Short Form Order

SUPREME COURT – STATE OF NEW YORK
TRIAL TERM, PART 7 NASSAU COUNTY

PRESENT:

Honorable Karen V. Murphy
Justice of the Supreme Court

x

WINNIE J. ESPADA, as ADMINISTRATRIX of the Estate of RIGOBERTO ESPADA, Deceased,

Plaintiff,

-against-

TOWNHOUSE OPERATING CO. LLC d/b/a TOWNHOUSE CENTER FOR REHABILITATION AND NURSING,

Defendants.

x

Index No. 610066/2016

Motion Submitted: 10/10/19
Motion Sequence: 002

The following papers read on this motion:

Notice of Motion/Cross-Motion.....	X
Answering Papers.....	X
Reply.....	X
Briefs: Plaintiff's/Petitioner's.....	
Defendant's/Respondent's.....	

Upon the foregoing papers, the motion by defendant, Townhouse Operating Co., LLC, d/b/a Townhouse Center for Rehabilitation for Rehabilitation and Nursing (hereinafter defendant) for an Order, pursuant to CPLR 3211(a)(5), dismissing all claims as to care of the decedent, Rigoberto Espada (hereinafter decedent), for the time period predating August 15, 2013 as time barred by the applicable three-year limitations periods governing causes of action for violations of PHL 2801-d, negligence and gross negligence; for an Order pursuant to CPLR 3212, granting summary judgment to defendant dismissing plaintiff's complaint in its entirety and directing the Clerk to enter Judgment in defendant's favor or in the alternative, for an Order, pursuant to CPLR 3212,

granting partial summary judgment dismissing plaintiff's claims for punitive damages, are determined as provided herein.

This is an action for nursing home negligence. Plaintiff seeks to recover damages for negligence, gross negligence, punitive damages and wrongful death based upon the defendant's alleged failure to take proper actions to prevent, diagnose, and treat decedent's bed sores a/k/a pressure sores from February 16, 2016 up until March 31, 2016, the date decedent was transferred to Winthrop Hospital. Defendant is a residential health care facility as defined in PHL 2801(3) and therefore had a duty to comply with PHL 2801-c as well as 42 USC 1395(I) et. seq., 42 CFR 483 et. seq., and all sections of 10 NYCRR 415. Plaintiff's decedent was a resident of defendant's nursing home from 2008 – 2016. The decedent was 57 years old when he was first admitted to the nursing home on September 11, 2008. Decedent presented from St. John's Queens-Hospital with a history of cerebrovascular accident (CVA) with residual left hemiparesis, Parkinson's disease, diabetes mellitus, unstable angina, diabetes, hypertension, hyperlipidemia, Benign Prostate Hypertophy (BPH) and he was status-post cardiac catherization. The alleged lack of care and treatment that gives rise to this action occurred in February and March 2016. According to decedent's death certificate, decedent died at age 64 on August 15, 2016, four months after he last resided at defendant's nursing home, due to cardiopulmonary arrest caused by atherosclerotic heart disease. The defendant presently seeks summary judgment dismissing the complaint against it.

To the extent that the defendant is seeking an Order dismissing all claims as to the care of the decedent for the time period predating August 15, 2013 as time barred by the applicable three-year limitation periods governing causes of action for violations of PHL 2801-d, negligence and gross negligence, the defendant's application is granted. In plaintiff's Affirmation in Opposition, dated August 20, 2019, she has withdrawn all claims for injuries allegedly sustained by the decedent prior to February 15, 2016. Accordingly, the Court grants summary judgment to defendant for all claims relating to the care defendant provided to the decedent prior to February 15, 2016 and all such claims in the plaintiff's complaint are dismissed and the Clerk is Ordered to enter said judgment in favor of the defendant.

