Jones v Queens Hosp. Ctr.
2023 NY Slip Op 35237(U)
October 16, 2023
Supreme Court, Queens County
Docket Number: Index No. 708418/2018
Judge: Tracy Catapano-Fox
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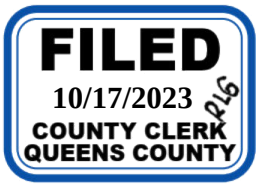

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

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DYANE JONES, as Administratrix of the Estate of LOIS JONES, and DYANE JONES, Individually,

Plaintiff,

-against-

QUEENS HOSPITAL CENTER, NEW YORK CITY HEALTH & HOSPITALS CORP., and MARGARET TIETZ NURSING AND REHABILITATION CENTER,

Defendants.

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Index No. 708418/2018

Part MDP
Motion Date: September 27, 2023

Calendar No. 13
Sequence No. 2

The following papers numbered EF-26 through EF-64 read on this motion by defendant MARGARET TIETZ NURSING AND REHABILITATION CENTER for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3211 and §3212.

	Papers Numbered
Notice of Motion, Affirmation, Exhibits	EF26-EF52
Affirmation in Opposition, Exhibits	EF54-EF56
Reply Affirmation, Exhibits	EF58-EF64

Upon the foregoing papers, it is ordered that this motion is determined as follows:

Defendant Margaret Tietz Nursing and Rehabilitation Center (hereinafter referred to as "Tietz")'s motion for summary judgment and dismissal of plaintiff's Complaint pursuant to CPLR §3212 and §3211 is denied. Plaintiff commenced this action for medical malpractice, negligence and violations of Public Health Law §2801-D and §2803-C while plaintiff decedent was in defendant's care during three admissions from November 30, 2015 and June 7, 2016. It is noted that plaintiff decedent passed away on June 24, 2016. Plaintiff filed the Summons and Complaint on May 31, 2018 and issue was joined by defendant on July 11, 2018.

Defendant Tietz argues that summary judgment is warranted, as there are no issues of fact that would warrant liability for plaintiff's injuries. Defendant presents the pleadings, deposition

testimony of the parties, medical records and expert affirmation of Dr. Lawrence Diamond in support of its motion. Defendant argues that plaintiff decedent presented as a 95 year old woman with a complicated medical history and severe co-morbidities. It argues that the medical records show plaintiff decedent developed a sacral pressure ulcer prior to her admittance to defendant's facility, and did not worsen clinically during her time at defendant's facility. Defendant further argues that the medical records and deposition testimony show that plaintiff decedent was not deprived of any statutory rights under PHL §2801-D and §2803-C, and defendant did not act willfully or recklessly to deprive plaintiff decedent of any rights that would warrant punitive damages.

Defendant presents the expert affirmation of Dr. Lawrence N. Diamond in support of its motion. Dr. Diamond affirms he is a licensed physician in New York who is board certified in Geriatric and Family Medicine. He reviewed the pleadings, medical records, deposition transcripts and defendant's policies and procedures in rendering his opinions. Dr. Diamond opined within a reasonable degree of medical certainty that the nursing and medical care defendant provided to plaintiff decedent was appropriate and did not depart from accepted standards of care, and did not cause or contribute to plaintiff decedent's injuries and death. He also opined that defendant's care and treatment did not violate the Public Health Law relating to minimum standards and no evidence supports plaintiff's claim that defendant's willfully or recklessly violated plaintiff decedent's rights.

Dr. Diamond noted that plaintiff decedent was admitted to defendant's facility on three different occasions. He noted that plaintiff decedent first was admitted to defendant's facility on February 16, 2016 after a 10-day admission at Queens Hospital Center. Dr. Diamond further noted that the medical records show plaintiff decedent was bedbound, had very poor circulation, refused medication and her blood work showed several abnormalities. He further noted that plaintiff decedent had a pre-existing stage 3 sacral ulcer, and her medical records from Queens Hospital Center noted a previous stage 2 sacral ulcer. Dr. Diamond opined that defendant appropriately and correctly evaluated plaintiff decedent as being at risk for developing pressure ulcers, and timely and properly initiated a care plan for skin breakdown. Dr. Diamond reviewed defendant's medical records for plaintiff decedent and noted that turning and position was regularly performed every two to three hours throughout her admission at defendant's facility. He found that defendant performed a wound care consult which documented the stage 3 sacral ulcer, and opined that the change from Hydrogel to Santyl was reasonable in treating the pressure ulcer.

