Chin v Khan
2019 NY Slip Op 32163(U)
July 8, 2019
Supreme Court, New York County
Docket Number: 805184/14
Judge: Joan A. Madden
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS PART 11
-- X
JESSIE CHIN, Index No.: 805184/14
Plaintiff,

-against-

FEROZE KHAN, M.D. and RICHMOND
UNIVERSITY MEDICAL CENTER,
Defendants,
-- X
JOAN A. MADDEN, J.:

In this action alleging medical malpractice in connection with the diagnosis, care, and treatment of plaintiff Jessie Chin ("plaintiff") for two pressure ulcers, defendant Richmond University Medical Center ("RUMC") moves and defendant Feroze Khan, M.D. ("Dr. Khan") cross moves for summary judgment dismissing the complaint. Plaintiff opposes the motion and cross motion.

Background

This action seeks to recover damages for bedsore injuries allegedly arising out of defendants' post-operative treatment of the then 19 year-old plaintiff after he suffered a gunshot wound to the right side of his chest on July 21, 2012, and was taken to the emergency department at RUMC. Plaintiff arrived at the emergency department unresponsive and was later transferred to the operating room for emergency surgery, which occurred on July 22, 2012. Following surgery, plaintiff was transferred to the Surgical Intensive Care Unit ("SICU") at RUMC. Plaintiff remained there until September 4, 2012, at which point he was transferred to a step down unit until he was discharged on September 11, 2012. After plaintiff was transferred to the SICU, he was provided with a neurology consult which revealed that the gunshot had caused trauma to his spine. As a result, plaintiff was rendered paraplegic, paralyzed from the waist down. Thereafter, plaintiff received various interventions to deter skin breakdown due to his critical condition. Dr. Khan was plaintiff's attending physician during his stay at RUMC.

The Bill of Particulars alleges that RUMC and Dr. Khan were negligent, committed medical malpractice, and departed from the good and accepted standards of care when they failed to properly prevent, diagnose, and treat plaintiff's pressure sores/ulcers, including by failing to set forth a proper care program to avoid the development of pressure ulcers. While plaintiff alleges various failures in connection with the treatment and care of the pressure sores/ulcers,[1] which are addressed in defendants' expert affidavit, plaintiff has abandoned these departures with the exception of the departures relating to defendants' failure to move and reposition plaintiff every two hours and that Dr. Khan failed to timely evaluate the pressure sores and to direct treatment and to communicate with RUMC's nursing staff regarding plaintiff's development of a pressure sore.

With respect to causation, it is alleged that these departures from the standard of care in the prevention and treatment of plaintiff's pressure sores, including turning and repositioning plaintiff, resulted in plaintiff's injuries, including a stage IV sacral decubitis ulcer; stage II right buttock pressure ulcer; stage IV pressure ulcer at 24 cm in area; placement of picc lines; scarring; skin/tissue weakness at sites of ulcers causing likelihood of repeated pressure ulcers and/or injury requiring future medical treatment including debridement and flap surgery at a cost of $1,000,000; and a blood infection.

[1] These failures included, *inter alia*, failing to order pressure distributive mattresses; failing to provide a Hill-Rom, Clinitron, or other bed designed to prevent pressure sores prior to and during the developments of the pressure sores, as well as after the diagnosis of decubitis ulcers; failing to use air fluidized therapy to reduce pressure to areas of the plaintiff's body; failing to timely order and use hydrocolloid dressings to treat the pressure ulcers; failing to timely use a vacudrain and antibiotic treatment; failing to timely provide proper and necessary wound care; failing to implement the Braden Scale for predicting plaintiff's risk of developing pressure ulcers; negligently and improperly evaluating plaintiff for the risk of pressure ulcers; failing to follow written rules and/or protocols with regard to evaluating plaintiff for the potential risk of developing pressure ulcers and/or prevent against the risk of developing pressure ulcers; failing to timely debride necrotic tissue; failing to provide proper nutritional support; failing to ensure that plaintiff remained clean and dry and allowing plaintiff to remain in a soiled and wet condition for prolonged periods of time; and failing to utilize proper padding and protection to avoid the formation of pressure ulcers.

