At an IAS Part 83 of the Supreme Court of the State of New York held in and for the County of Kings at 360 Adams Street, Brooklyn, New York, on the 11th day of October 2024.

PRESENT: HON. INGRID JOSEPH, J.S.C.
SUPREME COURT OF THE STATE OF NEW YORK COUNTY OF KINGS

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YARA SINCLAIR as Administratrix of the Estate of FEDERICO SINCLAIR,

Plaintiff(s)

-against-

INTERFAITH MEDICAL CENTER and FSNR SNF, LLC, d/b/a FOUR SEASONS NURSING AND REHABILITATION CENTER,

Defendant(s)

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Index No: 511700/2020
Motion Seq. 1

DECISION AND ORDER

The following e-filed papers read herein:	NYSCEF Nos.:
Notice of Motion/Affidavits Annexed Exhibits Annexed/Reply.....	31-42; 48-56
Affirmation in Opposition/Affidavits Annexed/Exhibits Annexed.....	43-46

In this matter, FSNR SNF LLC, d/b/a Four Seasons Nursing and Rehabilitation Center ("Four Seasons") moves (Motion Seq. 1) for summary judgment pursuant to CPLR 3212 to dismiss the complaint of Yara Sinclair ("Plaintiff"), as Administratrix of the Estate of decedent Federico Sinclair ("Plaintiff Decedent") on the grounds that it was not negligent since it complied with applicable standards of care, Public Health Laws ("PHL"), and State and Federal regulations. Plaintiff has opposed the motion.

In her complaint, Plaintiff seeks to recover damages for, among other things, alleged negligence, and violations of Public Health Law in the care and treatment provided to Plaintiff Decedent, while he was a patient at the defendant's facility. The complaint alleges that Four Seasons failed to employ the skill, care and diligence commonly and ordinarily possessed by, and required of nurses, aides and healthcare assistants in the community in the care and treatment of the Plaintiff Decedent, including but not limited to failing to supervise and monitor Plaintiffs decedent's condition with respect to the development and prevention of pressure ulcers, failing to carry out the orders given; failing to adhere to Plaintiff Decedent's care plan; and in failing to adequately train their employees to enable them to properly care for patients. Plaintiff contends that as a result of the Defendant's negligence, Plaintiff Decedent was rendered sick and disabled; suffered severe injuries both internal and external; was confined to his bed for a lengthy period of time; suffered from severe pain and mental anguish; was compelled to seek medical care and attention; and was caused to die on August 5, 2017.

In support of its motion, Defendant submits its own medical records for Plaintiff Decedent, an affirmation of its expert Gisele Wolf-Klein M.D. ("Wolf-Klein"), excerpts of Brookdale Hospital Records,

and Plaintiff's deposition testimony. Defendant contends that it is entitled to summary judgment because it complied with the accepted standards of care and did not proximately cause the Plaintiff Decedent's alleged injuries. Defendant asserts that it provided all reasonably necessary care, interventions, and treatment to prevent and limit the alleged injuries and deprivation of rights and that any alleged skin breakdown was unavoidable due to the Plaintiff Decedent's underlying conditions and risk factors. Additionally, Defendant argues that Plaintiff's claim of "negligence" and "carelessness" sound in medical malpractice and not ordinary negligence because the duty arises from the physician-patient relationship or is substantially related to medical treatment. Moreover, Defendant states that because the record is devoid of any wrongdoing that was "willful" or in "reckless disregard" in caring for the Plaintiff Decedent that there is no basis for Plaintiff's claim for punitive damages.

In opposition Plaintiff submits an affirmation of their medical expert Dr. Perry Starer ("Dr. Starer") and portions of Interfaith Medical Center's records. Plaintiff argues that Defendant's motion should be denied because it failed to meet its burden since its motion lacks support to establish that Plaintiff's claims are solely related to medical malpractice rather than negligence. Plaintiff contends that the crux of its complaint is that Defendant failed to actually implement, follow, and/or carry out the protocol and/or care plans that were already in place for Plaintiff Decedent, thus her claims are for ordinary negligence rather than medical malpractice. Plaintiff contends that Defendant failed to accurately document Plaintiff Decedent's pressure ulcers as well as scheduled skin consultations, and that it cannot be confirmed if they were actually performed. Additionally, Plaintiff states that Defendant failed to take precautions to prevent and/or relieve pressure from Plaintiff Decedent's sacrum by the use or implementation of safety devices, and that Defendant failed to hire efficient personnel to render such care. Moreover, Plaintiff alleges that Defendant's expert opinion is without merit and is inconsistent with the evidence submitted because it is conclusory and speculative, whereas Dr. Starer argues that Defendant's actions in failing to accurately and consistently stage and/or size Plaintiff Decedent's pressure ulcers, were a departure in the standards of acceptable medical and nursing practices in violation of the PHL. Plaintiff asserts that Plaintiff Decedent had the ability to heal but was not properly nourished nor cared for while he was a patient.

