Knight v Mary Manning Walsh Nursing Home Co., Inc.
2025 NY Slip Op 33459(U)
September 12, 2025
Supreme Court, New York County
Docket Number: Index No. 153104/2020
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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INGRID KNIGHT, as Administrator of the Estate of CLARA SANCHEZ, Deceased,

Plaintiff,

- v -

THE MARY MANNING WALSH NURSING HOME COMPANY, INC., ARCHCARE COMMUNITY SERVICES, INC., and CALVARY HOSPITAL, INC.,

Defendants.

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INDEX NO. 153104/2020

MOTION DATE 07/23/2025
07/23/2025

MOTION SEQ. NO. 002, 003

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 85, 87, 88, 89, 90, 91, 97, 98, 99, 100, 101, 108, 109, 110, 112

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

The following e-filed documents, listed by NYSCEF document number (Motion 003) 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 86, 92, 93, 94, 95, 96, 102, 103, 104, 105, 106, 107, 111, 113

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

This is an action to recover damages for medical malpractice based on alleged departures from good and accepted practice, pursuant to Public Health Law § 2801-d for purported violations of statutes and regulations governing nursing homes, and wrongful death.

The defendant Calvary Hospital, Inc. (Calvary), moves pursuant to CPLR 3212 for summary judgment dismissing the complaint insofar as asserted against it (MOT SEQ 002). The defendant The Mary Manning Walsh Nursing Home Company, Inc. (MMW), moves for summary judgment dismissing the complaint insofar as asserted against it (MOT SEQ 003). The plaintiff opposes both motions. The motions are granted to the extent that both Calvary and MMW are awarded summary judgment dismissing (1) the wrongful death cause of action insofar as asserted against each of them, (2) so much of the medical malpractice cause of action, insofar as asserted against each of them, as was premised upon their alleged (a) negligent

hiring, training, supervision, and retention of healthcare personnel, (b) creation of or contribution to infection of the plaintiff's decedent's skin, sepsis, and septic shock, (c) failure to maintain a safe environment, (d) failure to obtain necessary consultations from specialists, (e) failure to promulgate appropriate rules and regulations, (f) failure properly to examine the plaintiff's decedent, undertake assessments, including risk assessments, and perform workups, (g) failure to diagnose the decedent with any particular condition, (h) failure to prescribe and administer appropriate medications, and (i) failure to provide the decedent with proper nutrition and hydration, and (3) so much of the Public Health Law § 2801-d cause of action, insofar as asserted against each of them, as was premised upon violations of 10 NYCRR 763.5, 10 NYCRR 763.6, 10 NYCRR 10 763.13, 42 USC §§ 1396r(b) (3)(A),(B),(C) and (b)(4)(B), and 42 USC §§ 1395i-3(b) (3)(A),(B),(C) and (b)(4)(B). That motion is otherwise denied.

The court concludes that there are triable issues of fact as to whether Calvary and MMW departed from good and accepted practice in failing to monitor and supervise the skin condition of the plaintiff's decedent, failing to turn and position her frequently enough, failing to provide items that would relieve pressure on the decedent's sacrum, failing to assure that its healthcare personnel fully followed official procedures that had been promulgated, and failing adequately or properly to document and record both the nature and frequency of the turning and repositioning of the decedent. The court further concludes that there are triable issues of fact as to whether Calvary and MMW violated Public Health Law § 2803-c, 42 USC §§ 1396r(b)(1)(A),(B), (b)(2), and (b)(4)(A), 42 USC §§ 1395-3(b)(1)(A),(B), (b)(2), and (b)(4)(A), 10 NYCRR 96.1(m)(14), 10 NYCRR 415.11, 10 NYCRR 415.12(c)(1), 10 NYCRR 415.22, and 42 CFR 483.20. In addition, there are triable issues of fact as to whether these alleged departures and violations caused or contributed to the decedent's development of pressure ulcers, and the exacerbation thereof.

The crux of the plaintiff's claim is that the defendants, including Calvary and MMW, departed from good and accepted standards of care, and violated several statutes and regulations governing nursing homes and hospital nursing care departments, by failing to

monitor the condition of her decedent's skin, failing to position, turn, and move her decedent on a sufficiently frequent basis, and failing to provide her decedent with appropriate pressure-relieving equipment, thus causing her decedent to develop ulcers and pressure sores that worsened, both over the course of her decedent's residency at Calvary Hospital Hospice at the Mary Manning Walsh Nursing Home from January 2, 2018 until March 9, 2018, and after her discharge to home hospice care under the supervision and care of Calvary from March 9, 2018 until March 17, 2018, leading both to infection and her concomitant death on April 11, 2018.

In her complaint, the plaintiff alleged, among other things, that the defendants failed properly to supervise the nursing and medical care, treatment, and services that they rendered to their patients, including her decedent, failed to provide for her decedent's safety and security while she was a resident of or patient at their facilities, and failed to provide her decedent with a safe environment. She further asserted that the defendant failed properly to take note of, evaluate, and respond to the physical conditions manifested by her decedent, failed to assure that their personnel followed the protocols and procedures that were in place at their facilities, and failed to obtain necessary consultations. More specifically, she alleged that the defendants failed properly to immobilize her decedent's right lower extremity and failed to take all steps necessary to prevent the formation of ulcers on that extremity. In addition, the plaintiff averred that the defendants failed properly to promulgate and/or enforce reasonable rules, regulations, standards, and policies regarding the relevant medical treatment to be rendered, failed to record adequate medical notations regarding her decedent's condition and progress, and failed to administer appropriate medications to treat that condition. Furthermore, she contended that the defendants negligently hired their personnel, and failed to provide her decedent with adequately and properly trained, experienced, and competent nursing and medical personnel.[1]

[1] The court notes that, while allegations of negligent hiring, training, supervision, and retention constitute a cause of action independent of a medical malpractice cause of action, and the plaintiff did not separately plead a such cause of action, the court will address that claim as if it had been separately pleaded (*see Estate of Gebert v Huntington Hills Ctr. for Health*, 2024 NY Misc LEXIS 51911, *16 [Sup Ct, Suffolk

As a predicate for her Public Health Law cause of action, the plaintiff asserted that the defendants violated the federal Social Security Act,[2] 10 NYCRR 96.1(m)(14) (failure to exercise true regard for the safety, health, and life of patients/residents), and 10 NYCRR 763.5 (patient assessment at time of admission), 10 NYCRR 763.6 (patient assessment and plan of care), and 10 NYCRR 763.13 (supervision and training of nursing home personnel).

In her bill of particulars as to Calvary, in addition to general allegations that Calvary failed to treat her decedent in accordance with the standards of care and treatment generally accepted in the community, the plaintiff alleged that its personnel failed adequately and properly to examine her decedent, failed to perform a proper risk assessment of her decedent in connection with 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 heightened scrutiny. In addition, she contended that Calvary failed to heed, detect, and diagnose her decedent's symptoms and complaints as they related to the latter's pain and development of pressure ulcers. Furthermore, the plaintiff alleged that Calvary's staff failed to turn and position her decedent either every two hours or as more frequently needed, failed timely to order and follow-up with consultations with surgeons and specialists to address her decedent's pressure ulcers, and failed properly to monitor and treat her decedent's pressure ulcers by, among other things, failing to order appropriate and proper medications necessary to manage and care for those ulcers.