RUMC moves and Dr. Khan cross moves for summary judgment, arguing that they properly appreciated plaintiff's risk of developing pressure ulcers and instituted appropriate preventative care and wound care from his admission to RUMC on July 21, 2012, until his discharge on September 11, 2012, and that they acted in accordance with the standard of care by timely diagnosing the pressure ulcers and providing appropriate wound care and prevention. Defendants assert that upon admission, plaintiff presented in extremis with multiple co-morbidities, including, but not limited to, a gunshot wound in the chest, bradycardia, severe hypotension, spinal trauma, atelectasis of the right lung, and later suffered ventilator acquired pneumonia, acute respiratory failure, recurrent fevers, leukocytosis, acute renal failure, and incontinence of urine and bowel. Additionally, plaintiff's gunshot wound rendered him paraplegic, paralyzed from the waist down. Due to plaintiff's injuries as well as his co-morbidities, he was considered at high risk for skin breakdown and thus measures were taken to prevent this breakdown, as described in the testimonies of both Dr. Khan and Nurse Annmarie Baratta, who were part of plaintiff's care team at RUMC.

In support of their motions, RUMC and Dr. Khan submit the expert affidavit of Lorraine Domaradzki, R.N., a nurse practitioner licensed to practice nursing in the state of New York. After reviewing the pertinent hospital and medical records, plaintiff's Bill of Particulars, and the deposition testimonies of plaintiff, Ruth Chin, Dr. Khan, and Nurse Baratta, Nurse Domaradzki opines, to a reasonable degree of medical certainty, that RUMC "implemented clear and decisive care plans to ensure plaintiff was given quality care" during his stay at RUMC, including care plans to "address plaintiff's critical state and co-morbidities," and care plans "to ensure plaintiff's skin was properly assessed and cared for" to prevent plaintiff's risk of developing pressure ulcers (Domaradzki Aff ¶ 6). Nurse Domaradzki opines that the nursing notes within the RUMC chart clearly indicate that the care plans aforementioned were "routinely and

regimentally carried out throughout the entirety of plaintiff's admission at RUMC," and that "the nursing staff at RUMC fully complied with these care plans" (Id ¶ 8).

In this connection, Nurse Domaradzki states:

> … the nursing notes clearly document that skin protection measures were utilized, from the early onset of plaintiff's admission, in an effort to prevent plaintiff from developing pressure ulcers… As plaintiff's sacral ulcer progressed, additional interventions, such as Comfeel, pillows for lateral positioning, Tegaderm and foot drop booties were implemented into plaintiff's nursing regimen. The nursing personnel at RUMC daily noted that skin protection measures were carried out throughout plaintiff's admission at RUMC, up until his discharge on September 11, 2012… Putting aside plaintiff's allegations that care plans and interventions to deter skin breakdowns were not properly adhered to, plaintiff was a paraplegic patient within the SICU at RUMC… regardless of whether the RUMC chart notes turning and positioning… or adherence to care plans were carried out, plaintiff received these interventions automatically as he was a patient in the SICU.

(Id ¶ 10).

With respect to repositioning plaintiff, Nurse Domaradzki states that the RUMC nursing chart contains entries since August 1, 2012, which "referenced that plaintiff was in fact turned and positioned on a routine basis" (Id ¶ 11). She further states that after plaintiff's stage II sacral pressure ulcer was discovered on August 7, 2012, he "was continuously turned and positioned every two hours by the nursing staff at RUMC in an effort to ameliorate plaintiff's pressure ulcer and prevent further skin breakdown" (Id). Nurse Domaradzki notes that Nurse Annemarie Baratta testified that turning and positioning a paraplegic patient is "the basic standard of care practiced at RUMC," and that she did not document when she completed these tasks because it "was customary and routine practice" (Id).

Nurse Domaradzki further states that plaintiff's sacral ulcer progressed into a stage III ulcer on August 21, 2012, "despite proper care and treatment rendered by RUMC."[2] By August

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[2] Specifically, she opines that RUMC properly cared for plaintiff's wound by treating the stage III ulcer with hydrocolloid dressings and by assessing the ulcer routinely twice per day (Id ¶ 14).

29, 2012, plaintiff's pressure ulcer had developed to a stage IV pressure ulcer (Id ¶ 15). Nurse Domaradzki opines that this development occurred despite RUMC's proper care and treatment of plaintiff (Id). At this point, Dr. Khan requested a plastic surgeon to examine plaintiff's sacral ulcer (Id). After this, an order was placed for a Flexi-Bed, and the head of plaintiff's bed was elevated about 30 degrees to "reduce pressure and sheer force" (Id). However, Nurse Domaradzki states that "despite RUMC's efforts to reduce plaintiff's risk of incurring any additional skin breakdowns, a stage II pressure ulcer was discovered on plaintiff's right buttock on September 6, 2012" (Id ¶ 16). By September 10, 2012, plaintiff's right buttock ulcer and stage IV sacral ulcer had decreased in size and formed granulation tissue (Id). It was further noted by Dr. Khan on September 11, 2012, that plaintiff's sacral ulcer had granulated fully (Id).

