Polanco v Mount Sinai Morningside
2025 NY Slip Op 30913(U)
March 17, 2025
Supreme Court, New York County
Docket Number: Index No. 805196/2021
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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BERKY POLANCO as Administratrix of the Estate of JOSE POLANCO, and BERKY POLANCO, Individually

Plaintiff,

- v -

MOUNT SINAI MORNINGSIDE, MOUNT SINAI MORNINGSIDE, formerly known as MOUNT SINAI ST. LUKE'S, PREMIER HOME HEALTH CARE SERVICES, INC., and CENTERLIGHT CERTIFIED HOME HEALTH AGENCY,

Defendants.

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INDEX NO. 805196/2021

MOTION DATE 01/27/2025

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 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, 95

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice, negligent hiring, training, supervision, and retention, and wrongful death, the defendants Mount Sinai Morningside (MSM), and Mount Sinai Morningside, formerly known as Mount Sinai St. Luke's (together the Mount Sinai defendants), move pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against them. The defendant Premier Home Health Care Services, Inc. (Premier), in papers erroneously denominated as a cross motion, separately moves for summary judgment dismissing the complaint insofar as asserted against it. The plaintiff opposes both motions. The Mount Sinai defendants' motion is granted only to the extent that they are awarded summary judgment dismissing, insofar as asserted against them, the wrongful death cause of action, the negligent hiring, training, supervision, and retention cause of action, and so much of the medical malpractice cause of action as sought to recover for deep tissue injury, infection, and

dehydration, and their motion is otherwise denied. Premier's separate motion is granted to the extent that it is awarded summary judgment dismissing, insofar as asserted against it, the wrongful death cause of action, the negligent hiring, training, supervision, and retention cause of action, and so much of the medical malpractice cause of action as sought to recover for (a) acts or omissions predating February 25, 2019, (b) infection, dehydration, and malnutrition, and (c) failure to diagnose the decedent, order proper care and evaluation, undertake a proper risk assessment, and transfer him to a hospital. Premier's motion is otherwise denied.

The crux of the plaintiff's claims against the Mount Sinai defendants is that, between January 28, 2019 and February 25, 2019, her decedent, Jose Polanco, had been admitted to MSM, at which time those defendants departed from good and accepted medical practice by subjecting him to improper toileting and hygiene practices, negligently failing to satisfy his nutritional and hydrational needs, and negligently failing to heed the signs and warnings of pressure ulcers, skin breakdown, and infection, thus causing him to experience pain and suffering, and ultimately causing or contributing to his death on March 17, 2021. With respect to Premier, the gravamen of the plaintiff's claims is that, between 2010 and March 17, 2021, Premier departed from the standard of care applicable to the home healthcare services that it provided to her decedent, by negligently failing to treat him in a careful and skillful manner, failing to monitor and supervise him, permitting his medical condition to deteriorate, failing timely to transfer him to a hospital, failing timely to order necessary care and evaluation, and failing to treat his pressure ulcers. She further alleged that both the Mount Sinai defendants and Premier negligently hired, trained, supervised, and retained their employees or agents, thus causing or contributing to her decedent's injuries and death.

In her bills of particulars as to both the Mount Sinai defendants and Premier, the plaintiff alleged that they failed adequately and properly to examine her decedent, failed to perform a proper risk assessment with respect to the development of pressure ulcers, and failed to employ the required vigilance and diligence necessary to prevent skin breakdown in a patient whose

age, mobility level, and general state of health demanded higher scrutiny. She further alleged that these defendants committed malpractice in failing to heed, detect, and diagnose her decedent's symptoms and complaints, as they related to his pain and development of pressure ulcers, and in failing to turn and position him every two hours, or as needed. In addition, the plaintiff alleged in her bills of particulars that these defendants failed timely to order consultations with surgeons and specialists to address these pressure ulcers, and failed to prescribe and administer appropriate and proper medications to manage and care for her decedent's pain and pressure ulcers, thus causing irreversible complications. The plaintiff reiterated that the Mount Sinai defendants and Premier failed to provide proper hygiene, nutrition, and hydration to her decedent. She additionally asserted that they failed timely to order and implement proper pressure relieving devices, equipment, and protocol, failed to maintain accurate records of the treatment rendered to her decedent, and ultimately failed to institute, adhere to, and, when necessary, modify, an effective care plan, which included their failure timely to perform debridement procedures the treat the decedent's pressure ulcers. The plaintiff additionally reiterated her contentions that the Mount Sinai defendants failed adequately to supervise and train personnel, failed to hire "efficient and sufficient" personnel, failed to institute proper and adequate policies and procedures for the prevention and treatment of pressure ulcers, and failed to adhere to the policies and procedures that they did institute.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether

summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp*., 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn*., 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr*., 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods*., 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr*., 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp*., 10 AD3d 521, 522 [1st Dept 2004]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial Hosp.*, 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *McGuigan v Centereach Mgt. Group, Inc*., 94 AD3d 955 [2d Dept 2012]; *Sharp v Weber*, 77 AD3d 812 [2d Dept 2010]; *see generally Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Koi Hou Chan v Yeung*, 66 AD3d 642 [2d Dept 2009]; *Jones v Ricciardelli*, 40 AD3d 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy his or her burden on a motion for summary judgment, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and/or opining that the defendant's acts or omissions were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at

207; *Landry v Jakubowitz*, 68 AD3d 728 [2d Dept 2009]; *Luu v Paskowski*, 57 AD3d 856 [2d Dept 2008]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, the opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24).

In support of their motion, the Mount Sinai defendants submitted the pleadings, the plaintiffs' bills of particulars, transcripts of the parties' deposition testimony, relevant medical and hospital records, the note of issue, discovery conference orders, the decedent's death certificate, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified family medicine specialist and geriatrician Lawrence N. Diamond, M.D., who averred that he had significant experience treating skin diseases and pressure ulcers. Dr. Diamond opined that no employee, agent, or affiliate of the Mount Sinai defendants departed from good and accepted practice in treating the plaintiff's decedent, and that nothing that those persons did or did not do caused or contributed to his injuries or death.

Initially, Dr. Diamond, based on his review of relevant medical records and deposition testimony, recounted the treatment and care that the Mount Sinai defendants rendered to the plaintiff's decedent between 2019 and 2021, as well as the treatment of his conditions by other health-care providers commencing in 2012. As relevant here, he noted that, on June 1, 2012, the decedent, who then was 74 years old, began receiving home health-care services through the defendant Centerlight Certified Home Health Agency (Centerlight), due to primary diagnoses

of paralysis agitans, dementia, and convulsions, and previous diagnoses of benign prostatic hyperplasia, Parkinson's disease, atrial fibrillation, seizures, and osteoarthritis.

On December 10, 2018, after having provided services to the decedent for several years, Centerlight updated its home health certification and plan of care for the period commencing on January 1, 2019 and ending on June 30, 2019. The relevant nursing assessment reported that the decedent generally was able to stay awake and alert, but was disoriented and forgetful, with short- and long-term memory impairment and bowel and bladder incontinence. On January 19, 2019, a Centerlight nurse visited the decedent for a monthly home visit, and reported that the decedent, who by then was 81 years old, was alert and oriented to person only, but not as to date and place, was ambulatory with a walker and could remain out of bed, with assistance, to the extent he could tolerate it. The Centerlight nurse wrote in her report that the decedent was being served by home health care attendants. As salient to this case, the nurse reported noted that his skin was intact with no edema present.

As Dr. Diamond explained it, on January 28, 2019, the decedent presented to the emergency department at MSM, which now is known as a division of St. Luke's-Roosevelt Hospital Center, accompanied by the plaintiff, who was the decedent's daughter. She complained to medical staff that the decedent had suffered from a seizure that had lasted five minutes. She also reported that he had not been eating well for two days, and provided hospital staff with his medical history, which, in addition to the conditions described above, also included hypertension, metabolic encephalopathy, impaired oral feeding, osteoarthritis, and cholecystectomy. Upon presentation, the decedent weighed 125 pounds. According to Dr. Diamond, although there was no obvious source of infection, hospital medical staff formulated a differential diagnosis that included occult infection, sepsis, meningitis, and/or encephalopathy, and formulated a plan to perform sepsis laboratory studies, urinalysis, a computed tomography (CT) scan of the head, and possibly a lumbar puncture, and to administer fluids and broad-spectrum antibiotics. Results of blood testing revealed elevated lactate and creatinine

phosphokinase level, but a normal level of blood urea nitrogen and a normal white blood cell count, with the lactate level reverting to normal when intravenous fluids were administered. As Dr. Diamond interpreted the Mount Sinai defendants' records, the head CT was negative for acute infarct or intracranial hemorrhage, and the chest x-ray was unremarkable.