Dr. Diamond opined to a reasonable degree of medical certainty that plaintiff decedent arrived at defendant's facility in a significantly compromised condition and was in the process of dying. He further opined that defendant's staff did everything they could to get plaintiff decedent to eat, and plaintiff decedent's family had an unrealistic expectation for plaintiff decedent's prognosis. Dr. Diamond further opined that Dr. Dugar appropriately evaluated plaintiff decedent

prior to her transfer to Queens Hospital Center, and opined that through no fault of defendant, plaintiff decedent's health was failing throughout her three admissions to defendant's facility. Dr. Diamond reviewed the medical records and opined that plaintiff decedent was appropriately assessed during her second admission to defendant's facility on March 7, 2016, and a pressure ulcer care plan was properly put into place during the less than 24 hour admission. Dr. Diamond further opined that defendant was not liable for plaintiff decedent's new pressure ulcers that pre-existed her third admission to defendant's facility on April 8, 2016. He opined that defendant properly reinforced the skin care plan, including addressing skin breakdown, pressure ulcers, and nutrition, as well as turning and positioning plaintiff decedent every two to three hours throughout her admission.

Dr. Diamond further opined within a reasonable degree of medical certainty that plaintiff decedent was not a candidate for a wound VAC, as plaintiff decedent did not have a wound with a tremendous amount of fluid, and there is no clear evidence the wound VAC would have sped up healing of the pressure ulcers. Dr. Diamond opined that defendant's wound care orders were appropriate, and that the increased swelling and size of the pressure ulcers is not evidence of improper care by defendant, but was unavoidable in light of plaintiff decedent's poor health, various comorbidities and refusal to eat. Dr. Diamond opined within a reasonable degree of medical certainty that defendant provided appropriate medical and nursing care on all three admissions. He opined that placing an NG or PEG tube in a nursing home patient with advanced dementia like plaintiff decedent was contraindicated and not appropriate for use in long term facilities such as defendant's facility. He further opined that any potential benefit of an NG or PEG tube would be outweighed by the risks and increased morbidity. Dr. Diamond further opined within a reasonable degree of medical certainty that the care and treatment provided to plaintiff decedent did not violate PHL §2801-d or PHL §2803-c, as none of defendant's actions deprived plaintiff decedent of her rights under the applicable law.

Plaintiff opposed defendant's motion, arguing defendant failed to present a prima facie case of entitlement to summary judgment, and there are issues of fact with regard to plaintiff's causes of action for negligence, medical malpractice and violations of PHL §2801-D and §2803-C. He presented the expert affirmation in support of his opposition. Plaintiff argues that it is undisputed that plaintiff decedent's pressure ulcers deteriorated under defendant's care. He further argues that defendant's expert did not define the standard of care, and made conclusory and speculative remarks with regard to plaintiff decedent's treatment. Plaintiff further argues that there are questions of fact raised by the conflicting medical experts with regard to plaintiff decedent's pressure ulcers and whether they were avoidable.

Plaintiff presented the expert affirmation of a licensed physician in New York who is board certified in Internal Medicine and Geriatric Medicine. The expert reviewed the pleadings, plaintiff's deposition transcript and medical records in support of the opinions rendered. Plaintiff's

expert opined within a reasonable degree of medical certainty that defendant's care and treatment to plaintiff decedent was not in accordance with good and accepted medical practice, and there were departures and deviations from accepted standards of care that proximately caused plaintiff decedent's injuries, including the development and deterioration of plaintiff decedent's pressure ulcers, pain and suffering. Plaintiff's expert argued that defendant's expert failed to state the applicable standard of care during plaintiff decedent's admission at defendant's facility. The expert opined within a reasonable degree of medical certainty that defendant's assessment, care plan and treatment for plaintiff decedent fell short of the medical standard of care, specifically by not documenting the skin breakdown and not properly staging or sizing plaintiff decedent's pressure ulcers. The expert opined that the failure to properly stage and size the pressure ulcer and note the staging and sizing within the medical records affected defendant's ability to ensure that the pressure ulcers were aggressively met with the appropriate level of treatment and care throughout the different medical caregivers on different shifts. The expert further opined that defendant's improper documentation was a departure from good and accepted medical and nursing practices and was the proximate cause of the development and deterioration of plaintiff decedent's pressure ulcers.