County, Sep. 5, 2024]; *see also Taylor v Methodist Hosp.*, 6 Misc 3d 1008[A], 2004 NY Slip Op 51750[U], *4, 2004 NY Misc LEXIS 2898, *9 [Sup Ct, Kings County, Nov. 1, 2004] [deeming claim alleging "negligent credentialing" to constitute an independent cause of action]).

[2] Although the complaint specified that the defendants violated Social Security Act § 1902, that section, codified at 42 USC § 1396a, articulates only administrative requirements for "state plans for medical assistance." The court infers that the plaintiff intended to cite to Social Security Act § 1919 (42 USC § 1396r) and § 1819 (42 USC § 1395i-3), which articulate federal statutory requirements governing the conduct and management of nursing homes receiving federal aid, and which are implemented in accordance with regulations codified at 42 CFR 488.402 and 42 CFR Part 483.

The plaintiff further asserted that Calvary's personnel failed to guard against the development of pressure ulcers or prevent concomitant irreversible complications by, among other things, failing to provide her decedent with proper nutrition and hydration, failing to provide proper hygiene, failing timely to provide proper pressure-relieving devices and equipment, failing timely to order and perform debridement procedures on the ulcers, and failing to keep accurate records of the treatment that actually was rendered to her decedent. The plaintiff also alleged in this bill of particulars that Calvary failed to institute and adhere to an effective care plan for her decedent and failed to modify the care plan as her decedent's condition changed. She averred that Calvary failed adequately to hire efficient and sufficient personnel or to supervise and train such personnel by assuring that they adhered to the policies and procedures that it actually instituted for the prevention and treatment of pressure ulcers, which she claimed were neither proper nor adequate in the first instance. Moreover, the plaintiff averred that Calvary departed from good and accepted practice by failing timely to transfer her decedent to another hospital for proper treatment and care.

The plaintiff alleged that Calvary's departures from good and accepted practice and violations of federal and state statutes and regulations caused her decedent to experience serious and irreversible complications from pressure ulcers, particularly a sacral pressure ulcer, resulting in deep tissue injury, infection, sepsis, septic shock, necrosis, and ultimately, death. She further asserted that these departures caused her decedent to experience dehydration and malnutrition that also caused or contributed to the development or exacerbation of the ulcers, and that her decedent also experienced pain, weakness, lethargy, and emotional trauma.

In her bill of particulars served in response to MMW's demand for particulars, the plaintiff essentially reiterated the departures from good and accepted care that she had alleged against Calvary, adding that MMW's staff failed to take a complete and adequate medical history of her decedent's conditions, failed notify her decedent's treating physician and family of injuries and significant changes in her decedent's medical condition, and caused that condition to worsen.

She also asserted that MMW health-care personnel failed properly and timely to diagnose her decedent's emergent medical conditions, failed to order diagnostic tests and studies in a timely fashion, and failed to monitor and evaluate her decedent's needs, including needs for wellness, the prevention of illness, and treatment by specialists. The plaintiff specifically asserted that MMW's nurses and certified nurses' assistants failed properly to assess and document her decedent's condition, failed to perform appropriate assessments and workups, and failed to follow MMW's orders, policies, and protocols. As a consequence of these alleged departures and violations of statutes and regulations by MMW, the plaintiff alleged that her decedent experienced and suffered from the same injuries and consequences as she alleged resulted from Calvary's alleged departures and violations, including her decedent's death.

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 Flanders v Goodfellow,* _____NY3d_____, 2025 NY Slip Op 02261, *1 [Apr. 17, 2025]; *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]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that 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 the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but 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]).

Moreover, where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . .

which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]).

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, 1044 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008])

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 also Pancila v Romanzi,* 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *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).

Public Health Law § 2801-d(1) provides, in relevant part, that "[a]ny residential health care facility that deprives any patient of said facility of any right or benefit, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation." That subsection defines "right or benefit" as a

> "right or benefit created or established for the well-being of the patient by the terms of any contract, by any *state statute*, code, rule or regulation or by any applicable *federal* statute, *code, rule or regulation*, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority"

(*id*. [emphasis added]). Where a plaintiff alleges a deprivation of such right or benefit, the subsection further makes the nursing home's compliance with the relevant contract, statute, code, rule, or regulation an affirmative defense, so that the burden of proof is on the nursing

home to prove compliance. The statute goes on to provide that

> "unless there is a finding that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient, compensatory damages shall be assessed in an amount sufficient to compensate such patient for such injury, but in no event less than twenty-five percent of the daily per-patient rate of payment established for the residential health care facility under section twenty-eight hundred seven of this article or, in the case of a residential health care facility not having such an established rate, the average daily total charges per patient for said facility, for each day that such injury exists."

(Public Health Law § 2801-d[2]). The statute also permits a patient's legal representative to prosecute such an action to recover damages (*see* Public Health Law § 2801-d[4-a]). Stated another way, to establish the right to recover pursuant to the cause of action created by Public Health Law § 2801-d, a patient must allege and prove that a nursing home deprived him or her of a right or benefit established for his or her well-being, as set forth in the terms of any contract or in any state or federal statute, code, rule or regulation (*see Cortez v Terrence Cardinal Cooke Health Ctr.,* 199 AD3d 450, 451 [1st Dept 2021]).

Public Health Law § 2803-c is a state statute that defines numerous rights of nursing home patients and articulates general duties and standards of care applicable to nursing home operators. As relevant here, it includes the "the right to receive adequate and appropriate medical care" (Public Health Law § 2803-c[3][e]). Where a demand for relief is predicated on that statutory provision, and it is alleged that a nursing home violated 10 NYCRR 415.12(c)(1) by failing to prevent the development of pressure sores and 10 NYCRR 415.12(i)(2) by failing to maintain adequate nutrition, "it states a cognizable cause of action under" Public Health Law § 2801-d (*Zeides v Hebrew Home for the Aged at Riverdale, Inc.*, 300 AD2d 178, 179 [1st Dept 2002]; *see Broderick v Amber Ct. Assisted Living,* 200 AD3d 840, 841 [2d Dept 2021] ["Public Health Law article 28 authorizes a private right of action by patients of 'residential health care facilities' for the deprivation of rights conferred by statute, regulation and contract, including those enumerated by Public Health Law § 2803-c"]; *Ward v Eastchester Health Care Ctr., LLC,* 34 AD3d 247, 248 [1st Dept 2006] [Public Health Law § 2801-d "authorizes a private right of

action for the violation of rights enumerated in section 2803-c of the statute"]; *Goldberg v Plaza Nursing Home Co.,* 222 AD2d 1082, 1084 [4th Dept 1995], overruled in part on other grounds, *Kash v Jewish Home & Infirmary of Rochester, N.Y., Inc.*, 61 AD3d 146 [4th Dept 2009] [statute affords remedy to patients denied rights enumerated in Public Health Law § 2803-c(3)]; *see also Begandy v Richardson*, 134 Misc 2d 357, 361-362 [Sup Ct, Monroe County 1987]).