Nurse Domaradzki opines:

> It is my expert opinion, based on a reasonable degree of certainty that RUMC provided plaintiff with proper and diligent care in not only preventing the development of pressure ulcers and skin deterioration; but also in the treatment rendered to the eventual pressure ulcers that developed... Given plaintiff's critical condition when he presented to RUMC, as well as the life-saving surgery performed and sequela of co-morbidities that developed as a result of his gunshot wound, plaintiff developed pressure ulcers despite RUMC's exhaustive interventions to reduce plaintiff's risk for same... plaintiff's critical medical situation and co-morbidities caused his skin to breakdown... plaintiff's paraplegic state put him at high risk for developing pressure ulcers and... given all the proper care in the world, plaintiff could and did develop pressure ulcers. Plaintiff's development of pressure ulcer[s]... were not caused by the care and treatment rendered to him by the staff at RUMC; rather, plaintiff's pressure ulcers were caused by his critical condition and the fact that [he] was paraplegic after sustaining a gunshot wound to his chest.

(Id ¶ 17).

Plaintiff was provided a skin care consultation on August 22, 2016, noting the measurements and appearance of his pressure ulcer, and RUMC continued the use of "Comfeel to plaintiff's buttocks, applications of treatment to the area and noted use of an air mattress" (Id).

Plaintiff opposes RUMC's motion and Dr. Khan's cross motion, asserting that there was insufficient communication between the nursing staff and the attending physician, Dr. Khan, and that Dr. Khan was not aware that plaintiff had developed the initial pressure ulcer until August 22, 2012, over 15 days after it was first discovered by the nursing staff on August 7, 2012. Plaintiff also asserts that throughout his stay at RUMC, the nurses and other health care providers at RUMC "failed to consistently move and reposition [him] every two hours, which all involved acknowledge to be the standard of care," and that this departure is evident from the hospital chart and the fact that plaintiff developed serious stage IV wounds.

In support of his opposition, plaintiff submits the redacted affirmation of a physician licensed to practice medicine in Rhode Island and Connecticut (hereafter, "plaintiff's expert"), who is board certified in plastic surgery, and has "significant experience in the treatment and prevention of pressure ulcers" (Plaintiff's Expert Aff. ¶ 4). Upon review of plaintiff's Bill of Particulars and plaintiff's hospital chart from RUMC, plaintiff's expert opines to a reasonable degree of medical certainty that Dr. Khan and RUMC "were negligent and committed malpractice by failing to turn and reposition the plaintiff, Jessie Chin, every two hours (Q2), and properly documenting the same" (Id). Plaintiff's expert states that the hospital order states that beginning on August 1, 2012, plaintiff was to be turned and repositioned every two hours to prevent the formation of pressure ulcer, and notes Dr. Khan's testimony that as plaintiff was paralyzed it was necessary for him to be moved every two hours (Id ¶ 5). Plaintiff's expert disagrees with Nurse Domaradzki's opinion that the nursing notes clearly indicate the utilization of skin care protection measures, and in particular, opines that "the documentation of turn and position rotation do not support turns every two hours" (Id ¶ 6).

Specifically, plaintiff's expert states:

> After a review of the hospital records, it is clear that the documentation of turn and reposition notations do not support turns every two hours. The order states every two hours (Q2) starting on August 1, 2012 through August 13, 2012 but only (Q12) assessments are documented. (Q12 refers to once ever 12 hours which would be in contravention of defendants own orders, and would be a departure from good and accepted medical practice for a patient who was paralyzed, like the plaintiff, Jessie Chin.) It is clear that the order is for every two hours and only Q12 [is] documented. Based upon the documentation, the plaintiff's testimony, and the fact that Jessie Chin developed a stage IV pressure ulcer, it is clear that this paralyzed patient was not being turned and repositioned every two hours in contravention of the standard of care. During the period of time during which he developed the ulcers, he was not too critically ill to be moved and repositioned at least every two hours, and by doing this he would not have developed the ulcers that he did.

(Id).

