EXHIBIT 12

Sheniqua Moore, as Administrator of the Estate of Katherine Moore v. Gold Crest Care Center, Inc.; Bronx Center for Rehabilitation and Healthcare, LLC; and New York Westchester Square Medical Center; 2018 Jury Verdicts LEXIS 36517

22012/2013E

January 11, 2018

Headline: Estate Of Nursing Home Patient Who Developed ***Pressure Ulcers*** Reaches $ 225,000 Settlement Against Homes In New York State Court Action

Party Names

Plaintiff(s):

Sheniqua Moore, as Administrator of the Estate of Katherine Moore

Defendant(s):

Gold Crest Care Center, Inc.

Bronx Center for Rehabilitation and Healthcare, LLC

New York Westchester Square Medical Center

Topic: Medical Malpractice

Injury: Economic Injury; Emotional Or Mental Injury; Physical Injury

Method of Resolution: Settlement

Case Resolution: Mixed

All Dates: 07/27/2011-10/07/2011 Moore Treated by Westchester

2010-08/21/2011 Moore Treated by Gold Crest

08/26/2011-09/04/2011 Moore Treated by Bronx

06/04/2013 Complaint Filed

06/28/2013 Answer Filed

01/11/2018 Settlement; Proposed Compromise Order Filed

04/17/2018 Compromise Order Entered

06/19/2018 Stipulation of Discontinuance Filed

State: New York

Court: Supreme Court of New York, Twelfth Judicial District

Plaintiff Counsel

Salvatore Marino

Firm Name: Dalli & Marino, LLP

Address: Mineola New York

Walter Osuna

Defendant Counsel

David LaFarga

Firm Name: Lewis Brisbois Bisgaard & Smith, LLP

Address: New York New York

Nicholas M. Atlas

Firm Name: Wilson Elser Moskowitz Edelman & Dicker, LLP

Address: White Plains New York

Jessica M. DeMichiel

Firm Name: Caitlin Robin & Associates PLLC

Address: Buffalo New York

Judge: Norma Ruiz

Case Summary

Katherine Moore was a hospital patient at New York Westchester Square Medical Center, and was also treated at Gold Crest Care Center, Inc. and Bronx Center for Rehabilitation and Healthcare, LLC, which were both nursing homes. It was alleged that during her care and treatment at those facilities, Moore developed ***pressure ulcers*** due to their failure to properly maintain her skin integrity and render appropriate care. It was further asserted that those facilities failed to otherwise treat Moore pursuant to the regulatory statutes as to her other needs, including dental, cleanliness, and social well-being.

Sheniqua Moore, as Administrator of the Estate of Katherine Moore, filed a complaint in the Supreme Court of New York, Twelfth Judicial District for the County of Bronx against Gold Crest, Bronx Center, and Westchester Square, alleging medical malpractice and negligence per se claims. Gold Crest Filed an answer with affirmative defenses that included apportionment of liability, assumption of the risk, setoff, failure to mitigate damages, and contributory negligence.

Judge Norma Ruiz entered a compromise order, approving the settlement with Gold Crest and Bronx Center for $ 225,000, with Gold Crest paying $ 125,000 and Bronx Center paying $ 100,000. Moore and Bronx Center filed a stipulation of discontinuance of the claims against it with prejudice.

Award: $ 225,000

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Cynthia Hunter as Adminstratrix of the Estate of Sadie Holmes v. Greater Harlem Nursing Home Co., Inc., and Greater Harlem Nursing Home Co., Inc; 2012 Jury Verdicts LEXIS 11987

24110/06

April 04, 2012

Headline: Woman's Bedsores Led to Malnutrition, Death, Suit Alleged

Published Date: August 27, 2012

Topic: Nursing Homes - Abuse or Neglect - Health Law - Nursing Home - Health Law - Patients' Rights

Injury: Malnutrition, Bedsore/decubitus ***Ulcer/pressure*** Sore, Death, Infection, Hip, Dehydration

State: New York

Court: Bronx Supreme

Plaintiff Counsel

Philip J. Rizzuto

Firm Name: Philip J. Rizzuto, P.C.

