SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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EDWARD MALONEY,

Plaintiff,

-against-

MEADOWBROOK CARE CENTER, INC.,

Defendant.

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SCAN

MICHELE M. WOODARD
J.S.C.
TRIAL/IAS Part 14
Index No.:10359/07
Motion Seq. No.: 03

DECISION AND ORDER

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Defendant Meadowbrook Care Center, Inc., ("the Center") moves for an order pursuant to CPLR § 3211, 3212, 3012-a, 3406 and 3025 dismissing the complaint against it; dismissing the Plaintiff's claims for certain time periods and for punitive damages; and, requiring the Plaintiff to file and serve a Notice of Malpractice and Certificate of Merit. The Plaintiff opposes the Defendant's application.

In his complaint, the Plaintiff in this action alleges that the Defendant Center, a long-term care facility/nursing home, was negligent and negligent *per se* in its care and treatment of him from January 11, 2006 through April 27, 2006, and that it violated Public Health Law § 2801-d *et seq.* and 10 NYCRR Part 415; the statute and regulations which protect nursing home residents.

Public Health Law § 2801-d(1) provides:

> Any residential health care facility that deprives any patient of said facility of any right or benefit, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation, except as hereinafter provided. For purposes of this section a "right or benefit" of a patient of a residential health care facility shall mean any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation, where noncompliance by said

> facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority.

The statute provides residential health care facilities with the following defense:

> No person who pleads and proves, as an affirmative defense, that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury for which liability is asserted shall be liable under this section.

Public Health Law § 2801-d(2) sets forth a formula for computing damages and in addition, provides that "where the deprivation of any such right or benefit is found to have been willful or in reckless disregard of the lawful rights of the patient, punitive damages may be assessed." Public Health Law § 2801-d(4) provides that "[t]he remedies provided in this section are in addition to and cumulative with any other remedies available to a patient, at law or in equity or by administrative proceedings." Pursuant to Public Health Law § 2801-d(5), the damages recovered by a resident are exempted when calculating their eligibility for medical assistance and are deemed unavailable to pay the costs of their medical care and services. Finally, Public Health Law § 2801-d(6) affords the court discretion to award attorneys' fees to a successful Plaintiff.

In his complaint, the Plaintiff alleges that the Center by allowing bed sores to develop and failing to diagnose and treat them in a timely fashion; providing negligent wound care and pain management; failing to provide him with proper hydration and nutrition; failing to properly position and support him and prevent him from falling; and, failing to develop and follow a comprehensive care plan, the Center, *inter alia*, violated federal and state regulations. More specifically, the Plaintiff alleges, *inter alia*, that in caring for him, the Center violated the State's quality of care and medical regulations pertaining to pressure sores (10 NYCRR § 415.12[c]); drug therapy (10 NYCRR § 415.12[1]); and medical services (10 NYCRR § 415.15).

10 NYCRR § 415.12 provides that "[e]ach resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination." 10 NYCRR § 415.12(c)(1), (2) requires the Center to ensure both that "[a] resident who enters [its] facility without pressure sores does not develop pressure sores

unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them" and that "[a] resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." 10 NYCRR § 415.12(l)(1) provides:

> Each resident's drug regimen shall include only those medications prescribed to treat a specific documented illness or condition and not otherwise contraindicated for a given resident. The drug regimen shall be monitored for evidence of both adverse actions and therapeutic effect. Dose changes or discontinuation of the drug must be made if the drug is ineffective and/or is causing disabling or harmful side effects and/or the condition for which it was prescribed has resolved.

10 NYCRR § 415.15(a) requires the Center to develop and implement medical services to meet its residents' needs; 10 NYCRR § 415.15(a)(4) requires it to assure "that each resident's responsible physician attends to the resident's medical needs, participates in care planning, follows [a] schedule of visits . . . and complies with facility policies" and, 10 NYCRR § 415.15(b)(2)(i), (iii) requires the Center to ensure that the Plaintiff's responsible physician "participates as a member of the interdisciplinary care team in the development and review of the resident's comprehensive care plan with the understanding that the minimum level of physician participation in interdisciplinary development and review of the care plan shall be a person-to-person conference with the registered professional nurse who has principal responsibility for development and implementation of the resident's care plan" and that his responsible physician "reviews the resident's total program of care, including medications and treatments, at each regularly scheduled visit."

