Martinez-Rivera v Gupta
2020 NY Slip Op 35089(U)
August 31, 2020
Supreme Court, Westchester County
Docket Number: Index No. 63306/2018
Judge: Charles D. Wood
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as of right (CPLR 5513[a]), you are advised to serve a copy
of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

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LUZ MARTINEZ-RIVERA,

Plaintiff,

-against-

DECISION & ORDER
Index No.: 63306/2018
Seq Nos. 1,2,3

SHIKTA GUPTA, M.D., LOUIS KAPLAN, M.D., BRONX HARBOR HEALTH CARE COMPLEX INC. d/b/a KINGS HARBOR MULTICARE CENTER and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendants.

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WOOD, J.

New York State Courts Electronic Filing ("NYSCEF") Documents Numbers 108-185, were read in connection with separate motions for summary judgment of moving defendants Louis Kaplan, P.A., (Seq 1); Shikta Gupta, M.D. (Seq 2); and Bronx Harbor Health Care Complex Inc. d/b/a Kings Harbor Multicare Center (Seq 3).

Plaintiff brings this action sounding in medical malpractice, negligence, negligent hiring and supervision, and violation of the Public Health Law §2801-d against medical personnel and the hospital from complications from right leg surgery stemming from injuries sustained from a motor vehicle accident.

On March 18, 2011, plaintiff, then 78 years of age, was a pedestrian struck by a motor vehicle, and sustained a severely comminuted fracture of the right proximal tibia with

displacement of the medial and lateral plateaus. Plaintiff allegedly developed complications from the wound sites. As a result, plaintiffs commenced this action.

Now, based upon the foregoing, the motions are decided as follows:

It is well-settled that a 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 demonstrate the absence of any material issues of fact" (Alvarez v Prospect Hospital, 68 NY2d 320, 324 [1986]; see Orange County-Poughkeepsie Ltd. Partnership v Bonte, 37 AD3d 684, 686-687 [2d Dept 2007]; see also Rea v Gallagher, 31 AD3d 731 [2d Dept 2007]). Failure to make such a prima facie showing requires a denial of the motion, regardless of the sufficiency of the motion papers (Winegrad v New York University Medical Center, 64 NY2d 851, 853 [1986]; see Jakabovics v Rosenberg, 49 AD3d 695 [2d Dept 2008]; see also Menzel v Plotkin, 202 AD2d 558, 558-559 [2d Dept 1994]). Once the movant has met this threshold burden, the opposing party must present the existence of triable issues of fact (see Zuckerman v New York, 49 NY2d 557, 562 [1980]; see also Khan v Nelson, 68 AD3d 1062 [2d Dept 2009]). In deciding a motion for summary judgment, the court is "required to view the evidence presented in the light most favorable to the party opposing the motion and to draw every reasonable inference from the pleadings and the proof submitted by the parties in favor of the opponent to the motion" (Yelder v Walters, 64 AD3d 762, 767 [2d Dept 2009]; see Nicklas v Tedlen Realty Corp., 305 AD2d 385, 386 [2d Dept 2003]). The court's function in considering a summary judgment motion is not to resolve issues, but to determine if any material issues of fact exist (Sillman v Twentieth Century-Fox Film Corp., 3 NY2d 395 [1957]; Stukas v Streiter, 83 AD3d 18, 23 [2d Dept 2011]).

"To establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries" (Stukas v Streiter, 83 AD3d 18,23 [2d Dept 2011]). "A defendant physician seeking summary judgment must make a prima facie showing that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby" (Iulo v Staten Island University Hospital, 106 AD3d 696,697 [2d Dept 2013]). To defeat defendant's application, the plaintiff must only submit evidentiary facts or materials to rebut the defendant's prima facie showing. In other words, "this means that if the defendant demonstrates only that he or she did not depart from good and accepted medical practice, plaintiff need only raise a triable issue of fact as to whether such a departure occurred. The plaintiff is required to raise a triable issue of fact as to causation only in the event that the defendant makes an independent prima facie showing that any claimed departure was not a proximate cause of the plaintiff's injuries" (Stukas v Streiter, 83 AD3d 18).

