Little v Isabella Geriatric Ctr., Inc.
2020 NY Slip Op 32273(U)
July 1, 2020
Supreme Court, New York County
Docket Number: 805280/2014
Judge: George J. Silver
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Index No. 805280/2014

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10
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CHERYL LITTLE, as Administrator of the Estate of MICHAELA LITTLE, deceased,

Decedent,

Index No. 805280/2014
Motion Seq. 003

-v-

DECISION & ORDER

ISABELLA GERIATRIC CENTER, INC., MOUNT SINAI ROOSEVELT HOSPITAL d/b/a ST. LUKE'SROOSEVELT HOSPITAL CENTER, MOUNT SINAI ROOSEVELT HOSPITAL, ST. LUKE'SROOSEVELT HOSPITAL CENTER and NEW YORK PRESBYTERIAN HOSPITAL-COLUMBIA UNIVERSITY MEDICAL CENTER,

Defendants.
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GEORGE J. SILVER, J.S.C.:

Defendant NEW YORK PRESBYTERIAN HOSPITAL-COLUMBIA UNIVERSITY MEDICAL CENTER ("NYPH" or "defendant") moves for summary judgment. Plaintiff CHERYL LITTLE ("plaintiff"), as administrator of the estate of MICHAELA LITTLE ("decedent"), deceased, opposes the motion. For the reasons discussed below, the motion is granted in part.

On March 31, 2005, decedent, then 54-years-old, was admitted to Isabella Geriatric Center, Inc. ("Isabella") following a surgery to her right foot, which included amputations to her second, third, fourth, and fifth toes. At the time of admission, decedent had decubiti, which was described as gangrene on her right foot. Decedent was discharged on April 18, 2005.

Decedent had two other admissions at Isabella in 2006 and 2007. Decedent had a primary diagnosis of right foot osteomyelitis, hypertension, diabetes mellitus, and peripheral vascular

disease. Decedent underwent physical and occupational therapy, and was taught self-care for activities of daily living.

On October 12, 2011, decedent presented to NYPH via ambulance with complaints of flank pain for one week and a pulling sensation over her lower abdomen during urination. Decedent reported a history of coronary artery disease ("CAD"), acute kidney disease, and hypertension. Decedent had also previously undergone a coronary artery bypass grafting ("CABG"), a right superior femoral artery angioplasty, an amputation to her right foot and left fifth toe, and a right foot wound debridement. Upon examination, decedent's right foot wound was open, and had an odor. Decedent had an elevated glucose level, and her urinalysis was positive for infection. A CT scan of decedent's abdomen and pelvis was significant for non-obstructing renal stones, and decedent had air in her bladder. Decedent was then admitted to NYPH for intravenous ("IV") antibiotics for emphysematous cystitis.[1] Upon discharge on October 15, 2011, decedent was prescribed with Keflex, and was advised to follow up with her primary care physician ("PCP") and vascular surgery for her right foot ulcer.

On October 26, 2011, decedent returned to NYPH with recurring dysuria,[2] back pain, and a non-healing ulcer on the bottom of her right foot. Upon examination, decedent had a 2 x 2 centimeter ("cm") right plantar ulcer with purulent discharge. The ulcer was malodorous with no erythema, fluctuance, or induration. Decedent was admitted to the hospital, and a surgical consult was requested for a possible debridement procedure, however, no intervention was indicated. Decedent was discharged on October 29, 2011 with instructions to follow up with her PCP.

In January of 2012, decedent was admitted at Isabella for wound care and pain control following a debridement procedure of her right foot osteomyelitis.

[1] Emphysematous cystitis refers to inflammation of the bladder wall caused by gas-forming bacteria.
[2] Dysuria is painful or difficult urination.

From March 1, 2012 to March 14, 2012, decedent was admitted to St. Luke's-Roosevelt Hospital Center ("St. Luke's") due to generalized weakness and anemia. Decedent received two units of packed red blood cells. Decedent subsequently developed an electrolyte imbalance and difficulty breathing, and was diagnosed with chronic renal failure. Decedent was started on hemodialysis, and had an AV graft inserted. On March 12, 2012, it was noted that decedent had developed a stage II pressure ulcer on her right gluteal area. On March 14, 2012, decedent was discharged to Isabella with instructions to follow up at the renal clinic in two weeks.

On March 21, 2012, decedent returned to St. Luke's due to shortness of breath. Decedent was admitted for two days for observation, and subsequently requested to return to Isabella.

On May 7, 2012, a nurse at Isabella documented that decedent had developed a stage II pressure ulcer on her right gluteal area, and that decedent had lost 33 pounds over the past month. It was also noted that decedent was non-compliant with wound care, and that decedent mostly slept in a chair. On May 10, 2012, it was noted that decedent had fallen, but there were no visible wounds, and on May 14, 2012, it was documented that decedent had a left middle finger infection. Decedent was referred to NYPH for evaluation of the wound for a possible debridement.

On May 22, 2012, decedent presented to St. Luke's with complaints of pain and swelling to her left middle finger for the past three weeks. Upon examination, decedent had multiple decubitus ulcers, including a stage IV sacral ulcer measuring 7 x 6 x 1.5 cm, and a stage III coccyx ulcer that measured 1 x 1 cm. Decedent also had chronic osteomyelitis secondary to her right foot amputation. Vascular surgery was consulted, and it was documented that decedent previously had a synthetic fistula graft inserted for hemodialysis which became occluded, and led to the swelling of decedent's left middle finger.

