Novick v South Nassau Communities Hosp.
2013 NY Slip Op 34045(U)
February 4, 2013
Supreme Court, Queens County
Docket Number: 3507/2008
Judge: Peter J. O'Donoghue

NEW YORK SUPREME COURT - QUEENS COUNTY

Present: HONORABLE PETER J. O'DONOGHUE IA Part MDP

Justice

05

Esther Novick, Laurie Novick Sylla and Mindy Novick, as Executrices of the Estate of Abraham Abe Novick a/k/a Abraham Novick,

Plaintiff

-against-

South Nassau Communities Hospital, et. al.

Index Number 3507 2008

Motion Date September 5, 2012

Motion Seq. Nos. 5-7

The following papers numbered 1 to 33 read on this motion by defendant Long Beach Memorial Hospital Nursing Home, Inc. d/b/a Komanoff Center for Geriatric and Rehabilitative Medicine, s/h/a Long Beach Memorial Nursing Home, Inc. d/b/a The Komanoff Center for Geriatric and Rehabilitative Medicine (Komanoff Center) pursuant to CPLR 3212 granting summary judgment dismissing the plaintiffs' complaint, or alternatively pursuant to CPLR 3212 granting partial summary judgment dismissing plaintiffs' claims for punitive damages; on the motion by defendant Andrew Goldstein, M.D. pursuant to CPLR 3212 for summary judgment dismissing the plaintiffs' complaint in its entirety; on the motion by defendant South Nassau Communities Hospital (SNCH) pursuant to CPLR 3212 for summary judgement dismissing the plaintiffs' complaint, or in the alternative pursuant to CPLR 3212 for summary judgment dismissing the plaintiffs' cause of action pursuant to Article 28 of the New York Public Health Law; and on the cross motion by defendant Long Beach Medical Center pursuant to CPLR 3212 for summary judgment dismissing the complaint.

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Answering Affidavits - Exhibits.....	18-21
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Upon the foregoing papers it is ordered that the motions and cross motion are determined as follows:

This is an action for medical malpractice and wrongful death. Plaintiffs also maintain a cause of action for statutory violations pursuant to Public Health Law Article 28. It is alleged that the

defendants Dr. Goldstein, SNCH, Komanoff Center, and LBMC deviated from the requisite standard of care in failing to prevent, timely diagnose and property treat the decedent Abraham Novick's decubitus skin ulcer, thereby causing his death.

On August 31, 2006, the decedent suffered various injuries in a motor vehicle accident. He was transported to non-party Nassau University Medical Center (NUMC). An initial CT scan of the neck did not reveal a fracture. He was released with a cervical collar. On September 7, 2006, the decedent, was seen again in the emergency room of NUMC. On September 9, 2006, the decedent arrived at the emergency room of defendant SNCH, where he was diagnosed and admitted with a fracture of the cervical vertebrae at C6-7 and surgery was scheduled. The planned surgery had to be postponed due to fever. Mr. Novick underwent neurosurgery on September 18, 2006. Following the surgery he developed difficulty swallowing, which led to the placement of a nasogastric feeding tube, which was eventually replaced by a PEG tube. Additionally his ability to ambulate was hampered by the spinal injury. On September 23, 2006, the decedent was noted to have a Stage I sacral decubitus ulcer. The sacral ulcer progressed to a Stage II on October 5, 2006 and the decedent was treated by a wound care specialty team, which regularly assessed the decedent. The records indicated that the sacral ulcer progressed to a Stage III on October 13, 2006, and Stage IV on October 18, 2006, though it was noted to be a Stage II on November 2, 2006.

On November 3, 2006, the decedent was transferred to defendant Komanoff Center, where he resided until January 29, 2007. Mr. Novick was noted to be alert, but confused, wearing a cervical collar, with a central line in his right chest wall and a PEG tube. He presented with a Stage III sacral ulcer with a necrotic wound base and Stage I ulcers in areas below the right knee and the right elbow. Upon admission care plans were developed including for his skin integrity and sacral pressure ulcers. The care plan for the ulcer included the use of a special "Alpha Active" mattress, turning and positioning every two to three hours, encouraging the resident as to the importance of changing position, nutritional intervention, assessing skin integrity every shift, use of a wheelchair seat cushion and bi-lateral heel lifts. Wound documentation records indicated that Mr. Novick's skin ulcers were examined on a weekly basis. Treatment of the ulcers called for the application of normal saline and wet to dry dressings to mechanically debride the lesion to remove the necrotic tissue. On November 14, 2006, the treatment orders for the sacral ulcer were changed to irrigation with normal saline, pat dry, and application of Collagenase ointment, followed by coverage with a wet to damp dressing daily. On January 11, 2007, the treatment orders were changed to cleansing with normal saline, pat dry and packing with wet to dry saline gauze and covering it with a dry dressing every

