

**Brosen v Woodmere Rehabilitation & Health Care
Ctr., Inc.**

2012 NY Slip Op 32113(U)

August 1, 2012

Sup Ct, Nassau County

Docket Number: 1602/09

Judge: Karen V. Murphy

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Short Form Order

**SUPREME COURT - STATE OF NEW YORK
TRIAL TERM, PART 11 NASSAU COUNTY**

PRESENT:

Honorable Karen V. Murphy
Justice of the Supreme Court

_____x

CAROL BROSEN,

Index No. 1602/09

Plaintiff(s),

Motion Submitted: 5/29/12

**Motion Sequence: 002, 003, 004, 005,
006**

-against-

**WOODMERE REHABILITATION AND HEALTH
CARE CENTER, INC., SHELDON GREENSPAN,
M.D. and SAM YEE, M.D.,**

Defendant(s).

_____x

The following papers read on this motion:

- Notice of Motion/Order to Show Cause.....XXXXX
- Answering Papers.....XXXXXXXX
- Reply.....XXX
- Briefs: Plaintiff's/Petitioner's.....
- Defendant's/Respondent's.....X

This motion by the plaintiff Carol Brosen (sequence no. 2) for an order pursuant to CPLR §§ 3124, 3126 striking defendant Woodmere Rehabilitation and Healthcare Center, Inc.'s (Woodmere Rehabilitation) Answer or, in the alternative, precluding the defendant from producing witnesses to testify at trial is determined as provided herein.

This motion by the defendant Sheldon Greenspan, M.D. (Dr. Greenspan) (sequence no. 4) for an order pursuant to 22 NYCRR 130-1.1 imposing sanctions on the plaintiff's attorney Jeffrey A. Rubin, Esq. is determined as provided herein.

These motions by the defendant Sam Yee, M.D. (Dr. Yee) (sequence no. 3); defendant Woodmere Rehabilitation and Healthcare Center Inc. (Woodmere Rehabilitation) (sequence

no. 5); and defendant Sheldon Greenspan, M.D. (sequence no. 6) for an order pursuant to CPLR § 3212 granting them summary judgment dismissing the complaint and any and all cross-claims against them is determined as provided herein.

The plaintiff has had a long history in excess of ten years of osteoarthritis in her hips and knees. In fact, in 2002, she had laproscopic surgery on her right knee and in 2007, she underwent a laminectomy for spinal stenosis, following which she had to use a walker for ambulation. In fact, for several years prior to her hip replacement, Mrs. Brosen had to use a walker. She was virtually homebound as well as chair bound. She developed contractures in her lower extremities and suffered from hypertension, peptic ulcer disease and hypercholesterolemia.

The plaintiff underwent bilateral hip replacement surgery at New York University Hospital for Special Diseases ("NYU") on May 7, 2008 by surgical orthopedist Dr. Stubin. Post-operatively, she began occupational and physical therapy one day later and she was transferred to NYU's Acute Rehabilitation Unit approximately one week later. The admitting nurse's note of May 14, 2008 states that the surgical wounds were "clean, dry, red and swollen." On May 16th, she began treatment for a suspected urinary tract infection with the antibiotic Cipro. On May 22nd, Dr. Vitale cleared Mrs. Brosen for discharge to a skilled nursing facility for continued rehabilitation and she was discharged to Woodmere Rehabilitation that day. Mrs. Brosen's discharge note provides that her hip wounds were "clean, dry and intact, with no drainage" noted as well as that wounds were "kept open to air with no drainage" indicating that no bandages were needed.

Upon her admission to Woodmere Rehabilitation, the plaintiff was examined by Dr. Greenspan. Dr. Greenspan documented her medical history of hypertension, high cholesterol, duodenal ulcer and gastrointestinal disease as well as her surgical history of a laminectomy, bilateral total hip arthroplasties and a cholecystectomy. She was noted to be alert, oriented and fully expressive. However, she required extensive assistance with bed mobility, transfers to wheelchair, hygiene, bathing and toilet use and dressing due to the surgery as well as her history of osteoarthritis. She only ambulated during her physical and occupational therapy sessions. Upon admission, her skin was noted to be in tact with non-blanchable redness (Stage 1 pressure sores) to her bilateral heels. Her right hip was noted to be healing with crusts, with swelling to the surrounding areas. Her left hip was noted to be healing with crusts. Dr. Greenspan found her white blood count of 10.6 obtained two days prior to her admission to be within normal limits. Thus, he concluded that Mrs. Brosen did not have an infection at the time of her admission. His findings were "the wounds on [plaintiff's] hips were closed and there were no signs of infection or necrotic tissue or foreign bodies." In fact, at her examination-before-trial the plaintiff testified that the skin at her surgical site was completely closed, that the skin had grown over and that no bandages were