Plaintiff's expert further states:

> In the chart there is a change in the order documentation to Q shift (appears to be twelve hours in this setting) from the original Q2 and this continues through August 21, 2012. This change from Q2 to Q12 fits [consistently] with the documentation of turns every twelve hours. It is during this time period, specifically on August 7, 2012, that the pressure ulcers are first documented. Once again, there is a change back to Q12 hour turns on August 29, 2012 and this continues through September 11, 2012. This indicated the decrease in turns from Q2 to Q12 as per documentation.
> During this period of time the ulcer [that] was noted on August 7, 2012 as stage 2, worsened to stage 3 on August 21, 2012… Days later when the wound worsened to stage 4 the turn documentation decreased again from Q2 to Q12. On September 5, 2012 the patient developed a new pressure sore.

(Id ¶ 7).

Plaintiff's expert opines that Nurse Domaradzki's statement "regardless of whether the RUMC chart notes turning and position… plaintiff received these interventions automatically as he was a patient in the SICU," is not supported by the further deterioration of plaintiff's original pressure ulcer from stage II to stage IV, the development of an additional pressure ulcer, and the "clear documentation of Q12 hour turns in all but the date range of August 23 – August 29" (Id). Plaintiff's expert states that during the time in which plaintiff developed the pressure ulcers, in

August 2012, he was not too critically ill to be moved and repositioned every two hours, and that it is clear that the defendants did not adhere to this standard based on plaintiff's development of the two bedsores. Plaintiff's expert further opines, to a reasonable degree of medical certainty, that "had the defendants adhered to the standard of care of turning and repositioning every two hours, it is more likely than not that he would not have developed the pressure wounds, and would not have had to undergo the surgical procedures to address the same" (Id ¶ 8).

Plaintiff's expert also opines that the defendants' failure to follow the known and accepted protocol of turning paraplegic patients every two hours is supported by the testimonies of both the plaintiff, Jessie Chin, and his mother, Ruth Chin, and cites part of plaintiff's testimony in which he states that he was not being turned and repositioned every two hours, and that this only occurred when he was being cleaned by RUMC staff "almost every other morning" (Id ¶ 9). Plaintiff's expert also references Ruth Chin's testimony, where she states that she would visit her son in the hospital daily for approximately three to four hours per day, and that she never observed RUMC staff turn or reposition her son during those visits (Id).

As for Dr. Khan, plaintiff's expert opines that he was negligent and committed malpractice by failing to timely diagnose plaintiff's pressure ulcers, failing to order appropriate treatment, and failing to ensure that such treatment was rendered to plaintiff, and that as plaintiff's attending physician, Dr. Khan was in charge of plaintiff's care and treatment (Id ¶ 10). In this connection, plaintiff's expert notes that while plaintiff's initial pressure ulcer was first noted to exist by RUMC staff on August 7, 2012, it was not until 15 days later, on August 22, 2012, that Dr. Khan became aware of plaintiff's pressure ulcer (Id ¶ 11-12). Plaintiff's expert states that "even once Dr. Khan became aware, the very next day he did not view the wound because turning of the patient is a nursing function," and opines that "this is a departure from

good and acceptable medical practice," since the standard of care regarding treatment of pressure ulcers requires assessment, input, and recommendations from the physician even when nursing protocols are in place, and that Dr. Khan failed to adhere to this standard with plaintiff (Id ¶ 10). Plaintiff's expert further opines that there was a "clear breakdown of communication between the attending physician (Dr. Khan) and the nursing staff, with the nurses failing to notify the attending of a pressure ulcer when it develop[ed], and the physician failing to examine his paraplegic patient and order the appropriate treatment" (Id ¶ 12).

Furthermore, plaintiff's expert opines that:

> The staff at RUMC violated their own protocols which call to "notify the physician of any changes in status of pressure ulcer." As per the deposition of the physician he was first notified of the wound on August 22, 2012 and not on August 7, 2012. If he had been notified it would have been documented… The physician also states that he would have noted the occurrence of a wound in his progress note and would call the plastic surgery wound care team… The very appearance of the wound, and change in stage from 2 to 3 then 3 to 4 and the appearance of a new wound would all constitute "change in status." It seems that notification was ad-hoc at best and quite delayed or not done at worst. There is no clear documentation of status change and discussion. This is in clear violation of the institutional protocol and a departure from good and accepted medical practice.

(Id ¶ 13).