Address: New York, NY

Plaintiff Name: (Estate of Sadie Holmes)

Defendant Counsel

Rocco Conte

Firm Name: O'Connor McGuinness Conte Doyle Oleson & Collins

Address: White Plains, NY

Defendant Name: (Greater Harlem Nursing Home Co. Inc)

Judge: Stanley B. Green

Case Summary

On Feb. 3, 2004, plaintiff's decedent Sadie Holmes, a 92-year-old woman who suffered dementia, became a resident of the Greater Harlem Nursing Home, which is located at 30 W. 138th St., in the Harlem section of Manhattan. During the ensuing four months, Holmes developed bedsores of a hip and her sacrum. She also suffered malnutrition that caused a severe reduction of her weight.

In June 2004, Holmes was transferred to another facility. Her condition deteriorated, and she died on Sept. 8, 2004. Holmes' oldest granddaughter, Cynthia Hunter, claimed that Holmes' death was a result of the bedsores and malnutrition that she suffered at Greater Harlem Nursing Home. She contended that those manifestations were results of improper care.

Hunter, acting as the administrator of Holmes' estate, sued Greater Harlem Nursing Home's operator, Greater Harlem Nursing Home Co. Inc. The estate alleged that the facility's staff negligently failed to provide adequate care. The estate further alleged that the staff's negligence constituted a violation of New York Public Health Law ?? 2801-d.

The estate's counsel claimed that the facility's staff did not properly assess Holmes' likelihood of developing bedsores. He noted that Holmes' admission was accompanied by a nurse's performance of a Braden test, which is an assessment of various factors that could cause the development of bedsores. He contended that the nurse improperly totaled the test's numerical scores, and he claimed that the error led to the incorrect determination that Holmes could independently reposition her bedbound body. He contended that Holmes was not able to reposition herself, and he claimed that she resultantly maintained a static position that allowed the formation of bedsores. He also claimed that the facility's staff did not inspect the condition of Holmes' skin.

The estate's counsel further claimed that the facility's staff did not properly chart Holmes' condition. He noted that her residency was interrupted by a brief hospitalization, but that Greater Harlem Nursing Home's records include seemingly false entries that were created during the days of her hospitalization.

Defense counsel contended that Holmes was properly evaluated and treated. He claimed that her bedsores, malnutrition and death were unpreventable results of her age and other pre-existing conditions that included dementia, hypertension and malnutrition.

Injury Text:

During the months that followed February 2004, Holmes developed stage-IV bedsores of her sacrum and her right hip. The sores became infected. The estate's counsel claimed that the resultant pain diminished Holmes' appetite, and he contended that she suffered resultant dehydration and malnutrition that caused a severe reduction of her weight.

Holmes, 92, died Sept. 8, 2004. She was survived by a daughter and three grandchildren. Holmes' estate sought recovery of damages for Holmes' past pain and suffering.

Insurer:

Medical Liability Mutual Insurance Co.

Award: $ 350,000

Award Details: The parties negotiated a pretrial settlement. Greater Harlem Nursing Home's insurer agreed to pay $350,000.

www.verdictsearch.com/index.jsp

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Estate of Wilbert Stokes, Deceased, by and Through His Proposed Administrator, Richard Stokes v. Carlton Nursing Home, Inc; 2008 Jury Verdicts LEXIS 31979

22800/03

February 25, 2008

Headline: Estate Claimed Home's Lax Care Led to Resident's Fatal ***Ulcers***

Published Date: April 05, 2008

Topic: Nursing Homes - Wrongful Death - Survival Damages

Injury: Death, Bed Sores, Decubitus ***Ulcer***, Necrosis, Infection, Gangrene, Debridement, Amputation, Above-the-knee, Foot, Leg

State: New York

Court: Kings Supreme

Plaintiff Counsel

Melissa C. Ingrassia

Firm Name: Sanders, Sanders, Block, Woycik, Viener & Grossman P.C.

