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SHORT FORM ORDER

INDEX No. 06-27244
CAL. No. 13-00485MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 43 - SUFFOLK COUNTY

PRESENT:

Hon. ARTHUR G. PITTS
Justice of the Supreme Court

MOTION DATE 8-12-13 (#007, #008, #010)
MOTION DATE 8-1-13 (#009)
MOTION DATE 11-21-13 (#011)
ADJ. DATE 12-19-13
Mot. Seq. #007 - MG # 010 - MG
008 - MG # 011 - XMG
009 - MG

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ROSE WALTERS, as Executor of the Estate of PAUL WALTERS, Deceased, and ROSE WALTERS, Individually,

Plaintiffs,

- against -

BRADLEY WHITE, VIKTOR B. SMIRNOV, ARTHUR LOWY, GARY MOSKOWITZ, PLAINVIEW MEDICAL GROUP, P.C., LESLY HONORE, DONOVAN F. NEMBHARD, FRANK L. ROSS, UNITED PRESBYTERIAN HOME AT SYOSSET, INC., d/b/a UNITED PRESBYTERIAN RESIDENCE and its Successor in Interest COLD SPRING HILLS CENTER FOR NURSING AND REHABILITATION,

Defendants.

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Upon the following papers numbered 1 to 122 read on these motions for summary judgment and to preclude; Notice of Motion/ Order to Show Cause and supporting papers (007) 1-25; (008) 26-51; (009) 52-76; (10) 77-99; Notice of Cross Motion and supporting papers (011) 100-102; Answering Affidavits and supporting papers 103-104; Replying Affidavits and supporting papers 105-106; 107; 108-109; 110-113; 114-115; 116-119; 120-122; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (007) by defendants, Cold Spring Hills Center for Nursing and Rehabilitation s/h/a United Presbyterian Home at Syosset, Inc. d/b/a United Presbyterian Residence and its Successor in Interest Cold Spring Hills Center for Nursing and Rehabilitation, pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims asserted against it is granted with prejudice, and it is further

ORDERED that motion (008) by defendant, Donovan F. Nembhard, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims against him is granted, and it is further

ORDERED that motion (009) by defendant, Lesly Honore, D.P.M., pursuant to CPLR 3212 for summary judgment dismissing the complaint is granted and the complaint and any cross claims asserted against Dr. Honore are dismissed, and it is further

ORDERED that motion (010) by defendant, Frank L. Ross, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint and any cross claims asserted against him is granted, and it is further

ORDERED that motion (011) by plaintiff, Rose Walters as Executor of the Estate of Paul Walters, to preclude the remaining defendants for whom summary judgment has not been granted from asserting the benefits of Article 16 against those co-defendants to whom summary judgment has been granted, is granted and the remaining co-defendants are precluded from asserting the benefits conferred by Article 16 against defendants United Presbyterian Residence, Donovan F. Nembhard, M.D., Lesly Honore, D.P.M., and Frank L. Ross, M.D. at the time of trial.

In this medical malpractice action, plaintiff, Rose Walters, as Executor of the Estate of Paul Walters, alleges that the defendants negligently departed from good and accepted standards of care and treatment of the plaintiff's decedent Paul Walters while treating him for a fracture of his right ankle and a non-healed wound of his right leg and other allegedly related conditions. It is alleged that the defendants failed to prevent and timely and properly treat plaintiff's decedent for decubitus ulcers, failed to mobilize him, call appropriate consults, and to heal and prevent a worsening of such ulcers. It is also alleged that the defendants failed to timely diagnose and treat the plaintiff's decedent for vascular insufficiency and its sequela, causing him to suffer severe personal injuries, pain and suffering, and to incur special damages. A derivative claim has been asserted on behalf of decedent's spouse, Rose Walters.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of motion (007), Cold Spring Hills Center for Nursing and Rehabilitation s/h/a United Presbyterian Home at Syosset, Inc. d/b/a United Presbyterian Residence and its Successor in Interest Cold Spring Hills Center for Nursing and Rehabilitation (hereinafter United Presbyterian Residence) has submitted, inter alia, an attorney's affirmation; the original and copy of the affidavit of Beth Anne Maas, RN, BSN, MHA; copies of the summons and complaint, its answer, the answers served by defendants White, Smirnov, Lowy, Moskowitz, Plainview Medical Group, Honore, Nembhard, and Ross; plaintiff's verified bills of particulars; certified copy of the records of Cold Spring Hills Center for Nursing and Rehabilitation; transcripts of the examinations before trial of Rose Walters dated February 12, 2009 which is unsigned but not objected to and is considered (***Zalot v Zieba***,

81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]), and non-party Debra Walters dated September 2, 2009, which is not signed and is not considered (*see* ***Martinez v 123-16 Liberty Ave. Realty Corp,*** 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus,*** 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.*** 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]); the signed transcripts of the Bradley White dated October 22, 2009, Viktor Smirnov dated November 17, 2009, Gary Moskowitz dated January 26, 2010, Frank Ross dated June 28, 2010, Arthur Lowry dated January 4, 2010, Donovan Nembhard dated May 7, 2010, and the unsigned but certified transcripts of Leslie Honore dated April 5, 2010 and Karleen Volcy dated October 27, 2010; and affidavit of Judy Koerner-Freedman dated October 3, 2012.

In support of motion (008), Donovan Nembhard submitted, inter alia, an attorney's affirmation; affirmation of Lawrence Diamond, M.D.; copies of the summons and complaint, his answer, and plaintiff's verified and amended verified bill of particulars; transcripts of the examinations before trial of Rose Walters, Debra Walters and continuing, Bradley White, M.D., Viktor Smirnov, M.D., Arthur Lowy, Gary Moskowitz, M.D., Leslie Honore, M.D., Donovan Nembhard, M.D., Frank Ross, M.D., and Karleen Volcy; and the United Presbyterian Residence uncertified record.

In support of motion (009), Lesly Honore submitted, inter alia, an attorney's affirmation; the affirmation of Paul Greenberg, M.D.; summons and complaint, answer, and plaintiff's verified bill of particulars; uncertified copies of medical records from New Island Hospital, United Presbyterian, Winthrop Hospital various excerpts from tests and other medical records and reports; and the transcripts of the examinations before trial of Drs. Honore, White, Smirnov, Lowy, Moskowitz, Nembhard, and Ross, and Rose Walters, and Debra Walters.

In support of motion (010), Frank Ross, M.D. has submitted, inter alia, an attorney's affirmation; affidavit of Steven G. Friedman, M.D. copies of the summons and complaint, his answer, and plaintiff's verified bill of particulars; medical records from New Island Hospital, Winthrop University Hospital, and Hempstead Park Nursing Home; and copies of the transcripts of the examinations before trial of defendants Honore, White, Smirnov, Lowy, Moskowitz, Nembhard, and Ross, and non-party Volcy.

In support of motion (011), the plaintiff, Rose Walters, has submitted an attorney's affirmation and a redacted physician's affirmation.

ROSE WALTERS

Rose Walters testified that her husband's primary physician for many years was Dr. Polofsky. She stated that her husband had taken pills for diabetes since age sixty. He had cardiac bypass surgery in 2000. He also had right hip surgery due to arthritis, and was able to ambulate without any assistance or devices. In 2004, he fell getting out of the bathtub and fractured his right ankle. He was taken to New Island Hospital emergency room, admitted and had surgery to his ankle. He remained hospitalized for about two weeks with the cast in place, and under the care of Dr. White. During his time at New Island Hospital, he did not develop any sores. He was discharged for rehabilitation at United Presbyterian Residence. After about three to four weeks at the residence, her husband began to complain of pain in his right ankle. Her daughter, Deborah, brought plaintiff's decedent to Dr. White's office, where the cast was removed. Dr. White advised that everything was alright. She noted black and red sores and swelling on her husband's leg. Dr. White bandaged his leg again. He continued to complain of pain in his right leg and was taken to Winthrop Hospital where it was found that her husband's leg was all black and the skin was falling off his leg. His right leg was amputated. She stated that he also developed a bed sore while he was at the residence. She described the sore as a tunnel which she could put her fist into. It was about the size of a lemon when she first saw it while changing his bed, and it continued to grow. There came a time that his left leg was also amputated.

He had abdominal surgery and a bag was attached. He had a catheter which kept causing infections. He eventually returned home where she and her daughter cared for him. At the last stage of his life, hospice came in to assist.

DEBRA WALTERS

Debra Walters testified that she started a nursing program at Farmingdale, but only completed prerequisites before she left. She was last employed in 2000 as a 411 information operator. She became her father's health care proxy in 2004 after her father fractured his ankle on March 27, 2004. He suffered from diabetes prior to 2004, and had hip replacement surgery. Sometimes he walked with a cane. She testified that the day before her father fell, he stated that his right leg did not feel good. When he fractured his ankle, he was taken by ambulance to New Island Hospital where he was seen by the orthopedic physician on call for the emergency room, Dr. White, who admitted him to the hospital for a week. During that admission, Dr. White performed surgery on her father's ankle on March 28, 2004. She spoke with Dr. White prior to the surgery and was advised that he was placing a plate and screws to treat the fracture. He was discharged for rehabilitation with a cast in place to United Presbyterian Residence. When her father began to complain of pain about three weeks after the cast was placed, she spoke with Dr. White and brought her father to his office. Dr. White put a hole in the cast so he could examine the surgical wound. She was advised that it was healing well. He closed the hole up and sent her father back to the facility.

During his stay at the residence, he developed pain in his left heel from a sore, so his leg was elevated on a pillow and his heel bandaged. During that admission, her father was getting out of bed sitting in a recliner in his room, but needed assistance to get up. She obtained a motorized wheelchair for him and took him outside and around. She complained to the nurse that her father was not being given his diabetes medication. After about six weeks at the facility, her father began experiencing pain in his right ankle and went for another office visit to Dr. White. At some point, the cast was removed in her presence, and she saw a layer of skin fall off her father's leg. Ms. Walters testified that during one of his admissions for rehabilitation, that her father stubbed his large toe, but did not know how he did it. He was instructed to start walking, but began to have a lot of pain in his right leg and was seen by Dr. White. Thereafter, her father experienced syncope and was blacking out, so he was sent to Winthrop Hospital.