It is well settled 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 (***Winegrad v. New York Univ. Med. Center***, 64 N.Y.2d 851, 853, 487 N.Y.S.2d 316, 476 N.E.2d 642; ***Zuckerman v. City of New York***, 49 N.Y.2d 557, 562, 427 N.Y.S.2d 595, 404 N.E.2d 718; ***Sillman v. Twentieth Century-Fox Film Corp.***, 3 N.Y.2d 395, 404, 165 N.Y.S.2d

498, 144 N.E.2d 387). Failure to make such prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v. New York Univ. Med. Center,*** *supra,* 64 N.Y.2d at p. 853, 487 N.Y.S.2d 316, 476 N.E.2d 642). Once this showing has been made, however, 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 (***Zuckerman v. City of New York,*** *supra,* 49 N.Y.2d at p. 562, 427 N.Y.S.2d 595, 404 N.E.2d 718; ***Alvarez v Prospect Hosp.,*** 68 NY2d 320, 324 [1986]).

In support of its motion, the nursing home has submitted the affirmation of Barbara Tommasulo, who is Board Certified in Internal Medicine and Geriatric Medicine. Having reviewed the pertinent medical and legal records, she opines to a reasonable degree of medical certainty as follows:

Dr. Tommasulo opines that the care and treatment of the decedent's ulcers and the care plan formulated and implemented conformed to accepted standards of medical care and were reasonable, adequate and appropriate. She further opines that there were no departures or failures to act in accordance with accepted medical standards by any of the staff at the nursing home in their care and treatment of the decedent that proximately caused his injuries or death. Dr. Tommasulo also opines that the decedent did not sustain any injuries that were proximately caused by the nursing home's staff's violation of any specific duties imposed by statute. On account of the alleged lack of proximate cause, she seeks dismissal of the cause of action sounding in wrongful death. She opines that the nursing home's staff's care and treatment of the decedent did not amount to a deprivation of his nursing home rights or benefits and that there is no evidence of conduct that is so recklessly or wantonly negligent as to be the equivalent of a conscious disregard for the rights of others, or smacks of intentional wrongdoing. Therefore, she opines that the cause of action for gross negligence must be dismissed as well. Finally, she opines that the nursing home's staff's care and treatment of the decedent did not amount to a deprivation of his nursing home rights or benefits and that there is no evidence of intentional or reckless conduct. Therefore, she opines that the request for punitive damages must be dismissed as well.

Dr. Tommasulo notes that the decedent's health was in a debilitated and medically compromised state which rendered the complete healing of decubitis ulcers difficult, if not impossible. She notes that the care plan in effect in February 2016, when the negligence and malpractice were alleged to have begun, called for turning and repositioning every two hours, encouraging the decedent to change his position in bed, use of a pressure relief mattress, pressure relieving devices for chairs, topical medicines,

preventive skin care at every shift, monitoring for redness of the skin or skin breakdown, toileting, a therapeutic diet, hydration interventions and treatments and medications as ordered by doctors. Dr. Tommasulo opines that this care plan was proper and that the decedent's records reflect that it was properly implemented. She opines that the decedent's chart reflects that the plan was followed, negating the plaintiff's allegations that his decubits ulcers were not properly evaluated, monitored and treated; that he was not turned and repositioned every two hours; that the seriousness of his ulcers was not fully appreciated; and, that the ulcers were permitted to advance to a severe stage on account of a failure to provide timely and proper wound care. She also opines that the care plan conformed with the Federal and State regulations regarding the care of pressure ulcers in a nursing home. Dr. Tommasulo further opines that the plan was revised as warranted throughout the decedent's admission at the nursing home.

Dr. Tommasulo opines that the decedent's dramatically compromised state of health eventually made his worsening status unavoidable. In fact, she opines that the skin lesions that ultimately developed in February and March of 2016 (bilateral heels/sacral/buttocks/ischium), shortly before his transfer from the facility on March 31, 2016 , were clinically unavoidable, secondary to the relentless progression of Parkinson's disease with its associated end-stage debility, dementia and dysphagia in the setting of an unavoidable infection, in addition to the above-mentioned medical co-morbidities, including longstanding peripheral vascular disease, anemia, diabetes mellitus, heart disease (which required cardiac catheterization) and hyperlipidemia.