To successfully oppose a motion for summary judgment dismissing a cause of action sounding in medical malpractice, a plaintiff must submit a physician's affidavit of merit attesting to (depending on the defendant's prima facie showing) a departure from accepted practice and/or containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury (Domaradzki v Glen Cove Ob/Gyn Associates, 242 AD2d 282 [2d Dept 1997]; see Arkin v Resnick, 68 AD3d 692, 694 [2d Dept 2009]). Conclusory or general allegations of medical malpractice, "unsupported by competent evidence tending to establish the essential elements are insufficient to defeat a motion for summary judgment" (Mendez v City of New York, 295 AD2d 487 [2d Dept 2002]; see Alvarez v Prospect Hospital, supra, at 325).

To establish proximate cause in a medical malpractice action, "a plaintiff needs do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the injury was caused by the defendant" (Johnson v Jamaica Hospital Medical Center, 21 AD3d 881, 883 [2d Dept 2005] citing Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 [2d Dept 1998]; see Clarke v Limone, 40 AD3d 571, 571-572 [2d Dept 2007]). Since the burden of proof does not ask the plaintiff to eliminate every possible cause of her injury, "the plaintiff's expert need not quantify the exact extent to which a particular act or omission decreased a patient's chances [of a cure or increased her injury], as long as the jury can infer that it was probable that some diminution" in the plaintiff's chance of a better outcome (Jump v Facelle, 275 AD2d 345, 346 [2d Dept 2000]; see Flaherty v Fromberg, 46 AD3d 743, 745 [2d Dept 2007]; Calvin v New York Medical Group, P.C., 286 AD2d 469, 470 [2d Dept 2001]). In addition, summary judgment "is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions...such credibility can only be resolved by a jury" (Feinberg v Feit, 23 AD3d 517, 519 [2d Dept 2005] quoting Shields v Baktidy, 11 AD3d 671, 672 [2d Dept 2004]; see generally Darwick v Paternoster, 56 AD3d 714, 715 [2d Dept 2008]; Adjetey v New York City Health and Hospitals Corp., 63 AD3d 865 [2d Dept 2009]).

In pertinent part, the record shows that :

-After the motor vehicle accident on March 18, 2011, plaintiff was admitted to Jacobi Hospital.

-On March 19th, an external fixator was placed on plaintiff's right leg to stabilize and lengthen the extremity while clearance for open reduction internal fixation surgery was obtained.

-On March 29th, the external fixator was removed and plates were inserted into the right leg. Postoperatively, plaintiff was transferred to the acute rehab department at Jacobi Hospital, where she was fitted with a Bledsoe brace locked in extension.

-On April 13, 2011, plaintiff was admitted to Kings Harbor Multicare Center for rehabilitation, and plaintiff's attending physician was co-defendant Dr. Gupta. A physical examination was performed on admission, whereby two scabs were noted to the right thigh, and surgical steri-strips were located to the right tibia. Additionally, a skin risk assessment was performed by nursing on admission which resulted in her score of "16," meaning the plaintiff was classified as "high risk" for potential skin impairment. Care plans for the plaintiff's wounds and clinical needs were commenced.

-On April 14th, PA Kaplan first saw plaintiff, and performed a wound care evaluation. Plaintiff did not have any complaints or pain at the time of the assessment. PA Kaplan performed an examination of plaintiff's right leg. Dr. Gupta wrote an admission history & physical. Examination showed that plaintiff's vital signs were stable.

-On April 17, 2011, Sandy Harris, RN noted minimal bleeding from the leg, intact steristrips and the brace in place.

-On April 18, 2011, an orthopedic consultation was completed by Dr. Wilson who noted the incision was healing with steri-strips but without erythema or cellulitis.

-Dr. Gupta saw the plaintiff again on April 19, 2011, due to complaints of poor pain control in the right lower extremity. Plaintiff was afebrile and the Bledsoe brace remained in place. Medications were ordered for pain control.

-On April 22, 2011, plaintiff complained of itching at the surgical site to Daisy M. Phillips, RN. There was slight redness was noted around the steri strips. A Physiatry

consultation done on April 22, 2011 noted that the Bledsoe brace was in place, and the surgical wound showed a dry eschar with slight oozing over the medial aspect.

-On April 24, 2011, Claudia Gayle, RN, noted an open wound to the right inner/medial knee. The wound bed had slight blackness and yellowish flesh. No odor was noted.