After his stay at Winthrop Hospital, her father returned to United Presbyterian Residence. Her testimony was somewhat uncertain as to the sequence of events, but she stated that he began to develop severe pain in his right leg. When her father complained of pain and she spoke to the staff at the facility, and asked to see his wound on his right ankle, she was told to take the bandages off herself. She stated it was horrendous. Her father was taken back to Winthrop Hospital by ambulance, where she told Dr. White that she wanted a second opinion. Her father's right calf was black and open with green pus oozing out. She could see the tendons and bones. Her father was seen by Dr. Zarat, who took over the care. Dr. Zarat debrided her father's right leg. He told him the hardware was falling off and the fracture never healed, so he removed the hardware and applied an external fixator. Her father was thereafter transferred to Hempstead Park for rehabilitation for a short time and was discharged with home care. Her father was again admitted to Winthrop Hospital where his right leg was partially amputated below the knee. She thought her father had bedsores on his back during that admission. Thereafter, she experienced problems upon his readmission to United Presbyterian, her father was not receiving his medications, no one was taking care of his bedsores, and he was not being seen by any doctors. She complained to Dr. Nembhard who saw her father with some other doctors. She learned that no doctor had actually seen her father after his admission until that meeting with Dr. Nembhard. It was decided that he needed wound care. Her father was eventually discharged home and had some return visits to New Island Hospital. The previous sore on his left foot heeled, but he developed another wound. He had an elective amputation of his left lower leg. Her father remained home with home care and she helped to care for him. Her father died on September 1, 2007.

ARTHUR LOWY, M.D.

Arthur Lowy, M.D. testified that he is licensed to practice medicine in New York State. He is an employee of Plainview Medical Group, practicing gastroenterology and internal medicine, and is board certified in both those areas. He became a shareholder in the professional corporation at the end of 2004. In May 2004, he provided services at United Presbyterian Residence after undergoing the credentialing process. Dr. Nembhard was the medical director at the facility. He stated that the decedent was a resident in Pavilion II at the facility, and he was assigned the patient by the admitting office. A patient at the facility who had no prior affiliation with another physician who had privileges at the facility would not ordinarily be given a choice of physicians. He stated that he shared coverage with Dr. Moskowitz who had primary responsibility for the patients at the facility. Dr. Lowy testified that he never saw the decedent at the facility, but received a phone call upon the decedent's readmission to United Presbyterian Residence on May 3, 2004, upon the decedent's transfer from Winthrop Hospital. Dr. Lowy stated that he was requested to review and approve the admitting orders, as he was the on call physician. He stated that during the decedent's prior admission to the facility, he had been under the care of Dr. Choudry, who was not associated with Plainview Medical Group.

Dr. Lowy's responsibility during a patient's admission to the residence was to provide general internal medical care to patients assigned to him. Dr. Lowy continued that when a patient came in, the on call admitting nurse evaluates the patient, then takes orders from the admitting physician. He had been contacted to approve the admission orders upon the decedent's admission to the facility. He continued that patients arrive with a list of medications, medical history, and treatments, and he reviews those lists and decides which medications should be used. With regard to the decedent, he approved the diabetic medication, Glyburide, and ordered finger sticks before meals and at bedtime to check the decedent's sugar. He also ordered wound care instructions for the left heel blister, the stage three coccyx lesion, and the left great toe. He ordered physical and occupational therapy screening and evaluation, and an orthopedic consultation with Dr. White. Other subspecialties, such as dietary, would be triggered automatically. His partner, Dr. Moskowitz, co-signed his orders the following day on May 4, 2004. A physical exam was conducted on the decedent by Dr. Moskowitz on May 4, 2004. He continued that on May 19, 2004, he approved orders for special shoes and a knee brace as recommended by the therapist attending the decedent. Those orders were co-signed by Dr. Moskowitz.

Dr. Lowy testified that on May 20, 2004, he approved skin care recommendations made by the wound care team, however, he did not have the decedent's chart when he received the recommendations. Generally, the wound care team takes the lead in terms of making recommendations. If a wound is getting larger, then it might require further intervention. He continued that the decedent had certain medical conditions which could interfere with healing, such as vascular disease, coronary artery disease, myocardial infarction, hypertension, and diabetes. On May 26, 2004, he ordered Percocet because the decedent was having pain in his right leg, which the note indicated was sharp pain in the right ankle, rating 5 on a scale of zero to five. Had he been made aware that a vascular consult with Dr. Ross had been recommended on May 27, 2004, he would have inquired as to the status of those studies or the status of the consult. Dr. Lowy indicated that on June 2, 2004, he gave an order for an additional pain medication and also for a pain consult. That was his last involvement with the decedent.

GARY MOSKOWITZ, M.D.

Gary Moskowitz, M.D. testified that he is licensed to practice medicine in New York State and is board certified in internal medicine. He was employed with Plainview Medical Group since 1989, and was in partnership in that group with Robert Shoenfeld in 2004. Arthur Lowry, M.D., a gastroenterologist, was an employee of the group in 2004. As a physician, he attended patients in North Shore Plainview, North Shore Syosset which became

New Island Hospital, and also at United Presbyterian Residence, White Oaks, Woodbury, and Central Island Nursing Homes. At United Presbyterian, he was assigned patients by the facility on one floor of long term patients at Evan 1 and 2 as the only physician on that floor, and was also assigned random short term patients in a separate part of the facility. He usually went to the facility on Mondays, Wednesdays, and Fridays. On the days that he did not go to United Presbyterian, sometimes Dr. Lowy, and possibly Dr. Lotfi, a physician in the evening coverage group, would attend his patients. He was not paid by United Presbyterian.

Dr. Moskowitz testified that he first saw the decedent on May 4, 2004, after he had been re-admitted on May 3, 2004, to the short term floor upon transfer from a hospital. Upon examination of the decedent, he noted a sacral decubitus, and that his blood sugar and kidney function stabilized. He noted that the decedent had a history of diabetes, chronic renal failure, ASHD, atrial fibrillation, CHF, and was status post ORIF (open reduction internal fixation) of the right ankle. He also noted that the decedent had a left heel blister, his left toe was necrotic, and his right ankle was in a cast. Dr. Lowy had been called about the decedent the day of admission, ordered medications, and notified him of the decedent's admission. Dr. Moskowitz ordered laboratory work. On May 5, 2004, he ordered nutritional supplements, and on the following day, co-signed some orders changing the times of some of the medications. On May 7, 2004, the dressing to the decedent's left heel was changed, and on May 10, 2004, his diet was changed. Consultation with his cardiologist and orthopedist was ordered for follow-up. He stated that the facility was responsible for calling the consults. The decedent's left great toe, left fourth toe, and left heel were ordered to be cleaned and dressed daily, as requested by the wound team which evaluated all wounds in the facility and made recommendations. He did not remember if he checked the pulses in the decedent's lower extremities. He saw the decedent again on May 14, 2004, as he was being seen on an as needed basis. Antibiotics were started due to cellulitis of the decedent's left toe, and accuchecks to monitor sugar levels were ordered. He also co-signed the decedent's standing orders from the April 14, 2004 admission.

Dr. Moskowitz testified that Dr. Nembhard is the medical director at Presbyterian, who wrote a note which stated that new wounds are expected complications of the cast, and to plan with the private medical doctor, and consider plastic versus vascular consultation. Dr. Moskowitz did not have any discussion with Dr. Nembhard regarding the note. On May 17, 2004, Dr. Moskowitz noted that the decedent was to have a surgical re-evaluation by Dr. Ross, a general/vascular surgeon. He also added Glucotrol daily with sliding scale coverage for the diabetes. On May 17, 2004, he noted that the decedent has peripheral vascular disease (PVD) of the toe, and that the decedent had daily pain. He stated that Dr. Ross did not see the decedent until May 27, 2004, and at that visit, ordered non-invasive vascular studies/PVRs, and to consider vascular surgical consultation. He did not recall any conversation with Dr. Ross, and found his note on June 2, 2004. Dr. Moskowitz stated that he was under the impression that Dr. Ross was a vascular surgeon. Dr. Moskowitz transferred the decedent to Winthrop Hospital due to complaints of increasing pain in his leg, and to rule out osteomyelitis. Dr. Moskowitz stated that he did not see the decedent again after that.

FRANK ROSS, M.D.

Frank Ross, M.D. testified that he has certification for general surgery with a subspecialty in undersea and hyperbaric medicine. In or about 2004, he became an outside general surgery consultant to United Presbyterian Residence, and would consult at the facility, generally on a Thursday, every two weeks. Dr. Ross testified that he had a vague recollection of the decedent being a very sick man when he saw him on May 27, 2004. He indicated that the decedent was a 74 year old status post right ankle fracture, now with multiple ulcers, both lower extremities. He noted the decedent's past medical history, medications, and prior surgeries, and the descriptions of his various ulcers, and concluded that there was not an emergent pallor or ischemic color present at the time. He was unable to palpate the decedent's dorsalis pedis (DP), posterior tibial (PT), or Popliteal (Pop) pulses. His recommendation

was for non-invasive vascular studies/PVRs to evaluate the absence of pulses. He continued that when a patient has tissue loss or ulcers and nonpalpable pulses, it has to be considered that they will not heal due to lack of blood flow. He also recommended that a vascular surgical consultation be obtained to determine whether the decedent was a candidate for vascular or revascularization surgery due to the ulcers and peripheral vascular disease that required evaluation. He did not have available to him any prior measurement of the decedent's peripheral pulses, and even if he did, he still would have made the recommendations.

Dr. Ross stated that as a consultant at United Presbyterian Residence, he did not have the authority to make his own consultation request. He continued that as a general surgeon, he would perform surgery on ulcerations such as the decedent's, but not within the United Presbyterian setting. On rare occasions, he could admit a patient, but the majority of the patients were sent to Winthrop University Hospital. The vascular surgeon, who picked up the case, would follow up unless it was requested that the general surgeon return. If emergent surgery were needed, he would let the facility know. However, he did not feel that the decedent needed emergency surgery or emergency admission to a hospital as he was not exhibiting an emergent limb threat wherein his limb appeared to be in immediate jeopardy within 24 or 48 hours, or a very short time. He felt that the decedent appeared to have chronic peripheral vascular disease with ulceration as his foot had a normal color, no pallor or continuing rest pain. He did not check capillary refill. He had no further follow up with the decedent. Dr. Ross testified that prior to his consultation on May 27, 2004, he was not made aware that a consultation had been sought from his service. He would perform the consultation on the day he received it at United Presbyterian Residence.