necessary. However, Mrs. Brosen did complain of hip pain. An abductor wedge to be used at all times when in bed was ordered. The admission plan formulated by Woodmere Rehabilitation's Dr. Greenspan was pain management with Dilaudid; daily physical and occupational therapy; daily bilateral surgical site cleansing with normal saline left open to the air; application of Silvadene to surgical sites at every shift; bilateral heel pads; and monitoring of surgical sites for signs and symptoms of infection. On May 24th, a nurse noted "bilateral hip surgical site dry and in tact" and on May 25th a nurse noted "surgical sites on both hips dry and clean – healing well." On May 26th, Stage 1 pressure ulcers on her heels were found by a wound care nurse which were treated with pads and zinc oxide. A nurse's note that day reflects "surgical sites on both hips dry and intact." Nursing care plans carefully were documented on May 27, 2008 which included notations as follows:

- Alteration in comfort/pain;
- Cardiovascular dysfunction secondary to hypertension;
- At risk for impaired skin integrity . . . ;
- At risk for falls;
- At risk for constipation;
- Self care deficits;
- Potential alteration in tissue perfusion;
- Potential for alteration in nutrition;
- Potential discharge to home;
- Potential for maladjustment to placement;
- Surgery of bilateral hip replacement with goal of healing surgical wounds and preventing complications.

Interventions included:

- (1) monitor for pain and medicate per MD order;
- (2) monitor for skin changes, i.e. redness, breakdown, erythema, edema, blisters;
- (3) provide treatment as ordered;
- (4) maintain hip precautions;
- (5) monitor for signs and symptoms of emboli;
- (6) monitor for unusual bruising/bleeding (patient receiving Arixtra); and,
- (7) therapy as ordered by MD.

On May 28, 2008, defendant Dr. Yee, a physiatrist, examined Mrs. Brosen for the first time. He examined range of motion and muscle strength. He did not note any abnormalities at Mrs. Brosen's hips and found the surgical sites to be closed. Mrs. Brosen complained that Dilaudid was not adequately helping her so Dr. Yee recommended that that medication be switched to Vicodin. He also recommended that physical therapy be continued and that ice

and warm heat be used to compliment her therapy and a "TENS" (a Transcutaneous Electrical Nerve Stimulator) unit be used.

On June 2, 2008, she was seen and examined by a podiatrist. The redness to her heels was noted to be resolved on June 3rd. On June 5th, she was seen by Physician Assistant Miller regarding her desire to be taken off of Colace. No other complaints were noted and her pain management plan was reviewed with her. That day, she was able to ambulate 100 feet with a rolling walker with supervision. According to the nurses' notes, the plaintiff's only complaints of pain were at her surgical sites for which she was receiving medication. The Vicodin which she had been switched to was providing her relief. Her records indicate that the surgical sites were clean, dry and intact. On June 6th, Dr. Greenspan examined Mrs. Brosen after the nursing staff reported a weight gain. She was noted to have no complaints but some lower extremity edema was noticed. She was put on a low sodium diet. Dr. Greenspan testified at his examination-before-trial that he did not check her wound sites because he did not think it was necessary. Her surgical sites are noted to be healed on June 8th on which date Silvadene was terminated by the attending physician.