The Plaintiff asserts that as a result of the Center's alleged negligence, he suffered Stage IV pressure ulcers to the back/sacrum, a fall resulting in lacerations to the ear and scalp requiring sutures, recurrent urosepsis requiring medical care, decreased mobility and the need for permanent physical therapy and occupational therapy, wheelchairs, walkers and crutches. He also alleges to have suffered further disability and reduced mobility, permanent anxiety and a loss of dignity and enjoyment of life along with depression, mental anguish and fear and pain and suffering.

The Center seeks summary judgment on several grounds: (1) pursuant to CPLR §3012-a, CPLR §3406 because this is a medical malpractice action and a Notice of Medical Malpractice and a

Certificate of Merit have not been filed; pursuant to CPLR § 3025 as improperly plead; and, pursuant to CPLR § 3212 on the merits. The Plaintiff was intermittently a resident at the Center from January 2005 through April 27, 2006. More specifically, he was a resident from January 11, 2005 through March 3, 2005; from November 29, 2005 through December 15, 2005; and, from January 6, 2006 until he was discharged on April 27, 2006. The negligence alleged in the complaint occurred only during his last stay.

A party may not use his Bill of Particulars to advance new theories of liability not alleged in his complaint. See, *Manning v City of New York*, 11 AD3d 335 (1st Dept 2004). The Center's motion pursuant to CPLR §3025 to preclude the Plaintiff from recovering any damages premised upon negligent care during his first two stays at their facility from January 11, 2005 through March 3, 2005 and November 29, 2005 through December 15, 2005 (because those stays were only referred to in the Plaintiff's Bill of Particulars and were not referred to in the complaint) is ***granted,*** without opposition.

As for the Plaintiff's failure to file a Notice of Medical Malpractice and a Certificate of Merit, while it has been held that a three-year statute of limitations applies to claims pursuant to Public Health Law §2801-d because they are premised upon violations of regulations (*Zeides v Hebrew Home for the Aged at Riverdale, Inc.*, 300 AD2d 178, 179 [1st Dept 2002], citing CPLR § 214[1]), all such claims are not necessarily negligence claims. "The critical question in determining whether an action sounds in medical malpractice or simple negligence is the nature of the duty to the Plaintiff which the Defendant is alleged to have breached." *Halas v Parkway Hosp.*, 158 AD2d 516 (2d Dept 1990) citing *Bleiler v Bodnar*, 65 NY2d 65 (1985); *see also, Caso v St. Francis Hosp.*, 34 AD3d 714 (2d Dept 2006); *Rice v Vandenebossche*, 185 AD2d 336, 337 (2d Dept 1992). "The distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of the common everyday experience of the trier of facts (quotations omitted)." *Barresi v State of New York*, 232 AD2d 962 (3d Dept 1996), quoting *Smith v Pasquarella*, 201 AD2d 782 (3d Dept 1994), quoting *Miller v Albany Medical Center Hospital*, 95 AD2d 977 (3d Dept 1983). "When the challenged conduct constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician, the claim sounds in medical malpractice (quotations omitted)." *Caso v St. Francis Hosp.*, supra, at p. 714-715 quoting,