BRADLEY WHITE, M.D.

Bradley White, M.D. testified that he is a physician licensed to practice in New York State and practices in the specialty of orthopedic surgery. The decedent came under his care and treatment at the emergency room at New Island Hospital on March 28, 2004, for a dislocated ankle that was reduced and splinted and for which he was admitted to the hospital. He did not have a copy of his consult note, and indicated that it would have been his custom to make sure the neurovascular status was normal. He continued that in determining the neurovascular status of the ankle, he would feel pulses, look at the overall perfusion of the skin, and make sure that things were moveable and grossly intact. If the wound is closed, as was the decedent's, it would be reduced immediately or as soon as possible, and splinted. X-rays would then be obtained. Here, the post-reduction x-rays of the decedent's right ankle revealed a fracture of the decedent's ankle at the lateral malleolus, which was fixated without complication. Follow up outpatient orthopedic care was required. A cast is not applied post-surgically until the stitches are removed. However, he stated, he applied a short leg plaster cast in the operating room. The wound, he stated, could be examined when the cast is removed.

Dr. White continued that the decedent remained hospitalized at New Island Hospital after the surgery. The first postoperative visit on April 14, 2004 entailed removal of the sutures, obtaining x-rays, and observation of the surgical wound. He did not know when the decedent's cast was removed. On April 16, 2004, he spoke with Dr. Chaudhry due to concerns about the decedent's ankle, so he gave instructions for the decedent to come to his office for immediate follow-up. Dr. White noted that the decedent was admitted to Winthrop University Hospital for pacemaker placement, and that he wrote a consultation note on April 30, 2004, noting that the short leg cast extending from the bottom of the kneecap to the toes was in place, and that the decedent had no pain in his right lower extremity. It was also noted that the decedent was developing a left heel pressure sore, for which he ordered that the heel be kept off the bed. On May 14, 2004, the cast was removed at his office. It was noted that the surgical wounds, one on the medial side and one on the lateral side, were well healed, but then testified that the lateral wound needs some attention, such as daily dressing changes. Dr. White then stated that generally a wound that is well

healed does not need daily dressing changes. He did not have an opinion concerning why, after seven weeks, the wound was not well healed. The decedent was placed in an ankle brace.

The decedent followed up with Dr. White in his office on May 24, 2004, at which time it was noted that there was slight wound breakdown laterally in which there was flap breakdown or necrosis. He did not know if he checked the peripheral pulses. The wound was cleaned and dressed, and the decedent was instructed to return in two weeks. Dr. White stated that he filled out the UPA Care Corp. resident transfer consult form for the decedent's return to the nursing home. He suggested a surgical consult for the left heel pressure sore, and that he return in two weeks. One June 2, 2004, the decedent was admitted to Winthrop Hospital from United Presbyterian, where he was seen by Dr. White on orthopedic consult. In his consulting note, Dr. White indicated that the decedent was readmitted because of pressure sores on the right lower extremity and contra lateral ankle, with some wound breakdown at the lateral wound, and also a left lower extremity heel ulcer. He indicated that the decedent was in need of wound care, and intravenous antibiotics as per infectious disease, medical consult and follow up, and blood work including blood culture and sensitivity. He further testified that the June 2, 2004 admission note indicated that the plan was that the decedent was to be admitted "to ortho, Dr. White, discussed on telephone." Dr. Robert Carter, Dr. White's partner, saw the decedent on June 3, 2004 and referred him to the vascular laboratory for a lower arterial plethysmography. On June 7, 2004, Dr. White had a telephone consult with Dr. Zaret, an orthopedist who works at Winthrop, and with whom the decedent's daughter advised she was obtaining a second opinion from, as indicated in Dr. White's June 4, 2004 office note.

In his June 4, 2004 note, Dr. White indicated that the right ankle wounds were looking better. Wound Care Services was asked to evaluate the decedent. Dr. White stated that the June 5, 2004 note of the ortho attending, off-service, indicated that the decedent was readmitted for wound breakdown laterally, with pressure sores and cellulitis, and a left heel pressure sore. He indicated that the family wished to transfer the decedent's care to Dr. Zaret. On June 7, 2004, Dr. White noted that there were areas of breakdown and subcutaneous tissue about the surgical wound, with no purulence, and distal antra (sic) lateral pressure sore, which may need surgical debridement, including hardware removal. Dr. Zaret, the orthopedic foot specialist saw the decedent, as indicated by the hospital note of June 7, 2004, spoke with Dr. White, and indicated the surgical plan to debride the wound, remove the hardware, and place an external fixator. Dr. White stated that there was confusion in the hospital record concerning whose patient the decedent was, and that he does not order consultations or investigation on a patient that is not his, but may order imaging studies. However, he continued that the emergency room record indicated that the decedent was admitted to his group.

VIKTOR SMIRNOV, M.D.

Victor Smirnov, M.D. testified that he is licensed to practice medicine in New York State. He did not make available the curriculum vitae which he had at the time he gave his testimony as he felt there were parts of it which were privileged. He stated that he has a clinical practice in general and vascular surgery, in which he is board certified. He saw the decedent at Winthrop Hospital as a private patient on June 3, 2004, on vascular surgery consultation called by the physician's assistant on June 2, 2004, after the decedent had been admitted to the orthopedic service. He recommended pulse volume recording (PVR) and intravenous antibiotics, as he believed that the decedent was admitted to rule out osteomyelitis and venous insufficiency. He was to evaluate the ulcer on the decedent's right lower leg and foot. He stated that the basis for a non-healing ulcer is the absence of adequate blood flow. The decedent also had cellulitis, or an infection of the skin and subcutaneous tissue. Vascular insufficiency can create conditions in the lower leg that promote the development of infection, and necrotic or dead tissue can provide a medium for the development of infection. Dr. Smirnov stated that on June 2, 2004, the doppler exam of the left lower extremity revealed that the examiner did not find a signal suggestive of blood flow in the

dorsalis pedis artery, but found a signal in the posterior tibial artery. In the right lower extremity, the examiner did not detect flow in the dorsalis pedis but found it in the posterior tibial artery. Dr. Smirnov testified that these findings were not significant, as it is a result of individual opinion, and the presence of a signal in one of the arteries of the foot suggested no evidence of acute ischemic.

Dr. Smirnov testified that he felt the presence of diabetes in the decedent was significant with regard to the dorsalis pedis pulse, as diabetes accelerates arteriosclerosis and changes in micro circulation. He also considered the decedent's history of hypertension and peripheral vascular disease as significant. Dr. Smirnov recommended that the decedent have a right leg venous duplex to rule out a deep vein thrombosis (DVT). The exam was negative. Because the decedent had an ulcer, he considered that there may be diminished pulses. According to the tests, the decedent had insufficiency of the arterial circulation in his distal right leg below the knee and more prominent insufficiency in the left leg. He continued that the testing was suggestive of occlusive vascular disease as the PVRs were abnormal in both legs. After he obtained the results of the PVR, he spoke with the orthopedist with regard to future management and whether the patient needed improvement (bypass) of arterial flow to his right foot. Dr. Smirnov testified that he believed the patient's arterial circulation could be helped with a bypass procedure by normalizing blood flow to the right foot. He did not recommend it to the orthopedist, but, instead, between June 4 and June 7, 2004, recommended that a bilateral angiogram be performed due to the presence of a non-healing ulcer and osteomyelitis on the right foot, and an ulcer on the left heel. An angiogram would permit him to obtain an exact picture of the decedent's occlusive disease, and to see if it were technically possible to perform bypass, as it would show areas of stenosis or occlusive extent at certain degrees, and the status of vessel walls.

Dr. Smirnov testified that the decedent did not have acute ischemic, thus there was no significance if the angiogram was done immediately or two or three days later. He did not feel at the time of his examination that the decedent was at risk for losing his right limb. He continued that in a patient with vascular insufficiency and infection which is not eradicated, it could potentially lead to the loss of the limb. Dr. Smirnov testified that he ordered the angiograms for the purpose of operative planning for revascularization. He continued that emergency angiograms were not warranted for infection, cellulitis, and the non-healing ulcer. On June 5, 2004, he saw the decedent for the purpose of placing a right subclavian central venous line, triple lumen catheter, likely requested by infectious disease. He next saw the decedent on June 10, 2004, in preparation for a right arterial bypass procedure as the angiogram suggested findings of multiple areas of stenosis in the right leg arteries, likely occlusions of the anterior, tibial, and peroneal arteries. He stated that the decedent had an artery available for bypass to improve the blood supply to the right foot so that he could bypass the posterior tibial artery. He stated that the best time for performing the bypass would be after the hardware was removed from the decedent's foot as the foreign body could support infection. In reviewing Dr. Zarat's note of June 8, 2004 concerning his removal of the hardware from the decedent's right ankle and debridment of the wound, Dr. Smirnov stated that the degree of necrotic tissue that was removed was unrelated to the likelihood of success of a bypass procedure. Bypass was accomplished successfully on June 12, 2004 by Dr. Smirnov, and after the procedure, the decedent had a palpable pulse in the posterior tibial artery distal to the stenosis, indicating the bypass was patent and delivering blood flow to the posterior tibial artery. The following day, the decedent's right foot was noted to be warmer than his left foot, indicating good perfusion. He provided care relative to the bypass through June 17, 2004, when he inserted a Hackman catheter. The decedent was discharged back to the nursing home by the thoracic vascular team on June 21, 2004. He next saw the decedent on July 2, 2004, as the decedent was readmitted to Winthrop Hospital on June 30, 2004. He felt the bypass was patent. Dr. Smirnov stated that he felt the decedent had evidence of sepsis when he saw him. He performed a right below the knee amputation after discussion with the patient and due to the presence of the infected wound. It wasn't that the leg could not be salvaged, but it was the patient's decision to have the amputation after being offered the choice of debridement with plastic reconstruction, or amputation of the lower leg by the plastic surgeon and orthopedist. Dr. Smirnov testified that he would have performed a bypass on the decedent's left leg if there was

evidence of a chronic progressive peripheral vascular disease, such as a non-healing ulcer. Thereafter, he saw the decedent on several occasions in the emergency room at Winthrop Hospital.

DONOVAN NEMBHARD, M.D.

