SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

P R E S E N T : HON. JEFFREY S. BROWN
JUSTICE

----------X **TRIAL/IAS PART 12**

MORRIS RUBIN,

INDEX # 606628/15

Plaintiff(s),

Mot. Seq. 2, 3
-against- **Mot. Date 3.16.18**
Submit Date 8.9.18

MERCY MEDICAL CENTER,

Defendant(s).

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The following papers were read on this motion:	Documents Numbered MS 2	MS 3
Notice of Motion, Affidavits (Affirmations), Exhibits Annexed.....	76	88
Answering Affidavit	101,112	123
Reply Affidavit.....	117	125

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Defendant Mercy Medical Center moves by notice of motion pursuant to CPLR 3212 for an order granting summary judgment in its favor and dismissing all claims with prejudice. Defendant further moves for an order pursuant to CPLR 2221 granting leave to renew its prior motion to vacate the note of issue and certificate of readiness on the grounds that all pre-trial discovery is not complete and that this matter is not trial ready. The court considers defendant's motion for summary judgment first.

This case sounds in medical malpractice arising out of an alleged failure to properly prevent, diagnose, and treat plaintiff's decubitus ulcers, leading to a stage III ulcer, infection, sepsis, and hypoglycemic shock. The salient facts are as follows. Rubin Morris, then 83 years old, was admitted to Mercy Medical Center Subacute Rehabilitation Center on August 1, 2013 from St. Francis Hospital with a diagnosis of congestive heart failure. His prior medical history included diagnoses of congestive heart failure, diabetes mellitus, pneumonia, and urinary obstruction. He had previously had a coronary artery bypass graft and cardiac catherterization.

Upon admission to Mercy, plaintiff was noted to have moisture associated skin deterioration, known as MASD, with excoriations on the right buttock. He was seen by wound care specialist Mary Donovan, R.N. the following day, who recommended the application of Desitin® twice daily and repositioning every two hours. Plaintiff alleges that because of a failure to monitor his skin condition and follow the required protocol, he developed a severe decubitus ulcer.

> It is well established that 'the proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact.' (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]; *see also William J. Jenack Estate Appraisers & Auctioneers, Inc. v. Rabizadeh*, 22 N.Y.3d 470, 475-476 [2013]; CPLR 3212[b]). Once the movant makes the proper showing, 'the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action' (*Alvarez*, 68 N.Y.2d at 324). The 'facts must be viewed in the light most favorable to the non-moving party' (*Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499, 503 [2012] [internal quotation marks omitted]). However, bald, conclusory assertions or speculation and '[a] shadowy semblance of an issue' are insufficient to defeat summary judgment (*S.J. Capelin Assoc. v. Globe Mfg. Corp.*, 34 N.Y.2d 338, 341 [1974]), as are merely conclusory claims (*Putrino v. Buffalo Athletic Club*, 82 N.Y.2d 779, 781 [1993]).

(*Stonehill Capital Management, LLC v. Bank of the West*, 28 N.Y.3d 439 [2016]; *see also Fairlane Financial Corp. v. Longspaugh*, 144 AD3d 858 [2d Dept 2016]; *Phillip v. D&D Carting Co., Inc.*, 136 AD3d 18 [2d Dept 2015]).

"In order to establish the liability of a professional health care provider for medical malpractice, a plaintiff must prove that the provider '"departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries."' (*Schmitt v Medford Kidney Ctr.*, 121 AD3d 1088, 1088 [2d Dept 2014] [quoting *DiGeronimo v Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]]; *Stukas v Streiter*, 83 AD3d 18, 23 [2d Dept 2011]; *Fink v DeAngelis*, 117 AD3d 894, 896 [2d Dept 2014]). "A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing, *prima facie*, either that there was no departure from the applicable standard of care, or that any alleged departure did not proximately cause the plaintiff's injuries." (*Michel v Long Is. Jewish Med. Ctr.*, 125 AD3d 945, 945 [2d Dept 2015], lv denied, 26 NY3d 905 [2015]; *see also Barrocales v New York Methodist Hosp.*, 122 AD3d 648, 649 [2d Dept 2014]; *Berthen v Bania*, 121 AD3d 732, 732 [2d Dept 2014]; *Trauring v Gendal*, 121 AD3d 1097, 1097 [2d Dept 2014]; *Stukas*, 83 AD3d at 23). "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on

which the defendant met the *prima facie* burden." (*Gillespie v New York Hosp. Queens*, 96 AD3d 901, 902 [2d Dept 2012]).

