

**Colvil v New Carlton Rehab & Nursing Ctr., LLC**

2022 NY Slip Op 30921(U)

March 21, 2022

Supreme Court, Kings County

Docket Number: Index No. 519544/18

Judge: Ellen M. Spodek

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This opinion is uncorrected and not selected for official publication.

At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 21<sup>st</sup> day of March, 2022.

P R E S E N T:

HON. ELLEN M. SPODEK,

Justice.

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FRANCES COLVIL, as Administratrix of the Estate of  
LEON SINGLETON, and FRANCES COLVIL, Individually,

Plaintiffs,

-against-

NEW CARLTON REHAB AND NURSING CENTER, LLC,  
THE BROOKLYN HOSPITAL CENTER,  
and KFG OPERATING I, LLC, d/b/a  
HOPKINS CENTER FOR REHABILITATION AND HEALTHCARE,

Defendants,  
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DECISION, ORDER, AND JUDGMENT

Index No. 519544/18

Mot. Seq. No. 7

The following e-filed papers read herein:

NYSCEF Doc No.:

Notice of Motion, Affirmations, and Exhibits Annexed \_\_\_\_\_

85-136

Opposing Affirmations and Exhibits Annexed \_\_\_\_\_

163-194

Affirmation in Reply \_\_\_\_\_

195-196

Upon the foregoing papers in this action for negligence and medical malpractice, defendant The Brooklyn Hospital Center (“TBHC”) moves in Seq. No. 7 for an order, pursuant to CPLR 3212, granting it summary judgment dismissing the amended complaint as against it. Frances Colvil, individually and as the administratrix of the estate of Leon Singleton, deceased (collectively, “plaintiff”), opposes TBHC's motion. Defendant New Carlton Rehab and Nursing Center, LLC (“Carlton”) has filed no response to TBHC's motion. The remaining defendant KFG Operating I, LLC, doing business as Hopkins

Center for Rehabilitation and Healthcare (“Hopkins”), settled plaintiff’s claims as against it at an ADR conference held on July 21, 2021 (NYSCEF Doc No. 162).

### Background

TBHC and plaintiff have stipulated to a set of agreed facts (NYSCEF Doc No. 87 and 194). Plaintiff’s decedent, Leon Singleton (the “patient”), began residing at Carlton’s nursing home on August 9, 2011 when he was 63 years old. Thereafter, he resided at Carlton without interruption from December 24, 2014 to March 24, 2016.

In March 2016,<sup>1</sup> the patient, while residing at Carlton, was suffering from at least three bedsores.<sup>2</sup> In particular, by March 23<sup>rd</sup>, the patient had: (1) a *sacral* bedsore measuring 4 x 3 x 1.3 cm; (2) an infected and foul-smelling *left buttock* bedsore; and (3) a reopened *right buttock* bedsore measuring 4 x 3 x 0.2 cm.

The following day, March 24<sup>th</sup>, the patient was transferred by ambulance to TBHC after the Carlton staff had found him unresponsive, weak, and lethargic. On his way by ambulance to TBHC, his pulse was not palpable; his blood pressure was 80/50 (severe hypotension); and he was “unconscious, taking shallow breaths with little air movement” (TBHC’s Records at 03946).<sup>3</sup> On presentation to TBHC, the patient’s principal medical problems were: (1) sepsis “likely due to [a] urinary tract infection and [the] infected

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<sup>1</sup> Unless otherwise indicated, all subsequent references are to year 2016.

<sup>2</sup> In fact, TBHC’s records reflect that the patient had been suffering from “chronic decubitus ulcers” since at least August 2014 (TBHC’s Records at 02943).