On May 24, 2012, decedent underwent an AV graft ligation, which improved the swelling of her finger. On May 30, 2012, decedent was discharged to Isabella. Upon decedent's return to Isabella, decedent had an ecchymosis[3] on her right upper extremity, three staples on her left upper extremity from the AV fistula ligation, a stage IV decubitus ulcer on her right ischial area, a stage III ulcer on her right buttock, a right transmetatarsal ("TMA") wound with swelling and necrosis.

On June 4, 2012, decedent reportedly fell, but she did not have any apparent injuries. On June 7, 2012, decedent had shortness of breath and facial/eyelid edema. Decedent was also lethargic, and had a hypoglycemic[4] episode. Decedent received glucose, and was transferred to St. Luke's, where she was "diuresed," and given IV insulin. On June 11, 2012, decedent was discharged to Isabella. Upon decedent's return to Isabella, decedent had a stage IV right ischium/posterior thigh ulcer, a stage III sacral ulcer, and an opening/tear of the skin at left genital area. Decedent also reported that she had a persistent cough with white sputum, and sacral and right foot pain.

On June 13, 2012, one of the admissions at issue, decedent had a hypoglycemic episode, and was transferred to NYPH. Upon decedent's admission, it was noted that decedent had a fungal rash on her left breast fold, a stage II sacral pressure ulcer, a stage IV malleolus right venous stasis ulcer, a left third finger ulcer, and a right ischial tuberosity pressure ulcer. Decedent had a blood pressure of 175/63, a heartrate of 68, and an oxygen saturation level of 76%. Decedent also had an elevated white blood cell ("WBC") count of 19.1, consistent with an infectious process, and a low albumin level, consistent with severe malnutrition. A physical examination was notable for bibasilar crackles, diffuse bilateral wheezing, perineal drainage, and a gangrenous left third finger. Decedent had transient hypertension, and was given Lasix, Azithromycin, and Albuterol/Atrovent

[3] An ecchymosis is a collection of blood under the skin (a type of bruise).
[4] Hypoglycemia refers to low blood sugar.

nebulizer. Decedent was admitted to rule out pneumonia, sepsis, and a myocardial infarction. Orthopedics also evaluated the gangrene on decedent's left third digit.

That same day, an orthopedic consult noted that decedent's left upper extremity had a grossly swollen left third digit without extension over the metacarpals. There was an open wound over the distal interphalangeal joint with no frank pus or bloody discharge. However, there was a serous layer covering the wound. Decedent's ulnar and radial pulses were palpable, and decedent's second, fourth, and fifth digits were warm and well-perfused. Decedent was unable to respond to commands at that time, and the "neurological status" of her left-hand digits could not be determined. Decedent then underwent an aspiration of her left third digit. An abdominal CT scan showed marked edema throughout decedent's body with marked anasarca.[5]

On June 14, 2012, microbiology from decedent's left finger aspiration was positive for Enterococcus faecalis, and Vancomycin and Levofloxacin were continued. Nurse Enerio Rossan ("Nurse Rossan") documented that decedent had a stage II sacral pressure ulcer with scant serous drainage, but no odor, a stage IV right malleolus venous stasis ulcer with scant serosanguinous drainage, but no odor, and a stage IV right ischial tuberosity pressure ulcer with scant foul-purulent drainage. Decedent's wounds were cleansed with normal saline, and a foam dressing was applied. Nurse Rossan also noted that decedent's left third finger ulcer was edematous, and the dressing clean, dry, and intact. Decedent was then placed on a specialty bed surface, and Nurse Rossan documented that the Pressure Ulcer Prevention and Treatment Protocol ("PUPTP") was initiated, and that MD/NP/PA was notified. The plan was to turn and reposition decedent, notify the staff when decedent was wet or soiled, and use a barrier cream or ointment.

[5] Anasarca refers to generalized swelling of the body secondary to abnormal fluid retention in the tissues.

On June 15, 2012, Nurse Bernadette Melido ("Nurse Melido") conducted a wound consult, and documented that decedent had a right ischial stage IV pressure ulcer with a small amount of drainage, but no odor. Nurse Melido also noted that areas over decedent's sacrum and thighs had healed, but decedent's left TMA site had an open wound with a moderate amount of serous drainage. Nurse Melido observed that the wound could benefit from an antimicrobial dressing to decrease bioburden that may prevent wound-healing, and considered consulting vascular to assess the perfusion. Nurse Melido also noted that decedent was instructed how to reposition herself in a wheelchair, and recommended that decedent be turned every two hours, cleansed with sterile water, and have Acticoat secure dry dressing applied to her right ischial and left TMA sites. Decedent remained stable on antibiotics over the next several days with no changes to her wounds.

On June 18, 2012, the infectious disease ("ID") team documented that decedent's left third finger was swollen and painful to touch. Decedent was diagnosed with active chronic osteomyelitis of the left third finger, with decedent's left finger/hand cellulitis as the source of the bacteremia/sepsis. Decedent was continued on Vancomycin monotherapy, and the ID team determined that an amputation of the middle and distal phalanges of decedent's left third digit was necessary to manage decedent's chronic osteomyelitis.