It is well established that "the proponent of a summary judgment motion 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" (*Ayotte v. Gervasio,* 81 NY2d 1062, 1063 [1993], *citing Alvarez v. Prospect Hospital,* 68 NY2d 320, 324 [1986]; *Zapata v. Buitriago*, 107 AD3d 977 [2d Dept 2013]). Once a prima facie demonstration has been made, the burden shifts to the party opposing the motion to produce evidentiary proof, in admissible form, sufficient to establish the existence of material issues of fact which require a trial of the action. (*Zuckerman v. City of New York,* 49 NY2d 557 [1980]).

Summary judgment is a drastic remedy which should not be granted where there is any doubt as to the existence of a triable issue or where the issue is even arguable (*Elzer v. Nassau County*, 111 A.D.2d 212, [2d Dept. 1985]; *Steven v. Parker*, 99 AD2d 649, [2d Dept. 1984]; *Galeta v. New York News, Inc.*, 95 AD2d 325, [1st Dept. 1983]). When deciding a summary judgment motion, the Court must construe facts in the light most favorable to the non-moving party (*Marine Midland Bank N.A. v. Dino & Artie's Automatic Transmission Co.*, 168 AD2d 610 [2d Dept. 1990]; *Rebecchi v. Whitemore*, 172 AD2d 600 [2d Dept. 1991]).

Plaintiff's Second Cause of Action as asserted against Defendant Four Seasons is for violation of Public Health Law 2801-d and 2803-c. Under the statute, Public Health Law form a separate basis for liability from medical malpractice or negligence claims (*Viliani v Kings Harbor Multicare Center*, 37 NY3d 1085 [2021]). The basis for liability under PHL 2801-d is neither a deviation from accepted standards of medical practice nor breach of a duty of care, and instead the statute "contemplates injury to the patient caused by the derivation 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 (*Schwartz v Patridge*, 179 AD3d 963, 965 [2d Dept. 2020]; *Novick v South Nassau Communities Hosp.*, 138 AD3d 999 [2d Dept. 2016]; quoting *Zeides v Hebrew Home for the Aged at Riverdale, Inc.*, 300 AD 2d 178 [1st Dept. 2002]). PHL 2801-d, states in relevant part that "[a]ny residential health care facility that deprives any patient of said facility of any right or benefit ... shall be liable to said patient for injuries suffered as a result of said deprivation."

Here, Plaintiff asserts in part that Plaintiff Decedent's rights were violated pursuant to PHL 2801-d as codified by 10 New York Codes, Rules, and Regulations ("NYCRR") 415.22, 10 NYCRR 415.11, 10 NYCRR 415.12, and 42 C.F.R. 483.20, and enumerated in PHL 2803-c.[1]

10 NYCRR 415.11 requires that upon admission and periodically thereafter the facility shall conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Based on the results of these assessments, the facility shall develop and keep current an individualized comprehensive plan of care to meet each resident's needs. 10 NYCRR 415.22 requires that records be maintained "in accordance with accepted professional standards and practice," "readily accessible," "complete," and "systematically organized.

[1] Plaintiff asserts Defendant violated NYCRR 415.3, 415.4, 415.5, 415.5, 415.11, 415.12, 415.13, 415.14, 415.15, 415.16, 415.17, 415.18, 415.19, 415.20, 415.21, 415.22, 42 C.F.R. § 483, 483.10 (11)(i), 483.13, 483.15, 483.20, 483.20 (b) (2) (i), 483.20 (b) (2) (ii), 483.25, 483.25 (c), 483.25 (i), 483.30, 483.65, 483.75, 483.75 (1), 483.75 (L) (5), OBRA 1987, and New York Public Health Law 2801 and § 2803.

10 NYCRR § 415.12 states:

> Quality of Care.
> (c) Pressure sores. Based 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.

42 CFR § 483.25 states:

> Quality of Care.
> (c) Pressure sores. Based on the Comprehensive Assessment of a resident, the facility must 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; and
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

PHL 2803-C, entitled "Rights of patients in certain medical facilities," enumerates the rights of patients in such facilities, including nursing homes, declares them to be "the public policy of the state" and requires that a "copy of such statement of rights and responsibilities shall be posted conspicuously in a public place in each facility covered hereunder. PHL 2803-c(s) specifies that the statute is applicable to nursing homes and facilities providing health related services as defined in PHL 2801(2) and PHL 2801(4)(b). 18 NYCRR 487 enumerates the standards for adult homes.

In its moving papers, Defendant states that Plaintiff Decedent was initially admitted to Defendant facility from Interfaith Medical Center on May 2, 2017. Defendant's expert doctor Dr. Wolf-Klein declares that Defendant facility did not violate any applicable federal and/or state regulations pursuant to PHL 2801-d. Defendant's expert opines that Defendant facility provided Plaintiff Decedent with all necessary care including treatment and services to promote healing and prevent new pressure sores from developing. Defendant's expert states that Defendant facility timely assessed Plaintiff Decedent's skin risk, started an individualized care plan for his skin, implemented a host of interventions during his admissions, and that Plaintiff Decedent was provided comprehensive, multidisciplinary care including medical, nursing, dietary, physical and occupational therapy. Defendant's expert asserts that Plaintiff Decedent was followed weekly by the wound team who extensively documented their clinical assessments, recommendations, and order, and that the wound care provided to Plaintiff Decedent is conspicuously documented in his chart.