Donovan Nembhard, M.D. testified that he is currently licensed to practice medicine in New York State and Florida. He is not board certified in any area of medicine. He was hired in 1991 to work at United Presbyterian Residence, a skilled nursing facility for long-term, but not acute care patients, which provided rehabilitative services. He was employed by Winthrop University Hospital for that position, but did not know why Winthrop Hospital paid his salary. In 1995, he became medical director at United Presbyterian. His general responsibilities were to oversee patient care. He would investigate complaints from administration or family members. He was on call for private patients of Winthrop Hospital at United Presbyterian. Other than on call responsibilities on the weekends, he would see or evaluate patients at United Presbyterian as medical director upon receiving a call from the CEO or an administrator that there was a problem. He did not remember how many administrators there were. There was a credentialing process at United Presbyterian in May 2004 with regard to physicians seeing patients at the facility, consisting of background check, license check and DEA check. As medical director, he was not involved in selecting primary physicians to see patients at the facility, or for assigning primary care physicians to patients who did not have pre-existing primary care physicians. He stated that there was no requirement at the facility concerning how often a primary care physician was to visit patients.

Dr. Nembhard testified that the decedent was not a patient of Winthrop Hospital, and that he did not manage his case. He stated that he made no recommendations concerning treatment of the decedent. However, he stated, he wrote a note in the decedent's record on May 15, 2004, addressed to the decedent's physician, to consider certain treatment for the decedent. Dr. Nembhard then testified that to consider and/or recommend treatment are not the same, and it was up to the physician to determine whether or not to follow his recommendations. He believed he wrote that note after a meeting with the decedent's son or daughter. His note indicated that the decedent's "chart reviewed, meeting with son and daughter, administration, nursing, social worker, and myself. Yesterday. And addressed all family concerns. Medications were adjusted, and Amiodarone, Enduron were discontinued on 5-13-04 at the discussion of the cardiologist. Resident had cast removed yesterday and was noted to have open surgical wound of both medial and lateral foot with some eschar anteriorly. Left heel clean, no signs of infection. Consult with podiatry today, change dressings to moist to dry. New wounds are expected complications of cast. Follow up with private medical doctor. Message left, communication for private medical doctor, Dr. Moskowitz. Consider vascular versus plastics." He performed a partial examination of the decedent's feet. He did not measure the decedent's peripheral pulses. The eschar, which he described as a hard crust, was on the front/anterior foot in conjunction with an open surgical wound. He did not measure the depth of the wound. He called the primary doctor and left a message to follow up on the case.

Dr. Nembhard testified that he wrote the note for his own use and did not intend to see the patient again. When asked if writing "consider vascular versus plastics" was for his own benefit, he stated that it was a conclusion. He continued that he cannot tell a private physician what to do. He did not know why he recommended changing the dressings from wet to dry, where the bottom of the dressing is moist and the top is dry. He stated that such dressing held to get rid of eschar by acting as a debriding agent. He wrote that new wounds are expected as complications of casts, as they develop inside the cast, usually from pressure. He was unsure if vascular insufficiency would contribute to the development of wounds from the cast. He testified that there was nothing specific that he felt required follow up by the primary medical doctor. He did, however, order a podiatry consultation to evaluate the surgical wound and eschar because the family wanted something done. He did not order either the plastic or vascular consult at that time because it was up to the primary physician to do so. He continued

that the podiatrist was in house, so the patient would be seen immediately. He then stated that the podiatrist was not necessarily in house on May 15, 2004. He also stated that there were no plastic surgeons in house. It would not be his practice to ask a podiatrist in this situation to defer his consultation for six days. Dr. Nembhard continued that if a primary medical doctor wanted a consult, the consultant could be called by the primary. There are also order forms.

Dr. Nembhard stated that he did not remember if there was Doppler equipment available at the residence to measure peripheral pulses in May 2004. There were rulers, usually sterile, available for measuring the depth of wounds. He was asked if there was someone responsible for contacting a consultant to arrange a consult when a physician ordered a consult on May 17, 2004, Dr. Nembhard answered that the consult could be called in by the physician. He also thought that because it was an order, that nursing would pick it up. He testified that in a nursing home, it could be 72 hours or so until the order is picked up by nursing if it were urgent. If it was not urgent, the time would vary.

LESLY HONORE, M.D.

Lesly Honore, M.D. testified that at the time, he was not licensed to practice medicine in New York State as he just completed the residency program last February and had not yet taken the licensing examination. He completed a two-year residency in general surgery, and completed a residency in internal medicine. During his internal medicine residency, he was practicing podiatry part-time, as he had attended New York College of Podiatry School and received his degree in 1995. He completed medical school in 2002, and did his residency through 2005. He opened his office for podiatry in 2000, and was still working there in May 2004. He is certified in wound care and in podiatry. Sometime after he completed medical school in 2002, and possibly prior to 2004, he began providing consulting services to United Presbyterian Residence. His consultation services at the facility were generally initiated by a call to his office. If the attending physician indicated that it was an urgent consult, the consult is seen within 24 hours. Non-urgent consults are seen on his next visit on Fridays as the wound care team rounds on Friday. This provides him with the opportunity to see the wound care they are doing on patients he is going to see.

Dr. Honore stated that the wound care team does not record notes in the record, and that any such note is written by the consultant, the medical director, the attending, or the nurses. On May 15, 2004, when he was about to leave the facility, Dr. Nembhard asked him to see the decedent, and he was told that the consult needs to be done later, not on that particular date, and that he could see him on Friday during his rounds. He wrote a note on May 15, 2004 indicating that a full consult was to follow Friday, but stated that note was not part of the rounds. He did not examine the decedent or his wound on that date, and was not advised of the decedent's medical history, whether he had other wounds, or that he had peripheral vascular disease or other chronic diseases. Dr. Nembhard mentioned a vascular consult, but he did not know why or if he called it. He stated Dr. Nembhard did not mention a plastic consult. Dr. Honore stated that usually consult requests come from the attending physician, a call from the staff at the facility, or by the medical director.

Dr. Honore testified that he saw the decedent on May 21, 2004, while on rounds with the wound team, and he believed that Dr. Nembhard was present. He learned about the patient from the team and by speaking to the decedent. He learned that the decedent had a cast removed from his right foot and that he had a wound on the foot. He stated that a wound could be caused by the cast causing pressure over a bony prominence. He indicated that a wound does not heal sometimes due to a vascular problem. He noted that the decedent had non-insulin dependent diabetes. He indicated the decedent was in a wheelchair, in no acute distress, and was being seen for multiple leg and foot ulcers. Bilaterally, the dorsalis pedis and posterior tibial artery pulses were nonpalpable. Capillary refill

was less than two seconds for all toes. Dr. Honore stated that although the pulses were nonpalpable, the capillary refill demonstrated blood flow to the toes. He noted that the right lower extremity had a lateral fibula serpentine lesion (wound) with mild necrotic tissues; and the medial lower anterior tibia had a 2 x 0.2 cm longitudinal ulceration covered with necrotic tissues, no exudate, no malodor, and no erythema. On the right foot he noted a 3 x 3 cm ulcer limited to subepithelium, healthy tissues at base, clean and pink; no exudate, erythema or malodor. He set forth his treatment plan which was previously set by either the medical doctor or the doctor rounding on the patient. He thought he might have removed necrotic tissue which could overwhelm infection. Dr. Honore stated that wound ulcers in diabetic patients can be difficult to heal due to the physiological effects of diabetes and vascular insufficiency. If the blood sugar is not controlled, healing processes are delayed. Diabetes can also affect sensation in the lower extremities and cause diabetic neuropathy. He found the decedent had some decreased (partial) sensation in his feet, and parts that had no feeling at all in the right lower extremity.

Dr. Honore continued that a Doppler can be used to evaluate peripheral disease. Although he had nonportable Doppler equipment in his office, he did not believe United Presbyterian Residence had such equipment. He did not probe the wounds to determine their depth as to do so would introduce bacteria down into the deeper tissue. He testified that it would be up to the primary care physician (orthopedist) who did the surgery on the decedent's right leg to determine if bone was underlying the ulcer, so he recommended that the decedent see the orthopedist. Based upon what he saw and evaluated, he did not feel that the decedent required a surgical procedure to the wounds. He stated that debridement of the right leg wound should be done by the orthopedist. He felt that the decedent should have a vascular consult. He felt the ulcer on the decedent's left heel was due to pressure on the heel. His recommendations were to address the wounds, offload the ulcers, have the patient seen by the orthopedist, and wait for the vascular consult.

KARLEEN VOLCY

Karleen Volcy testified that for nine years she was an employee of Cold Springs Hill, also known as United Presbyterian Residence. She was hired as a licensed practical nurse, then became a registered nurse. She was employed there in May 2004, and worked 7:00 a.m. until 3:00 p.m. as the only nurse on the floor, except for the charge nurse. There were three individuals providing nursing services. Medication and wound care would be provided by the licensed practical nurse (LPN). The registered nurse (RN) is at the desk, gives reports, provides assignments to the certified nursing assistant (CNA), and assesses patients. Nurse Volcy testified that if a concern or medical issue developed, the patient was put on report. On May 17, 2004, the decedent was placed on report because he was on antibiotic therapy. A separate treatment book is maintained which does not become part of the patient's record, except for the pages which are initialed by the provider of treatment. There was a wound care team to provide treatment at the residence, but she was not part of the team. She did not know who the nurse on the wound care team was at the time.

Nurse Volcy stated that there was a bin for consultation request forms at the nursing desk. The unit manager would take the consult request to the medical office, which sets up the appointment for the patient. The consult form will come back from the medical office with a master list of appointments, and who the appointment was with and for. If there was difficulty obtaining a consult, the ordering doctor would be notified and additional directives would be charted. She set forth the nursing care and treatment provided by her on May 17, 2004. She did not work on the decedent's unit on any other days. There was an order dated May 17, 2004 for Dr. Ross for surgical consultation of the decedent, which she picked up that same day. She placed the consult request in the bin, and it was picked up the same day and sent to the medical office.