"Establishing proximate cause in medical malpractice cases requires a plaintiff to present sufficient medical evidence from which a reasonable person might conclude that it was more probable than not that the defendant's departure was a substantial factor in causing the plaintiff's injury" (*Semel v Guzman*, 84 AD3d 1054, 1056 [2d Dept 2011] [citing *Johnson v Jamaica Hosp. Med. Ctr.*, 21 AD3d 881, 883 [2d Dept 2005]]; *Goldberg v Horowitz*, 73 AD3d 691 [2d Dept 2010]; *see also Skelly–Hand v Lizardi*, 111 AD3d 1187, 1189 [2d Dept 2013]). A plaintiff is not required to eliminate all other possible causes (*Skelly–Hand* at 1189). "'The plaintiff's evidence may be deemed legally sufficient even if [her] expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury.'" (*Alicea v Ligouri*, 54 AD3d 784, 786 [2d Dept 2008][quoting *Flaherty v Fromberg*, 46 AD3d 743, 745 [2d Dept 2007]]; *Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624 [2d Dept 2003]; *Wong v Tang*, 2 AD3d 840, 840-841[2d Dept 2003]; *Jump v Facelle*, 275 AD2d 345, 346 [2d Dept 2000], lv denied 95 NY2d 931 [2002], lv denied 98 NY2d 612 [2002]).

"'[G]eneral allegations that are conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice are insufficient to defeat a defendant's motion for summary judgment (citations omitted)'" (*Bendel v Rajpal*, 101 AD3d 662, 663 [2d Dept 2012] [quoting *Bezerman v Bailine*, 95 AD3d 1153, 1154 [2d Dept 2012]]; *see also Savage v Quinn*, 91 AD3d 748, 749 [2d Dept 2012]; *Myers v Ferrara*, 56 AD3d 78, 84 [2d Dept 2008], citing *Alvarez*, 68 NY2d at 325; *Thompson v Orner*, 36 AD3d 791, 792 [2d Dept 2007]; *DiMitri v Monsouri*, 302 AD2d 420, 421 [2d Dept 2003]). Furthermore, an expert's opinion which is conclusory and fails to set forth his or her rationale, methodology and reasons therefor also fails to establish an issue of fact. (*Rivers v Birnbaum*, 102 AD3d 26, 44 [2d Dept 2012]; *Dunn v Khan*, 62 AD3d 828, 829-830 [2d Dept 2009]). Finally, "[s]ummary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Feinberg v Feit*, 23 AD3d 517, 519 [2d Dept 2005]). "Such conflicting expert opinions will raise credibility issues which can only be resolved by a jury." (*DiGeronimo* 101 AD3d at 936).

Defendant contends that during his admission, the plaintiff refused to comply with care, physical therapy, and requests to get out of bed. Nonetheless, according to the defendant, plaintiff's skin condition did not worsen during his admission and no additional skin breakdown was noted. He was discharged from Mercy Medical Center on August 15, 2013 with the MASD that he had on admission.

In support of its motion, defendant submits the medical records reflecting plaintiff's stay at the facility, the deposition transcripts of the plaintiff, Mary Donovan, R.N., and Christine Engelhard, R.N., as well as the expert affidavit of Cindy Kiely, R.N., M.S.B., C.W.C.N.