In her affirmation, Dr. Wolf-Klein states that based on her education, training, and years of experience in internal medicine and geriatric medicine, including expertise in wound care, that she is fully familiar with the standard of care as it pertains to the prevention, diagnosis, and treatment of decubitus

ulcers and well as the State and Federal standards pertaining to residential health care facilities such as the Defendant's facility. Dr. Wolf-Klein states that upon admission to the Defendant facility, Plaintiff Decedent was an elderly man with multiple chronic and acute comorbidities including history of a heart attack (NSTEMI), acute kidney failure, respiratory failure, pneumonia with resolved sepsis, status-post intubation, a trach collar that was placed on April 21, 2017, status-post-PEG placement, seizure disorder, anemia, glaucoma, legal blindness and vascular dementia. Additionally, upon admission to Defendant's facility, Plaintiff Decedent was noted to have the following nine pre-existing pressure ulcers:

- Pressure vs vascular wounds to right and left toes;
- Right heel unstageable DTI, measuring 2 x 2 cm;
- Left heel unstageable, measuring 4 x 4 cm;
- MASD to penile shaft/ scrotum;
- Left parietal area unstageable, measuring 4 x 4 cm;
- Right parietal area unstageable, measuring 4 x 4 cm;
- Right ear unstageable, measuring 1 x 1 cm;
- Left ear unstageable, measuring 1 x 1 cm;
- Sacrum unstageable DTI, measuring 2 x 2 cm.

Based on these underlying conditions, Dr. Wolf-Klein concludes that Plaintiff Decedent was already approaching end of life when he was first admitted to Defendant's facility on May 2, 2017, and that his skin – "the largest organ in the human body, had already failed. Many of the wounds were called unstageable, meaning that they had some level of depth that was obscured by a level of necrosis or eschar." Furthermore, Dr. Wolf-Klein states that because Plaintiff Decedent was anemic, that his pre-existing wounds would have a poor prognosis for healing since they cannot repair themselves and that further skin breakdown in someone with this condition is often expected. Dr. Wolf-Klein contends that Plaintiff Decedent's chart documents that a skin assessment was performed on admission that noted that he would be at risk for further skin breakdown.

With respect to Plaintiff's claim that Defendant failed to provide necessary support structures or adhere to the implemented wound care plan, Dr. Wolf-Klein asserts that specialty support surfaces, weekly wound care and turning and positioning are documented in the care plan press notes, and CNA records (see Exhibit B). Additionally, Dr. Wolf-Klein contends that the chart contains weekly wound rounds wherein the wound descriptions were documented, and measurements provided, and that Plaintiff Decedent was seen by a dietician (see Exhibit B at 296-300; 309-316). Therefore, Dr. Wolf-Klein contends that all of the interventions set forth in the care plans were carried out, modified as needed, and well-documented by staff throughout Plaintiff Decedent's admissions, and that as a result many of his wounds healed or improved during his admissions and never became infected at any point during either of his admissions at the Defendant facility. Dr. Wolf-Klein claims that it was also repeatedly documented that due to his numerous comorbidities, that Plaintiff Decedent's wounds would have poor healing potential (see Exhibit B at 99,

120, 36, 153, 166, 181, 195, 214, 234, 248, 264), and that based on her opinion within a reasonable degree of medical certainty, that the pre-existing wounds were unlikely to completely heal and that it was very likely for Plaintiff Decedent to develop new skin breakdown since his condition continued to deteriorate. Additionally, Dr. Wolf-Klein asserts that Plaintiff Decedent's chart notes that Plaintiff was adequately and consistently informed of Plaintiff Decedents condition each time that there was a change in his condition – specifically with regard to his skin, and that skin care plans and goals were discussed repeatedly and at length and documented as having transpired (see Exhibit B at 129,135, 196, 222, 229, 297-341). Dr. Wolf-Klein states that from June 27, 2017, through July 18, 2017, that Plaintiff Descendant was transported and hospitalized at Brookdale University Hospital due to sepsis and respiratory failure, related to conditions of his failing health and that when he returned to Defendant Facility he was then totally dependent for all Activities of Daily Living ("ADLs"), further clinical proof of the irreversible decline in his condition. Accordingly, Dr. Wolf-Klein asserts that the Defendant adhered to the standard of care and fulfilled its statutory obligations to ensure that the Plaintiff Decedent received necessary treatment and services; and at no time did Defendant violate his statutory rights or deprive him of any statutory benefits, inasmuch as its evaluation and treatment of the Plaintiff Decedent was timely, thorough, and appropriate in all respects in the course of his stay at its facility, and ultimately that his death was simply due to natural causes.

The court finds that Defendant has made the requisite prima facie showing, thus the burden of production shifts to Plaintiff to raise one or more triable issues of material fact warranting a trial (*see McHale v Sweet*, 217 AD3d 666, 668 [2d Dept 2023]; *Russell v River Manor Corp.*, 216 AD3d 827, 829 [2d Dept 2023]; *see generally Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986]).