Bleiler v Bodnar, supra. Halas v Parkway Hosp., Inc., supra, at p. 516. That is, when the alleged negligent conduct constitutes an integral part of the process of rendering medical treatment to the Plaintiff, the conduct must be characterized as malpractice. *Scott v Uljanov*, 74 NY2d 673 (1989); *Bleiler v Bodnar, supra; Smee v Sisters of Charity Hosp.*, 210 AD2d 966 (4d Dept 1994). Nevertheless, a personal injury action against a medical practitioner or medical facility may be based on negligence principles. *Coursen v New York Hospital-Cornell Med. Ctr.*, 114 AD2d 254, 256 (1st Dept 1986). "[I]f the conduct complained of may be readily assessed on the basis of common, everyday experience of the trier of facts, and expert testimony is unnecessary for such a review, then the cause of action sounds in negligence." *Rice v Vandenebossche*, supra, at p. 337 citing *Fox v White Plains Med. Ctr.*, 125 AD2d 538 (2d Dept 1986); *Tighe v Ginsburg*, 146 AD2d 268 (4d Dept 1989); *see also, DeLeon by DeLeon v Hospital of Albert Einstein College of Medicine*, 164 AD2d 743, 748 (1st Dept 1991). That is, where "the alleged negligent act may be readily determined by the trier of the facts based on common knowledge," the claim sounds in negligence. *Coursen v New York Hosp.-Cornell Med. Ctr.*, supra, at p. 256, citing *Bleiler v Bodnar*, supra. Generally, where a party asserts a claim against a hospital for its failure to fulfill a clearly identifiable medically unrelated duty, the claim has been deemed to sound in negligence. *Rodriguez ex rel. Estate of Mendez v Mount Sinai Medical Center*, 5 Misc3d 1009(A) (Supreme Court Bronx County 2004). "These medically unrelated duties include such obvious administrative tasks as the maintenance of facilities and equipment, and providing a safe facility." *Rodriguez ex rel. Estate of Mendez v Mount Sinai Medical Center*, supra, citing *Alaggia v North Shore University Hospital*, 92 AD2d 532 (2d Dept 1983) (hospital bed not properly equipped); *Gould v New York City Health and Hospitals Corp.*, 128 Misc2d 328 (Supreme Court New York County 1985) (furnishing defective equipment); *Holtfoth v Rochester General Hospital*, 304 NY 27, 32 (1952) (failure to provide a functioning wheelchair); *McCormack v Mt. Sinai Hospital*, 85 AD2d 596 (2d Dept 1981) (same).

When examined closely, here, all of the Plaintiff's claims predicated upon violations of the state regulations applicable to the Defendant Center relate to medical care and sound in medical malpractice: A lay person cannot make a determination as to whether the Center violated the regulations relied upon by the Plaintiff without the assistance of experts. See, *Yamin v Baghel*, 284 AD2d 778 (3d Dept 2001); *Rice v Vandenebossche*, supra; *Pacio v Franklin Hospital*, Index No. 9041/06, SFO June 10, 2008

(Supreme Court Nassau County); *Slobin v Boasiako*, 19 Misc3d 1110(A) (Supreme Court Nassau County 2008).

The Plaintiff's reliance on *Morisett v Terence Cardinal Cooke Health Care Center* (8 Misc3d 506 [Supreme Court New York County 2005]) in maintaining that his claims sound in negligence is misplaced. The distinction that presents itself here between medical malpractice and negligence was not addressed in that case.

Nevertheless, the Center's motion to dismiss the complaint pursuant to CPLR §§3012-a and 3406 based on the Plaintiff's failure to file a Notice of Malpractice and Certificate of Merit is ***denied***.

CPLR § 3012-a requires a plaintiff's attorney to file a Certificate of Merit in a medical malpractice action. However, in lieu thereof, CPLR § 3012-a(g) allows a plaintiff to provide the defendant with that information via CPLR § 3101(d). And, the plaintiff's failure to comply with CPLR § 3012-a in a timely fashion cannot result in dismissal of the action. *Russo v Pennings*, 46 AD3d 795 (2d Dept 2007); *Grant v County of Nassau*, 28 AD3d 714 (2d Dept 2006). Instead, a conditional order of compliance is issued. *Rice v Vandenebossche*, supra, at p. 338. The Plaintiff has provided the requisite information via his response to this motion as well as his compliance with CPLR § 3101(d).

