

**Puzino v Park**

2010 NY Slip Op 31698(U)

June 30, 2010

Supreme Court, Nassau County

Docket Number: 009002/07

Judge: Randy Sue Marber

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SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF NASSAU

Present: **HON. RANDY SUE MARBER**  
**JUSTICE**

TRIAL/IAS PART 20

\_\_\_\_\_  
THOMAS PUZINO, Individually and as  
Administrator of the Estate of MADELINE  
PUZINO, deceased,

Plaintiff,

-against-

Index No.: 009002/07  
Motion Sequence...02, 04  
Motion Date...03/24/10

YUNGDO PARK, M.D., NILOFAR K. HAVA,  
M.D., BARRY MAIZEL, M.D., DOC CARE  
a/k/a DOC CARE 1 d/b/a AMB MEDICAL  
SERVICES, P.C., JASON M. CHAMIKLES, D.O.,  
HARVEY ZALTZMAN, M.D., RONALD J.  
GULOTTA, M.D., CHRISTOPHER LAMENDOLA,  
M.D., NEWELL B. ROBINSON, M.D., HAROLD A.  
FERNANDEZ, M.D., CARDIOTHORACIC  
SURGERY, P.C., CINDY VONA, R.N., VISITING  
NURSE SERVICE OF NEW YORK, ANDREW S.  
PUMERANTZ, M.D., DAVID B. BRIEFF, M.D.,  
NORTH SHORE INFECTIOUS DISEASE  
CONSULTANTS, P.C. and ST. FRANCIS HOSPITAL,

Defendants.

\_\_\_\_\_  
Papers Submitted:  
Notice of Motion.....X  
Notice of Motion.....X  
Affirmation in Opposition.....X  
Reply Affirmation.....X

Upon the foregoing papers, the motions, brought pursuant to CPLR § 3212, by

the Defendants, Cindy Vona, R.N. (VONA) and Visiting Nurse Service of New York (VNS) and by the Defendant, Jason M. Chamikles, D.O. respectively, for summary judgment dismissing the complaint as to said Defendants are determined as hereinafter provided.

### **BACKGROUND**

The Plaintiff, individually and as Administrator of the estate of his deceased wife, Madeline Puzino, commenced this action seeking damages for the decedent's wrongful death resulting from Defendants' alleged medical malpractice. During the period May 20 through June 9, 2005 the Defendant, VNS provided home care services<sup>1</sup> to the decedent after her discharge from the Defendant, St. Francis Hospital, following mitral valve replacement surgery due to endocarditis and mitral valve regurgitation. On June 13, 2005, four days after her discharge from the care of the Defendant, VNS, decedent was diagnosed with shortness of breath, a large right pleural effusion and pericardial effusion and readmitted to St. Francis Hospital. The following day she underwent a surgical procedure in which fluid, which had accumulated around the heart, was drained. Her physical condition deteriorated following the surgery and she died on June 20, 2005.

According to the Plaintiff's Bill of Particulars, the Defendant, Vona and the Defendant, VNS vicariously, committed malpractice, *inter alia*, in failing to appreciate and

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<sup>1</sup>The Defendant, Vona assessed the decedent's condition on three occasions: May 20, May 25 and June 2, 2005. At home physical therapy commenced on May 25, 2005 when an initial physical therapy assessment revealed that the decedent was experiencing shortness of breath and generalized body fatigue. The physical therapist visited the decedent again on June 6, 2005 and June 9, 2005.

timely report symptomology and/or relevant findings regarding the decedent's worsening medical condition to physicians and a nursing supervisor and in failing to follow up with physicians on the decedent's worsening symptomology.

The Defendants, VNS and Vona have made a *prima facie* showing of entitlement to judgment as a matter of law dismissing the complaint asserted against them based upon the affidavit of their medical expert, Paula Milone-Nuzzo, R.N., Phd. who denies, based upon review of the deposition testimony and medical records, that the Defendant, Vona departed from good and accepted medical practices. Specifically, the expert states, *inter alia*, that:

home nursing care following [decedent's] mitral valve replacement surgery was, at all times, entirely reasonable, appropriate and consistent with accepted practice and there was no indication for other or different home care under presenting circumstances;

records confirm physician examinations of decedent on May 19, May 31 and June 11, and reveal no basis for claim that any alleged delay or non-reporting of signs or symptoms by home care providers caused or contributed to any injury;

decedent's physicians examined decedent immediately before home care admission, during home care admission and after discharge from home care;

decedent's physicians were aware of and assessed patient's shortness of breath and dyspnea;

decedent's physicians determined that the medical care at issue was reasonable, appropriate and proper and there was no indication to order care, other than what was ordered. Any suggestion that alleged improper medical care resulted from any

non-reporting of signs or symptoms by home care providers is without basis.