In opposition, Dr. Starer states in his affirmation that based on his education, training, and years of experience, that he is fully familiar with the medical standards of accepted practice in the fields of internal medicine and geriatrics as well as the standards for the prevention and treatment of pressure and skin ulcers existing for the dates of negligence in home, nursing home, and hospital settings. Dr. Starer opines that within a reasonable degree of medical certainty, that the care rendered to Plaintiff Decedent by Defendant was inconsistent with the applicable state and federal regulations applicable during his admission to the Defendant facility which caused and contributed to the development and deterioration of his injuries. Further, Dr. Starer states that Defendant's actions constitute a violation of Plaintiff Decedent's rights under PHL 2801-d as codified by 10 NYCRR 415.22 and 10 NYCRR 415.11 and 42 CFR 483.20.

Dr. Starer states that Plaintiff Decedent should never have developed pressure ulcers on his body. Dr. Starer asserts that the development and deterioration of pressure sores has been recognized as a medical error that should never occur and that development of any stage III, stage IV or unstageable pressure ulcer acquired after admission to a healthcare setting has been recognized as a never event encompassed in the

care management category.[2] Dr. Starer states that Defendant failed to complete a skin assessment on the day Plaintiff Decedent was admitted on May 2, 2017, and that despite the numerous ulcers ultimately noted, an infectious disease consultation was not ordered until seven days after admission for purposes of treating a urinary tract infection (see Exhibit B at 35). Dr. Starer further contends that while admitted, Plaintiff Decedent was noted to have developed pressure ulcers to his right buttock on May 12, 2017, and that Plaintiff was consulted about the concern of Plaintiff Decedent's skin integrity on May 15, 2017, however "no skin breakdown" was documented within Plaintiff Decedent's Care Plan Activity Report on May 13, 14, 15, 16, and 18, and was finally documented on May 19, 2017, (Exhibit B at 119, 120, 123, 126, 128,130, 132, 134, 298, 327, 522). Dr. Starer states that on May 19, 2017, the weekly wound care rounds reclassified the right buttock excoriation to an unstageable right buttock DTPI ("deep tissue pressure injury") which increased in length and width measuring 3 x 3 cm (Exhibit B at 135), however on May 21, 23, and 24 that Plaintiff Decedent's chart was noted with no skin breakdown (Exhibit B at 141, 144, 148). Dr. Starer states that on May 26, 2017, Plaintiff Decedent was noted with a suspected DTPI to the sacrum, measuring 1 x 1 cm; and an unstageable left ear pressure ulcer with eschar, measuring 0.5 x 0.5 cm – a decrease in size of both wounds (Exhibit B at 152-154), and that on the same day, abnormal lab work indicated a high sodium concentration (Exhibit B at 154). On May 29, 2017, he was noted with hypernatremia, which resolved a few days later (Exhibit B at 155, 170). On May 30, 2017, for the first time, he was noted with a left buttock excoriation measuring 1 x 1 cm (Exhibit B at 336, 522).

Further, Dr. Starer states that on June 2, 2017 Plaintiff Decedent was noted with no skin breakdown, however on the same day, he was noted with an unstageable left ear pressure ulcer measuring 0.5 x 0.5 cm; an unstageable right parietal pressure ulcer with eschar, measuring 4 x 4 cm; an unstageable left parietal pressure ulcer with eschar measuring 3 x 3 cm; a sacral DTPI measuring 1 x 1 cm; a right buttock DTPI, which increased in size now measuring 5 x 5 cm with serous discharge; a left buttock excoriation, measuring 2 x 2 cm; an unstageable right heel pressure ulcer, which increased in size now measuring 3 x 3 cm; an unstageable left heel pressure ulcer with eschar measuring 4 x 4 cm; and wounds to the right and left toes (Exhibit B at165, 166, 299). Dr. Starer states that although Plaintiff Decedent was noted to be "ill looking, sick" the following day, that there was no modification made to his care plan (Exhibit B at 170) and that despite the multiple notations of pressure ulcers on his left and right heels and toes, a podiatry consultation was not ordered for Plaintiff Descendent until four days later on June 7, 2017 (Exhibit B at 36). Moreover, Dr. Starer claims that on June 16, 2017, Plaintiff Decedent was noted with no skin breakdown by two different Defendant employees, however on the same day, the unstageable sacral ulcer was noted to have

[2] While Defendant argues that the term "Never Event" has been replaced by what is called a "Serious Reportable Events" as described by the National Quality Forum, the submitted National Quality Forum list states that "Serious Reportable Events" are also known as SRE or "Never Events." The National Quality Forum's list of SREs includes stage 3 and 4 pressure ulcers that occur after admission to a healthcare facility.

increased in length and width, now measuring 3 x 3 cm; the left buttock excoriation increased in length and width, now measuring 3 x 3 cm; and the unstageable right heel pressure ulcer with eschar increased in size, now measuring 4 x 4 cm. (Exhibit B at 194, 195, 197). Additionally, on June 18, 2017, June 20, 2017, June 21, 2017, and June 22, 2017, he was noted with no skin impairments, however by June 23, 2017 the unstageable sacral pressure ulcer with eschar was noted to increase in length and width, now measuring 4 x 4 cm and the unstageable right heel wound with eschar was also noted to increase in length and width, now measuring 5 x 5 cm., and the following day, he was noted with no skin breakdown by two Defendant employees (Exhibit B at 199, 204, 208-209, 211, 215-216, 217, 219).