Similarly, while CPLR § 3406(a) requires a plaintiff to file a Notice of Medical Malpractice within 60 days of when issue is joined, that time may be extended upon a motion pursuant to CPLR § 2004. "Neither the plain language of CPLR § 3406(a) nor the structure of the . . . procedural scheme supports the conclusion that the Legislature intended dismissal to be a sanction for failure to timely file the notice." *Tewari v Tsoutsouras*, 75 NY2d 1, 7 (1989); see also, *Grant v County of Nassau*, supra. Furthermore, "[c]onsistent with the statute, the rules promulgated by the Chief Administrator do not authorize dismissal as a sanction for noncompliance with the notice requirement of CPLR § 3406(a)." *Tewari v Tsoutsouras*, supra, at p. 8. "The notice requirement [of CPLR § 3406(a)] is a rule of calendar practice which functions to trigger the pre-calendar conference required by CPLR § 3406(b)." See, *Tewari v Tsoutsouras*, supra, at p. 12. Since the case is on the trial calendar, requiring the Plaintiff to file a Notice of Medical Malpractice serves no purpose. *D'Esposito, as Administrator for Estate of Stella D'Esposito v Haym Salomon Home for the Aged,* 23 Misc 3d 1116 (A) (Supreme Court Kings County 2009); *Osborne ex rel. Osborne v Rivington House–The Nicholas A. Rango Health Care Facility*, 19 Misc3d 1132 (A) (Supreme Court New York County 2008).

It is not entirely clear whether the burden normally required for an award of punitive damages in a medical malpractice action and the burden set forth at Public Health Law § 2801-d(2) differ as the courts have not been consistent in determining that. In *Osborne ex rel. Osborne v Rivington House-The Nicholas A. Rango Health Care Facility*, supra, the court stated that the standard to recover punitive damages under the Public Health Law § 2801-d(2) "**appear(s)** be a less stringent standard than that under the law governing medical malpractice (emphasis added)." However, other courts have analogized the standard for punitive damages under Public Health Law § 2801-d(2) and medical malpractice. See, *Everett v Loretto Adult Community, Inc.*, 32 AD3d 1273 (4d Dept 2006) (punitive damages under Public Health Law § 2801-d(2) analogous to availability in medical malpractice actions and all punitive damage claims dismissed because plaintiff failed to raise an issue of fact as to whether defendant's conduct could be viewed as so reckless or wantonly negligent as to be the equivalent of a conscious disregard of rights of others); *Passet v Menorah Nursing Home*, 16 Misc3d 1117(A) (Supreme Court Kings County 2007) (all punitive damages claims dismissed because Plaintiff presented no evidence of reckless or wanton conduct); *Williams v Ruby Weston Manor, et al.*, Index No. 6667/05 SFO, June 23, 2006 (Supreme Court Kings County) (all punitive damages claims dismissed because plaintiff failed to allege failures by defendant that transcended normal negligence or malpractice).

Punitive damages are not available here. The Plaintiff has not alleged conduct that meets the burden under medical malpractice or Public Health Law principles. The Plaintiff's claim for punitive damages is **dismissed**.

Turning next to the Center's motion for summary judgment on the merits, "[o]n a motion for summary judgment pursuant to CPLR § 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." *Sheppard-Mobley v King*, 10 AD3d 70, 74 (2d Dept 2004), *aff'd. as mod.*, 4 NY3d 627 (2005), citing *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986); *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." *Sheppard-Mobley v King*, supra, at p. 74; *Alvarez v Prospect Hosp.*, supra; *Winegrad v New York Univ. Med. Ctr.*, supra. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material

issue of fact. *Alvarez v Prospect Hosp.*, supra, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. See, *Demishick v Community Housing Management Corp.*, 34 AD3d 518, 521 (2d Dept 2006), citing *Secof v Greens Condominium*, 158 AD2d 591 (2d Dept 1990).