A nurse's note on June 10th noted that Mrs. Brosen was running a temperature of 102 degrees. Dr. Greenspan referred that issue to the covering doctor Dr. Halbrecht and at whose direction several tests were ordered including blood work, a stat chest x-ray, a urinalysis and a urine culture and sensitivity. Tylenol was prescribed. Physician's Assistant Jacobs examined Mrs. Brosen who noted redness and warmth to the touch at the left hip surgical site and so an x-ray was ordered, the results of which were negative. It revealed a left hip arthroplasty without loosening or dislocation and no signs of osteomyelitis. Dr. Greenspan admitted at his examination-before-trial that the fever coupled with "redness and warm to the touch" were possible signs of an infection but he did not consider prescribing antibiotics or calling the surgeon. The blood culture came back negative. The nurse noted "[b]ilateral hips surgical sites clean, dry, without drainage noted." The blood tests and chest x-ray done that day were also essentially negative. The 7:00 a.m. - 7:00 p.m. nursing note of June 10th-11th reflects Mrs. Brosen saying "I'm OK now. I feel much better." Her temperature was 100.5 degrees and the nurse noted "bilateral hips surgical sites clean, dry, without drainage noted."

Upon being informed by the staff of a temperature elevation, Dr. Greenspan examined the plaintiff on June 11, 2008. Aside from diarrhea in the morning, Mrs. Brosen had no complaints, *i.e.*, no cough, no shortness of breath and no burning sensation upon urination. Her temperature was normal and Dr. Greenspan's examination of the surgical sites revealed no abnormalities. The redness and warmth of the day before were gone. Dr. Greenspan assessed Mrs. Brosen as suffering from a viral syndrom based on the fever and diarrhea. He planned to await the lab and urine test results and to check the results of the hip x-ray.

A nurse's note of 2:00 p.m. on June 11th reflects a recurrence of fever of 101.3. Tylenol was administered. At 12:00 a.m. on June 12th Mrs. Brosen's temperature was 100.4 and Tylenol was administered again and fluids were encouraged. At 6:00 a.m. on the 12th her temperature was 99.5. Laboratory results relayed to Woodmere Rehabilitation and Dr. Greenspan on June 12th revealed an elevated white blood count of 15.3 and her absolute neutrophils and lymphocytes were high. Dr. Greenspan was concerned about a possible urinary tract infection because the plaintiff had had one at NYU Hospital and a C-difficile test done there was negative, so he ordered the stat administration of Potassium and Levaquin daily for 10 days to treat Mrs. Brosen empirically. These orders were promptly carried out. Dr. Greenspan also ordered that the blood work be repeated on June 14, 2008. At his examination-before-trial, Dr. Greenspan admitted that he did not go see Mrs. Brosen and that she had not made any complaints which would comport with a urinary tract infection. No fever was noted on the nurse's note on June 12th nor were any complaints of pain.

Physician Assistant Jacobs saw Mrs. Brosen on June 13, 2008 for complaints of a rash in her groin area. His notes reflect that his examination of her surgical sites revealed "negative bilateral hip redness, no warmth, tenderness or swelling." His notes also document that Mrs. Brosen's hip pain had decreased and that she "feels much better." He ordered the antifungal preparation Nystatin powder to be applied to the groin area.

Nurse Practitioner Catherine Nozdrovicky examined the plaintiff on June 14th with regard to her complaints of a sore throat. Cepacol lozenges were prescribed. She noted that Mrs. Brosen's temperature was 100.2 and Levaquin was being continued. Mrs. Brosen's temperature during the 7:00 a.m. - 7:00 p.m. shift on June 14th was 99.5 degrees. The nurse wrote "Resident verbalized that she feels much better." The lab results of June 14th revealed that Mrs. Brosen's white blood count had returned to normal. Nurses notes from June 16th and 17th reflect a normal temperature and that Mrs. Brosen was alert and responsive without complaints.

Mrs. Brosen was seen again by Physician's Assistant Miller on June 17th, 2008 who notes at 1:40 p.m. that she continued to suffer from a low grade fever of 100.3 despite Levaquin being taken, seemingly with no benefits. Dr. Greenspan did not order Penicillin. He ordered a retest of the urinalysis, blood culture and sensitivity test of June 10th because they had been lost. His record states: "nothing is bothering her: no cough, no chest pain, no shortness of breath, no nausea or vomiting, no leg pain, no burning on urination, all labs have been negative including WBC, negative chest x-ray, negative left hip x-ray, bilateral hip incisions without erythema/drainage. Plan: follow-up urinalysis and monitor for any hip/groin pain." She was seen by Physician's Assistant Stevens who noted the need for another urine culture because the last one could not be processed. Another was obtained and sent for analysis. A nurse's note of June 18, 2008 reflects that Mrs. Brosen's temperature

continued at 100.4 but went down to 99.3 degrees. Physician's Assistant Miller saw Mrs. Brosen that day and noted "incisions healing, no erythema, no drainage, no calf tenderness."