Dr. Starer states that Plaintiff Decedent should have been properly assessed under the Braden Scale consistently to evaluate his risk for development and deterioration of pressure ulcers and prevent a medical error that should never occur. Dr. Starer states that although reviewing such assessment quarterly was noted as an intervention within the Care Plan Activity Report, that the medical records fail to indicate whether this intervention was implemented, thus the failure to implement such intervention fully and adequately within his Care Plan Activity Report constitutes a departure from the standard of good and accepted medical practices. Additionally, Dr. Starer contends that Defendant's assessments, care plan and treatment fell short of medical standards of care with respect to Plaintiff Decedent's need for consistent skin checks. For example, Dr. Starer states that although skin checks/care were scheduled to be performed three times per day during May 2017 (during the hours of 7:00 a.m. through 3:00 p.m.; 3:00 p.m. through 11:00 p.m. and 11:00 p.m. through 7:00 a.m.), that there is no documentation of such skin checks/care being performed on May 6, 2017, May 14, 2017, May 15, 2017; and May 24, 2017, between the hours of 3:00 p.m. through 11:00 p.m. Additionally, during Plaintiff Decedent's June 2017 admission, skin checks/care were scheduled to be performed three times per day during June 2017 (during the hours of 7:00 a.m. through 3:00 p.m.; 3:00 p.m. through 11:00 p.m. and 11:00 p.m. through 7:00 a.m.), however there is no documentation of such skin checks/care being performed on June 8, 2017 from the hours of 7:00 a.m. through 3:00 p.m. and on June 26, 2017 from the hours of 3:00 p.m. through 11:00 p.m. Further, Dr. Starer states that although skin checks/care were scheduled to be performed three (3) times per day during July 2017 (during the hours of 7:00 am through 3:00 pm; 3:00 pm through 11:00 pm and 11:00 pm through 7:00 am), there is no documentation of such skin checks/care being performed on July 22, 2017 and July 23, 2017 from the hours of 11:00 pm through 7:00 am. Dr. Starer contends that once a pressure ulcer has developed, personalized care plans including detailed documentation of multiple wound descriptive factors are needed, wherein the first step is to offload pressure from the wound site, then implement a mixture of interventions treat and heal the ulcer and/or surgery to repair the ulcer (see Plaintiff's Expert affirmation at 15-16). Thus, Dr. Starer asserts that implementing the necessary steps to offload pressure from the wound site and accurately and consistently staging of pressure ulcers is necessary to ensure that appropriate care is provided across

different medical shifts and to facilitate effective communication amongst staff members, and that the failure to do so constitutes a departure from accepted medical standards and violation of statute.

Furthermore, Dr. Starer states that several progress notes entered into Plaintiff's Decedent's medical records were late entries. Dr. Starer states that on June 26, 2017, at approximately 1:14 pm Plaintiff Decedent was not noted to be in acute respiratory distress (Exhibit B at 220), and that at approximately 5:00 p.m. on the same day, he was noted to experience difficulty breathing, which was later stabilized (Exhibit B at 221), but that note was not entered until approximately 6:52 p.m. Similarly, Dr. Starer claims that by 8:51 pm on the same day, he was agitated and later evaluated by a respiratory therapist (Exhibit B at 221), and that upon examination later that same evening by Dr. Samir Farhat, a progress note indicates that Ativan was given to Plaintiff Decedent (Exhibit B at 223). Dr. Starer states that this was also a late progress note by Dr. Samir Farhat that was input into Plaintiff Decedent's medical records well over twenty-four hours after such evaluation (Exhibit B at 223).

With respect to accurately and consistently sizing of Plaintiff Decedent's pressure ulcers, Dr. Starer opines that Defendant was reckless in failing to create and maintain proper documentation of Plaintiff's decedent's multiple pressure ulcers that developed and deteriorated during his multiple admissions at the Defendant facility. Dr. Starer contends that because Plaintiff Decedent was noted with stage IV and unstageable pressure ulcers on his body that he needed a particularized care plan to avoid the increase of skin loss, and that Defendant failed to do so. Moreover, Dr. Starer asserts that offloading of pressure is necessary to prevent the development of pressure ulcers including frequent turning and positioning of patients at least every two hours and more frequently if the two-hour turning schedule has failed, as in the case with Plaintiff Decedent, and that Defendant failed to record a detailed turning and positioning chart, which could have provided insight as to when Plaintiff Decedent was allegedly turned, the specific positioning allegedly done and the specific time constituting a deviation from good and accepted standards of medical care, the PHL, and the proximate cause of the deterioration of Plaintiff's Decedent's pressure ulcers.