"The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted practice and evidence that such departure was a proximate cause of the injury." *Hernandez v Hochman*, 56 AD3d 427, 428 (2d Dept 2008) citing *Roca v Perel*, 51 AD3d 757 (2008); *DiMitri v Monsouri*, 302 AD2d 420, 421 (2003). "In a medical malpractice action, a plaintiff must prove that there was a deviation or a departure from good and accepted practice and that such departure or deviation was a proximate cause of injury or damage." *Luu v Paskowski*, 57 AD3d 856 (2d Dept 2008), citing *Myers v Ferrara*, 56 AD3d 78 (2d Dept 2008). In contrast, "[o]n a motion for summary judgment dismissing the complaint, a defendant physician has the burden of establishing the absence of any departure from good and accepted practice, or, if there was a departure, that the plaintiff was not injured thereby." *LUU v Paskowski*, supra, citing *Rebozo v Willen*, 41 AD3d 457, 458 (2d Dept 2007); *Thompson v Orner*, 36 AD3d 791, 791-792 (2d Dept 2007); *Taylor Nyack Hosp.*, 18 AD3d 537, 538 (2d Dept 2005); *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). If the defendant meets his burden, "a plaintiff must submit the affidavit of a physician attesting to a departure from good and accepted practice, and stating the physician's opinion that the alleged departure was a competent producing cause of the plaintiff's injuries." *Luu v Paskowski*, supra, citing *Rebozo v Wilen*, supra, at p. 458; *Thompson v Orner*, supra, at p. 792; *Taylor v Nyack Hosp.*, supra, at p. 538; *Domaradzki v Glen Cove Ob/Gyn Assoc.*, 242 AD2d 282 (2d Dept 1997). "[A]n expert's affidavit containing general allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" does not suffice. *Luu v Paskowski*, supra, citing *Alvarez v Prospect Hosp.*, supra, at p. 324-325; *Rebozo v Wilen*, supra, at p. 458-459; *Thompson v Orner*, supra, at p. 792; *Furey v Kraft*, 27 AD3d 416, 418 (2d Dept 2006), *lv den.*, 7 NY3d 703 (2006); *Taylor v Nyack Hosp.*, supra, at p. 538. Furthermore, "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions . . . . Such credibility issues can only be resolved by a jury." *Feinberg v Feit*, 23 AD3d 517, 519 (2d Dept 2005), citing *Shields v Baktidy*, 11 AD3d 671 (2d Dept 2004); *Barbuto v Winthrop*

University Hosp., supra; *Halkias v Otolaryngology-Facial Plastic Surgery Assoc.*, 282 AD2d 650 (2d Dept 2001); see also, *Roca v Perel, supra; Graham v Mitchell*, 37 AD3d 408 (2d Dept 2007).

In support of its motion for summary judgment on the merits, the Center has submitted the affirmation of Luigi Capobianco, M.D. Dr. Capobianco is Board Certified in Family Practice and Wound Care with a subcertification in Geriatric Medicine. He affirms that he has reviewed the Plaintiff's allegations, the pertinent medical records and the testimony given at the examinations-before-trial and opines "within a reasonable degree of medical certainty, that there were no departures in the care and treatment rendered by the Center, its staff, agents, servants and/or employees in connection with its treatment of [the Plaintiff] that proximately caused and/or contributed to his alleged injuries . . . and that there were no violations of the Public Health Law or nursing home regulations that proximately caused or contributed to any harm, violation or injury as alleged by the Plaintiff in the complaint and Bill of Particulars." He states that "the decline in [the Plaintiff's] medical condition, the need for a wheelchair, walker, cane, hospitalizations, urinary catheter, depression, mental anguish, decrease in mobility and ability to function were secondary to his multiple co-morbidities, including longstanding Parkinson's disease, Lewy Body Dementia and Benign Prostate Hyperplasia ("BPH") with supra-pubic catheter all which existed prior to his admission to Meadowbrook."

Dr. Capobianco opines that the Plaintiff's sacrum ulcer diagnosed on April 21, 2006 was diagnosed Stage IV because it was "unstageable" on account of the eschar and notes that it became a Stage II ulcer when the eschar cleared up. It is also Dr. Capobianco's opinion that neither the fall the Plaintiff suffered on April 27, 2006 nor the urosepsis were the result of any wrongdoing by the Center.

Dr. Capobianco notes that the Plaintiff was diagnosed with Parkinson's disease, Lewy Body Dementia and urine retention many years prior to the care at issue in this case. He notes that the Plaintiff had suffered numerous urinary tract infections as well as falls before his last stay at the Center. He states that "[p]atients with Parkinson's as it progresses frequently suffer falls, limitations in ambulation, and suffer limitations in all activities of daily living" and that "Lewy Body Dementia caused the Plaintiff to be at an elevated risk of falls and his activities of daily living to diminish, including his independence in ambulation resulting in the need for a wheelchair and physical and occupational therapy." He states that these conditions also caused the Plaintiff's anxiety, depression and mental anguish.

