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| Campbell v Northern Manhattan Nursing Home, Inc. |
| 2022 NY Slip Op 33463(U) |
| October 14, 2022 |
| Supreme Court, New York County |
| Docket Number: Index No. 151403/2017 |
| Judge: Arlene P. Bluth |
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 14

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SUSANNA CAMPBELL, GERTIE CAMPBELL

Plaintiff,

- v -

NORTHERN MANHATTAN NURSING HOME,
INC.,NORTHERN MANHATTAN REHAB AND NURSING
CENTER,

Defendants.

INDEX NO. 151403/2017

MOTION DATE 10/11/2022

MOTION SEQ. NO. 002

**DECISION + ORDER ON
MOTION**

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HON. ARLENE P. BLUTH:

The following e-filed documents, listed by NYSCEF document number (Motion 002) 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94 were read on this motion to/for JUDGMENT - SUMMARY.

Defendants’ motion for summary judgment on plaintiff’s negligence, gross negligence, and New York Public Health Law §§ 2801-d and 2803-c claims is denied.

Background

Plaintiff Susanna Campbell was admitted to Northern Manhattan Rehab and Nursing Center, a facility run by defendant Northern Manhattan Nursing Home, Inc., on November 26, 2014 at the age of 91 after a stay at Metropolitan Hospital for a stroke. Ms. Campbell had a history of strokes, second-degree AV block, hypertension, right side weakness, aphasia, and a pacemaker. Upon admission, Ms. Campbell displayed signs of a pressure ulcer and she was subsequently assessed as a high risk for developing further ulcers (NYSCEF Doc. No. 72 at 5). Ms. Campbell was given a care plan that included “adjusting her position in bed every two hours,

weekly skin assessments, a specialty mattress, a wheelchair cushion, and skin protection measures” (*id.*). By the summer of 2015, Ms. Campbell had developed multiple pressure ulcers and her left buttocks ulcer deteriorated into developing an abscess. According to the Resident CAN Documentation History Detail Report, Ms. Campbell spent anywhere from 4 to 12 hours in one position on at least 31 different days from July 13, 2015 until September 12, 2015 (NYSCEF Doc. No. 89).

On September 15, 2015, Ms. Campbell was admitted to Metropolitan Hospital with a urinary tract infection (UTI), sepsis likely from clostridium difficile colitis, ulcers on her left buttocks and foot, and painful constipation. Ms. Campbell was treated for her constipation and UTI; however, on October 4, 2015, Ms. Campbell’s fever spiked and staff at Metropolitan Hospital met with Ms. Campbell’s family to discuss a plan of care. Ms. Campbell was admitted to Calvary Hospital for inpatient hospice care on October 8, 2015, and passed away on September 14, 2016 from pneumonia complications.

Plaintiff filed a claim as administrator for Ms. Campbell’s estate against defendants, alleging negligence and gross negligence for failing to adhere to the requisite standard of care exercised by nursing homes in the community and failing to adequately follow the care plan laid out for Ms. Campbell. Additionally, plaintiff alleged violations of New York Public Health Law § 2801-d and § 2803-c for depriving Ms. Campbell of her rights to appropriate medical and nursing care and seeks punitive damages for these violations.

Defendants bring this summary judgment motion contending they provided Ms. Campbell with acceptable medical care and did not deprive her of any resident’s rights. Defendants offer the affidavit of Dr. Lawrence Diamond indicating defendant performed requisite treatments for the care of Ms. Campbell. Any nonperformance was due to Ms.

Campbell refusing certain courses of treatment, and defendants acted with reasonable care in evaluating and adjusting Ms. Campbell's care plan. Among these refusals, defendants claim Ms. Campbell's refusal to receive wound dressings led to further deterioration of her ulcers.

In response, plaintiff offered the affidavit of Dr. Starer asserting that defendant routinely left Ms. Campbell in fixed positions contrary to her care plan, that the dressing refusals happened only on a few occasions if at all, and that lab results for Ms. Campbell indicated her overall health was sufficient for promoting healing of her ulcers, however such healing did not occur. Plaintiff also claims defendants did not address the testimony of a defense witness who admitted defendants' failure to reposition Ms. Campbell every two hours was not in accordance with the highest quality of care.

In reply, defendants claim Dr. Starer's statements are conclusory, speculative, and insufficient to overcome a summary judgment request. Additionally, defendants assert that plaintiff does not point to any causation between defendants' apparent deficiencies in care and the injuries alleged.

Discussion

To be entitled to the remedy of summary judgment, the moving party "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 487 NYS2d 316 [1985]). The failure to make such a prima facie showing requires denial of the motion, regardless of the sufficiency of any opposing papers (*id.*). When deciding a summary judgment motion, the court views the alleged facts in the light

most favorable to the non-moving party (*Sosa v 46th St. Dev. LLC*, 101 AD3d 490, 492 [1st Dept 2012]).

