

Weitzman v Bon Secours Charity Health Sys., Inc.
2021 NY Slip Op 33254(U)
March 9, 2021
Supreme Court, Westchester County
Docket Number: Index No. 60980/2018
Judge: James W. Hubert
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

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MICHAEL WEITZMAN as Executor of the Estate of
GLORIA WEITZMAN, and MICHAEL WEITZMAN,
Individually,

Index No.: 60980/2018

DECISION & ORDER

Plaintiff,

Motion Seq. #1 and #2

- against -

BON SECOURS CHARITY HEALTH SYSTEM,
INC. d/b/a GOOD SAMARITAN HOSPITAL and
NORTHERN MANOR MULTICARE CENTER, INC.,

Defendants.

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Hubert, J.S.C.

Plaintiff Michael Weitzman commenced the instant action on July 19, 2018, on behalf of himself and his late mother, decedent Gloria Weitzman, against Bon Secours Charity Health System, Inc. d/b/a/ Good Samaritan Hospital (“GSH”) and Northern Manor Multicare Center, Inc. (“Northern Manor”) for medical malpractice, wrongful death, negligence, and violations of New York’s Public Health Law.

The events leading to this action began on January 13, 2016, when decedent, an elderly woman with an extensive prior medical history, was transported to GSH by ambulance with a number of different ailments. Upon her admission, decedent was diagnosed with respiratory failure, anemia, c-diff, renal disease, hypertension, high cholesterol, E coli sepsis, lymphoma and chronic malnutrition. In addition, she had recently undergone chemotherapy and was suffering from malnutrition and abnormal blood cell counts.

As all parties acknowledge, decedent had a complicated hospital course at GSH. She required transfusions of red blood cells and platelets, and developed acute respiratory distress. More than once, decedent was intubated and placed on a ventilator and feeding tube. Decedent

also developed a significant sacral pressure ulcer that worsened during her hospitalization at GSH. According to the medical records, by early February, the sacral wound had increased to 3 x 4 cm and was documented as a necrotic sacral ulcer with blanching in the surrounding erythema. On February 4, 2016, decedent was discharged and transferred to Select Specialty Hospital, a long-term acute care hospital, where she underwent six sacral debridements.

On March 21, 2016, decedent was discharged from Select Specialty Hospital and transferred to Northern Manor, a skilled nursing facility. As of that date, the sacral ulcer was documented as a Stage IV pressure ulcer¹ measuring 5 x 5 x 2.5 cm, with the entire wound area measuring 10 x 10.5 cm. In addition to the sacral ulcer, Northern Manor nursing staff documented a Stage II left buttock pressure ulcer measuring 3 x 4 cm. At the time, decedent was wheelchair bound and on a ventilator. She underwent seventeen additional sacral debridement procedures at Northern Manor, and was prescribed Percocet and Fentanyl for severe pain. Decedent also developed a heel pressure ulcer while under the care of Northern Manor staff. However, by the time that decedent was discharged from Northern Manor on June 8, 2017, the heel ulcer and buttock ulcer had both healed, and the sacral ulcer measured 1.0 x 0.4 x 0.3 cm.

Decedent died two months later, on August 6, 2017. The cause of death on decedent's death certificate was listed as cardiopulmonary arrest due to coronary artery disease and hypertension. Plaintiff's bill of particulars alleges that as a result of medical malpractice and negligence of the staff at each Defendant facility, the decedent suffered, *inter alia*, a sacral pressure ulcer, a buttock pressure ulcer, debridement, infection, necrosis, sepsis, deep tissue

¹“Stage I is intact skin with nonblanchable localized redness that does not disappear when the pressure to the area is relieved; Stage II pressure ulcer is a blister and/or superficial skin breakdown; Stage III is a full thickness skin loss involving damage or necrosis of subcutaneous tissue; Stage IV breakdown exposes bone, tendon or muscle. A pressure ulcer is unstageable when the full thickness tissue loss is covered by slough and/or eschar where the damage cannot be determined.” *See Hood v. Southside Hospital*, 2008 N.Y. Misc. LEXIS 7617, *9, 2008 NY Slip Op 30063(U)(Sup. Ct. Suffolk Co. 2008).

injury, malnutrition, emotional trauma, pain and suffering, and death.

On the motions before the Court, GSH and Northern Manor move separately for summary judgment dismissing the complaint insofar as asserted against them. In support of their respective motions, the Defendants have each submitted, *inter alia*, expert physician affirmations and decedent's medical records.

GSH's expert opines that the sacral pressure ulcer that decedent developed at GSH was an unavoidable consequence of her grave medical condition and GSH's life-saving measures, and there was no deviation from the standard of care. For its part, Northern Manor's expert opines that decedent's pressure ulcers were not caused by any act of negligence by Northern Manor, inasmuch as she had developed the ulcers prior to her admission, and that "[a]ll reasonable, necessary and appropriate interventions were in place for the decedent as is evidenced by the records, which show that the wounds were closely followed and, with the exception of the sacral ulcer, all wounds had resolved less than two months after treatment."

