pm; however, an ambulance was not called until approximately 9:49pm (see Exhibits D-E). Thus, the resident's fracture remained untreated for days exacerbating her injury and causing her further conscious pain and suffering.

Ms. [redacted] presented to [redacted] around 10:49pm on January 13, 2015 with significant "left groin pain status post fall at a nursing home" (see Exhibit I). Swelling was also noted on her leg and she would yell in pain every time her left extremity was touched or moved (see Exhibit I). She was diagnosed at [redacted] Hospital with a left intertrochanteric left hip fracture (see Exhibits G-I). Upon physical examination, significant discomfort upon range of motion of the left lower extremity was noted (see Exhibits G-I). In addition, on her admission to [redacted] Hospital it was also documented that the resident suffered from a Stage II decubitus ulcer on her right buttocks (see Exhibit I).

On January 14, Dr. [redacted] performed surgery on Ms. [redacted], during which an intramedullary rod was inserted (see Exhibits G, I, and example images below).





Ms. [redacted] was advised that, based on the type of injury and location of the fracture, the injury is was indicative of fall related trauma (see Exhibits G, L p. 156, 159-160, 188, N p. 105-106). As a result of her fracture and subsequent surgery with hardware, Ms. [redacted] was confined to a wheelchair, continued to experience pain, and her functional level and ability to perform activities of daily living diminished (see Exhibit J, Exhibit L p. 161, 175-176). Prior to the fall that broke her hip, Ms. [redacted] was able to walk up the stairs and transfer to her bed to chair with assistance (see Exhibit L pp. 110, 162).

Ms. [redacted] has been a resident of [redacted] since January 19, 2015, where she

remains to the present time (see Exhibit J).

II. CONTENTIONS/CAUSATION

According to plaintiff's medical expert, Ms. [redacted] hip fracture was traumatic and was the proximate cause of the fall of on or before January 11, 2015. Sudden hip fractures, such as the one sustained by Ms. [redacted], do not occur spontaneously. Furthermore, it is undisputed that Ms. [redacted] needed assistant to transfer and was not the kind of patient that could get in and out of bed on her own (see Exhibits B, C, D, L p. 79, 109-110, and M p. 44).

Henceforth, defendant [redacted] through its agents, servants, and/or employees, was negligent in that it rendered medical and/or nursing care and treatment in deviation from accepted standards of care and in violation of Public Health Law §2803-c; Public Health Law §2801-d; 10 NYCRR §415.3 (a); 10 NYCRR §415.3(e)(i); 10 NYCRR §415.5(a); 10 NYCRR §415.11; 10 NYCRR §415.11(c)(3); 10 NYCRR §415.12; 10 NYCRR §415.12(h); 10 NYCRR §415.12(h)(1); 10 NYCRR §415.12(h)(2); and 10 NYCRR §415.13.

Defendant failed to adequately and frequently monitor Ms. [redacted] despite assessing the resident at a high risk for falls due to a medical history that included dementia, Alzheimer's disease, confusion, need for assistance to ambulate, and the falls she sustained at their facility on April 8, 2014, June 1, 2014, and December 3, 2014, prior to the one that caused her fracture.

Furthermore, defendant failed to order adequate accident and fall prevention mechanisms, and failed to ensure that those in place were functioning properly. Defendant's own policies and procedures require the implementation of appropriate interventions to decrease and/or prevent falls (see Exhibit O). There is no indication that floor mats were implemented for this resident despite being available at defendant's facility or that the bed sensors were in place and functional around the time of the accident (see Exhibits D, M p. 81, N pp. 50). The resident's daughter,

had previously complained about the chair and bed alarms not working as she observed while visiting her mother (see Exhibit L 122). Moreover, the restraints implemented, such as the self-releasing vest, were not adequate as restraints present safety concerns for patients, as they can strangulate and injury themselves. Henceforth, regulations have implemented against their general issue as there are fall prevention interventions that are more benign; restraints are consider the easiest but not the most effective route.

Despite the resident's multiple falls, defendant failed to adequately implement and modify the care of plan according to the resident's change in condition, as required by law and the facility's own policies and procedures, to allow her to attain and maintain the highest practicable mental, physical and psychosocial well-being (see Exhibit O). Based on the medical records and testimony available, the plan of care was not updated and adapted to account for the aforementioned falls and implement further interventions, which defendant's staff was responsible for (see Exhibits D and M p. 48-50, 60). Defendant negligently failed to develop a plan to protect the resident from future falls that could cause serious injuries, including a fracture such as the one that occurred on or before January 11, 2015. For example, defendant's staff failed to perform a wheelchair assessment and/or evaluation to ensure that the resident was able to fit in the wheelchair provided and could be adjusted accordingly, which lead to her fall on June 1, 2014.