Address: Mineola, NY

Plaintiff Name: (Wilbert Stokes)

Alejandro Fiol

Firm Name: Fiol & Gomez

Address: Tampa, FL

Plaintiff Name: (Wilbert Stokes)

Defendant Counsel

Roslyn Ross

Firm Name: Ptashnik & Associates LLP

Address: New York, NY

Defendant Name: (Carlton Nursing Home, Inc)

Judge: Marsha L. Steinhardt

Case Summary

In October 2002, plaintiff's decedent Wilbert Stokes, a man in his mid-80s, developed stage-IV ***pressure*** sores of his heels and stage-III sacral decubitus ***ulcers***, or bedsores. Stokes was a near-three-year resident of Carlton Nursing Home, which is located at 405 Carlton Ave., in Brooklyn. His medical history included Alzheimer's disease, benign hypertrophy of his prostate, dementia, diabetes and hypertension.

By Nov. 18, 2002, Stokes' ***pressure*** sores had become infected and gangrenous. His condition quickly deteriorated, necessitating amputation of one leg. He died Nov. 26, 2002. Stokes' family claimed that the ***ulcers*** were a product of negligent care and that they ultimately caused his death.

Stokes' estate sued the nursing home's operator, Carlton Nursing Home Inc. The estate alleged that the home's staff was negligent in its care and treatment of Stokes.

The estate's counsel claimed that the nursing home's staff failed to accurately assess and monitor Stokes' ***pressure ulcers***. They also contended that the staff did not consistently off-load Stokes or provide adequate relief of ***pressure***. They claimed that the staff did not consistently treat Stokes' wounds, that it did not sufficiently manage his diabetes, that it did not accurately monitor his consumption of food and liquids, and that it did not provide all necessary care and treatment.

Injury Text:

In October 2002, Stokes developed necrotic, stage-IV ***pressure*** sores of his heels and necrotic, stage-III sacral ***ulcers***. By Nov. 18, 2002, the ***pressure*** sores had become infected and gangrenous. Stokes underwent debridement of his left foot and leg, but the leg could not be saved, and an above-the-knee amputation was performed. Stokes' condition continued to decline, and he died Nov. 26, 2002.

The estate's counsel claimed that Stokes' ***pressure*** sores stemmed from negligent care and treatment. He contended that the sores ultimately led to Stokes' death.

Stokes' estate sought recovery of wrongful-death damages that included damages for Stokes' pain and suffering.

Award: $ 450,000

Award Details: The parties agreed to a $450,000 settlement.

www.verdictsearch.com/index.jsp

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Jeffrey Manas as Executor of the Estate of Miriam Silverman v. Peninsula Hospital Center Peninsula Center of Extended Care & Rehabilitation; 2011 Jury Verdicts LEXIS 202973

9949/07

April 05, 2011

Headline: Untreated Osteomyelitis, Bedsores Turned Fatal, Suit Alleged

Published Date: January 23, 2012

Topic: Medical Malpractice - Delayed Diagnosis - Medical Malpractice - Delayed Treatment - Medical Malpractice - Failure to Monitor - Wrongful Death - Survival Damages

Injury: Decubitus ***Ulcer***, Amputation, Above-the-knee, Death, Bed Sores, ***Pressure*** Sores, Leg, Heel Injury, Sepsis, Respiratory Arrest, Cardiac Arrest, Debridement

State: New York

Court: Queens Supreme

Plaintiff Counsel

Brad A. Kauffman

Firm Name: Law Office of Brad A. Kauffman

Address: New York, NY

Plaintiff Name: (Estate of Miriam Silverman, Estate of Miriam Silverman)

Defendant Counsel

James F. Furey

Firm Name: Law Offices of Furey & Furey

Address: Hempstead, NY

Defendant Name: (Peninsula Center for Extended Care and Rehabilitation)

John F. Toto

Firm Name: Gordon & Silber, P.C.