JUDY KOERNER-FREEDMAN

Judy Koerner-Freedman submitted an affidavit averring that she was formerly employed at United Presbyterian Residence, but she suffered a stroke after leaving her employment there. At some point, she stated, she worked as a clinical coordinator in the medical office, but she did not know when. She was responsible for scheduling on-site clinic visits for residents after the medical office received the consult request form via interoffice mail. She would then call the consulting physician to schedule the visit. Such visits were scheduled to take place within 30 days of receipt of the request, unless the request was on an urgent basis or provided for a different time frame. She tracked the consultations in a looseleaf binder, and the clinic lists were kept according to the physician. When the consulting physician came to the facility, a consult request form and a blue form to be used by the consultant to write the progress note upon were provided. Upon completion of the consult, the blue form was placed in the patient's chart, sticking out to get the attention of the charge nurse and the attending physician so they would be aware the consult was completed and any recommendations would be noted. She testified that she knew Dr. Ross was a surgeon who performed on site clinic visits, but she had no recollection of speaking with him, or any staff members, regarding the decedent. She stated that she did not know the decedent.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503[2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420 [1999]). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* ***Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 224 AD2d 674, 638 NYS2d 700 [2d Dept1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* ***Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Machac v Anderson***, 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by defendants, plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendants' acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

MOTION (007)

The Cold Spring Hills Center (United Presbyterian Residence) defendants have submitted the affidavit of Beth Anne Maas, RN, BSN, MHA, who avers that she is licensed to practice nursing in Pennsylvania and was formerly licensed as an assisted living facility administrator in Pennsylvania. She set forth her education and

training, as well as various positions held in nursing and administration. She set forth the medical records and materials which she reviewed, however, most of the medical records have not been provided with the moving papers, as required. Nurse Maas stated the standards for the care required by residential skilled nursing facilities respecting prevention and treatment of decubitus ulcers requires implementation of a care plan utilizing reasonable nursing efforts directed at the prevention of these sores. If a patient already has decubiti upon entering the nursing facility, the standard of care requires implementation of a care plan directed toward the prevention of new sores, efforts to heal the existing sores, and efforts to prevent infection. Risk factors for the development and/or progression of decubiti include immobility, incontinence, diabetes, congestive heart failure, peripheral vascular disease, nutritional compromise, and occlusive source of unavoidable pressure on the patient's skin. Nurse Maas opined that nursing skin care plans were drafted and implemented in a timely fashion for the decedent, and the care plan reflected consideration by the staff of the resident's various medical conditions and related risk factors. She continued that an appropriate skin plan was implemented for the decedent with regard to the existing skin issues and directed at the prevention of further skin breakdowns.

Nurse Maas stated that the 71 year old Paul Walters was admitted to Cold Spring Hills Center/United Presbyterian Residence on April 14, 2004 from New Island Hospital where he had been hospitalized since March 27, 2004 for a right ankle injury in a fall at home. He was post open reduction and internal fixation and casting of the right ankle, foot, and leg. His co-existing medical conditions included coronary artery disease, myocardial infarction; type 2 diabetes, peripheral vascular disease, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, and chronic renal failure. He had previous coronary artery bypass graft, lift hip replacement, and left hydrocelectomy. Upon admission to the facility, the decedent was alert and oriented. The toes on his right foot were warm and mobile. There was a 1.5 x 2 cm bruise on the tip of his right great toe which occurred when he stubbed his toe doing exercises in the hospital. He also had a blister on his left heel.

Nurse Maas continued that the decedent was seen by the attending physician on his admission date, and on the following day on April 15, 2004, at which time his laboratory results were reviewed, and the decedent's status was reviewed with orthopedist Dr. Weiss, who was to give the directions for the decedent's management. She continued that the presence of the cast prevented evaluation of the pulses on the right foot, however, nursing notes documented positive popliteal pulses, positive capillary refill, and warm, mobile toes. Heel booties were applied to his left leg for protection from the formation of decubiti. On April 16, 2004, the decedent's blood pressure medication was increased as his blood pressure was elevated. The decedent complained of pain on April 18, 2004, however, Nurse Maas does not indicate the location of said pain. It is noted that on April 19, 2004, the attending physician indicated a modification of the initial skin care plan and the decedent's left heel blister was to be washed with normal saline and an antiseptic twice a day for seven days, with re-evaluation thereafter. On April 21, 2004, while in physical therapy, the decedent became very diaphoretic and less responsive. The physician was notified and Nitro Paste was applied to the decedent's chest. Nurse Maas stated that the decedent was timely transferred to Winthrop University Hospital to rule out myocardial infarction, arrhythmia, and syncope, and that he remained at Winthrop until May 3, 2004 for pacemaker placement. She added that the care provided during this admission to United Presbyterian was within the applicable standard of nursing and skin care, and indicated that upon transfer to Winthrop, the decedent had a bruise on his right great toe and a blister on his left heel.

Nurse Maas indicated that the decedent was readmitted to the facility on May 3, 2004 from Winthrop University Hospital, and that the transfer sheet indicated the decedent had developed a sacral pressure ulcer to which SoloSite was being applied. She stated that, upon readmission, a stage III (not stage II) 4 x 3 x .2 cm pressure ulcer with serosanguinous drainage was present on the decedent's coccyx; a stage IV 3 x 2 cm pressure ulcer with necrotic tissue and induration of the surrounding skin of the left great toe was noted; a stage IV 1 x 1.2 pressure ulcer with necrotic tissue and induration of the surrounding skin was noted on the left 4th toe; and a stage II 4 x 3 cm pressure

ulcer of the left heel with induration of the surrounding skin, were noted. The wound care plan of May 3, 2004 provided for customized daily wound care treatment and dressing protocols for each wound, which treatments were initialed by the staff member assigned to perform and direct the daily wound treatment. The left heel and foot were kept elevated and protected to relieve the pressure on the left heel. Nurse Maas stated that there were countersigned wound care evaluations and individual treatment and prevention protocols on May 7, May 20, and May 24, 2004 for the wounds, as well as the addition of newly discovered skin lesions on the right foot and leg with appropriate wound care instructions.

Nurse Maas continued that on May 5, 2004, upon dietary review, Prostat protein supplement, zinc, multivitamins, and additional supplements were ordered. On May 7, 2004, the physician readmission note provided for the addition of Glyburide for diabetes, Epogen for anemia, as well as vitamin and nutritional supplements. The decedent required a wheelchair for mobility, and assistance for bathing and turning and positioning in bed. On May 12, 2004, it was noted that the decedent developed a cellulitis of the left 4th toe, for which an antibiotic was started. On May 14, 2004, when the decedent was seen by the cardiologist and the orthopedist, the right leg cast was removed and a necrotic area was found under the cast. Again, an antibiotic was ordered. On May 15, 2004, the medical director met with the decedent's family about the skin wounds on the right leg, and the open surgical wound on the medial and lateral right foot with eschar anteriorly, and contemporaneous documentation that the wound on the left heel was clean with no signs of infection.

On May 17, 2004, the decedent's daughter had multiple complaints, including that of a thick black area that was tender to touch on the right lateral malleolus, and requested a transfer of the decedent to another facility. On May 18th, the interdisciplinary team modified applicable care plans. On May 21, 2004, a podiatry consult was obtained for the foot and leg ulcers. The assessment was right lower leg extremity lateral fibula serpentine lesion with mild necrotic tissue, medial lower anterior fibula 2 x .2 longitudinal ulcer covered with necrotic tissue, and left heel 3 x 3 cm ulcer. No palpable pulses were found in the lower extremities, and there was decreased sensation to touch and vibration. Nurse Maas stated that a surgical consultation was obtained on May 24, 2004, and the surgical recommendation was for non-invasive vascular studies, vascular surgical consult, and new treatments for the open wound areas with elevation of the feet. On May 29, 2004, the decedent began to complain of pain in his right lower extremity, and on June 1, 2004, his daughter notified the nurse of the same. On June 2, 2009, when the decedent complained of pain in his right ankle, the physician was notified and the decedent was transferred to Winthrop emergency room to rule out osteomyelitis. He was admitted to Winthrop and did not return to the facility again.

Based upon the foregoing, it is determined that Cold Spring Hills Center/United Presbyterian Residence has demonstrate prima facie entitlement to summary judgment dismissing the complaint as asserted against it.

MOTION (008)

Dr. Nembhard seeks dismissal of the complaint as asserted against him on the bases that at all times his involvement with the plaintiff was within good and accepted standards of care, and that he did not proximately cause the injuries claimed to have suffered by the plaintiff's decedent. Dr. Nembhard submitted the affirmation of Lawrence Diamond, M.D. as his supporting expert who affirms that he is licensed to practice medicine in New York State and is board certified in family practice with a subspecialty in geriatric medicine. Although Dr. Diamond refers to his curriculum vitae as to his specialty and experience as a physician, the same has not been provided to this court. Dr. Diamond indicates that he is the medical director and an attending physician at A. Holly Patterson Extended Care Facility in Uniondale, and that he is familiar with the standard of care, and Federal and State statutes and rules and regulations applicable to nursing home residents's rights and care. He set forth that he reviewed medical records, including the record of United Presbyterian, but has not identified the other medical records which

he reviewed, and the same have not been provided with the moving papers. Despite the omissions, Dr. Diamond opined within a reasonable degree of medical certainty that the care and treatment provided to the decedent by Dr. Nembhard was within the good and accepted standards of medical practice, and that he did not proximately cause any of the injuries to the decedent alleged by the plaintiff.

Dr. Diamond set forth that the decedent was admitted to the service of Dr. Moskowitz, his primary care physician, to United Presbyterian Residence on May 3, 2004, following a presentation to Winthrop University Hospital due a fracture of his right ankle with open reduction internal fixation, and cast application. He stated that Dr. Moskowitz ordered all consults and medications, and that the patient's family requested that the decedent be seen by the medical director. Therefore, Dr. Nembhard saw the decedent on May 15, 2004, and recommended a podiatry consult as well as an examination by the primary medical doctor, and further advised that a surgical consultation be considered. The decedent was seen by podiatrist, Dr. Honore that same day, and by Dr. Moskowitz on May 17, 2004, who became aware of Dr. Nembhard's recommendation of May 17, 2004 and ordered a surgical consult with Dr. Ross. He continued that Dr. Honore saw the decedent again on May 21, 2004, who, upon examination, found there were no palpable dorsalis pedis or posterior tibial pulses bilaterally, but that there was good capillary refill indicating blood flow to the toes. He described the decedent's wounds on both lower extremities. Dr. Diamond continued that Dr. Ross saw the decedent on consult on May 27, 2004 and recommended non-invasive vascular studies/PVRs, and to consider a vascular surgical consult.