After testing and intravenous administration of fluids, the decedent was admitted to MSM on January 28, 2019 at 9:30 p.m., upon which MSM internist Omar Amir, M.D., examined the decedent, and concluded that the physical examination was "unremarkable," except for his inability to follow commands and the presence of Stage II sacral pressure ulcers. Dr. Amir reported his impression as unclear etiology of altered mental status, but included, in his differential diagnosis, both a breakthrough seizure and toxic metabolic encephalopathy, with likely underlying Parkinson's dementia, while he characterized the decedent's clinical presentation as inconsistent with meningitis. Dr. Amir formulated a plan to take an electroencephalogram, increase the dosage of the anticonvulsant drug Keppra, perform a magnetic resonance imaging (MRI) scan, and consult with a neurologist.

As germane to the plaintiff's clams here, Dr. Diamond explained that, on January 29, 2019, at 12 midnight and 12:32 a.m., respectively, MSM's nursing wound flow sheet documented the presence of two Stage II pressure injuries, while a nursing assessment completed on January 29, 2019 at 3:00 a.m. documented that the decedent was experiencing one Stage II left ischial tuberosity pressure ulcer measuring 1.0 centimeters (cm) by 0.5 cm, with purple and maroon areas but no exudate, and a second Stage II left ischial tuberosity pressure ulcer measuring 0.5 cm by 0.5 cm, with purple and maroon areas but no exudate. According to Dr. Diamond, at that time, hospital nursing staff also documented that they assessed the decedent as at risk for skin breakdown, with a Braden Scale Score of 10. As Dr. Diamond interpreted the decedent's chart, nursing staff simultaneously implemented pressure ulcer prevention interventions, consisting of turning and repositioning the decedent every two hours if he was lying in bed, or every hour if he was sitting in a chair, promoting increased range

of motion and mobility, employing a lift sheet to move and position him, elevating his head 30 degrees unless contraindicated, providing heel protectors, and elevating his heels off his mattress. According to Dr. Diamond, nursing staff ordered a skin and wound care consultation to validate the staging of the existing wounds. On January 29, 2019 at 3:35 a.m., nursing personnel assessed the decedent as disoriented to place and time, as non-ambulatory, and as evincing Stage II buttock pressure ulcers that had been present on admission. Dr. Diamond asserted that nurses thereupon applied bilateral heel and sacral foam dressings.

As Dr. Diamond interpreted the decedent's chart, the decedent met the criteria for severe malnutrition due to his fat and muscle depletion, minimal oral intake, and low body mass index. He also asserted that, according to the chart, on January 30, 2019, the decedent had difficulty following one-step commands and had tremors bilaterally, with rigidity to his bilateral upper and lower extremities and the inability to straighten his legs. On February 1, 2019, health-care personnel from the neurology department reported that the decedent was stuporous, with no speech and an inability to follow commands, while nursing personnel reported that they had changed the foam dressing for the Stage II sacral ulcers, and that both Stage II left ischial tuberosity ulcers remained pink in color and without signs or symptoms of infection. The MSM chart reported that, on February 2, 2019, the decedent was "sick looking." As relevant to the instant dispute, the chart reported that, from February 2, 2019 through February 5, 2019, the decedent's wounds were assessed every shift by nursing personnel and both were still described as Stage II left ischial tuberosity pressure ulcers without exudate, pink in color, and without signs or symptoms of infection.

According to a nursing note entered into the plaintiff's chart at MSM, on February 5, 2019, the decedent was turned and repositioned and, according to Dr. Diamond, "his sacral breakdown was healing well." Dr. Diamond explained that, several hours after that note was written, wound care nurse Mariza Lising was consulted to evaluate "pressure injury on sacral area," and she assessed the wound as one that caused moisture-associated skin damage to the

sacral crease, present upon the decedent's admission to the hospital, measuring 4.0 cm by 4.0 cm, with no exudate, tunnelling, or erythema. Nurse Lising prescribed the application of triad cephalic cream daily, and dressing the wounds with Mepilex bandages, and recommended that the decedent be turned and repositioned every two hours, that he wear bilateral heel booties, that hospital staff perform skin checks every eight hours, and that staff notify a wound-care nurse of any further skin changes.

On February 6, 2019, an MSM neurologist who examined the decedent reported that his recent electroencephalogram (EEG) was consistent with diffuse encephalopathy, likely due to a neurodegenerative process, and recommended an outpatient follow-up examination to optimize Parkinson's disease medications. That same day, a nurse reported the decedent's temperature as 101.6 degrees Fahrenheit, and physicians administered the antibiotic vancomycin, while a February 7, 2019 chest CT scan revealed small right and minimal left pleural effusions and dependent atelectasis, which, according to Dr. Diamond, raised the likelihood of superimposed pneumonia and a lipomatous lesion, causing MSM physicians to administer cefepime to treat pneumonia. On February 7, 2019, a hospital wound care nurse ordered weekly dressings to be applied to the decedent's gluteal cleft, consisting of triad cream and a Mepilex bandage. An MSM infectious disease specialist examined the decedent on February 9, 2019, reporting that he had a resolving fever and improving mental status, with a slightly low white blood cell count of 3,700 cells per microliter (μL) of blood, and administered the antibiotics ceftriaxone, Flagyl, and vancomycin. According to Dr. Diamond, the nursing flowsheets "continued to indicate that treatment to the wound was performed daily and there were no signs of infection."

As Dr. Diamond summarized the decedent's medical chart, on February 13, 2019, the decedent spiked a fever of 105.4 degrees Fahrenheit and had a white blood cell count of 2,300 cells per μL of blood, in response to which hospital personnel administered ice packs and a cooling blanket. Hematologist/oncologist Anwar Hossain, M.D., examined the decedent, concluded that he continued to spike fevers despite the administration of broad-based

antibiotics, and thus formulated an impression of persistent fevers of unclear etiology and a plan for abdominal and pelvic CTs to rule out lymphoma, which, in fact, revealed stercoral proctitis and small left inguinal hernia, without obstruction. An infectious disease specialist who examined the decedent on February 14, 2019 reported that, despite a high fever, there were no signs of tachycardia or systemic signs of infection, and that blood and urine cultures were "grossly" negative. Consequently, that physician formulated a differential diagnosis that included non-infectious sources of the fever, including a reaction to medications, recommending that the decedent discontinue antibiotics and that he be monitored after discontinuing them. Dr. Diamond described the nursing flowsheets as continuing to indicate that treatment to the decedent's wounds was performed daily, with no signs of infection. On February 15, 2019, MSM's social work department reported that, while the decedent himself requested placement in a skilled nursing facility, the plaintiff expressed her preference that he return home, with home care services provided by Centerlight, and home health attendants provided by Premier. Laboratory studies of blood samples collected on February 15, 2019 revealed that the decedent had a normal blood urea nitrogen level of 21.0 milligrams per deciliter (mg/dL) of blood. The decedent's chart indicated that, by the end of February 16, 2019, he had been afebrile for 48 hours, but remained lethargic. Hospital personnel characterized his overall prognosis as poor, and suggested that palliative care might be warranted if there were no clinical improvement.

On February 20, 2019, hospital palliative care personnel reported that they had spoken with the plaintiff, who purportedly understood that the decedent was rapidly declining both functionally and mentally, and allegedly stated that she wanted the decedent to return to home, with full-time home health care. The nursing flowsheets in the decedent's chart continued to report that wound care was performed as ordered. Based on his vital signs, the decedent was discharged to his home on February 25, 2019, with home care. As relevant to this case, the flowsheet reported the continued existence of sacral/perineum moisture-associated skin disease, with open macerated areas. The decedent's discharge instructions allegedly included

measures to address existing pressure ulcers and to avoid development of additional pressure ulcers. Premier provided home health assistance to the decedent beginning on that day, in 12-hour shifts, consisting of assistance in cleaning, dressing, incontinence care, meal preparation, turning and positioning, skin care, walking, medication assistance, grocery shopping, foot care, transfers, shower, diet reinforcement, mouth care, and laundry. On February 26, 2019, Centerlight also resumed providing the decedent with home nursing care, and reported that, although the decedent was alert, he was disoriented, and required total assistance with all of his activities of daily living, was confined to his bed, had bilateral lower extremity contractures, and had both bowel and bladder incontinence. A skin assessment revealed that he was at high risk for skin breakdown. He had a Stage II sacral ulcer, measuring 4.0 cm by 4.0 cm, with granulating tissue, which Centerlight personnel treated with Allevyn wound dressing bandages every second day.

Dr. Diamond summarized the outpatient wound examination and treatment protocol that Centerlight's nursing and wound-care personnel periodically provided to the decedent over the next two years. Initially, he explained that Centerlight's March 3, 2019 nursing evaluation reported that the decedent's Stage II sacral ulcers were by then "unstageable," and produced a small amount of serosanguineous drainage, upon which it treated the wound with Argales antimicrobial powder and an Allevyn dressing, and provided the decedent with "bunny boots" for both feet. According to Dr. Diamond, Centerlight educated the decedent's family members and Premier home health aides on turning and positioning his body, as well as offloading pressure.