Address: New York, NY

Defendant Name: (Peninsula Hospital Center)

Judge: Peter J. O'Donoghue

Case Summary

On Feb. 10, 2005, plaintiff's decedent Miriam Silverman, 74, a retiree, was admitted to Peninsula Hospital Center, in the Far Rockaway section of Queens. Silverman was suffering severe fractures of her pelvis and her right leg's femur.

During the ensuing six months, Silverman resided at the hospital and a neighboring facility: Peninsula Center for Extended Care and Rehabilitation. Her lower legs developed bedsores and osteomyelitis, and she ultimately underwent amputations of her legs.

Silverman claimed that her bedsores and osteomyelitis were not timely detected or treated, and she contended that prompt treatment would have preserved her legs. Silverman died Sept. 5, 2005, and her family claimed that her death was a result of inadequate treatment.

Silverman's estate sued Peninsula Hospital Center and Peninsula Center for Extended Care and Rehabilitation. The estate alleged that the defendants' staffs failed to properly diagnose, monitor and treat Silverman's condition. The estate further alleged that the failures constituted malpractice.

The estate's counsel contended that bedsores and osteomyelitis can be slowed by prompt treatment, but that Silverman's bedsores and osteomyelitis rapidly progressed to severe conditions. He claimed that their rapid progression indicated that they were not promptly diagnosed, properly monitored or properly treated.

Defense counsel contended that Silverman's condition was adequately monitored and treated. They claimed that her bedsores and osteomyelitis were unavoidable consequences of a combination of largely unmanageable conditions that included diabetes, a deficiency of her vascular system, her right leg's fracture and the fracture's resultant restriction of her mobility.

Injury Text:

Silverman's legs developed osteomyelitis and bedsores, which are alternately termed "decubitus ***ulcers***" or "***pressure*** sores." Her bedsores were initially addressed via several rounds of debridement, but their condition worsened. On June 6, 2005, she underwent a calcanectomy, which involved a removal of an ulcerated portion of her right heel. On Aug. 2, 2005, she underwent amputations of most of each leg.

After several weeks had passed, Silverman developed sepsis. The infection could not be reversed, and it led to arrest of her cardiac and respiratory functions. Silverman, 74, died Sept. 5, 2005. She was survived by a niece and a nephew.

Silverman's estate claimed that Silverman's death was a result of a failure to promptly diagnose and treat her bedsores and osteomyelitis. The estate sought recovery of wrongful-death damages that included damages for Silverman's pain and suffering.

Defense counsel contended that Silverman's bedsores, osteomyelitis, amputations and death were unavoidable consequences of medical conditions that predated the defendants' treatment of Silverman.

Insurer:

Medical Liability Mutual Insurance Co. for Peninsula Center for Extended Care and Rehabilitation

Physicians' Reciprocal Insurers for Peninsula Hospital Center

Award: $ 500,000

Award Details: The parties negotiated a pretrial settlement. Each defendant's insurer agreed to pay $250,000. Thus, the estate's recovery totaled $500,000.

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PATANE vs. ST. TERESA'S NURSING HOME, INC; 2006 NY Jury Verdicts Review LEXIS 634

154/05

May, 2006

Published: May, 2006

Topic: NURSING HOME NEGLIGENCE - VIOLATION OF REGULATIONS AND PUBLIC HEALTH LAW RELATING TO EVALUATION AND TREATMENT OF NURSING HOME RESIDENT - DECUBITIOUS ***ULCERS*** - DEATH ACTION