-Dr. Gupta saw the plaintiff on April 25, 2011, to evaluate foul smelling discharge from right inner upper leg wound. Exam revealed an irregular, linear surgical wound on the medial aspect of the upper leg under the knee. Assessment was a right lower extremity medial leg wound. The plan was to start Keflex, treat with collagenase (i.e. chemical debridement) and order a CBC and ESR. Dr. Gupta also requested follow-up by Orthopedic Surgery and Physiatry.

-On April 26, 2011, PA Kaplan ordered Santyl ointment to the wound area. Dr. Gupta also saw plaintiff, and observed the wound was less foul smelling, and was improving.

-On April 27th, PA Kaplan noted that the surgical incision had shallow dehiscence with superficial slough necrosis. There was no drainage, odor, or cellulitis of the wound.

-On April 29th, Dr. Gupta ordered an orthopedic consult to evaluate whether infection was present. Nurse Phillips had noted the surgical site had a small amount of yellowish drainage but without foul odor. Keflex was continued, and plaintiff remained afebrile. Nurse Singh-Rankishun noted some unpleasant odor during wound care, and PA Kaplan was called to assess the site and removed the steri-strips and debrided the dehisced wound.

-On April 30, 2011, there was no active bleeding/drainage noted from the surgical site.

-On May 1, 2011, Nurse Harris noted the wound was open with yellowish, whitish tissue and the physician was made aware via the communication book. No bleeding or drainage was noted. Plaintiff remained afebrile, and Keflex was continued without adverse effects

-On May 2, 2011, the patient was seen by an in-house orthopedist, and referred to the Emergency Room at Jacobi Hospital for treatment by her original orthopedic surgeon. Plaintiff was diagnosed with dehiscence of the surgical wound with opening of the medial and lateral wound sites. Plaintiff was hospitalized for two days and then discharged.

-Plaintiff was admitted to Beth Abraham for rehabilitation on May 6, 2011 (through July 8, 2011), and had returned to Jacobi Orthopaedic Clinic for follow up care. The wounds were described as healing well with a fibrinous exudate.

Plaintiff contends that moving defendants Kings Harbor, PA Kaplan, and Dr. Gupta deviated from accepted standards of medical and nursing care, and violated applicable nursing home regulations in treating plaintiff in April and May 2011.

Turning to the motions for summary judgment, the record shows that PA Kaplan is a physician's assistant, and an employee of Kings Harbor. Plaintiff alleges that PA Kaplan was negligent and departed from accepted standards of care in failing to adhere to PA standards of practice regarding wound care and failing to properly prevent, diagnose, and treat the wound infection in the plaintiff's right leg.

In support of his motion, PA Kaplan offers the Affidavit of Bruce Farber, M.D, Board Certified in Infectious Disease and Internal Medicine. It is his opinion that there was no departure from the standard of care by P.A. Kaplan in the care and treatment he provided to plaintiff, nor was P.A. Kaplan the proximate cause of plaintiff's injuries.

According to Dr. Farber's reading of the medical records, at the time of P.A. Kaplan's examination of plaintiff, the wound was clean dry and intact meaning that it was not showing any signs of drainage, separation or odor. Given plaintiff's clinical condition there was no need

for antibiotics or any other measures to address the preexisting surgical wounds, and there was no need to place plaintiff on wound rounds, as the surgical incision sites were healed.

Dr. Farber notes that the same day as PA Kaplan performed his assessment, Plaintiff was also examined by the attending physician, Dr. Gupta who compiled a diagnosis and plan of treatment. PA Kaplan was not involved in these decisions. The allegation that PA Kaplan failed to prescribe appropriate medications an adequate dose of antibiotic or obtain a culture are unsupported by any facts. Dr. Farber affirms that physician assistants are not autonomous healthcare providers pursuant to Education Law § 6542, which allows a physician assistant to perform medical services, within the scope of practice of such supervising physician. See, Education Law §6542 (1) ; See also 10 NYCRR 94.2. Thus, Dr. Gupta remained responsible for the oversight of plaintiff's care, including plaintiff's diagnosis and medications, and the accusations by plaintiff of negligent care by PA Kaplan could not be true.