By her affidavit, Nurse Kiely states that she is a registered nurse with certifications in wound care and is a certified nurse leader. She states that she had reviewed the pertinent medical records and reports, which, together with her training and experience, form the basis of her opinions. Nurse Kiely notes that upon admission to the center, plaintiff was noted to have a pre-existing denuded area to the right buttock and on the following day, it was noted that plaintiff's right buttock had moisture associated skin deterioration, an MASD, with scattered excoriations. Nurse Kiely stresses that this is not a pressure ulcer. The wound, which measured 6cm x 6cm, was to be assessed weekly. Upon evaluation by Mary Donovan, R.N., it was recommended that the plaintiff have a gentle foam incontinence cleanser, Desitin® twice daily, and repositioning every two hours. As he required assistance with turning and positioning, plaintiff was placed on a Stryker pressure redistribution surface with pillows for support and positioning and was given a wheelchair cushion. Nurse Kiely states that these orders were within the standard of care and there was no medical indication to perform any other treatment or enter any other orders. In addition, Nurse Kiely indicates that the plaintiff was followed by nutrition during his admission but his family eventually declined placement of a PEG tube.

Nurse Kiely opines that the plaintiff's medical record reflects that pressure ulcer protocol was properly followed, including continuously turning and repositioning the patient every two hours, daily incontinence care, continuously monitoring and assessing his skin, continuously rendering treatment to the buttocks, applying Desitin® every twelve hours, and continuously performing daily Braden scale assessments. Nurse Kiely states that due to the continuous care and treatment provided, plaintiff's MASD did not worsen during his admission and no further skin breakdown was noted.

Nurse Kiely also states that the records reflect several instances where the plaintiff refused to participate in physical or occupational therapy. In particular, plaintiff refused therapy on August 3, August 7, August 9, and August 12, 2018. Nurse Kiely also indicates that the plaintiff refused to get out of bed or to be repositioned on a number of occasions. On August 13, plaintiff was discharged from the acute rehabilitation unit and transferred to a medical floor and considered for a PEG tube placement, which was declined. He was still receiving Desitin® every 12 hours for skin integrity. On August 14th, it was noted that plaintiff's family arranged for an L.P.N. and home care, and he was to be discharged to home the following day. Based upon a review of the records, Nurse Kiely opines that plaintiff's need for services at that point was based upon his multiple co-morbities, including congestive heart failure, diabetes, and advanced age. Nurse Kiely opines that the need for services cannot be attributed to the MASD.

Nurse Kiely further states that at no point during the plaintiff's admission to Mercy Medical Center, did he develop a pressure ulcer. Rather, the appropriate protocols and interventions to treat MASD and prevent skin breakdown were implemented and followed and the treatment provided to the plaintiff for his skin breakdown was at all times within accepted standards in regard to MASD care and pressure ulcer prevention. He was admitted with skin damage and the nursing staff implemented appropriate interventions. Despite Mr. Rubin's non-

compliance with care, repositioning, and his impaired mental status, according to Nurse Kiely, his MASD did not worsen.

Alternatively, Nurse Kiley opines that any skin breakdown was inevitable and unavoidable due to the deterioration of plaintiff's overall state of health, including his comorbities and his refusal to participate in physical therapy and the care plans designed by his care team. Any claimed deterioration of the MASD was, in Nurse Kiely's opinion, unavoidable and not due to any act or omission on the part of Mercy Medical Center.

In opposition, plaintiff submits the expert affidavit of Diane A Weber, B.S.N., R.N. CWOCN, LNC-CSp, who states that she is a registered nurse with certifications in wound, ostomy, and incontinence nursing and is a legal nurse consultant certified specialist. Her affidavit is based upon her review of all relevant materials including, but not limited to plaintiff's bill of particulars, the deposition transcripts in this action, and the pertinent medical records, including records of the defendant and the record of St. Francis Hospital, as well as her training and experience. She had also reviewed the affidavit of Nurse Kiely.

Nurse Weber opines, to a reasonable degree of nursing certainty, that the stage III pressure ulcer on plaintiff back and buttocks developed and were permitted to intensify during the time in which plaintiff was admitted as a patient at Mercy. Moreover, Nurse Weber finds that the defendant failed to take any action to reduce the risk of pressure ulcers and failed to promote healing of plaintiff's skin injuries.