As for causation, plaintiff's expert opines, within a reasonable degree of medical certainty, that the defendants departed from good and acceptable medical practice in their care and treatment of Jessie Chin, and that these departures "were a substantial factor in causing the pressure ulcers, and its sequela thereof as set forth in Plaintiff's Bill of Particulars" (Id ¶ 14).

In reply, both RUMC and Dr. Khan assert that the court should not consider plaintiff's expert affirmation as it is unsworn and thus does not comply with CPLR 2106, which provides that unsworn physician affirmations can only be given the same force and effect as an affidavit when provided by a physician licensed to practice medicine in New York. They also argue that

plaintiff's expert ignores evidence that plaintiff's post-operative condition was a factor in causing plaintiff's pressure sores.

RUMC also asserts in reply that plaintiff's expert's opinion is based on an interpretation of RUMC's chart which contrasts the information provided in the deposition testimony of Nurse Barrata. Specifically, RUMC asserts that plaintiff's expert erroneously claims that "Q12" refers to being turned and repositioned every twelve hours, when the full note reads "QSHIFT12HR," and refers to the duration of the nursing shifts at RUMC, as Nurse Barrata explained in her testimony. Nurse Barrata also testified that the plaintiff was turned every two hours during each twelve-hour shift (Id). RUMC also argues that plaintiff's expert ignores Nurse Barrata's testimony where she states that as a patient in the SICU, plaintiff automatically received skin interventions, "including routine turning and positioning," to avoid breakdown of the skin, and that this was RUMC's custom and practice.

In reply, Dr. Khan additionally argues that the care provided to plaintiff at RUMC was within the standard of care, and that the alleged departures were not a proximate cause of plaintiff's injuries. With respect to plaintiff's expert analysis of plaintiff's medical records, Dr. Khan asserts that plaintiff's expert submitted "conclusory and speculative opinions" with respect to the cause of plaintiff's injuries, and has failed to "articulate the specific manner in which Dr. Khan caused plaintiff's injuries… and… establish the requisite link between Dr. Khan's actions and the injuries."

Discussion

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing "that in treating the plaintiff there was no departure from good and accepted medical practice or that any

departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 A.D.3d 204, 206 (1st Dep't 2010). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record and addresses the essential allegations in the Bill of Particulars. Id The expert opinion relied on by defendant must be based on the facts in the record or those personally known to the expert. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must also "explain what defendant did and why." Id. (quoting Wasserman v. Carella, 307 A.D.2d 225, 226 [1st Dep't 2003]).

In this case, defendants have met this burden based on the expert affidavit of Nurse Domaradzki who opines after reviewing the medical records and other evidence, that there were no departures from standards of practice as to the care and treatment rendered to plaintiff at RUMC with respect to the skin protective measures taken to prevent plaintiff from developing pressure ulcers, and that nothing defendants did or did not do resulted in the asserted injuries to plaintiff.

Accordingly, the burden shifts to plaintiff "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Alvarez v. Prospect Hosp., 68 N.Y.2d 320, 324-325 (1986). Specifically, in a medical malpractice action, this requires that a plaintiff opposing a defendant's summary judgment motion "submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact... General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant['s]... summary judgment motion." Id.

In addition, a plaintiff's expert's opinion "must demonstrate the requisite nexus between the malpractice allegedly committed and the harm suffered." Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 307 (1st Dep't 2007) (internal citations and quotations omitted). If "the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation… the opinion should be given no probative force and is insufficient to withstand summary judgment." Diaz v. Downtown Hospital, 99 N.Y.2d 542, 544 (2002). On the other hand, "[t]he law is well settled that when competing experts present adequately supported but differing opinions on the propriety of the medical care, summary judgment is not proper." (See Rojas v. Palese, 94 A.D.3d 557 (1st Dep't 2012))

Here, based on the opinion of plaintiff's expert, which is supported by the record, including the deposition testimonies of plaintiff, Ruth Chin, Dr. Khan, and RUMC's records, plaintiff has raised triable issues of fact as to whether defendants departed from the applicable standard of care in connection with the turning and repositioning of plaintiff every two hours beginning in August 2012, and as to whether Dr. Khan departed from the standard of care by failing to adequately monitor plaintiff's pressure ulcers during this period, including by failing to communicate with nursing staff in light of the worsening condition of such ulcers.