Dr. Diamond opined that Dr. Nembhard only saw the decedent on one visit on May 15, 2004 in his position as medical director, at which time the decedent was receiving the appropriate wound care, the dressings were in place, and he was in stable condition. Dr. Diamond stated that it was completely appropriate for Dr. Nembhard to see the decedent, order the podiatry consult, and advise a surgical consult. Dr. Nembhard's recommendations were followed, and he was never again requested by the family to see the decedent.

Based upon the foregoing, it is determined that Dr. Nembhard has demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against him, on the bases that he did not depart from the standard of care and did not proximately cause the injuries claimed to have been suffered by the plaintiff's decedent.

MOTION (009)

Dr. Honore seeks summary judgment dismissing the complaint on the bases that the decedent's wounds were already present when he saw the decedent; he did not depart from the standards of care; and the injuries claimed by the decedent are causally related to the progression of the decedent's co-morbitities, including diabetes, peripheral vascular disease, and hypertension, and not to any care or treatment rendered by him. In support of this application, Dr. Honore submitted the affidavit of Paul Greenberg, D.P.M. who avers that he is licensed to practice podiatric medicine in New York State and is board certified in podiatric surgery. Dr. Greenberg set forth his current work experience and extensive experience in treating pressure and diabetic ulcers of the foot, including the condition for which Dr. Honore consulted the decedent. He set forth the materials and records he reviewed and opined within a reasonable degree of podiatric certainty that the care and treatment provided by Dr. Honore on May 15, 2004 and May 21, 2004, at all times comported with the podiatric standard of care and did not proximately cause the injuries claimed to have been suffered by the decedent.

Dr. Greenberg set forth the decedent's medical history and treatment related to this action, as well as his later health issues concerning femoral popliteal bypass, colostomy, bowel surgery, urosepsis, MRSA infection, and chronic renal failure which resulted in the decedent's death. Dr. Greenberg noted that on April 21, 2004, a podiatrist, not Dr. Honore, found that the decedent had a palpable left dorsalis pedis pulse, however, the posterior

tibial pulse was absent. He continued that the dorsalis pedis artery is responsible for carrying blood to the dorsal surface of the foot, whereas the posterior tibial artery supplies blood to the posterior portion of the leg and plantar surface of the foot. The palpation of these vessels enables the examiner to determine if there is blood flow to the lower extremity and foot to aid in the evaluation of the patient's vascular status. The pulses on the decedent's right foot could not be ascertained due to the cast being in place. The podiatrist also noted a traumatic hematoma on the decedent's left hallux (big toe) and an intact blister on the decedent's left heel. Taking into consideration the decedent's history of peripheral vascular disease, diabetes, and risk of skin breakdown, pressure sore precautions were recommended along with care of the hematoma. The podiatrist's ongoing care of the decedent was interrupted by the decedent's admission to Winthrop Hospital when he became diaphoretic and slow to respond to commands.

Dr. Greenberg continued that the decedent was diagnosed with paroxysmal ventricular tachycardia and first degree heart block, for which an internal cardiac defibrillator was inserted on April 28, 2004. Wound care was provided to the intact blister on decedent's left heel and eschar on the decedent's left hallux and 3rd toe during the admission, but on April 26, 2004, progression of the left heel ulcer was noted. The decedent was seen by Dr. White who determined the cast on the decedent's right leg should remain in place for two weeks. The decedent was transferred back to United Presbyterian facility with a stage III sacral ulcer (intact blister) above the buttocks; an intact blister on the left heel; and stage IV necrotic ulcers on the 1st and 4th digits of the left foot. Dr. Greenberg set forth the care and treatment ordered. He continued that when Dr. White removed the cast from the decedent's right leg on May 14, 2004, the surgical incisions from March 28, 2004,were unhealed and open, requiring daily wound care and dressing changes. On May 15, 2004, Dr. Nembhard observed necrotic areas on the medial and lateral areas of the right foot with eschar (dry, hardened, dead skin) anteriorly, called a podiatric consult, and recommended to the decedent's primary physician to consider a vascular or surgical consult. Because Dr. Honore was present at the facility, Dr. Nembhard asked him to evaluate the decedent and perform a formal consultation the next time he was at the facility.

Dr. Greenberg stated that since Dr. Honore was a consulting provider, he could not issue orders, but could only make recommendations that could be adopted or rejected by the decedent' treating providers and the wound care team at the facility. Dr. Greenberg set forth Dr. Honore's recommendations for treatment, and opined that the treatment was appropriate. He continued that on May 21, 2004, Dr. Honore performed a complete physical examination and drafted a comprehensive note, noting the dorsalis pedis and posterior tibial pulses were non-palpable bilaterally, but the capillary refill of all the toes was normal at less than two seconds, indicating sufficient blood flow to the foot. The decedent also had decreased touch sensation and decreased vibratory sensation to both feet. Dr. Honore noted a serpentine wound on the lateral fibular area of the right extremity and an ulcer on the medial lower anterior tibial area, both covered with necrotic tissue. Dr. Greenberg set forth Dr. Honore's orders to promote autolytic debridement of the necrotic tissue and noted he was to follow up in one week with the decedent, if requested by the medical attending or Dr. Nembhard. Vascular and plastic surgery consultations had been previously ordered on May 15, 2004, so Dr. Honore recommended to the wound care team that the decedent be seen by Dr. White, his orthopedic surgeon for further evaluation of his right foot. Thereafter, Dr. Honore did not see the decedent, and was not requested to.

Dr. Greenberg continued that, three days later, the decedent was seen by Dr. White, and on May 27, 2004, was seen by Dr. Ross, the general surgeon who noted the decedent had 3+ bilateral femoral pulses. Dr. Ross ordered non-invasive vascular studies and PVR, and a referral to a vascular surgeon. On June 1, 2004, the decedent began expressing complaints of pain in his right ankle. No signs of infection were noted, but the decedent had a low grade infection and was transferred to Winthrop University Hospital on June 2, 2004. Upon arrival, the decedent was evaluated by the wound care nurse and was seen by Dr. Zaret, who felt the wound and hardware in the right ankle were

infected, that the wound required debridement, and that the hardware needed removal, which he performed on June 8, 2004. Due to the severity of the decedent's vascular disease, Dr. Zaret discussed the possibility of amputation for failure of the wound to heal. The decedent was also seen by Dr. Smirnov, the vascular surgeon, who ordered various vascular studies and determined that the decedent had stenosis of the right common femoral artery, however, he determined that the decedent's vascular condition was not an acute condition requiring immediate treatment. On June 11, 2004, Dr. Smirnov performed a right femoral posterior tibial bypass to increase chances of wound healing. On June 21, 2004, the decedent was transferred to Hempstead Park Nursing Home for further rehabilitation, and where he was followed by Dr. Zarat who noted persistent infection in the right leg wound on June 28, 2004. The decedent was transferred back to Winthrop Hospital, whereupon an amputation of the decedent's right lower leg below the knee was performed on July 2, 2004 by Dr. Smirnov.

Dr. Greenberg stated that the decedent's condition slowly deteriorated over the next three years, wherein he developed multiple sacral ulcers requiring surgical debridement and reconstruction in October 2004, and a diverting colostomy to prevent further sacral breakdown due to bowel incontinence. The heel ulcer on the left lower extremity resolved, and the ulcer on the top of his left foot was being treated, but, by December 2004, the left foot ulcer worsened. The vascular surgeon noted the decedent suffered from end stage advanced arterial insufficiency and recommend amputation of the left leg which, was done on December 22, 2004. Thereafter, the decedent underwent multiple hospitalizations for repeated infections, renal disease, urinary tract infections, congestive heart failure, various pressure ulcers of the buttocks and sacrum, and dementia. The decedent died on September 1, 2007 as a result of his various, multiple medical issues.

Dr. Greenberg opined that the care and treatment by Dr. Honore comported with the accepted standard of podiatric care and treatment of the decedent for his right foot ulcers, in that he appropriately assessed the decedent's vascular status during the May 15, and May 21, 2004 visits, recommended appropriate wound treatment, and requested proper consultations with wound care and Dr. White, aware that a vascular surgery consultation had already been recommended. He stated that Dr. Honore was consulted for the purpose offering possible wound care suggestions to address the ulcers that developed previously on the lower extremities. He set forth the treatment of the wounds recommended by Dr. Honore to allow the tissue to fall off naturally and the wound to heal. He continued that in a patient with a history of chronic peripheral vascular and arterial disease and diabetes, and in the absence of any evidence of an acute occlusion, it was proper to attempt conservative autolytic measures to debride the wounds. He continued that capillary refill to the toes was good, evidencing blood flow. There was no cyanosis or blueness of the toes or feet, severe pain, or coolness of the extremities to evidence acute conditions that required immediate intervention, or immediate transfer to the hospital for vascular surgery consultation or vascular studies. He stated that Dr. Honore properly communicated his orders which were implemented by the wound care team. However, he stated, it is clear from the chart that on May 15, 2004, that the recommendation to consider a vascular surgical consult was made to the decedent's private medical attending via a telephone call and by written note in the decedent's chart. As a consulting podiatrist, Dr. Honore could only recommend such consult and could not order it. Dr. Greenberg continued that Dr. Honore is not responsible for any lapse in the steps taken by the facility staff or the decedent's medical providers in response to Dr. Honore's recommendation for vascular consultation. Dr. Greenberg set forth the additional care and treatment and orders by Dr. Honore, the charting of his findings upon examination, and that there was no change in the ulcers from May 15, 2004 to May 21, 2004. On May 24, 2004, there were no signs of infection, as supported by Dr. Ross' findings as well, that the decedent did not require immediate intervention or demonstrate risk of acute limb loss.

