STATE OF NEW YORK
SUPREME COURT COUNTY OF SCHENECTADY

PRESENT: **HON. MARK L. POWERS**
Supreme Court Justice

DECISION AND ORDER

TINA COOK, as Administrator
of the Estate of JOHN W. COOK, Deceased,
Plaintiff(s),

-against-

ELLIS HOSPITAL
and
FULTON OPERATIONS ASSOCIATES, LLC, d/b/a FULTON CENTER FOR REHABILITATION AND NURSING,
Defendant(s)

Index No. 2017-0215
RJI No. 46-1-2017-0735

NOTICE: PURSUANT TO ARTICLE 55 OF THE CIVIL PRACTICE LAW AND RULES, AN APPEAL MUST BE TAKEN WITHIN 30 DAYS AFTER SERVICE BY A PARTY UPON THE APPELLANT OF A COPY OF THIS ORDER WITH PROOF OF ENTRY EXCEPT THAT WHERE SERVICE IS BY MAIL PURSUANT TO RULE 2103(b)(2) or 2103(b)(6), THE ADDITIONAL FIVE DAYS PROVIDED SHALL APPLY, REGARDLESS OF WHICH PARTY SERVES THE ORDER WITH NOTICE OF ENTRY.

APPEARANCES:

Jeffrey M. Adams, Esq., Adams Law Firm, P.C., 455 Route 304, Suite 105, Bardonia, New York 10954; *Counsel for the Plaintiff, Tina Cook, as Administrator of the Estate of John W. Cook, Deceased;*

Brian P. Henchy, Esq., Thorn, Gershon Tymann and Bonanni, LLP, 5 Wembley Court, PO Box 15054, Albany, New York 12212; *Counsel for the Defendant, Ellis Hospital.*

COURTESY COPY:

Kathleen Ryan, Esq., Kaufman, Borgeest and Ryan, LLP, 200 Summit Lake Drive, Valhalla, New York 10595; *Counsel for the Defendant, Fulton Operations Associates, LLC, d/b/a Fulton Center for Rehabilitation and Nursing.*

HON. MARK L. POWERS, JSC

The instant action arises from the medical care rendered to John W. Cook (hereinafter, "the decedent") during his hospitalization a year prior to his eventual death in a nursing home, at the age of 69. The administrator of his estate – Tina Cook – (hereinafter, "Cook" or "the plaintiff") commenced this action on February 6, 2017, sounding in negligence, violation of the Public Health Law, medical malpractice and wrongful death. Although the action initially named both Ellis Hospital (hereinafter, "Ellis" or "the defendant") and Fulton Operations Associates, LLC, d/b/a Fulton Center for Rehabilitation and Nursing (hereinafter, "Fulton") as co-defendants, the plaintiff thereafter resolved her claims as against Fulton.[1] Inasmuch as no cross-claims were interposed between the co-defendants, Fulton is no longer a party to this litigation.

It is acknowledged and undisputed by the parties that the decedent was extremely ill prior to, and throughout, the two separate hospitalization periods at issue: the first of which was from February 14, 2015 to March 3, 2015; and the second from March 22,

[1]The Court has neither received a partial stipulation of discontinuance nor been informed of the manner in which plaintiff's claim(s) as against Fulton were resolved.

2015 to April 16, 2015.[2] His pre-existing history included diabetes, kidney disease, vascular disease, neuropathy, congestive heart failure, coronary artery disease, hypertension, hyperlipidemia, heart attack, skin cancer, non-healing foot ulcers, gangrene, toe amputation, and nutritional deficiencies. Ultimately, the decedent's cause of death was cardiac arrest.

Importantly, Cook does not allege negligence with regard to any of the treatment the decedent received for his myriad of pre-existing conditions and co-morbidities. Rather, it is *exclusively* the wound care attendant to a pressure ulcer (hereinafter, "the bed sore") which developed on the decedent's sacrum[3], which is at issue herein. Cook maintains that, as a result of improper care, the bed sore became infected and exacerbated, leading to sepsis, pneumonia and, eventually, death.