Dr. Diamond asserted that Centerlight's nursing staff and wound-care specialists thereafter examined and treated the decedent on a weekly or twice weekly basis. He addressed only the examinations conducted on March 6, 2019, March 10, 2019, May 9, 2019, June 22, 2019, August 7, 2019, September 1, 2019, November 6, 2019, and January 1, 2020, as well as a June 10, 2020 "six-month follow up," along with examinations on September 25, 2020 and February 21, 2021. He stated that the relevant chart indicated that the ulcers either

were growing in size or advancing in stage, and emitting larger amounts of serosanguineous drainage, granulating tissue, and loose yellow/tan slough, progressing in some instances to deep tissue injury, although some ulcers occasionally retreated in response to the application of silver alginate or other topical medications. Dr. Diamond further asserted that, based on his review of the decedent's chart, Centerlight treated the wounds with different medications, cleansers, and dressings, depending on severity, and that the fluid discharge fluctuated from examination to examination. With respect to the September 25, 2020 examination, Dr. Diamond explained that the decedent's primary care provider, internist Yvonne Ablorh-Odjidja, M.D., reported, after evaluating the decedent's wounds, that the decedent was progressively declining, nonverbal, bedbound, and required total assistance with his activities of daily living, and memorialized the plaintiff's statements that the decedent's wounds had been worsening over the preceding month. Dr. Ablorh-Odjidja further reported that the Premier "HHA was not repositioning/turning the pt in the evenings." At the time, the decedent's sacral ulcer measured 4.0 cm by 1.8 cm by 1.0 cm, with undermining and "odor or drainage noted."

When a Centerlight nurse examined the decedent on February 10, 2021, he was reported as weak, unresponsive, and lethargic. The nurse notified a physician, who ordered that the decedent be transferred by ambulance to Lenox Hill Hospital (LHH) for further evaluation and treatment. Upon his arrival at LHH that day, that hospital's emergency department triaged him, reporting that his complaints were for a cough and shortness of breath, after which he was diagnosed with COVID-19, and administered four liters of oxygen via nasal cannula. Emergency department personnel described him as non-verbal at baseline, with "rhonchi and rales to the bilateral lung fields." As relevant to the instant dispute, nurses at LHH documented the presence of a Stage IV sacral ulcer, measuring 8.0 cm by 6.0 cm, with drainage. Throughout his stay at LHH, the decedent was reported to be persistently hypotensive, with rising lactate, and was administered five liters of intravenous fluids. By February 11, 2021, he was reportedly in respiratory distress and febrile, and hospital personnel

ordered palliative care. On February 16, 2021, an LHH wound care nurse documented the presence of a Stage III sacral ulcer, measuring 3.5 cm by 1.0 cm by 1.0 cm, with undermining, non-granulating tissue, and a small amount of serosanguinous exudate.

On February 22, 2021, the decedent was discharged to The Plaza Rehabilitation & Nursing Center (Plaza), a subacute rehabilitation facility, for comfort care. Plaza health-care staff reported that decedent was non-verbal and winced in response to painful stimuli. They assessed him as having bowel and bladder incontinence, contracted, and requiring total assistance by two persons for his activities of daily living. His skin assessment reportedly revealed a Stage III sacral ulcer, measuring 12.0 cm by 7.5 cm, a left ankle scab measuring 3.5 cm by 2.0 cm, a left lower leg scab measuring 5.0 cm by 1.0 cm, and redness in his right ankle. According to Dr. Diamond, Plaza records indicated that Plaza staff conducted wound rounds on March 4, 2021, and had concluded that the decedent then was suffering from a Stage II sacral ulcer measuring 3.0 cm by 1.0 cm by 1.0 cm, with no odor or discharge and a clean and pink wound bed, while the left-ankle deep tissue injury measured 2.0 cm by 2.0 cm. According to Dr. Diamond, on March 16, 2021, the decedent was medically stable and discharged to his home.

Centerlight evaluated the decedent on March 17, 2021, and reported that he was s responsive to tactile and painful stimuli, and, although he was receiving three liters of oxygen via nasal cannula, his oxygen saturation level was only 87%. Centerlight nurses reported that they repositioned him and increased his oxygen intake to four liters, which increased his oxygen saturation level to 93%. The nurse's skin assessment on that day reported a Stage II left lateral malleolus ulcer, measuring 2.0 cm by 2.0 cm, a left medial foot blood blister, measuring 1.0 cm by 3.0 cm, a right lateral foot blood blister, measuring 1.0 cm by 2.5 cm, a right 1st metatarsal deep tissue injury, measuring 0.4 cm by 0.3 cm, a right heel deep tissue injury, measuring 3.0 cm by 2.5 cm, a right lateral medial malleolus deep tissue injury, measuring 0.5 cm by 1.0 cm, a left shin deep tissue injury, measuring 0.4 cm by 3.0 cm, a left flank deep tissue injury measuring 1.0 cm by 3.0 cm, a left shoulder deep tissue injury, measuring 1.0 cm by 1.5 cm, a

right flank deep tissue injury, measuring 0.4 cm by 1.2 cm, a left knee deep tissue injury measuring 0.5 cm by 0.5 cm, a right ankle deep tissue injury measuring 1.0 cm by 1.0 cm, multiple small deep tissue injuries on the right ear lobe, a Stage II Posterior right ear lobe ulcer measuring 0.5 cm by 5.0 cm, and a Stage IV sacral ulcer measuring 1.3 cm by 3.5 cm. The decedent died at home on March 17, 2021. The decedent's death certificate reported his cause of death as Parkinson's disease due to consequences of arteriosclerotic cardiovascular disease.

After noting that the decedent was under the care of MSM only from January 28, 2019 until February 25, 2019, Dr. Diamond opined that the wound and skin care and treatment rendered to the decedent by MSM was in accordance with appropriate standards of care, and did not cause or contribute to the injuries identified by the plaintiff, let alone his death.

Dr. Diamond explained that moisture-associated skin damage is defined as either an inflammation or softened areas of open skin, known as open maceration, caused by prolonged exposure to a source of moisture, such as urine, stool, sweat, or wound drainage, and that advanced age, environmental factors, immobility, use of occlusive containment products such as plasticized undergarments, diminished cognition, an inability to perform personal hygiene, fever, the use of antibiotics and immunosuppressants, poor nutrition, and critical illness all increase a patient's risk for developing such skin damage. He described common manifestations of such damage as local inflammation with erythema, inflamed skin with irregular borders, erosion of superficial skin layers, and rash from fungus or bacteria. Dr. Diamond asserted that, if a patient were at risk for moisture-associated skin damage due to immobility and incontinence of the bowel and bladder, as the decedent was here, the standard of care required the patient to be placed on a toileting program to ensure the patient's skin does not have prolonged exposure to urine or feces and that, typically, such a toileting program requires that a patient's undergarments be checked for soilage every two hours. Dr. Diamond further explained that pressure ulcers are caused by sustained pressure on a bony prominence that cuts off blood flow. He asserted that the areas of the body most vulnerable to pressure ulcers

are the heels, hips, sacrum, and buttocks. As he described it, pressure ulcers are classified based on the type of tissue visualized or palpated, which is called staging. He explained that Stage I pressure ulcers evince intact reddened skin that is non-blanchable, Stage II pressure ulcers have skin openings or breaks in the superficial layers that typically are described as scrapes, abrasions, blisters, or shallow craters in the skin, Stage III pressure ulcers reflect skin openings or breaks not only in the superficial layers, but also into the fatty tissue, and Stage IV pressure ulcers evince skin openings or breaks that reach into muscle, tendons, ligaments, and potentially bone, while "unstageable" pressure ulcers describe skin openings or breaks with slough and eschar that prevent a determination of the depth of the wound. In addition, he defined deep tissue injury pressure ulcers as characterized by intact skin with adverse subcutaneous consequences to fatty tissue and muscle. He opined that patients with comorbidities such as cardiovascular disease, diabetes, ventilation dependence, artificial feeding apparatus, diminished cognition, poor personal hygiene, poor nutrition, and confinement to bed have an increased likelihood of pressure ulcers becoming chronic and incurable.

Dr. Diamond opined that, when a patient such as the decedent presents to a hospital, the standard of care requires a full head-to-toe skin assessment and a Braden Scale skin breakdown risk score, and that, depending on these assessments, the initiation of a skin integrity care plan may be indicated. He explained that such a plan included turning and positioning the patient every two hours, providing the patient with a pressure-reducing mattress, implementing a skin hygiene protocol that consisted of incontinence care, offloading, evaluating the patient to determine the need for physical or occupational therapy, consulting a dietician or nutritionist, encouraging adequate fluid intake and nutrition, monitoring blood laboratory results, providing the patient with nutritional supplements, providing the patient with heel booties, and initiating a consultation with a wound care physician. He averred that a consultation with a general surgeon to assess the need for debridement would be necessary only for Stage III and IV or unstageable ulcers. He opined that, in a hospital setting, "there is no standard of care with

respect to the time frame in which a consult should occur." Dr. Diamond further asserted that, with respect to treatment of moisture-associated skin damage or pressure ulcers, "there are several treatment options depending on the wound condition, [and,] as such[,] the only standard is to ensure the treatment ordered is appropriate for wound description. Debridement, whether chemical or surgical, are only indicated if necrotic and/or infected tissue is present."