Dr. Yee examined Mrs. Brosen again on June 19, 2008 at her request because her left hip had become swollen. She told him that she had been suffering from a fever which Dr. Greenspan was following and treating. Dr. Yee noted that a sepsis work-up had been undertaken, that Mrs. Brosen had been on Levaquin for six days and that blood cultures were negative and they were awaiting the results of urine tests. Dr. Yee further noted that Mrs. Brosen was able to stand with a contact guard and was ambulating with a walker. His examination revealed swelling the size of an orange on Mrs. Brosen's left hip which was mildly warm without any discharge. He also found her muscle strength to be 3/5 proximally and 4/5 distally and found her sensation to be intact. At her examination-before-trial, the plaintiff who pointed the swelling out to Dr. Yee testified that she first noticed the swelling that day. No one had noted any swelling in her hip prior to this nor had plaintiff made any complaints of surgical site wounds. Following his exam, Dr. Yee contacted the plaintiff's orthopedist Dr. Stuchin to discuss the case. Dr. Stuchin recommended that Mrs. Brosen be transferred back to NYU's Immediate Care Center and the plaintiff and her husband agreed. Dr. Yee arranged for the nursing supervisor to make the transfer. He also informed Dr. Greenspan of his findings and Dr. Stuchin's desire to have Mrs. Brosen transferred.

At the time of her discharge, Mrs. Brosen's surgical sites were noted to be clean, dry and intact.

Dr. Stuchin's records reflect that Mrs. Brosen advised him that she noticed the swelling and redness of her left hip on June 19, 2008. Dr. Stuchin operated and found septic-looking granulation tissue at the subcutaneous level beneath the fascia at the lining around the capsule of the implant. The infection was deep-seated in the joint space. Open debridement with incision and drainage and intravenous antibiotic treatment were done.

"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 and citations omitted)." (*Russo v Shah*, 278 AD2d 474-475 [2d Dept 2000]). Generally, "a claim sounds in medical malpractice when the challenged conduct constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician (quotations and citations omitted)." (*Weiner v Lenox Hill Hosp.*, 88 NY2d 784, 788 [1966]). "Thus, when the complaint challenges the medical facility's performance of functions that are an integral part of the process of rendering medical treatment and diagnosis to a patient, such as taking a medical history and determining the

need for restraints, it sounds in medical malpractice (quotations and citations omitted).” (*D’Elia v Menorah Home & Hosp. for the Aged and Infirm*, 51 AD3d 848, 851 [2d Dept 2008]). “By contrast, when the gravamen of the action concerns the alleged failure to exercise ordinary and reasonable care to insure that no unnecessary harm befell the patient, the claim sounds in ordinary negligence (quotations and citations omitted).” (*D’Elia v Menorah Home & Hosp. for the Aged and Infirm, supra*, at p. 851).

The plaintiff faults the defendants for failing to prevent, diagnose and treat her infection. Her claim sounds in medical malpractice. (See, *Harris v Gupta*, 57 AD3d 1421 [4th Dept 2008]; *Perre v Vassar Bros. Hosp.*, 52 AD3d 670 [2d Dept 2008]; *Lipschitz v Stein*, 26 Misc 3d 1214(A) [Sup Co Kings Co 2009]; *Slobin v Boasiako*, 19 Misc 3d 1110(A) [Sup Co Nassau Co 2008]).

“The essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury (quotations and citations omitted).” (*Faicco v Golub*, 91 AD3d 817, 818 [2d Dept 2012]). “Thus, [o]n a motion for summary judgment dismissing the complaint in a medical malpractice action, the defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby (quotations and citations omitted).” (*Faicco v Golub, supra*, at p. 817). “In order to sustain this burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff’s bill of particulars (citations omitted).” (*Wall v Flushing Hosp. Med. Ctr.*, 78 AD3d 1043, 1045 [2d Dept 2010]).