In opposition, Plaintiff relies primarily on his own expert affirmations which dispute the Defendants' expert opinions, and opine that with a reasonable degree of medical certainty, each Defendant departed from the standard of care in treating decedent's pressure ulcers and proximately caused her injuries.

"[T]he requisite elements of proof in a medical malpractice action are a deviation or departure from accepted community standards of medical practice, and evidence that such deviation or departure was a proximate cause of injury or damage." *Rauci v. Shinbrot*, 127 A.D.3d 839, 841, 5 N.Y.S.3d 314, 317 (2d Dep't 2015)(citations omitted).

Thus, "a physician moving for summary judgment dismissing a cause of action to recover damages for medical malpractice must establish, *prima facie*, either that there was no departure

from good and accepted medical practice or that any alleged departure was not a proximate cause of the plaintiff's injuries." *Id.*, citing *Bhim v. Dourmashkin*, 123 A.D.3d 862, 863-64, 999 N.Y.S.2d 471 (2d Dep't 2014).

"[W]here a defendant physician makes a prima facie showing that there was no departure from good and accepted medical practice, as well as an independent showing that any departure that may have occurred was not a proximate cause of the plaintiff's injuries, the burden shifts to the plaintiff to rebut the defendant's showing by raising a triable issue of fact as to both the departure element and the causation element." *Stukas v. Streiter*, 83 A.D.3d 18, 25, 918 N.Y.S.2d 176, 182 (2d Dep't 2011). However, "the party opposing the motion is entitled to every favorable inference that may be drawn from the pleadings and affidavits submitted by the parties." *Rosario v. Our Lady of Consolation Nursing & Rehabilitation Care Ctr.*, 186 A.D.3d 1426, 128 N.Y.S.3d 906 (2d Dep't 2020).

Additionally, "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury." *Feinberg v. Feit*, 23 A.D.3d 517, 806 N.Y.S.2d 661 (2d Dep't 2005); see *Rodriguez v. Bursztyn*, 187 A.D.3d 1230, 1231, 131 N.Y.S.3d 569, 570 (2d Dep't 2020).

GSH's Motion for Summary Judgment

The Court first addresses GSH's motion for summary judgment, designated as Motion Sequence No. 2 in NYSCEF, for the sake of chronological clarity.

In support of its motion, GSH has submitted decedent's medical records, deposition testimony of the parties, and an expert affirmation from Dr. Jeffrey Levine, a board certified physician in internal medicine and geriatric medicine. Dr. Levine opines that based on his review of the relevant medical records, the pressure ulcer that decedent developed at GSH was

an unavoidable consequence of her grave medical condition and GSH's life-saving measures, and there was no deviation from the standard of care.

Dr. Levine notes that in addition to lymphoma of the spleen and stomach, decedent also had a history of kidney disease, anemia, urinary retention, left pleural effusion, hypertension and hyperlipidemia. She also suffered from pancytopenia, low levels of all three blood cell types, and was "nutritionally compromised." He further states upon her admission to GSH, decedent required transfusions of red blood cells and platelets, and two days later, on January 15, 2016, she developed acute respiratory distress and was transferred to the ICU. On January 17, decedent went into respiratory distress a second time and was intubated and placed on a ventilator. Dr. Levine states that decedent's bed had to be elevated while she was on the ventilator in order to avoid aspiration and ventilator associated pneumonia, and that "[u]nfortunately, keeping the head of the bed elevated puts greater pressure on the sacrum, resulting in the unavoidable development of sacral pressure ulcers."

On January 18, decedent was extubated but still required a ventilator for oxygenation. On January 21, she suffered respiratory fatigue and was re-intubated. According to the medical records, neither a nasogastric tube nor a percutaneous endoscopic gastrostomy could be used due to her low platelet count and pulmonary status.

Dr. Levine states that when decedent was admitted, hospital staff determined that she was at risk of skin breakdown and pressure ulcer prevention measures were put into place. She received a pressure redistribution bed, heel lift boots, regular skin assessments, blood glucose control, position changes, and nutrition promotion. Dr. Levine further states that GSH nursing staff checked decedent's skin on a daily basis, and that turning and repositioning was done every two hours with pillows and wedges, "when it was safe."

According to Dr. Levine, a nurse first noticed a small deep tissue injury to decedent's sacrum on January 21, 2016, and applied a foam dressing to the wound. On January 27, 2016, decedent was evaluated by a wound care nurse. At that point, the injury measured 3 x 1 cm with discoloration on the sacrum and surrounding area. The nurse classified the wound as an "unstageable deep tissue injury, skin failure and multi-organ failure." She recommended continued foam dressing every 72 hours and preventative care, noting that decedent had a high risk of skin breakdown due to multi-organ failure, immobility, and malnutrition.

By February 3, 2016, the wound care nurse documented the wound as a 3 x 4 cm necrotic sacral ulcer with blanching in the surrounding erythema, and requested a surgical evaluation. The surgeon recommended debridement under local anesthesia to remove the necrotic tissue, but the procedure was not done at GSH. Dr. Levine opines that it was reasonable to postpone the procedure because it was not an "emergent procedure."