Once a movant meets its initial burden, the burden shifts to the opponent, who must then produce sufficient evidence to establish the existence of a triable issue of fact (*Zuckerman v City of New York*, 49 NY2d 557, 560, 427 NYS2d 595 [1980]). The court's task in deciding a summary judgment motion is to determine whether there are bonafide issues of fact and not to delve into or resolve issues of credibility (*Vega v Restani Constr. Corp.*, 18 NY3d 499, 505, 942 NYS2d 13 [2012]). If the court is unsure whether a triable issue of fact exists, or can reasonably conclude that fact is arguable, the motion must be denied (*Tronlone v Lac d'Amiante Du Quebec, Ltee*, 297 AD2d 528, 528-29, 747 NYS2d 79 [1st Dept 2002], *affd* 99 NY2d 647, 760 NYS2d 96 [2003]).

Negligence and Gross Negligence

In a malpractice action, “[s]ummary judgment is not appropriate [where] the parties adduce conflicting expert opinions” (*Amendola v Brookhaven Health Care Facility, LLC*, 150 AD3d 1061, 1062, 55 NYS3d 348 [2d Dept 2017]; *see also Henry v Sunrise Manor Ctr. For Nursing & Rehabilitation*, 147 AD3d 739, 46 NYS3d 649 [2d Dept 2017] [finding that summary judgment was inappropriate after the plaintiff's expert opined that defendant's actions were a proximate cause of the plaintiff's death]).

Defendants fail to meet their burden for summary judgment. Plaintiff offered a conflicting expert opinion regarding the adequacy of care administered by defendants. Contrary to defendants' assertions, plaintiff's expert, Dr. Starer, offered more than conclusory statements. Dr. Starer outlined how Ms. Campbell's lab results, coupled with her consistent weight gain,

indicated she was healthy enough to promote healing of wounds and instead her ulcers further deteriorated (NYSCEF Doc. No. 89 at 6-7). Dr. Starer further stated that nursing staff failed to follow Ms. Campbell's care plan and left her sitting in her wheelchair or laying on her back for hours at a time (*id.* at 12-13). For instance, on September 3 and September 11, 2015, Ms. Campbell sat in her wheelchair for 12 hours (*id.*). Given Ms. Campbell's initial assessment upon admission that she was vulnerable to developing ulcers, deviating from the care plan is more than enough to indicate a triable issue of fact for these causes of action.

Dr. Starer's affidavit further outlined a discrepancy between the various reporting documents related to Ms. Campbell's care. While defendants claim that Ms. Campbell's treatment refusals in July 2015 were a factor in the deterioration of her condition, Dr. Starer's affidavit indicates that there is conflicting documentation – both that Ms. Campbell refused wound dressing in July and that Ms. Campbell was fully cooperative with all treatments in July (*id.* at 8).

Finally, plaintiff submitted the deposition transcript of Ms. Jean Charles, a retired nurse formerly employed by defendant Northern Manhattan Nursing Home. In response to a question asking whether treatment records were “consistent with providing the highest quality of care for the residents,” Ms. Charles admitted they were not (NYSCEF Doc. No. 90 at 162). Defendants offered no response to Ms. Charles' admission regarding the quality of care.

In sum, a fact finder must make its own assessment about the care provided to Ms. Campbell. Clearly, there is no basis to dismiss this matter.

New York Public Health Law §§ 2801-d and 2803-c

Pursuant to Public Health Law § 2801-d, “[a]ny residential health care facility that deprives any patient of said facility of any right or benefit, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation.”

“The statutory basis of liability 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, subject to the defense that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient,” (*Zeides v Hebrew Home for the Aged at Riverdale, Inc.*, 300 AD2d 178, 179, 753 NYS2d 450 [1st Dept 2002][internal quotation marks and citation omitted]). The legislature recognized specific rights of vulnerable nursing home patients in both statutes and regulations. Pursuant to Public Health Law § 2803-c (3)(e), patients have “the right to receive adequate and appropriate medical care.” Furthermore, nursing home facilities must ensure that “a resident who enters [a] 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” (10 NYCRR § 415.12 [c][1]).

Plaintiff’s expert demonstrated that Northern Manhattan deviated from the care plan assigned to Ms. Campbell. Dr. Starer specifies 31 different dates that Ms. Campbell was left sitting in her wheelchair or in bed for longer than two hours at a time (NYSCEF Doc. No. 89 at 12). Dr. Starer noted Ms. Campbell’s condition, stating that her lab reports indicated she had sufficient metabolic rates to promote healing of any wounds (*id.* 6). Plaintiff offered sufficient evidence to indicate there is a triable issue of fact as to whether Ms. Campbell received the medical care to which she was statutorily entitled. Plaintiff raised a material issue of fact about

whether the ailments Ms. Campbell suffered in September 2015 that necessitated her admission to the hospital could have been prevented if defendants had merely followed the care plan.

Accordingly, it is hereby

ORDERED that defendants' motion for summary judgment is denied.

10/14/2022
DATE


ARLENE P. BLUTH, J.S.C.

CHECK ONE:

CASE DISPOSED

NON-FINAL DISPOSITION

GRANTED

DENIED

GRANTED IN PART

OTHER

APPLICATION:

SETTLE ORDER

SUBMIT ORDER

CHECK IF APPROPRIATE:

INCLUDES TRANSFER/REASSIGN

FIDUCIARY APPOINTMENT

REFERENCE