

Benjamin v Jewish Home Lifecare
2020 NY Slip Op 32300(U)
July 13, 2020
Supreme Court, New York County
Docket Number: 805026/2014
Judge: Eileen A. Rakower
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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: Hon. EILEEN A. RAKOWER

Justice

PART 6

**PATRICIA A. BENJAMIN AND LAWRENCE
K. BENJAMIN, As Co-Executors of the Estate
of ALBERTHA L. BENJAMIN, Deceased, and
PATRICIA A. BENJAMIN, as Executor of the
Estate of Cecil A. Benjamin,**

Plaintiffs,

- against-

**JEWISH HOME LIFECARE, ST. LUKE'S
HOSPITAL, ST. CABRINI NURSING
HOME AND ST. JOHN'S RIVERSIDE
HOSPITAL,**

Defendants.

The following papers, numbered 1 to _____ were read on this motion for/to

Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...

Answer — Affidavits — Exhibits _____

Replying Affidavits

PAPERS NUMBERED

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Cross-Motion: Yes No

Defendant Jewish Home Lifecare (“JHL”) moves for an Order granting (1) summary judgment in JHL’s favor on the grounds that no genuine, material issues of fact exist such as would warrant a trial of this matter; and (2) an award of costs for the making of this motion given JHL’s request for a voluntary discontinuance for two and a half years from the date of the motion. No opposition is submitted.

Summary Judgment Standard

CPLR § 3212 provides in relevant part, that a motion for summary judgment,

shall show that there is no defense to the cause of action or that the cause of action or defense has no merit. The motion shall be granted if, upon all the papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any

party... [t]he motion shall be denied if any party shall show facts sufficient to require a trial of any issue of fact.

A defendant moving for summary judgment in a medical malpractice case has the burden of making a prima facie showing of entitlement to judgment as a matter of law by showing that “there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged” by introducing expert testimony that is supported by the facts in the record. *Rogues v. Nobel*, 73 A.D.3d 204, 206 [1st Dept. 2010].

Once the defendant has made this showing, the burden shifts to the party opposing the motion “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 Hospital*, 68 N.Y.2d 320, 324 [1986]. Specifically, a plaintiff “must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact.” *Alvarez*, 68 N.Y.2d at 324.

Public Health law § 2801-d requires a facility to provide “all care reasonably necessary” to prevent the deprivation of a patient’s rights.

Pursuant to Public Health Law § 2805-d[2], “[t]he right of action to recover for medical, dental or podiatric malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body.”

Discussion

This is an action sounding in negligence, gross negligence, wrongful death, negligent hiring, lack of informed consent, loss of services, and violation of Public Health Law Sections 2801(d) and 2803(c).

According to the Complaint, Plaintiff alleges that the decedent, “suffered grave bodily injury, complications related thereto, need for additional surgery and treatment, mental anguish, and wrongful death” as a result of Defendants’ care and treatment of the decedent from July 9, 2013 through November 16, 2013.

According to the Bill of Particulars, Plaintiff alleges that during the decedent’s admission to JHL, JHL “allow[ed]” her to develop decubitus ulcers and “allow[ed]” the ulcers to “grow and spread.” Plaintiff alleges that JHL failed to timely diagnose the ulcers; perform appropriate physical examinations of the decedent; evaluate her risk for developing ulcers; adequately monitor the progression of the wounds; prevent bacterial contamination; prevent ischemia, tissue anoxia, cell death, necrosis, and ulceration; provide pressure relieving devices; turn and reposition the decedent; and provide the appropriate wound care treatment. There are no cross claims against JHL.

In support of JHL’s motion for summary judgment, JHL submits the expert affidavit of Francine Cox, RN, BS, COCN, CWCN (“Nurse Cox”). Nurse Cox is a registered nurse actively licensed in the State of New York and is “Board Certified in wound care and ostomy with 44 years of experience as a nurse employed in a multitude of health care settings including hospitals

and home health.” Nurse Cox opines that based on her review of the medical records, JHL “did not depart from the standard of care or violate the Public Health Law in its care and treatment of the decedent,” and “that at no point while the decedent was a resident of JHL was she caused to suffer, nor did she suffer a decubitus wound, pressure ulcer, or skin impairment of any kind, as is evidenced by the fact that not only do the JHL records show no development of any skin wound, but also when the decedent was transferred from JHL to St. Luke’s Hospital on August 6, 2013, the hospital admission records show no evidence of any skin impairment.”