Social Security Act § 1919 (42 USC § 1396r) provides, among other things, that

> "[a] nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.
>
> "[a] nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies"

(42 USC § 1396r[b][1][A], [B]). It further recites that a nursing facility "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care" (42 USC § 1396r[b][2]) and that a nursing facility

> "must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity; (ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A); (iii) uses an instrument which is specified by the State under subsection (e)(5); and (iv) includes the identification of medical problems"

(42 USC § 1396r[b][3][A]). The statute sets forth the administrative requirements for such an assessment and the necessary frequency of such an assessment (*see* 42 USC § 1396r[b][3][B], [C]), and further provides, as relevant here, that

> "a nursing facility must provide (or arrange for the provision of)—(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; (ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; (iii) pharmaceutical services (including procedures that assure the accurate

> acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; (iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident; (v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident"

(42 USC § 1396r[b][4][A]), also requiring that "[t]he services provided or arranged by the facility must meet professional standards of quality" (*id.*), and must be provided by "qualified persons in accordance with each resident's written plan of care" (42 USC § 1396r[b][4][B]). Social Security Act § 1819 (42 USC § 1395i-3) sets forth virtually identical requirements applicable to "skilled nursing facilities," which are defined as an institution, or a distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases (*see* 42 USC § 1395i-3[a][1][A], [B]).

42 CFR Part 483 is a set of federal regulations, promulgated pursuant to the Social Security Act, that governs nursing home operations. As relevant here, those regulations require a nursing home to "[c]are for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life" (42 CFR 483.15).

10 NYCRR 763.5 sets forth detailed requirements for an initial patient assessment by a nursing home upon a patient's admission. 10 NYCRR 763.6 requires that a nursing home complete a "comprehensive interdisciplinary patient assessment" that addresses "the medical, social, mental health and environmental needs of the patient" (10 NYCRR 763.6[a]), which must be developed within 10 days of the patient's admission (*see* 10 NYCRR 763.6[b]), and cover

> "all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, need for palliative care, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items"

(10 NYCRR 763.6[c]). 10 NYCRR 763.13 articulates the required qualifications of nursing home

personnel, and the requirements that nursing homes promulgate personnel policies and undertake recurring assessments both of those policies and of their individual employees. 10 NYCRR 96.1(m)(14) prohibits a nursing home from failing "to exercise true regard for the safety, health and life of patients/residents."

Although the plaintiff's claim that Calvary and MMW violated the Social Security Act, Public Health Law § 2803-c, 10 NYCRR 96.1(m)(14), 10 NYCRR 763.5, 10 NYCRR 763.6, and 10 NYCRR 763.13 directly asserted the private right of action created by Public Health Law § 2801-d (*see Cameron v 150 Riverside Op., LLC*, 2020 NY Slip Op 30921[U], *1, 2020 NY Misc LEXIS 1438, *1-2 [Sup Ct, N.Y. County, Apr. 10, 2020]), Public Health Law § 2801-d does not itself "impose a 'specific duty' of care or standard of conduct" (*Whitehead v Pine Haven Operating LLC*, 75 Misc 3d 985, 993 [Sup Ct, Columbia County 2022]; *see generally Elliott v City of New York*, 95 NY2d 730, 736 [2001]). Rather, that provision created a private right of action to recover for the violation of *other* statutes, codes, rules, and regulations, and articulated general, rather than specific, duties and standards of care applicable to nursing home operators (*see Hoyos v Riverside Premier Rehabilitation & Healing Ctr.*, 2023 NY Slip Op 30446[U], *4, 2023 NY Misc LEXIS 609, *5-6 [Sup Ct, N.Y. County, Feb. 9, 2023] [Kelley, J.]). Hence, the plaintiff may not recover for the "violation" of Public Health Law § 2801-d, but may employ that statute as a vehicle to recover for the alleged violation of the provisions of Social Security Act described above, Public Health Law § 2803-c, and the regulations promulgated thereunder, such as 10 NYCRR 415.12(c)(1) and 10 NYCRR 415.12(i)(2), as well as 10 NYCRR 96.1(m)(14), 10 NYCRR 763.5, 10 NYCRR 763.6, and 10 NYCRR 763.13.

In support of its motion, Calvary submitted the pleadings, the plaintiff's bill of particulars as to it, transcripts of the parties' deposition testimony, relevant medical, hospital, and nursing home records, the plaintiff's notice of medical malpractice action, a statement of allegedly undisputed material facts, the decedent's death certificate, an attorney's affirmation, and the

expert affirmation of geriatrician and family medicine practitioner Lawrence N. Diamond, M.D., who opined that Calvary's personnel did not depart from good and accepted practice or violate any of the statutes or regulations claimed by the plaintiff, and that nothing that such personnel did or did not do caused or contributed to the decedent's injuries or death.

Dr. Diamond only addressed the care rendered by the home hospice healthcare and personal-care workers employed by Calvary to care for the decedent between March 9, 2018 and March 17, 2018, immediately after her discharge from MMW. He first explained that the decedent had a past medical history significant for advanced dementia and heart failure, with reduced ejection fraction, atrial fibrillation, deep vein thrombosis that occurred subsequent to a post-inferior vena cava filter placement, and hospital admissions for influenza and a urinary tract infection in the months immediately before her admission to Calvary. According to Dr. Diamond, during that period of time, the decedent had been hospitalized four times, the first time at Lenox Hill Hospital in early November 2017 to address altered medical status caused by B. fragilis bacteremia, which was treated with Augmentin, the second time at Columbia University Medical Center/New York Presbyterian Hospital from November 25, 2017 to November 26, 2017 to treat acute chronic systolic heart failure, and the third time at New York-Presbyterian/Columbia University Irving Medical Center (CUIMC) from December 8, 2017 to December 17, 2017 for the treatment of influenza and parainfluenza pneumonia. As he read the CUIMC chart, the plaintiff reported to Calvary that, immediately after her decedent's discharge from CUIMC, the latter was doing well, but then began to evince decreased oral intake, was lethargic, less responsive, was not mentating at her baseline, was short of breath, was making a "weird gasping noise," and appeared to be experiencing chest discomfort.

On December 23, 2017, the decedent again presented to CUIMC, this time with shortness of breath and altered mental status, and "do not resuscitate/do not intubate" orders were recorded in her chart. Dr. Diamond explained that, upon her second admission to CUIMC, the decedent was diagnosed with a non-ST-segment elevation myocardial infarction, a type of

heart attack involving a partial blockage of a coronary artery. He asserted that blood test results reflected that she had an initial troponin level of 0.24 nanograms per liter of blood, while the results of an electrocardiogram (EKG) revealed that she was then experiencing atrial fibrillation, with rapid ventricular response, and an underlying known left bundle branch block, which Dr. Diamond explained was a condition where the electrical conduction in the left side of the heart is delayed, leading to abnormal depolarization and repolarization patterns on an EKG. Dr. Diamond asserted that this assessment was made despite the fact that the decedent's condition did not meet certain waveform criteria known as Sgarbossa criteria, which clearly would have established the presence of that block. CUIMC health-care personnel assessed her with acute decompensated heart failure, likely in the setting of the infarction that she had sustained. The CUIMC chart reported that the decedent's heart ejection fraction had decreased to 10%, with global hypokinesis and regional wall motion abnormalities, that she was medically managed with aspirin, Plavix, heparin, and a statin, and that she was treated for pneumonia with a five-day course of Zosyn, due both to respiratory symptoms and an opacity that was observable on a chest X-ray. Dr. Diamond asserted that the decedent was then determined to have a life expectancy of less than six months, due to very advanced dementia and worsening heart failure. He stated that, after the decedent's family members discussed the goals of continuing care, they determined to place the decedent in inpatient hospice care, after which CUIMC personnel developed a discharge plan, whereby comfort care would be initiated and the decedent would be discharged to a hospice care facility.

