Short Form Order

SUPREME COURT – STATE OF NEW YORK
TRIAL TERM, PART 7 NASSAU COUNTY

PRESENT:

Honorable Karen V. Murphy
Justice of the Supreme Court

NIGEL FRESCO, as Administrator of the ESTATE OF UNA PAUL FRESO, and NIGEL FRESO, Individually,

Plaintiffs,

-against-

PLAINVIEW HOSPITAL, NORTHWELL HEALTH, INC., d/b/a PLAINVIEW HOSPITAL and CATHOLIC HEALTH SERVICES OF LONG ISLAND, INC., d/b/a CATHOLIC HOME CARE,

Defendant.

Index No. 606006/2017

Motion Submitted: 08/06/2019
Motion Sequence: 001, 002

The following papers read on this motion:

Notice of Motion/Order to Show Cause..... XX
Answering Papers..... XXX
Reply..... XX
Briefs: Plaintiff's/Petitioner's.....

This motion by the defendant Catholic Health Services of Long Island, Inc., d/b/a Catholic Home Care for, *inter alia*, an order pursuant to CPLR 3212 granting it summary judgment dismissing the complaint against it or in the alternative, an order pursuant to CPLR 214-a dismissing any and all claims that accrued on December 25, 2014 is determined as provided herein.

This motion by the defendant Plainview Hospital, Northwell Health Inc., d/b/a Plainview Hospital ("the Hospital") for, *inter alia*, an order pursuant to CPLR 3212 granting it summary judgment dismissing the complaint against it is determined as provided herein.

The plaintiff seeks to recover from Catholic Home Care ("CHC") for the allegedly negligent treatment provided to his mother, the decedent Una Paul Freso, at their home

by its employees from January 21, 2014 through February 3, 2015, with respect to their care of her skin ulcers. He also seeks to recover for negligent hiring, supervision and retention. In his Bill of Particulars, he alleges that CHC failed to perform a proper assessment of his mother for the development ulcers; failed to prevent the further breakdown of her ulcers; failed to heed the decedent's symptoms as they related to the development and worsening of her ulcers; failed to turn and reposition her as it should have; failed to provide adequate nutrition, hydration and pressure relieving devices, failed to keep adequate records; failed to implement and adhere to an effective treatment plan and to modify it when warranted; failed to notify the decedent's physicians of changes in her status and to refer her to a hospital in a timely fashion; and failed to prevent the decedent's medical condition from deteriorating. He also alleges that CHC failed to hire and train proper staff. The defendant CHC seeks dismissal of any and all claims which accrued more than two- and one-half years before this action was commenced pursuant to CPLR 214-a as well as dismissal of all claims pursuant to CPLR 3212.

The plaintiff seeks to recover of the defendant Plainview Hospital, Northwell Health Inc., d/b/a Plainview Hospital ("the Hospital") for medical malpractice based upon the negligent care it allegedly provided his mother, the decedent Una Paul Freso, during her admissions there from January 19 through January 30, 2015; from February 4 through March 17, 2015; and, from July 3 through July 15, 2015. He alleges that the Hospital was negligent in failing to prevent his mother's ulcers, failing to diagnose and treat them, and in failing to prevent their exacerbation which lead to an infection and ultimately her demise. In his Bill of Particulars, the plaintiff alleges that the Hospital failed to timely and adequately examine his mother, failed to properly assess her risk of ulcers, failed to take proper measures to prevent skin breakdown, failed to heed the and detect the symptoms that indicated that his mother was developing ulcers, failed to properly turn and reposition her every two hours and/or as needed; failed to follow up on consultations with specialists to address her ulcers; and, failed to administer proper medications. The defendant Hospital seeks dismissal of all the claims against it pursuant to CPLR 3212.

The facts pertinent to the determination of this motion are as follows:

The decedent began living with her son, the plaintiff, sometime before 2008. While she lived with him, he was responsible for her care but eventually, he had the assistance of Personal Care Aides attending her nearly daily for twelve-hour shifts. The plaintiff testified at his examination-before-trial that even before the aides began, his mother had been diagnosed with dementia, hypertension and diabetes mellitus. In fact, he testified that even when CHC began treating his mother, she had wounds on her back and feet. Plaintiff testified that CHC aides came to care for his mother's wounds and provided him with specific instructions on how to care for her. He was told to make sure that she did not lay on the wounds and to make certain that she moved around at least every two hours. He did recall that he never treated his mother's wounds in any way

despite the extensive periods he was alone with her. He denied being told to check his mother's diaper during the night to ensure that she would not wake up soaked in urine and he could not recall how often he checked her throughout the night. However, at one point he testified that he did turn and reposition his mother every two hours throughout the night but could not state how he was reminded to do so or describe how he accomplished that. He did not recall being told by the aides that his mother was grossly incontinent and that she was soaked in urine when they arrived in the morning. Nor did he recall being told that her wounds worsened due to her incontinence, that her dementia, bladder and urine incontinence worsened her risk of pressure ulcers and that he was responsible for cleaning her when the aides were not there. He also denied being informed that his mother had a decreased life expectancy due to her medical conditions. He admitted however that he knew that diabetes put her circulatory system at increased risk. The plaintiff was unable to provide any details regarding his mother's admissions to the Hospital other than the fact that she was completely bed ridden while there.