Dr. Levine opines that GSH staff kept decedent alive despite her poor prognosis; skin assessments were done regularly; GSH staff formulated an appropriate plan of care; and appropriate measures were taken to prevent skin breakdown. Dr. Levine further states that based upon his review of decedent's medical records:

[. . .] while she was in the ICU she was regularly turned and positioned, when possible. However, there were times when she was so sick that it was dangerous to move her. For instance, there are notes indicating that she desaturated when re-positioned. This means that her blood oxygen dropped. In other words, her precarious pulmonary function prevented safe repositioning. Moving her to save the health of her skin could have been fatal; therefore, it was appropriate for staff to not move her even knowing that this could lead to skin breakdown.

Dr. Levine concludes that GSH did not cause or contribute to decedent's injuries in this case, opining that "[e]ven with the most diligent of care and implementation of pressure prevention measures, patients with metastatic cancer and acute comorbid conditions such as

those present in [decedent] may develop pressure ulcers because of the symptoms of the disease and consequences of the treatment.” He further states that “the pressure ulcer that [decedent] developed at GSH was unavoidable despite all reasonable efforts to prevent it and directly resulted from [decedent’s] severe medical condition and measures taken that were necessary to save her life.”

In view of this evidence, the Court finds that GSH has made a prima facie showing of its entitlement to judgment as a matter of law by demonstrating that the sacral ulcer that decedent had developed was an unavoidable result of her chronic conditions and other risk factors, and that GSH provided appropriate nutrition and medical care to decedent in an effort to maintain her skin health and her overall condition.

In opposition, Plaintiff has submitted an affirmation from a duly licensed physician who is board certified in internal medicine and geriatric medicine, with 39 years of experience. Based upon his review of the medical records, Plaintiff’s expert opines that the care and treatment rendered to decedent by GSH was not in accordance with good and accepted medical practice.

Specifically, Plaintiff’s expert states that based upon his review of decedent’s medical records, she was not turned or repositioned every two hours. For example, Plaintiff’s expert notes that on January 14, 2016, decedent was turned at 3:17 a.m. and again at 6:51 a.m. to the supine position, and at 6:23 p.m. and 8:48 p.m. to the left side, showing that she remained in the same position, on her back, for over fifteen hours. Plaintiff’s expert further notes that on January 15, 2016, the medical records indicate that decedent was turned on her right side at 12:07 a.m. and again 5:55 a.m., reflecting that she was only turned twice in a twenty-four hour period.

Plaintiff’s expert states there are no detailed turning and positioning records for January 16, 2016, and that the following day she was emergently intubated. There are no specific turning

records on January 17, 2016 until 5:00 p.m., although continuous lateral rotation therapy was noted at 4:00 p.m. and 7:10 p.m.

Plaintiff's expert further notes that decedent did not have a nutrition consultation with a dietician until January 18, 2016, despite her low albumin levels that were documented during her admission. He states that decedent was extubated on January 18, 2016, but was only turned twice on that date. And while the medical records reflect that GSH staff first documented decedent's deep tissue injury on January 21, 2016, there are no turning records from January 22, 2016, from 6:00 a.m. until 7:33 p.m., over thirteen hours later. Additionally, no staging or measurements were noted with respect to a wound to decedent's buttock.

Plaintiff's expert states that on January 27, 2016, GSH staff documented that decedent had an unstageable pressure ulcer of the sacral region and was on a "Total Care Sport surface." Her albumin level was substantially below the normal range. By February 3, 2016, the sacral pressure ulcer measured 4 x 3 cm, yet decedent did not have a timely sacral pressure ulcer consultation. Plaintiff's expert also notes that while decedent was supposed to be on continuous lateral rotation therapy, there are no turning records from 5:33 a.m. until 7:56 p.m., reflecting that she was not turned for over twelve hours.

Plaintiff's expert states that decedent underwent a total of twenty-three sacral debridements; six at Select Specialty Hospital and seventeen additional procedures at Northern Manor, and was given Percocet and Fentanyl for pain relief, which affected her appetite, mobility, and ability to sleep. Plaintiff's expert concludes that, in his opinion, within a reasonable degree of medical certainty, decedent's skin breakdown was not properly documented in her medical records, and GSH deviated from good and accepted medical and nursing care by, *inter alia*, failing to turn and position decedent, and failing to timely arrange for a wound care team.

The expert opines that although her medical condition increased her risk of developing pressure ulcers, decedent's condition did not render the sacral pressure ulcer to be clinically unavoidable. Instead, the deterioration of Plaintiff's decedent's sacral pressure ulcer could have been avoided with the proper medical and nursing care.

GSH contends that "[t]he Second Department, along with other appellate courts, has upheld the dismissal of claims against health care facilities involving patients who, because of preexisting and ongoing medical conditions, suffer an unavoidable breakdown of the skin." In support of its argument, GSH cites *Korszun v. Winthrop Univ. Hosp.*, 172 A.D.3d 1343, 101 N.Y.S.3d 408 (2d Dep't 2019). In *Korszun*, the 69-year-old patient, who was in a vegetative state, sustained decubitus ulcers during his hospitalization, allegedly as a result of negligent care provided by hospital staff. In opposition to the defendant's summary judgment motion, plaintiff submitted an expert affirmation from a physician whose practice was limited to family and pediatric medicine. The Second Department upheld dismissal of the complaint as against the hospital on the grounds that "[t]he expert affirmation proffered by the plaintiffs failed to lay the requisite foundation for the expert's asserted familiarity with the applicable standards of care in the fields of geriatric medicine and wound care."

