

Failure to Monitor Antibiotic Therapy at Nursing Facility Results in Death

On September 12, 2007, 66-year-old Holly DeRosa heard the landscapers start their lawnmowers and she rushed outside, knowing that her domesticated pet raccoon, Patches, would be frightened. For years, Holly and her husband, Michael, a quartermaster at the North Palm Beach Police Department, kept a number of exotic pets and were properly licensed to do so. Patches had been at their home for over eight years. When Holly reached down to pick up the animal, it was startled and scratched her on the leg. She brought Patches in the house, then cleaned and bandaged her leg.

The following day, her leg started to swell and she began to feel ill. Holly called Michael at work and told him that she was not feeling well. When Michael came home, he immediately took his wife to a clinic where she was given a tetanus booster and some antibiotics. When she awakened the next morning, she noticed her leg was very swollen and patchy red in places. Again, she phoned her husband at work. Recognizing the severity of her condition, he told her to call for an ambulance and get to the hospital.

When Holly arrived at Palms West Hospital in Loxahatchee, Florida, she was admitted with a preliminary diagnosis of cellulitis, a very serious infection. She was placed on a broad-spectrum antibiotic via a PICC line – a peripherally-inserted central catheter typically used to administer treatments such as antibiotics to patients in acute care. Holly remained an inpatient at Palms West for ten days. Throughout her care there, she received antibiotics through the PICC line, carefully monitored by her treating physicians. On September 24, 2007, Holly was discharged to the Manor Care/Heartland nursing facility in Palm Beach Gardens for continued antibiotic therapy and rehabilitation. Palms West medical records indicated that, at the time of her discharge, Holly had an excellent prognosis and was responding well



Michael and Holly DeRosa.

to the antibiotics. On the day of discharge, her physician personally checked and flushed Holly's PICC line to make sure it was functioning properly. He confirmed his order that Holly was to receive the antibiotics throughout her stay at Manor Care.

Admission records at Manor Care indicated that no physician documented Holly's arrival, nor confirmed her treatment plan. Four doctors were assigned to Holly's care and not one of them ever came to the facility to monitor her condition. Each day Michael visited Holly at the nursing facility, and each day he noticed his wife's condition deteriorating. He asked Holly how she felt, and Holly said she had complained to Manor Care staff of problems with the PICC line. She believed that she was not receiving the antibiotics. Michael tried to follow up

on Holly's complaint, but not one of the doctors was available to talk with him. Holly pleaded with Michael, "Please get me out of here."

On the third day of her stay at Manor Care, the nursing staff finally examined the PICC line and found it had malfunctioned. Holly had not been receiving the antibiotics. An outside healthcare provider confirmed the PICC line malfunction and advised that Holly be transferred to a hospital to have the PICC line reinserted. Holly was finally transferred to the Palm Beach Gardens Medical Center the next day. *(Continued on page twelve.)*

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Medical records at Palm Beach Gardens Medical Center indicated that Holly's condition had substantially worsened from the date of her discharge from Palms West. The infection in her leg had spread to her ankle and foot. She had developed open sores and signs of necrosis. Palm Beach Gardens Medical Center began emergent antibiotic care for Holly. However, the spread of the infection worsened and she now required debridement surgery to remove necrotic tissue. Despite massive efforts to control her infection, Holly went into septic shock and suffered multi-system organ failure. She died on October 3, 2007. Her family was devastated.

Michael contacted SDSBS attorneys **Karen Terry** and **Brian Sullivan** and asked them to represent him in an action challenging Manor Care's lack of care for Holly. An aggressive investigation of medical records, along with depositions from defendant physicians and nurses, revealed that Manor Care staff had ignored the directive for Holly's antibiotic therapy. Their failure to monitor her PICC line function and physical condition had resulted in her untimely death.

On the eve of the summary jury trial, defendants jointly settled the case for \$1.56 million.

Michael DeRosa mourns the loss of his wife and soul mate. He continues his work for the local police department. He still finds time to volunteer at his church and provide care for the animals Holly loved so much. ♦

Horroric Crash Caused by Tired Truck Driver Results in \$17.5 Million Settlement for Family

(Continued from page one.)

The defendants were willing to take partial responsibility for the accident, but they denied any responsibility for punitive damages. The driver, Mr. Wright, gave differing statements as to how the accident occurred. His basic story was that he was looking in his mirrors and towards the on ramp to see if there were any vehicles getting ready to enter the highway. SDSBS hired an accident reconstructionist, Dr. Brian Pfeifer, to determine the view that Mr. Wright would have had immediately before the accident, and to prepare an animation to show what happened. The animation showed that Mr. Wright would have had a view of the truck in front of the Modicas' vehicle 14 seconds prior to impact. The animation also showed that Mr. Wright would have had a complete view of the Modicas' vehicle, stopped or slowing to a stop, 10 seconds before impact. In the distance of over 1,000 feet, the driver could have brought his truck to a complete stop before hitting the car in front of him. What was the truck driver doing?

After an extensive investigation, the attorneys were able to demonstrate that the driver had been consistently working more hours than allowed under federal regulations. The driver and the company were covering the excessive hours by not logging all of the driver's hours on duty. They specifically failed to record the driver's pre- and post-trip inspections. There was also a question as to whether the company was involved in tampering with the XATA system used on the truck to track driving times and locations.

On the day before the accident, Mr. Wright had worked from approximately 3:30 a.m. until at least 8:15 p.m. This would have been two hours in violation of the hours of service regulations. The driver had testified that he did not leave the Tree of Life facility until 6:30 a.m., the day of the crash. However, attorneys for the Modicas' estate were able to show that he could not have completed all of his deliveries on the day of the accident unless he had gone on duty much earlier than 6:30 a.m. Additionally, Mr. Wright lived almost an hour's drive from work. He had almost no time to sleep in the short time he was off-duty. Hours of service regulations require 10 continuous off-duty hours after a day of driving. Therefore, it was illegal for the Tree of Life to dispatch Mr. Wright as a driver on the day of the accident.

After two and one-half weeks in trial, the defendants finally grasped the magnitude of their negligence. The case was settled for \$17.5 million. Although no amount of money could make up for Kevin and Brian's loss, they feel some justice has been gained in being able to describe to the judge and jury the tremendous grief they experienced in losing both parents in a horrible and senseless tragedy.

Every day our highways are crowded with commercial drivers hauling goods across America. Kevin and Brian Modica hope that these drivers and their employers take notice of this tragic case, and that they accept their responsibility to comply with the federal and state laws that restrict work hours in order to maximize safety for everyone. ♦