<sup>3</sup> Except where otherwise indicated, all references are to the documents included in the copy of the patient’s respective charts maintained by: (1) TBHC, which are Bate-stamped 00001-07809 (NYSCEF Doc No. 112-133) (“TBHC’s Records”); (2) Carlton, which (to the extent provided to the Court) are Bate-stamped 0002-01418 (NYSCEF Doc No. 111) (“Carlton’s Records”); and (3) Hopkins, which are Bate-stamped 0001-0489 (NYSCEF Doc No. 135-136) (“Hopkins’s Records”). The Court, when quoting from the patient’s charts, has spelled out all abbreviations.

unstageable decubitus ulcer next to [the] gluteal fold (*i.e.*, a bedsore on his *buttocks*); (2) hypernatremia likely due to dehydration; (3) coronary artery disease and peripheral artery disease, in the presence of hypertension, diabetes, and the above-the-knee amputation of his left leg; and (4) dementia/schizoaffective disorder (TBHC's Records at 03846-03848). The patient was non-verbal and disoriented; he was "bedfast," "completely immobile," and had "difficulty swallowing foods"; he depended on others for all activities of daily living in all respects (toileting, bathing, eating, etc.) (TBHC's Records at 03859-03860). He "appear[ed] much older than [his] stated age [of 67]" (TBHC's Records at 03841). In sum, the patient's prognosis was grim, with the projected life expectancy of six months or shorter (TBHC's Records at 03848).<sup>4</sup>

The patient was admitted to TBHC's Level-1 medical intensive care unit, from the date of his initial presentation on March 24<sup>th</sup> until his discharge from TBHC on April 8<sup>th</sup> (the "first TBHC admission"). On March 25<sup>th</sup> (one day after the start of the first TBHC admission), the nursing team documented that the patient was suffering from several pre-existing bedsores: (1) an unstageable coccyx (*i.e.*, *sacral*) bedsore; (2) a stage IV *left buttock* bedsore measuring 9 x 10 x 5 cm; and (3) a stage II bedsore covering his entire *buttocks* and upper thighs. Three days later on March 28<sup>th</sup>, a surgical consult noted that the patient was suffering from: (1) a stage II *sacral* bedsore measuring 10 x 14 cm; and (2) a stage IV bedsore (no site indicated) measuring 2 x 4 cm. The following day (March 29<sup>th</sup>), an 8 x 10 cm area of the patient's *sacral* bedsore was surgically debrided to the level of the fresh bleeding tissue. On March 31<sup>st</sup>, a nursing assessment documented

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<sup>4</sup> The patient's body mass index was 29.936 (overweight), with the height of 5 feet and the weight of 180 pounds (TBHC's Records at 03835).

a stage IV upper *right buttock* bedsore measuring 5 x 5 cm with 8 cm of tunneling (TBHC's Records at 04066). The patient's condition thereafter improved to the extent that on April 6<sup>th</sup> he was weaned off mechanical ventilation. Two days later, on April 8<sup>th</sup>, the patient was discharged from TBHC to defendant Hopkins which, at the patient's family's request, succeeded Carlton as the patient's nursing home.

The patient's initial stay at Hopkins lasted for approximately one month, from April 8<sup>th</sup> to May 9<sup>th</sup>. During his initial stay, the Hopkins staff had him evaluated (with negative results) for an infected *sacral* bedsore on May 5<sup>th</sup> at TBHC. Four days later, on May 9<sup>th</sup>, however, the Hopkins staff had the patient transferred to TBHC on account of his non-healing *sacral* bedsore.

The patient was readmitted to TBHC from May 9<sup>th</sup> to June 14<sup>th</sup> for a second round of treatment (the "second TBHC admission"). On May 10<sup>th</sup>, a review of the patient's skin confirmed that he was suffering from four bedsores: (1) a stage IV *sacral* bedsore measuring 16 x 16 cm with 7 cm of tunneling; (2) a stage II *right buttock* bedsore measuring 20 x 20 cm; (3) an unstageable *left buttock* bedsore measuring 8 x 8 cm with black eschar; and (4) a stage II left [no further location provided] bedsore measuring 12 x 10 cm (TBHC's Records at 05086-05087). On May 11<sup>th</sup>, a bone scan of the patient's *sacrum* confirmed the presence of acute osteomyelitis (bone inflammation). In the course of his second TBHC admission, the patient underwent four separate surgical debridements. Despite multiple debridements, the patient's *sacral* bedsore failed to heal, requiring the placement of a wound vacuum on the affected site on June 12<sup>th</sup>.