Dr. Farber also points out that plaintiff was over 70 years of age with a history of diabetes and was clearly at risk for infection, which could have been introduced at multiple points during plaintiff's care.

In support of Dr. Gupta's Motion, Alan A. Pollock, M.D., an attending physician in the Division of Infectious Diseases at Lenox Hill Hospital and NYU Langone Hospital, Board Certified in both Internal Medicine and Infectious Diseases by the American Board of Internal Medicine and Subspecialty Board of Infectious Diseases, opines that risk factors for infection were clearly appreciated by Dr. Gupta, including a history of diabetes and having previously been in a healthcare facility. Dr. Pollack opines that laboratory and diagnostic studies were timely ordered; Dr. Gupta properly assessed the patient with right lower extremity medial leg wound and that the plan to start Keflex, treatment of the wound with collagenase, ordering

Orthopedic and Physiatry follow up as well as appropriate blood studies met the standard of care. Debridement with Collagenase (and subsequently Santyl) at Kings Harbor was indicated, timely and appropriately ordered and administered. These medications are chemical agents that remove ("debride") dead tissue in order to promote growth of new healthy tissue. Dr. Pollock continues that plaintiff did not demonstrate signs or symptoms consistent with an infected surgical incision on April 25, 2011, or any time thereafter, while at Kings Harbor. The chart further reflects Dr. Gupta appropriately monitored the patient following the use of Keflex by seeing her the following day, April 26, 2011. At that time, the wounds appeared improved, there was no odor and the patient was afebrile. Dr. Pollack disagrees with plaintiff's contention that failing to perform of a wound culture at Kings Harbor was a departure from the standard of care. While there was an initial improvement in the appearance of the wound following treatment with Keflex, Dr. Gupta recognized that there was a subsequent deterioration in the wound status; and also recognized that there was no Infectious Disease consultation available at Kings Harbor.

Francine A. Cox., a Registered Professional Nurse licensed in the State of New York, affirmed that she is a wound care specialist with extensive clinical knowledge regarding the treatment of post-operative wounds and the prevention of infection, and is continuously board-certified in wound, ostomy and continence care since 1980. Nurse Fox opines that the nursing wound care for the surgical wound in plaintiff, from April 13, 2011, to May 2, 2011, was at all times entirely reasonable, appropriate and consistent with accepted standards of care. Nurse Cox continues that there were no blatant signs of infection that were ignored by either the nursing or medical staff. The first significant changes to the wound are noted on April 25, 2011, when Dr. Gupta noted a foul-smelling discharge coming from the wound. That change

was appropriately addressed by starting the patient on Keflex, an antibiotic to treat infections, and daily collagenase. Though the patient was treated for cellulitis, she remained afebrile. On April 27, 2011, a wound care evaluation was performed by PA Kaplan in response to a note that the incision had opened. There was no indication that the wound had opened before then. Despite this change, the patient had no pain, and no drainage was noted. There was no odor, edema, or cellulitis. It is Nurse Fox's opinion that the care rendered to the plaintiff by Kings Harbor during the time period alleged in this action was entirely reasonable, proper and consistent with good and accepted nursing standards of care as reflected in the records.

In light of the foregoing, moving defendants demonstrated their prima facie entitlement to judgment as a matter of law by presenting the expert affirmations whom opined that they followed normal practice, good and accepted medical and nursing standards, and in the case of PA Kaplan, appropriately followed the orders of Dr. Gupta, that those orders were not contraindicated by normal practice, and that he did not commit any independent acts of negligence (Martinez v La Porta, 50 AD3d 976, 977 [2d Dept 2008]).

In opposition to moving defendants' motions, plaintiff first argues that PA Kaplan has failed to make a prima facie showing because the opinions of his expert, Dr. Farber, have no support in the record evidence. Dr. Farber's liability opinions are founded upon two allegedly false concepts: (1) that Mr. Kaplan had no duty to prescribe plaintiff indicated antibiotics or obtain indicated consults because it was Dr. Gupta that was responsible for such care; and (2) that plaintiff never had clinical signs and symptoms of infection in her surgical sites while she was at Kings Harbor. As to the first assertion, as the Director of Subacute Services at Kings Harbor and a member of the Kings Harbor wound team, PA Kaplan did have a responsibility to ensure that plaintiff received adequate and indicated medical care at the facility. He testified

that as a physician's assistant, he was able to order medications and wound cultures for residents (Kaplan Tr., pp. 37, 38, 44).

