At an IAS Term, Part 15 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse thereof at 360 Adams St., Brooklyn, New York on the 17th day of June 2021.

P R E S E N T:
HON. PAMELA L. FISHER,
J.S.C.

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ONIEL ROSE, as Administrator of the Estate of Ella Rose, and ONIEL ROSE Individually,

Plaintiff,

DECISION/ORDER

- against -

Index No: 503630/2018

BROOKDALE HOSPITAL MEDICAL CENTER,
Defendant.

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Recitation, as required by CPLR §2219(a), of the papers considered in the review of this motion:

	Papers Numbered
Notice of Motion/Cross Motion/Order to Show Cause and Affidavits (Affirmations) Annexed	1, 2
Opposing Affidavits (Affirmations)	3
Reply Affidavits (Affirmations)	4

Upon the foregoing papers in this medical malpractice action, defendant moves, pursuant to CPLR § 3212, for summary judgment, dismissing plaintiff's complaint in its entirety.

Plaintiff commenced this action by filing a summons and complaint on or about February 21, 2018 (Summons & Complaint, annexed as Exhibit B to defendant's motion papers; Defendant's Affirmation in Support ¶ 5). Issue was joined on or about April 9, 2018, and plaintiff served a bill of particulars on or about June 14, 2018 (*Id.* at ¶¶ 6, 7; Answer annexed as Exhibit C to defendant's motion papers; Verified Bill of Particulars annexed as Exhibit D to defendant's motion papers). In his complaint and bill of particulars, plaintiff alleges that the staff at Brookdale Hospital deviated from the standard of care in their treatment of the decedent from August 7, 2015 through November 18, 2015 by neglecting "to turn and position the decedent every two hours and as needed," "failing to provide proper nutrition and hydration to the decedent," "failing to timely order and implement the proper

pressure relieving devices and equipment," and "failing to keep accurate records of the treatment rendered to the plaintiff's decedent" (Complaint ¶ 6; Verified Bill of Particulars ¶ 3). As a result of defendant's alleged malpractice, plaintiff is claiming that decedent sustained the following injuries: sacral pressure ulcer, left ear pressure ulcer, right shoulder pressure ulcer, upper back pressure ulcer, debridement, infection, sepsis, necrosis, deep tissue injury, dehydration, malnutrition, emotional trauma, pain and suffering, and death (Verified Bill of Particulars ¶ 9).

The following facts are not in dispute. On August 7, 2015, decedent, a 75-year-old woman, first presented to the Emergency Room at Brookdale Hospital Medical Center (Brookdale), complaining of a severe headache (Plaintiff's Expert Affirmation ¶ 6, annexed as Exhibit 1 to plaintiff's opposition papers). At this visit, her skin was "noted to be warm, dry, and negative for rash," and she was discharged that same day (*Id.* at ¶ 7). On August 31, 2015, decedent returned to Brookdale "after being found aphasic at home" (*Id.* at ¶ 8). After a CT scan of her brain was performed, the decedent was diagnosed with an intracerebral hemorrhage; the records also indicate that she had high blood pressure and diabetes (Defendant's Expert Affirmation ¶¶ 5, 6, annexed as Exhibit A to defendant's motion papers). Another CT scan was performed on September 1, 2015, "reveal[ing] an acute evolving hemorrhage in the left front lobe with surrounding edema" (*Id.* at ¶ 7). The notes from a physical examination performed on August 31, 2015 state that her skin was intact, she weighed 180 pounds, and she was "neglecting the right side of her body" (*Id.* at ¶ 6; Plaintiff's Expert Affirmation ¶¶ 10, 11). During her hospital stay at Brookdale, decedent had seizures on September 2, 2015, September 3, 2015, and October 28, 2015 (*Id.* at ¶¶ 12, 13, 50). On September 3, 2015, Dr. Louis Cornacchia, the attending neurosurgeon, "recommended surgical decompression and hematoma evacuation to improve decedent's condition" (Defendant's Expert Affirmation ¶ 7). On September 4, 2015, the chart indicates that "registered dietician ("RD") Nicole Boland recommended Glucerna 1.2 at a rate of 30 ml per hour for 20 hours to be increased to a rate of 70 ml per hour" (*Id.* at ¶ 8). On September 5, 2015, turning and