As for Nurse Domaradzki's position that plaintiff's expert misinterpreted plaintiff's chart as showing that plaintiff was turned every twelve hours, such argument is insufficient to eliminate issues of fact raised by the record regarding whether defendants departed from the standard of care with respect to turning and repositioning plaintiff, which is not documented on the chart to have occurred every two hours. Morever, both plaintiff and his mother[3] testified that

[3]Defendants' assertion that Ruth Chin's visits were limited to three to four hours at a time do not provide a basis for disregarding her testimony, particularly as plaintiff was to be turned every two hours.

plaintiff was not turned and repositioned every two hours. Furthermore, while defendants rely on evidence that plaintiff was in critical condition and was sedated for most of time he was treated at RUMC, factual issues remain as to whether plaintiff was turned and repositioned every two hours once his condition permitted such turning and repositioning, particularly in light of evidence that in August 2012, it was directed that he be turned every two hours.

As for causation, plaintiff has demonstrated "the requisite nexus between the medical malpractice allegedly committed and the harm suffered" (Wasiman, 39 A.D.3d at 307), based on plaintiff's expert's opinion that defendants' departures from the standard of care were a substantial factor in causing or contributing to plaintiff's pressure ulcers and related injuries.[4] Furthermore, with regard to defendants' argument that plaintiff's critical post-operative condition caused him to develop pressure ulcers, such argument ignores that the alleged malpractice "need not be the only cause which produces the injury... [and] [a] plaintiff is not required to eliminate every other possible cause." Mortensen v. Memorial Hospital, 105 A.D.2d 151, 158 (1st Dept 1984)(internal citations and quotations omitted); see also King v. St. Barnabas Hosp., 87 A.D.3d 238 (1st Dept 2011).

Finally, contrary to defendants' argument, the submission of a redacted expert affirmation from an out-of-state physician is not fatal under circumstances where, as here, plaintiff has raised an issue of triable fact. See Cleasby v. Acharya, 150 A.D.3d 605 (1st Dep't 2017) (holding that plaintiff's non-compliant affirmation raised an issue of triable fact and that

[4] The cases relied on by defendants, Swezey v. Montague Rehab & Pain Mgt., P.C, 59 A.D.3d 431, 433 (2d Dep't 2009), and Murray v. Hirsch, 58 A.D.3d 701 (2d Dep't), lv denied 12 N.Y.3d (2009), are not to the contrary. While these cases require that a plaintiff opposing summary judgment in a medical malpractice case show that a departure was a competent producing cause of an injury, plaintiff has met this burden by showing that the asserted departures here resulted in, or worsened, plaintiff's pressure ulcers. In any event, as noted above, case law in the First Department requires that a plaintiff demonstrate a nexus between the alleged departure and the injuries (Wasiman, 39 A.D.3d at 307), and plaintiff has met this standard.

the plaintiff may correct the defect before the motion court), Brightly v. Liu, 77 A.D.3d 874 (2d Dep't 2010) (holding that a defect in an affirmation is not invariably fatal, and that plaintiff may seek leave to renew and submit a notarized affidavit by their medical expert).[5]

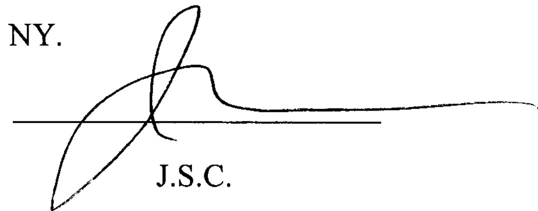
Conclusion

In view of the above, it is

ORDERED that RUMC's motion, and Dr. Khan's cross-motion for summary judgment are denied to the extent that plaintiff has raised triable issues of fact regarding whether defendants departed from the standard of care with respect to the turning and repositioning of plaintiff to prevent pressure ulcers, every two hours beginning in August 2012, and as to whether Dr. Khan departed from the standard of care by failing to adequately monitor plaintiff's pressure ulcers during this period, including through communicating with RUMC's nursing staff; and it is further

ORDERED that the parties shall appear for a pre-trial conference on August 8, 2019, at 11:00 am, in Part 11, room 351, 60 Centre Street, New York, NY.

Date: July 8, 2019



J.S.C.

HON. JOAN A. MADDEN
J.S.C.

[5]Defendants cite Worthy v. Good Samaritan Hosp. Med., 50 A.D.3d 1023, 1024 (2d Dep't 2008) to argue that a redacted affirmation from an out-of-state physician is insufficient to defeat summary judgment. However, unlike the circumstances here, in that case, the court found that the affirmation at issue was insufficient to raise a triable issue of fact.