In *Vargas v. St. Barnabas Hosp.*, 168 A.D.3d 596, 596, 92 N.Y.S.3d 265 (1st Dep't 2019), also cited by GSH, the First Department held that the plaintiff's expert affidavit in opposition to the defendant's summary judgment motion was insufficient. In that case, the decedent had developed a sacral decubitus ulcer while under the defendant hospital's care. The hospital's expert opined that decedent's ulcer was an unavoidable consequence of underlying comorbidities and maintaining a head-of-bed elevation of greater than 30 degrees to avoid ventilator-related pneumonia. The First Department held that plaintiff's expert affirmation in opposition was

conclusory, misstated the record, mischaracterized the decedent as “relatively healthy,” and failed to address the defendant’s expert’s assertions regarding the necessity of maintaining a head-of-bed elevation.

Finally, in *Novick v. South Nassau Communities Hosp.*, 136 A.D.3d 999, 1001, 26 N.Y.S.3d 182, 185 (2d Dep’t 2016), the Second Department determined that the defendants had established their prima facie entitlement to judgment as a matter of law dismissing the medical malpractice and wrongful death causes of action by submitting affirmations of expert physicians who stated that the decedent’s sacral ulcer was inevitable considering his neck fracture, uncontrolled diabetes, and his nutritional difficulties, noting that the sacral ulcer did not contribute to the decedent's death. The court held that the affirmation of plaintiffs’ expert physician “failed to address these issues,” and an affidavit of a registered nurse was insufficient to raise a triable issue of fact since the nurse lacked the qualifications to render a medical opinion as to the relevant standard of care and whether the defendants deviated from such standard.

Here, GSH does not challenge the qualifications of Plaintiff’s expert or argue that he or she is unqualified to render an opinion on the standard of care for the decedent. The Court finds that the opinions of Plaintiff’s expert are not conclusory or based on speculation, but based on a detailed analysis of decedent’s medical records.

As noted above, “[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions” because “[s]uch conflicting expert opinions will raise credibility issues which can only be resolved by a jury.” *Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902, 48 N.Y.S.3d 420 (2d Dep’t 2017), citing *DiGeronimo v. Fuchs*, 101 A.D.3d 933, 936, 957 N.Y.S.2d 167 (2d Dep’t 2012). The court’s role at the summary judgment stage is only to determine if there are disputed issues of material fact, not to

resolve them. *Zuckerman v. City of New York*, 49 N.Y.2d 557, 427 N.Y.S.2d 595 (1980).

When the experts' disagreement presents a credibility battle, issues of credibility are properly left to a jury for resolution. *Samer v. Desai*, 179 A.D.3d 860, 862, 116 N.Y.S.3d 377, 381 (2d Dep't 2020); see *Feinberg v. Feit*, 23 A.D.3d at 519; *DiGeronimo v. Fuchs*, 101 A.D.3d 933, 957 N.Y.S.2d 167 (2d Dep't 2012). Additionally, "[t]he issue of whether a doctor's negligence is more likely than not a proximate cause of a plaintiff's injury is usually for the jury to decide." *Polanco v. Reed*, 105 A.D.3d 438, 963 N.Y.S.2d 57, 58 (2d Dep't 2013)(internal quotation marks omitted); see *Reid v. Soultz*, 138 A.D.3d 1087, 31 N.Y.S.3d 527, 530 (2d Dep't 2016).

The Court finds that Plaintiff has raised a triable issue of fact with respect to whether Defendants departed from good and accepted medical practice. Plaintiff's expert asserts that the failure of GSH staff to turn and position decedent every two hours and to provide timely and adequate nutritional consultations contributed to the formation and/or worsening of decedent's skin ulcers, directly contradicting Dr. Levine's conclusion that the development of the ulcers was an unavoidable consequence of decedent's comorbidities. See *Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902, 903-04, 48 N.Y.S.3d 420 (2d Dep't 2017); *Pichardo v. St. Barnabas Nursing Home, Inc.*, 134 A.D.3d 421, 424-25, 21 N.Y.S.3d 42 (1st Dep't 2015).

Nevertheless, GSH's motion for summary judgment should be granted to the extent that it seeks dismissal of Plaintiff's causes of action for negligent hiring and supervision and for wrongful death.

A hospital may be liable for a claim of negligent hiring, retention, or supervision if an employee commits an "independent act of negligence outside the scope of employment" and the employer "was aware of, or reasonably should have foreseen, the employee's propensity to

commit such an act.” *Seiden v. Sonstein*, 127 A.D.3d 1158, 1160-61, 7 N.Y.S.3d 565 (2d Dep’t 2015). Here, Plaintiff has failed to allege that anyone employed by GSH committed an act of negligence outside the scope of his or her employment. To the contrary, Plaintiff’s allegations are conclusory and unsupported by any factual allegations. GSH’s motion for summary judgment dismissing the cause of action based upon negligent hiring, training, supervision and retention is therefore granted. *See Evans v. City of Mount Vernon*, 92 A.D.3d 829 (2d Dep’t 2012)(negligent hiring claim must be dismissed when there is no evidence that the employee committed the torts upon which the negligent hiring claim was based).