shift for 14 days. The treatment order was changed again on January 23, 2007, to irrigation with normal saline, pat dry, then applying a wet to dry dressing and coverage with a dry dressing. While at Komanoff Center, Mr. Novick was treated three times by the defendant LBMC, on December 7, 2006 for the placement of a suprapubic tube, on January 6, 2007 for a dislodged suprapubic tube and on Janaury 16, 2007 for a blocked suprapubic tube.

On January 29, 2007, the decedent was transferred to defendant LBMC, where he remained until February 9, 2007, when he was discharged to non-party Grandell Nursing Home. On his admission to defendant LBMC, Mr. Novick had a two-day history of loose, foul-smelling stools, lethargy, and fever. He was treated with antibiotics. Additionally, blood cultures were negative which ruled out sepsis. With respect to the sacral ulcer it was present upon admission to LBMC. The record indicates that Mr. Novick received care and treatment for the ulcer including, debridement of necrotic tissue, sterile saline washing of the wound on a daily basis, frequent monitoring and dressing application, repositioning every two hours, and the use of a double bubble mattress. The records and lab results indicate that when Mr. Novick was discharged to the Grandell Nursing Home he did not have sepsis and was in a stable medical state.

The records from Grandell Nursing indicate that throughout the night of February 11, 2007, mucous secretions were suctioned from the patient's airways several times. On the morning of February 12, 2007, at 9:15 a.m. the patient appeared stable. At 9:50 a.m. the same morning, however, Mr. Novick was found to be unresponsive and despite resuscitation efforts he could not be revived and subsequently died.

Each of the defendants have now moved for summary judgment dismissing the complaint. On a summary judgment motion, the movant has to offer sufficient evidence to establish entitlement to judgment as a matter of law *(see Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851 [1985]). 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 injury or damages (*see Rebozo v Wilen*, 41 AD3d 457 [2007]; *Thompson v Ornder*, 36 AD3d 791 [2007]). Therefore, on a motion for summary judgment in a medical malpractice action, a defendant 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 (*see Rebozo*, 41 AD3d at 458; *Williams v Sahay*, 12 AD3d 366, 368 [2004]).

The defendant Komanoff Center submitted the expert affirmation of Barbara Tommasulo, M.D., C.M.D., L.N.H.A., C.W.S.P. who is board certified in internal medicine with a sub-certification in

geriatric medicine. Dr. Tommasulo opined to a reasonable degree of medical certainty that the defendant Komanoff Center did not depart from accepted standards of care during its treatment of the decedent. Dr. Tommasulo stated that the care plan and treatment received by Mr. Novick for his sacral ulcer conformed to accepted standards of care and the fact that the sacral ulcer increased in size does not constitute medical malpractice or a violation of Public Health Law. Dr. Tommasulo opined that defendant Komanoff Center complied with all regulations regarding pressure sores. Further, Dr. Tommasulo stated that the decedent's ulcer did not heal due to several factors including his frequent infections, his nutritional compromise and need for feeding via a PEG tube and that in response to these risk factors adequate and appropriate responses were instituted.

The defendant Dr. Goldstein submitted the expert affidavit of John W. O'Grady, M.D., F.A.C.P. who is board certified in internal medicine. Dr. O'Grady opined to a reasonable degree of medical certainty that the actions taken by Dr. Goldstein in his treatment of Mr. Novick were at all times medically reasonable and appropriate under the circumstances and that there were no departures from the accepted standard of care. He further stated that all medical treatments ordered by Dr. Goldstein and his physician's assistant were reasonable and proper. He stated that the decedent's decreased mobility in the presence of diabetes and poor nutrition led to the development of a sacral decubitus ulcer despite the best efforts of the hospital staff to prevent it. The decedent 's inability to swallow was neurogenic in origin secondary to the spinal fracture. Dr. O'Grady stated that the defendant SNCH evaluated Mr. Novick as high risk for ulcers and that he was checked on a regular basis for them and that Dr. Goldstein appropriately had the decedent evaluated by a wound care team.