On June 26, 2012, Dr. Melvin Rosenwasser, an orthopedic attending physician, performed an amputation of decedent's left third finger without complication. Decedent completed antibiotic therapy on June 27, 2012, at which time an ID fellow noted that there was no additional need for IV antibiotics. Decedent was instructed to follow up with orthopedics the following week.

On July 5, 2012, decedent followed up at NYPH's outpatient orthopedic clinic. Decedent had been exercising her fingers to the best of her ability, and had minimal pain at the amputation

site. Upon examination, decedent's incision appeared to be healing without drainage. The dressing was changed, and decedent was instructed to return to the clinic in one week.

On July 15, 2012, decedent returned to NYPH due to low hemoglobin/hematocrit levels. Decedent denied any complaints, and her vital signs were normal. Decedent refused an ultrasound guided IV, and stated that she wanted to go home. Decedent then returned to Isabella.

On July 25, 2012, decedent had a hypoglycemic episode, and was transferred to NYPH after she was found in an unresponsive state. Decedent's blood glucose that morning was 84, and "insulin was held." Glucagon was subsequently administered, however, decedent's blood glucose remained at 66. Decedent was also given dextrose, after which she became "more responsive." Decedent had not eaten that morning, and could not remember what had happened that day. Decedent was diagnosed with hypoglycemia, and was discharged to Isabella after her creatinine level retuned to baseline.

On August 7, 2012, decedent was taken to NYPH via ambulance due to increasing lethargy and drowsiness. It was reported that decedent was in her usual state of health until Friday, at which time she became drowsy and more lethargic than usual. Decedent had also reportedly fallen from her wheelchair, however, Isabella denied any trauma or injuries. At NYPH, decedent had mild slurring of speech, and was only alert and oriented twice. It was documented that decedent had a stage IV sacral decubitus ulcer of the right posterior hip, and scattered unstageable sacral decubitus ulcers, with a stage I decubitus ulcer on the superoposterior aspect of her right hip. Decedent also complained of significant abdominal pain, but there was no evidence of peritonitis.

Decedent was diagnosed with severe sepsis, and a wound, urine, and blood culture were ordered. Decedent was also anemic, and was given two units of packed red blood cells. An orthopedic consult was called for an osteomyelitis evaluation, and a debridement of decedent's

right hip and amputation sites. The possible sources of decedent's infection included decedent's sacral decubitus ulcer, a "dirty urinalysis," decedent's history of urinary tract infections, and an intraabdominal source. Decedent was started on Vancomycin and Levaquin, which subsequently switched to Linezolid, Levaquin, and Flagyl.

On August 9, 2012, Dr. David Lisle documented that based on decedent's recent anemia and an international normalized ratio ("INR") of 1.85, decedent was not amenable to a debridement procedure. That same day, Nurse Juliet Smith ("Nurse Smith"), a wound consult, evaluated decedent's pressure ulcers, and documented that decedent did not tolerate repositioning well. Nurse Smith also documented that decedent had a sacral ulcer in the remodeling phase of healing, and right Stage IV ischial pressure ulcer with copious serous drainage, but no odor. Nurse Smith further noted that decedent likely had osteomyelitis that tracked to the bone, and that decedent may benefit from an enzymatic debrider followed by antimicrobial dressing. Nurse Smith recommended float heels with Prevalon boots, and to maintain a PUPTP. Decedent's wound was also cleaned with normal saline, and collagenase was applied daily.

On August 14, 2012, decedent continued to experience sacral pain, which improved with morphine. Decedent had a WBC of 16.5, a hemoglobin of 9.9, and an INR of 1.8. A nuclear medicine bone scan confirmed osteomyelitis of decedent's right ischium, and the plan was for a debridement procedure after optimizing decedent's INR, hemoglobin, and platelets. An abdominal CT scan was also significant for colitis. On August 19, 2012, surgery documented that debridement of decedent's sacral wound was not feasible at that time.

On August 21, 2012, the rapid response team was called after decedent became unresponsive, hypotensive, and desaturated. Arterial and central lines were inserted, and decedent was intubated and placed on a cardiac monitor. Decedent was also started on a dopamine drip, and

was admitted to the medical intensive care unit ("MICU"). Upon arrival at the MICU, decedent had a bradycardic arrest without a pulse for less than five seconds. Compressions were started, and doppler pulses were consistently obtained with manual blood pressures. Decedent was intubated, and pressors were administered. An arterial blood gas revealed profound acidosis, and decedent's family requested that decedent not be resuscitated. At approximately 6:00 p.m., decedent had a cardiac arrest, and was pronounced dead at 6:23 p.m.

Plaintiff alleges that defendant's negligent treatment of decedent's pressure ulcers contributed to decedent's development of sepsis, congestive heart failure, cardiac dysrhythmias, and subsequent death.

ARGUMENTS

Based on the record before the court, defendant argues that summary judgment must be granted, because plaintiff cannot establish that defendant's medical treatment of decedent deviated from accepted standards of care or proximately caused decedent's alleged injuries and/or death.