Dr. Tommasulo opines that the decedent's decline was caused by his co-morbidities and lack of mobility which rendered it unlikely that the decedent's ulcers would heal. She also notes that the decedent's decreased oxygen levels also compromised the ability of his ulcers to heal. She explains that sufficient oxygen levels are necessary to cell metabolism and energy production which are critical to the wound healing process. Furthermore, the decedent's oxygen levels were severely inadequate for healing. The decrease in oxygen in his blood inhibited the essential nourishment of skin tissue thereby impairing healing. Similarly, Dr. Tommasulo opines that the decedent's catabolic state which included a destructive metabolic process rendered decedent's body unable to convert nutrients to living tissue which is essential to wound healing. Despite efforts to increase the decedent's protein, his body was unable to synthesize it to promote wound healing. Dr. Tommasulo also opines that the decedent's compromised nutritional state also impaired wound healing. In fact, Dr. Tommasulo opines that the decedent's co-morbidities are factors that contribute to the formation of pressure ulcers.

In opining that the care given to the prevention and healing of ulcers conformed with applicable medical standards, Dr. Tommasulo notes that other ulcers did eventually

heal. As far as the deficiencies in turning and repostitioning the decedent, she notes that his co-morbidities contributed immensely to his physical condition. Similarly, as for his nutritional state, she notes that the decedent's nutritional compromise was not only unavoidable, it was exacerbated by his own inability to chew and swallow food which further inhibited wound healing. Even with maximum nutrition, it is difficult to maintain or restore body weight during a catabolic state. Clearly, the skin, with its rapidly dividing cells/constant turnover, is at increased risk of breakdown and impaired healing when the body is in a prolonged catabolic state, as is true in decedent's case.

As for the plaintiff's allegation that the nursing home acted improperly with respect to the risk and treatment of infections, Dr. Tommasulo opines that the staff at the nursing home conducted all reasonable and practical steps in controlling, identifying and treating infections. Hospitalizations, diagnoses and medications including antibiotics were timely implemented. And, there is no indication that the ulcers were a source of infection. Adequate and proper interventions were taken. As for the plaintiff's allegation that supervision was inadequate and that defendant was negligent in failing to prevent falls, Dr. Tommasulo notes that no evidence of injuries resulting therefrom have been advanced. The plaintiff's claim that supervision did not conform with PHL § 2801-d and that there was negligence in preventing falls accordingly fails.

Dr. Tommasulo opines that the applicable federal and state regulations, i.e., 42 CFR 483.25 (c) and 10 NYCRR 415.12 (c) were not violated. Those regulations require the facility to ensure that a resident that enters the facility without pressure sores does not develop them unless they are "unavoidable" in light of his or her condition. The state regulation also requires that they were unavoidable "despite every reasonable effort to prevent them." Those regulations also require the facility to provide the resident with necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Dr. Tommasulo opines that the nursing home complied with the aforementioned requirements as the decedent's risk factors and risk of ulcers was known as indicated by the development and implementation of preventive care plans to prevent ulcers and skin breakdown. She opines that adequate and appropriate interventions were instituted in response to the decedent's risk factors as evidenced by the healing of some of his ulcers. In addition, she notes that the decedent was treated to prevent infection and new sores. Dr. Tommasulo opines that the lesions were clinically unavoidable considering the decedent's myriad risk factors and medical co-morbidities like Parkinson's disease. Dr. Tommasulo has established the defendant's *prima facie* entitlement to summary judgment dismissing the claims sounding in negligence. In view of the fact that the nursing home has established that none of the decedent's injuries were the result of any negligence or gross negligence on its part, it has established its entitlement to summary judgment dismissing the wrongful death claim, as well (***Anonymous v Gleason***, 175

AD3d at 617; ***Henry v Sunrise Manor Ctr. for Nursing and Rehabilitation***, 147 AD3d 739, 740 [2d Dept 2017]).