On June 14<sup>th</sup>, the patient, upon discharge from TBHC, was returned to Hopkins for his second stay which lasted for less than one month until July 7<sup>th</sup>. On June 14<sup>th</sup>, the

patient's *sacral* bedsore was measured at Hopkins at 12 x 10 x 5 cm. It appears that, as of June 14<sup>th</sup>, the patient had developed two additional bedsores: (1) a bedsore on the *right ischium* (the lower back part of the hip bone) measuring 6 x 5 x 0.5 cm; and (2) a bedsore on *left ischium* measuring 4 x 4 x 0.5 cm. During his second stay at Hopkins, the condition of his *sacral* bedsore worsened. On July 7<sup>th</sup>, when the patient's *sacral* bedsore increased in size to measure 14 x 15.5 x 3 cm, he was re-admitted at TBHC for acute care and management.

The patient's third and final round of treatment at TBHC lasted from July 7<sup>th</sup> until July 22<sup>nd</sup> (the "third TBHC admission"). On July 7<sup>th</sup>, the patient's skin was significant for: (1) a stage IV *sacral* bedsore reaching down to the gluteus and measuring 20 x 20 cm;<sup>5</sup> and (2) a stage III *right gluteal* bedsore (TBHC's Records at 06703). On July 9<sup>th</sup> and again on July 11<sup>th</sup>, the patient underwent excisional debridements of his *sacral* as well as of his *bilateral ischial* bedsores. He was intubated between July 8<sup>th</sup> and July 12<sup>th</sup>. He received three separate blood transfusions between July 9<sup>th</sup> and July 17<sup>th</sup>. The patient died on July 22<sup>nd</sup>, which was approximately mid-way through the six-month life expectancy as had been projected at the start of his first TBHC admission. The immediate cause of his death was a cardiopulmonary arrest as a consequence of lobar pneumonia.

On September 27, 2018, the patient's sister, Frances Colvil, commenced this action against TBHC (among other defendants) (NYSCEF Doc No. 1). On January 9, 2019,

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<sup>5</sup> It appears that TBHC, in measuring the patient's *sacral* bedsore at 20 x 20 cm on his third admission, combined it with that of his adjacent bedsore at the *left ischium*. Earlier on the day preceding the third admission, Hopkins had measured the *sacral* and the *left ischium* bedsores at 14 x 15.5 x 3 cm and 5.2 x 5 x 0.6 cm, respectively, for a combined total measurement of 19.2 x 20.5 cm, which is nearly equivalent to TBHC's later-day combined measurement of 20 x 20 cm (Hopkins's Records at 0091).

TBHC joined issue (NYSCEF Doc No. 9). In the course of discovery, plaintiff waived pretrial depositions of all defendants.

### Discussion

In a medical malpractice case, “[a] defendant moving for summary judgment . . . must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, or (2) that such a departure was a *proximate cause* of the plaintiff’s injuries” and, where wrongful death is alleged, of wrongful death as well (*see Rosenthal v Alexander*, 180 AD3d 826, 827 [2d Dept 2020] [internal citation omitted; emphasis added]; *Mandel v New York County Pub. Adm’r*, 29 AD3d 869, 871 [2d Dept 2006]).<sup>6</sup> “When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition” (*Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020] [internal citations omitted]).

A similar principle governs negligence claims. “Where the evidence adduced reveals the existence of several possible causes of an injury, for one or more of which the defendant is not responsible, a plaintiff cannot recover without proving the injury was sustained wholly or in part *by reason of* the defendant’s negligence” (*Ramirez v Sears*,

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<sup>6</sup> Inasmuch as TBHC, unlike the other defendants, is not a nursing home, it falls outside the scope of Public Health Law § 2801-d. “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 AD3d 999, 1001 [2d Dept 2016]).

*Roebuck & Co.*, 286 AD2d 428, 431 [2d Dept 2001] [internal quotation marks omitted; emphasis added]).