In support of its motion for summary judgment, defendant annexes the affirmation of VINCENT MARCHELLO, M.D. ("Dr. Marchello"), a physician board-certified in geriatric medicine. Dr. Marchello opines that decedent's pre-existing comorbidities, and subsequent "severely compromised condition" caused decedent to be predisposed to decubitus ulcers, and prevented decedent's wounds from properly healing despite timely and appropriate treatment and preventive measures. According to Dr. Marchello, when a person with severe pre-existing conditions experiences an acute illness that necessitates prolonged intensive care, the risk for further adverse outcomes, such as worsening wounds and sepsis, increases even with the "best of care." In that regard, Dr. Marchello notes that decedent had severe peripheral vascular disease that led to a right-foot amputation in 2005, and that decedent's right TMA amputation severely

impacted decedent's mobility over the years. Dr. Marchello also points out that decedent had severe CAD that led to heart surgery, and that decedent's CAD and peripheral vascular disease led to significantly decreased perfusion, which prevents wounds from properly healing. Dr. Marchello explains that vascular disease can impair blood flow to the region of the wounds, and that decedent's surgical wounds (right TMA amputation), which are not friction and shear injuries, were not able to adequately heal. Dr. Marchello further highlights that decedent's right TMA site subsequently became infected, which led to the development of osteomyelitis.

Similarly, Dr. Marchello avers that decedent was severely anemic during her August of 2012 admission at NYPH, which impaired proper wound healing, and that decedent had diabetes, which increased her risk of decubitus ulcers due to its association with nerve damage and poor blood circulation. Dr. Marchello also notes that decedent was malnourished[6] during her admission at NYPH, which significantly delayed wound healing, and contributed to the vulnerability of decedent's disuse and the chronicity of decedent's sacral wound. Likewise, Dr. Marchello highlights that decedent had anasarca, which makes a patient susceptible to skin ulcerations and/or infection. Dr. Marchello further points out that decedent slept in a chair for many nights at Isabella, which "would have contributed" to the development of sacral, ischial tuberosity, and/or hip ulcers.

Dr. Marchello also opines that although decedent's decubitus ulcers were inevitable, defendant took reasonable and necessary steps to treat decedent's existing ulcers, and prevent the development of new ulcers. Dr. Marchello contends that during decedent's June 13, 2012 admission at NYPH, defendant properly treated decedent's stage II sacral ulcer and stage IV right malleolus venous stasis ulcer with saline and a foam dressing. Dr. Marchello also notes that based

[6] Dr. Marchello notes that decedent had low albumin levels during her June and August of 2012 admission, and had significant weight loss (approximately 33 pounds) prior to her NYPH admissions.

on decedent's skin assessment, defendant properly placed decedent on NYPH's PUPTP, and properly set forth a care plan with respect to the treatment and prevention of decedent's ulcers.

In Dr. Marchello's opinion, defendant properly adhered to NYPH's protocols in effect in October of 2013. Dr. Marchello notes that defendant properly placed decedent on a specialty bed, which included a P 500 low air mattress to reduce the pressure on decedent's skin, and properly set forth a turning and repositioning schedule for every two hours. Dr. Marchello also highlights that the nursing staff maintained the head of the bed at the lowest degree of elevation possible, and properly treated decedent's existing skin injuries with lubricants, wound dressings, and bandages. Dr. Marchello further points out that decedent had comprehensive wound assessments, which were detailed in nature, and always included the location and stage of the wound, as well as the size, drainage, odor, color, and treatment of the wound. Dr. Marchello also opines that defendant properly reassessed decedent during every shift for changes in skin integrity, which complied with NYPH's protocol, and properly contacted the Wound, Ostomy, and Continence nurse for guidance on the assessment and treatment of stage III to stage IV pressure ulcers.

Additionally, Dr. Marchello opines that decedent's pre-existing wounds remained uninfected, and that there is no evidence that her wounds worsened. Dr. Marchello notes that decedent's sacral area had a healed scar with some divots on the skin, which indicated that decedent's stage II sacral ulcer had closed and healed. Nevertheless, Dr. Marchello maintains that the skin in the area of a healed ulcer is "never normal," and is likely to reopen. Dr. Marchello also posits that there is no evidence that decedent's right ischial tuberosity ulcer increased in size, or became infected despite the discrepancies in measurement of this ulcer. Dr. Marchello further avers that defendant properly diagnosed decedent's left third finger as the source of decedent's sepsis, and properly amputated the finger.

Dr. Marchello also opines that upon decedent's August of 2012 presentation at NYPH, decedent was already septic as she was admitted with a diagnosis of sepsis secondary to an infected decubitus ulcer. Dr. Marchello highlights that decedent's sacral ulcer had worsened since her June admission, and that decedent's stage IV ischial ulcer was possibly infected. However, Dr. Marchello asserts that defendant properly implemented protocols based on decedent's skin assessment, including turning/repositioning decedent, and recommending cleansing and dressing of decedent's wounds with saline, collagenase, and Mepilex Border dressing. Dr. Marchello also contends that while the wound consult recommended a debridement procedure, the surgical team properly recognized that decedent was not a candidate for debridement due to her anemia and coagulopathy issues which posed a risk of bleeding. According to Dr. Marchello, the risk of bleeding, which could lead to death, outweighed the benefits of surgical debridement. Instead, Dr. Marchello concludes that defendant properly treated decedent's osteomyelitis with an enzymatic debridement (debridement using enzymatic chemicals) to assist in wound healing.