Turning to the alleged violations of the decedent's nursing home rights and claim sounding in negligence *per se* "[liability under the PHL [§ 2801-d] contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule, subject to the defense that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient...." (***Gold v Park Ave. Extended Care Ctr. Corp.***, 90 AD3d 833, 834 [2d Dept 2011], quoting PHL§ 2801-d [1], [2]; citing CPLR 214 [2]; *see also*, ***Novick v S. Nassau Communities Hosp.***, 136 AD3d 999, 1001 [2d Dept 2016]). The nursing home has established its prima facie entitlement to judgment as a matter of law on that branch of its motion which was for summary judgment dismissing the cause of action which is based on PHL § 2801-d as well as state and federal regulations via Dr. Tommasulo's affirmation. She has established, inter alia, that the preventive measures and care provided with respect to the decedent's ulcers conformed with the obligations imposed by those laws. The decedent's status was regularly evaluated and responded to. Nor is there evidence to support any of the other alleged regulatory violations including "quality of life," accidents, medication errors, nursing services, dietary services, infection control or clinical records. Dr. Tommasulo has accordingly established that the decedent's rights were not violated since the care and treatment provided by the defendant nursing home did not violate the various federal and state regulations set forth in the plaintiff's bill of particulars as the basis for this cause of action. Furthermore, even if any were violated, none of the alleged injuries was proximately caused by these violations (***Gold v Park Ave. Extended Care Ctr. Corp.***, 90 AD3d at 834 [citations omitted], citing PHL § 2801-d [1]; ***Craig v St. Barnabas Nursing Home***, 129 AD3d 643, 644 [1st Dept 2015] ["The medical records support the nursing home's expert's opinion that decedent's skin ulcers and other complications were unavoidable and the result of preexisting conditions, as well as other risk factors," citing ***Negron v. St. Barnabas Nursing Home***, 105 AD3d 501 [1st Dept.2013]). Dr. Tommassulo has also established the defendant's entitlement to summary judgment dismissing the claims premised on violations of the PHL.

The nursing home has also established its prima facie entitlement to judgment as a matter of law dismissing the request for punitive damages both generally and under the PHL by demonstrating that its "conduct did not evidence a high degree of moral culpability, was not so flagrant as to transcend mere carelessness and did not constitute willful or wanton negligence or recklessness" (***Rey v Park View Nursing Home, Inc.***, 262 AD2d 624 [2d Dept 1999] [citations omitted]) and that their conduct was not in willful or reckless disregard of the decedent's rights (***Valensi v Park Ave. Operating Co., LLC***, 169 AD3d 960, 962 [2d Dept 2019] [citations omitted]). Construing the evidence

in a light most favorable to the non-movant plaintiff, the defendant has met its burden of establishing "the absence of any conduct that could be viewed as so reckless or wantonly negligent as to be the equivalent of a conscious disregard of the rights of others (citations omitted)" (***Vissichelli v Glen-Haven Residential Health Care Facility, Inc.***, 136 AD3d 1021, 1023 [2d Dept 2016]).

The burden shifts to the plaintiff to establish the existence of material issues of fact with respect to negligence, gross negligence, wrongful death, claims founded on the Public Health Law and punitive damages.

In opposition to the nursing home's motion, the plaintiff has submitted the affirmation of Dr. Perry Starer who is Board Certified in Internal and Geriatric Medicine. Having reviewed the pertinent medical and legal records, he opines to a reasonable degree of medical certainty as follows:

Dr. Starer opines that the nursing home departed from the appropriate standards in caring for the decedent and that those departures were the proximate cause of his injuries and his death. He opines that defendant departed from standards of medical and nursing care of the decedent in that they failed to provide adequate and appropriate medical care and that their actions were a substantial factor in causing the development of the decedent's numerous ulcers; sepsis; septicemia; gangrene; osteomyelitis; a reduced mental state; anemia; elevated white blood cell count; an inability to perform the activities of daily life; infections; dehydration; malnutrition; weakness; shortness of breath; loss of appetite; weight loss; severe conscious; pain and suffering; and death. He also opines that the nursing home's staff violated the PHL and Federal and State regulations in their care of the decedent and deprived him of his rights as a resident of a nursing home.

Dr. Starer opines that the nursing home failed to implement an appropriate care plan to prevent the decedent's skin breakdown or to update the care plan to prevent pressure ulcers from worsening once they formed. He explains that a proper plan necessitated protection from pressure on the decedent's heels and on his bony prominences since he was of limited mobility. Dr. Starer opines that the ulcers that formed were avoidable and that all possible measures were not taken to prevent or treat them. Dr. Starer alleges that there is no record of the decedent being properly turned and repositioned from February 2016 - March 2016; He opines that a lack of documentation means that this was not done. Considering the decedent's subsequent development of ulcers, he opines that the nursing home's failure to turn and reposition the decedent caused the ulcers to form. He opines that the failure to turn the decedent every two hours during this time period constituted a deprivation of his rights under 42 CFR § 483.25 (b) and 10 NYCRR 415.12 (c) and that this deprivation of the decedent's rights was a

proximate cause of the development and progression of his ulcers. Dr. Starer opines that it was the nursing home's staff's responsibility to find a way to make him comfortable when turned and repositioned such as by using cushions, wedges and turning sheets to accommodate him. Dr. Starer opines that the failure to assure that the decedent was turned and repositioned was a cause of the development of his ulcers. Since every reasonable effort to turn and reposition the decedent was lacking, Dr. Starer opines that his ulcers were avoidable.