Medical Malpractice vs Negligence: Statute of Limitations

"A cause of action to recover damages for medical malpractice accrues on the date of the alleged act, omission, or failure complained of, and is subject to a 2 ½-year statute of limitations"; a three-year statute of limitations applies to an action alleging ordinary negligence (***Santana v St. Vincent Catholic Med. Ctr. of New York***, 65 AD3d 1119, 1119 [2d Dept 2009], lv denied 14 NY3d 707 [2010], *citing* CPLR 214–a; ***Young v New York City Health & Hosps. Corp.***, 91 NY2d 291, 295–296 [1998]) CPLR 214[5]). " 'The distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of the common everyday experience of the trier of the facts (citations omitted)' " (***Jeter v New York Presbyt. Hosp.***, 172 AD3d 1338, 1339 [2d Dept 2019], *quoting* ***Miller v Albany Med. Ctr. Hosp.***, 95 AD2d 977, 978 [3d Dept 1983] [internal quotation marks omitted]). "A defendant who seeks dismissal of a complaint on the ground that it is barred by the statute of limitations bears the initial burden of proving, *prima facie*, that the time in which to commence an action has expired (citations omitted)" (***Mello v Long Is. Vitreo-Retinal Consultant,*** P.C., 172 AD3d 849, 850 [2d Dept 2019], citing CPLR 214–a).

"In applying the statute of limitations, courts 'look to the "reality" or the "essence" of the action and not its form' " (***Pacio v Franklin Hosp.***, 63 AD3d 1130, 1132 [2d Dept 2009], *quoting* ***Matter of Paver & Wildfoerster*** [***Catholic High School Assn.***], 38 NY2d 669, 674 [1976]). " 'In that medical malpractice is simply a form of negligence, no rigid analytical line separates the two' " (***Pacio v Franklin Hosp.***, 63 AD3d at 1132, *quoting* ***Scott v Uljanov***, 74 NY2d 673, 674 [1989]; *citing* ***Weiner v Lenox Hill Hosp.***, 88 NY2d 784, 787 [1996]). "In distinguishing whether conduct may be deemed malpractice or negligence, '[t]he critical factor is the nature of the duty owed to the plaintiff that the defendant is alleged to have breached' " (***Pacio v Franklin Hosp.***, 63 AD3d at 1132 *quoting* ***Caso v St. Francis Hosp.***, 34 AD3d 714, 714 [2d Dept 2006]). "Accordingly, a claim sounds in medical malpractice 'when the challenged conduct "constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician" ' " (***Pacio v Franklin Hosp.***, 63 AD3d at 1132, *quoting* ***Weiner v Lenox Hill Hosp.***, 88 NY2d at 788, *quoting* ***Bleiler v Bodnar***, 65 NY2d 65, 72 [1985]; *citing* ***Scott v Uljanov***, 74 NY2d at 674; ***Bazakos v Lewis***, 12 NY3d 631 [2009]; ***Scivoli v Levit***, 79 AD3d 1011, 1012 [2d Dept 2010]). "In contrast, a claim sounds in negligence 'when "the gravamen of the complaint is not negligence in furnishing medical treatment to a patient, but the hospital's failure in fulfilling a different duty" ' " (***Pacio v Franklin Hosp.***, 63 AD3d at 1132, *quoting* ***Weiner v Lenox Hill Hosp.***, 88 NY2d at 788, *quoting* ***Bleiler v Bodnar***, 65 NY2d at 73; *citing* ***Papa v Brunswick Gen. Hosp.***, 132 AD2d 601 [2d Dept 1987]; ***D'Elia v Menorah Home & Hosp. for the Aged & Infirm***, 51 AD3d 848 [2d Dept 2008]).

"Thus, an action sounds in ordinary negligence when jurors can utilize their common everyday experiences to determine the allegations of a lack of due care" (***Rabinovich v Maimonides Med. Ctr.***, AD3d, 2019 WL 6519430 at *1 [2d Dept 2019], *citing* ***Jeter v New York Presbyt. Hosp.***, 172 AD3d at 1339; ***Reardon v Presbyterian Hosp. in City of N.Y.***, 292 AD2d 235, 237 [1st Dept 2002]). "In contrast, an action sounds in medical malpractice where the determination involves a consideration of professional skill and judgment" (***Rabinovich v Maimonides Med. Ctr.***, 2019 WL 6519430 at *1, *citing* ***Weiner v Lenox Hill Hosp.***, 88 NY2d at 788; ***Bleiler v Bodnar***, 65 NY2d at 72; ***Rey v Park View Nursing Home***, 262 AD2d 624, 626–627 [2d Dept 1999]; ***Payette v Rockefeller Univ.***, 220 AD2d 69 [1st Dept 1996]; ***Halas v Parkway Hosp.***, 158 AD2d 516. 516–517 [2d Dept 1990]; ***Zellar v. Tompkins Community Hosp.***, 124 AD2d 287, 288 [3d Dept 1986]). "More specifically, an alleged negligent act constitutes medical malpractice when it can be characterized as a 'crucial element of diagnosis and treatment' and 'an integral part of the process of rendering medical treatment to [the plaintiff]' " (***Spiegel v Goldfarb***, 66 AD3d 873, 874 [2d Dept 2009], lv denied 15 NY3d 711 [2010], *quoting* ***Bleiler v Bodnar***, 65 NY2d at 72). "Obviously, not every negligent act of a nurse would be medical malpractice, but a negligent act or omission by a nurse that constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician constitutes malpractice" (***Bleiler v Bodnar***, 65 NY2d at 72). "In the sphere of cases dealing with whether claims are governed by the