Defendant also failed to properly document the resident's condition, assessments, and her medical progression in the medical chart (see Exhibit O). For instance, there is a considerable gaps in progress notes between December 29, 2014 and January 11, 2015, which is during the period where Ms. fell at (see Exhibit B). It can be assumed that Ms. was not properly assessed if it was not documented. In a nursing home setting, when a

resident suffers a fall, the nursing staff must write a clear note as to what happened, how it happened, who was notified, and the sequence of events. There is no documentation as to the actual fall that caused Ms. [redacted] left femur fracture, which is a clear deviation from the standard of care (see Exhibit O).

In addition, a proper and timely investigation was not conducted or documented at the actual time of her fall (see Exhibit O). Based on the statements from Ms. [redacted] roommate and the type of fracture, it is evident that she sustained a fall at the facility that was unreported and untreated. Ms. [redacted] roommate was adamant that she had fallen days before and one of the nurses indicated without further detail or investigation that Ms. [redacted] was complaining of pain at least since January 8, 2017.

Moreover, defendant caused a delay in treatment of Ms. [redacted] fracture that exacerbated her injuries and caused her further excruciating pain than if she had been promptly transferred to a hospital. Based on the evidence available, it is possible that Ms. [redacted] had sustained a fall days prior to January 11, 2015. There is no indication that a clinical assessment or evaluation was made for instance on January 8, 2015, when nurse [redacted] noticed her complaints of pain and before asking a CNA to place her back to bed (see Exhibit C).

Even assuming that the fall had occurred on such date, Ms. [redacted] was not properly evaluated and treated. On January 11, 2015, she was not transferred to the emergency room despite the indication for the same (see Exhibit C). She remained in severe pain on her left hip area for two more days and without adequate treatment. It is noted that on January 12, 2015, Ms. [redacted] was still crying of pain on her left hip area (see Exhibits B and D). However, no studies were conducted on such date. If an x-ray is negative and pain persists, the standard of care requires the performance of a CT scan or MRI. The x-ray report itself noted that follow up was

suggested if pain persisted and that "a small percentage of hip fractures [are] occult radiographically" (see Exhibit E). However, despite the persistent complaints no further studies or interventions were taken until the afternoon of January 13, 2015.

Defendant's agents also did not adequately and timely inform her primary care physician, Dr. [redacted] or the [redacted] daughter of all of her multiple falls.

Based on the above, it is clear that defendant [redacted] was negligent in rendering care and treatment to Ms. [redacted] and allowed her to sustain multiple falls during her residency on April 8, 2014, June 1, 2014, December 3, 2014, and the one on or before January 11, 2015 that lead to the left femoral fracture. In allowing for the resident to sustain a left hip fracture, defendant proximately caused the need for surgical intervention, the insertion of a rod, for her ability to ambulate and functionality to further diminish, and significant pain and suffering.

III. DAMAGES

As a result of the incident, C[redacted] suffered a left femoral neck fracture, required surgical intervention and the insertion of an intramedullary rod, needed physical therapy, and continues to experience left hip pain, continuous pain and suffering, and diminished mobility and functionality to carry out activities of daily living (see Exhibits A– J). Defendant is expected to continue to be confined at [redacted] and in total need of assistance for her activities of daily living.

IV. STATUS OF NEGOTIATIONS/POSITIONS OF PARTIES

Defendant, [redacted] is self-insured for $250,000 and possess umbrella insurance with [redacted] in the amount of $1,000,000.00 (see Exhibit P).

Plaintiff made a formal demand of $850,000.00 during the Preliminary Trial Conference of . A *trial date* was scheduled for

Defendant has made no offer at this time, however defense counsel agreed to this mediation to attempt to resolve this case. Defendant M.D. did not want to participate in the mediation.

V. LIENS/MEDICAL BILLS

Defendant alleges that a bill in the amount of remains outstanding and has been attempting to collect the same from Ms. see Exhibit Q).

Medicare is asserting a lien against any proceeds from this action in the amount of . A request for Medicaid and/or Public Assistance liens was made to the Department of Social Services on . However, we have not been informed whether any lien will be asserted at this time. Enclosed as Exhibit Q is Medicare's Lien Letter and Medicaid's Request Form.

VI. CASE VALUE

Attached are several cases with injuries similar to those suffered by Ms. with settlements and verdicts ranging from $500,000.00 to $1,766,142.00 (see Verdicts and Settlements annexed herein as Exhibit R).

Based on the extent of her injuries, length of time she has endured the same, and taking in consideration the above, it is our position that a demand of **$850,000.00** is certainly reasonable.

CONCLUSION

Defendants caused and created serious and irreversible complications by their failure to adequate monitor the resident, implement adequate safety precautions, prevent her multiple falls, and provide prompt and adequate treatment. Thus, the aforementioned departures of defendant from the standard of care were the proximate cause of C [redacted] injuries, including her left him fracture, surgical intervention, insertion of hardware, left hip pain, impaired mobility, and pain and suffering.

Respectfully submitted,

The Jacob D. Fuchsberg Law Firm, LLP

By: Brad Zimmerman, Esq.

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By: Walter Osuna, Esq.