The defendant SNCH submitted the expert affirmation of Anthony J. Lechich, M.D. who is board certified in internal medicine. In Dr. Lechich's opinion to a reasonable degree of medical certainty that at no time were there any departures from acceptable medical and nursing practice in the care and treatment of Mr. Novick during his admission to defendant SNCH. He further stated that given Mr. Novick's clinical condition when he came to the hospital he was at an increased risk to develop pressure ulcers and there was very little, if anything, that the hospital's staff could have done to prevent a decubitus ulcer to the sacral region from happening. Furthermore, Dr. Lechich stated that Mr. Novick received appropriate care including the use of a Hill-Rom Zone Air Mattress, frequent re-assessments, regular turning and positioning of the patient, various ointments and barrier creams, as well as dressing changes, were properly utilized, but that there was little if anything that would have allowed the sacral ulcer to heal or not progress once it developed.

The defendant LBMC submitted the expert affirmation of Howard Kolodny, M.D. who is board certified in the specialty of internal medicine and the sub-specialty of Endocrinology, Diabetes and Metabolism. Dr. Kolodny opined to a reasonable degree of medical certainty that the defendant LBMC did not depart from accepted standards of care during its treatment of the decedent. He further opined that no act or omission on LMBC 's part was in any way the proximate cause of the injuries or death of the decedent. Dr. Kolodny stated that based on the review of the medical records of the defendant LMBC, the decedent was cared for and treated properly including proper treatment of the preexisting sacral decubitus ulcer by debridement of necrotic tissue, sterile saline washing of the wound on a daily basis, frequent monitoring and dressing application and repositioning the patient every two hours. Furthermore, he stated that Mr. Novick's long-standing poorly controlled diabetes mellitus which resulted in wound healing difficulties, limited mobility due to his spinal fractures and poor nutrition from dysphgia led to the development of the sacral decubitus ulcer and made resolution of the sacral decubitus ulcer difficult. Further, he stated that any claims of statutory violations are meritless.

As a result of the affirmations from the medical experts who opined, to a reasonable degree of medical certainty, that the defendants acted within good and accepted standards of medical practice in their care and treatment of the decedent, the defendants met their burden of establishing, prima facie, their entitlement to summary judgment as a matter of law on the issue of medical malpractice (*Reyz v Khelemsky*, 10 AD3d 714 [2004]; *Fhima v Maimonides Med. Ctr.*, 259 AD2d 559 [2000]).

Plaintiffs, in opposition to the motion are required to submit evidentiary facts or materials to rebut the prima facie showing by the defendants so as to demonstrate the existence of a triable issue of fact (*Alvarez v Prospect Hosp.*, 68 NY2d 320 [1986]). When a defendant has come forward with expert medical evidence that it did not depart from good and accepted medical practice, plaintiffs are required to submit an expert medical opinion in order to demonstrate the merit of their action (*Simms v N. Shore Univ. Hosp.*, 192 AD2d 700 [1993]). In medical malpractice actions where the parties submit conflicting opinions of medical experts summary judgment will not be awarded (*Shields v Baktidy*, 11 AD3d 671 [2004]; *Barbuto v Winthrop University Hosp.*, 305 AD2d 623 [2003]). General allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat summary judgment (*see Sun v City of New York*, 99 AD3d 673 [2012]; *Bezerman v Bailine*, 95 AD3d 1153 [2012]).

In opposition, the plaintiffs submitted an affirmation of a

medical expert redacted pursuant to CPLR 3101(d) and offered to provide an unredacted copy to the Court for in camera review. The expert is board certified in internal medicine and anesthesiology. The plaintiffs also submitted an affidavit of Jeanette Sandor, R.N. Inasmuch as Ms. Sandor is not competent to proffer the requisite expert medical opinion testimony as to accepted standards of medical care her affidavit will not be considered in opposition to the medical malpractice cause of action, but only in opposition to branches seeking to dismiss the New York Public Health Law Article 28 cause of action (*see Elliot v Long Island Home, Ltd.*, 12 AD3d 481 [2004]; *Mills v Moriarty*, 302 AD2d 436 [2003]).

Contrary to the argument by the defendant Dr. Goldstein, though the plaintiffs did not disclose the experts pursuant to CPLR 3101[d] prior to the filing of the note of issue and certificate of readiness, the court can in its discretion consider the expert affirmation. Furthermore, the Second Department has recently stated that "[p]recluding the expert's affidavit solely on the ground that the offering party did not disclose the expert's identity pursuant to CPLR 3101[d][1][i] prior to the filing of the note of issue and certificate of readiness is not consistent with the purpose and procedural posture of a motion for summary judgment" (*Rivers v Birnbaum*, 102 AD3d 26, 42 [2012]). Thus, the court will consider the expert affirmation and affidavit submitted by plaintiffs in opposition to the summary judgment motion.