Cook filed a Note of Issue, with demand for Jury Trial, on March 4, 2020. By Notice of Motion, filed January 15, 2021, Ellis has moved for summary judgment dismissing the complaint. Ellis posits that, based upon its several expert affidavits and decedent's medical records, there was no deviation from the standard of care and even if, *arguendo*, a departure could be shown, the bed sore was "unavoidable", given that decedent was at high risk due to his significant pre-existing co-morbidities. Thus, Ellis maintains that plaintiff cannot establish the element of causation and/or proximate cause.

FACTUAL BACKGROUND

The decedent was admitted to Ellis on February 14, 2015, experiencing respiratory distress, including shortness of breath. He was determined to be suffering from pneumonia, loculated pleural effusion (scar tissue creating fluid in the membrane between the lungs and chest which impedes lung movement necessary for breathing),

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[2]Although Cook initially asserted additional claims as to the decedent's three separate emergency room visits on January 31, 2015 (for a sprained wrist and sinus infection), February 5, 2015 (for back pain and a strained rib) and March 20, 2015 (for back pain), she has expressly withdrawn such claims relative to the former two dates and proffered no factual assertions nor expert opinion with regard to the latter date. On none of these occasions was there any complaint by the decedent as to his skin integrity. Thus, all claims pertaining to decedent's case in the emergency department are now immaterial.

[3]The sacral area is the bony structure of the lower back/buttocks. The sacrum is the triangular bone formed from fused vertebrae and situated between the two hipbones of the pelvis.

MRSA, bacteremia, sepsis, respiratory failure, and myocardial infarction. Upon admission, he was noted to have a "slightly reddened bottom."

The following day - February 15, 2015 - hospital staff again observed that decedent had a slightly reddened area of skin with blanching (paleness due to obstructed blood flow). As this observation is known to be an early predictor of a possible bed sore, the area was evaluated and scored within the mild risk range of the Braden Scale.[4] A protocol of regular turning and re-positioning was implemented, along with the application of protective ointments, and the decedent was encouraged to get up from his hospital bed often and at his own will.

By February 16, 2015, the decedent's overall condition had deteriorated and he underwent immediate thoracentesis surgery (the placement of a catheter in his chest to drain fluid build-up). The procedure, however, was unsuccessful, resulting in blood clots, and, by February 19, 2015, required that he be placed in the Intensive Care Unit (ICU). He then underwent an emergency thoracotomy wedge resection (removal of a portion of a lung), on February 20, 2015. While his post-surgical care necessitated that he be on a ventilator and remain immobilized in the ICU for the next three days, he was placed on a rotating mattress designed to relieve pressure to his skin, by automatically rotating his body position, as portions electrically inflated and deflated.

Upon his return to a regular room – on February 24, 2015 – the reddened area was classified as a Stage One Sore, meaning that there was an observable change in the skin insofar as temperature, sensation and/or color. The turning protocol was reinstituted, with the decedent being re-positioned every two hours. In addition, he was provided with a specialty pressure-reducing mattress and gel cushion with extra pillows intentionally placed so as to re-distribute the high-pressure points on his body. His medical team was also expanded to include a physical therapist, an occupational therapist and a nutritionist, each of whom, in conjunction with the nursing crew, attempted to dissuade him from an insistence on remaining inactive. The decedent's family members, while visiting, were educated as to proper treatment for a bed sore as well as the importance of increasing the decedent's physical activity level. The proof, however, reflects that, notwithstanding all such efforts, the decedent was adamant about his preference to remain confined to bed.

[4]The Braden Scale is an assessment tool used to evaluate a patient's risk for bed sores, via grading six categories to wit: moisture, activity, mobility, nutrition, friction/shear, and sensory perception. A total score is ascribed, generally between 9 and 23, with lower scores meaning higher risk. Thus, a score between 9 and 12 is high risk; a score of 13 or 14 is moderate risk; a score between 15 and 18 is low risk; and a score of 19 or more suggests there is no risk.