Here, TBHC has established a prima facie case of entitlement to summary judgment via its medical records (as well as those of its codefendants) and the affirmation of its medical expert, Gisele Wolf-Klein, M.D. (“Dr. Wolf-Klein”). As part of TBHC’s prima facie showing, Dr. Wolf-Klein opines, in relevant part, that the patient “was critically ill when he was admitted to TBHC on March 24, 2016 and had a dismal outlook for recovery” (Dr. Wolf-Klein’s Expert Medical Affirmation, dated July 13, 2021 [NYSCEF Doc No. 88], ¶ 31 [underlining omitted]). According to Dr. Wolf-Klein, “the pre-existing and infected [pressure] ulcers to [the patient’s] skin were unable to heal” because of: (1) his persistent hypoalbuminemia (as demonstrated by his below-normal and continuously declining blood-albumin levels); (2) his persistent iron-deficiency anemia despite blood infusions; and (3) his “overall decline in health as he was at the end stages of life” (Dr. Wolf-Klein’s Aff., ¶¶ 32-34). In Dr. Wolf-Klein’s opinion, the patient’s bedsores were not causally related to any care and treatment (or lack thereof) by TBHC; rather, their lack of healing was due to the patient’s “complex medical issues which impaired circulation to the skin, skin viability, resistance to damage from minor contact, ability to heal, ability to resist infection and necrosis” (*id.*, ¶ 33) (*see Cerrone v North Shore-Long Is. Jewish Health Sys., Inc.*, 197 AD3d 449, 450 [2d Dept 2021]; *Korszun v Winthrop Univ. Hosp.*, 172 AD3d 1343, 1345 [2d Dept 2019]; *Cummings v Brooklyn Hosp. Ctr.*, 147 AD3d 902, 903 [2d Dept 2017]).

In opposition to TBHC’s prima facie showing, plaintiff’s expert, a board-certified internist and geriatrician (“plaintiff’s expert”), has failed to raise a triable issue of fact on

the element of proximate cause (*see* Expert Affirmation in Opposition, dated October 18, 2021 [NYSCEF Doc No. 164]). His/her opinion on causation is based on the oversimplified assumption that “unrelieved pressure causes pressure ulcers” (Plaintiff’s Expert Aff., ¶ 72 [underlining omitted]). It is true, as plaintiff’s expert contends (in ¶¶ 69, 71, and 73 of his/her affirmation), that certain comorbidities, when considered in isolation from other comorbidities, do not individually cause pressure ulcers. It is also true, however, that the skin is the largest organ in the body, and its integrity depends on the function of all other organ systems for nutrition, circulation, and immunity. The burden of disease can overwhelm the skin, despite appropriate preventive and treatment interventions. That is what happened with this patient whose multiple, life-threatening comorbidities escalated (and ultimately caused his death) during his prolonged, multi-year residence at Carlton, his three separate admissions at TBHC, and his two month-long stays at Hopkins. When one attentively reviews and critically assesses all the evidence in the patient’s medical records, cast in their aggregated and interwoven symmetry (as Dr. Wolf-Klein does in this case, but which plaintiff’s expert fails to do), the conclusion becomes inescapable that plaintiff’s expert’s opinion as to *proximate cause* is speculative and factually unsupported.

As noted, prior to the patient’s first admission at TBHC on March 24, 2016, he had an extensive, long-standing medical history encompassing coronary artery disease, peripheral artery disease, hypertension, diabetes, and the above-the-knee amputation of his left leg. Further, he was bedfast – as well as incontinent of bowel and bladder – in the context of his dementia/schizoaffective disorder. His malnutrition, as evidenced by his ever-falling blood albumin (protein) level – coupled with his persistent iron-deficiency

anemia – contributed to his poor outcome. Viewed against that background, the patient’s sepsis and his pre-existing bedsores made it reasonably likely (as, in fact, was confirmed by the subsequent events) that, on his first TBHC admission, he was then suffering (and he continued to suffer) from terminal and debilitating medical conditions, with the overall life expectancy of under six months.