The affirmation of the plaintiffs' medical expert, however, fails to raise an issue of fact that would warrant denial of any of the summary judgment motions. The affirmation of the plaintiffs' expert which relies upon facts, including lack of frequent repositioning of the decedent, the lack of wound care, lack of use of a speciality mattress, and lack of a care plan, contradicted by the various medical records is speculative and conclusory and failed to raise an issue of fact as to whether any of the defendants' actions were a departure from the accepted standard of care in the medical community (*see DiGeronimo v Fuchs*, 101 AD3d 933 [2012]; *Lahara v Auteri*, 97 AD3d 799 [2012]; *Gillespie v New York Hosp. Queens*, 96 AD3d 901 [2012]; *Lau v Wan*, 93 AD3d 763 [2012]; *Shapiro v Gurwin Jewish Geriatric Nursing & Rehabilitation Ctr.*, 84 AD3d 1348 [2011]; *Kane v Ausubel*, 44 AD3d 717 [2007]).

Furthermore, the affirmation by the plaintiffs' expert is insufficient to raise a triable issue of fact as it fails to address the opinion of the defendants' experts that the sacral ulcer developed and did not heal due to the decedent's multiple medical problems and co-morbidities, including, diabetes mellitus, frequent infections requiring antibiotics, nutritional compromise his inability to eat by mouth, and his immobility due to the neck fracture. The affirmation, thus, did not establish that if any departure by the defendants occurred, such departure was a

proximate cause of the decedent' s death (*see Bererman*, 95 AD3d at 1154; *Graziano v Cooling*, 78 AD3d 803 [2010]; *Barila v Comprehensive Pain Care of Long Is.*, 44 AD3d 806 [2007]; *Keevan v Rifkin*, 41 AD3d 661 [2007]; *Chance v Felder*, 33 AD3d 645 [2006]; *Mendez v City of New York*, 295 AD2d 487 [2002]).

Additionally, the plaintiffs offer new theories of liabilities, including that the timing of the placement of the PEG tube, maintaining the decedent's nutritional status, pain management, and maintaining clinical records. These claims were not contained in the bill of particulars and were raised for the first time in opposition to these summary judgment motions and therefore should not be considered (*see Dolan v Halpern*, 73 AD3d 1117 [2010]; *Golubov v Wolfson*, 22 AD3d 635 [2005]; *Winters v St. Vincent's Med. Ctr. of Richmond*, 273 AD2d 465 [2000]). Even considering these theories, the plaintiffs failed to raise an issue of fact. The plaintiffs' expert failed to rebut the defendants' experts' opinions with competent medical opinion testimony that the ulcers would have not have occurred and/or improved and healed notwithstanding the decedent's multitude of co-morbidities. Thus, the expert's opinion that any of these new theories were the proximate cause of the injury were conclusory and not supported by the medical record (*see Swanson v Raju*, 95 AD3d 1105 [2012]).

Finally, each of the defendants are entitled to dismissal of the cause of action under Public Health Law Article 28. The plaintiffs do not have a private cause of action against Dr. Goldstein, an individual physician. The other defendants established their entitlement to dismissal of this cause of action through their experts' affirmations which established that there were no violations of the allegations set forth in the plaintiffs' bill of particulars that was the proximate cause of any injury (*see Gold v Park Ave. Extended Care Ctr. Corp.*, 90 AD3d 833 [2011]; *Shaprio*, 84 AD3d at 1348).

In opposition to the branches of the motions to dismiss the Public Health Law Article 28 cause of action, the plaintiffs failed to raise an issue of fact. The affidavit of the plaintiffs' expert registered nurse, offered only speculative, conclusory and unsubstantiated allegations of violations of the subject regulations and no evidence of injuries as resulting from these violations (*see Gold*, 90 AD3d at 834; *Shaprio*, 84 AD3d at 1348).

Accordingly, the motion by defendant Komanoff Center for summary judgment dismissing the complaint is granted and the complaint is dismissed against Komanoff Center. The motion by defendant Dr. Goldstein for summary judgment dismissing the complaint is granted and the complaint is dismissed against Dr.

Goldstein. The motion by defendant SNCH for summary judgment is granted and the complaint is dismissed against SNCH. The cross motion by defendant LBMC for summary judgment dismissing the complaint is granted and the complaint is dismissed against LBMC.

Dated: February 4, 2013

Hon. Peter J. O'Donoghue, J.S.C.

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