Nurse Weber states that the discharge summary from St. Francis Hospital notes no decubitis ulcers immediately prior to his transfer to Mercy. Plaintiff was admitted to Mercy with a Braden Score of 14, indicating a high risk for skin breakdown. According to Nurse Weber, plaintiff should have been treated accordingly. Nurse Weber indicates that upon admission, it was documented at approximately 4:09 p.m. that plaintiff had a "5 x 3 cm right buttocks bleeding incision with attached edges and clean, dry, intact periwound" and at 4:33 p.m., it was noted that the plaintiff has "buttocks mid excoriation with serosanguinous scant drainage, MASD, POA." Additionally, at 11:00 p.m. on the same day, it was documented that the plaintiff had limited movement of the right and left lower extremities, thus indicating an inability to move himself in bed.

Nurse Weber states that the appropriate standard of care would have required the cleansing of the wound with normal saline solution and covering it with an appropriate dressing, as per hospital policy.

Nurse Weber indicates that the records show that the plaintiff was first repositioned at 11:00 p.m. on August 1, 2013 and was not again turned until 7:00 a.m. on August 2, 2013. On this basis, Nurse Weber finds that despite plaintiff's elevated risk of skin breakdown, the nurses at Mercy failed to take measures to reduce the risk of skin breakdown by turning and repositioning him every two hours, which is a departure from the standard of care. According to

Nurse Weber, the standard of care requires a consistent schedule of turning and repositioning to heal skin and prevent further damage from pressure. However, Nurse Weber finds that the records indicate that no such schedule was followed during the course of plaintiff's admission, which directly contributed to his pressure injury, especially in light of his risk factors and the excoriation and damage that was already present upon admission.

Moreover, Nurse Weber states that defendant departed from the standard of care by failing to document and maintain proper records. Physical therapy noted that the plaintiff required "bed maintenance-rolling-maximum assistance" and Nurse Donovan noted that the plaintiff "requires assistance with turning and reposition" whereas the nurses repeatedly documented on their flow sheets that the plaintiff "turns self." Additionally, Nurse Weber states that the plaintiff's wound was assessed on only three occasions August 2, 2013, August 7, 2013, and August 9, 2013, with all three assessments indicating the same thing and was not assessed thereafter despite the requirement of daily assessments and the plaintiff's complaints of pain . Nurse Weber opines that in her experience, this type of rote computer clicking does not reflect actual patient care or assessments.

Nurse Weber disagrees with the opinion that plaintiff had moisture associated skin damage rather than a pressure ulcer because (1) the plaintiff had a foley catheter for a majority of the relevant time and there is no record of urinary or fecal incontinence, and (2) the plaintiff was unable to move himself in bed and was experiencing discomfort as a result of the buttocks wound. Nurse Weber also disagrees with Nurse Kiely's contentions that the plaintiff refused physical therapy and refused to get out of bed on a number of occasions. Nurse Weber opines that the refusal to engage in physical therapy was related to plaintiff's discomfort and pain, including sacral pain and that sufficient pain relieving measures were not implemented.

Nurse Weber further opines that the defendant departed from the standard of care by failing to change plaintiff's plan of care to address surrounding deep tissue injury after he exhibited signs of wound worsening. The standard of care would dictate that complaints of wound pain warrant reassessment and changing of the nursing care plan to implement new actions to aid in relieving pain and healing wounds. However, Nurse Weber indicates that no such plains or interventions are reflected in the medical records. Rather, the wound was identified when plaintiff was transferred back to St. Francis on August 15, 2013, which records indicate that upon admission to St. Francis, it was noted that the plaintiff presented with a stage III decubitus ulcer on his right buttocks/coccyx area measuring 4 x 3 cm with a surrounding tissue injury. Nurse Weber explains that such ulcers are vastly different than mere moisture associated skin damage.