positioning of the decedent was ordered to prevent pressure ulcers (*Id.* at ¶ 9). On September 6, 2015, the notes indicate that decedent's condition was improving, and that surgery to "evacuate the hematoma was no longer [necessary]" (*Id.* at ¶ 10). On September 8, 2015, decedent was being fed through a "nasogastric tube" (*Id.* at ¶ 11). On September 10, 2015, the medical records reveal that "Mepilex was [being] applied to the decedent's sacrum and heel" to prevent decedent from developing pressure ulcers (*Id.*). On September 11, 2015, Venodynes and heel protectors were also used, "in addition to Mepilex on the sacrum and heels," to prevent pressure ulcers (*Id.* at ¶ 12). On September 14, 2015, the decedent was examined by Dr. Raman Sharma, M.D., who recorded that decedent had a low Braden score, indicating that she "was at a high risk for pressure ulcers" (*Id.* at ¶ 14). The notes also state that decedent's condition "was deteriorating," and "she developed sepsis due to streptococcus pneumoniae, postoperative aspiration pneumonia, and nosocomial pneumonia" (*Id.*). She was also intubated on September 14 "for airway protection and respiratory distress" (Plaintiff's Expert Affirmation ¶ 23). On September 15, 2015, it was noted that decedent had lost 33 pounds over a two-week period (*Id.* at ¶ 24). Decedent developed a fever on September 18, 2015, which continued to increase through September 22, 2015 (*Id.* at ¶ 28; Defendant's Expert Affirmation ¶ 17).

On September 20, 2015, the chart indicates that decedent had developed a "purple blister" on her left ear "measuring 2 cm x 1 cm" (Plaintiff's Expert Affirmation ¶ 29). On September 22, 2015, "a closed blister on plaintiff's decedent's back was noted for the first time" (*Id.* at ¶ 30). On September 23, 2015, the medical records reflect that decedent had "two intact blisters to the right shoulder area," and "a left ear deep tissue injury" (*Id.* at ¶ 31; Defendant's Expert Affirmation ¶ 19). One note from September 24, 2015 states that decedent weighed 160 pounds, but in a note from later that day, her weight is recorded at 151 pounds (Plaintiff's Expert Affirmation ¶ 33). A tracheostomy procedure was performed on September 24, 2015 (Defendant's Expert Affirmation ¶ 20). On September 25, 2015, "RN Karlene Campbell noted an ulcer to the left ear, a right upper back open blister, a right ribcage

open blister, and one intact blister to the right upper back" (*Id.* at ¶ 21). Dr. Zagoruychenko also examined the patient, and advised that decedent had a low Braden score; he "ordered full bed care, including turning and positioning every two hours" (*Id.*). Dr. Jackson "ordered bacitracin to be applied twice daily" to the "open blisters on the decedent's right upper back" (*Id.*). On September 27, 2015, Dr. Zagoruychenko observed "a small excoriation on the decedent's right scapular area," measuring 1.5 cm by 1 cm, "with a clear base, and a left deep tissue injury" (*Id.* at ¶ 22). The notes indicate that decedent had an infection, but the source of the infection was unknown (*Id.*). Bacitracin was applied to decedent's excoriation and deep tissue injury, and turning and positioning was ordered every 2 hours (*Id.*). On September 28, 2015, Mepilex "was applied to the scapular excoriation" (*Id.* at ¶ 23). On September 29, 2015, Dr. Zagoruychenko suspected "decedent's right knee was a possible source of infection due to its edema;" he "recommended 1 dose of vancomycin" (*Id.*). The records from September 30, 2015 reveal that "decedent received local wound care, protective dressing, and bed repositioning every two hours" (*Id.* at ¶ 24). Dr. Zagoruychenko observed "denuded skin" on decedent's sacrum, which had "deteriorated to a Stage III" (*Id.*). On October 1, 2015, "decedent underwent arthrocentesis of her right knee," and Dr. Sharma indicated that "decedent's knee arthrocentesis showed no growth, and was negative for crystals" (*Id.* at ¶ 25). Bacitracin was applied to the decedent's blisters (*Id.*). From October 3, 2015 through October 5, 2015, "decedent entered the diuretic phase of acute renal function, and exhibited anemia, fever, and hypoxia" (*Id.* at ¶ 26). On October 5, 2015, decedent "received packed red blood cells" (*Id.* at ¶ 26).