On February 26, 2015, the bed sore was characterized as a Stage Two Sore, meaning its appearance resembled an abrasion or blister. The prescribed care continued to be two-hour re-positioning, ointments, protective dressings, special mattress, nutritional counseling and physical and occupational therapeutic intervention. The medical records reflect that the bed sore appeared to have slightly improved.

At the time of his first discharge from hospitalization on March 3, 2015, he remained in overall poor health with mobility limitations. Indeed, the medically recommended discharge plan was for continuity of care via transfer to Sunnyview Rehabilitation Hospital, an acute care facility. However, this recommendation was refused by the decedent who insisted on returning to his home and having further care arranged through Visiting Nurse Services (VNS), a private agency with which the decedent had obtained home health care services previously.[5]

The next few weeks -- from March 4, 2015 to March 20, 2015 - - saw a decline in the decedent's overall health. Indeed, the VNS caregivers were especially concerned with his pre-existing foot ulcers and the sacral pressure ulcer, none of which appeared to be healing, despite their attention and treatment. While the decedent was seen during this time period by his primary physician, his cardiothoracic surgeon, his cardiologist, and VNS providers - - all of whom reinforced the importance of reducing the friction and sheer to his sacral area - - the records reflect that the decedent remained disinclined to increase his level of physical activity, despite his ability to do so at that time. His providers opined, and cautioned him, that his progressive conditions would likely lead to pneumonia, and/or deep vein thrombosis (DVT) blood clot(s) and/or death within a year.

On March 22, 2015, the decedent was re-admitted to Ellis, presenting with paraplegia, osteomyelitis, swelling, the unhealed bed sore, spinal cord compression, pneumonia and respiratory failure. His legs were numb and he was unable to sit up. His relatives informed emergency medical personnel of his prolonged inactivity. The following day - - March 23, 2015 - -, the decedent underwent emergency surgery to repair the spinal issues that were resulting in his lower body paralysis. He remained immobilized for the remainder of his care at Ellis, during which time the bed sore was

[5]In fact, VNS visited the decedent in his home from January 31, 2015 through February 14, 2015, rendering care to the nonhealing foot ulcers, educating the family on pressure ulcer prevention, monitoring his condition, and delivering medical supplies. VNS noted that the decedent's illnesses were progressing and could lead to death. VNS also noted that, despite having only a slight limitation in mobility, the decedent would spend considerable time seated, or in bed, making bed sores more likely.

characterized as a Stage Four, meaning that there was full thickness skin loss with extensive destruction, subcutaneous tissue necrosis (appearing as a deep crater), with possible damage to muscle or bone. In fact, Theresa Pittman, R.N., a wound ostomy continence nurse who personally attended to the decedent, noted that the bed sore's depth was not readily determinable due to exuding yellow slough. Treatment then included debridement (the removal of necrotic tissue) and cross-hatching with a scalpel (allowing for increased medication penetration into the tissue). The area was regularly cleansed and treated via packing, along with two hour re-positioning on a special mattress. Despite being encouraged to use a provided wheelchair, equipped with a gel cushion, the decedent insisted on lying on his back and remained non-ambulatory.

Ultimately, the decedent was transferred by Ellis to the Fulton Center for Rehabilitation and Nursing Care on April 16, 2015, where he remained until his death on April 17, 2016.

ARGUMENTS

Ellis contends that there was neither a departure from accepted standards of care nor was the care rendered the proximate cause of the decedent's sickness or death. Pointing to the decedent's overall poor state of health at the time of his hospitalizations, Ellis posits that he was at an "unavoidable" and "insurmountable" risk for developing a bed sore(s). The staff frequently assessed and monitored his skin integrity, offering various means of relieving pressure at the affected area and educating the decedent and his family members as to prevention and care, which was often refused. According to Ellis, it was the decedent's pre-existing conditions and co-morbidities, coupled with his inadequate activity and resistance, which caused the bed sore to develop and worsen.