Dr. Greenberg also opined that there is no causal connection to Dr. Honore's treatment and the decedent's eventual amputation and claimed injuries, as the decedent exhibited the natural history of the disease of diabetes, and that nothing that Dr. Honore did or could have done would have prevented the deterioration of the decedent's right leg and subsequent injuries. He stated that the decedent had co-morbidities of diabetes, peripheral vascular and arterial

disease, diabetic peripheral neuropathy, and hypertension, which were the cause of the decedent's foot and leg ulcers, gangrene, and eventual amputations, due to the impairment in arterial blood flow to the lower extremities, and microvascularization of the digits. The limitations impair wound healing and minor trauma or pressure often leads to ulceration and eventual amputation. By the time Dr. Honore became involved in the decedent's care, the decedent already exhibited signs of the natural progression of diabetes that could not have been stopped, even with the most aggressive treatment. He could not have prevented the progression of the wounds prior to seeing the decedent on May 15, 2004. Thereafter, the decedent was evaluated by his orthopedic surgeon, Dr, White, and by his general surgeon, Dr. Ross, who were both fully competent in making wound care and other treatment recommendations. Dr. Greenberg stated that the subsequent treatment plans at United Presbyterian, as per decedent's other health care providers, superceded his care and treatment as they no longer followed his recommendations, and Dr. Honore did not see or reevaluate the decedent. Even with the subsequent popliteal bypass surgery on June 11, 2004, the wound on the right leg did not heal and required amputation two months later.

Based upon the foregoing, it is determined that Dr. Honore has established prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

MOTION (010)

Frank L. Ross, M.D. seeks summary judgment dismissing the complaint of this action as asserted against him on the bases that he did not depart from the accepted standards of care and did not proximately cause the injuries to the decedent claimed by the plaintiff. He has submitted the affidavit of his expert, Steven G. Friedman, M.D. who avers that he is licensed to practice medicine in New York State and is board certified in general and vascular surgery. Dr. Friedman, however, has not provided his education, training, or work experience, and has not provided a copy of his curriculum vitae. He set forth the materials and records which he reviewed in offering his opinions. Dr. Friedman opined within a reasonable degree of medical certainty that the care and treatment rendered by Dr. Ross at all times comported with good and accepted medical practice, and that he did not proximately cause any injury or damage to the decedent.

Dr. Friedman noted the decedent's past medical history of previous falls at home, coronary artery disease, myocardial infarction, type II diabetes, peripheral vascular disease, severe hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, and chronic renal failure. Past surgical history included coronary artery bypass grafting by using the saphenous vein from his right leg, left carotid endarterectomy, left total hip replacement, and a right shoulder rotation cuff repair. After the decedent fell on March 27, 2004, he was taken to New Island Hospital where Dr. White performed an open reduction with internal fixation of the ankle fracture and placement of a short leg plaster cast on the right foot and ankle, giving visibility to only the toes on the right foot. The decedent remained hospitalized through April 14, 2004 at New Island Hospital due to cardiac and neurological issues, and was then transferred to United Presbyterian Residence, a skilled nursing facility, for rehabilitation.

Dr. Friedman set forth the findings of the pressure sores on the plaintiff's sacrum, and left foot, and then the open surgical wound on his right ankle/foot upon removal of the cast. He noted the April 21, 2004 consultation with a podiatrist who found a palpable dorsalis pulse of the left foot and absence of the posterior tibial pulse on the left foot. Since these arteries provide blood supply to the lower extremities, palpation helps to determine if there is blood flow, and to assist in the evaluation of the vascular status. Due to the presence of the cast on the decedent's right foot, pulses could not be obtained. When the decedent became diaphoretic that day, he was transferred to Winthrop Hospital wherein an internal pacemaker was inserted for paroxysmal ventricular tachycardia and first degree heart block. During that admission, care was given for an intact blister on his left heel, and eschar on the left hallux and third toe. He was seen by Dr. White on April 30, 2004 and transferred to United Presbyterian on May

3, 2004 with a stage III sacral ulcer and an intact blister on his left heel, and stage IV necrotic ulcers on the 1st and 4th digits of the left foot. Wound care was described, as well as commencement of antibiotics on May 13, 2004. On May 14, 2004, when Dr. White removed the cast from decedent's right leg at his office, the operative incisions from the surgery of March 28, 2004 were open and unhealed, and required daily dressings and wound care. On May 15, 2004, Dr. Nembhard, the medical director at United Presbyterian, where the decedent was returned to, noted the necrosis on the decedent's medial and lateral areas of the right foot with eschar anteriorly. Dr. Friedman discussed the various treatments for the eschar, dependent upon the medical condition of the patient. Dr. Nembhard placed a note in the chart directing the primary care physician, Dr. Moskowitz, to consider either a plastic surgery or vascular surgery consultation. On May 17, 2004, Dr. Moskowitz ordered a surgical consultation with Dr. Ross, and the order was picked up by nurse Karleen Volcy, taken to the office of the medical director, which office was then to set up the appointment with the consultant.

Dr. Friedman notes that Dr. Ross had no involvement with any of the decedent's care and treatment prior to his consult on May 27, 2004. This consult was pursuant to a second order by Dr. Moskowitz on May 26, 2004, as there was no indication that Dr. Ross was ever notified pursuant to the first order of May 17, 2004. Dr. Ross completed an examination of the decedent and entered a comprehensive note, and made recommendations that could be adopted or rejected by the decedent's treating providers. As a consultant, Dr. Ross could not issue orders. Dr. Friedman stated that Dr. Ross made no entry indicating or raising the suspicion of an infection of the right leg lesion. His impression was that of multiple pressure ulcers of the lower extremities, accompanied by chronic peripheral vascular disease. Dr. Ross deferred the care and treatment. Dr. Ross was not requested to follow up with the decedent after that first visit. Dr. Friedman set forth the decedent's ongoing problems and treatments, including evaluation at Winthrop Hospital on June 1, 2004. Dr. Zaret saw the decedent and noted that the pulses located in both of the decedent's feet were not palpable, and that he exhibited signs of peripheral neuropathy. He obtained an evaluation by Dr. Smirnov, a vascular surgeon. Upon the conduction of non-invasive studies, Dr. Smirnov diagnosed stenosis of the right common femoral artery, which was not an acute condition which required immediate treatment. Dr. Friedman described the treatment, including surgical removal of the hardware and application of external fixation by Dr. Zaret on June 8, 2004. A plastic surgeon applied a wound VAC to promote wound healing, and noted that should the VAC fail, that the decedent would likely require amputation of the affected extremity. He also considered a small flap or skin graft to close the wound to promote healing.

Dr. Friedman stated that on June 11, 2004, Dr. Smirnov performed a right femoral posterior tibial bypass to increase blood flow to the lower extremity to increase chances of wound healing. He was then transferred to Hempstead Park Nursing Home for rehabilitation, under the continuing care of Dr. Zaret. Due to persistent infection in the right leg, the plaintiff was transferred back to Winthrop Hospital on June 30, 2004. On July 2, 2004, Dr. Smirnov performed a below the knee amputation of the decedent's right leg when Dr. Zaret determined that the lower right leg was no longer viable. He was discharged to Central Island Healthcare for Rehabilitation on July 8, 2004. However, the left foot also deteriorated. The vascular surgeon noted that the decedent had end stage advanced arterial insufficiency and recommended amputation of the left leg which was performed on December 22, 2004.

Dr. Friedman opined that Dr. Ross at all times comported with the accepted standard of care in assessing the decedent's lower extremity on May 27, 2004, and recommended appropriate care and treatment, as well as recommending consultation with a vascular surgeon and obtaining vascular studies, and did not delay in seeing the decedent. He set forth the bases for his opinions as well as noting the absence of any signs that the decedent required immediate intervention or treatment. He properly charted and communicated his findings and recommendations. Dr. Friedman further opined that there is no causal connection between the care and treatment that Dr. Ross provided to the decedent on May 27, 2004, and the decedent's eventual amputations and claimed

injuries. Decedent's diseases progressed on the natural courses of the disease process for diabetes and peripheral vascular disease. There is nothing that Dr. Ross could have done which would have prevented the deterioration of the decedent's right leg and subsequent injuries. The decedent's co-morbidities, including diabetes, peripheral vascular disease, diabetic neuropathy, hypertension and COPD were the cause of the decedent' foot and leg ulcers, gangrene, and eventual amputations. Chronic vascular disease and diabetes created impairments to the arterial blood flow to the extremities, foot, and microvascularization of the digits. The natural progression of the diseases suffered by the decedent could not have been stopped, even with the most aggressive forms of treatment.

Based upon the foregoing, it is determined that Dr. Ross has demonstrate prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

The plaintiff has submitted a redacted copy of her expert's affirmation. A redacted version of an expert affirmation lacks evidentiary value. A party may successfully oppose a summary judgment motion without disclosing the names of the party's expert witnesses (*see* ***Marano v Mercy Hospital,*** 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). In opposition to such a motion the party defending against a summary judgment motion may serve the movant with a redacted copy of its expert's affirmation as long as an unredacted original is provided to the court for its in camera inspection (***Marano v Mercy Hospital***, *supra*). This procedure preserves the confidentiality of the name of plaintiff's medical expert while also preserving plaintiff's obligation in opposing defendant's motion, in that by submitting a redacted affirmation and by offering the original to the court for in camera inspection, plaintiff has opposed the motion by evidence in admissible form (***Rubenstein v Columbia Presbyterian Medical Center,*** 139 Misc.2d 349, 527 NYS2d 680 [NY County 1988]). An unredacted copy of the affirmation with the expert's name and signature has not been provided to this court under separate cover. Accordingly, plaintiff's expert affirmation is not in admissible form and is insufficient to raise a triable issue of fact as to the defendant's alleged malpractice (***Rose v Horton Medical Center,*** 29 AD3d 977, 816 NYS2d 174 [2d Dept 2006]). However, even considering the affirmation of plaintiff's expert, the expert has failed to raise a factual issue with regard to the issue of departures from the standard of care by the various moving parties and proximate cause to preclude summary judgment.

Plaintiff's expert set forth that he is licensed to practice medicine in New York State and is board certified in surgery. He has been an attending physician at various metropolitan area hospitals in general and vascular surgery for 25 years. Plaintiff's expert does not set forth any opinions regarding the quality of care that the decedent received from Drs. White, Smirnov, Lowy, or Moskowitz, and the Plainview Medical Group, and limits his opinions to the care and treatment rendered by defendants Nembhard, Ross, Honore, and United Presbyterian Residence at the United Presbyterian Residence. The plaintiff's expert set forth the various materials which he reviewed, including the angiogram of the decedent's right lower extremity performed on June 7, 2004. Plaintiff's expert set forth the decedent's past medical history and the course of his care and treatment following his fall on March 27, 2004 wherein he fractured his right ankle and was admitted to New Island Hospital where he underwent surgery by defendant Dr. White for open reduction and internal fixation. He described the decedent's care and treatment and findings by the moving defendants.