Plaintiff also offers the affidavit of its unidentified expert, an internist and infectious disease physician.[1] Plaintiff's expert points out that the record shows that PA Kaplan did see and treat plaintiff, and did order medications, consultations, imaging, laboratory testing, and treatments for her, independently of Dr. Gupta. As a physician's assistant, the Director of Subacute Services at Kings Harbor, and a member of Kings Harbor's wound team, PA Kaplan had the responsibility to ensure that plaintiff received indicated medical care while she was at the facility. He was under the same duties as Dr. Gupta to ensure that plaintiff timely received indicated antibiotic therapy, to order indicated wound cultures, to order an indicated infectious disease consult, to reevaluate the prescribed antibiotic therapy.

As for Dr. Gupta, plaintiff's expert details that Dr. Gupta saw plaintiff on April 25, 2011, and documented additional signs of infection including "foul smelling discharge," a wound base "with fibrinous necrosis," and wound margins "with edema [that were] warm to the touch." Dr. Gupta ordered collagenase to chemically debride the fibrinous necrosis of the wound and she prescribed two 250mg capsules of Keflex (an antibiotic) every twelve hours for seven days. Plaintiff's expert points out the following: that the Keflex was not started until the following day, April 26, 2011; neither Dr. Gupta nor PA Kaplan ordered an infectious disease consult or wound cultures for plaintiff; nor did they order a repeat CBC after the Keflex was

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[1]Moving Defendants contend that Plaintiff's expert is licensed in New Jersey and did not provide a Certificate of Conformity required under CPLR § 2309(c) is a mere irregularity. All other arguments against the court considering plaintiff's expert's affirmation are denied. The Second Department recognizes that even where one party requests trial expert disclosure during discovery pursuant to CPLR 3101(d)(1)(i), a recipient party who does not respond to the request until after the filing of the note of issue and certificate of readiness will not automatically be subject to preclusion of its expert's trial testimony (Rivers v Birnbaum, 102 A.D.3d 26, 36–37, [2d Dept 2012]). There is no evidence of prejudice to the Westrans defendants from the plaintiffs' late disclosure of their expert (Abreu v Metro. Transp. Auth., 117 AD3d 972, 974, [2d Dept 2014]).

started; Dr. Gupta did not examine plaintiff's wounds at any point after April 26, 2011; and by April 29, 2011, plaintiff's wound had increased yellow drainage and an "unpleasant odor" which were signs of infection. PA Kaplan debrided the wound on April 29, 2011, and Dr. Gupta (who did not examine the wound) ordered an ortho consult, but again, no wound culture, lab work, or ID consult were ordered and no change was made to the antibiotic therapy. Plaintiff's expert also points out that: an antibiotic was indicated for plaintiff on April 22, 2011, when she was first noted to have redness around her surgical sites, however, no antibiotic was started until four days later, on April 26, 2011; and when the antibiotic was started, it was prescribed in an inadequate dose for a post-operative infection. Keflex needs to be administered every six hours or four times per day, but Dr. Gupta ordered that the Keflex be administered every twelve hours.

Additionally, plaintiff's expert disagrees with all of defendants' respective experts, whom assert that the administration of Keflex to plaintiff was appropriate. According to plaintiff's expert, the administration of Keflex in the low doses given here, was enough to mask the signs and symptoms of infection that moving defendants' experts claim should have been present, and the use of Keflex as a prophylactic advocated by defendants' respective experts represents yet another departure from accepted standards of care. By April 29, 2011, plaintiff's wound had increased drainage and foul odor again. Despite this, Dr. Gupta did not re-examine the incision sites and did not reevaluate or change the antibiotic therapy. Nor did she order an ID consult or wound cultures at that time or transfer plaintiff to a hospital for an ID workup. Instead, she let the infection seed for several more days.

Plaintiff's expert also believes it was a departure for Dr. Gupta to fail to order wound cultures and an infectious disease consult. Without wound cultures, a provider cannot know if a

prescribed antibiotic will be effective against a particular bug. An infectious disease consult would have ensured that Ms. Martinez-Rivera obtained the ID workup she required in order to prevent the local infection from becoming systemic or progressing to osteomyelitis.