Applying the standards of care that he had just described, Dr. Diamond concluded that MSM timely and appropriately performed a head-to-toe skin assessment of the decedent upon his January 28, 2019 admission, both by assigning a Braden Scale score and noting the presence of Stage II sacral ulcers, and, after the decedent's admission and transfer to a regular floor, by noting the presence, size, and relevant characteristics of two Stage II left ischial tuberosity pressure ulcers. He opined that "because the ischial tuberosity (known colloquially as the sit bones or sitz bones) is close to the sacrum, the discrepancy in the location of the wound is irrelevant, as it is more important that an open skin condition is observed and appreciated, which is exactly what happened here."

Dr. Diamond characterized MSM's care plan as being in accordance with good and accepted practice because it implemented pressure ulcer prevention interventions, consisting of turning and repositioning the defendant every two hours if in bed or every hour if in a chair, promoting increased range of motion and mobility, employing a lift sheet to move and position him, elevating his head 30 degrees unless contraindicated, elevating his heels off of his mattress, and providing him with a specialty bed and heel protectors. Moreover, he asserted that MSM satisfied the standard of care when, less than 24 hours after the decedent's presentation, its nursing department ordered a skin and wound care consultation for the purposes of validating the staging of the existing wound. He further opined that MSM performed the wound-care consultation in accordance with good and accepted practice, inasmuch as, on February 5, 2019, although Nurse Lising evaluated a "pressure injury on sacral area," she correctly classified it as moisture-associated skin damage, rather than a pressure ulcer,

measuring 4.0 cm by 4.0 cm, with no exudate, tunnelling, or erythema, and properly recommended treating it with triad cephalic cream daily, to be covered with a Mepilex dressing. He validated her recommendations with respect to turning and repositioning the decedent every two hours, furnishing him with heel booties, performing skin checks every eight hours, and notifying a wound-care nurse such as herself if any further skin changes were observed. He reiterated that, inasmuch as "there is no standard time frame within which a hospital wound care consult is to occur, . . . the timing of Nurse Lising's consultation was appropriate." Moreover, he noted that moisture-associated skin damage and Stage II pressure ulcers are, by their very definitions, superficial open areas of maceration and that moisture- associated skin damage can occur on common pressure areas, such as the sacrum,. He thus concluded that "it is unsurprising to see MASD and Stage II pressure ulcers to be used interchangeabl[y]." With respect to the treatment rendered at MSM, Dr. Diamond asserted that the topical application of triad cream was appropriate for areas of open maceration, since it adheres to wet skin, keeping the wound covered and protected from incontinence, and that the MSM chart indicated that nurses carried out this treatment order on a daily basis. He concluded that, in light of the nature and size of the wounds, and the absence of exudate, tunnelling, or erythema, "debridement was not indicated because the wound was superficial with no evidence of infection or necrosis."

Dr. Diamond expressly opined that the care and treatment that MSM provided during the decedent's admission, from January 28, 2019 through February 25, 2019, "in no way negatively affected the decedent's outcome" and "was not the result of any act or omission of MSM staff during the decedent's admission." With respect to these opinions, Dr. Diamond initially noted that, when the decedent presented to MSM on January 29, 2019, he had a preexisting skin condition or wounds and, hence, MSM did not cause or contribute to the development of the wounds. He further explained that the sacral moisture-associated skin damage identified at MSM, which measured 4.0 cm by 4.0 cm on February 5, 2019, was the same condition that Centerlight identified in its February 26, 2019 assessment as a Stage II sacral ulcer, inasmuch

as the two conditions both describe superficial areas of open maceration. Hence, Dr. Diamond concluded that "the sacral wound did not deteriorate during the decedent's admission to MSM and therefore, MSM did not cause or contribute to any alleged subsequent deterioration."

Dr. Diamond further opined that, notwithstanding the plaintiff's allegation in her bill of particulars, MSM provided proper nutrition and hydration to the decedent while he was an inpatient. In this respect, he noted that an MSM dietician saw the decedent on January 29, 2019, observing that the decedent was thin, with moderate muscle depletion, and mild fat depletion, and thereupon concluded that, in light of these depletions, as well as the frequency of exceedingly minimal oral intake, his decreasing oral intake, and low body mass index of 17, the decedent met the criteria for severe malnutrition upon admission. Thus, Dr. Diamond concluded that the decedent was properly diagnosed with malnutrition, that the MSM dietician properly arranged for the decedent to be placed on a thin liquid diet, consisting of pureed food and Ensure twice daily, and properly provided him assistance with feeding. He further noted that, throughout the decedent's admission, MSM staff frequently documented that the decedent's oral intake increased and that, on February 5, 2019, a nurse reported in the chart that the decedent ate a full tray of food for dinner with assistance. Moreover, he adverted to the plaintiff's deposition testimony, in which she asserted that she brought food from home for the decedent, who would eat it all. Hence, Dr. Diamond concluded that MSM did not cause or contribute to the decedent's malnutrition. With respect to the plaintiff's claims of dehydration, Dr. Diamond noted that, throughout the decedent's admission, he was administered intravenous fluids, that the decedent's blood urea nitrogen level on admission was 15 mg/dL and that, shortly before his discharge, it was 21 mg/dL. Dr. Diamond concluded that, in light of the fact that the decedent received such fluids, and the fact that blood urea nitrogen level was not elevated, which he asserted would have been an indicator for dehydration, MSM did not cause or contribute to the decedent's alleged dehydration.

Inasmuch as the decedent died two years after his discharge from MSM, and his death certificate indicated that he died from Parkinson's disease due to consequences of arteriosclerotic cardiovascular disease, rather than infection, sepsis, or conditions related to wounds and pressure ulcers, Dr. Diamond explicitly concluded that nothing that any MSM employee did or did not do caused or contributed to the decedent's death.

In opposition to the Mount Sinai defendants' motion, the plaintiff relied on the submissions made by those defendants. She also submitted her own affidavit, an attorney's affirmation, excerpts from the decedent's medical records, a counter statement of material facts, and the expert affirmation of a board-certified internist and geriatrician. The expert opined that the Mount Sinai defendants departed from good and accepted practice and that these departures caused or contributed to many of the decedent's injuries.

The plaintiff's expert, upon reviewing the decedent's chart from MSM, concluded that, although it had formulated a plan for turning and repositioning the decedent every two hours over the course of his admission, it did not adhere to that plan. Rather, as the expert interpreted the relevant chart, MSM's records of turning and positioning "are replete with instances where decedent was noted to be in the same position for more than two . . . hours." Specifically, the plaintiffs' expert asserted that, from 4:38 p.m. on January 28, 2019, until 7:19 a.m. on February 1, 2019, the decedent continuously was in a supine position, that is, on his back, a period of approximately 86 hours, and because the notation for 7:31 p.m. on that date was left blank, the expert concluded that, from 9:24 p.m. on February 1, 2019, until 8:06 a.m. on February 3, 2019, the decedent continuously was supine for approximately 34 hours. The expert asserted that, from 9:00 a.m. until 12:00 noon on February 4, 2019, the decedent was supine for approximately 3 hours, while, from 8:00 p.m. on February 4, 2019, until 7:00 a.m. on February 5, 2019, and again from 1:00 p.m. to 5:00 p.m. on February 5, 2019, he was supine.

The plaintiff's expert continued to expound upon MSM's records, noting that, from 8:19 p.m. on February 5, 2019, until 6:00 a.m. on February 6, 2019, a period of approximately 10

hours, the decedent remained on his left side, and, between 6:00 a.m. and 9:32 a.m. on that latter date, he remained in a supine position. The expert further explained that, from 1:40 p.m. on February 6, 2019, to 6:00 a.m. on February 7, 2019, a period of approximately 16 hours, the decedent continuously remained in a supine position. The expert noted that the entry for February 7, 2019, at 11:00 a.m. was left blank, and he thus concluded that MSM left the decedent in a sitting position on that day for approximately 5.5 hours, specifically, from 9:16 a.m. to 2:50 p.m. The expert further noted that the 6:20 p.m. notation for that date also was left blank, leading him to the conclusion that MSM left the decedent in a supine position for approximately 6.5 hours, specifically, from 2:51 p.m. to 9:25 p.m. The expert also asserted that MSM records reflected that, from 2:08 a.m. on February 8, 2019, until 10:28 p.m. on February 9, 2019, a period of approximately 44 hours, MSM left the decedent in a supine position. As the expert further averred, the relevant notations for 2:04 p.m. and 7:20 p.m. on February 10, 2019, were left blank, and, hence, concluded that, from 5:31 a.m. to 8:33 p.m. on that date, a period of approximately 15 hours, MSM left the decedent on his left side.