Dr. Capobianco notes that upon his admission to the Center, the Plaintiff was already suffering from urosepsis and was post-fall. His medical diagnosis included hypertension, dementia, Parkinson's, BPH, eczema and dermatitis. He was incontinent and had a supra-public catheter due to urinary retention and BPH. Dr. Capobianco states that a comprehensive care plan was established. He states that the plan addressed the Plaintiff's skin integrity being at risk for breakdown and the plan also included providing adequate nutrition and hydration and vitamin supplements per the medical doctor orders. He states that the plan also addressed the Plaintiff being at an elevated risk for falls due to his fall history and psychoactive drug use. He states that the plan's goal was for the Plaintiff to remain free from injury due to falls and that interventions included keeping the call bell within reach, encouraging call bell usage, keeping the bed in the lowest position, anticipating and meeting needs as possible, providing a safe, clutter free environment as well as bed and chair alarms, floor mats and providing transport to activities. As for the Plaintiff's nutritional deficiency, Dr. Capobianco states that the proposed interventions included monitoring weights and labs, observing oral intake, 8 ounces of milk with meals, and giving a multivitamin, vitamin C, and zinc. Dr. Capobianco states that the Plaintiff was routinely monitored and adjustments were made to maintain and improve his nutritional status. He states that hydration was also addressed in the care plan and monitored routinely. Dr. Capobianco states that the care plan also addressed the issue of the Plaintiff's potential for urinary tract infections and the need for supra-pubic catheter care. Urine cultures were taken and when a urinary tract infection was noted, antibiotics given.

Dr. Capobianco notes that upon his admission, the Plaintiff had a Stage II ulcer on his right buttocks and a red inner left buttock and several ecchymosed areas. Silvadene ointment and later Xenaderm was ordered and a Pegasus cushion was ordered, which was changed to a gel cushion. A pressure reduction mattress was utilized in bed. Dr. Capobianco notes that the Plaintiff's wound records show that the ulcer was healed on February 24. Dr. Capobianco notes that the Plaintiff's records reveal that Xenaderm was ordered again on March 1, March 21 and April 5 to preserve the Plaintiff's skin and his care plan was updated on April 18 to reflect his continued risk of skin breakdown and bowel incontinence. Dr. Capobianco notes that on April 21 the Plaintiff's doctor was asked to evaluate a sacral ulcer, which was Stage IV measuring 6 x 4 cm with black eschar on the surface. The Plaintiff's records reflect that treatment orders were written that same day for Collagenase and Allevyn cover daily and

nursing noted that several pressure relief devices including an alternating pressure mattress, wheelchair cushion, turn and position frequently, were already in place. He notes that while the Plaintiff's laboratory values on April 6 reflected that he had sufficient protein stores for wound healing with an albumin level of 4.2 gm/dl, the dietary department recalculated the Plaintiff's nutritional needs based on the sacral ulcer and recommended supplements to increase calories. Dr. Capobianco notes that by April 26, the wound was smaller and noted to be a Stage II because the eschar was gone. The care plan also reflected the turning and positioning schedule was in place.

As for the Plaintiff's falls, Dr. Capobianco notes that the Plaintiff was agitated, for which he was regularly medicated and that his dosages were routinely adjusted. Dr. Capobianco notes that the Plaintiff notoriously tried to climb out of bed. Despite constant interventions including a chair alarm, a bed alarm, safety belts and mats, the Plaintiff continued to fall. As for the Plaintiff's April 27 fall, he notes that the Certified Nurses Aide "CNA" was present with him and tried to stop the fall. The CNA described the Plaintiff as jerking immediately before he fell and he said that this had never occurred previously after showering. Dr. Capobianco noted that even during his subsequent hospitalization, the Plaintiff's agitation continued and despite the fact that efforts to medicate and restrain him were continued, he was still able to climb out of bed. In addition, subsequently, at East Rockaway Progressive Center, the Plaintiff continued to try to climb out of both his bed and his wheelchair and suffered urinary tract infections as well as skin breakdown and falls.