While Ellis concedes that immobility was necessary during the decedent's recovery from surgeries, insofar as he was in a critical care unit, the standard of care relative to a bed sore was adhered to and, in fact, the decedent continued to be inactive even when in a regular room and capable of ambulation. Stated otherwise, Ellis proffers that the fact that the treatment was ineffective does not mean it was deficient or not provided. Rather, here, it was negated by decedent's overall poor health and circumstances which rendered it "impossible" to mitigate. Thus, its occurrence and progression are not due to negligence but, instead, resulted from decedent's overall poor health and circumstances that negated the appropriate care rendered.

Ellis further argues that even if, *arguendo*, there was a deviation in care, the plaintiff has proffered no link as to how the bed sore caused or contributed to the decedent's illness and/or the cardiac arrest which resulted in his death a year later. Thus, Ellis maintains that plaintiff has wholly failed to withstand summary judgment as to both the standard of care and the element of causation.

In contrast, the plaintiff argues that the bed sore was not sudden, spontaneous or unpreventable but, rather, resulted from multiple departures from good and accepted nursing practices. In particular, plaintiff avers that Ellis failed to evaluate the effectiveness of turning and re-positioning the decedent, failed to implement side-to-side turning, failed to cover the bed sore with preventative dressings, failed to ensure that the special bed was in good working order, and failed to update and revise the Plan of Care as the bed sore worsened.

Plaintiff further posits that both the "unavoidability" of the bed sore and the determination as to proximate cause are questions for the jury, as is the credibility of the competing experts. Thus, in plaintiff's view, Ellis has failed to sustain its initial burden and, as such, the burden does not shift to plaintiff to establish any nexus between the malpractice and the injury.

THE LAW AND DISCUSSION

"The elements of a medical malpractice cause of action are 'a deviation or departure from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries.' " *Schwartz v Partridge, 179 AD3d 963 [2d Dept, 2020] quoting DiLorenzo v Zaso, 148 AD3d 1111, 1112 [2d Dept, 2017].* Summary judgment dismissing a medical malpractice action should be granted when the defendant demonstrates the absence of any material factual issues with respect to either of these elements, unless the plaintiff raises a triable factual issue in opposing the motion. *Id.*

In order to prevail on a motion for summary judgment seeking dismissal of a complaint, a defendant must establish a prima facie case, by submitting admissible evidence demonstrating that it is entitled to dismissal as a matter of law. *See Rossi v Arnot Ogden Medical Center, 268 AD2d 916 [3d Dept, 2000]; and Olinsky-Paul v Jaffe, 105 AD3d 1181 [3d Dept, 2013].* Where the complaint sounds in negligence-based medical

malpractice, a defendant's tender of deposition testimony, documents, affidavits and/or other factual proof, which lays out that the course of treatment was rendered in accordance with accepted medical standards, without departure, or alternatively, that any such deviation did not cause plaintiff's injuries, satisfies this burden. *See D'Orta v Margaretville Mem. Hosp., 154 AD3d 1229 [3d Dept, 2017]; Donnelly v Parikh, 150 AD3d 820 [2d Dept, 2017]; Suib v Keller, 6 AD3d 804 [3d Dept, 2004]; Toomey v Adirondack Surgical Associates, 280 AD2d 754 [3d Dept, 2001]; Menard v Feinberg, 60 AD3d 1135 [3d Dept, 2009]; Amodio v Wolpert, 52 AD3d 1078 [3d Dept, 2008]; Sloane v Repsher, 263 AD2d 906 [3d Dept, 1999]; and Stewart v Ellis Hospital, 198 AD2d 559 [3d Dept, 1993].*