“Once a defendant physician has made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the *prima facie* showing by the defendant . . . so as to demonstrate the existence of a triable issue of fact (quotations and citations omitted).” (*Savage v Quinn*, 91 AD3d 748, 749 [2d Dept 2012], see also, *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]; *Stukas v Streiter*, 83 AD3d 18, 24 [2d Dept 2011]). “The formulation of the applicable standard makes it evident that the nonmoving party is required only to ‘rebut’ the moving party’s *prima facie* showing.” (*Stukas v Streiter, supra*, at p. 24). Thus, “where a defendant physician . . . demonstrates only that he or she did not depart from the relevant standard of care, there is no requirement that the plaintiff address the element of proximate cause in addition to the element of departure.” (*Stukas v Streiter, supra*, at p. 25). “Of course, where a defendant physician makes a *prima facie* showing that there was no departure from good and accepted medical practice, as well as an independent showing that any departure that may have occurred was not a proximate cause of the plaintiff’s injuries, the burden shifts to the plaintiff to rebut the defendant’s showing by raising a triable issue of fact as to both the departure element and the causation element (citations omitted).” (*Stukas v Streiter, supra*, at p. 25).

“In determining a motion for summary judgment, the court must view the evidence in the light most favorable to the nonmoving party (citations omitted).” (*Caggiano v Cooling*, 92 AD3d 634 [2d Dept 2012]). However, “[g]eneral allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant’s motion for summary judgment (citations omitted).” (*Savage v Quinn, supra*).

Moreover, “[i]n a medical malpractice action, where causation is often a difficult issue, a plaintiff need do no more than offer 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 (quotations and citations omitted).” (*Goldberg v Horowitz*, 73 AD3d 691, 694 [2d Dept 2010]). “A plaintiff’s evidence of proximate cause may be found legally sufficient even if his or her expert is unable to quantify the extent to which the defendant’s act or omission decreased the plaintiff’s chance of a better outcome or increased the injury, as long as evidence is presented from which the jury may infer that the defendant’s conduct diminished the plaintiff’s chance of a better outcome or increased [the] injury (quotations and citations omitted).” (*Goldberg v Horowitz, supra*, at p. 94). Finally, conflicting expert opinions supported by facts in the record suffice to raise an issue of fact regarding medical malpractice. (*Hayden v Gordon*, 91 AD3d 819 [2d Dept 2012]).

In support of his motion the defendant Dr. Yee has submitted the affirmation of Craig H. Rosenberg, M.D., who is Board Certified in Physical Rehabilitation Medicine. Having reviewed the pertinent medical records and legal documentation, he opines to a reasonable degree of medical certainty that Dr. Yee’s care of Mrs. Brosen was at all times within good and accepted practice and that his treatment of Mrs. Brosen was not a cause and did not contribute to her injuries. He opines that in his role as a physical medicine and rehabilitation specialist, he appropriately worked-up and cared for her. As for Dr. Yee’s May 28, 2008 examination of Mrs. Brosen, he opines that his clinical examination and recommendations regarding pain management were appropriate and within the standard of care, as there was no indication regarding the need for further testing and/or assessments based upon the results of the clinical examination. He notes that his evaluation/examination and recommendations were especially appropriate since Mrs. Brosen was being treated by the nursing staff and internist Dr. Greenspan daily who agreed that there were no abnormalities regarding the wound sites. Dr. Rosenberg similarly opines that Dr. Yee’s evaluation/examination was appropriate as was his reaction, *i.e.*, contacting Mrs. Brosen’s orthopedic surgeon Dr. Stuchin to consult and in view of Dr. Stuchin’s recommendation of a transfer, there was nothing further for Dr. Yee to do other than arrange the transfer.

Dr. Yee has established his entitlement to summary judgment by establishing both that he did not commit medical malpractice and that in any event, his care of Mrs. Brosen was not

a cause of any of her injuries. The burden is therefore transferred to the plaintiff to establish the existence of material issues of fact as to both of those issues.