2½-year statute of limitations for medical malpractice versus the 3–year statute of limitations for ordinary negligence the medical malpractice statute of limitations has been applied to actions involving the alleged negligent conduct of nonphysicians who rendered medical-related services, including nurses whose duties were related to medical treatment (***Rabinovich v Maimonides Med. Ctr.***, AD3d, 2019 WL 6519430 at *2, *citing* CPLR 214–a; CPLR 214[3], [4], [5]; ***Bleiler v Bodnar***, 65 NY2d at 71; ***Bamert v Central Gen. Hosp.***, 53 NY2d 656 [1981], affg 77 AD2d 559 [2d Dept 1980]; ***Schmitt v Medford Kidney Ctr.***, 121 AD3d 1088, 1089 [2d Dept 2014]).

The plaintiff couches his claims as sounding in ordinary negligence despite the fact that the issue presented here is, *inter alia*, whether the care provided by CHC's employees in treating the decedent's skin conditions and skin ulcers was appropriate. Furthermore, in the event that the claims are in fact found to sound in medical malpractice, the plaintiff maintains that he is entitled to recover for the entire period during which CHC cared for his mother pursuant to the continuous treatment doctrine.

The plaintiff alleges that CHC's employees were negligent in their care and treatment of the plaintiff's skin including bed sores and pressure ulcers. The prevention as well as care and treatment of skin abrasions, ulcers and wound care falls within the realm of medical care, not ordinary negligence (***Cummings v Brooklyn Hosp. Ctr.***, 147 AD3d 902, 903 [2d Dept 2017]; ***Messina v Staten Is. Univ. Hosp.***, 121 AD3d 867, 868 [2d Dept 2014]; ***Pacio v Franklin Hosp.***, 63 AD3d at 1131; ***O'Connor v Kingston Hosp.***, 166 AD3d 1401, 1402 [3d Dept 2018]). Therefore, the medical malpractice Statute of Limitations of two and one-half years applies (CPLR 214-a). In fact, in opposing CHC's motion, the plaintiff's expert opines that "the Defendant's conduct constitutes medical treatment and bears a substantial relation to the rendition of medical treatment and bears a substantial relation to the rendition of medical treatment by a licensed physician," thereby conceding that the plaintiff's claims against CHC sound in medical malpractice.

CHC has established that the plaintiff's claims which accrued before December 25, 2014, two- and one-half years before this action was commenced are untimely.

The plaintiff maintains that all of his claims against CHC are timely under the application of the continuous treatment doctrine. The law with respect to that doctrine is as follows:

"Under the continuous treatment doctrine, the period of limitations does not begin to run until the end of the course of treatment if three conditions are met: (1) the patient 'continued to seek, and in fact obtained, an actual course of treatment from the defendant

physician during the relevant period'; (2) the course of treatment was 'for the same conditions or complaints underlying the plaintiff's medical malpractice claim'; and (3) the treatment is 'continuous'. To satisfy the requirement that treatment is continuous, further treatment must be explicitly anticipated by both the physician and the patient, as demonstrated by a regularly scheduled appointment for the near future. 'The law recognizes, however, that a discharge by a physician does not preclude application of the continuous treatment toll if the patient timely initiates a return visit to complain about and seek further treatment for conditions related to the earlier treatment' " (***Hillary v Gerstein***, AD3d, 2019 WL 6519774 [2d Dept 2019], *quoting* ***Gomez v Katz***, 61 AD3d 108, 111–113 [2d Dept 2009]; ***Roca v Perel***, 51 AD3d 757, 760 [2d Dept 2008]; ***Young v New York City Health & Hosps. Corp.***, 91 NY2d at 296 [internal quotation marks omitted]; ***McDermott v Torre***, 56 NY2d 399, 406 [1982]; ***Ramos v Rakhmanchik***, 48 AD3d 657, 658 [2d Dept 2008]).

"A patient's continuing general relationship with a physician, or routine, periodic health examinations will not satisfy the doctrine's requirement of continuous treatment of the condition upon which the allegations of medical malpractice are predicated" (***Young v New York City Health & Hosps. Corp.***, 91 NY2d at 296).

CHC has submitted the affirmation of Luigi M. Capobianco, M.D. in support of its motion. Having reviewed the pertinent legal and medical records, he opines to a reasonable degree as follows:

Dr. Capobianco describes the process followed by the parties here in detail: First the plaintiff's doctor had to determine the level of services required. Next, an authorization for those services had to be obtained from the decedent's health insurer. Then, physician's orders had to be issued and a referral for home care services had to be issued by the insurer. Even then, only the services that had been approved could be provided for the period specified. Once that period came to an end, Home Health Change of Care Notices were provided, and Discharge Notices were issued along with a Notice of the right to appeal that decision. The services were terminated unless and until a new physician's order and authorization for services was issued.