On December 27, 2017, the plaintiff contacted Calvary Hospital Hospice at the Mary Manning Walsh Nursing Home, a facility owned by the defendant Archcare Community Services, Inc., and affiliated with and/or managed in part by Calvary, to initiate plans to transfer her decedent to MMW. Most of the admissions documentation was entered on Calvary forms and letterhead. According to Dr. Diamond, on January 2, 2018, the decedent was transferred and admitted to hospice care at MMW, with what he described as end-stage systolic congestive

heart failure. He asserted that, due to the presence of numerous areas of ecchymosis over the decedent's skin, the plaintiff agreed to discontinue the administration of blood thinners to her decedent, and to administer morphine to control her decedent's pain and shortness of breath. Dr. Diamond stated that the MMW chart reflected that, upon admission, although the decedent was moaning, she did not appear to be in significant discomfort because the moaning appeared to be "a comfort/soothing mechanism for the decedent."

On January 3, 2018, Calvary internist Gail Chrzanowski, M.D., completed a physician's history and physical examination, writing that the decedent was admitted to MMW for hospice care with a focus on comfort and cardiac symptom treatment. A nutritional assessment documented the decedent with dysphagia, and noted that she was on a diet of pureed foods, with a risk for weight loss and dehydration. As Dr. Diamond described it, by January 11, 2018, the decedent was described as sleeping frequently and appearing comfortable, although constipated. He asserted that Calvary staff ordered Nystatin topical powder on January 12, 2018 for the purpose of drying moist abdominal skin folds. Dr. Diamond further asserted that, on January 15, 2018, a "new" stage II pressure ulcer was found on the decedent's right gluteal fold, upon which Calvary personnel developed a plan for cleansing, patting the area dry, applying skin preparation ointment, and covering the ulcer with a foam dressing every three days. He stated that, by January 18, 2018, the decedent had a small skin tear in the region of her buttock and that, on February 24, 2018, black discoloration was noted on her lower extremities due to poor circulation, while on March 2, 2018, skin tears were found near the decedent's buttocks and left groin that were treated with the antibiotic ointment Bacitracin and the loosening of her diaper. Dr. Diamond further explained that, on March 5, 2018, a small slit-like wound in the sacral crevice and another wound in the left groin region were noted and treated with Optifoam. He averred that at, this stage, preparations were made to transfer the decedent to her home for routine home hospice care, and that, on March 8, 2018, plans for her discharge were finalized.

As Dr. Diamond recounted it, on March 9, 2018, the decedent was discharged to her home from MMW so that she could die there, "per her family's wishes," although Calvary's records indicated that her formal discharge from Calvary's care did not occur until March 17, 2018. Dr. Diamond implicitly confirmed that, even after the decedent's physical discharge from MMW, she remained under Calvary's care between March 9, 2018 and March 17, 2018, when she was transported to Mount Sinai Beth Israel Hospital (MSBI). He stated that the plan that Calvary formulated involved the assignment of a home personal-care aide attend to the decedent for 12 hours each day, seven days each week, and a hospice nurse for 4 hours each day, five days eacj week, all to be provided via Guildnet LTC, a long-term, home-healthcare service. Dr. Diamond stated that relevant records reflected that the decedent received such care from March 9, 2018 to March 16, 2018, and that either nurses, health-care aides, or personal-care aides examined her skin each day from March 12, 2018 through March 16, 2018. As he interpreted those records, on March 9, 2018, a hospice assessment noted that the decedent had a resolved stage I wound on her buttocks, and that there were instructions for her to be turned and repositioned every two to three hours. Dr. Diamond further asserted that the home-care records reported that the plaintiff and her family members "refused to administer the prescribed pain medications," which he concluded "directly impacted the scope of care provided," as the hospice staff respected their wishes while continuing to monitor the decedent's condition. Dr. Diamond additionally stated that, on March 14, 2018, Nurse Rachel Gaglione documented that the decedent had a developing Kennedy ulcer, which he described as a type of pressure ulcer, also known as a terminal ulcer, that typically appears in individuals nearing the end of life when their bodies are no longer able to heal due to diminished blood flow. He averred that a visiting nurse advised the plaintiff to turn and reposition the decedent regularly while cleaning the wound with antibiotic cream, but that the "decedent's daughter insisted on only natural pain relief, rejecting the nurse's suggestion for more comprehensive pain management and inpatient care."

Dr. Diamond stated that, based on his review of the relevant records, on March 17, 2018, the decedent's family called 911 to have her transported by ambulance to MSBI. At the time, the decedent was not eating any solid food, and consumed only sips of protein drinks. According to Dr. Diamond, she was agitated at times and restless, "but her daughter refused to administer pain medication." When the decedent was assessed at MSBI on March 18, 2018, healthcare personnel reported that she had a stage II sacral ulcer with some odor, but that there were no signs of acute infection such as purulence. On March 19, 2018, MSBI personnel reported the presence of an "erosion [of the sacrum] with underlying erythema and surrounding violaceous skin," measuring approximately 10 cm in length, with "punctate lesion superior to anus draining some pus." That same day, MSBI personnel reported that the decedent was suffering from severe malnutrition, related to chronic illness, that was evidenced by a 14.5% weight loss in less than six months, severe muscle loss, and severe fat loss. On March 20, 2018, a 14 cm by 7 cm "broken blister" of the sacrum was documented. Dr. Diamond asserted that, on March 23, 2018, this wound nonetheless showed no signs of infection, and that the decedent manifested no signs of systemic infection. On March 26, 2018, MSBI internist Christie Mulholland, M.D., examined the decedent, and told the plaintiff that her decedent was dying. Dr. Diamons explained that, from March 27, 2018, until her death on April 11, 2018, the decedent was in inpatient hospice care at MSBI, during which time she was treated with opioids for pain, but remained unresponsive as her condition deteriorated.