Dr. Capobianco notes that the Plaintiff had a history of ulcers and his ulcers reoccurred regardless of the facility where he resided. Based upon his review of the records, Dr. Capobianco opines that it appears that the Plaintiff's ulcers were the result of his thrashing in his chair as opposed to resulting from pressure. He opines that the Plaintiff's record is devoid of any evidence of wrongdoing by the Center that caused or contributed to the worsening or happening of pressure sores. Similarly, Dr. Capobianco opines that the Plaintiff was properly hydrated and provided adequate nutrition. He notes that the Plaintiff's lab studies were monitored and his nutrition levels were maintained appropriately, and that he was given vitamin supplements and encouraged with fluid intake. He opines that despite all reasonable preventive measures, the ulcer in April 2006 developed and that this ulcer was not a result of inadequate care but the friction caused by the Plaintiff's movement in his chair and on his bed due to his agitation from his Parkinson's disease, his multiple co-morbidities and his bowel incontinence. He

notes that unfortunately, the Plaintiff's Parkinson's disease and Lewy Body Dementia caused his rigidity and tremors and the medications that could have reduced his thrashing caused lethargy and were not given at the family's request. Dr. Capobianco notes the Plaintiff's history of skin breakdowns and development of pressure ulcers.

Dr. Capobianco correctly opines that 10 NYCRR § 415.12(c)(1) does not apply because the Plaintiff was admitted with pressure sores. As for 10 NYCRR § 415.12(c)(2), Dr. Capobianco notes that the ulcer Plaintiff presented with resolved and it is his opinion that the April 21, 2006 ulcer was unavoidable and every reasonable effort was made to prevent it from occurring. He opines that it occurred as did the Plaintiff's numerous prior ulcers as a result of his co-morbidities and overall progression of his chronic illness and as a result of his thrashing in his chair because of agitation, despite the Center's employment of all reasonable efforts including use of pressure reducing devices, turning and positioning and providing proper nutrition.

It is also Dr. Capobianco's opinion within a reasonable degree of medical certainty that the Plaintiff's allegations regarding the Center's failure to prevent the Plaintiff from suffering falls is totally without merit. He notes that the Plaintiff's records are replete with a history of falls long before the admission at issue and it is his opinion that the Center undertook every reasonable effort to avoid the Plaintiff's falls and instituted the least restrictive measures possible and when those measures failed, the Center repeatedly instituted further measures to avoid falls. He opines that the falls the Plaintiff suffered were largely due to his dementia combined with his Parkinson's disease. While efforts were repeatedly made to adjust the Plaintiff's medication dosage, his Parkinson's symptoms continued regardless of the care provided or the institution. He notes that the Plaintiff's final fall at the Center occurred with the CNA present. It is Dr. Capobianco's opinion within a reasonable degree of medical certainty that this fall did not occur because of improper assessments or care plan. Dr. Capobianco notes that the Plaintiff required minimal assistance with transfer at that time; he had been ambulating over 200 feet with a rolling walker and had met his therapeutic goals. Dr. Capobianco notes that the CNA that cared for the Plaintiff at the time of his fall was familiar with him and had previously showered him numerous times without incident. The aide was also familiar with his tremors and rigidity and had never seen the Plaintiff jerk in any manner during showering previously and there was no reason to expect it would have occurred on this date. There is, in Dr. Capobianco's opinion, no evidence that the Plaintiff

required more than one person to assist with the transfer and nothing Meadowbrook did or failed to do that caused or contributed to the happening of this fall.

It is also Dr. Capobianco's opinion that the urinary tract infection the Plaintiff suffered from was not caused by the Center. He notes the Plaintiff suffered numerous urinary tract infections and that he was at risk for urinary tract infections at his admission and that his risk was monitored via lab work and maintenance of his catheter as well as urologist consults. He opines that his infection was the result of urine retention and BPH along with Parkinson's disease and his need for a supra-pubic catheter.

It is also Dr. Capobianco's opinion that an appropriate care plan was outlined, evaluated, updated and modified as needed.

The Center has not demonstrated its entitlement to summary judgment. Its medical expert's opinion is advanced in a most conclusory fashion, which is unacceptable. *Luu v Paskowski*, supra, citing *Alvarez v Prospect Hosp.*, supra, at p. 324-325; *Rebozo v Wilen*, supra, at p. 458-459; *Thompson v Orner*, supra, at p. 792; *Furey v Kraft*, 27 AD3d 416, 418 (2d Dept 2006), lv den., 7 NY3d 703 (2006); *Taylor v Nyack Hosp.*, supra, at p. 538. While he makes reference to the Plaintiff's records from the Center, in support of his conclusions, an exhibit of several hundred pages has been submitted and no further identification of what he is referring to is made.