As the plaintiffs' expert further described the MSM chart, the notations for 8:38 p.m., 9:00 p.m., and 11:40 p.m. on February 10, 2019, as well as the notations for 2:29 a.m. and 8:20 a.m. on February 11, 2019, were left blank, leading him to conclude that MSM left the decedent in a supine position from 8:34 p.m. on February 10, 2019 to 9:39 a.m. on February 11, 2019, a period of approximately 13 hours. The expert asserted that, from 9:40 a.m. to 2:26 p.m. on February 11, 2019, or approximately 4.5 hours, the decedent was left in a sitting position. The expert asserted that the notation for 9:04 p.m. on February 11, 2019 was left blank, leading to the conclusion that, from 2:27 p.m. on February 11, 2019 to 6:40 a.m., a period of approximately 16 hours, MSM left the decedent in a supine position. Similarly, the expert explained that the notations for 5:29 p.m. on February 12, 2019, and 6:11 a.m., 5:40 p.m., and 5:51 p.m. on February 13, 2019 were left blank, yielding the conclusion that MSM left the decedent in a

supine position continuously from 3:00 p.m. on February 12, 2019 to 9:00 p.m. on February 13, 2019, a period of approximately 30 hours.

Inasmuch as there were blank spaces where chart notations should have been for 2:24 a.m. and 10:20 p.m. on February 14, 2019, 2:00 a.m. on February 16, 2019, 9:20 a.m., 10:20 a.m. and 8:20 p.m. on February 19, 2019, 7:15 a.m. and 8:10 p.m. on February 20, 2019, 5:58 a.m. and 4:13 p.m. on February 21, 2019, and 6:02 a.m. on February 22, 2019, the expert concluded that, for the approximately 211 continuous hours from 2:00 a.m. on February 14, 2019 until 9:20 p.m. on February 22, 2019, MSM let the decedent remain supine. Based on the fact that the relevant chart notations for 6:14 a.m. and 10:19 a.m. on February 23, 2019 were left blank, the expert concluded that MSM left the decedent on his right side from 4:40 a.m. to 2:27 p.m. on that date, a period of approximately 9 hours. Moreover, due to blank entries in the chart for 7:23 p.m. on February 23, 2019, and 1:51 p.m. and 7:40 p.m. on February 24, 2019, the expert concluded that MSM left the decedent in a supine position from 2:28 p.m. on February 23, 2019 to 4:41 a.m. on February 25, 2019, a period of approximately 48 hours.

In addition, the plaintiff testified at her deposition that she would visit the decedent daily at MSM for approximately two to three hours each day, and that, when she observed him, he was always on his back.

Based on an analysis of the MSM chart, and the plaintiff's deposition testimony, the plaintiff's expert concluded that the Mount Sinai defendants departed from good and accepted practice in their implementation of a skin, wound, and ulcer care plan, and that this departure caused or exacerbated the condition of decedent's pressure ulcers during the course of his admission at MSM. As the expert explained it, accurate documentation of pressure ulcers is essential in ensuring that pressure ulcers are aggressively met with the appropriate level of treatment, and that such proper documentation constitutes the applicable standard of care. The expert asserted that the decedent's skin breakdown and, more particularly, the location of the skin breakdown while he was at MSM, were not properly documented. As an example, the

expert averred that MSM's chart noted a pressure ulcer to the ischial tuberosity upon admission, while on February 5, 2019, it noted that the pressure ulcer was to the sacrum. The plaintiff's expert explicitly rejected Dr. Diamond's explanation that the close proximity of the ischial tuberosity and the sacrum excuses the discrepancy in the notation of the wound, and that the discrepancy thus was irrelevant. Rather, the expert asserted that the documentation of the precise location of the pressure ulcer is necessary to ensure that a proper plan of care exists, particularly with respect to the positioning of a patient. The expert concluded that this failure of documentation, and, hence, the failure to assure proper positioning, was a proximate cause of the deterioration of the decedent's pressure ulcers over the course of his admission to MSM. The expert explained that pressure ulcers can form within two to six hours, and that prevention thus required proper documentation, proper identification of persons at risk for development or exacerbation of pressure ulcers, and application of appropriate preventative measures. As the expert explained it, the appropriate standard of care for pressure ulcer prevention is to turn and reposition a patient at least every two hours.

The expert further asserted that, once a pressure ulcer has developed, personalized care plans that include ongoing, detailed documentation of descriptive factors of multiple wounds are needed. The expert described the first step as offloading pressure from the wound site, and thereafter, a mixture of interventions to treat conditions leading to ulcer formation, such as proper support surfaces, nutritional support, and interventions to protect and promote healing, such as wound dressings, topical ointment applications, wound-vacuums, hydrotherapy, hyperbaric oxygen, and surgical repair.

The plaintiff's expert expressly rejected Dr. Diamond's opinion that the initial medical consultation with respect to wound care was timely merely because MSM emergency department staff ordered the consultation within 24 hours of the decedent's admission. Rather, the expert concluded that, inasmuch as the actual consultation was not conducted until one week after the decedent's admission, the consultation was not timely, and the delay constituted

a departure from the applicable standards of care. As relevant to that opinion, the expert asserted that, when MSM finally conducted the wound-care consultation, the decedent had Stage II pressure ulcers on his body and, thus, "needed a particularized care plan to avoid the increase of skin loss," but that MSM had, until then, failed to provide the decedent with a such personalized plan for his skin. In addition to the offloading of pressure, the expert asserted

> "[f]requent turning and positioning of patients in hospitals, particularly those susceptible of developing pressure ulcers, is critical as it distributes pressure to different parts of the body so that no one part receives pressure for any great deal of time. In this same vein, it is critical that pressure be kept off of those parts of the body where a pressure ulcer is in danger of developing or has already developed. Not doing so leads to unabated pressure on the patient's sacrum and ischial tuberosity – the very place pressure ulcers appeared and thereafter deteriorated on the Plaintiff's decedent."

The expert opined that, regardless of whether they formulated a plan, MSM did not properly turn and position the decedent every two hours in accordance with the standard of care, and that this departure from the standard of care was a proximate cause of the deterioration of the decedent's pressure ulcers. Specifically, the expert noted that the MSM chart revealed that the decedent's pressure ulcers deteriorated and increased in size during his admission, initially measuring 1.0 cm by 0.5 cm, increasing within 24 hours to 2.0 cm by 2.0 cm, and, by February 5, 2019, when the wound consultation was finally performed, deteriorating and increasing to 4.0 cm by 4.0 cm. As the expert noted, not only were there times during the decedent's January 27, 2019 to February 25, 2019 admission when MSM staff did not turn or reposition him every two hours, but sometimes several days lapsed before he was turned or repositioned.

The plaintiff's expert opined that the decedent's skin breakdown and deterioration was caused by unrelieved pressure, rather than his clinical medical condition; in other words, it was not caused by the condition for which he sought treatment at MSM. The expert asserted that the development and deterioration of pressure ulcers "could have been avoided with the proper medical and nursing care, provided by and under the supervision of" MSM, particularly because MSM health-care personnel knew, immediately upon his admission, that the decedent was at

high risk for the development and deterioration of pressure ulcers. Contrary to the opinion of Dr. Diamond, the plaintiff's expert opined that the decedent's medical condition did not render the deterioration of his pressure ulcers "unavoidable," and that proper attention, investigation, evaluation, and wound-care treatment, including timely turning and repositioning, would have mitigated the size and extent of the ulcers that the decedent evinced at the time of his discharge. The expert further asserted that, had MSM personnel truly concluded that nothing could have been done properly and appropriately to care for the decedent's wounds, it should have investigated what physiological changes were occurring that caused "such drastic change in the Plaintiff's decedent." Inasmuch as the expert could not find any records of such an investigation, or of subsequent changes in a care plan, the expert concluded that MSM departed from good practice in failing to update the care plan as the decedent's sacral and ischial tuberosity pressure ulcers deteriorated, thus causing or contributing to the decedent's injuries.

The plaintiff's expert asserted that MSM's records were "at best unclear with respect to the specific type of bed and mattress that was provided to" the decedent. As explained,

> "[t]here 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. Gel and foam mattresses and overlays are of particular utility in high-risk patients in accordance with the standard of care, as these type of specialty mattresses assist with the pressure redistribution. Plaintiff's decedent should have been on a pressure redistributing mattress at the beginning of his admission to Defendant MOUNT SINAI's hospital facility, which Defendant's medical records failed to specify. For example, Defendant's medical records do not include a notation of a pressure relieving mattress administered to Plaintiff's decedent during his admission, despite Defendant MOUNT SINAI being fully aware of Plaintiff's decedent pressure ulcers during that point in time. Further, Plaintiff stated in her Affidavit that the mattress given to decedent looked like a standard hospital mattress and that she was never advised by any staff member at Defendant MOUNT SINAI'S facility that the decedent was placed on a special pressure redistribution mattress."