Plaintiff’s cause of action for wrongful death, as asserted against GSH, is also dismissed. As noted above, decedent was discharged from GSH on February 4, 2016, and died eighteen months later on August 6, 2017. Plaintiff’s expert does not refute Dr. Levine’s opinion that the development of the sacral ulcer and medical departures alleged by Plaintiff did not contribute to decedent’s death, nor does the expert otherwise challenge the cause of death listed on decedent’s death certificate. Accordingly, there is no genuinely disputed material issue of fact as to this claim. *See Vissichelli v. Glen-Haven Residential Health Care Facility, Inc.*, 136 A.D.3d 1021, 1023-24, 25 N.Y.S.3d 639 (2d Dep’t 2016).

Northern Manor’s Motion for Summary Judgment

In support of its own motion for summary judgment, Northern Manor has also submitted, *inter alia*, a copy of decedent’s medical records, in addition to a sworn affirmation of Dr. Roy Goldberg, a board certified physician in internal medicine and geriatric medicine.

Dr. Goldberg notes that as of the date of her admission to Northern Manor on March 21, 2016, decedent was non-ambulatory, wheelchair bound and required assistance with all activities of daily living. The Northern Manor nursing staff documented the sacral pressure ulcer as

measuring 8 x 6 x 4 cm, and a left buttock pressure ulcer measuring 3 x 4 cm. The nursing staff performed a Braden Scale assessment of decedent and scored her at 16, reflecting a low risk for developing additional pressure ulcers.

According to Dr. Goldberg's review of the medical records, after the initial nursing assessment, multiple skin impairment care plans were implemented in order to address decedent's pre-existing pressure ulcers, and to prevent additional wounds from developing. These measures included an "alteration in comfort" care plan and a "skin impairment" care plan, consisting of a turning and positioning schedule, wound consultations, and the use of pressure relieving devices. There were also weekly wound assessments of decedent's ulcers and daily monitoring for signs of infection. She was also provided with potassium and protein supplements to promote wound healing, and began occupational and physical therapy.

Dr. Goldberg also notes that several days after her admission, decedent was evaluated by Dr. Sree Panda, a wound care physician. Dr. Panda documented decedent's pressure ulcers, treated them and performed numerous debridements. The "alteration in comfort" care plan for the sacral ulcer was updated to include the application of warm/moist towels, observation for non-verbal signs of pain, frequent repositioning, moisturize skin as needed, and educating decedent and staff about the importance of repositioning. Dr. Panda continued to see the decedent weekly throughout her admission to Northern Manor.

Based on his review of the medical records, Dr. Goldberg notes that the sacral pressure ulcer began to heal during the following weeks. The medical records reflect that as of May 26, 2016, the sacral wound measured 3.5 x 1.5 x 1 cm, and the left buttock wound had healed. However, on June 24, 2016, decedent was noted with a stage II left heel pressure ulcer measuring 2 x 0 cm. The attending physician was notified, and skin prep was applied followed

by a dry protective dressing. Dr. Goldberg states that protective heel pads were used, and the decedent continued to be turned and repositioned every two hours.

Specialists from Vohra, a wound care speciality practice, also treated decedent weekly from June 24 through July 21, 2106, when Dr. Panda noted that the left heel wound had healed. Decedent did not develop any additional pressure ulcers after June 21, 2016. Dr. Goldberg further notes that when decedent was discharged from Northern Manor on June 8, 2017, the sacral wound measured 1.0 x 0.4 x 0.3 cm.

Plaintiff's bill of particulars alleges that during the decedent's admission to Northern Manor, the facility failed to use reasonable and proper skill in caring for the decedent, adequately manage the decedent's wounds, perform a proper risk assessment of the decedent for development of pressure ulcers, perform an adequate skin assessment, institute an appropriate plan of care and adhere to that plan of care, document the care and treatment rendered, order and follow up with the appropriate regimen, turn and position the decedent every two hours, order the proper pressure relieving devices including a special mattress and heel boots, develop a nutritional plan, implement a physical therapy regimen, and timely order debridements of the decedent's wounds.

However, upon a review of decedent's medical records, Dr. Goldberg opines that the skin impairment care plans implemented for both the sacral and left buttock ulcers with interventions "were appropriate to promote wound healing, and reduce the potential for wound deterioration, which they did," opining "to a reasonable degree of medical certainty, that the staff at Northern Manor properly assessed the decedent's risk for development and worsening of pressure ulcers and implemented the appropriate interventions to avoid both the deterioration of the current wounds as well as the development of any additional wounds."

Dr. Goldberg also opines that “decendent’s dietary needs were appropriately evaluated and the proper wound healing methods were implemented,” noting that Dr. Panda monitored the sacral wound and changed the medication several times until it was effective, and decendent’s care plan was updated to include all additional interventions.