Dr. Starer also opines that the nursing home violated 42 CFR §§ 483.25 and 483.21 by failing to maintain the decedent's nutrition. He also alleges that the nursing home failed to monitor and assess the decedent's protein stores which effected wound healing. Similarly, he opines that it failed to provide speech therapy to ensure that the decedent was swallowing properly. Pointing to the decedent's weight loss, Dr. Starer opines that the nursing home failed to implement nutritional interventions in violation of 42 CFR § 483.21

Dr. Starer opines that the decedent was deprived of his right to be treated with dignity in that his needs were not always met since he was not turned as scheduled or fed in accordance with his plan. He attributes this to a lack of staff. He also opines that such care was reckless.

Dr. Starer opines that Dr. Tommasulo fails to address the lack of documentation in the record of the preventive interventions in place, and more importantly, how they were implemented in the preceding days prior to the ulcers being noted in the chart on February 25, 2016, is a fatal flaw in her opinion that the nursing home is missing some of decedent's medical records regarding the nurses rotating and repositioning the decedent every two hours, the decedent's wound care treatment and planning records and the nursing shift staffing sheets. (*see* plaintiff's exhibits D and E). Glaringly omitted, however, is any reference to the turning and repositioning forms that Nurse Faucher testified would be prepared to document that the turning and positioning schedule of at least every two hours was being carried out. Most importantly, a review of the extensive turn and reposition schedule records contained in decedent's chart reveal that there are no records for February -March 2016. (*see* defendant's Exhibit K, p. 5743 -5864). Additionally, prominently lacking from Dr. Tommasulo's affirmation are any references to Progress notes by the nurses documenting that decedent was being turned and positioned from February 23, 2016, when he was noted to be lethargic in bed up until the ulcers were noted in the chart on February 25, 2016. Dr. Starer opines that the absence of documentation of turning and positioning in the nurse's notes in the days preceding the development of the ulcers, coupled with the absence of the turning and positioning forms,

is overpowering evidence that a turning and positioning schedule was not being carried out.

Dr. Starer opines that on February 25, 2016, decedent was seen by Wound Care Consultant, Dr. Andrew Isopo notes in the Wound Care Assessment records (see defendant's Exhibit H) decubitus ulcers to the right and left heels and left hip and classifies them as deep tissue injuries. Significantly, Dr. Isopo notes the "healing potential' for these wounds as "reasonable." Dr. Starer opines that this assessment is demonstrably inconsistent with Dr. Tommasulo's opinion that decedent's injuries were unavoidable, since the same risk factors considered for a patient developing pressure ulcers are also considered for a patient's healing potential. As to changes in the plan of care, there are no changes noted regarding the skin integrity and the presence of skin breakdown on right buttock, left hip and bilateral heels until the earliest March 1, 2016, and a review of the Skin Integrity section of the Care Plan Activity Report indicates Nurse Faucher did not make entries updating the Goals and Interventions in the care plan until March 7, 2016. (see Defendant's Exhibit F at p 181 -185). Decedent's care plan should have been updated as early as February 15, 2016 when NP Britton-Morris specifically noted to "monitor for skin breakdown/ulceration; encourage use of protective footwear; offload pressure areas." This was not done.

Dr. Starer opines that on February 23, 2016, when decedent was noted to be lethargic in bed, which represented a significant change in his condition, the care plan should have been updated with respect to monitoring for skin care and implementing specific prevention measures, such as following a patient repositioning schedule, off-loading his heels with pillows, using pressure-reducing services. There is no documentation that this was done and certainly Dr. Tommasulo does not speak to this issue. Dr. Starer opines, most importantly, when the pressure ulcers to right heel, left heel, and left hip were noted in the chart for the first time on February 25, 2016 the standard of care necessitated that the care plan be updated immediately. However, the care plan regarding skin integrity was not updated until at least March 1, 2016, and the specific prevention measures were not entered until March 7, 2016. Dr. Starer opines that the nursing home staffs' failure to promptly conduct a comprehensive assessment and update the care plan, violated 10 NYCRR 415.11, and those failures were a substantial factor in causing decedent's injuries.