Based on a review of the MSM chart and the plaintiff's deposition testimony, the plaintiffs' expert opined that MSM failed to provide the decedent with a pressure-redistribution specialty mattress, or some sort of cushion, and that this failure constituted a departure from the standard of care, thus proximately causing the development and deterioration of pressure ulcers.

In addition, the plaintiff's expert opined that MSM departed from good and accepted practice in failing to provide the decedent with proper nourishment during the course of his admission there. The expert asserted that good nutritional status is essential for the care and treatment of pressure ulcers, and that MSM failed timely and properly to implement a comprehensive nutritional regimen for the decedent, including proper evaluations and follow-up examinations, despite several notations in the decedent's chart that he was suffering from malnutrition throughout his admission. The expert concluded that this departure caused or contributed to the development and deterioration of pressure ulcers.

The plaintiff's expert did not address the issue of whether MSM negligently hired, trained, supervised, or retained any of its employees who were responsible for the decedent's care. Neither did the expert contradict Dr. Diamond's opinion that nothing that MSM employees did or did not do caused or contributed to the decedent's death two years after his discharge from MSM. Nor did the expert address Dr. Diamond's opinions that the decedent did not sustain deep tissue injury, infection, dehydration, or emotional trauma as a result of the Mount Sinai defendants' alleged malpractice. In fact, the plaintiff expressly withdrew her claims to recover for wrongful death and for dehydration injuries insofar as asserted against the Mount Sinai defendants.

In an attorneys' reply affirmation, the Mount Sinai defendants argued that the affirmation of the plaintiff's expert was, in effect, conclusory, speculative, and unsupported by the medical records, and reiterated that they timely, appropriately, and properly investigated and evaluated the decedent's skin condition and nutrition issues, and implemented a sufficient plan of evaluation and care over the course of the decedent's admission.

The Mount Sinai defendants established, prima facie, that they did not cause or contribute to the decedent's death, and demonstrated that they neither "knew, [n]or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York*

Presbyt./Weill Cornell Med. Ctr., 205 AD3d 480, 481-482 [1st Dept 2022]). Inasmuch as the plaintiff did not address this issue in her opposition papers, she failed to raise a triable issue of fact in opposition to that showing. They further established, prima facie, that they were not responsible for the decedent's development of any deep tissue injury or infection, and that the decedent did not sustain emotional trauma, as a result of their alleged malpractice.

Although the Mount Sinai defendants made a prime facie showing of their entitlement to judgment as a matter of law in connection with the remainder of the medical malpractice cause of action, the plaintiff, through her own affidavit and the affirmation of her expert, raised triable issues of fact as to whether those defendants departed from good and accepted practice by failing properly and timely to evaluate the decedent's skin condition and risk of pressure ulcers, and by failing to implement an appropriate skin-care and wound-avoidance plan that included providing the decedent with proper nutrition, turning or repositioning him every two hours, and providing him with an appropriate mattress or cushions. The court notes that 8 NYCRR 29.2(a), among other things, requires physicians and hospitals to maintain accurate records, and that a violation of that state regulation may, under certain circumstances, constitute a departure or deviation from accepted practice (*see generally Collado v New York and Presbyterian Hosp.,* 2022 NY Misc LEXIS 43557, *61-62 [Sup Ct, N.Y. County, Aug. 3, 2022] [Kelley, J.]; *Khosrova v Westermann*, 2011 NY Slip Op 32628[U], *5, 2011 NY Misc LEXIS 4768, *13 [Sup Ct, Suffolk County, Oct. 4, 2011]). Here, in opposition to the Mount Sinai defendants' prima facie showing of entitlement to judgment as a matter of law in connection with their record keeping, the plaintiff raised a triable issue of fact with her expert's affirmation as to whether deficient record keeping prevented them from implementing the plan that they initially had formulated, which required turning and repositioning every two hours. The plaintiff also raised a triable issue of fact, with her expert's affirmation, as to whether these alleged departures caused or contributed to the creation, exacerbation, and deterioration of the decedent's pressure ulcers during the time that he was an inpatient at MSM.

Hence, the Mount Sinai defendants' motion is granted only to the extent that they are awarded summary judgment dismissing, insofar as asserted against them, the wrongful death cause of action, the negligent hiring, training, supervision, and retention cause of action, and so much of the medical malpractice cause of action as sought to recover for deep tissue injury, infection, dehydration, and emotional trauma, and their motion is otherwise denied.

Premier's application does not constitute a proper cross motion because it does not seek relief against a moving party; instead, its application was, in effect, a separate motion seeking relief against a nonmoving party (*see* CPLR 2215; *Asiedu v Lieberman*, 142 AD3d 858, 858 [1st Dept 2016]; *Kershaw v Hospital for Special Surgery*, 114 AD3d 75, 88 [1st Dept 2013]; *Guzetti v City of New York*, 32 AD3d 234 [1st Dept 2006]; *Gaines v Shell-Mar Foods, Inc.*, 21 AD3d 986 [2d Dept 2005]; *Sheehan v Marshall*, 9 AD3d 403, 404 [2d Dept 2004]; *Lucheux v William Macklowe Co., LLC*, 2017 NY Slip Op 31044[U], 2017 NY Misc LEXIS 187 [Sup Ct, N.Y. County, May 11, 2017]). CPLR 2214(b) requires such a separate motion to be made on at least eight days' notice. The mislabeling of a motion as a cross motion, however, may treated as a "technical" defect to be disregarded, particularly where the nonmoving party does not object and the consideration of the application results in no prejudice to the nonmoving party (*see Sheehan v Marshall*, 9 AD3d at 404), and where, as here, the moving party made its application more than eight days prior to the return date, thus giving the plaintiff ample opportunity to be heard on the merits (*see Daramboukas v Samlidis,* 84 AD3d 719, 721 [2d Dept 2011]; *Matter of Jordan v City of New York*, 38 AD3d 336, 338 [1st Dept 2007]; *Della-Mura v White Plains Hosp. Med. Ctr.*, 2022 NY Slip Op 31085[U], *3, 2022 NY Misc LEXIS 1697, *3-4 [Sup Ct, N.Y. County, Mar. 31, 2022] [Kelley, J.]). Hence, Premier's cross motion is deemed to be a separate motion.

In support of its motion, Premier submitted many of the same documents that the Mount Sinai defendants submitted in support of their motion, and also submitted a statement of allegedly undisputed material facts, an attorney's affirmation, and the affirmation of board-

certified surgeon William A. Lois, M.D., who asserted that he has extensive experience in diagnosing and treating pressure ulcer wounds.

Dr. Lois opined that Premier, as an agency that provides the services of health-care aides to persons generally confined to their homes, had no obligation to diagnose any medical conditions, perform risk assessments, establish wound care/pressure ulcer treatment protocols, order medications, order or perform debridements, or order consultations with specialists or surgeons. He asserted that these aides cannot modify any care plan established by the nurses and physicians who are treating a patient. Rather, he asserted that all of these responsibilities are solely within the purview of the licensed medical and nursing providers. Moreover, he opined that, in any event, Premier's home health aides properly tended to the decedent at all times, and conformed to the applicable standard of care, and that nothing that they did or failed to do caused or contributed to the decedent's injuries or death.

Initially, Dr. Lois asserted that there was no record of Premier having provided home health care services to the decedent prior to February 25, 2019 and that, hence, there is no basis for any allegations of negligence or malpractice against Premier occurring between 2010 and that date, as set forth in the complaint and the plaintiff's bills of particulars.

With respect to the home care provided by Premier's aides between February 25, 2019 and the date of the decedent's death on March 17, 2021, Dr. Lois first asserted that patients such as the decedent, who was elderly with advanced Parkinson's disease at the time when Premier's aides began caring for him,

> "become over stiff over time. They develop rigidity in their face and extremities, their legs bend because of the nature of the disease which causes the muscles to contract and the joints to stiffen. In addition, due to the muscles['] contractures, such patients have difficulty eating, and they become malnourished with a reduced ability to fight illnesses and reduced ability to heal. Patients with advanced stage of Parkinson's become immobile and bed bound. Because of the rigidity of their joints, services such as turning and positioning, toileting, transfers, active and passive range of motion, become extremely difficult to perform. Feeding may take an inordinate amount of time because patients with this condition stop chewing."

He asserted that patients with advanced Parkinson's disease may develop skin ulcerations as a result of the patient's functional decline.