Result: $ 525,000 Recovery

Award: $ 525000

State: New York

County: Orange

Court: ORANGE COUNTY SUPREME

Judge: Lewis J. Lubell

Plaintiff Counsel

Robert A. Hyman of Pleasantville, N.Y

Case Summary

The plaintiff contended that the 87-year-old patient was admitted to the defendant nursing home with a history of mild dementia, congestive heart failure, depression and hypothyroidism, but in good nutritional condition and with totally intact skin. The plaintiff contended that the defendant nursing home failed to properly evaluate the patient for the risk of decubitis ***ulcers*** and negligently failed to implement procedures to avoid the formation of such ***ulcers*** and provide treatment once they formed. The plaintiff further contended approximately three months after the patient was admitted to the facility, she died from sepsis secondary to decubitis ***ulcers***. The plaintiff maintained that the facility violated PHL 2801-d in that it violated PHL2803-c and numerous New York State and Federal regulations in addition to committing gross negligence and medical malpractice and such violations give rise to liability.

The evidence reflected that upon admission to the nursing home, the patient was assessed by the defendant's nurses as being at "moderate" risk for decubitis ***ulcer*** development when she scored "high" risk because of incontinence and immobility. The plaintiff contended that the care plan for dealing with the risk of decubitis ***ulcers*** was incomplete in that it failed to identify risk factors and it failed to identify goals. The plaintiff maintained that nurses soon noted that the patient had a poor appetite and they did nothing about it. The resident spoke Italian and no staff did so. The plaintiff also contended that although both the family and health care proxy regularly visited, the staff did not discuss food preferences nor inform the family of her poor appetite. The plaintiff contended that proper maintenance of nutrition is essential to prevent the skin from becoming brittle and more susceptible to decubitis ***ulcers***. The plaintiff established that after an initial assessment that is conducted when the patient is first admitted, the defendant must complete a Minimum Data Set (MDS) form from days 14 to 21 enabling the staff to conduct a thorough assessment once they have had the opportunity to observe the patient for a period of time. The plaintiff contended that although the first comprehensive MDS assessment should have triggered a resident assessment protocol (RAP) for ***pressure ulcers***, the defendant failed to conduct such an assessment. In her deposition, the plaintiff maintained that the charge nurse admitted that the facility had no RAPs for ***pressure ulcers***. The plaintiff

contended, therefore, that pertinent interventions for incontinence and immobility, the necessity of addressing the issues of toileting and skin care in order to prevent skin breakdown, were not included in the care plan. The plaintiff maintained that no clear direction was provided for the certified nursing assistants (CNAs) regarding toileting and types of incontinence care. The plaintiff further maintained that there were no directives regarding heel pads, wheelchair cushions or turning and positioning on the CNA's records.

The plaintiff further contended that although the patient's appetite was still noted as poor, no action was taken to address the issue. The defendant denied that the plaintiff's claims should be accepted. The defendant pointed to handwritten orders by a charge nurse, on admission, for ***ulcer*** preventative care, such as turning and positioning, the use of an air mattress and the use of heel pads. The nurse testified that the order with the handwritten additions was faxed to the pharmacy. The plaintiff presented evidence from the pharmacy of the orders without the handwritten entries. The plaintiff contended that the implication of false charting was reinforced by the plaintiff's expert who identified that there were no turn and position records in the chart and that the heel pads and air mattress were ordered by doctors much later. At deposition, the defendant's witness stated there were, in fact, turn and positioning records kept, but that they must have been misfiled in someone else's chart.