The defendant Dr. Greenspan has also submitted an affirmation of Craig Rosenberg, M.D., who is Board Certified by the American Board of Physical and Rehabilitation Medicine in support of his motion. Having once again reviewed the plaintiff's medical records and the pertinent legal documents, he opines with a reasonable degree of medical certainty that Dr. Greenspan did not depart from good and accepted practice of medicine in his management of Mrs. Brosen's care during her stay at Woodmere Rehabilitation and that his care of her was within the proper standards of the practice of medicine and did not cause or contribute to her injuries. He states that it is not unusual for patients to develop urinary tract infections post hip replacement surgery and that Dr. Vitale noted that her hips were clean, dry and intact with no drainage when she was discharged to Woodmere Rehabilitation. He notes repeated documented references in Mrs. Brosen's charts which reflect that her wounds were dry and intact with no drainage and no signs of infection. He opines that "Mrs. Brosen was seen frequently by doctors, physicians' assistants and nurse practitioners as well as by the nursing staff responsible for the day-to-day care of the resident" and that "[a]ll of the appropriate tests were ordered" He notes that on "June 10th Mrs. Brosen was examined by the nursing facility's Physician's Assistant Jacobs who found redness and warmth to the touch at the left hip and ordered an x-ray of the left hip which demonstrated a left hemiarthroplasty in place without loosening or dislocation, no fracture and no report of osteomyelitis or an abnormality of the joint space to raise an index of suspicion for infection." He further notes that "a mere positioning on June 10th while laying in bed could have caused a temporary finding of redness and warmth on an area that the patient had been putting pressure on." He notes that Physician's Assistant Jacobs examination on June 13th was negative for bilateral hip redness, warmth, tenderness and swelling and that "[t]he complete disappearance of any redness or warmth as of June 13th indicates that the findings on June 10th were not with reasonable medical certainty, indicia of a wound infection."

As for the fever, Dr. Rosenberg opines that the test results confirm that Dr. Greenspan treated Mrs. Brosen entirely appropriately based on her presenting symptomatology. He notes that there was no drainage from the wound documented at any time prior to June 19th and no need for a culture as there were no symptoms of infection prior to that date. More specifically, he opines that "[t]ransient redness and warmth that was not seen again after June 10th even on examination by the same health care practitioner three days later are not (in the absence of sustained findings) signs or symptoms of wound infection" and that "[t]he fever and elevated white blood count that the plaintiff demonstrated responded after she was appropriately placed on an antibiotic, and therefore, were, with reasonable medical certainty secondary to a urinary tract infection and not to a deep wound infection." He further explains with reasonable medical probability that in any event, "a deep wound infection would not

have responded to an antibiotic because the infected joint does not have blood supply to carry the antibiotic to the joint space and if it were the infected joint that was causing the fever and elevated white count, with reasonable medical certainty, the fever would not have abated and the white blood count would not have decreased to normal following the administration of an oral antibiotic." He further notes that Dr. Stuchin's findings provide ample evidence that the infection was deep seated and incapable of being detected and diagnosed prior to the appearance of swelling and drainage on June 19, 2008. He additionally opines with a reasonable degree of medical certainty that an earlier diagnosis would not have altered the treatment and outcome.

Defendant Dr. Greenspan has established his entitlement to summary judgment by establishing both he did not commit medical malpractice as well as that his care of Mrs. Brosen was not a cause of any of her injuries, thereby transferring the burden to the plaintiff to establish the existence of material issues of fact as to both of those issues.

In support of its motion for summary judgment, the defendant Woodmere Rehabilitation has submitted the affidavit of Barbara Darlington, a Registered Nurse, Certified Adult Nurse-Practitioner and a licensed Nursing Home Administrator. Having reviewed the plaintiff's pertinent medical records and the legal documents, she opines to a reasonable degree of medical certainty that it is commonly known that any surgery always entails the risk of infection. Unfortunately, despite any clinician's best attempts to control for this risk including using scrupulous sterile technique during surgery and careful attention to the surgical site post surgery, infection can still develop. She explains that "the staff of Woodmere complied with all regulations and standards of care with regard to their care and treatment of Carol Brosen, and did not violate any state or federal regulation in connection with her care." She opines that "[t]here is no evidence that any infection control procedure was violated regarding this patient" and that "the infection originated internally at the surgical site and eventually made itself known by swelling at the surgical site on 6/19/08." She explains that "the surgical site was already closed and healed at the time of the resident's admission, if the infection had originated from outside of the surgical site, redness and swelling of the site would have been immediately observed with the temperature elevation." Finally, she opines that "[u]nfortunately, Mrs. Brosen developed a surgical infection in the left hip, which can be an unfortunate complication, and is a commonly accepted risk of hip arthroplasty."