Dr. Lois averred that, although the decedent died on March 17, 2021, he was "considered terminal" as of March 5, 2019, more than two years earlier, when his family made the decision that he receive only palliative care and that non-essential medications be discontinued. According to Dr. Lois, once medication for treating Parkinson's disease is withdrawn, the disease develops faster, as do all associated contractures, stiff joints, inability to eat, and progressive dementia, which, in turn, cause the body's functional decline to advance at an even faster rate. Dr. Lois asserted that "[d]eveloping pressure ulcers at this stage is essentially unavoidable," and that the decedent developed these types of unavoidable ulcers. He asserted that, despite the initial ulcers, the decedent received appropriate care from Premier's aides for almost two years, as "evidenced by the fact that the ulcer did not get infected and did not exponentially increase in size," but instead "actually reduced in size and was at no point considered as the cause for decedent's ultimate outcome." Dr. Lois opined that Premier provided qualified and properly trained aides, all of whom "adhered to the applicable standard of care in providing appropriate services in accordance with the established plan of care for decedent's pre-existing co-morbidities," in particular, his preexisting pressure ulcers. He averred that the decedent's inability to heal and his propensity for slow healing,

> "despite the appropriate and timely turning and positioning, toileting, skin care, [and] passive and active range of motion[,] was unavoidable due to his comorbidities, including advanced Parkinson's disease, contractures, dementia, and failure to thrive, which cumulatively reduced the delivery of oxygenated blood and necessary nutrients to maintain the integrity of the skin and facilitate wound healing."

Dr. Lois adverted to Centerlight's December 10, 2018 home health certification and plan of care, which had diagnosed the decedent with dementia, Parkinson's disease, benign prostatic hyperplasia, convulsions, and osteoarthritis, and reported that he was on a regimen of medications including heat-generating topical cream for arthritis, 81 milligrams (mg) per day of

aspirin, 25 mg per day of carbidopa, a daily Cerovite vitamin supplement, 0.4 mg per day of Flomax, 250 mg per day of Keppra, 17 g per day of Miralax, 8.6 mg per day of senna, 25 mg per day of Seroquel, and 325 mg per day of Tylenol. Dr. Lois described in detail the follow-up care that Centerlight provided to the decedent on January 19, 2019, as well as the medical conditions diagnosed, and treatment rendered during, the decedent's January 28, 2019 through February 25, 2019 admission to MSM. He further described, in much the same detail as Dr. Diamond had provided, the course of the decedent's treatment at home between February 25, 2019 and March 16, 2021, noting, as did Dr. Diamond, the measurements and characterizations of the ulcers observed on the decedent's body on numerous days during that period of time. Dr. Lois stated that Premier aides provided the decedent with assistance with his activities of daily living, comprising two 12-hour shifts each day, consisting of assistance with showering, mouth care, foot care, skin care, nail care, toileting, dressing, meal preparations, medication reminders, cleaning, grocery shopping, and laundry, as well as assistance in walking with a device, turning and positioning the decedent, and accompanying him to medical appointments.

As Dr. Lois described it, between February 25, 2019 and March 5, 2019, Premier's aides fully assisted the decedent with all activities of daily living, including turning and positioning him every two hours, providing assistance with his toilet, skin care, and showering, all in accordance with Centerlight's care plan. He asserted that, after the March 3, 2019 diagnosis of an unstageable sacral ulcer, and the provision of treatment by Centerlight nurses, Centerlight educated both the decedent's family and Premier aides with respect to turning, positioning, and offloading weight. Dr. Lois asserted that, in this respect, the decedent received appropriate care by Premier aides, who he concluded had adhered to the plan of care. He further stated that, after the decedent was seen on March 5, 2019 by Dr. Ablorh-Odjidja, his primary care provider, her plan was to continue with wound care for the uninfected Stage II sacral ulcer by applying zinc oxide and Allevyn dressings daily, with evaluation by a wound care specialist for further recommendations. Dr. Lois opined that, at this stage,

> "the decedent's condition was a natural progression of his underlying disease and comorbidities. From this point on, because of the absence of medications which would otherwise alleviate the symptoms of Parkinson's disease to some extent, the decedent's care was essentially palliative and the development of ulcers would be a natural progression of the disease through no fault on the part of Premier HHAs or any other medical personnel and despite all care provided according to good and accepted home care practice."

The decedent had a wound care consultation on March 6, 2019, and Dr. Lois concluded that, subsequent to that examination, Premier aides provided appropriate turning, positioning, and skin care, but, despite their best efforts, "the decedent's compromised condition through his underlying comorbidities" prevented wound healing and promoted further wound development, despite a registered dietician's March 13, 2019 note to the effect that the decedent's caloric intake was adequate to promote wound healing. He opined that, between March 6, 2019 and May 9, 2019, "according to good and accepted home care practice, Premier HHAs performed all A[ctitivies of] D[aily] L[iving], including turning and positioning every 2 hours, toileting, skin care and showering per the plan of care," while the decedent received almost daily wound care from Centerlight's visiting nurses, who appropriately trained and educated Premier's aides. Dr. Lois similarly averred that, over the next three months, even though the ulcers persisted, Premier's aides were performing "appropriate and timely turning and positioning and were taking all appropriate precautions to promote wound healing and to reduce the risk of new ulcers developing as evidenced by the nurse's note."

In connection with the January 12, 2020 nursing note indicating that the Stage IV sacral ulcer had grown, and had evinced both granulation and a moderate amount of serous drainage, Dr. Lois concluded that Centerlight adequately explained to the plaintiff and the Premier aide that they needed to reposition the decedent every two hours and provide him with incontinence care every two hours. Dr. Lois reiterated Dr. Diamond's interpretation of the decedent's home chart, noting that, although that same ulcer had shrunk to some extent by June 10, 2020, Dr. Ablorh-Odjidja had concluded, by September 25, 2020, that the decedent was progressively declining with chronic pressure ulcers and failure to thrive, while nonetheless noting

improvement in the ulcer over the previous week. Dr. Lois thus opined that Premier's aides performed appropriate turning and positioning, as well as all tasks necessary to reduce the risk of wound deterioration and promote healing. He further noted that, on December 10, 2020, the wound had further diminished in size to 3 cm by 1.8 cm by 0.8 cm, and was healing well, and that, consequently, Premier's aides performed appropriate turning, positioning, and toileting. Dr. Lois explained that, between December 10, 2020 and February 9, 2021, the decedent received regular wound care by Centerlight nurses, and that the sacral wound had slightly diminished in size, suggesting that, to the extent that Premier's aides continued to be involved in the decedent's daily care, they appropriately had turned, positioned, and toileted him, and otherwise had fully implement Centerlight's care plan.

Dr. Lois recounted the decedent's admission to LHH on February 10, 2021, and the February 22, 2021 transfer to Plaza, during which time the decedent was not seen by Premier aides, as well as the decedent's March 16, 2021 discharge back to his home, and the decedent's March 17, 2021 death at home. He thereupon concluded that decedent "received appropriate care measures" from Premier aides "at all times," inasmuch as those aides "executed their duties as per the established plan of care and properly and in accordance with good and accepted practice performed turning and positioning, toileting, skin care, bathing, and all remaining ADLs as instructed." Dr. Lois opined that the decedent received the appropriate amount of bed care, and that, although his sacral wound remained more or less unchanged, with some fluctuations, that course was consistent with his advanced Parkinson's disease and attendant comorbidities. In other words, Dr. Lois concluded that the decedent remained relatively stable for more than two years while in Premier's care. He thus asserted that nothing that Premier's aides did or did not do caused or contributed to the persistence or deterioration of the decedent's ulcers. Moreover, Dr. Lois concluded that nothing that those aides did or did not do caused or contributed to the decedent's death.

In opposition to Premier's motion, the plaintiff not only relied on Premier's submissions, but submitted an attorney's affirmation, a counter statement of material facts, and an expert affirmation from the same board-certified internist and geriatrician as had submitted the affirmation in opposition to the Mount Sinai defendants' motion. The expert opined that "the lack of care given to Plaintiff's decedent by Defendant, its nurses, aides, agents, servants, and employees deviated from good and accepted nursing and home care and resulted in Mr. Polanco's development and deterioration of pressure ulcers."

Specifically, the plaintiff's expert opined that Premier's aides "failed to turn and reposition Mr. Polanco at least every two hours to prevent the development and deterioration of his sacral pressure ulcer, thereby failing to adhere to the standard of care." The expert came to this conclusion because, on numerous occasions between February 25, 2019 and March 16, 2021, there were blank spaces left by Premier's aides in Premier's chart that were meant to account for their turning and positioning of the decedent while he was under their care. Thus, the expert stated that the decedent's chart provided "no usable turning and positioning record" for those dates and times. More particularly, the expert noted that there were blank spaces in the records for 8:00 p.m. on March 10, 2019, March 28, 2019, and March 30, 2019, where there should have been notations that the decedent had been turned and repositioned, as well as for 8:00 a.m. on March 21, 2019, March 23, 2019, and March 24, 2019. There also were blank spaces in the chart for 8:00 a.m. and 8:00 p.m. on April 13, 2019, April 16, 2019, where there should have been notations that the decedent had been turned and repositioned. The expert made similar observations that there were blank entries in the records generated in connection with the required turning and repositioning of the decedent for 8:00 a.m. on April 14, 2019, April 18, 2019, and April 21, 2019, for 8:00 p.m. on April 15, 2019, April 17, 2019, April 26, 2019, and April 29, 2019, for 8:00 a.m. and 8:00 p.m. on May 1, 2019, for 8:00 p.m. on May 4, 2019, May 7, 2019, May 12, 2019, May 17, 2019, and May 26, 2019, for 8:00 a.m. on May 11, 2019, for 8:00 p.m. on June 5, 2019, June 7, 2019, June 8, 2019, and June 18, 2019, for 8:00 a.m. on

July 3, 2019, July 23, 2019, July 24, 2019, and July 27, 2019, and for 8:00 p.m. on July 6, 2019, and July 11, 2019.