On October 6, 2015, Dr. Zagoruychenko observed a Stage II sacral pressure ulcer, measuring 8 cm by 7 cm, "with a clear base without discharge" (*Id.* at ¶ 27). The physician recorded that this ulcer was "unpreventable," and developed despite the frequent turning and positioning, and the use of a special mattress (*Id.*). Nystatin powder was ordered, and was supposed to be applied around the sacral and perianal area (*Id.*). On October 7, 2015, "plaintiff's decedent's sacral pressure ulcer was described

as 'healing denuded skin;' the left ear pressure ulcer was described as 'healing stage II,' and the back blisters were described as 'two areas of healing open blisters'" (Plaintiff's Expert Affirmation ¶ 41). A nurse practitioner recommended a crusting procedure with nystatin powder to treat decedent's sacrum, application of miconazole cream twice a day to the "perineal area," application of mepilex dressing every 5 days to decedent's back lesions, and Sensi-Care protective barrier cream two times daily to the decedent's left ear (Defendant's Expert Affirmation ¶ 28). She also recommended turning and positioning every 2 hours, and using heel protectors (*Id.*). On October 12, 2015, the notes reveal that the decedent's sacrum pressure ulcer and upper back pressure ulcer were "healing with clean bases and no discharge;" she "remained febrile with the source of the fevers still not known" (Plaintiff's Expert Affirmation ¶ 42). On October 16, 2015, decedent's sacrum pressure ulcer was documented as improving, and her upper back pressure ulcer was unchanged (*Id.* at ¶ 43). A PEG tube was inserted on October 19, 2015 (*Id.* at ¶ 44). The upper back pressure ulcer had healed, and the sacral pressure ulcer had deteriorated to Stage III "with a foul smelling yellowish-greenish discharge, indicating signs of infection" (*Id.*). On October 20, 2015, "plaintiff's decedent's sacral pressure ulcer was described as Stage II measuring 8 cm x 7 cm with some yellowish discharge;" the "excoriation at the left scapular area" measured 2 cm x 3 cm, and was "described to be in a healing stage" (*Id.* at ¶ 45). The left ear excoriation was also noted to be healing (*Id.*). The "decedent's sacral ulcer was covered with mepilex, and treated with Santyl." A note written a few hours later on October 20, 2015, states that decedent's sacral pressure ulcer was at Stage III (*Id.* at ¶ 46).

On October 21, 2015, the notes document that the decedent had a "Stage III sacral pressure ulcer measuring 9.5 cm x 13.5 cm x 1 cm," and the left ear ulcer that "had been described" as healing the previous day, was now Stage IV, "measuring 1 cm x 0.6 cm with scant exudate and red tissue" (*Id.* at ¶ 47). On October 22, 2015, plaintiff's decedent's sacral ulcer was described as "Stage II measuring 8 cm x 7 cm with some yellowish discharge," and the left ear ulcer was noted to be healing (*Id.* at ¶

48). On October 26, 2015, decedent had "two unstageable sacral ulcers on the right and left with black eschar on the surface," which were debrided that same day (*Id.* at ¶ 49). After the debridement, the "decedent's excoriation at the left scapular area [measured] 2 cm by 3 cm" (Defendant's Expert Affirmation ¶ 34). Collagenase and Sensi-Care barrier cream were applied to decedent's ulcers (*Id.*). Plaintiff had three seizures in the morning of October 28, 2015, and a CT scan revealed "acute hemorrhage in the left frontal lobe;" "the decedent was comatose but" "hemodynamically stable" (Plaintiff's Expert Affirmation ¶ 50). Her skin was treated with "ammonium lactate, bacitracin ointment, collagenase, and white petrolatum ointment" (Defendant's Expert Affirmation ¶ 35). On November 2, 2015, the decedent's sacral ulcer had a "clear base with no discharge," and the left ear ulcer and the left scapular area were healing (Plaintiff's Expert Affirmation ¶ 51). On November 5, 2015, decedent's sacral pressure ulcer measured 12 cm x 10 cm, and it was "noted to be at Stage II during plaintiff's decedent's nutrition follow up" on November 16, 2015 (*Id.* at ¶¶ 53-54). On November 18, 2015, decedent's sacral ulcer was documented to be at Stage III "measuring 9.5 cm x 13.5 cm x 0.1 cm," and "[w]ound bed with 60% subcutaneous tissue, 40% tan necrotic tissue, and small serosanguineous exudate were also noted" (*Id.* at ¶ 55). Plaintiff's left ear ulcer was at "Stage IV measuring 1 cm x 0.6 cm," and "[w]ound bed with subcutaneous tissue and scant exudate was also noted" (*Id.*). Decedent was discharged from Brookdale on November 18, 2015, and was transferred to The Pavilion Nursing Home (*Id.* at ¶ 57). Plaintiff was found unresponsive by nursing staff at the Pavilion Nursing Home on February 22, 2016, and she was admitted to Flushing Hospital, where she was diagnosed with hypotension and hemorrhage (*Id.* at ¶ 60). She passed away on February 29, 2016 at Flushing Hospital (*Id.*).