Dr. Capobianco notes that CHC provided care to the decedent on seven separate occasions, to wit: From March 4, 2014 through April 1, 2014; May 6, 2014 through June 18, 2014; June 21, 2014 through July 4, 2014; July 14, 2014 through September 9, 2014; September 26, 2014 through November 14, 2014; November 27 through January 19, 2015; and, January 30, 2015 through February 1, 2015. Dr, Capobianco opines that for each session, CHC provided skilled nursing services and restorative therapy for different conditions, each of which was ordered separately by various physicians and clearly terminated when completed. There is no evidence that there was ever any anticipation of

further treatment, let alone treatment of the condition which treatment had been provided for.

Via Dr. Capobianco, CHC has established that the claims that accrued before December 25, 2014, which are the majority of the claims, are untimely and that the continuous treatment doctrine does not apply here (***Chambers v Mirkinson***, 68 AD3d 702, 705 [2d Dept 2009]). CHC's care of the decedent was clearly limited to precise segments of time for discrete problems. Each regiment of care was distinct and separate. Each treatment was prescribed by a physician, approved by the decedent's insurer and ran for a specific period of time. Further treatment was not anticipated when each certified period ended. In fact, each time an order was issued to CHC to provide care for the decedent, there was a certified period during which the services could be provided; absent a doctor's order prescribing further services, CHC no longer had any contact whatsoever with the decedent. Each session ended with a clear discharge indicating that CHC's services had come to an end and were terminated. Again, there was never any expectation that further treatment was anticipated let alone for the same conditions. In fact, the plaintiff executed discharge notices at the end of every session and was advised of his right to appeal the termination of services. And, there is no evidence that the decedent ever returned to CHC seeking further treatment for conditions related to previous treatment (***Chambers v Mirkinson***, 68 AD3d at 705).

Assuming, arguendo, that all of the claims advanced here were timely, CHC has nevertheless established its entitlement to summary judgment dismissing all of them.

"The requisite elements of proof in a medical malpractice action are a deviation or departure from accepted community standards of practice and evidence that such departure was a proximate cause of injury or damage (citations omitted)" (***Stiso v Berlin***, 176 AD3d 888, 889 [2d Dept 2019]). In addition to negligence, there must be damages that resulted therefrom in order for a plaintiff to recover for medical malpractice; Absent causation, liability does not lie (***Anonymous v Gleason***, 175 AD3d 614, 617 [2d Dept 2019]). "To prevail on a motion for summary judgment in a medical malpractice action, a defendant must establish, *prima facie*, either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries (citations omitted)" (***Stiso v Berlin***, 176 AD3d at 889). Once a defendant meets his or her burden, "the burden then shifts to the plaintiff to produce evidence in admissible form sufficient to establish the existence of triable issues of fact" (***Stiso v Berlin***, 2019 WL 5057390 at *1, citing ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 324 [1986]; ***Stukas v Streiter***, 83 AD3d 18, 25–26 [2d Dept 2011]), but only with respect to the issues the defendant has established, i.e., either a deviation or departure from accepted community standards of practice or evidence that such departure was a proximate cause of injury or damage, or both (***In***

***Sook Choi v Doshi Diagnostic Imaging Services**, P.C.*, 152 AD3d 750, 751-52 [2d Dept 2017]).

" ' "[A] plaintiff must submit evidentiary facts or materials to rebut the defendant's *prima facie* showing, so as to demonstrate the existence of a triable issue of fact' " (***Alvarez v Gerberg***, 83 AD3d 974, 975 [2d Dept 2011], *quoting* ***Stukas v Streiter***, 83 AD3d at 24], *quoting* ***Deutsch v Chaglassian***, 71 AD3d 718, 719 [2d Dept 2010]). "Although conflicting expert opinions may raise credibility issues which can only be resolved by a jury, expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact (citations omitted)" (***Wagner v Parker***, 172 AD3d 954, 955 [2d Dept 2019]). " 'In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on "specifically cited evidence in the record" ' " (***Wagner v Parker***, 172 AD3d at 955, *quoting* ***Tsitrin v New York Community Hosp.***, 154 AD3d 994, 996 [2d Dept 2017], *quoting* ***Roca v Perel***, 51 AD3d at 759). " 'An expert opinion that is contradicted by the record cannot defeat summary judgment' " (***Wagner v Parker***, 172 AD3d at 955, *quoting* ***Bartolacci–Meir v Sassoon***, 149 AD3d 567, 572 [1st Dept 2017]). " '