Dr. Diamond opined that the at-home hospice care that the decedent received from March 9, 2018 through March 17, 2018 adhered to all applicable standards of care, including an appropriate assessment and management of pre-existing skin breakdowns, while prioritizing the decedent's comfort. Specifically, he concluded that the decedent received proper and appropriate wound care from Calvary home hospice workers. As he explained it, the primary goal of hospice care is to maintain comfort and quality of life as the patient approaches the end of life, since hospice care focuses on symptom management at the end of life, such as relief

from pain and discomfort, rather than interventions aimed at reversing terminal illness. He asserted that, in cases like the decedent's, where significant organ failure, immobility, and impaired circulation are present, pressure ulcers "may be inevitable" due to the body's decline, and that "skin changes at life's end," which he described as a "known syndrome that can be associated with skin breakdown." Dr. Diamond opined that the standard of care requires the management of these wounds by appropriate wound-site assessment and pressure offloading, but only to the extent that these measures do not compromise patient comfort. He stated that "there is virtually no expectation that a terminal patient nearing the end of life will heal a skin wound, or have such a wound improve given the terminal patient's compromised state, regardless of the cause."

Dr. Diamond opined that Calvary home hospice staff adhered to these standards since they assessed the decedent for skin breakdowns upon her transfer to home hospice care on March 9, 2018, and because they provided appropriate care according to a proper schedule for both nurses and personal-care aides. He nonetheless asserted Calvary was not responsible for ensuring that the aides strictly adhered to the home hospice care recommendations, and that hospice staff instructed the family on turning and repositioning the decedent when staff members were not present. In any event, he concluded that "more aggressive turning was contraindicated due to the decedent's discomfort during such actions, as noted when she cried out during repositioning." Dr. Diamond expressly averred that Calvary's home hospice aides did not cause the decedent's sacral wound, inasmuch as records clearly show that the sacral skin breakdown was present prior to the start of her at-home hospice care. Moreover, he concluded that the decedent's sacral wound was not exacerbated by any acts or omissions by Calvary's homecare employees but that, rather, that "[t]he worsening of such wounds was an unavoidable consequence of the decedent's failing organs and terminal condition" since " end-of-life care that sacral ulcers, particularly in bedridden, geriatric patients with multiple comorbidities, such as the decedent, often worsen despite appropriate care." As Dr. Diamond framed the issue,

"[t]he decline of the patient's skin was a further manifestation of her approaching death and was not due to, nor caused by, any of the care provided by Calvary." He asserted that more aggressive interventions, such as frequent turning or specialized equipment, would have been "futile," and likely would have compromised the decedent's comfort. Since he considered comfort to have been the primary goal of hospice care, and believed that providers must balance wound management with the need to maintain patient comfort, he concluded that the absence of aggressive treatment was consistent with applicable hospice care principles.

With respect to the examinations that Calvary homecare staff performed, Dr. Diamond explained that they were performed at appropriately frequent intervals since the decedent's skin was assessed during virtually every home care visit, save two, and that, upon a March 12, 2018 re-assessment, there were no significant changes to her skin or her pre-existing wound that any nurse or aid observe. He concluded that, consequently, any alleged failure to perform a skin assessment on those two dates was "absolutely inconsequential and did not cause any injury," and that the attention provided to the sacral wound was "correct given the totality of the circumstances."

Additionally, Dr. Diamond opined that Calvary's homecare personnel made appropriate efforts to provide nutrition and hydration, and did not cause the decedent to become malnourished or dehydrated. Rather, he asserted that, in light of her terminal condition, the decedent already was in a process of nutritional decline prior to the inception of hospice home care. He explained that, prior to hospice treatment, the decedent was on a honey thick liquid diet due to dysphagia, and had been consistently documented as malnourished, with difficulty eating and drinking, even prior to transfer to home hospice. Dr. Diamond asserted that, while in home hospice care, efforts to satiate and hydrate were documented, but that her dysphagia persisted, and that there was no indication for the initiation of alternative means of supplemental nutrition and hydration, such as intravenous fluids or tube feedings, because such interventions are contraindicated for patients with a terminal diagnosis who are receiving end-of-life care. He

thus approved of the regiment of providing the decedent with oral intake via pureed foods, shakes, and liquids to the extent that she desired them. Dr. Diamond further asserted that the decedent did not contract sepsis, nor did her sacral wound become infected, during the period of home hospice care, concluding that she never was diagnosed with sepsis or septic shock, and that neither sepsis nor septic shock caused or contributed to her death, which he asserted was "entirely due to natural causes," as set forth in her death certificate. Dr. Diamond asserted that these "natural causes" included the decedent's underlying terminal conditions, including severe dementia with dysphagia and systolic heart failure.

Even though Dr. Diamond was retained by Calvary as its expert, he did not address any of the plaintiff's claims concerning the care rendered to her decedent at Calvary Hospital Hospice at the Mary Manning Walsh Nursing Home from January 2, 2018 until March 9, 2018, even though Calvary apparently had overall oversight responsibility, along with Archcare, for that hospice facility, while Calvary's physicians examined and treated the decedent during her residency at MMW. Neither he nor anyone else explained the operational relationship between Calvary and MMW and, thus, Calvary did not establish, prima facie, that it was not responsible for the care rendered to the decedent while she resided at MMW. Calvary's submissions, in fact, reflected the existence of triable issues of fact as to whether Calvary was jointly responsible with MMW for the care rendered to the decedent while she was at MMW.[3]

[3] Calvary submitted medical records in support of its motion that it denominated as the "MMW Record," and uploaded them to the New York State Court Electronic Filing system as Docket Nos. 70 and 71. Those records indicate, among other things, that "MMW staff will work in collaboration of P[lan] O[f] C[are] with Calvary Hospice." Moreover, an eight-page entry in the chart consists of a document entitled "Calvary Hospital Hospice Visit and Careplan Coordination Log/Calvary Hospital Hospice Inpatient IDT Care Plan," containing handwritten notes dated between January 3, 2018 and March 7, 2018, when the decedent was an inpatient at MMW. In addition, a January 2, 2018 entry, on letterhead from Calvary Hospice, identifying its address as the Bronx address of the main campus of Calvary Hospital, memorialized the decedent's admission to MMW. Furthermore, an additional 20 pages of those records indicate that they were forwarded from "Calvary Inpatient Hospice TO MMW 15 Floor," suggesting that Calvary was responsible for generating and maintaining those records. The court further notes that the decedent was designated in the MMW records as a "Calvary Hospice Patient," that Calvary internist Gail Chrzanowski, M.D., was the physician assigned to supervise the decedent's care, and that this physician actually ordered that Bacitracin be applied to the decedent's buttocks during the last week of her stay at MMW to treat a newly formed wound. The "admission note report" was also on a Calvary Hospital form,

In connection with the care rendered to the decedent at MMW between January 2, 2018 and March 9, 2018, that entity, in support of its separate motion, relied on many of the documents that Calvary had submitted, and also submitted additional medical records, a statement of allegedly undisputed material facts, an attorney's affirmation, and the expert affirmation of board-certified internist and geriatrician Jeffrey M. Levine, M.D., who opined that MMW personnel did not deviate from the standard of care applicable to nursing home care or violate any of the statutes or regulations that the plaintiff invoked, and that nothing that they did or did not do caused or contributed to the decedent's injuries or death.