In Dr. Marchello's opinion, defendant's treatment of decedent did not proximately cause decedent's alleged injuries and/or death. Dr. Marchello reiterates that decedent presented to NYPH with sepsis and acute osteomyelitis to the ischium, and that defendant took appropriate measures to prevent decedent's ulcers from worsening, and to avoid the development of new ulcers. Dr. Marchello also submits that even if decedent's wounds had worsened during her admission at NYPH, the worsening of her wounds were unavoidable given decedent's underlying medical condition and significant comorbidities. Dr. Marchello further posits that because decedent already had acute osteomyelitis from her stage IV ischial tuberosity ulcer upon her presentation at NYPH on August 7, 2012, and because surgical debridement was not possible, decedent's course and

outcome could not have been reversed although defendant did all that it could to treat decedent's sepsis and osteomyelitis.

In opposition, plaintiff annexes the affirmation of Ronald Jeffrey Schwartz, M.D. ("Dr. Schwartz"), a physician board-certified in long term care, geriatric medicine, and hospice and palliative care medicine. According to Dr. Schwartz, defendant's treatment of decedent fell below the standard of care, and proximately caused decedent's injuries[7] and death.

In Dr. Schwartz's opinion, while decedent had risk factors for the development of pressure sores, and was first admitted at NYPH with a stage IV inferior gluteal pressure sore, stage II sacral pressure sore, and an ulcer on her left third digit, these ulcers should not have deteriorated as they did, but could have been healed with proper care and treatment. According to Dr. Schwartz, despite the discrepancies of the measurement and tracking of decedent's wounds, decedent's stage IV right ischial pressure sore deteriorated, and increased in dimension over the course of decedent's admission at NYPH. Dr. Schwartz notes that this ulcer "persisted with" decedent throughout her subsequent admissions at Isabella, and throughout her final admission at NYPH in August of 2012. According to Dr. Schwartz, when a patient is admitted with "high risk," it is necessary to undertake more aggressive and diligent evaluations and follow-up care consistent with the patient's needs.[8]

[7] Dr. Schwartz lists decedent's injuries as unstageable right ischium pressure ulcer with slough tissue, stage IV right ischial pressure ulcer and probe to the bone, stage III & IV right buttock pressure ulcers, stage II & III right gluteal pressure ulcer, stage III & IV sacral pressure ulcer with foul odor, acute osteomyelitis of the right hip, infection, sepsis, malnutrition, and dehydration.

[8] Dr. Schwartz notes that this includes turning and positioning more frequently than every two hours, more frequent follow-up by wound specialists to prevent the progression and further development of pressure ulcers, more frequent follow-up by a surgical physician who specializes in wound care and surgical debridement, more frequent evaluation by a dietician to maximize decedent's nutritional status to prevent the progression and further development of her pressure ulcers, and close monitoring of decedent's risk for the development of pressure ulcers using the Braden Scale Score to predict a patient's risk for the development and subsequent deterioration of pressure-related injuries.

Specifically, Dr. Schwartz opines that although there were orders to turn/position decedent every two hours, there are no logs or records to indicate that NYPH complied with the orders. According to Dr. Schwartz, the standard of care requires turning/repositioning a patient at least every two hours to off-load the pressure and ensure that the bony prominences do not lead to pressure-related injuries. Dr. Schwartz explains that a patient should be turned/positioned as frequently as needed to prevent the worsening of pre-existing ulcers and the development of new ulcers, and that this "crucial intervention" can be implemented as often as every 15 minutes if clinically indicated. In that regard, Dr. Schwartz highlights that decedent's "Daily Flow Sheets" documented that decedent was turned/positioned with staff assistance a total of 10 times over the course of 13 days, with no more than two turning/positioning rotations a day. According to Dr. Schwartz, this does not comport with the two-hour schedule as recommended and ordered.

Additionally, Dr. Schwartz asserts that NYPH did not implement preventative measures for off-loading to help prevent the worsening of decedent's pre-existing ulcers and the development of new pressure-related injuries during decedent's August admission. According to Dr. Schwartz, while defendant provided decedent with a pressure-relieving mattress and heel booties, and recommended a two-hour turning/positioning schedule, defendant should have used pillows, wedges, and alternative off-loading devices to ensure that pressure was not applied to the bony prominences for extended periods of time. However, Dr. Schwartz notes that NYPH did not implement any of the above to assist decedent in off-loading pressure from her existing pressure-related injuries.

Dr. Schwartz also opines that NYPH should have implemented "closer monitoring" by a wound care specialist to prevent the progression and further development of decedent's pressure ulcers. According to Dr. Schwartz, the standard of care requires that a wound care specialist follow

up with a patient on a weekly basis, or as often as needed to prevent wound progression and deterioration, including several times weekly if clinically indicated. In that regard, Dr. Schwartz concludes that based on decedent's clinical presentation at NYPH, a wound care specialist should have followed decedent more closely, and that defendant should have immediately performed a wound care consultation based on decedent's heightened risk factors for the development and deterioration of pressure ulcers. Similarly, Dr. Schwartz avers that defendant should have performed more "intensive monitoring" of decedent's Braden Scale Score since decedent presented with significant comorbidities and nutritional compromise. However, Dr. Schwartz notes that defendant failed to closely monitor or update decedent's Braden Scale Score during her admissions at NYPH.