The plaintiff's expert noted that there had been a podiatry consult on April 21, 2004 at the United Presbyterian Residence wherein the examination revealed the absence of the posterior tibial pulse on the left side. The absence of the posterior tibial pulse, he stated, while it is evidence of peripheral vascular disease, there was no critical interference of perfusion as the dorsalis pedis artery was functioning. There were no pulses obtained on the decedent's right foot due to the presence of the cast. Thereafter, the decedent was taken to Winthrop Hospital and was returned for a second admission to United Presbyterian Hospital on May 3, 2004. On May 14, 2004, when the decedent was taken to Dr. White's office, the cast was removed and breakdown in the surgical wound was noted

bilaterally. On May 15, 2004, the decedent's daughter requested a meeting with Dr. Nembhard, the medical director at United Presbyterian as she had concerns that the leg wound was not being addressed at the facility. Dr. Nembhard examined the decedent and noted the open surgical wound of the medial and lateral right foot with some eschar anteriorly. Dr. Nembhard did not palpate the decedent's pulses, but called a podiatry consult with Dr. Honore. Dr. Honore saw the decedent with respect to the wound care on May 15, 2004, but did not examine the decedent as he was to conduct the full consult on Friday. While there is confusion as to whether or not Dr. Honore examined the decedent on May 15, 2004, he did see the decedent on May 21, 2004. Dr. Nembhard wrote in the chart for the internist to consider vascular or plastic consult. On May 27, 2004, Dr. Ross performed his surgical consultation and found an absence of palpable peripheral pulses and recommended non-invasive vascular studies and vascular consult to be considered.

The plaintiff's expert continued that on May 27, 2004, the decedent first began to complain of pain. When the pain increased on June 2, 2004, the decedent was transferred to Winthrop Hospital. Obstructive disease of the bilateral lower extremities was note on PVR. A June 7, 2004 angiogram revealed that the decedent was a candidate for femoral bypass and revascularization. On June 8, the hardware was removed from his right ankle and the wound was debrided. On June 11, 2004, a right femoral posterior tibial bypass was performed by Dr. Smirnov and was initially successful in accomplishing a revascularization of the right lower extremity. On June 21, 2004, the decedent was transferred to Hempstead Park Nursing Home. The wound continued to be necrotic and susceptible to repeated infection. On June 30, 2004, Dr. Smirnov examined the decedent and stated the right foot was now viable, but later that day, the decedent had to be readmitted to Winthrop Hospital with sepsis, a fever, and purulent drainage from the wound. On July 12, 2004, Dr. Smirnov performed an amputation of the right lower leg below the knee.

Plaintiff's expert stated that he disagrees with the moving defendants' experts that the amputation of the right lower leg was inevitable as a result of the natural course of his underlying diabetes. He continued that it is true that diabetes is a risk factor for the development of peripheral vascular disease and was a likely significant contributing cause of the decedent's occlusive disease, as reflected by the angiogram and femoral tibial bypass. He continued that although Dr. Smirnov stated that the right foot was viable on June 30, 2004, as it restored the blood flow to the area, by the time the bypass was performed, the chances of successfully avoiding the need for amputation had been greatly diminished due to ischemia and infection. The plaintiff's expert continues that the fact that the decedent's left leg was subsequently amputated is irrelevant, as he could never have become ambulatory even if his left leg were salvaged, so there was no benefit to saving the left leg.

The plaintiff's expert continued that the extensive necrosis and tissue loss set the stage for infection causing further tissue loss. The poor circulation limited the ability to deliver antibiotics to the affected areas. He continued that by the time Dr. Smirnov revascularized the limb, it was too late to save the limb, but on the other hand, he stated, had revascularization been performed even days earlier, there would have been a chance for long term limb survival.

The plaintiff's expert opined that United Presbyterian Residence and Dr. Nembhard departed from good and accepted practice as they were responsible for ensuring the decedent received appropriate medical care at the facility. When peripheral vascular insufficiency was found on May 14, 2004 upon removal of the cast, the physician should have conducted an evaluation of the peripheral vascular condition by palpating the peripheral pulses. Thus, Dr. Nembhard's failure to palpate the decedent's peripheral pulses was a departure from the standard of care. The plaintiff's expert contradicts that statement by saying that the absence of the peripheral pulses may not represent critical ischemia, as there can be collateral flow of the blood, and further evaluation should have been done. However, he does not set forth the time frame for such evaluation or demonstrate what injury was proximately

caused by the failure to do such examination. He adds that United Presbyterian Residence and Dr. Nembhard departed from accepted practice through the actions of its assigned physicians. He stated that Dr. Moskowitz, who noted a necrotic left toe, and peripheral vascular disease, should have then re-examined the right leg and assessed the vascular status. However, while Dr. Moskowitz had admitting privileges at the facility, he was not an employee of the facility for whom United Presbyterian and Dr. Nembhard would be vicariously liable. Additionally, Dr. Nembhard wrote on the chart that Dr. Moskowitz should consider a vascular or plastic consult. He continued, that unfortunately, the vascular status was not evaluated until a week later by Dr. Honore on May 21, 2004. Plaintiff's expert has not set forth any injury proximately caused by the failure to do so during those following six days.

Based upon the foregoing, it is determined that the plaintiff has failed to raise a factual issue to preclude summary judgment from being granted to United Presbyterian Residence and Dr. Nembhard.

Accordingly, motions (007) and (008) are granted, and the complaint and any cross claims asserted against United Presbyterian Residence and Dr. Nembhard are dismissed.

The plaintiff's expert stated that on May 21, 2004, when Dr. Honore saw the decedent, he noted the absence of peripheral pulses bilaterally, a change from April 21, 2004 when the dorsalis pedis pulse was present on the left, and the decedent should have been sent for vascular studies and been evaluated by a vascular surgeon. However, Dr. Honore testified, and it has been established through testimony, that the procedure was for the facility to schedule the consult and that Dr. Honore could not order a vascular consult, only recommend it, which he did. Dr. Honore was not asked to follow-up with the decedent's care thereafter. Again, proximate cause and the alleged injury resulting from Dr. Honore's care and treatment have not been established and the plaintiff has failed to raise a factual issue to preclude summary judgment from being granted to defendant Lesly Honore, M.D.

Accordingly, motion (009) is granted and the complaint and any cross claims asserted against Dr. Honore are dismissed.

The plaintiff's expert stated that Dr. Ross saw the decedent six days later on May 27, 2004, and found the absence of peripheral pulses bilaterally, and appropriately suggested that this finding, along with a non-healing necrotic surgical wound, required non-invasive vascular testing and a vascular surgery consult. However, no one at United Presbyterian ordered the vascular testing or consult, and it was not done until June 2, 2004 when the decedent was transferred to Winthrop Hospital. The plaintiff's expert continued that it was a departure from the standard of care for Dr. Moskowitz not to have ordered an immediate PVR testing and vascular consultation. He stated that timely consults can often involve sensitive issues where delay in treatment can have serious consequences to the patient. However, the plaintiff's expert has not set forth the consequences for the delay in obtaining such testing, irregardless of any issues concerning notification for the testing or consult, and whether such requests were timely made. The plaintiff's expert continued that Dr. Moskowitz should have examined the decedent's peripheral pulses on or after May 4, 2004, and would have discovered an absence of pulses in the left lower extremity, and after the cast was removed from the right lower extremity. Had the PVR testing been done on May 4, 2004, the results would have been grossly abnormal, and angiography would have been required then. However, he does not offer a basis for this conclusory opinion, especially in light of Dr. Honore's testimony that the decedent demonstrated good capillary refill on May 27, 2004, which the plaintiff's expert does not dispute. Plaintiff's expert continues that on June 3, 2004, the PVR was grossly abnormal and required angiography, which was done on June 7, and showed reversible ischemia indicating that the decedent was a good candidate for posterior tibial bypass surgery. The plaintiff's expert continued that, while it is true that the bypass surgery was not done until June 11, 2004, one week after the abnormal PVR, the circumstance that were present and which had contributed to this delay had not been present in May 2004. However, he does not indicate the circumstances which contributed to the delay which had

not been present in May 2004. In light of the plaintiff's expert's opinion, that, by the time Dr. Smirnov revascularized the limb, it was too late to save the limb, but on the other hand, he stated, had revascularization been performed even days earlier, there would have been a chance for long term limb survival. Plaintiff's expert does not set forth how the moving defendants contributed to the delay in surgery once the decedent was admitted to Winthrop Hospital on June 2, 2004, and when the June 3, 2004 PVR results were obtained. Consequently, plaintiff's expert has not demonstrated proximate cause of the decedent's loss of limb and other injuries as to Dr. Ross or any of the moving defendants as they were no longer involved in the decedent's care and treatment. The plaintiff has failed to raise a factual issue as to Dr. Frank Ross as well.

Accordingly, motion (010) by defendant Frank Ross, M.D. is granted and the complaint and any cross claims asserted against him are dismissed.

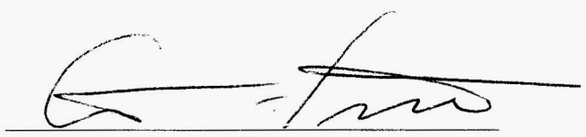
MOTION (011)

Rose Walters seeks an order precluding any of the remaining defendants from asserting the benefits and defenses afforded by CPLR Article 16 in their favor as to any defendant to whom summary judgment has been granted.

Since a summary judgment motion is the procedural equivalent of a trial, it follows therefrom that any defendant intending to obtain the limited liability benefits of CPLR Article 16 must adduce proof on point in admissible form (***Hendrickson v Philbor Motors, Inc.***,102 AD3d 251, 955 NYS2d 384 [2d Dept 2012]; ***Tapogna v Tan***, 2010 NY Slip Op 331818(U) [Sup Ct, Suffolk County]; ***Drooker v South Nassau Communities Hosp.***, 175 Misc2d 181, 669 NYS2d 169 [1988]). In support of preservation of the benefits afforded by Article 16, no defendant has submitted a cross motion setting forth the relief requested, except plaintiff. No party has submitted opposition and an affirmation from his expert setting forth alleged departures by any co-defendant for whom summary judgment has been granted. Thus, the remaining defendants have not demonstrated a basis for preservation of Article 16 benefits as a matter of law as to any of the defendants who have been granted summary judgment.

Accordingly, plaintiffs' motion (011) is granted.

Dated: February 19, 2014



J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION

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