Dr. Capobianco notes that CHC did not ever provide home health aide services to the decedent. Nor did it provide medical equipment, supplies, meals, nutritional supplements, prosthetics, orthotics, podiatric care or transportation. Dr. Capobianco opines that the plaintiff's allegations that CHC failed to prevent further skin breakdown, failed to turn and reposition the decedent every two hours and as needed, failed to provide proper nutrition, hydration and hygiene to her, and failed to implement proper pressure relieving devices and equipment are meritless. The administrator Guildnet was at all times responsible for arranging for those things. Nor were CHC's employees responsible for caring for the decedent around the clock: that job belonged to the Personal Care Assistants and the plaintiff and included meal preparation, grooming, dressing, bathing, toileting, diaper changes, ambulation, medication administration, instituting and maintaining adequate pressure relief measures, shopping, laundry, housekeeping and accompanying the decedent to medical appointments. Dr. Capobianco notes that the decedent's medical records are replete with the plaintiff's failure to follow instruction in caring for his mother, including repositioning her, cleaning her when soiled, administering her medications as prescribed, ensure her dietary and nutritional quotas were being met and keeping his mother clean when the aides were not present. Dr. Capobianco opines that those failures contributed significantly to the worsening of the decedent's skin condition. He opines that it was the plaintiff's and Personal Care Aides' failure to adhere to the care plan implemented by CHC that caused the decedent's injuries. Dr. Capobianco attributes the plaintiff's failure to comply with CHC's staff's instructions regarding pressure relief measures to the decedent experiencing prolonged

pressure to portions of her body including her right heel which was only exacerbated by the decedent's pre-existing co-morbidities, decreased physical and neurological capacity and bladder and bowel control. Similarly, Dr. Capobianco opines that the decedent's skin breakdown was also the result of diabetic and ischemic wounds which were consistent with the natural progression of her physical and neurological decline. Likewise, the decedent's hypertension, congestive heart failure, bladder and bowel incontinence and limited mobility hindered her ability to perfuse her major organs including her skin, thereby contributing to its break down.

Dr. Capobianco also opines that CHC's employees provided care and restorative services in conformity with the decedent's physicians' orders which included keeping the medical providers and the decedent's insurer agent Guildnet aware of the decedent's response to treatment. From his review of the decedent's CHC records, he opines that CHC'S employees properly performed wound and pain assessments, wound measurements and descriptions and treatments at the appropriate frequencies as ordered by the decedent's doctors. He also opines that all of the orders received by CHC were appropriate and its employees never had cause to question any of them. And, when warranted, they took action to verify orders. Dr. Capobianco opines that whether or not the decedent responded favorably to the treatments was not within CHC's employees' domain; their responsibility was to relay her responses to treatment and significant changes in her status to her physicians, which they did. And, again, he opines that the development of additional wounds was because of her co-morbidities.

Dr. Capobianco opines that Plainview Hospital Hyperbaric and Wound Care Center was the primary caregiver for the decedent's wound care and that CHC provided only supplemental home wound care in coordination with the physicians at the Hyperbaric and Wound Care Center. The physicians at the Hyperbaric and Wound Care Center evaluated the decedent's wounds and ordered treatment including local wound treatment, sharp debridement and hyperbaric treatment. It was the decedent's doctors' responsibility to order wound care; CHC was only responsible for carrying out the physicians' orders, which it did. He opines that CHC's employees' care of the decedent conformed with that directed by her doctors and that they communicated regularly with the decedent's caregivers to coordinate care. He opines that the decedent's records do not reflect any deviations from care by CHC's staff. In conclusion, he opines that the care provided by CHC's staff to the decedent was within the accepted standards of nursing and restorative care and did not deviate or depart from the orders provided them. Nor did he observe any omissions or affirmative acts of negligence by the CHC's staff in their care and treatment of the decedent. Furthermore, he opines that CHC's care and treatment of the decedent was not a proximate cause of harm to her and did not contribute to her condition.

Via Dr. Capobianco's affirmation, CHC has established its entitlement to summary judgment dismissing the claims against it sounding in medical malpractice. It has established that the care provided by its employees conformed to the standard of care and that nothing its staff did or failed to do was a proximate cause of the decedent's injuries, including her death. The burden shifts to the plaintiff to establish the existence of material issues of fact with respect to negligence as well as proximate cause.

"Generally, where an employee is acting within the scope of his or her employment, the employer is liable for the employee's negligence under a theory of respondent superior and no claim may proceed against the employer for negligent hiring, retention, supervision or training (citations omitted)" (***Quiroz v Zottola***, 96 AD3d 1035, 1037 [2d Dept 2012]). "However, 'such a claim is permitted when punitive damages are sought based upon facts evincing gross negligence in the hiring or retention of an employee (citations omitted)' " (***Quiroz v Zottola***, 96 AD3d at1037, *quoting* ***Coville v Ryder Truck Rental***, 30 AD3d 744, 745 [3d Dept 2006]). The plaintiff has not stated a claim for punitive damages. In view of the fact that the plaintiff seeks to hold CHC vicariously liable for its employees' alleged malpractice, the negligent hiring and supervision claims are dismissed.

CHC has also established its entitlement to summary judgment dismissing the claim for negligent hiring, retention and training. The burden also shifts to the plaintiff to establish the existence of a material issue of fact with respect to that issue as well.