Plaintiff’s expert’s contention (in ¶ 76 of his/her affirmation) that TBHC “had an obligation to investigate into any issues that were interfering with its ability to properly and appropriately treat [the patient] and care for his conditions,” sidesteps the substance and magnitude of the patient’s medical problems at the time of his initial TBHC admission. Similarly, beside the point is plaintiff’s expert’s contention (in ¶ 59 of his/her affirmation) that “[n]o turn and position flowsheets are to be found anywhere in . . . TBHC’s record.” As a general proposition, however, “[a] failure to document each element of the skin care protocol does not equate to a failure to perform each element or to a cause of the [pressure] ulcer itself” (*Braunstein v Maimonides Med. Ctr.*, 161 AD3d 675, 675 [1st Dept 2018]). More to the point, though, is that the patient’s sacral bedsore (together with the other bedsores) which he had acquired during his long-term residence at Carlton *before* his initial TBHC admission, not only failed to heal, but also continued to expand in size, despite the extensive surgical and wound-care treatment which he subsequently received both at TBHC and Hopkins.

Contrary to plaintiff’s expert’s broadly stated contention, the development and/or worsening of a bedsore is not a ground, in and of itself, on which an inference of negligence or medical malpractice can be premised against TBHC. As a general matter, “[t]he presence of an injury does not mean that there was negligence” (*Landau v Rappaport*,

306 AD2d 446, 447 [2d Dept 2003]). More fundamentally, plaintiff's expert's position (in ¶ 80 of his/her affirmation) that "the care rendered to the [patient] . . . by . . . TBHC was inconsistent with the applicable [albeit, uncited] state and federal regulations," runs contrary to the explicit language of 10 NYCRR 415.12 (c) (1) which exempts medical facilities from liability where "the individual's clinical condition demonstrates that they were unavoidable," as was the case here (*see also* 42 CFR 483.25 [b] [1] [i] [same]). The Court has considered plaintiff's remaining contentions and finds them to be without merit.

Accordingly, dismissal of the amended complaint as against TBHC is warranted (*see Moore v St. James Health Care Ctr., LLC*, 141 AD3d 701, 702 [2d Dept 2016]; *Gold v Park Ave. Extended Care Ctr. Corp.*, 90 AD3d 833, 834 [2d Dept 2011]; *see also Vargas v St. Barnabas Hosp.*, 168 AD3d 596, 597 [1st Dept 2019]; *Craig v St. Barnabas Nursing Home*, 129 AD3d 643, 644 [1st Dept 2015]; *see generally Schwartz v Partridge*, 179 AD3d 963, 964 [2d Dept 2020] ["An expert opinion that is contradicted by the record cannot defeat summary judgment."] [internal quotation marks omitted]).

### Conclusion

Accordingly, it is

ORDERED that the motion of TBHC in Mot. Seq. No. 7 for an order, pursuant to CPLR 3212, granting summary judgment dismissing all claims insofar as asserted against it is *granted*, and the amended complaint is dismissed in its entirety as against it without costs and disbursements; and it is further

ORDERED that the action is severed and continued as against the remaining defendant New Carlton Rehab and Nursing Center, LLC; and it is further

ORDERED that to reflect the dismissal of defendant The Brooklyn Hospital Center, as well as the prior stipulated dismissal of defendant KFG Operating I, LLC, d/b/a Hopkins Center for Rehabilitation and Healthcare, the caption is amended to read in its entirety as follows:

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FRANCES COLVIL, as Administratrix of the Estate of  
LEON SINGLETON, and FRANCES COLVIL, Individually,

Plaintiffs,

-against-

Index No. 519544/18

NEW CARLTON REHAB AND NURSING CENTER, LLC,

Defendant.  
-----X

; and it is further

ORDERED that TBHC's counsel is directed to electronically serve a copy of this decision, order, and judgment with notice of entry on the respective counsel for plaintiff and Carlton, and to electronically file an affidavit of service thereof with the Kings County Clerk.

This constitutes the decision, order, and judgment of the Court.

ENTER,

  
J. S. C.