Dr. Starer opines that the decubitus ulcers of the right heel, left heel, left hip, right buttock, left ischium and sacrum noted in the chart were avoidable and would not have developed if the nursing home staff developed, implemented and updated a proper care plan for pressure ulcer/skin breakdown prevention for decedent, performed proper and

timely pressure relief intervention and turned and positioned decedent's body at least every two hours.

Dr. Starer opines that in connection with the development of pressure ulcers during decedent's admission that the staff at the nursing home failed to comply with the respective Federal and New York State regulations 42 CFR 483.25 c and 10 NYCRR 415.12 c ("The facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.") and (a resident having pressure sores receives the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing".)

Dr. Starer opines that decedent developed infection, including sepsis and osteomyelitis, because of the Stage IV sacral decubitus ulcer he developed while a resident at the nursing home. Dr. Bagdig Baghdassarian's Winthrop University Hospital Discharge Summary Progress Note of April 8, 2016, (see Plaintiff's Exhibit H) which reads in part: "This is a 64-year old man with a past medical history of dementia, Parkinson, (bed bound). HTN. GERD, seizures, CAD, HDL, depression, DM who is presenting with abdominal pain, lethargy found to be in sepsis from Stage IV sacral decubitus ulcer." Furthermore, a surgical pathology revealed that the result of a sacrum bone biopsy was positive for acute osteomyelitis. (*see* Winthrop University Wound Healing PA Note of 4/15/16 annexed to Plaintiff's Exhibit I) and the final diagnosis in the Discharge Summary Progress Note was sepsis secondary to acute osteomyelitis not related to diabetes. (*see* Plaintiff's Exhibit H). Dr. Starer espouses that this confirms that the sacral ulcer was the source of the infection and thus refutes Dr. Tommasulo's assertion of diabetes as a potential cause of infection. Accordingly, Dr. Starer opines that decedent's development of infection, including sepsis and osteomyelitis, were caused by the Stage IV sacral decubitus ulcer he developed while a resident at defendant nursing home.

Dr. Starer opines that decedent's septic condition, that was secondary to osteomyelitis caused by decedent's Stage IV sacral decubitus ulcer, contributed to the malfunctioning of various organs, including his heart and lungs, thereby placing his body in a catabolic state superimposed on a patient with a history of coronary artery disease, was a substantial factor in causing his cardiopulmonary arrest and death.

Dr. Starer opines that the staffing was insufficient to provide adequate nursing and related services to the decedent to ensure his safety and well-being in accordance with 42 CFR 483.35 and 10 NYCRR 415.13 and that was a substantial factor in causing him to develop multiple decubitus ulcers, osteomyelitis, sepsis and death. Dr. Tommasulo's

affirmation makes no reference to the daily assignment sheets that Nurse Faucher testified would reveal the actual staff present on any given shift on given day. (Faucher; p 39). Likewise, no references were made to the Patient Acuity Records or Case Index records that Director of Nursing Carol Frawley testified are utilized to indicate the acuity of every resident on the unit, which can then be used to determine the level of care a nursing unit requires. (Frawley; p 84-86). Nor does she reference any testimony of Daniel Schaffer, the Administrator at defendant nursing home, and what factors he considered in formulating staffing plans, such as Par Staffing Level Plans and the Case Mix Index Records. (see Schaffer's deposition, Plaintiff's Exhibit J:21-28;81-83). Moreover, these records are also inexplicably no longer available for review. (*see* Affidavits of Nina Jose, RN dated July 19, 2018; Plaintiff's Exhibit D and E). It is well established that insufficient staffing in a nursing home facility can lead to adverse and negative outcomes.