The plaintiff contended that the patient's nutrition and hydration levels were diminishing and no one acted. Within weeks, the ***ulcers*** began. The plaintiff maintained that after the ***ulcers*** began to develop, there were serious delays, deficiencies, and many failures in documenting, assessing, monitoring, tracking, and treating the ***pressure ulcers*** by both the nursing staff and the physicians at the nursing home. The first documentation of the ***ulcers*** indicated that the resident had "another" open area. At deposition, the defendant responded that there was no ***pressure ulcer*** prevention protocol in the facility at that time. The plaintiff established that the care plan for ***pressure ulcers*** was not updated and that there were no treatment orders or actual treatment for another ten days. The plaintiff contended that when the nursing home finally began treating the ***ulcers***, the treatment was improper and/or incomplete in that no wound cultures were taken and no medicines, including antibiotics were ordered to treat an obvious infection. There was now degradation to the sacrum to a stage IV ***pressure ulcer*** with infection. The nursing home doctor testified that he did not examine the ***ulcers*** under the dressing as the nurse failed to tell him the ***ulcers*** were infected. The plaintiff contended that the progress notes then indicated that her motivation had decreased secondary to decubitis on buttocks and pain from being in bed for the past week. The following day, a physician attended and addressed her edema, but never mentioned her severe ***pressure ulcers***. The resident's lab results revealed that her albumin level was now at 2.1. However, the physician reviewing the lab results did not address the lower albumen level. The ***pressure ulcers*** were still not being tracked to determine if the treatment was effective. The resident had a significant weight loss of eight pounds in one month. The plaintiff maintained that although the records noted that protein supplements were contraindicated, the nursing home made no determination regarding what protein the patient was getting from her meals. The plaintiff contended that in view of such a significant and unintended weight loss, the nursing home was required to properly address the weight loss, and failed to do so. The plaintiff maintained that the staff "watched the patient starve" and suffer malnutrition and did not perform an assessment. The plaintiff further contended that although a podiatry evaluation was performed that indicated a stage IV ulceration of the left medial heel and the instructions indicated "dispense heel protectors to patient's left heel," the heel ***ulcer*** had not received pads as supposedly ordered earlier.

The plaintiff also maintained that the defendant never told the family that that the ***ulcers*** had developed, nor were they told that the ***ulcers*** had become infected and that whatever opportunity the family had to intercede to secure medical help was not possible due to the lack of disclosure by the facility. The facility had no policies or procedures and the staff was not trained to inform the family. The plaintiff contended that a significant change MDS assessment was required to have been done due to the development of stage IV ***pressure ulcers*** and a significant weight loss and that the defendant failed to perform the new assessment and failed to properly maintain nutrition and hydration status. The plaintiff contended that on December 30, 2002, it was noted that the patient had two stage IV ***pressure ulcers*** on her buttocks, a stage IV ***pressure ulcer*** on her right upper thigh, and a stage IV left heel ***pressure ulcer***. All of the ***pressure ulcers*** were badly infected. The resident was malnourished and dehydrated. She had an unresponsive episode and was transferred to the hospital where the admitting doctor noted large and infected ***ulcers***. At the hospital, plaintiff received intravenous antibiotics for the numerous infections caused by the ***pressure ulcers***, percocet and a morphine drip in an attempt to relieve her of the pain. The patient succumbed and passed

away on January 11, 2003. The cause of death was sepsis secondary to multiple decubitis ***ulcers***. The case settled prior to trial and after numerous depositions for $ 525,000. As part of the settlement, the facility agreed to revise its policies and now requires staff to inform the family when there is any significant change in condition or where an ***ulcer*** develops, and the hire and use of translators to enhance communication with residents.

Published in: Volume 23, Issue 5

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BLUTNER vs. MOUNT SINAI HOSPITAL; 2017 NY Jury Verdicts Review LEXIS 101

704146/13

March 17, 2017

Published: June, 2017

Topic: Medical malpractice - Failure of nurses to properly turn and reposition patient in bed at regular intervals following surgery - Stage iv ***pressure ulcer*** - ***Ulcer*** requires wound VAC and nine months to heal - Scar formation - Permanent pain and difficulties sitting for extended periods

Result: $ 1,100,000 Verdict

Award: $ 1100000

State: New York

County: New York

Judge: Pam Jackman Brown

Plaintiff Counsel

Jason M. Rubin of Wingate, Russott, Shapiro and Halperin, LLP in New York, NY

Case Summary

The plaintiff contended that after she underwent surgery to repair an anastomotic leak several days after gastric bypass surgery, the defendant hospital's staff negligently failed to properly turn and reposition her in bed at regular intervals as was required. The plaintiff asserted that as a result, she developed a deep tissue injury to the sacrum that progressed to a Stage IV ***pressure ulcer***.