In any event, assuming, *arguendo*, that the Center met its burden thereby shifting the burden to the Plaintiff to establish the existence of a material issue of fact, the Plaintiff has done so as to certain claims.

In opposition, the Plaintiff has submitted the affidavit of Karim J. Khimani, M.D., a board certified internist and geriatric doctor. He attests to having reviewed the Plaintiff's records from April 2003 through May 2006. He concluded that the Center failed to provide proper skin care to the Plaintiff during his final stay there which led to the development of the pressure sore on his sacrum/coccyx, which would not have occurred had proper care been provided. More specifically, Dr. Khimani notes that "[p]lan interventions did not include use of pressure relieving surfaces despite the presence of two Stage II buttock wounds at the time of [the Plaintiff's] admission to Meadowbrook" and that while "[a] comprehensive care plan was subsequently developed January 9, 2006 which included the use of pressure relieving devices, . . . the [Center's] records fail to demonstrate implementation of this mandated intervention." He also notes that the Center's record also failed to include documentation of a

turning and repositioning schedule to ensure pressure offloading was maintained on a routine two-hour basis. He notes that while the Plaintiff's care plan interventions mandated vitamin supplements "as per MD order," nursing staff failed to solicit orders for these dietary supplements until January 13, 2006. Dr. Khimani also notes that the Plaintiff presented with pressure sores which ultimately healed and opines that this was indicative of his susceptibility to pressure sores and the need for preventive measures. Yet, he notes that no preventive or protective care is reflected in the Plaintiff's records from February 24, 2006 until March 3, 2006 when Xenaderm ointment to the buttocks was ordered. He further notes that the use of a criss-cross seat belt ordered on February 22, 2006 should have provoked regular release for skin inspection, toileting, position changes and assistance with daily living every two hours, yet the Plaintiff's records reflect that at times, he was restrained with the cross seat belt for up to eight hours at a time during February and March. Dr. Khimani notes that the Xenaderm was stopped March 24, 2006 but from the Plaintiff's records, it cannot be discerned whether it was effective, and it was reordered on March 31, 2006, two times a day for 30 days, but the Plaintiff's record indicates it was not done for 30 days. He notes that while wound care for ten days was ordered on April 5, 2006 for 10 days to cleanse, apply Xenaderm ointment to excoriate the Plaintiff's buttocks for 10 days, no record exists of its effectiveness at its completion and in fact no record exists reflecting the Plaintiff's skin condition from April 4, 2006 to April 21, 2006 when the Stage IV pressure sore was discovered, for which a new care plan was not developed until April 26, 2006. Dr. Khimani notes that the black eschar on the sore when it was discovered indicates that it was in its late stages of tissue ischemia which can result from prolonged unrelieved pressure.

As for the Plaintiff's April 27, 2006 fall, Dr. Khimani opines that the Center's records simply do not reflect a proper fall risk assessment or the implementation of preventive precautions.

It is Dr. Khimani's opinion that the Center's records reflect violations of 10 NYCRR §§415.12 and 415.12(c)(2).

The Plaintiff has established the existence of a material issue of fact with respect to two issues: Whether the Defendant violated 10 NYCRR § 415.12 and 415.15(a) and 415.12(c)(2), (l)(1) in failing to prevent and timely diagnose the April 21, 2006 pressure sore including a failure to hydrate and provide nutrition and in failing to prevent his April 27, 2006 fall. In view of the Plaintiff's lack of opposition with respect to all other allegations of negligence, medical malpractice or statutory or

regulatory violations, those claims are **dismissed**. It is hereby

ORDERED, the parties are directed to appear in Central Jury on June 17, 2009 at 9:30 a.m. for a trial on the remaining issues.

This constitutes the Decision and Order of the Court.

DATED: May 13, 2009
Mineola, N.Y. 11501

ENTER:

HON. MICHELE M. WOODARD
J.S.C.

ENTERED
MAY 15 2009
NASSAU COUNTY
COUNTY CLERK'S OFFICE

H:\Maloney v Meadowbrook Care Center Mot Seq 3.wpd