In support of its motion for summary judgment, defendant submits an expert affirmation from Cindy Ilsa Kiely, MSN, RN, CNML, CWCN, VHA-CM, a registered nurse "[c]ertified as a Wound, Ostomy, Continence Nurse," contending that the treatment rendered to the decedent at Brookdale did

not deviate from the standard of care, and that her injuries did not result from any act or omission of the hospital or their staff. (Defendant's Expert Affirmation ¶¶ 2, 40). Nurse Kiely's opinion is based on review of "various materials, including but not limited to, plaintiff's Bill of Particulars and the Brookdale medical records" (*Id.* at ¶ 4). Nurse Kiely opines that the staff at Brookdale took appropriate measures to prevent pressure ulcers, and treat them once they developed, by turning and positioning decedent every two hours, assessing and cleansing the skin, using a pressure reducing mattress, and monitoring the decedent's nutrition (*Id.* at ¶¶ 42, 43, 46). Further, she maintains that defendant's documentation of decedent's pressure ulcers was consistent with the standard of care (*Id.* at ¶ 45). She states that variation in the measurement of pressure ulcers can occur due to the "tools used and the training of the nurse measuring the ulcer" (*Id.*). She explains that some nurses measure "the surface area of an ulcer, while others are trained to measure an ulcer edge to edge," and some nurses also include "Incontinence Associated Dermatitis, blisters, and excoriations, in their measurements of ulcers" (*Id.*). Nurse Kiely claims that decedent's pressure ulcers were unavoidable due to her co-morbidities, including "intracerebral hemorrhages," "diabetes, hypertension, renal disease and multiple infections" (*Id.* at ¶ 47). She suggests that these co-morbidities indicate that decedent had "multi-system organ failure, which decreased her skin's ability to recover and heal" (*Id.*). Nurse Kiely concludes that defendant did not proximately cause decedent's pressure ulcers (*Id.* at ¶ 48).

In opposition to defendant's motion for summary judgment, plaintiff submits a redacted expert affirmation from a physician board certified in internal medicine and geriatric medicine, who opines that defendant deviated from the standard of care, resulting in the development and deterioration of decedent's pressure ulcers (Plaintiffs' Expert Affirmation ¶¶ 1, 5). His/her opinion is based on review of the medical records, pleadings, bill of particulars, and deposition transcript (*Id.* at ¶ 4). Plaintiff's expert maintains that defendant departed from acceptable medical practice by "fail[ing] to accurately and consistently stage and/or size" decedent's pressure ulcers (*Id.* at ¶ 64). In support of this claim,

plaintiff's expert points out instances of variation in the measurement of decedent's pressure ulcers in the medical record. For example, on October 21, 2015, the medical record states that decedent had a Stage III sacral pressure ulcer measuring 9.5 cm x 13.5 cm x 1 cm, but a note written the next day documented that the sacral pressure ulcer was at Stage II measuring 8 cm x 7 cm (*Id.*). Plaintiff's expert explains that accurate documentation of the stage and size of the ulcers is critical to enable healthcare providers to effectively communicate and treat pressure ulcers (*Id.* at ¶ 63). Plaintiff's expert also contends that defendant deviated from the standard of care by failing to turn and position the decedent at least every two hours (*Id.* at ¶¶ 65-66, 69). He/she points out instances in the medical record where the decedent is documented in one position for more than two hours. For example, on September 15, 2015, decedent was "lying on her right side from 11:00 AM to 3:00 PM, before being repositioned to her left side" (*Id.* at ¶ 67). He/she claims that frequent turning and positioning "is critical, as it distributes pressure to different parts of the body so that no one part receives pressure for any great deal of time" (*Id.* at ¶ 65). Further, plaintiff's expert alleges that defendant deviated from the standard of care by not providing adequate nutrition and hydration to decedent, evidenced by her thirty-three-pound weight loss during the first two weeks of her admission, and the failure to insert a PEG-tube until October 19, 2015 (*Id.* at ¶ 68). Plaintiff's expert suggests that this departure proximately caused decedent to develop pressure ulcers, as "maintaining proper nutrition and hydration contributes to the prevention and promotion of healing skin breakdowns" (*Id.* at ¶ 68). Plaintiff's expert disagrees with Nurse Kiely's opinion that decedent's pressure ulcers were unavoidable due to her co-morbidities (*Id.* at ¶ 74). He/she affirms that while plaintiff's co-morbidities may have increased "her risk factor for the development of pressure ulcers," they were not unavoidable, and "greater care and attention should have been paid to her care and treatment" (Id. at ¶¶ 75-77). Plaintiff's expert concludes that defendant's deviations from the standard of care proximately caused the development and deterioration of decedent's pressure ulcers (*Id.* at ¶ 86).