With respect to the physical therapy services provided by the Defendant, VNS, Dr. Nuzzo states that physical therapy was provided as ordered and there was no indication that the services were either inappropriate or inappropriately provided or that other or different physical therapy was called for. Moreover, she states that the therapy administered did not cause or contribute to any alleged damage suffered by the decedent.

In summary, she noted that the Defendant, VNS's home care services were provided as ordered and were reasonable, appropriate and consistent with accepted standards of nursing care and neither the Defendant, VNS or the Defendant, Vona caused or contributed to any alleged damage.

In opposition to the motion of the Defendants, VNS and Vona, the Plaintiff offers the expert affidavit of Susan M. Cacciola, RN, BSN, CLNC who opines that:

the home care rendered by VNS Nurse Cindy Vona, materially deviated from good and accepted nursing practice standards of care and that such deviations contributed to her subsequent hospitalization and death.

Specifically, the expert attests, *inter alia*, that:

Nurse Vona, the assigned physical therapist and VNS supervisors failed to recognize decedent's deteriorating and compromised clinical condition and to advise a physician accordingly;

Nurse Vona failed to fully assess decedent and develop a plan of care based on presenting symptomology, limitations, medications, wound status, dietary restrictions and safety needs;

Nurse Vona failed to recognize abnormal signs and symptoms during May 20, 2005 visit and new signs and symptoms of loss of balance and assess and report accordingly;

VNS failed to advocate for client and question existing nursing and medical plans of care; failed to supervise; failed to assess and recognize abnormal signs, symptoms and changes in decedent's condition;

abnormal signs/symptoms noted by physical therapist were not addressed or communicated to Nurse Vona, VNS or Dr. Ronald J. Gulotta;

physical therapist failed to develop plan of care based on individual needs and refer for follow up, appropriate medical equipment and evaluation from physician for chest pain, posturing and fall risk;

Nurse Vona was not aware of the findings [decreased physiological response to exercise] of the physical therapist; and decedent was discharged from VNS care before reaching goal attainment due to a failure to properly assess, plan, implement, evaluate and change the plan of care to reach goal attainment; a failure to restore health through rehabilitative actions; and a failure to prevent deterioration through rapid analysis and identification allowing compromise of the clinical picture and the plan of care.

In summary, the Plaintiff's expert opined that the care provided by the Defendant, VNS and its employees, i.e., the Defendant, Vona and physical therapist, Anna Liza Sampayan, in the care and treatment of the decedent, from May 20, 2005 through June 9, 2005, departed from good and accepted practices and those departures were a substantial factor in causing severe injuries to the decedent which contributed to her death.

## ANALYSIS

To establish a *prima facie* case of liability in a medical malpractice action, the plaintiff must prove (1) the standard of care in the locality where treatment occurred; (2) that the defendant breached that standard of care; and (3) the breach was the proximate cause of plaintiff's injury. *Myers v Ferrara*, 56 AD3d 78, 83 [2<sup>nd</sup> Dept. 2008]; *Rosen v John J. Foley Skilled Nursing Facility*, 45 AD3d 558 [2<sup>nd</sup> Dept. 2007]. In order to sustain this burden, the plaintiff must present expert opinion testimony to prove that the defendant's conduct constituted a deviation from the requisite standard of care and to establish proximate cause. *Nichols v Stamer*, 49 AD3d 832, 833 [2<sup>nd</sup> Dept. 2008].

To establish proximate cause, a plaintiff must demonstrate sufficient evidence from which a reasonable person might conclude that it was more probable than not that the defendant's deviation was a substantial factor in causing the injury. *Alicea v. Ligouri*, 54 A.D.3d 784, 785 (2<sup>nd</sup> Dept. 2008).

On a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant has the burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby. *Luu v. Paskowski*, 57 A.D.3d 856, 857 (2<sup>nd</sup> Dept. 2008); *Roca v. Perel*, 51 A.D.3d 757, 758 (2<sup>nd</sup> Dept. 2008). To sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff's Bill of Particulars. *Koi Hou Chan v. Yeung*, 66 A.D.3d 642, 643 (2<sup>nd</sup> Dept. 2009). Once the movant has made such a showing,

the burden shifts to the opponent of summary judgment to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit attesting to a departure from accepted practice and containing an opinion that the defendant's acts or omissions were a competent producing cause of the injury. *Bjorke v. Rubenstein*, 53 A.D.3d 519 (2<sup>nd</sup> Dept. 2008); *DiGiario v. Agrawal*, 41 A.D.3d 764, 767 (2<sup>nd</sup> Dept. 2007). General allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence, however, are insufficient to establish the requisite elements of a medical malpractice action. *Taylor v. Nyack Hosp.*, 18 A.D.3d 537, 538 (2<sup>nd</sup> Dept. 2005). Where the parties adduce conflicting medical expert opinions, summary judgment is not appropriate as such credibility issues require resolution by the finder of fact. *Deutsch v. Chaglassian*, 71 A.D. 3d 718 (2<sup>nd</sup> Dept. 2010).