Dr. Goldberg states that “given the decendent’s physical condition at the time, including her comorbidities of cancer, kidney disease, and respiratory failure, that the development of the left heel wound was unavoidable, and not the result of any departure and/or deviation from the standard of medical or nursing care.” He further states that in his opinion, to a reasonable degree of medical certainty, “once the left heel wound developed, the care plans were appropriately updated with the proper interventions, all of which were followed.” With respect to decendent’s sacral ulcer, Dr. Goldberg opines that based upon his review of the medical records, the sacral wound was properly “measured, staged, and described, and the treatment plan and interventions were always evaluated and updated as necessary” and that “findings were appropriately documented in the decendent’s chart” and that decendent received a pressure reducing mattress, wheelchair cushion, and protein supplements, and the turning and positioning schedule was followed.

Dr. Goldberg further opines that decendent’s pressure ulcers “were not caused by any act of negligence by Northern Manor” noting that the sacral and left buttock ulcers both preceded decendent’s admission to Northern Manor, and neither those ulcers, nor the left heel wound, were caused by any act of negligence in the standard of care by Northern Manor staff. Instead, “[a]ll reasonable, necessary and appropriate interventions were in place for the decendent as is evidenced by the records, which show that the wounds were closely followed and, with the exception of the sacral ulcer, all wounds had resolved less than two months after treatment” and

“given the fact that the decedent was responsive to the treatment, [. . .] had she not been discharged home, at her request and at the request of her family, the sacral wound would have healed.”

Finally, Dr. Goldberg notes that based on his review of decedent’s medical chart, the facility staff held quarterly interdisciplinary meetings with decedent’s family to discuss her medical condition, in addition to the availability of social services, activities, and therapy. While being cared for at Northern Manor, decedent showed improvement in her overall physical condition, having gained nine pounds and becoming mobile. According to the medical records, decedent was able to walk more than 200 feet with limited assistance due to regular physical therapy sessions. Dr. Goldberg opines that “Northern Manor’s records reflect consistent and appropriate monitoring, evaluation, re-assessments, and treatment consistent with medical and nursing standard of care” and that “there exists no evidence of departure from good and accepted medical or nursing standards of practice.” He further states that there is no evidence in Northern Manor’s records that decedent developed sepsis, dehydration, malnutrition, or any ailment alleged by Plaintiff’s bill of particulars, other than a urinary tract infection, which was resolved after a five-day course of antibiotics.

Dr. Goldberg states that decedent was discharged from Northern Manor on June 8, 2017, at the request of the decedent and her family, and that in his opinion, to a reasonable degree of medical certainty, “any subsequent deterioration or complication of the decedent’s condition occurred after her admission to Northern Manor had concluded and was not the result of any departure, act or omission by anyone at Northern Manor.”

In view of this proof, the Court finds that Northern Manor has established, prima facie, that decedent’s death was unrelated to any care and treatment she received there, and that

Northern Manor did not depart from medical and nursing standards of care. In opposition, however, Plaintiff has submitted an expert report from a board certified physician who specializes in geriatric medicine. Plaintiff's expert states that, based on his review of the medical records, "decedent's skin breakdown at Northern Manor was not properly documented in her medical records" and "greater attention should have been paid to her care and treatment, including but not limited to turning and positioning." The expert states that the turning and positioning records were not filled out properly or accurately; there are contradictions in decedent's bed mobility charts; and there are other inaccuracies in her medical records. Plaintiff's expert states that "accurate documentation of pressure ulcers is essential in ensuring that pressure ulcers are aggressively met with the appropriate level of treatment," and that "such improper documentation by defendant Northern Manor was a departure in the good and accepted practices of medicine and nursing and the proximate cause of the development and deterioration of the Plaintiff's decedent's pressure ulcers."

Plaintiff's expert further states that it was a departure in the standard care for Northern Manor to fail to accurately and consistently stage and/or size the Plaintiff's decedent's pressure ulcers throughout the medical records. The expert notes, for example, that upon her admission to Northern Manor, decedent was noted with a stage IV sacral pressure ulcer measuring 8 x 6 x 4 cm and a stage II left buttock pressure ulcer measuring 3 x 4 cm, but the following day, on March 22, 2016, decedent's left buttock pressure ulcer was noted as measuring 8 x 2 x 0 cm, much larger than the previous day.

Plaintiff's expert further notes that decedent was not evaluated by a wound care specialist until March 25, 2016, four days after her admission to Northern Manor. The expert also states that even after a sacral infection was suspected by Northern Manor staff on April 18, 2016,

decedent was not evaluated by a wound care specialist until April 21, 2016. Additionally, on November 3, 2016, the medical chart reflects that decedent required a follow-up by a wound care specialist within seven days, but she was not seen by the wound care specialist until November 17, 2016. Plaintiff's expert opines that Northern Manor's failure to arrange for the wound care team to timely assess the Plaintiff's decedent's pressure ulcers constituted a deviation from good and accepted medical practice.