Likewise, Dr. Schwartz opines that defendant failed to implement "aggressive nutritional evaluations" during decedent's admissions at NYPH, and failed to provide decedent with more frequent treatment with a dietician to maximize decedent's nutritional status. Dr. Schwartz points out that decedent was in a severely compromised nutritional state based on her albumin level of 2.8, which indicated severe protein-calorie malnutrition. According to Dr. Schwartz, defendant should have implemented nutritional interventions to ensure that decedent's nutritional status did not deteriorate, including nutritional shakes with high protein and arginine, additional vitamin supplements, such as vitamin C and zinc, and proper hydration. Dr. Schwartz concludes that defendant's failure to rigorously monitor these interventions likely led to decedent's further deterioration.

Dr. Schwartz further opines that defendant failed to provide decedent with physical therapy during decedent's admissions at NYPH, which would have increased circulation, promote wound-healing, and deter the development of additional pressure ulcers. Dr. Schwartz highlights that

defendant did not conduct a physical therapy initial evaluation until June 22, 2012, nine days after decedent's June of 2012 admission, and that there is no indication that physical therapy was performed prior to decedent's discharge on June 26, 2012. Similarly, Dr. Schwartz contends that in terms of decedent's August of 2012 admission at NYPH, there is no indication that defendant ordered or recommended physical therapy prior to decedent's death on August 21, 2012.

Furthermore, Dr. Schwartz opines that defendant should have used a more conservative approach to treat the dry gangrene on decedent's left third finger. According to Dr. Schwartz, dry gangrene, as opposed to wet gangrene, is more stable and less harmful since it is eventually removed from the body. However, Dr. Schwartz avers that there is no indication as to whether defendant considered less-intensive alternatives to an amputation as the amputation could have likely been avoided had defendant followed decedent more intensively. Dr. Schwartz also highlights that defendant could have attempted a post lavash technique to remove the dead necrotic tissue as a means of preventing further infection since this approach would help with odiferous wounds such as the wounds on decedent's lower body and amputation sites. Dr. Schwartz further explains that the jet stream from the apparatus "knocks off" all residual necrotic tissue, which is a "great alternative" to sharp scalpel debridement.

Similarly, Dr. Schwartz points out that there is no evidence that defendant tried a surgical debridement of the affected ulcerations of decedent's left third finger or hyperbaric oxygen therapy as less aggressive interventions prior to amputating decedent's finger. Dr. Schwartz notes that hyperbaric oxygen therapy can help repair wounds and improve the healing process by boosting blood flow, and that this technique is particularly effective in treating diabetes-related foot ulcers. In that regard, Dr. Schwartz submits that had defendant attempted surgical debridement and/or

hyperbaric oxygen therapy, decedent would not have needed to undergo an amputation of the middle and distal phalanges of her left third finger.

Finally, Dr. Schwartz opines that notwithstanding decedent's multiple comorbidities, decedent's body was capable of healing with proper aid and nursing intervention. Dr. Schwartz notes that there was a reduction of decedent's pressure ulcers prior to decedent's second admission at NYPH, and that NYPH's initial nutrition assessment had stated that decedent's sacral area pressure ulcers were "healing." As such, Dr. Schwartz contends that the fact that decedent's sacral ulcers had healed belies defendant's argument that the deterioration of decedent's pressure ulcers was unavoidable.

In reply, defendant argues that the court should not consider plaintiff's untimely opposition papers. Defendant highlights that plaintiff served her opposition on October 9, 2019 in disregard of the parties' briefing schedule and the court's August 13, 2019 order. As a result, defendant contends that it only had two business days to submit its reply affirmation. Defendant also argues that Dr. Schwartz's opinion that decedent's amputation could have likely been avoided had defendant attempted less invasive measures is an impermissible new theory of liability. Defendant further submits that Dr. Schwartz, as an internist and geriatrician, is unqualified to render an opinion as to orthopedic surgery.[9]

Additionally, defendant argues that contrary to Dr. Schwartz's opinion, decedent was not always repositioned with staff assistance because decedent was able to turn/position herself, decedent was ambulating with assistance, and decedent was repositioned as frequently as needed. Defendant also avers that Dr. Schwartz did not opine as to why defendant should have turned

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[9] Specifically, defendant highlights that Dr. Schwartz is not qualified to opine as to less invasive means of treatment prior to amputation and/or that the orthopedic team utilized the incorrect approach (*i.e.*—a post lavash technique versus a sharp scalpel debridement).

decedent more frequently than the minimum standard, or why it was clinically indicated to implement frequent turning/positioning every 15 minutes, especially since decedent was able to walk. Similarly, defendant contends that Dr. Schwartz ignores the fact that decedent was followed by a wound care specialist, around-the-clock nursing, orthopedic, infectious disease, vascular surgery, and the internal medicine services, all of whom evaluated decedent's wounds throughout her admissions at NYPH. Likewise, defendant posits that Dr. Schwartz failed to mention that an infectious disease consult instructed that decedent be kept "NPO" (nothing by mouth) upon her admission on June 13, 2009, and therefore, it would have been impossible to give decedent a protein shake. Defendant further asserts that although decedent was listed as NPO, the nutrition team evaluated decedent, and prescribed her with a Glucerna shake.

Furthermore, defendant maintains that it assessed decedent with the Braden Scale at least once daily in compliance with NYPH's PUPTP, and that defendant implemented the PUPTP throughout decedent's admissions because her score was less than 18 during both admissions. Defendant also avers that even if defendant should have monitored decedent's Braden Scale Score more intensively, plaintiff does not demonstrate how this would have prevented decedent's alleged injuries.