While defendants' respective experts argue that plaintiff did not have an infection because she did not have a fever, plaintiff's expert disagrees. Regarding fever specifically, 20-30% of elderly persons with bacterial or viral infections will present with a blunted or entirely absent fever. Here, plaintiff had clear signs of infection consisting of "foul smelling discharge," a wound base "with fibrinous necrosis," and wound margins "with edema [that were] warm to the touch." Plaintiff's expert claims that there is no doubt that plaintiff had an infected post operative wound.

Plaintiff's expert further opines to a reasonable degree of medical certainty that Kings Harbor violated applicable nursing home regulations in: (1) failing to provide indicated medical care, as set forth above; (2) failing to develop complete, accurate, and adequate care plans for the monitoring and treatment of plaintiff's surgical incision sites; and (3) failing to update plaintiff's care plan as indicated.

Plaintiff's expert also opines that moving defendants' deviations and violations proximately caused plaintiff to suffer injuries including a local wound infection that eventually spread to her bone and caused chronic osteomyelitis and bone death. Plaintiff's expert opines that had the moving Defendants timely ordered the indicated interventions described herein, plaintiff's local, superficial infection would have been contained and eradicated and would not have spread to her bone causing her subsequent chronic osteomyelitis and the sequalae thereof. Plaintiff's expert rejects the defense expert's contentions there were no clinical signs of

infection in Ms. Martinez-Rivera's wounds during her admission to Kings Harbor and that wound cultures were not indicated for her while she was at the facility.

Taking into consideration these submissions, the court finds that regarding PA Kaplan, while physician's assistants are able to perform some medical services, but only when they are under the continuous supervision of a physician and only when those services are within the scope of the supervising physician (see Education Law §6542, see also 10 NYCRR §94.2), a physician's assistant may be held liable for his own negligent acts which are the proximate cause of a patient's injuries (Vaccaro v St. Vincent's Med. Ctr., 71 AD3d 1000 [2d Dept 2010]). As there is conflicting evidence in the record concerning whether PA Kaplan truly acted autonomously, and without negligence, PA Kaplan's motion for summary judgment is denied.

Further, although each moving defendant established their prima facie entitlement to judgment as a matter of law through the submission of his/her own deposition testimony and expert's affidavit, which opined that moving defendants did not deviate from good and accepted standards of medical care during the treatment they rendered to plaintiff, the affidavit of plaintiffs' expert, raised a triable issue of fact that precludes summary judgment (Seqs 1,2,3). Plaintiff's expert affirmations raise triable issues of fact whether the moving defendants' deviations and violations proximately caused plaintiff to suffer injuries, including a local wound infection that developed into a deep bone infection (osteomyelitis) which required extensive antibiotic therapy and three subsequent surgeries. Additionally, the opinion of the plaintiffs' medical expert is not conclusory or without evidentiary value, thus, summary judgment is not appropriate here, where the parties adduce conflicting medical opinions and raise credibility issues which can only be resolved by a jury (Barrocales v New York Methodist

Hosp., 122 AD3d 648, 649 [2d Dept 2014]). There is, in essence, a "battle of the experts" for the resolution of the trier of fact.

The court has considered the remainder of the factual and legal contentions of the parties and to the extent not specifically addressed, finds them to be without merit or rendered moot by other aspects of this decision. This constitutes the decision and order of the court.

Accordingly, based upon the stated reasons, it is hereby

ORDERED, that the motions for summary judgment of moving defendants Louis Kaplan, P.A., (Seq 1); Shikta Gupta, M.D. (Seq 2); and Bronx Harbor Health Care Complex Inc. d/b/a Kings Harbor Multicare Center (Seq 3) are denied; and it is further

ORDERED, that the parties are directed to appear at the Settlement Conference Part, Courtroom 1600, at the Westchester County Courthouse, 111 Dr. Martin Luther King Jr. Blvd., White Plains, New York 10601, at the time and place so designated by that Part.

Dated: August 31, 2020
White Plains, New York

HON. CHARLES D. WOOD
Justice of the Supreme Court

To: All Parties by NYSCEF