Dr. Levine reiterated much of the decedent's medical history that Dr. Diamond had described in his affirmation, and also set forth, in granular detail, the contents of the MMW chart as it related to a patient care plan, skin assessments, skin and wound care, nutrition, and hydration. He asserted that the decedent was properly assessed, and that healthcare providers at MMW developed a care plan that included proper measures for avoiding and treating pressures ulcers which conformed to the standard of care. Dr. Levine stated that the care plan was updated appropriately, while MMW staff properly implemented the pressure ulcer interventions, such as turning and repositioning the resident every two hours, applying topical ointment to the decedent's buttocks during every shift, and providing heel lifts for the decedent to use while she was in bed. He opined that, despite MMW's best efforts, the decedent developed a sacral ulcer because her body was failing and she was in the dying process.

As Dr. Levine explained it, even prior to the decedent's hospitalizations at CUIMC, which were, in turn, prior to her admission to MMW, she was a frail 87-year-old woman with multiple comorbidities, such as advanced congestive heart failure with an ejection fraction of 10%, severe end stage dementia, and failure to thrive, "who was unfortunately deteriorating and

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as were all of the admission documents generated in the week leading up to the decedent's admission to MMW. Moreover, a Physician's Order sheet on an Archcare/MMW form indicated that the decedent was a "Calvary Hospice In-patient."

clearly in the final stage of life." He asserted that the decedent had been deteriorating for at least five years prior to her admission to MMW. Hence, Dr. Levine concluded that the pressure ulcers that she later developed, which he characterized as "terminal ulcers," were unavoidable, and occurred in the absence of any negligence. Moreover, he averred that the ulcers did not cause the decedent's death, but were, instead, part of the dying process.

Dr. Levine explained that not all pressure ulcers are avoidable or preventable. He described the skin as the largest organ of the body, and stated that its integrity is impacted by age, medications, microclimate, functioning of other organs, and other diseases and illnesses, while the development of pressure ulcers is affected by numerous risk factors, such as those that commonly are seen in patients such as the decedent. Dr. Levine asserted that the sacral ulcer that the decedent developed on January 15, 2018 occurred "even with MMW taking reasonable measures to prevent it." He stated that, after that ulcer formed, MMW staff properly treated with an Optifoam dressing, and cleaned it at a regular frequency with normal saline solution, then patted it dry, and thereafter applied a fresh dressing, all in accordance with the standard of good and accepted medical practice. Dr. Levine noted that the ulcer eventually healed two weeks later, "in a further indication that MMW was taking reasonable measures to address her ulcers," and despite the decedent's weakened condition and poor prognosis. In this respect, Dr. Levine adverted to Dr. Chrzanowski's note, in which the latter wrote that the decedent was indeed on a strict "offloading" protocol to prevent otherwise "un-avoidable" pressure ulcers. With respect to the "small slit like wound" noted on the decedent's buttocks on March 6, 2018, Dr. Levine asserted that, while not a pressure ulcer at the time of the decedent's March 9, 2018 discharge, it nonetheless developed into another "unavoidable sacral ulcer." He noted that this wound worsened over the first week after the decedent had been discharged to her home, and that the Calvary homecare record even referred to the sacral ulcer as a "Kennedy ulcer," which he characterized as an unavoidable wound associated with the dying process that occurs despite medical providers' best efforts to prevent them. In this regard, he

explained that the skin, just like any other organ in the body, will begin to fail the same as any internal organs would during the end of life.

Dr. Levine opined that, based on his review of the CUIMC, MMW, and Calvary homecare records, the decedent's sacral ulcer never became infected and that, hence, she did not die as a consequence of the ulceration, specifically noting that, even in the course of the home hospice care rendered to the decedent between March 9, 2018 and March 17, 2018, although her sacral wound "rapidly advanced," it was "still noted to be not infected."

With respect to the plaintiff's allegations that MMW did not provide her decedent with adequate nutrition and hydration, Dr. Levine concluded that MMW established a proper nutrition plan to address the decedent's needs, and that MMW staff regularly documented the decedent as being a poor eater who was able to consume only between 25% to 50% of her meals. According to Dr. Levine, the decedent's poor eating habits not only constituted a sign of her inevitable deterioration, but also contributed to the unavoidable impairment of her skin integrity. As he phrased it, "[t]he fact that she had poor oral intake meant that her body did not have the necessary nutrition to help fight off and heel pressure ulcers."

Dr. Levine also asserted that no one at MMW ever noted that the decedent had complained of any pain in connection with her pressure ulcers. He conceded that, while there was some documentation of pain in the records, it always was in reference to some other part of her body, such as her abdomen, and that the decedent nonetheless was administered morphine when needed.

Ultimately, Dr. Levine asserted that the relevant medical records reflected that the decedent was in hospice care for four months before dying due to her multiple comorbidities, and that even the plaintiff and other family members knew that she was suffering from a terminal illness and were planning the decedent's funeral even before the ulcers developed. As he framed the issue, "the sacral ulcer played no role in the patient's death; it was merely an unavoidable symptom of the body's deterioration during the dying process."

In opposition to the motions of both Calvary and MMW, the plaintiff submitted counterstatements of material fact, medical records, attorney's affirmations, and two separate expert affirmations from a board-certified internist and geriatrician, who opined that both MMW and Calvary personnel departed from good and accepted practice and caused or contributed to the decedent's injuries, "including, but not limited to, the development and deterioration of Plaintiff's decedent's pressure ulcer, pain, and suffering." Notably, the expert did not attribute the decedent's death to MMW's alleged malpractice.

After recapitulating the decedent's numerous hospitalizations prior to her January 2, 2018 admission to Calvary Hospital Hospice at the Mary Manning Walsh Nursing Home, the plaintiff's expert, in both of the supporting affirmations, first asserted that accurate documentation is a necessary prerequisite to the appropriate updating of a patient's care plan, and is essential for ensuring that pressure ulcers are aggressively met with the appropriate level of treatment. The expert asserted that the standard of care requires accurate documentation of a patient's medical course, as well as the care that is provided. The expert averred that, in this respect, healthcare providers utilize staging and sizing of pressure ulcers to ensure that consistent and appropriate care is provided across different medical shifts and to communicate amongst different healthcare providers within a facility.

The plaintiff's expert averred that, contrary to both Calvary's and MMW's contentions that the decedent was turned and repositioned every two hours, it failed to generate or maintain a detailed turning and positioning chart that could have provided insight as to when the decedent actually was turned, the specific positioning allegedly effectuated, and the specific time when the turning was accomplished. With respect to Calvary's home hospice care, the expert asserted that the decedent's entire chart, consisting of 401 pages and forms, was poorly detailed as to any type of turning and positioning that was performed. As an example in connection with the MMW chart, the expert noted that the turning and positioning chart was replete with notations of a lowercase "b" and lowercase "l," with no index as to the meaning of

these letters. The expert expressly opined that such insufficient documentation not only was a departure from the applicable standard of care, but constituted a violation of 10 NYCRR 415.22, which requires a nursing home to maintain complete, accurately documented records, as well as a violation of 10 NYCRR 415.11 and 42 CFR 483.20, all of which proximately caused or contributed to the decedent's development of a pressure ulcer and the worsening thereof.