The inquiry, however, does not close upon the defendant's presentation of a prima facie case but, rather, the burden thereupon shifts to the plaintiff who must show that there exists a material, triable issue of fact, by admissible evidence, including expert medical proof. The plaintiff must proffer an expert opinion(s) that there was, indeed, a departure from the standard of care and establish that such deviation was a competent producing cause of the plaintiff's injuries. *See DeLorenzo v St. Clare's Hospital, 69 AD3d 1177 [3d Dept, 2010]; Chase v Cayuga Medical Center at Ithaca, Inc., 2 AD3d 990 [3d Dept, 2003]; Domaradzki v. Glen Cove, 242 AD2d 282 [2d Dept, 1997].* Where a sufficient nexus is not demonstrated, summary judgment is appropriate.

Moreover, expert opinions that are speculative, conclusory or unsupported by evidentiary foundation have no probative value and cannot defeat summary judgment. *See Schwartz, 179 AD3d at 964.* Rather, the plaintiff's expert opposition is to be supported by an explanation for the opinion specifically relying upon the record. *Schwartz, 179 AD3d at 964; and Donnelly v Parikah, 150 AD3d 820 [2d Dept, 2017].*

This Court finds that Ellis satisfied its initial burden. Among others, its expert, Sharon M. Bass, R.N., B.S.N., an experienced nurse supervisor of wound care opined that, to a reasonable degree of nursing certainty, there was nothing Ellis did, or failed to do, which compromised or exacerbated decedent's skin integrity. Rather, the bed sore developed and progressed despite clinical evaluation and intervention consistent with the standard of care. The decedent's medical records reflect that his individual needs were assessed and attended to throughout his hospitalizations but, nevertheless,

the bed sore was "unavoidable"[6] based on his decision-making and periods of immobility, coupled with his poor health and high risk factors.

The burden - - now shifted to the plaintiff - - requires that a genuine issue of material fact be brought to light by the plaintiff, without which the action comes to an end. However, the plaintiff need only submit proof sufficient to show that there remains a triable issue - - the existence of which defeats the defendant's prima facie showing. *Morrone v Chelnick Parking Corp., 268 AD2d 268 [1st Dept, 2000].*

Having carefully reviewed the plaintiff's submitted proof, it is apparent that the greater part of her arguments in support of a remaining triable issue focus on what treatment protocol constitutes the standard of care. For instance, the plaintiff asserts that, given the early suspicion of a bed sore, Ellis should have implemented turning and re-positioning and utilized protective dressings earlier in the decedent's care, and more frequently than every two hours, and that he not have been permitted to remain confined to bed.[7] The plaintiff also points to a "gap" in the decedent's medical records insofar as the turning, re-positioning, and bandaging which purportedly occurred between February 25, 2015 and March 1, 2015 but is not documented. The plaintiff, in fact, takes the position that the continuation of the same treatment plan, without revision, notwithstanding its ineffectiveness, is, in and of itself, a deviation from acceptable standards.

The Court is, of course, mindful, however, that summary judgment does not hinge upon the best or finest rendering of quality care but, rather, care in accordance with accepted community standards. The fact that the treatment protocol was ineffectual does not mean that the care rendered was deficient by legal standards nor that omissions in documentation necessarily mean that care was withheld.

There are, in addition, new arguments put forth by the plaintiff, raised for the first time in her opposition to the motion. Specifically, plaintiff now posits that Ellis failed to instruct its providers as to the particular manner in which to re-position the decedent, which should have been predominately side-to-side, rather than a right-left-

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[6]The Centers for Medicare and Medicaid Services (CMS) and the National Pressure Injury Advisory Panel (NPIAP) define an "unavoidable pressure ulcer" as one which develops "even though the provider evaluated the individual's clinical condition and pressure ulcer risk factors; defined and implemented interventions consistent with individual needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate."

[7]The Court is cognizant that the refusal of care is among the privileges provided-for within the Patient's Bill of Rights while hospitalized in New York State.

back rotation, especially as his Braden score worsened. The plaintiff also states, for the first time, that the frequency of re-positioning should have been, at least, hourly, rather than every two hours.