Nurse Darlington further opines that Woodmere Rehabilitation also properly notified doctors of the changes in Mrs. Brosen's status and followed their orders.

Woodmere Rehabilitation has also established its entitlement to summary judgment by establishing both that it did not commit medical malpractice and that in any event, its care

of Mrs. Brosen was not a cause of any of her injuries thereby transferring the burden to the plaintiff to establish the existence of material issues of fact as to both of those issues.

The plaintiff has submitted the affirmation of Ronald Gross, M.D., in opposition to the defendants Dr. Yee's, Dr. Greenspan's and Woodmere Rehabilitation's motions. Having reviewed the pertinent medical records and legal documents, he faults all of the doctors to a reasonable degree of medical certainty for failing to conform to the applicable medical standards in their care of Mrs. Brosen.

Dr. Yee challenges the admissibility of Dr. Gross' affirmation on the grounds that he has failed to set forth his qualifications, more specifically regarding rehabilitation. He has established that he is a doctor: What is challenged here does not specifically relate to rehabilitation but rather to medicine, namely, a failure to timely diagnose and properly treat an infection.

Dr. Gross notes that defendant Dr. Yee worked as a rehabilitation consultant to Mrs. Brosen's primary attending Dr. Greenspan. Dr. Gross notes that despite being responsible for Mrs. Brosen's surgical site, Dr. Greenspan had no concern for it at his initial evaluation and did not prescribe antibiotics. He criticizes Dr. Greenspan for not seeing Mrs. Brosen a second time until 14 days after her admission at which time he did not check the wound site because he did not "feel it was necessary," and for not seeing her when a fever began on June 10th or following up on Dr. Haltrecht's handling of her case that day. He notes that tests ordered on June 11th were not ordered stat and that Dr. Greenspan did not consider prescribing antibiotics when Mrs. Brosen's left site wound presented redness and warm to the touch on June 10th. He faults Dr. Greenspan for not ordering a stool sample on June 11th. Dr. Gross opines that the blood test results dated June 12th were most likely indicative of a bacterial infection due to the white blood count as well as high neutrophils and lymphocytes yet he notes that Dr. Greenspan did not go see Mrs. Brosen or have someone else do so but instead treated for a urinary tract infection by simply prescribing Levaquin, despite no sign of such an infection. He notes that despite Mrs. Brosen's continued fever on June 17th, Dr. Greenspan did not change her antibiotic but just ordered retests.

Dr. Gross opines that defendants Yee and Greenspan deviated and departed from good and accepted medical practices in their treatment of Mrs. Brosen while at defendant Woodmere Rehabilitation. He opines that based on the records and testimony, defendants Yee and Greenspan did not

"exercise the degree and care expected of a physician in their failure to 1) consider a post operative surgical infection, notwithstanding continuous complaints of pain by Mrs. Brosen;

2) by ignoring telltale symptoms of an infection, including but not limited to: redness, swelling, fever and warmth; 3) by failing to properly monitor and/or treat Mrs. Brosen during her almost 30 day stay, Dr. Greenspan by visiting with her on two occasions despite being in charge of her medical care; and, 4) by failing to prescribe antibiotics appropriate for Mrs. Brosen's symptoms."

He opines that these shortcomings were the proximate cause of plaintiff's injuries.

The plaintiff objects to the defendant Woodmere Rehabilitation's reliance on Nurse Darlington's affidavit on the grounds that it is conclusory and in any event, she is not qualified. In addition, Dr. Gross notes that Mrs. Brosen was prescribed pain medication upon admission to Woodmere Rehabilitation for pain in her hips which persisted throughout her stay there. He opines that Woodmere Rehabilitation's staff failed to monitor the surgical sites on May 30th and June 5th, 6th and 9th. He also notes that Mrs. Brosen had open skin on June 4th for which Silvadene was prescribed and that a sore was there on June 3rd. He notes that there were signs of an infection on June 10th, *i.e.*, a 102 degree fever and wound site warm to the touch with redness yet nothing was done. In sum, Dr. Gross notes that Mrs. Brosen's hip pain coupled with fever were signs of an infection which Dr. Greenspan never considered or pursued. He faults Woodmere Rehabilitation for failing to properly and consistently notify the primary care physician of findings and symptoms, losing lab requests and failing to proactively properly monitor the plaintiff. He opines that "within a reasonable degree of medical certainty that defendant Greenspan did not conform to accepted medical standards and care and as such was the proximate cause of plaintiff's injuries."