The 55-year-old morbidly obese, diabetic woman, with a history of hypertension and high cholesterol, went into the defendant hospital to undergo gastric bypass surgery. The surgery went well but, several days later, she started experiencing nausea and vomiting. A CT-scan was performed which revealed an anastomotic leak. She underwent further surgery to repair the leak.

While in the recovery room for this second surgery, her blood ***pressure*** dropped and her heart rate became elevated. She was given IV fluids, which stabilized her blood ***pressure***. She was then transferred to the Surgical Intensive Care Unit (SICU) for closer monitoring. While in the SICU, she became septic, and experienced tachycardia and tachypnea (elevated respiratory rate). Approximately 33 hours after the patient was transferred to the SICU, a nurse diagnosed a deep tissue injury on plaintiff's sacrum. This deep tissue eventually progressed to a Stage IV ***pressure ulcer***.

The plaintiff contended that the nurses in the recovery room and SICU should have turned and repositioned plaintiff in bed every two hours. The plaintiff asserted that such turning was required by both accepted nursing practices and a care plan that was formulated by the nurses for plaintiff. The plaintiff claimed that the deep tissue injury only could have occurred if the plaintiff was not turned and repositioned regularly.

The defendant maintained that the patient was, in fact, turned regularly, and that the deep tissue injury was unavoidable because of skin breakdown due to her underlying co-morbidities and septic state. Specifically, the defendant claimed that plaintiff's sepsis caused a lack of perfusion, or delivery of blood and oxygen to her skin, allowing it to break down. The plaintiff countered that despite her being septic, there was no clinical evidence of lack

of perfusion to the skin in that all peripheral vascular and skin exams were always within normal limits. The plaintiff also elicited concessions from the defense expert that there was no evidence of lack of perfusion to the skin or any other organs, that her blood ***pressure*** was within an acceptable range; her lactate levels on blood gas testing, as well as liver and kidney function were normal, and that the patient had no change in mental status.

The plaintiff further argued that the jury should consider that the only mention of turning in the records was once every 12 hour shift, and the plaintiff argued that the defendant's position that the patient was turned every two hours, but that the only error was in documentation, should be rejected. The plaintiff also argued that if the defendant's position that the plaintiff's condition rendered the formation of the ***pressure ulcer*** unavoidable despite side-to-side turning as the nurses claimed, the plaintiff would have developed a ***pressure ulcer*** on her hips and shoulders, which she did not do. The plaintiff also pointed out that during the surgery, the plaintiff was positioned in such a manner that she would not have suffered the wound to the sacrum.

The plaintiff required treatment with a wound vac for a one-month period and the wound took approximately nine months to fully heal because it re-opened several times. The plaintiff asserted that because of the formation of scar tissue, she will suffer permanent discomfort that is heightened upon sitting for prolonged periods. The plaintiff contended that she has difficulties riding in a car. The plaintiff claimed, and the defendant's experts did not dispute, that the pain will continue permanently. The plaintiff made no income claims.

The jury found for the plaintiff and awarded $ 500,000 for past pain and suffering; $ 500,000 for future pain and suffering and $ 100,000 for loss of services/consortium to plaintiff's husband.