Insufficient staffing can result in residents not getting the level of assistance in their daily living activities as indicated based on their acuity and diagnoses. This is often evidenced by poor or lack of documentation in the resident's chart. Proper documentation is how the staff and caregivers communicate with each other and is crucial for continuity of care from shift to shift in a nursing facility to maintain the highest practicable physical, mental and psychosocial well-being of each resident. The failure to provide sufficient staffing can also lead to neglect, and the development of pressure ulcers are often the result of such neglect, as here.
Dr. Starer notes that Nurse Faucher, as the nurse manager in February and March 2016, was responsible for both 2 North and 2 South and 80 residents as to previously only for one unit and 40 residents, and LPNs from a total of 4 for the two units or 80 beds to a total of 3, with 1 LPN per unit and the third LPN splitting her shift time between the two units. (Faucher:29-37). It is evident from Nurse Faucher's testimony that the staffing changes at defendant nursing home gave no consideration for the acuity or conditions of the residents or their level of assistance for their functional needs for activities of daily living but were done solely for budgetary reasons based upon corporate policy, which is a clear-cut violation of CFR 483.35 and 10 NYCRR 415.13. Accordingly, Dr. Starer opines that the staffing levels at the defendant nursing home was insufficient to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident and was a substantial factor causing decedent to develop multiple decubitus ulcers, osteomyelitis, sepsis and death.

Accordingly, the plaintiff has established the existence of a material issue of fact with respect to the nursing home's care and treatment of the plaintiff (***Gilmore v Mihail***, 174 AD3d 686, 688 [2d Dept 2019]). Simply put, he has demonstrated an issue of fact regarding the prevention and causation of the decedent's ulcers (***Cummings v Brooklyn***

Hosp. Ctr., 147 AD3d 902 [2d Dept 2017]; ***Novick v S. Nassau Communities Hosp.***, *supra*; ***Gold v Park Ave. Extended Care Ctr. Corp.***, *supra*]).

Dr. Starer has established a question of fact as to whether the nursing home's care of the decedent lead to the development of the decedent's ulcers or that it acted negligently in treating them. Dr. Starer has established a question of fact as to whether the nursing home's alleged mistreatment of the decedent played a role in his demise. Furthermore, Dr. Starer's opinion has established the existence of material issue of fact regarding the nursing home's alleged violations of statutory or regulatory requirements and he has demonstrated that there is an issue of fact with respect to any proximate cause from any such violations. (***Moore v St. James Health Care Ctr.***, *LLC, supra*; ***Novick v S. Nassau Communities Hosp.***, *supra*; ***Gold v Park Ave. Extended Care Ctr. Corp.***, *supra*]).

Dr. Starer opines that the conduct of defendant nursing home's staff, owners and administrators represented a reckless and gross failure to provide adequate supervision and appropriate medical care and a reckless deviation from the acceptable standard of care. Defendant's actions and inactions were willful and a reckless disregard of decedent's rights as a nursing home resident. Furthermore, the inexplicable loss or destruction of records critical to the issues in this matter including the turning and positioning forms, skin change occurrence reports, daily assignment sheets, patient acuity and case mix index records and staffing level plans, evidences a high degree of moral culpability and conduct that is so flagrant as to transcend mere carelessness but conduct that constitutes willful or wanton negligence or recklessness. Finally, Dr. Starer opines that defendant's actions and inactions were willful and a reckless disregard of decedent's rights as a nursing home resident and said departures were a substantial factor in causing decedent's injuries.

Summary judgment is a drastic remedy which should not be granted if there is any doubt as to the existence of triable issues (***Barclay v. Denckla***, 182 AD2d 658 [2d Dept 1992]). In the instant matter, plaintiff's and the defendant's documentary evidence together with sharply conflicting affidavits and affirmations raise triable issues of fact precluding summary judgment (***McEvoy v. Garcia***, 114 AD2d 401 [2d Dept 1985]).

The plaintiff has met her burden of demonstrating the existence of material issues of fact. The defendant's motion seeking dismissal of plaintiff's complaint is denied except for that branch of defendant's motion seeking dismissal of plaintiff's claim for injuries due to any falls, which is granted.

All matters not decided herein are denied.

This constitutes the decision and Order of this Court.

Dated: December 18, 2019
Mineola, N.Y.

Karen V. Murphy
J. S. C.

ENTERED
JAN 0 2 2020
NASSAU COUNTY
COUNTY CLERK'S OFFICE