The expert opines that while decedent had multiple comorbidities and prior medical conditions which may have increased her risk for the development and deterioration of pressure ulcers, they did not render the pressure ulcers that developed and deteriorated as clinically unavoidable. Instead, "Plaintiff's decedent's skin breakdown and deterioration was caused by unrelieved pressure, rather than her critical medical conditions" and "the development and deterioration of Plaintiff's decedent's pressure ulcers could have been avoided with the proper medical and nursing care, provided by and under the supervision of defendant Northern Manor."

Additionally, the expert notes that a wound biopsy on July 7, 2016, revealed the existence of a bacterial infection, but decedent was not transferred to a hospital at any time during her residency, and the failure to transfer decedent to a hospital "is a clear deviation from the good and acceptable standards of medical care, and was the proximate cause of decedent's injuries." Moreover, decedent was in pain from the pressure ulcers, as evidenced by Northern Manor's records indicating that she was treated with Percocet, and the pain affected her ability to sleep, her appetite, and her desire to participate in activities and her overall mobility. With respect to the heel pressure ulcer, Plaintiff's expert notes that heel booties were not provided on a number of dates, although the ulcer had healed as of July 29, 2016.

As noted above, "the requisite elements of proof in a medical malpractice action are a

deviation or departure from accepted community standards of medical practice, and evidence that such deviation or departure was a proximate cause of injury or damage.” *Raucci v. Shinbrot*, 127 A.D.3d 839, 841, 5 N.Y.S.3d 314 (2d Dep’t 2015).

Ultimately, Plaintiff’s expert opines that Northern Manor’s departure from accepted standards of care was a proximate cause of the development and deterioration of decedent’s pressure ulcers, pain and suffering, and death. Plaintiff’s expert acknowledges that decedent’s left buttock wound had healed by May 26, 2016, and the heel pressure ulcer healed within approximately one month. Plaintiff’s expert does not specifically state that these wounds would have healed faster had Northern Manor not departed from the standard of care. With respect to the sacral pressure ulcer, however, decedent underwent numerous surgical debridements while under Northern Manor’s care and developed a bacterial infection, and experienced substantial pain. The healing of the wound was not linear--it initially improved, then deteriorated, and subsequently improved.

At trial, “where causation is often a difficult issue, a plaintiff need do no more than offer sufficient evidence from which a reasonable person might conclude that it was more probable than not’ that the defendant’s deviation was a substantial factor in causing the injury.” *Goldberg v. Horowitz*, 73 A.D.3d 691, 901 N.Y.S.2d 95 (2d Dep’t 2010), citing *Johnson v. Jamaica Hosp. Med. Ctr.*, 21 A.D.3d 881, 800 N.Y.S.2d 609 (2d Dep’t 2005); see also *Neyman v. Doshi Diagnostic Imaging Servs., P.C.*, 153 A.D.3d 538, 59 N.Y.S.3d 456 (2d Dep’t 2017). “As to causation, the plaintiff’s evidence may be deemed legally sufficient [at trial] even if its expert cannot quantify the extent to which the defendant’s act or omission decreased the plaintiff’s chance of a better outcome or increased his injury, as long as evidence is presented from which the jury may infer that the defendant’s conduct diminished the plaintiff’s chance of a better

outcome or increased his injury.” *Id.*, quoting *Flaherty v. Fromberg*, 46 A.D.3d 743, 745, 849 N.Y.S.2d 278 (2007).

Here, the Court finds that Plaintiff has raised a triable issue of fact as to whether the alleged departures by Northern Manor caused decedent’s sacral bacterial infection, prolonged the healing process of all of the pressure ulcers, and caused or contributed to the many surgical debridements that decedent ultimately underwent at Northern Manor. Plaintiff has also raised a triable issue of fact as to whether Northern Manor’s alleged departures caused decedent’s left heel pressure ulcer.

However, Plaintiff has failed to raise a triable issue of fact in opposition to Northern Manor’s showing that decedent died from underlying medical conditions, not any treatment or care rendered by Northern Manor. *Anzalone v. Long Is. Care Ctr., Inc.*, 26 A.D.3d 449, 810 N.Y.S.2d 514 (2d Dep’t 2006). Nor has Plaintiff raised a triable issue of fact as to whether any employee of Northern Manor committed an act of negligence outside the scope of his or her employment. Thus, Plaintiff’s cause of action against Northern Manor for negligent hiring and retention is dismissed, as is the claim for wrongful death. *Henry v. Sunrise Manor Ctr. for Nursing & Rehabilitation*, 147 A.D.3d 739, 46 N.Y.S.3d 649 (2d Dep’t 2017); see *Seiden v. Sonstein*, 127 A.D.3d 1158, 1160-61, 7 N.Y.S.3d 565 (2d Dep’t 2015).

Public Health Law

Finally, the Court addresses Plaintiff’s causes of action against Northern Manor based on Public Health Law. The complaint alleges violations of Public Health Law §§ 2801-d and 2803-c, and NYCRR 415.12, 42 U.S.C § 1395(i) et seq.,² and 42 C.F.R. Part 483.

Public Health Law § 2801-d allows a patient of a residential health care facility to maintain a private action against the facility when the facility deprives him or her of “any right

² This section is not addressed by the parties.

or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation.” § 2801-d (1).