Nurse Weber concludes that the defendant's delay in diagnosing and treating the plaintiff and the decubitus ulcers from which he was suffering was a departure from the standard of care, in particular by the failure to take measures to regularly turn the plaintiff and to properly identify and treat his skin conditions. Nurse Weber states that these departures resulted in significant deterioration of the plaintiff's overall health requiring extensive further care and treatment and

procedures that would not have otherwise been necessary had he been timely and properly diagnosed and treated during the course of his admission. Nurse Weber opines that the defendant's departures are related to the damages to the plaintiff, which included extensive follow-up hospitalizations, debridement procedures, and therapies over a period of months.

On this record, the court finds significant issues of fact that preclude summary judgment. In particular, the plaintiff submits evidence, including through the affidavit of Nurse Weber, that raise questions of whether the defendant failed to timely and appropriately assess and diagnose plaintiff's decubitus ulcer, which was diagnosed shortly after his readmission to St. Francis Hospital. Moreover, there is a question as to whether the nursing staff appropriately followed the written protocol for this patient, and sought the necessary interventions during his admission to defendant's facility. Conflicting expert opinions supported by facts in the record are sufficient to raise an issue of fact regarding medical malpractice. Thus, the plaintiff has established the existence of material issues of fact with respect to whether the hospital's care and treatment of the plaintiff deviated from the acceptable medical standards resulting in injury to the plaintiff. (*Pichardo v St. Barnabas Nursing Home, Inc.*, 134 AD3d 421, 424 [1st Dept 2015]; *Kytka v Dry Harbor Nursing Home & Rehabilitation Ctr., Inc.*, 26 Misc 3d 1207[A] [Sup Court Richmond County 2010]). Moreover, despite defendant's contentions that plaintiff's claim for home care is improper because of his co-morbidity, the issue of compensation for plaintiff's out-of-pocket expenses is a matter for the jury.

With respect to the motion to vacate the note of issue and certificate of readiness, defendant seeks an order compelling plaintiff to provide complete copies of his tax returns, or, in the alternative, precluding the plaintiff from introducing evidence of his alleged lost earnings at the time of trial. By order dated January 24, 2018, this court ordered the plaintiff to provide his tax returns for the years 2014, 2015 and 2016 within ten days of service of notice of entry and granted defendant leave to renew should plaintiff fail to produce these items.

Defendant points out that plaintiff's bill of particulars, served February 20, 2016 indicated that the plaintiff's lost earnings would be particularized at a later time. Defendants contend that in response to its motion, plaintiff provided only the 1040 forms for the calendar years 2010-2016, showing only totals, but without any of the supporting schedules. Defendant contends that because the plaintiff is a sophisticated investor and real estate owner, the 1040 forms did not provide detailed information other than summary amounts. Without such detail, defendant contends that it cannot assess plaintiff's claim for lost profits.

In opposition, plaintiff contends that vacature is not warranted because complete tax returns have now been provided for all tax years in question. In reply, defendant acknowledges that the plaintiff has produced what appears to be complete records but contends that rather than complying with the court's prior order within ten days as directed, plaintiff produced 1,800 pages of documents on June 22, 2018. Defendant submits that this delay was willful and contumacious and created prejudice in preparing for trial. Thus, defendant presses the issue of vacature.

Vacature at this point would be an extreme measure and this aspect of defendant's motion is denied. However, because of the plaintiff's willful disregard of the court's prior unequivocal order, the imposition of costs and fees may well be appropriate and the court will entertain an application for the same should the defendant seek such relief. (22 NYCRR § 130-1.1).

For the foregoing reasons, it is hereby

ORDERED, that the defendant's motion for summary judgment is **denied**; and it is further

ORDERED, that the defendant's motion to renew its application to vacate the note of issue and certificate of readiness is **granted** and upon renewal, the note of issue and certificate of readiness are **not vacated**.

This constitutes the decision and order of this Court. All applications not specifically addressed herein are denied.

Dated: Mineola, New York
September 27, 2018

ENTER:

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