Plaintiff's expert also opined within a reasonable degree of medical certainty that plaintiff decedent was not turned and positioned according to accepted medical standards. The expert argued that the medical records showed significant gaps in turning and positioning during plaintiff decedent's admission at defendant's facility, noting a more than five hour gap on February 23, 2016 and more than seven hours on February 24, 2016. The expert challenged defendant expert's conclusion that plaintiff decedent was turned and positioned every two to three hours as against the medical records, and opines that defendant's care was outside medical standards. The expert further opined within a reasonable degree of medical certainty that plaintiff decedent was not turned and positioned at least every two to three hours and this departure was a proximate cause of the deterioration and development of plaintiff decedent's pressure ulcers. The expert also opined within a reasonable degree of medical certainty that defendant's failure to maintain documentation of the turning and positioning of plaintiff decedent was a deviation from good and accepted medical practice and the proximate cause of plaintiff's injuries. The expert further opined that defendant failed to implement a care plan that called for turning and positioning plaintiff decedent more frequently than every two to three hours based upon her medical condition, and that this departure proximately caused plaintiff decedent's injuries.

Plaintiff's expert further opined within a reasonable degree of medical certainty that the above departures violated plaintiff decedent's rights under PHL §2801-d. The expert argued that defendant was reckless in failing to create and maintain a proper chart documenting the turning and positioning of plaintiff decedent, and said violation was a proximate cause of plaintiff decedent's injuries. The expert further opined within a reasonable degree of medical certainty that defendant's plan of care was vague, insufficient and constituted a departure from accepted

standards of care for medical and nursing and were a proximate cause of plaintiff decedent's injuries. The expert further opined that plaintiff decedent was not properly nourished while admitted to defendant's facility, and defendant failed to timely and properly implement a comprehensive nutritional regimen for plaintiff decedent. The expert opined that these departures were a proximate cause of plaintiff decedent's deterioration of pressure ulcers. The expert argued that plaintiff decedent's comorbidities and prior medical condition increased her risk for pressure ulcers but did not render them as clinically unavoidable. The expert noted plaintiff decedent's medical records showed the pressure ulcer on April 4, 2016 had less necrotic tissue, and by April 22, 2016 had been improving. The expert opined that the evidence of plaintiff decedent's ability to heal despite her prior medical conditions was evidence that the skin breakdown and pressure ulcers were not unavoidable. Rather, the expert opined within a reasonable degree of medical certainty that plaintiff decedent's significant skin breakdown and deterioration while at defendant's facility was caused by unrelieved pressure, not her medical conditions.

Pursuant to CPLR §3212, "[a] motion [for summary judgment] shall be granted if . . . the cause of action . . . [is] established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party." (CPLR 3212 [b]; *Rodriguez v. City of New Yor*k, 31 N.Y.3d 312 [2018].) The motion for summary judgment must also "show that there is no defense to the cause of action." (*Id*.). The party moving for summary judgment must make a prima facie showing that it is entitled to summary judgment by offering admissible evidence demonstrating the absence of any material issues of fact and it can be decided as a matter of law. (CPLR § 3212 [b]; *see Jacobsen v New York City Health and Hosps. Corp.*, 22 N.Y.3d 824 [2014]; *Brill v City of New York*, 2 N.Y.3d 648 [2004].) In deciding a summary judgment motion, the court does not make credibility determinations or findings of fact. Its function is to identify issues of fact, not to decide them. (*Vega v. Restani Constr. Corp*., 18 N.Y.3d 499, 505 [2012].) Once a prima facie showing has been made, however, the burden shifts to the non-moving party to prove that material issues of fact exist that must be resolved at trial. (*Zuckerman v. City of New York*, 49 N.Y.2d 557 [1980].)