With respect to Plaintiff's claim that Defendant failed to provide Plaintiff Decedent with support surfaces, Dr. Starer states that his chart fails to indicate whether any were provided. Dr. Starer claims that an intervention noted within his Care Plan on May 3, 2017 (one day after his admission to the Defendant facility) was to "provide pressure reducing mattress" and to "use pressure reducing cushion when in wheelchair," however, the medical records fail to indicate whether such pressure reducing mattress was ordered and provided to Plaintiff Decedent or whether he was in possession of a pressure reducing cushion for his wheelchair. Dr. Starer states that there is a progression of bed-type interventions and mattresses that are available depending on the level of risk a patient is for the development and/or deterioration of pressure ulcers including gel, foam, and sheep skin surface-based mattresses and overlays are of particular utility in

high-risk patients, andhe asserts that despite the progression of Plaintiff Decedent's wounds, that Defendant failed to implement new interventions or modify his care plan. Additionally, Dr. Starer opines that Plaintiff Decedent was not properly nourished while admitted to Defendant facility, and that Defendant failed to timely and properly implement a comprehensive nutritional regimen or follow ups for him. Dr. Starer states that upon initial admission to Defendant facility on May 2, 2017, Plaintiff Decedent weighed 117 pounds and that on May 12. 2017, Plaintiff Decedent was noted to have weighed 113 pounds, losing approximately four pounds within the first ten days. Furthermore, Dr. Starer claims that when Plaintiff Decedent was transported to Brookdale University Hospital on June 27, 2017, with sever sepsis secondary to pneumonia, he was also noted with malnutrition and a stage 3 right hip pressure ulcer. Plaintiff states that during his admission to Brookdale University Hospital, Plaintiff Decedent "required daily wound care to decubiti on his sacrum, bilateral buttocks, head and legs." Dr. Starer states that upon readmission to Defendant Facility on July 18, 2017, Plaintiff Decedent was noted to have weighed 126.6 pounds, having gained approximately 12.6 pounds while admitted to Brookdale University Hospital. Dr. Starer states that despite still being noted as "at risk," for malnutrition, a full nutritional assessment was not performed until eight days into his re-admission, and that Plaintiff Decedent weighed approximately 126.1 pounds on that day, losing around 0.5 pounds during the first eight days of readmission to Defendant facility (Exhibit B at 30). Moreover, Dr. Starer states that despite Defendant's failure to complete a skin assessment on the day that Plaintiff Decedent was readmitted, that there is documentation of treatment scheduled and performed for the stage 4 left heel, stage 4 left buttock and stage 4 right buttock pressure ulcers on that day (Exhibit B 537-540).

Dr. Starer contends that while Plaintiff Decedent did have prior medical conditions, none of them are a proximate cause of pressure ulcers, nor do they render pressure ulcers clinically unavoidable and that in his opinion based upon a reasonable degree of medical certainty that Plaintiff Decedent's skin breakdown and deterioration was caused by unrelieved pressure, rather than any of his medical conditions. Dr. Starer asserts that the submitted medical records demonstrate that Plaintiff Decedent had the ability to heal from his pressure ulcers, which is evidence that the development of skin breakdown was not unavoidable. Further, Dr. Starer contends that Plaintiff Decedent's right and left buttock pressure ulcers developed and deteriorated at the Defendant facility under their watch. Dr. Starer asserts that there is no record of any investigation, nor record of adequate subsequent changes in Plaintiff Decedent's care plans after the pressure ulcers began to develop and deteriorate. Assuming arguendo that Plaintiff Decedent's health issues did make him more prone to the development and deterioration of pressure ulcers for any reason, Dr. Starer states that this was well-known by Defendant and the nursing and medical staff, and therefore, greater attention should have been paid to the care and treatment of Plaintiff Decedent.

With respect to Plaintiff's claim that Defendant failed to properly notify or inform her of Plaintiff Decedent's ongoing condition, Dr. Starer states that although there is documentation of her being notified

about changes in his condition, there is no record of Defendant notifying Plaintiff's Decedent or any member of his family that Defendant's facility would be unable to provide proper care and treatment, nor any records regarding alternative medical facilities that would be able to provide the adequate care and treatment that he needed.