Finally, defendant asserts that as of June 14, 2009, the orthopedic team documented that decedent's left finger ulcer was unlikely to be the source of decedent's systemic infection, and decided against surgical intervention at that time. Instead, defendant notes that the orthopedic team continued to monitor decedent to see if any infection/fluid would "declare itself," and continued to administer IV antibiotics to see if the infection would heal. However, defendant posits that decedent's condition rapidly progressed to osteomyelitis despite wound care and antibiotics, and that decedent understood that due to the severe nature of her comorbidities, there was extreme

danger in maintaining the infected part of her finger. Defendant further notes that plaintiff agreed to the amputation, and that the amputation occurred on June 26, 2009, after it was clear that less invasive means of treatment, such as wound care and IV antibiotics, were attempted, but failed.

DISCUSSION

To prevail on summary judgment in a medical malpractice case, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause the patient's injury (*Roques v. Noble*, 73 A.D.3d 204, 206 [1st Dept. 2010]). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature (*see e.g.*, *Joyner-Pack v. Sykes*, 54 A.D.3d 727, 729 [2d Dept. 2008]). The opinion must be based on facts in the record or personally known to the expert (*Roques*, 73 A.D.3d at 207). The expert cannot make conclusions by assuming material facts which lack evidentiary support (*id.*). The defense expert's opinion should state "in what way" a patient's treatment was proper and explain the standard of care (*Ocasio-Gary v. Lawrence Hosp.*, 69 A.D.3d 403, 404 [1st Dept. 2010]). Further, it must "explain 'what defendant did and why'" (*id. quoting Wasserman v. Carella*, 307 A.D.2d 225, 226 [1st Dept. 2003]).

Once defendant makes a *prima facie* showing, the burden shifts to plaintiff "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 v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). To meet that burden, plaintiff must submit an expert affidavit attesting that defendant departed from accepted medical practice and that the departure proximately caused the injuries (*see, Roques*, 73 AD3d at 207). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions" (*Elmes v. Yelon*, 140 A.D.3d 1009 [2nd Dept

2016] [citations and internal quotation marks omitted]). Instead, the conflicts must be resolved by the factfinder (*id.*).

Here, defendant sets forth a *prima facie* case in favor of dismissal, as evidenced by the submission of defendant's medical records, and defendant's expert affidavits, all of which attest to the fact that defendant's treatment of plaintiff was in accordance with accepted standards of care and did not proximately cause plaintiff's alleged injuries. To be sure, defendant's expert affirmations are detailed and predicated upon ample evidence within the record. As defendant has made a *prima facie* showing, the burden shifts to plaintiff.

I. Preliminary Matters

As a preliminary matter, plaintiff's failure to timely serve opposition is in violation of the parties' stipulation dated June 6, 2019 and the court's order dated August 13, 2019. Plaintiff's blasé attitude towards complying with the timeline set forth above is further exacerbated by the fact that plaintiff filed her opposition three business days prior to defendant's deadline to serve reply papers, and by the fact that plaintiff failed to serve defendant with a copy of her opposition papers. While plaintiff's conduct is antithetical to the professionalism required for the practice of law, and is certainly reprehensible, in the absence of prejudice to defendant, and in the interest of deciding the motion in totality and on its merits, the court will consider plaintiff's opposition papers in the decision herein (*see, Bakare v. Kakouras*, 110 A.D.3d 838, 839 [2d Dept. 2013]; *Lawrence v. Celtic Holdings, LLC*, 85 A.D.3d 874, 875 [2d Dept. 2011]).

Secondly, defendant correctly argues that plaintiff has impermissibly raised a new theory of liability in opposition that decedent's amputation could have likely been avoided had defendant attempted less invasive treatment prior to the amputation. Indeed, plaintiff's bill of particulars does not allege any negligence with respect to defendant's decision to perform an amputation of

decedent's left third finger or defendant's performance of the amputation. At most, plaintiff asserts that defendant "failed to prevent, care and/or treat pressure ulcers, vascular ulcers, infection, pneumonia, osteomyelitis, sepsis, gangrene . . . [and] failed to prevent the development and/or worsening of pressure ulcers, vascular ulcers and infection." While plaintiff's allegation includes a general claim involving defendant's alleged failure to treat or prevent gangrene, plaintiff does not make any reference to an improperly performed amputation, or treatment alternatives that defendant should have pursued prior to performing the amputation. To be sure, plaintiff's bill of particulars lacks any mention of less invasive means of treatment, including a post lavash technique or hyperbaric oxygen therapy (*see, Marti v. Rana*, 173 A.D.3d 576, 577, 104 N.Y.S.3d 617, 619 [1st Dept. 2019]; *Biondi v. Behrman*, 149 A.D.3d 562, 565, 53 N.Y.S.3d 265, 268 [1st Dept. 2017]). Accordingly, plaintiff's claim that decedent's amputation could have likely been avoided had defendant attempted less invasive measures must be dismissed.

Because the court has dismissed plaintiff's newly pleaded allegation that defendant should have used a more conservative approach to treat the dry gangrene on decedent's left third finger, defendant's argument that Dr. Schwartz is unqualified to opine as to less invasive means of treatment and/or that the orthopedic team utilized the incorrect approach in treating plaintiff's finger is moot. Accordingly, the court will consider the parties' remaining arguments, *infra*.