In reply, defendant reiterates that the staff at Brookdale never deviated from the standard of care in their treatment of decedent, and that plaintiff's expert affirmation fails to raise a triable issue of fact (Defendant's Reply Affirmation ¶ 6). Defendant claims that a failure to document the turning and positioning of the decedent every two hours does not indicate that it was not done, and the lack of documentation is insufficient to defeat defendant's summary judgment motion (*Id.* at ¶¶ 7-8, 10). Further, plaintiff's expert opinion lacks specificity regarding how often the decedent should have been turned and positioned, and when certain measures, such as a feeding tube and pressure reducing mattress, should have been implemented (*Id.* at ¶¶ 11, 12). Defendant maintains that plaintiff's argument that the pressure ulcers were not unavoidable, is conclusory, as his expert has failed to address "how the decedent's co-morbidities may have affected the integrity of her skin and its ability to heal," or that the decedent "was experiencing multi-system organ failure" (*Id.* at ¶ 14).

To prevail on a cause of action for medical malpractice, the plaintiff must prove that defendant "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]). On a motion for summary judgment, defendant 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 Is. Univ. Hosp.*, 106 AD3d 696, 697 [2d. Dept. 2013]). Once the defendant meets its burden, the burden then shifts to the plaintiff to "raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing" (*Stukas*, 83 AD3d at 24). If the defendant "makes only a prima facie showing that he or she did not deviate or depart from accepted medical practice, the plaintiff, in order to defeat summary judgment, need only raise a triable issue of fact as to the alleged deviation or departure, and need not address the issue of proximate cause" (*Hayden v. Gordon*, 91 AD3d 819, 821 [2d. Dept. 2012]). Conclusory allegations that are "unsupported by competent evidence tending to establish the essential elements of

medical malpractice are insufficient to defeat defendant physician's summary judgment motion" (*Deutsch v. Chaglassian*, 71 AD3d 718, 719 [2d. Dept. 2010]). Where the parties have submitted conflicting expert reports, summary judgment should not be granted; "[s]uch credibility issues can only be resolved by a jury" (*Id.*).

Here, defendant met its prima facie burden. Defendant's expert, Nurse Kiely affirmed that the practice and procedures by the staff at Brookdale were within acceptable standards of medical practice, and that no act or omission of defendant proximately caused any injury to the decedent. She contends that decedent's pressure ulcers were unavoidable due to the decedent's co-morbidities. Nurse Kiely's opinion constitutes competent evidence, in that it is based on the medical records and bill of particulars.

In opposition, plaintiff produced an affidavit of merit from a physician board certified in internal medicine and geriatric medicine attesting to departures from accepted standards of medical practice, and that these departures were a competent producing cause of the decedent's injuries. Plaintiff's expert opinion, based on review of the medical records, pleadings, bill of particulars, and deposition transcript, raises triable issues of fact. Accordingly, questions of fact preclude summary judgment in defendant's favor on the medical malpractice and wrongful death causes of action due to the conflicting expert reports (*See Deutsch*, 71 AD3d at 719). As plaintiff has failed to oppose defendant's motion for summary judgment as to the claim for negligent hiring and supervision alleged in paragraph 21 of the complaint, the negligent hiring and supervision claim is hereby dismissed. Defendant's motion for summary judgment is granted in part and denied in part.

This constitutes the decision and order of the Court.

ENTER:

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HON. PAMELA L. FISHER