Plaintiff's complaint asserts a third cause of action against Defendant for negligence. In their moving papers, Defendant argues that Plaintiff's claims sound in medical malpractice rather than negligence. "[T]he distinction between medical malpractice and negligence is a subtle one, for medical malpractice is but a species of negligence and 'no rigid analytical line separates the two'" (*Rabinovich v Maimonides Med. Ctr.*, 179 AD3d 88 [2d Dept. 2019]; *Weiner v. Lenox Hill Hosp.*, 88 NY2d 784 [1996]; quoting *Scott v. Uljanov,* 74 NY2d 673 [1989]; *see Martuscello v. Jensen,* 134 AD3d 4 [3d Dept. 2015]). In distinguishing whether conduct should be deemed medical malpractice or ordinary negligence, the critical factor is the nature of the duty owed to the plaintiff that the defendant is alleged to have breached (*Id.; see Jeter v. New York Presbyt. Hosp.*, 172 AD3d 1338 [2d Dept. 2019]; *Pacio v. Franklin Hosp.*, 63 AD3d 1130 [2d Dept. 2009]). The distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of the common everyday experience of the trier of the facts" (*Rabinovich* at 93; *Jeter* at 139; *see Friedmann v. New York Hosp.-Cornell Med. Ctr.*, 65 AD3d 850 [1st Dept. 2009]; *Halas v. Parkway Hosp.*, 158 AD2d 516, 516–517 [2d Dept. 1990]; *Miller v. Albany Med. Ctr. Hosp.*, 95 AD2d 977 [3d Dept. 1983]). Thus, an action sounds in ordinary negligence when jurors can utilize their common everyday experiences to determine the allegations of a lack of due care (*Rabinovich* at 93; *see Jeter* at 1339; *Reardon v. Presbyterian Hosp. in City of N.Y.*, 292 AD2d 235 [1st Dept. 2002]). In contrast, an action sounds in medical malpractice where the determination involves a consideration of professional skill and judgment (*Rabinovich* at 93; *see Weiner* at 788; *Bleiler v. Bodnar,* 65 NY2d 65 [1985]; *Rey v. Park View Nursing Home,* 262 AD2d 624 [2d Dept. 1999]; *Payette v. Rockefeller Univ.*, 220 AD2d [1st Dept. 1996]; *Halas* at 516–517; *Zellar v. Tompkins Community Hosp.*, 124 AD2d 287 [3d Dept. 1986]).

A negligent act or omission by a health care provider that constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician to a particular patient constitutes medical malpractice (*see Davis v. South Nassau Communities Hosp.*, 26 NY3d [2015]; *Spiegel v. Goldfarb,* 66 AD3d 873 [2d Dept. 2009]; *Sosnoff v. Jackman,* 45 AD3d 568 [2d Dept. 2007]). When the gravamen of the complaint is not negligence in furnishing medical treatment to a patient, but the failure to fulfill a different duty, the claim sounds in ordinary negligence (*see Weiner* at 788; *see also Rodriguez v. Saal,* 43 AD3d 272 [1st Dept. 2007]; *Payette v. Rockefeller Univ.*, 220 AD2d 69 [1st Dept. 1996]).

Here, the court finds that Plaintiff's complaint consists of mixed allegations that sound in both medical malpractice and ordinary negligence. For instance, Plaintiff's allegations that Defendant failed to properly assess, monitor, supervise, or provide sufficient nutrients and fluids to Plaintiff Decedent and allegations relating to the assessment of a patient's consequent need for assistance, protective equipment or supervision are medical determinations that sounds in medical malpractice based on the necessary care to be rendered to Plaintiff Decedent (see *Snow v Gotham Staffing LLC*, 227 ad3D 1029 [2d Dept. 2024]; *Lasak v St. James Rehabilitation & Healthcare Center*, 199 AD3d 671 [2d Dept. 2021]; *Caso v St. Fransis Hosp.*, 34 AD3d 714 [2d Dept. 2006]; *Fox v White Plains*, 125 AD2d 538 [2d Dept. 1986]; *Currie v Onieda Health Systems, Inc.*, 222 AD3d 1284 [2d Dept. 2023]; *Mortuscello v Jensen,* 134 AD3d 4 [4th Dept. 2015]). However, allegations bearing on decision made "after the medical judgment has been exercised," such as orders to provide protective equipment and/or the failure to comply with such orders or follow the care plan sound in ordinary negligence (see *Currie v Onieda Health Systems, Inc.*, 222 AD3d 1284 [2d Dept. 2023]; *Pacio v Franklin Hosp.*, 63 AD3d 1130 [2d Dept. 2009]. Moreover, a contention of inadequate staffing, or the failure of staff to timely and/or adequately notify Plaintiff Decedent's treating physician, specialists, and/or family of injuries or significant changes in Plaintiffs Decedent's condition, speak to ordinary negligence (see *Currie*; *Zellar v Thompkins Community Hosp. Inc.*, 124 AD2d 287 [3d Dept. 1986]; *Bleiler v Bodnar*, 65 NY2d 65 [1985]).

With respect to Plaintiff's medical malpractice allegations, Dr. Wolf-Klein opines, to a reasonable degree of medical certainty, that the care rendered by Defendant to the Plaintiff Decedent conformed to the applicable and then-prevailing standards of care, and that Defendant's actions were not the proximate cause of the alleged injuries. Defendant also argues that Dr. Starer's affirmation is conclusory and speculative.

Although summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact" (*Getselevich v Ornstein*, 219 AD3d 1493, 1494-95 [2d Dept 2023]; *Barnaman v. Bishop Hucles Episcopal Nursing Home*, 213 A.D.3d 896 [2d Dept. 2023]; see *Gaston v. New York City Health & Hosps. Corp.*, 207 AD3d 705 [2d Dept. 2022]). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on specifically cited evidence in the record" (*Wijesinghe v. Buena Vida Corp.*, 210 AD3d 825 [2d Dept. 2022]; see *Valentine v. Weber*, 203 AD3d 992 [2d Dept. 2022]; *Longhi v. Lewit*, 187 AD3d 873 [2d Dept. 2020]).