II. Triable Issues of Fact

Substantively, plaintiff has raised triable issues of fact sufficient to preclude summary judgment. For example, the parties disagree as to whether decedent's pre-existing conditions caused or contributed to decedent's alleged injuries and/or death. Notably, while defendant argues that decedent's pre-existing comorbidities caused her to be predisposed to decubitus ulcers, and prevented wound-healing despite proper treatment, plaintiff asserts that defendant's treatment fell

below the standard of care, and proximately caused decedent's injuries. Specifically, contrary to defendant's argument that the risks for further adverse outcomes increase in a patient with severe pre-existing illnesses even with the "best of care," plaintiff emphasizes that when a patient is admitted with "high risk," it is necessary to undertake more aggressive and diligent evaluations and follow up care consistent with the patient's needs. As such, plaintiff underscores that while decedent had risk factors for the development of pressure sores, decedent's pre-existing ulcers should not have deteriorated as they did, but rather, they could have healed with proper treatment. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

The parties also disagree as to whether defendant properly treated decedent's ulcers. Defendant avers that although decedent's decubitus ulcers were inevitable, defendant took reasonable and necessary steps to prevent and treat decedent's ulcers. For example, defendant contends that it properly implemented NYPH's PUPTP, and properly set forth a care plan, which included placing decedent on a specialty bed, and turning/positioning decedent every two hours. By contrast, plaintiff maintains that defendant failed implement preventative measures for off-loading to help prevent and treat decedent's pressure-related injuries such as pillows, wedges, and alternative off-loading devices. Plaintiff also emphasizes that defendant failed to turn/position decedent every two hours, or as often as every 15 minutes if clinically indicated. Defendant, on the other hand, argues that decedent was not always repositioned with staff assistance because decedent was able to turn/position herself, decedent was ambulating with assistance, and decedent was repositioned as frequently as needed. In further challenging plaintiff's assertion, defendant highlights that Dr. Schwartz failed to opine as to why defendant should have turned/positioned decedent more frequently than the minimum standard, or why NYPH's two-hour

turning/positioning protocol does not meet the standard of care. Because these issues cannot be resolved by the facts before the court, summary judgment must be denied.

Plaintiff further raises a triable issue of fact as to whether defendant should have implemented closer monitoring by a wound care specialist to prevent the progression and further development of decedent's pressure ulcers. Notably, plaintiff avers that based on decedent's clinical presentation at NYPH, a wound care specialist should have followed decedent more closely and intensively during her admissions, and that defendant should have immediately conducted a wound care consultation given decedent's heightened risk-factors for the development and deterioration of pressure ulcers. By contrast, defendant contends that there is no evidence that decedent's pre-existing wounds worsened during her admissions at NYPH, and that decedent was properly followed by a wound care specialist, nursing, orthopedic, infectious disease, vascular surgery, and the internal medicine services. Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Similarly, while plaintiff posits that defendant should have used the Braden Scale to predict decedent's risk for the development and deterioration of pressure ulcers based on decedent's comorbidities and nutritional compromise, defendant argues that it properly assessed decedent with the Braden Scale at least once daily, and that even if decedent should have been monitored more intensively with the Braden Scale, plaintiff does not demonstrate how this would have prevented decedent's injuries. Likewise, while plaintiff asserts that defendant should have implemented nutritional interventions to ensure that decedent's nutritional status did not deteriorate, including providing decedent with nutritional shakes, vitamin supplements, and proper hydration, defendant posits that it would have been impossible to give decedent a protein shake as decedent was instructed to remain NPO upon her admission at NYPH on June 13, 2009. Moreover,

contrary to plaintiff's claim that defendant failed to implement aggressive nutritional evaluations, and failed to provide decedent with more frequent treatment with a dietician, defendant submits that NYPH's nutrition team evaluated decedent, and prescribed decedent with a Glucerna shake. Because there are issues of fact with respect to whether defendant properly treated decedent in accordance with the standard of care, summary judgment must be denied.

Finally, while plaintiff emphasizes that decedent's body was capable of healing with proper aid and nursing intervention despite decedent's comorbidities, defendant maintains that the worsening of decedent's wounds were unavoidable given decedent's underlying medical conditions and significant comorbidities, including severe peripheral vascular disease, anemia, diabetes, and anasarca. However, in refuting defendant's argument, plaintiff points out that decedent's sacral ulcers had healed as evidenced by the reduction of decedent's pressure ulcers prior to decedent's second admission at NYPH and NYPH's initial nutrition assessment stating that decedent's sacral pressure ulcers were "healing." Accordingly, there are triable issues of fact here sufficient to preclude summary judgment.

Based on the foregoing, it is hereby

ORDERED that defendant's motion for summary judgment is granted to the extent that plaintiff's claim that decedent's amputation could have likely been avoided had defendant attempted less invasive measures is dismissed; and it is further

ORDERED that the clerk is directed to enter judgment as to that claim accordingly, and it is further

ORDERED that the remainder of defendant's motion for summary judgment is DENIED; and it is further

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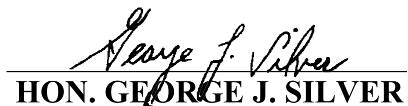
ORDERED that the parties are directed to appear for a virtual conference before the court on August 3, 2020 at 10:30 A.M.

This constitutes the decision and order of the court.

Date: July 1, 2020



HON. GEORGE J. SILVER