Dr. Gross' affirmation fails to articulate specifically what Dr. Yee did or failed to do that is alleged to have caused Mrs. Brosen's injuries nor has he established a causal connection. His affirmation *vis-a-vis* Dr. Yee is rejected as conclusory.

Similarly, Dr. Gross has failed to identify anything Dr. Greenspan did or failed to do that is supported by the record that was contrary to the applicable medical standards. The failure to speak with prior treating physicians has not been demonstrated to constitute negligence, let alone a cause of the plaintiff's infection and needed treatment. Similarly, the lapse in time between Dr. Greenspan seeing the plaintiff has not been demonstrated to have resulted in any negligence and Dr. Rosenberg has opined that, "[r]esidents in rehabilitation facilities are seen by the attending physician a minimum of once per month or on an as needed basis" which plaintiff has not refuted. The plaintiff's expert fails to address Physician Assistant's findings of June 13th and the complete disappearance of alleged symptoms which could have been caused by things other than an infection. And, the

plaintiff's expert's inference that the plaintiff's condition persisted through June 17th is not based on the record. Again, her record indicated "Follow up fever. T max 100.8, Patient on Levaquin since 6/12. She states nothing is bothering her – no cough, chest pain, shortness of breath, nausea, vomiting, leg pain, burning on urination. All labs have been negative including white blood count, negative chest x-ray, negative left hip x-ray. Vital signs stable, currently afebrile." It can hardly be said with medical certainty that her improved state was not a reaction to Levaquin. And the urinalysis of June 19th revealed white blood cells in her urine which is indicative of a urinary tract infection.

Nor has plaintiff's expert refuted Dr. Rosenberg's conclusion that a sooner diagnosis, which is the alleged result of negligence, would have affected the results. It appears uncontested that a deep seated infection like this would be treated the same exact way regardless of when it was diagnosed.

Likewise, Dr. Gross has not identified anything that Woodmere Rehabilitation's nursing or medical staff did which was negligent that is supported by the record. While he faults staff for not keeping doctors informed of symptoms of an infection, that claim is not supported by the record. Similarly, he faults Woodmere Rehabilitation's staff the lost lab order, that is also not supported by the records in that it was lost by an outside lab. Furthermore, it was rectified quickly and in any event, no correlation between that event and the ensuing infection and diagnosis has been established. Similarly lacking in support is the plaintiff's accusation that Woodmere Rehabilitation's staff failed to properly monitor the plaintiff's status. In fact, such claim is belied by the record.

Finally, the documents sought by way of plaintiff's April 14, 2011 Demand consist of Woodmere Rehabilitation's 24 Hour Report, TPR forms, CNA Accountability Sheets and Lab Request Book which Emily Punsalan made reference to in her testimony at her examination-before-trial. Those documents have now been produced.

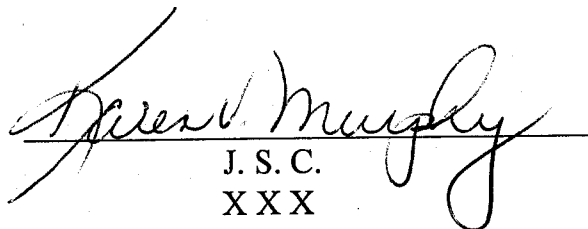
The defendant Dr. Greenspan's motion for sanctions based upon the plaintiff's failure to specify which defendant's Answer she sought to have stricken and which defendant's evidence she sought to preclude is denied. That minor error was of no consequence. It is obvious that it was Woodmere Rehabilitation's Answer the plaintiff sought to strike for failing to provide discovery.

In conclusion, the plaintiff's motion pursuant to CPLR § 3126 and the defendant Dr. Greenspan's motion for sanctions pursuant to 22 NYCRR 130-1.1 are denied.

The defendants' motions for summary judgment are granted and the complaint against them is dismissed.

The foregoing constitutes the Order of this Court.

Dated: August 1, 2012
Mineola, N.Y.


J. S. C.
XXX

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AUG 03 2012
NASSAU COUNTY
COUNTY CLERK'S OFFICE