The plaintiff has submitted an affidavit of a physician Board Certified in Internal and Geriatric Medicine. Having reviewed the pertinent legal and medical records, s/he opines to a reasonable degree of medical certainty as follows:

The plaintiff's expert opines that the care and treatment provided by CHC to the decedent departed from the accepted standards of care and was a cause of her development as well as the deterioration of her pressure ulcers and death. S/he opines that CHC failed to institute and adhere to an effective care plan for the decedent despite the fact that she was at an increased risk of developing ulcers from when they began caring for her. S/he faults CHC for failing to turn and reposition the decedent every two hours and/or ensuring that she was. While s/he acknowledges that CHC's records reflect that both the plaintiff as well as the Personal Care Aides were instructed on turning and repositioning the decedent, s/he opines that the decedent's caregivers were never evaluated to determine whether they were qualified for those tasks and there are no records of when they performed them. The plaintiff's expert also faults CHC for not turning and repositioning the decedent when they visited, for failing to stage and size her ulcers and for failing to provide wound care. S/he also faults CHC for not modifying the decedent's care plan when her Braden score worsened and for failing to assess the

decedent's albumin level, order a dietary nutritional consult, order a special mattress or boots and failing to use Mediplex in treating the decedent's ulcers. All of these errors are alleged to constitute a departure from the standard of care and to be causative elements of the decedent's ulcers and their deterioration. The plaintiff's expert also opines that because the decedent's son is not a medical professional, his failure to comply with CHC's instructions cannot be a proximate cause of the decedent's ulcers.

The plaintiff's expert opines that "documentation of pressure ulcers is essential in ensuring that [they] are aggressively ....treat[ed]." S/he also faults CHC for the failure to document that instructions were provided and when the decedent was turned and repositioned. While s/he acknowledges that the record reflects that "instructions" were provided, s/he opines that alone is conclusory. S/he opines that the decedent's records do not reflect whether adequate instructions were provided to the plaintiff and/or the Personal Care Aides including demonstrations of techniques. She opines that this constitutes a departure from the standard of care and was a proximate cause of the development and deterioration of the decedent's ulcers. S/he opines that CHC's employees' failure to "ensure" that the decedent was turned and repositioned every two hours and their failure to turn and reposition her every two hours was a departure from the applicable standard. S/he opines that CHC should have created a "written repositioning schedule" and that the decedent should have been on a pressure redistribution mattress. S/he opines that these errors, too, were a cause of the development of the decedent's ulcers. The plaintiff's expert also opines that CHC's failure to establish a record keeping system for the decedent's caregivers indicating the timing and positioning of turns was a departure from the standard of care and also contributed to the development of her ulcers. S/he also opines that proper turning and repositioning was not being done every two hours and that, too was a departure by CHC's employees. Similarly, s/he opines that the failure by CHC's employees to stage and size the decedent's ulcers affected their care and was also a departure from the applicable standard. To the extent that the ulcers were staged and sized, the plaintiff's expert opines that it was inconsistent and also negatively affected the decedent.

The plaintiff's expert also opines that the decedent's ulcers were not "clinically unavoidable" despite her numerous co-morbidities and that the ulcers and the decedent's death could have been avoided with "proper medical, nursing, and home health care, provided by and under the supervision of [CHC]." In fact, s/he opines that in view of the decedent's well-known increased risk of ulcers, "greater attention should have been paid to her care and treatment, including turning and positioning." S/he opines that the decedent's co-morbidities do not cause ulcers. The plaintiff's expert also opines that the decedent was continuously treated by CHC from January 21, 2014 through February 3, 2015 and she was therefore continuously treated by it. S/he affirms that the records reflect that CHC saw the decedent at least once a week during that time period and

consistently had ongoing certifications to treat her for her medical conditions including her ulcers, She opines that CHC's care of the decedent did not stop and restart.

The plaintiff has not met his burden. The plaintiff's expert's referral to CHC's continuous presence and interaction with the decedent are blatantly refuted by the records. While his expert continues to fault CHC for the plaintiff not being turned every two hours, that was not their responsibility. Visits by CHC's staff consisted of only a half hour to an hour a few days a week; it was the plaintiff and the Personal Care Aides' responsibility to meet the decedent's daily needs. Guildnet, the decedent's insurer, coordinated those services. The plaintiff even testified that CHC's employees were only there for half hour or hour shifts during which time they would clean and dress the decedent's wound and instruct him and the aides on how to care for the decedent. The Personal Care Aides were at the decedent's home 12 hours a day and even the plaintiff testified at his examination-before-trial that they were responsible for taking care of his mother. They would "move her around, shift her, make sure that she is mobile in moving around;" "bath her," "take care of her," and "go with her to doctor's visits." He also testified that they brought her food, walked her around, brought her to the bathroom, cleaned her and showered her. The plaintiff also testified that CHC's employees showed him and the aides how to move his mother around and that they were instructed by CHC to move her every two hours. The importance of the decedent being repositioned was certainly emphasized by the Plainview Hospital Hyperbaric and Wound Care Center. The decedent was brought there by either the plaintiff or a Personal Care Aide and either the decedent, the plaintiff or the aide was provided with written wound care instructions. In fact, the plaintiff testified that the Plainview Hospital Hyperbaric and Wound Care Center arranged for CHC to visit the decedent at her home at times. Similarly, while the plaintiff faults CHC for the decedent not being provided with pressure relieving tools, her records clearly indicate that she in fact was. She had pressure relieving mattresses on her bed and her wheel chair as well heel lift boots.

The defendant Catholic Health Services of Long Island, Inc., d/b/a Catholic Home Care motion is granted in its entirety and the complaint against it is dismissed.