In moving for summary judgment in a medical malpractice action, the defendant must establish a prima facie case that there was no departure from good and accepted medical practice or that the plaintiff was not injured thereby, and the plaintiff in opposition must submit evidentiary facts or materials to demonstrate the existence of a triable issue of fact. (*Stukas v. Streiter*, 83 A.D.3d 18, 24 [2d Dept. 2011].) In presenting opposition to raise a triable issue of fact, the plaintiff is required to provide an affidavit of merit by a medical expert, and the failure to submit an affidavit by a medical expert competent to attest to the meritorious nature of the plaintiff's claims requires dismissal of the Complaint. (*Id.* at 28.) Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. (*Buch v. Tenner*, 204 A.D.3d 635, 638 [2d Dept. 2022].)

Public Health Law contemplates liability when a patient is injured due to a 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. (*Public Health Law §2801-d*; *Gold v. Park Ave. Extended Care Ctr. Corp.*, 90 A.D.3d 833, 834 [2d Dept. 2011].)

While a medical expert need not be a specialist in a particular field in order to testify regarding accepted practices in that field, the expert should be possessed of the requisite skill, training, education, knowledge, or experience from which it can be assumed that the opinion rendered is reliable. (*Cerrone v. N. Shore-Long Is. Jewish Health Sys.*, 197 A.D.3d 449, 451 [2d Dept. 2021].) Any lack of skill or expertise that an expert may have goes to the weight of the opinion as evidence, not its admissibility. (*Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902, 904 [2d Dept. 2017].)

Defendant established a prima facie entitlement to summary judgment based upon the pleadings, deposition testimony, Dr. Diamond's expert affirmation, and medical records. (*See Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902 [2d Dept. 2017].) Defendant established it provided good and appropriate care to plaintiff, who presented at defendant's facility with pre-existing pressure ulcers and significant advanced comorbidities. (*See Craig v. St. Barnabas Nursing Home*, 129 A.D.3d 643 [1st Dept. 2015].) Defendant's expert Dr. Diamond demonstrated the care plan made for plaintiff was appropriate and particularized for her needs, and the pressure ulcers were treated appropriately and within the applicable standards of medical and nursing care. Defendant established through the expert affirmation that it did not violate the Public Health Law, as the medical records, deposition testimony and expert affirmation do not demonstrate any reckless or willful actions or inactions that proximately caused plaintiff decedent's injuries. Dr. Diamond sufficiently demonstrated that plaintiff decedent was admitted with significant comorbidities that prevented her from eating sufficiently, and on all three admissions, was in a deteriorating stage of life. Defendant's expert further demonstrated that the pressure ulcer was unavoidable based upon plaintiff decedent's underlying medical conditions, and that defendant provided proper and appropriate care within the federal and state standards.

However, plaintiff raised triable issues of fact as to her claims for medical malpractice, negligence, and violations of the Public Health Law. (*See Cerrone v. N. Shore-Long Is. Jewish Health Sys.*, 197 A.D.3d 449 [2d Dept. 2021]; *see also Cummings, supra.*) Plaintiff demonstrated issues of fact as to whether defendant departed from good and accepted medical practice in failing to timely and properly turn and position plaintiff decedent, and whether the departure was causally related to her injuries. Plaintiff also raised issues of fact as to whether defendant's failure to properly document, size and stage plaintiff decedent's pressure ulcers and implement a care plan that included pressure relieving interventions was a departure from good and accepted medical standards that caused plaintiff decedent's injuries.

Accordingly, defendant Margaret Tietz Nursing and Rehabilitation Center's motion for summary judgment pursuant to CPLR §3212 and §321 is denied. The parties are directed to appear for a pretrial conference on Wednesday, November 29, 2023 at 9:30am in courtroom 48.

This constitutes the decision and Order of the Court.

Dated: October 16, 2023

Hon. Tracy Catapano-Fox, J.S.C.