As to causation, the plaintiff's evidence may be deemed legally sufficient even if the expert cannot quantify the extent to which the defendant's acts or omissions decreased the patient's chance of a better outcome or increased her injury, as long as evidence is presented from which the jury might infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased her injury. *Flaherty v. Fromberg*, 46 A.D.3d 743, 744 (2<sup>nd</sup> Dept. 2007). The Plaintiff has made no such showing.

Here, the affidavit submitted by Dr. Nuzzo establishes a *prima facie* case that the movants' treatment of the Plaintiff's decedent was not negligent thereby shifting to the Plaintiff the obligation to show, by sufficient evidentiary proof, the existence of a triable

factual issue. The Plaintiff has failed to sustain that burden. The affidavit of the Plaintiff's expert, which is conclusory in nature, is insufficient to raise a triable issue of fact concerning medical malpractice and fails to specify the manner in which the Defendants' actions were the proximate cause the decedent's injuries and death.

Careful review of the record establishes that, notwithstanding assertions to the contrary by the Plaintiff's expert, the decedent's physicians were aware of her shortness of breath, both prior and subsequent to her mitral valve replacement surgery. The testimony of the Defendant, Ronald J. Gulotta, M.D., establishes that during the time the decedent was under the care of the Defendant, VNS, she complained to him on May 31, 2005 of shortness of breath, post nasal drip and dyspnea on exertion and that by the end of the day she was losing her breath with speech. Dr. Gulotta stated that he attributed those symptoms to the fact that she had just had major surgery. An EKG was performed on that date which revealed "normal sinus rhythm at 96, normal axis, non-specific ST and T wave changes" which did not constitute any change from the previous EKG. (EBT transcript, Ronald J. Gulotta, M.D., p. 57, lines 12-17). He recommended that she return to his office in one month and apparently discharged her from the Defendant, VNS' care on June 2, 2005.

When he next saw the decedent, it was in the emergency room at St. Francis Hospital on June 13, 2005. Her vital signs were stable and, according to Dr. Gulotta, she was not in acute distress. The decedent was, however, experiencing shortness of breath caused by "large right pleural effusion" at the time. (EBT transcript, Ronald J. Gulotta, M.D., p. 62,

lines 7-15).

The testimony of the Defendant, Harvey Zaltzman, M.D., the decedent's primary care physician, indicates that he examined the decedent on June 11, 2005. She was anxious and complained of shortness of breath. He found clear breathing sounds. In his opinion, she was not in acute distress and did not require emergency treatment. He did, however, advise that she get a chest x-ray immediately and return to his office if she experienced increased difficulty in breathing.

In her testimony, the Defendant, Vona stated that on June 2, 2005 she advised Dr. Gulotta, by telephone, that the decedent had a low grade temperature and instructed the decedent to monitor her temperature daily and to notify the doctor (Dr. Golotta) if her temperature rose above 100 degrees (EBT of Cindy Vona, R.N., transcript, p. 94, lines 17-20).

### **CONCLUSION**

Given the record, and the Plaintiff's experts' failure to establish any viable nexus between the alleged departures of the Defendant, Vona and the Defendant, VNS from accepted standard of care and the decedent's death, the Plaintiff has failed to raise a triable issue of fact sufficient to preclude an award of summary judgment dismissing the complaint as to the Defendants, Vona and VNS. As noted by the movants, during the period in which the Defendant VNS was caring for the decedent, she was examined by her own physicians who were aware of the very conditions which the Plaintiff alleges the movants failed to

properly assess and report to the treating physicians.

The unopposed motion (Mot. Seq. 04) by the Defendant, Jason M. Chamikles, D.O.<sup>2</sup> for summary judgment dismissing the complaint as to him is **GRANTED** based upon the affidavit of his expert cardiologist, Mark A. Goodman, M.D., who opines that there were no departures from accepted standards of care and treatment on the part of Dr. Chamikles, which were the proximate cause the decedent's death.

Based upon the foregoing, it is hereby

**ORDERED**, that the within motion (Mot. Seq. 02) for summary judgment seeking dismissal of the Plaintiff's complaint against the Defendant, VNS and the Defendant, Vona is **GRANTED**; and it is further,

All applications not specifically addressed herein are **DENIED**.

This constitutes the Decision and Order of the Court.

DATED: Mineola, New York  
June 30, 2010



Hon. Randy Sue Marber, J.S.C.

**ENTERED**

JUL 01 2010

**NASSAU COUNTY  
COUNTY CLERK'S OFFICE**

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<sup>2</sup>Dr. Chamikles had no contact with the decedent during her admission to St. Francis Hospital for mitral valve replacement on May 11, 2005 nor after her discharge from St. Francis Hospital on May 19, 2005 or until her readmission to St. Francis Hospital and death in June 2005.