Plaintiff Expert(s)

Nursing/***pressure ulcer*** expert: Joyce M. Black, Ph.D., RN from Omaha, NE

Published in: Volume 34, Issue 6

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Salvatore DePaolo as Administratrix of the Estate of Jerry DePaolo, Deceased v. Beth Israel Medical Ctr Kings Highway Div; 2014 Jury Verdicts LEXIS 6151

4073/10

May 07, 2014

Headline: Patient's Bedsore a Result of Nurses' Inaction, Suit Alleged

Published Date: July 28, 2014

Topic: Medical Malpractice - Failure to Treat

Injury: Bedsore/decubitus ***Ulcer/pressure*** Sore, Debridement, Infection

State: New York

Court: Kings Supreme

Plaintiff Counsel

Anthony T. Hirschberger

Firm Name: Krentsel & Guzman, LLP

Address: New York, NY

Plaintiff Name: (Estate of Jerry DePaolo)

Defendant Counsel

Susan D. Noble

Firm Name: Carroll, McNulty & Kull LLC

Address: New York, NY

Defendant Name: (Beth Israel Medical Center Kings Highway Division)

Judge: Michelle Weston

Case Summary

On Nov. 19, 2007, plaintiff's decedent Jerry DePaolo, 74, a retiree, was admitted to Beth Israel Medical Center's Kings Highway Division, in Brooklyn. DePaolo had fallen, and he was suffering a painful injury. Doctors feared that DePaolo's bedridden condition would lead to his development of a bedsore, which is alternately termed a "decubitus ***ulcer***" or a "***pressure*** sore." A doctor ordered that DePaolo had to be repositioned during each interval of two hours. The order was rescinded during the ensuing day.

After four additional days had passed, a nurse observed that DePaolo's sacrum had developed a bedsore. After three days had passed, DePaolo was transferred to a facility that provided specialized care.

DePaolo's family claimed that his bedsore progressed to a condition that necessitated surgeries. The family also claimed that the wound persisted until DePaolo's death, though it was not related to his death.

DePaolo's brother, Salvatore DePaolo, acting as the administrator of his brother's estate, sued Beth Israel Medical Center. The estate alleged that the hospital's staff failed to properly treat Jerry DePaolo. The estate further alleged that the staff's failure constituted malpractice and negligence.

Walter Osuna

The estate's counsel contended that repositioning should have been performed throughout the entirety of DePaolo's hospitalization, but that DePaolo's attending nurses did not consistently do so. He claimed that DePaolo developed a stage-II bedsore, which is characterized by an ulceration and broken skin. The estate's counsel further claimed that the sore progressed to the stage-IV classification, which is characterized by exposure of a bone, a muscle and/or a tendon. He also claimed that the wound became infected. He contended that the staff's inaction constituted a departure from an accepted standard of medical care.

Defense counsel contended that DePaolo required a single day of repositioning. He also claimed that DePaolo developed a stage-I bedsore, that the wound had fully healed by Dec. 3, 2007, and that DePaolo's surgeries addressed a subsequent, unrelated bedsore.

Injury Text:

In November 2007, DePaolo developed a bedsore that occupied his sacrum. The estate's counsel claimed that the wound progressed to the stage-IV classification. He also claimed that the wound became infected. He claimed that DePaolo underwent surgeries that involved debridement of infected and necrotic tissue, but that the wound persisted. DePaolo died on July 31, 2008, though his death was not related to his wound.

DePaolo's estate sought recovery of $3 million for DePaolo's pain and suffering.

Defense counsel contended that DePaolo's bedsore fully healed within nine days of its detection. She claimed that DePaolo's surgeries addressed a subsequent, unrelated bedsore.

Trial Length

5.0 days

Jury Deliberation

3.0 hours

Plaintiff Expert(s)

Kerin Hausknecht, M.D.

Address: Carle Place, NY

Specialty: Neurology

Affiliation: Anthony Hirschberger

Defendant Expert(s)

Mark S. Silberman, M.D.

Address: Dobbs Ferry, NY

Specialty: Critical Care

Affiliation: Susan Noble

Award: $ 2,000,000

Award Details: The jury found that the hospital's staff was negligent in its treatment of DePaolo. It determined that the estate's damages totaled $2 million, all for DePaolo's pain and suffering.