These latest suppositions are materially dissimilar theories of negligence, which are outside the Court's consideration, having not been raised by the plaintiff at an earlier point in the litigation. *Anonymous v Gleason, 175 AD3d 614 [2d Dept, 2019].* Similarly, the Court is unmoved by the plaintiff's claim that the specialized bed was not refused by the decedent but, rather, was non-functioning. This assertion is contradicted by the record, which reflects that its malfunction was merely a one-time occurrence repaired within a seven-hour timeframe.

The decisional law generally deems proximate cause and the credibility of competing experts to be jury determinations. *See Pichardo v St. Barnabas Nursing Home, Inc., 134 AD3d 421 [1st Dept, 2015]; Romanelli v Jones, 2020 NY Slip Op 00316 [2nd Dept, 2020]; Adams v Pilarte, 152 AD3d 97 [1st Dept, 2017]; Odoardi v Abramson, 144 AD3d 492 [1st Dept, 2016]; Mezzone v Goetz, 145 AD3d 573 [1st Dept, 2016]; but cf. E. Ann Holland v Cayuga Medical Center at Ithaca, Inc., 195 AD3d 1292 [3d Dept, 2021) (decided June 17, 2021 by Memorandum and Order #532192).*

Nevertheless, it is apparent to this Court that the plaintiff's expert has not set forth how the bed sore was avoidable nor how the care rendered by Ellis caused it despite the decedent's overwhelming co-morbidities, immobility, and persistent rejection of provider recommendations. *But cf. O'Conner v Kingston Hosp., 166 AD3d 1401 [3d Dept, 2018].*

Indeed, the decedent already had the health ailments complained of by the plaintiff at the time of his hospital admissions. Here, the Court finds that the plaintiff's expert has not identified the specific departure(s) from accepted standards of care nor illuminated how the defendant's care caused or worsened the bed sore, nor how such care brought about the decedent's injuries and death, by pointing to any facts in the record. Having proffered no more than speculation in a conclusory fashion, this Court finds that no triable issue has been raised by the plaintiff as to proximate cause nor credibility.

Having shown a prima facie entitlement to summary judgment, Ellis is entitled to summary judgment dismissing the complaint.

THE COURT'S RULING

NOW, therefore, based upon the foregoing, it is

ORDERED that the defendant's motion is **GRANTED** and the complaint is hereby dismissed with prejudice; and it is further

ORDERED that this decision constitutes the Order of this Court, which defendant's counsel shall file with the Schenectady County Clerk and serve an entered copy upon plaintiff's counsel within thirty (30) days.

HON. MARK L. POWERS
Supreme Court Justice

Signed at Schenectady, New York
this 28th day of July, 2021.

PAPERS CONSIDERED

Defendant, Ellis Hospital, Notice of Motion, filed January 15, 2021, for summary judgment; Attorney, Brian P. Henchy, Esq. Affirmation, dated January 15, 2021, in support of motion for summary judgment, together with annexed Exhibits A through U;

Defendant, Ellis Hospital, Memorandum of Law in Support of Motion for Summary Judgment, dated January 15, 2021;

Plaintiff's Attorney, Jeffrey M. Adams, Esq., Affirmation in Opposition, dated February 24, 2021, together with annexed Exhibits 1 – 3;

Plaintiff's Memorandum of Law in Opposition to Motion for Summary Judgment, dated February 24, 2021;

Plaintiff's Exhibit 1A, "Pressure Ulcers: Avoidable or Unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference, filed March 1, 2021, in further Opposition to Motion for Summary Judgment;

Defendant's Attorney, Brian P. Henchy, Esq., Reply Affirmation, dated March 9, 2021, in response to Plaintiff's Opposition to Defendant's Motion for Summary Judgment and in further support of Summary Judgment;

Defendant, Ellis Hospital, Supplemental Reply Memorandum of Law in Further Support of Motion for Summary Judgment, dated March 9, 2021.