The basis for liability under Public Health Law § 2801-d “is neither deviation from accepted standards of medical practice nor breach of a duty of care. Rather, it contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule.” *Novick v. South Nassau Communities Hosp.*, 136 A.D.3d 999, 1001, 26 N.Y.S.3d 182, quoting *Zeides v. Hebrew Home for Aged at Riverdale*, 300 A.D.2d 178, 179, 753 N.Y.S.2d 450; also see *Moore v. St. James Health Care Ctr., LLC*, 141 A.D.3d 701, 703, 35 N.Y.S.3d 464 (2d Dep’t 2016)(liability under the Public Health Law contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule, subject to the defense that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient).

Nevertheless, Pub. Health L. § 2801-d is not a “strict liability” statute. The existence of a violation alone, without more, will not suffice for the imposition of liability. In order to prevail on a claim predicated on Pub. Health L. § 2801-d, the plaintiff must establish that the alleged deprivation of a right or benefit proximately caused an injury. See *Gold v. Park Avenue Extended Care Ctr. Corp.*, 90 A.D.3d 833, 834, 935 N.Y.S.2d 597, 599 (2d Dep’t 2011).

Public Health Law § 2803-c provides that every nursing home and facility providing health related service adopt a statement of the rights and responsibilities of patients who are receiving care in such facilities and shall treat such patients in accordance with the provisions of such statement. The statute enumerates eighteen such rights and responsibilities to be afforded to patients who are receiving care in every nursing home and facility providing health related

service.

NYCRR 415.12 (c), provides, in relevant part, that “[b]ased on the comprehensive assessment of a resident, the facility shall ensure that: (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Finally, 42 CFR 483.25 (b) entitled “Quality of Care” provides that “[b]ased on the comprehensive assessment of a resident, the facility must ensure that (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

A healthcare facility can establish its entitlement to summary judgment through an expert affirmation that states that the regulations set forth in plaintiff’s bill of particulars as the bases for the causes of action asserted in the complaint were not violated, and even if they were, those violations did not proximately cause the alleged injuries. *Gold v. Park Ave. Extended Care Ctr. Corp.*, 90 A.D.3d 833, 834 (2d Dep’t 2001).

Here, Northern Manor has established its prima facie entitlement to summary judgment as a matter of law on that branch of its motion which was for summary judgment dismissing the cause of action based on Public Health Law § 2801-d and Public Health Law § 2803-c through the affirmation of its expert physician, Dr. Goldberg, who opined that Northern Manor did not

violate the various federal and state regulations set forth in the plaintiffs bill of particulars as the basis for this cause of action, and that even if any regulations were violated, none of the alleged injuries were proximately caused by these violations. *See Novick v. South Nassau Comm. Hosp.*, 136 A.D.3d 999, 26 N.Y.S.3d 182, 185 (2d Dep't 2016). Northern Manor also established that it exercised all care reasonably necessary to prevent any deprivation of decedent's rights by regularly and frequently monitoring her skin integrity, nutritional status, through physical conditioning and strength, and by implementing appropriate care plans and interventions, and that Northern Manor ensured that decedent was provided with appropriate care and consults by physicians, nurses and related providers, and that such care met the prevailing standards of medical care and services.

However, for the same reasons explained above, the Court finds that Plaintiff has raised triable issues of fact, through its expert, as to whether the care provided by Northern Manor, or lack thereof, caused decedent to develop a left heel pressure ulcer, and otherwise caused the deterioration of decedent's other pressure ulcers. Plaintiff has made a sufficiently detailed showing that the lack of care provided by Northern Manor, as alleged by Plaintiff, would constitute a deprivation of decedent's rights under the Public Health Law and the other relevant statutes. *Compare Gold v. Park Ave. Extended Care Ctr. Corp.*, 90 A.D.3d 833, 935 N.Y.S.2d 597 (2d Dep't 2011).

Accordingly, it is hereby:

ORDERED, that Defendant GSH's motion for summary judgment (Motion Seq. #2) is granted only to the extent that Plaintiff's causes of action for wrongful death and negligence based on negligent hiring, training, supervision are dismissed; and it is further

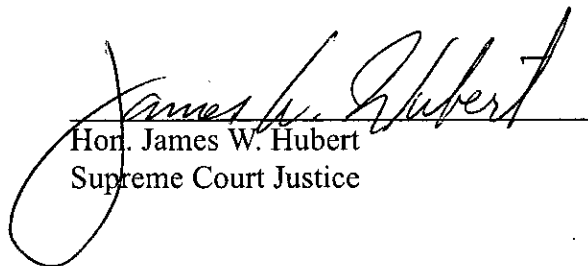
ORDERED, that Defendant Northern Manor's motion for summary judgment (Motion

Seq. #1) is granted only to the extent that Plaintiff's causes of action for wrongful death and negligence based on negligent hiring, training, supervision are dismissed; and it is further

ORDERED, that the parties are directed to appear for a ~~preliminary~~^{settlement} conference at a time and date to be established by the ~~Preliminary~~^{Settlement} Conference Part.

The foregoing constitutes the Decision & Order of the Court.

Dated: White Plains, New York
March 9, 2021


Hon. James W. Hubert
Supreme Court Justice