In connection with Calvary's home hospice care, the plaintiff's expert rejected Dr. Diamond's opinion that repeated repositioning would have caused the decedent to experience unnecessary discomfort and would have contradicted the ethos of palliative care. In this respect, the expert noted that the hospice plan of care included "measures to promote comfort, skin care and prevention, mobility/safety" and anticipated the use of interventions to assess the decedent's skin status and to keep the skin clean and dry, including the turning and positioning of the decedent every two hours as tolerated and the provisions of a therapeutic mattress. According to the expert, these interventions were in place in the care plan, with the goal of preventing skin breakdown, while proper turning and positioning to prevent the development and deterioration of a pressure ulcer was intended to be "part of the supportive medical care afforded" to the decedent that "aligned with the ethos of palliative care."

In addition, the plaintiff's expert opined that the decedent was entitled to supportive medical care, including proper skin care and prevention, and the right to a quality of life that was free from as much pain as possible. The expert explained that the decedent's inability clearly to express the location of her pain did not undercut fact that pressure ulcers are painful, particularly because she obviously was capable of feeling pain and was, in fact, given morphine to help ease this pain. In this respect, the expert adverted to an entry in the MSBI chart for March 18, 2018, one day after she was transferred there from home hospice care, in which the decedent was noted to have, "a resolved stage 1 wound closed with dark reddish area, on pts buttocks and is instructed to place mother side to side every 2-3 hours," and an entry in the same chart for March 26, 2018, in which the decedent was noted to cry out when she was

turned so that the wound could be inspected. Hence, the expert asserted that the decedent actually experienced discomfort as a result of developing a pressure ulcer.

The plaintiff's expert also concluded that MMW violated 42 CFR 483.25, which requires a nursing home to ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. The expert opined that MMW staff failed properly and adequately to turn and position the decedent, and failed to prevent new pressure ulcers from developing, and that, not only did these alleged failures constitute substantial departures from the standard of care, but violated that federal regulation. The expert explained that frequent turning and positioning of patients in nursing homes, particularly those susceptible of developing pressure ulcers, is critical, as the turning and positions distribute pressure to different parts of the body so that no one part receives pressure for any great deal of time. The expert asserted that 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, such as unabated pressure on a patient's sacrum. As the expert phrased it,

> "[c]ontrary to Defendant's expert's contention that turning and positioning was properly done, it is my opinion within a reasonable degree of medical certainty that proper turning and positioning was not being performed every two hours by Defendant MARY MANNING WALSH NH. Here, there are very few notations that Plaintiff's decedent was turned and repositioned at Defendant MARY MANNING WALSH NH's facility."

The expert noted that, although Dr. Levine, in his affirmation, had concluded that the decedent was turned and repositioned "each day," in fact, the notes in the decedent's MMW chart reflected that she was only turned and repositioned every other day and, hence, proper turning and repositioning "was not being done every two hours in accordance with the standard of care" during the decedent's admission to MMW. The expert further concluded that the failure to turn and reposition the decedent every two hours was a proximate cause of the development and deterioration of pressure ulcers and deep tissue injuries. Furthermore, the plaintiff's expert asserted that MMW staff should have given consideration to the decedent's postural alignment

and distribution of weight, and generated a written repositioning schedule or chart to assure that the decedent was turned and repositioned more often than every two hours.

The plaintiff's expert asserted that both Drs. Diamond and Levine

> "improperly attempt[ ] to place the blame of Plaintiff's decedent's development and deterioration of pressure ulcers on Plaintiff's decedent's hospice certification. However, in doing so, Defendant fails to recognize two things: first, that Plaintiff's decedent's hospice certification did not obviate the need for proper skin and wound care. Plaintiff's decedent's hospice orders at Defendant MARY MANNING NH consisted of comfort measures only which included, 'medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering.'"

As the expert framed the issue, "[t]he insistence that Plaintiff's decedent's hospice certification guaranteed the development of a pressure ulcer is medically inaccurate." The expert opined that the relevant chart actually demonstrated that the decedent had the ability to heal from her pressure ulcers. Specifically, the expert asserted that MMW's records revealed that, on February 5, 2018, the decedent's buttock wound was noted to be healed while under MMW's care, constituting "further evidence that the development of skin breakdown was not unavoidable." The expert thus concluded that the development and deterioration of the decedent's pressure ulcers could have been avoided had MMW provided proper medical care.

As the expert further explained it, according to Medicare's CMS-2 billing guidelines, and peer-reviewed literature published by the National Pressure Ulcer Advisory Panel, the definition of an avoidable pressure ulcer is one that develops despite the fact that a healthcare provider evaluated the individual's clinical conditional and pressure ulcer risk factors, defined and implemented interventions consistent with individual needs, goals, and recognized standards of practice, monitored and evaluated the impact of the interventions, and revised the approaches as appropriate. The expert concluded that the decedent's pressure ulcer did not satisfy these criteria and that, consequently, it could not be characterized as an unavoidable ulcer.

The plaintiff's expert explained, in further detail, that an entry in a March 26, 2018 MSBI

chart reported that the decedent had a developing stage I Kennedy ulcer, upon which Dr. Diamond relied in reaching his opinion that this was synonymous with unavoidability. The plaintiff's expert asserted that this was first and only mention of a "Kennedy ulcer." The expert faulted Dr. Diamond for failing to take a deeper look into the origin of the nomenclature, and the extensive medical knowledge that has been discovered since the term was coined in 1989 by Indiana nurse practitioner Karen Lou Kennedy. According to the plaintiff's expert, the term was employed to explain the development of pressure-based tissue injuries in patients with actual or presumed terminal conditions, but that a 2017 peer-reviewed article illustrated the outdated and problematic use of the term, characterizing the term as one that is "without physiologic basis and solely on observation." The expert compared the use of that term with the most current understanding of how pressure-based tissue injuries develop and progress, and concluded that the decedent's ulcer was mislabeled as a "Kennedy ulcer." Rather, the expert described the ulcer as a "never event," a concept introduced in 2001 by the National Quality Forum (NQF), a nonprofit organization that services the medical profession, among others, with reference to errors, particularly those of a medical nature, that should never occur. The plaintiff's retained expert agreed with the NQF's conclusion that the development of any stage II, stage III, or stage IV pressure ulcer after admission to a healthcare setting is a "never event" encompassed within the category of care management, and that the decedent's development of an ulcer thus occurred as a consequence of a medical error that never should have occurred.

Furthermore, the expert averred that, inasmuch as the decedent did not have any pressure ulcers prior to her admission to MMW, but was admitted only with "Scattered ecchymoses on bilateral upper extremities and upper legs; Healed surgical scars on bilateral knees; Hyperpigmantation of bilateral lower extremities," MMW personnel had a cause for concern that that heightened supervision was necessary to avoid the development of any further skin breakdown in other areas of the body, but that their failure to do constituted a departure from good practice that contributed to the development of the ulcer.

The expert further explained that, even though the decedent presented to MMW with certain medical risk factors, “the very reason patients seek treatment is because they lack the ability to properly care for themselves in a certain way,” and that MMW staff knew, or should have known, that she was at risk for the development of pressure ulcers, and relied on them to turn and reposition her, as she was completely dependent on assistance with her activities of daily living. The expert faulted Dr. Levine for attempting to place the burden of care upon the decedent herself, despite the fact that she was unable to care for herself.