Moreover, the plaintiff's expert asserted that, on several occasions, the decedent's home care chart reported that the decedent was "in the same position for more than twelve (12) hours and up to twenty-four (24) hours." The expert opined that

> "consideration should have been given to Plaintiff's decedent's postural alignment, distribution of weight, balance, and stability. There should have been a repositioning schedule. It is my opinion within a reasonable degree of medical certainty that the failure of Defendant to ensure that Plaintiff's decedent was repositioned at least every two hours by the aides during their shifts, was a deviation from the good and accepted standards of medical care and was the proximate cause of the development and deterioration of Plaintiff's decedent's pressure ulcers."

The expert expressly rejected Dr. Lois's conclusion that the development and deterioration of pressure ulcers were "unavoidable" in the decedent's case, explaining that, when proper home care was, in fact, rendered to the decedent between 2019 and 2021, the size of his ulcers diminished. The expert also took issue with Dr. Lois's opinion that the decedent's Parkinson's disease was the primary cause of his pressure ulcers, explaining that Parkinson's disease "does not directly cause pressure ulcers to develop," and that the decedent's skin breakdown was "limited to his sacrum, the place on his body susceptible to skin breakdown due to unrelieved pressure." The plaintiff's expert concluded that neither Parkinson's disease, nor any of the decedent's other comorbidities, rendered him "incapable of healing from pressure ulcers, and further did not make the development of a pressure ulcer clinically unavoidable," but that the pressure ulcers "could have been avoided with the proper turning and positioning and skin care provided by and under the supervision of defendant's home health aides."

The plaintiff's expert concluded that Premier's attempt to ascribe the decedent's propensity to develop pressure ulcers on his underlying medical condition was completely misplaced, inasmuch as

> "the very reason patients need treatment is because they lack the ability to properly care for themselves in a certain way. Defendant was aware of the

> Plaintiff's decedent's medical history. Defendant's expert effectively seeks to place the duty of care into the hands of the patient's family and accepts no accountability [on Premier's part], despite having home health aides in the plaintiff's decedent's home for up to 24 hours per day."

The plaintiff's expert did not address the issue of whether Premier's alleged malpractice proximately caused the decedent's purported infections, dehydration, and malnutrition. Neither did the expert address whether Premier's alleged malpractice proximately caused the decedent's death, and expressed no opinion on its hiring, training, supervision, and retention of home health-care aides. Nor did the expert address the issue of whether Premier provided any services to the decedent between 2010 and February 25, 2019.

In reply, Premier submitted an attorney's affirmation, noting that the plaintiff's expert did not address infection, dehydration, the cause of death, Premier's hiring and training protocol, or Premier's lack of involvement with the decedent between 2010 and February 25, 2019. Counsel explained that the plaintiff's expert's quotation that "decedent was noted to be in the same position for more than twelve (12) hours and up to twenty-four (24) hours" was extracted from MSM's records, not from Premier's or Centerlight's records, and that it antedated Premier's involvement with the decedent. She further asserted that the plaintiff herself testified at her deposition that Premier's aides "rotated [the decedent] from side to side. . . [e]very hour during the day" and "every two hours" during the night. Specifically, the plaintiff had testified that, "[o]vernight, they had a timer and I would hear it go off every two hours so he could sleep. So they would time themselves." Counsel characterized the affirmation of the plaintiff's expert as speculative, conclusory, and not based on facts in the record.

The court concludes that Premier established its prima facie entitlement to judgment as a matter of law with its submissions, including Dr. Lois's expert affirmation. In opposition, the plaintiff, by failing to address whether Premier's alleged negligence proximately caused the decedent's purported infections, dehydration, malnutrition, and death, failed to raise a triable issue of fact in opposition to Premier's showing with respect thereto. By failing to address

Premier's showing that it was not involved in the decedent's care between 2010 and February 25, 2019, the plaintiff failed to raise a triable issue of fact in connection with that issue, and by failing to address Premier's evidence in connection with the hiring, training, supervision, and retention of its home health-care aides, the plaintiff failed to raise a triable issue of fact in opposition to Premier's showing as to that issue. Similarly, the plaintiff's expert's failure to refute Premier's showing that it had no obligation to diagnose the decedent, order proper care and evaluation, undertake a proper risk assessment, or transfer him to a hospital requires summary dismissal of those claims insofar as asserted against Premier.

Nonetheless, contrary to Premier's contention, the affirmation of the plaintiff's expert was not speculative or conclusory with respect to whether Premier's aides turned and repositioned the decedent at least every two hours, every day and night, from February 25, 2019 through March 16, 2021, and whether Premier's alleged failure strictly to adhere to that schedule caused the development of pressure ulcers, caused them to increase in size, caused them not to shrink as much as they might have, and prevented a cure. The fact that numerous entries for turning and repositioning the decedent "are not recorded in the contemporaneous medical records, although suggestive, is not dispositive" (*Shewbaran v Laufer*, 177 AD3d 510, 511 [1st Dept 2019]). Hence, although the plaintiff testified that Premier aides did, in fact, turn and reposition the decedent every two hours, Premier's records raised a triable issue of fact as to whether Premier properly implemented Centerlight's care plan, particularly because Premier pointed to no testimony from their own aides in which they claimed to have any personal recollection of whether they strictly followed the plan to turn and reposition the decedent every two hours over a two-year period of time. Moreover, contrary to Premier's contentions, the plaintiff's expert explicitly rejected Dr. Lois's opinion that the decedent's classification as a "terminal" patient, as early as March 2019, rendered the pressure ulcers from which he suffered during the last two years of his life untreatable or incurable. The plaintiff, moreover, relied on Dr. Ablorh-Odjidja's written conclusion that Premier aides had not turned and positioned the decedent every two

hours each and every day, and Dr. Diamond's submissions indicating that the decedent suffered from deep tissue injury while being cared for at home between February 2019 and March 2021.

Consequently, Premier's motion is granted only to the extent that it is awarded summary judgment dismissing, insofar as asserted against it, the wrongful death cause of action, the negligent hiring, training, supervision, and retention cause of action, and so much of the medical malpractice cause of action as sought to recover for acts or omissions predating February 26, 2019, for infection, dehydration, and malnutrition, and for failure to diagnose the decedent, order proper care and evaluation, undertake a proper risk assessment, or transfer him to a hospital. Its motion is otherwise denied.

Accordingly, it is,

ORDERED that the motion of the defendants Mount Sinai Morningside and Mount Sinai Morningside, formerly known as Mount Sinai St. Luke's, is granted only to the extent that they are awarded summary judgment dismissing, insofar as asserted against them, the wrongful death cause of action, the negligent hiring, training, supervision, and retention cause of action, and so much of the medical malpractice cause of action as sought to recover for deep tissue injury, infection, dehydration, and emotional trauma, those causes of action and those claims are dismissed insofar as asserted against them, and their motion is otherwise denied; and it is further,

ORDERED that the separate motion of the defendant Premier Home Health Care Services, Inc., is granted only to the extent that it is awarded summary judgment dismissing, insofar as asserted against it, the wrongful death cause of action, the negligent hiring, training, supervision, and retention cause of action, and so much of the medical malpractice cause of action as sought to recover for acts or omissions predating February 25, 2019, for infection, dehydration, and malnutrition, and for failure to diagnose the decedent, order proper care and evaluation, undertake a proper risk assessment, or transfer him to a hospital, those causes of

action and those claims are dismissed insofar as asserted against it, and its motion is otherwise denied; and it is further,

ORDERED that that, on the court's own motion, the attorneys for all of the parties shall appear for an initial pretrial settlement conference before the court, in Room 204 at 71 Thomas Street, New York, New York 10013, on April 10, 2025, at 11:30 a.m., at which time they shall be prepared to discuss resolution of the action and the scheduling of a firm date for the commencement of jury selection.

This constitutes the Decision and Order of the court.

3/17/2025
DATE

JOHN J. KELLEY, J.S.C.

MOTION (NYPH):		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE
MOTION (PREMIER):		CASE DISPOSED			X	NON-FINAL DISPOSITION	
		GRANTED		DENIED	X	GRANTED IN PART	OTHER
APPLICATION:		SETTLE ORDER				SUBMIT ORDER	
CHECK IF APPROPRIATE:		INCLUDES TRANSFER/REASSIGN				FIDUCIARY APPOINTMENT	REFERENCE