Nurse Cox opines that at the time of the decedent’s admission to JHL, “the nursing staff conducted a proper and thorough initial assessment of the decedent,” decedent “did not have any skin impairment of any kind,” “[t]he nursing staff properly performed a Braden scale evaluation,” and the “decedent received a score of 15 putting her at mild risk for developing a pressure ulcer.” Nurse Cox opines that upon the decedent’s admission, JHL implemented “multiple care plans ... including a Potential Pressure Ulcer care plan and an Altered Skin Integrity care plan” which called for the monitoring of any skin changes during daily living; appropriately placed the decedent “on a turning and positioning schedule” which her “was adhered to throughout her admission to JHL;” and “properly assessed the decedent’s risk for development of a pressure ulcer and implemented the appropriate interventions to avoid the development of any pressure ulcers.”

Nurse Cox states her review of the records shows that the “decedent’s skin remained intact during the entirety of her admission to JHL;” “at no time during her one-month admission to JHL, did the decedent ever develop any skin wounds to her: right medial leg, right posterior knee, right lateral leg, left medial leg, right trochanter, left lateral leg, left trochanter or left flank;” and “decedent did not develop any skin wounds to any other part of her body during her one month admission to JHL.” Nurse Cox further states that the records also show “that not only was there no evidence of any skin wound, ulcer, or impairment documented in the JHL records during her one month admission or at the time of her discharge from JHL, but furthermore, no such wounds are noted in the St. Luke’s Hospital records for the decedent’s August 6, 2013 admission.” Nurse Cox states that St. Luke’s Hospital Records indicate that upon decedent’s presentation to the ER on August 6, 2013 and admission to the hospital on August 7, 2013, “the decedent’s skin was intact with no wounds, ulcers, or impairments.”

Nurse Cox states that the decedent never returned to JHL after she was transferred to St. Luke’s Hospital, and “did not develop pressure wounds until September 2013, more than a month after he had been discharged from JHL, and after she had been discharged from St. Luke’s.” Nurse Cox states that the decedent died on November 16, 2013 “from causes attributed to cardio-respiratory arrest due to septic shock.”

Nurse Cox opines “that the care and treatment the decedent received at JHL in no way caused or contributed to her death,” and “the decedent’s death was unrelated to any care or treatment rendered at JHL months earlier.” Nurse Cox further opines “that JHL staff took all steps reasonable and necessary to prevent the development of any skin breakdown, and that no skin breakdown occurred during the decedent’s one month admission to JHL.” Nurse Cox further opines “that any subsequent complication or deterioration of the decedent’s condition occurred after her admission to JHL had concluded and was not the result of any departure, set or omission by anyone at JHL.” Nurse Cox further opines that “JHL did not depart from the standard of care by failing to obtain informed consent.”

Nurse Cox opines “within a reasonable degree of nursing certainty that the care and treatment provided to the decedent was at all times appropriate and within the accepted standard of care in the nursing community, and the events at issue were unavoidable and not a result from any negligence on behalf of JHL.”

The burden now shifts to Plaintiff to demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action. *See Lindsay-Thompson v. Montefiore Med. Ctr.*, 147 A.D.3d 638, 639 (1st Dept 2017). Plaintiff fails to satisfy this burden. Plaintiff does submit an opposing expert affidavit. Plaintiff does not oppose JHL’s motion. Plaintiff therefore fails to raise an issue of fact in opposition to JHL’s prima facie showing that JHL did not depart from the accepted standard of nursing care in its treatment of the decedent.

Accordingly, JHL’s motion for summary judgment is granted and the action is dismissed as against JHL. JHL’s request for costs associated with bringing the motion is denied. The Clerk is directed to enter judgment accordingly.

Wherefore it is hereby

ORDERED that Defendant Jewish Home Lifecare’s motion for summary judgment is granted without opposition and the action is dismissed as against Jewish Home Lifecare; and it is further

ORDERED that Defendant’s request for fees is denied; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that the action is severed as against the remaining defendants and shall proceed accordingly.

This constitutes the Decision and Order of the Court. All other relief requested is denied.

Dated: JULY 13, 2020

ENTER: 
J.S.C.

HON. EILEEN A. RAKOWER

Check one: FINAL DISPOSITION X NON-FINAL DISPOSITION