The Hospital has submitted the affirmation of Lawrence Diamond, M.D., who is Board Certified in Family Medicine and Geriatrics. Having reviewed the pertinent legal and medical records, he opines to a reasonable medical certainty as follows:

Dr. Diamond notes that the decedent was an elderly frail women with numerous medical issues when she began being treated at the Hospital's Hyperbaric Wound Care Center in June 2014. He also opines that in light of her numerous medical issues, there was no medical treatment available that would have successfully prevented the progression of her ulcers that had developed while she was being cared for at home by

her son with limited assistance from caregivers. He explains that her body lacked the resources to repair itself at that stage since she was debilitated, malnourished and demented.

Dr. Diamond opines that the decedent's family was not realistic with respect to the decedent's condition. When she was at the Hospital, she was well into her 80's with multiple medical conditions. Furthermore, she had been living at home under her son's care with only part time assistance which was woefully insufficient to prevent her ulcers from developing and her medical condition to deteriorate. In fact, in light of her condition when she presented to the Hospital in June 2014- she presented with numerous ulcers in a number of places- Dr. Diamond questions the quality of the care she had been receiving at home. He notes that the decedent's medical records reflect sacral and heel ulcers being present before she presented at the Hospital in January 2015 and that she had been receiving treatment on seven separate ulcers at the Hyperbaric and Wound Care Center before she was hospitalized. Thus, he opines that her sacral ulcer was in an advanced state before she was hospitalized for the first time.

Dr. Diamond opines as follows :"[D]uring each of the hospital admissions, in January and February 2015, the physicians and hospital nursing staff properly documented and measured all of the ulcers present and instituted an appropriate and detailed Plan of Care which entailed regular dressing changes and wound care consultations and treatment. ...[A]n infectious disease consultation was properly requested and [the decedent] was properly placed on the correct antibiotic and proper cultures and biopsies were taken and antibiotics properly changed pursuant to test results." He further notes that the decedent's care was not left solely to the nursing staff, rather, the podiatry and specialized wound care physicians were involved from the outset and rendered appropriate care during the decedent's admissions in the Hospital. Debridements were timely and properly performed, a wound vac was placed on the decedent's sacral wound and there was a proper determination that she was not eligible for surgery in light of her chronic medical issues and debilitated condition. Dr. Diamond opines that the decedent's co-morbidities, lack of mental capacity, poor food and liquid intake and age conspired against her and prevented her healing despite the appropriate care she was provided. Dr. Diamond opines that the decedent's condition required far more extensive care than her son could provide at home which lead to a decline in her condition and prevented the ulcers from being able to be fully treated once she was hospitalized. He opines that despite the fact that the decedent received all the appropriate care at the Hospital, her ulcers did not heal. Finally, Dr. Diamond opines that the staff of the Hospital did not commit any of the acts alleged in the plaintiff's Bill of Particulars.

The Hospital has also established its entitlement to summary judgment dismissing the complaint against it (***Vargas v St. Barnabas Hosp.***, 168 AD3d 596, 596 [1st Dept

2019]). The burden shifts to the plaintiff to establish the existence of an issue of fact with respect to whether the care and treatment provided by the Hospital to the decedent conformed to the applicable standard of care as well as whether an act or omission by them was a proximate cause of the decedent's injuries and death.

In opposition to the Hospital's motion, the plaintiff relies on an affirmation of a physician Board Certified in Internal and Geriatric Medicine. Having reviewed the pertinent legal and medical records, he opines to a reasonable degree of medical certainty as follows:

The plaintiff's expert opines that the Hospital's care and treatment of the decedent was not in accordance with good and accepted medical practice, that there were departures and deviations from the standard of care and that its negligence was the proximate cause of the decedent's development of ulcers, their deterioration and her demise. S/he alleges that the Hospital staff departed from good and accepted practice in several ways.

The plaintiff's expert opines that the Hospital Staff failed to accurately and consistently stage and/or size the decedent's ulcers. The plaintiff's expert opines that "documentation of pressure ulcers is essential in ensuring that [they] are aggressively ....treat[ed], " and that the Hospital's failure to stage and size the decedent's ulcers was a deviation from good and accepted medical practice and that that failure was a proximate cause of their development and worsening.

The plaintiff's expert also opines that the Hospital's failure to keep records of the decedent being turned and repositioned including timing and positioning as well as what instructions were given the staff which is vital in caring for pressure ulcers constituted a departure from the accepted standard of care and was also a proximate cause of the development and deterioration of the decedent's ulcers. S/he opines that the failure to implement a reliable record keeping system was a departure from the standard of care as well as a cause of her pressure ulcers. Based on the lack of records, the plaintiff's expert opines that the Hospital failed to make sure the decedent was turned and repositioned every two hours and failed to take into consideration her postural alignment which contributed to the ulcers' development and deterioration. S/he also opines that based on the foregoing, the decedent in fact was not turned and repositioned every two hours which was a departure from accepted standards and a cause of her injuries.

The plaintiff's expert also opines that the hospital departed from good and accepted standards by failing to use pressure relieving devices including a specialized mattress, heel boots, wedges and pressure relieving pillows. S/he opines that in light of the decedent's status, pressure relieving interventions should have been applied and

provided to her soon after her admission and that the failure to do that was a proximate cause of her pressure ulcers as well as their deterioration.