Ultimately, the plaintiff’s expert opined that the decedent’s skin breakdown and deterioration was caused by unrelieved pressure, along with both MMW’s and Calvary’s failures fully to implement their care plans to fit the decedent’s specialized needs, and that skin integrity was in the decedent’s best interest in assuring that she remained as comfortable as possible at the end of her life.

In reply, both Calvary and MMW submitted attorneys’ affirmations, in which counsel characterized the opinions of the plaintiffs’ expert as speculative, conclusory, and unsupported by the medical records. Counsel further pointed out that the expert failed to address numerous opinions rendered by both MMW’s and Calvary’s experts in connection with several claims set forth in the complaint and the plaintiff’s bill of particulars.

The court concludes that both Calvary and MMW established their prima facie entitlement to judgment as a matter of law in connection with all three causes of action. The court further conclude that, inasmuch as the plaintiff’s expert did not opine that any conduct by Calvary and MMW staff caused the decedent’s death, the plaintiff failed to raise a triable issue of fact in opposition to the movants’ showings in connection therewith, and summary judgment must be awarded to both Calvary and MMW dismissing the wrongful death cause of action insofar as asserted against each of them. Additionally, the plaintiff’s expert rendered no opinion refuting the opinions of the movants’ experts as to whether Calvary or MMW departed from accepted standards of care by creating or contributing to a skin infection, sepsis, and septic

shock, failing to maintain a safe environment, failing to obtain necessary consultations from specialists, failing to promulgate appropriate rules and regulations, failing properly to examine the plaintiff's decedent, undertake assessments, including risk assessments, and perform workups, failing to diagnose the decedent with any particular condition, failing to prescribe and administer appropriate medications, and failing to provide the decedent with proper nutrition and hydration. Hence, summary judgment must be awarded to the movants dismissing so much of the medical malpractice cause of action as was premised upon those claims. Nor did the plaintiff's expert refute the opinions of the movants' experts that neither Calvary nor MMW violated 10 NYCRR 763.5, 10 NYCRR 763.6, 10 NYCRR 10 763.13, 42 USC §§ 1396r(b)(3)(A),(B),(C) and (b)(4)(B), and 42 USC §§ 1395i-3(b)(3)(A),(B),(C) and (b)(4)(B). Hence, summary judgment must be awarded to the movants dismissing so much of the Public Health Law § 2801-d cause of action as was premised upon alleged violations of those regulations and statutes.

Nonetheless, the court concludes that, in opposition to the movants' prima facie showing, the plaintiff, with her expert's affirmations, raised triable issues of fact as to whether MMW and Calvary departed from good and accepted practice in failing to monitor and supervise the skin condition of her decedent, failing to turn and position her frequently enough, failing to provide items that would relieve pressure on the decedent's sacrum, failing to assure that its healthcare personnel fully followed official procedures that had been promulgated, and failing adequately or properly to document and record both the nature and frequency of the turning and repositioning of the decedent, whether Calvary and MMW violated Public Health Law § 2803-c, 42 USC §§ 1396r(b)(1)(A),(B), (b)(2), and (b)(4)(A), 42 USC §§ 1395-3(b)(1)(A),(B), (b)(2), and (b)(4)(A), 10 NYCRR 96.1(m)(14), 10 NYCRR 415.11, 10 NYCRR 415.12(c)(1), 10 NYCRR 415.22, and 42 CFR 483.20, which essentially codify the aforementioned common-law obligations of nursing homes, and whether these alleged departures and violations caused or contributed to the decedent's development of pressure ulcers, and the exacerbation thereof.

Moreover, as explained above, Calvary failed to establish, prima facie, that it was not responsible for the conduct of the healthcare personnel who treated the decedent at MMW. Hence, those branches of Calvary's and MMW's motions seeking summary judgment dismissing those claims, as asserted in connection with the medical malpractice and Public Health Law § 2801-d causes of action, must be denied.

In light of the foregoing, it is,

ORDERED that the motion of the defendant Calvary Hospital, Inc., for summary judgment dismissing the complaint insofar as asserted against it (MOT SEQ 002) is granted to the extent that it is awarded summary judgment (1) dismissing the wrongful death cause of action insofar as asserted against it, (2) dismissing so much of the medical malpractice cause of action, insofar as asserted against it, as was premised upon its alleged

(a) negligent hiring, training, supervision, and retention of healthcare personnel,

(b) creation of or contribution to infection of the plaintiff's decedent's skin, sepsis, and septic shock,

(c) failure to maintain a safe environment,

(d) failure to obtain necessary consultations from specialists,

(e) failure to promulgate appropriate rules and regulations,

(f) failure properly to examine the plaintiff's decedent, undertake assessments, including risk assessments, and perform workups,

(g) failure to diagnose the decedent with any particular condition,

(h) failure to prescribe and administer appropriate medications, and

(i) failure to provide the decedent with proper nutrition and hydration, and

(3) dismissing so much of the Public Health Law § 2801-d cause of action, insofar as asserted against it, as was premised upon violations of 10 NYCRR 763.5, 10 NYCRR 763.6, 10 NYCRR 10 763.13, 42 USC §§ 1396r(b) (3)(A),(B),(C) and (b)(4)(B), and 42 USC §§ 1395i-3(b) (3)(A),(B),(C) and (b)(4)(B), that cause of action and those claims are dismissed insofar as

asserted against the defendant Calvary Hospital, Inc., and that motion is otherwise denied; and it is further,

ORDERED that the motion of the defendant The Mary Manning Walsh Nursing Home Company, Inc., for summary judgment dismissing the complaint insofar as asserted against it (MOT SEQ 003) is granted to the extent that it is awarded summary judgment (1) dismissing the wrongful death cause of action insofar as asserted against it, (2) dismissing so much of the medical malpractice cause of action, insofar as asserted against it, as was premised upon its alleged

(a) negligent hiring, training, supervision, and retention of healthcare personnel,

(b) creation of or contribution to infection of the plaintiff's decedent's skin, sepsis, and septic shock,

(c) failure to maintain a safe environment,

(d) failure to obtain necessary consultations from specialists,

(e) failure to promulgate appropriate rules and regulations,

(f) failure properly to examine the plaintiff's decedent, undertake assessments, including risk assessments, and perform workups,

(g) failure to diagnose the decedent with any particular condition,

(h) failure to prescribe and administer appropriate medications, and

(i) failure to provide the decedent with proper nutrition and hydration, and

(3) dismissing so much of the Public Health Law § 2801-d cause of action, insofar as asserted against it, as was premised upon violations of 10 NYCRR 763.5, 10 NYCRR 763.6, 10 NYCRR 10 763.13, 42 USC §§ 1396r(b) (3)(A),(B),(C) and (b)(4)(B), and 42 USC §§ 1395i-3(b) (3)(A),(B),(C) and (b)(4)(B), that cause of action and those claims are dismissed insofar as asserted against the defendant The Mary Manning Walsh Nursing Home Company, Inc., and that motion is otherwise denied; and it is further,

ORDERED 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 October 7, 2025, at 11:00 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.

9/12/2025
DATE

JOHN J. KELLEY, J.S.C.

MOTION 002:		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 003:		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