Here, Defendant's expert Dr. Wolf-Klein asserts that Plaintiff Decedent had pre-existing injuries and comorbidities that contributed to his death and that he was already near the end of life upon admission to Defendant facility. Dr. Wolf-Klein contends that Plaintiff Decedent's skin was already failing before admission and that Defendant facility sufficiently worked to address the pre-existing wounds and prevent

additional wounds from developing. Dr. Wolf-Klein states that the pre-existing wounds were unlikely to heal completely, and it was very likely that Plaintiff Decent would develop new skin breakdown as his condition continued to deteriorate. In addressing Defendant's expert's assertions, Dr. Starer contends that while Plaintiff Decedent did have prior medical conditions, none of them were the proximate cause of pressure ulcers, nor did they render pressure ulcers clinically unavoidable. Dr. Starer contends that Plaintiff Decedent's skin breakdown and deterioration was caused by unrelieved pressure rather than any of his medical conditions and that pressure relieving interventions were not properly and/or timely provided and that skin checks were not done in accordance with Plaintiff Decedent's care plan. Dr. Starer contends that Plaintiff Decedent had the ability to heal from his pressure ulcers and even if his condition and comorbidities make him more prone to the development of the pressure ulcers for any reason, that this was well known by Defendant, thus great attention and care should have been paid to his care and treatment. Furthermore, Dr. Starer contends that Defendant failed to prevent the development and worsening of pressure ulcers by not performing proper assessments, not developing appropriate care plans, not administering proper treatments, adequate nutrition and/or performing necessary interventions including offloading the pressure and/or providing more appropriate pressure relieving support surfaces to Plaintiff Decedent.

Accordingly, the court finds that Dr. Starer's affirmation is not conclusory and speculative, and that Plaintiff has raised triable issues of fact as to the aforementioned purported violations of law.

With respect to Plaintiff's claim against Defendant based on negligent hiring, retention or supervision, to establish a cause of action based on negligent hiring, retention, or supervision of an employee, it must be shown that the employer knew or should have known of the employee's propensity of the conduct which caused the accident (see *Brophy v Big Bros. Big Sisters of Am., Inc.*, 224 AD3d 866 [2d Dept. 2024]; quoting *Fuller v Family Servs. Of Westchester, Inc.*, 209 AD3d 983 [2d Dept. 2022]). Generally, where an employee is acting within the scope of his or her employment, the employer is liable under the doctrine of respondeat superior and no claim may proceed against the employer under a theory of negligent hiring, retention, or supervision (*S.W. v Catskills Regional Medical Center*, 211 AD3d 890 [2d Dept. 2022]; *Quiroz v Zottola*, 96 AD3d 1035 [2d Dept. 2012]; *Talavera v Arbit*, 18 AD3d 738 [2d Dept. 2005]; *Weinberg v The Cuttman Breast & Diagnostic Institute*, 254 AD 213 [1st Dept. 1998]). An exception exists where the plaintiff seeks punitive damages from the employer based on alleged gross negligence in the hiring or retention of the employee (*S.W.* at 891; *Talavera* at 738-739; *Decker v State of New York*, 164 AD3d 6650 [2d Dept. 2018]).

Here, Plaintiff has failed to assert specific facts to allege what employee was negligently hired or supervised, the actual acts upon which the claims are based, or what manner Defendant should have been

aware of or reasonably foreseen the act. Thus, Plaintiff's claim for negligent hiring is conclusory and speculative.

Accordingly, that branch of Defendant's motion for summary judgment to dismiss Plaintiff's claim for negligent hiring, retention or supervision is granted.

With respect to Plaintiff's claim for punitive damages, Plaintiff seeks punitive damages against defendants pursuant to PHL 2801-d(2), which states, in relevant part, that "where the deprivation of any such right or benefit is found to have been willful or in reckless disregard of the lawful rights of the patient, punitive damages may be assessed. Here, Plaintiff's complaint only asserts that "punitive damages pursuant to PHL 2801-d(2) as the deprivation of the aforesaid rights and benefits to the plaintiff's decedent were willful and/or in reckless disregard of the lawful rights of plaintiff's decedent." Neither Plaintiff nor Dr. Starer however alleges with specificity the conduct amounting to a willful deprivation or in reckless disregard of a right or benefit owed to the Plaintiff Decedent.

Accordingly, that branch of Defendant's motion for summary judgment to dismiss Plaintiff's claim for punitive damages is granted.

Issues not addressed herein are either moot or without merit.

Accordingly, it is hereby,

ORDERED that Defendant's motion for summary judgment is granted to the extent that Plaintiff's claims for negligent hiring, retention, or supervision and for punitive damages pursuant to PHL 2801-d(2) are dismissed.

This constitutes the decision and order of the court.

Hon. Ingrid Joseph J.S.C.

Hon. Ingrid Joseph
Supreme Court Justice