The plaintiff's expert also opines that the Hospital's failure to test the decedent's albumin levels consistently was a departure from the standard of care since below average albumin levels indicate that a patient is at a higher risk of developing ulcers and bed sores. Similarly, s/he opines that the Hospital's failure to call for a nutritional consultation as well as to provide the decedent with a protein supplement in light of the decedent's low albumin levels, low Braden scores and rapidly deteriorating pressure ulcers constituted a departure from the standard of care as well as a proximate cause of her ulcers' development and worsening.

The plaintiff's expert also opines that the decedent's ulcers were not "clinically unavoidable" despite her numerous co-morbidities and that the ulcers and the decedent's death could have been avoided with "proper medical, nursing, and general health care, provided by and under the supervision of [the Hospital]." In fact, s/he opines that in view of the decedent's well-known increased risk of ulcers, "greater attention should have been paid to her care and treatment, including turning and positioning." S/he opines that the decedent's co-morbidities do not cause ulcers; unrelieved pressure does and therefore, the decedent's pressure ulcers could have been prevented if the defendants had not failed to relieve pressure from the decedent's bony protuberances.

In Reply, the Hospital's expert Dr. Diamond explains that any failure to consistently stage or size the decedent's ulcers did not affect the manner in which they were treated and therefore was not a proximate cause of the decedent's injuries. He also opines that in any event, the standard of care in a hospital does not require ulcers to be staged daily; rather, everyone to two weeks is sufficient with intermittent observations. And, Dr. Diamond tracks in fine detail the entries in the decedent's chart which clearly reflects that her ulcers were in fact carefully tracked by the Hospital's staff.

As for the alleged lack of adequate record keeping regarding turning and repositioning, "[a] failure to document each element of the skin care protocol does not equate to a failure to perform each element or to a cause of the ulcer itself" (***Braunstein v Maimonides Med. Ctr.***, 161 AD3d 675, 675 [1st Dept 2018], *citing* ***Topel v Long Is. Jewish Med. Ctr.***, 55 NY2d 682, 684 [1981]; ***Rivera v Jothianandan***, 100 AD3d 542, 543 [1st Dept. 2012], lv denied 21 NY3d 861 [2013]). Furthermore, Dr. Diamond has explained that at Hospitals, it is not required that every turn and repositioning be charted including the time and exact positioning. Rather, the development of a Plan of Care is required, and it is expected that the staff will abide by the plan. Here, there was an Adult Plan of Care in place beginning on February 4, 2015 which required that the decedent be turned and repositioned every two hours and noted that her son asked that she not be

placed on her back. In addition, Dr. Diamond cites the numerous chart entries during the decedent's admission in the Hospital which reflect consistent efforts to keep the decedent in positions which assisted in healing her ulcers including the use of specialty mattresses and heel elevation. Furthermore, Dr. Diamond notes the numerous entries in the decedent's chart which reflect persistent detailed care of the decedent's ulcers which related to positioning including only being positioned on her side to avoid pressure on her sacrum ulcer, devices to be used, cleansing and dressing instructions, etc. Dr. Diamond again opines that the decedent was appropriately turned and repositioned throughout her hospital stay and the lack of detailed record keeping is irrelevant.

And, contrary to the plaintiff's expert's conclusions, Dr. Diamond notes that the medical records indicate that numerous pressure relieving devices were used including an appropriate specialty bed, heel boots and elevation devices. And, Dr. Diamond opines that there has been no showing why Hydrogel should have been utilized as opposed to Santyl, which he opines was appropriate. In fact, even the plaintiff's expert fails to demonstrate how or why it would have been the better course here and therefore has not made any showing with respect to causation.

As for the failure to test the decedent's albumin levels often enough and to order a nutritional consult, Dr. Diamond opines that there was no need to test it any more often than was done here since the decedent was elderly and infirm. He notes that there was a nutritional assessment and multi-vitamins and protein supplement shakes were ordered and provided. He opines that more frequent albumin level testing and nutritional consults would have been of no consequence here. The court notes that the plaintiff did not correlate the failure to test the decedent's albumin levels more frequently with any damages.

In opposition, the plaintiff has submitted a conclusory affirmation, which voices opinions that are simply unsupported by the record and more importantly, have not been shown to have related to the plaintiff's injuries or her demise. The plaintiff has failed to establish the existence of an issue of fact with respect to either the Hospital's negligence or proximate cause (***Vargas v St. Barnabas Hosp.***, 168 AD3d at 597 [1st Dept 2019]; ***Craig v St. Barnabas Nursing Home***, 129 AD3d 643, 644 [1st Dept 2015]; ***Negron v St. Barnabas Nursing Home***, 105 AD3d 501, 501 [1st Dept 2013]).

The defendant Plainview Hospital, Northwell Health Inc., d/b/a Plainview Hospital's motion for summary judgment dismissing the complaint against it is granted.

In conclusion, the defendant Catholic Health Services of Long Island, Inc., d/b/a Catholic Home Care and Plainview Hospital, Northwell Health Inc., d/b/a Plainview

Hospital's motions for summary judgment dismissing the complaint against them are granted and the complaint is dismissed in its entirety.

The foregoing constitutes the Order of this Court.

Dated: December 23, 2019
Mineola, NY

Karen V. Murphy
J.S.C.
XXX

ENTERED
JAN 02 2020
NASSAU COUNTY
COUNTY CLERK'S OFFICE