At an IAS Term, Part 88 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 25th day of March, 2021.

PRESENT:

HON. DAWN JIMENEZ-SALTA,
Justice.

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JEAN GILUS, as Administrator of the Estate of BLAIRCIN GILUS,

Plaintiff,

- against-

Index No. 522567/17

Mot. Seq. 2

PALM GARDENS CARE CENTER LLC, d/b/a PALM GARDENS CENTER FOR NURSING AND REHABILITATION,

Defendant.

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The following e-filed papers read herein:	NYCEF Doc. Nos.
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	42-56
Opposing Affidavits (Affirmations)	57-99
Reply Affidavits (Affirmations)	102

Upon the foregoing papers, defendant Palm Gardens Care Center LLC d/b/a/ Palm Gardens Center for Nursing and Rehabilitation (Palm Gardens or defendant/defendant facility) moves, in motion sequence (mot. seq.) two, for an order, pursuant to CPLR 3212, granting it summary judgment and directing entry of judgment in its favor, or, alternatively, granting it partial summary judgment and limiting the issues for trial. Defendant also moves to deem this action as sounding in medical malpractice as opposed to general negligence, to compel plaintiff to serve a certificate of merit, notice of medical malpractice and expert witness disclosure, and to move the case to the medical malpractice part.

Background

A. The Complaint and Bill of Particulars

Plaintiff Jean Gilus (plaintiff), as administrator of the Estate of Blaircin Gilus (decedent or Gilus) commenced this action on behalf of decedent for injuries that decedent allegedly sustained while residing at defendant nursing home. The complaint alleges that decedent was continuously under defendant's care and treatment from January 27, 2014 through December 15, 2016. Decedent allegedly sustained decubitus ulcers (pressure ulcers or bedsores) due to, among other factors, defendant's failure to properly assess decedent's condition, failure to adequately care and treat decedent, including failing to move decedent, hydrate decedent, and treat the ulcers. The complaint asserts the following causes of action: (1) negligence; (2) violation of Public Health Law § 2801-d relating to health care facilities and related regulations; and (3) gross negligence entitling decedent to punitive damages pursuant to Public Health Law § 2801-d. Plaintiff also demands attorneys' fees. The complaint alleges that plaintiff will prove the causes of action by the doctrine of res ipsa loquitur.

The bill of particulars asserts that decedent's injuries were permanent pressure ulcers, including but not limited to sacrum, left and right buttocks, and lower extremities. The bill of particulars also states that defendant violated Public Health Law §§ 2801-d, 2803-c, and alleges multiple violations of the federal and state regulations concerning minimum standards and requirements for nursing homes and long-term care facilities, 42 CFR Sections 483 *et seq*. and 10 NYCRR Sections 415 *et seq*.

In plaintiff's opposition to the instant motion, plaintiff states that "There is no claim for medical malpractice" and that "[a]ll claims of negligence are hereby withdrawn" (NY St Cts Elec Filing [NYSCEF] Doc No. 57, affirmation of plaintiff's counsel in opposition at 2, ¶¶ 4-5). Accordingly, the court will not address the parties' contentions with respect to dismissal of the first cause of action for negligence unless those contentions relate to the other causes of action.

B. Plaintiff's Medical Condition and Care at Defendant Facility

At the time that decedent was admitted to Palm Gardens on January 27, 2014, he was 81 years old, had difficulty walking and was wheelchair bound. Decedent had preexisting diagnoses of hypertension, osteoarthritis, dementia, vascular disease, hyperlipidemia (i.e. high cholesterol), arteriosclerotic heart disease and benign prostatic hyperplasia (i.e. prostate gland enlargement). Decedent also had a history of impaired skin integrity and pressure ulcers. Upon admission, decedent had a Stage I sacral ulcer measuring 2 x 1 cm, and was assessed as a "mild risk" for developing pressure ulcers on the Braden Scale. The facility determined that decedent would need extensive assistance with bed mobility, transfers, dressing, eating and toileting. He was given an air overly mattress, heel protection, medications and dietary supplements, and, according to defendant's expert, Vincent P. Garbitelli, M.D. (Garbitelli), was to be turned and positioned every two to three hours.

On April 8, 2014, decedent's sacral ulcer, which was present upon admission, was a Stage II ulcer measuring 2 x 1 cm, and decedent was assessed on the Braden Scale for "mild risk" of skin breakdown. On April 10, 2014, a note indicated that decedent had a

facility-acquired Stage IV sacral ulcer measuring 0.5 x 0.5 x 0.1 cm. Weekly skin assessments through April and mid-May 2014 noted improvement in the sacral wound. On April 26, 2014, it was noted that the sacral wound measured 2 x 1 x 0.2 cm and was a Stage II wound, and on April 30, 2014, it was noted to have decreased to 0.5 x 0.1 x 0.1, as Stage I. By May 15, 2014, the wound was noted to have healed. In May of 2014, decedent was noted to have a moderate risk of developing pressure ulcers.

Nursing notes on June 1, 2014, indicate that decedent had left upper thigh cellulitis, which resolved in July of 2014 after several courses of antibiotics. On August 13, 2014, decedent was noted to have no ulcers. Decedent was not noted to have any pressure ulcers from approximately December 2014 through the next several months.

Thereafter, on September 3, 2015, decedent was noted to have redness in the area of his left ischium, which was treated with zinc oxide and resolved by October of 2015. On September 4, 2015, there was a note to reposition decedent every two hours. On November 13, 2015, a Stage I ulcer to the buttocks in the area of the left ischium was noted, decedent's son was notified, zinc oxide was again applied, and the wound healed by December 10, 2015. At that time, decedent had an air mattress and was also given a wheelchair cushion.

On December 1, 2015, a wound care consult was ordered for evaluation of a left heel blister, which on December 10, 2015 was assessed as Stage II, measuring 1.5 x 2 cm with dry eschar (i.e. a collection of dry, dead tissue) present. The next day, a left lower extremity lateral ankle wound was also assessed as a Stage II, measuring 1.8 x 1.5 x 0.1 cm. The wound was initially listed as a "pressure ulcer," but subsequently identified as a

vascular/arterial wound. On December 22, 2015, the left heel blister measured 2 x 2 cm (but remained at Stage II) and the left lower extremity lateral wound measured 2.5 x 2 x 0.3 cm. One week later, the left heel ulcer remained the same and the lateral left ankle wound increased to 3 x 2 x 0.3 cm. On December 29, 2015, decedent had a vascular consult secondary to the absence of vascular flow in his left posterior tibial artery, and it was noted that decedent had a chronic left ankle venous stasis ulcer. Also in December of 2015, decedent was again assessed as mild risk for development of pressure ulcers on the Braden Scale. Decedent was placed on a turning and positioning regimen where he was to be turned every three hours.

On January 4, 2016, decedent consulted with a vascular surgeon, who recommended placing decedent's left foot in an Unna boot. On January 11, 2016, the vascular surgeon noted that the left lower extremity wounds were doing well. The wounds were noted to be a left lower extremity posterior vascular/arterial wound in the area between the ankle and calf measuring 5 x 4 cm, and the lateral ankle wound measuring 4 x 1.5 cm. The wounds were clean, and decedent was directed to continue using the Unna boot. On January 19, 2016, it was documented that decedent's lower left extremity wound had worsened, decedent's son was notified, and a further wound care consult was ordered.

On January 22, 2016, decedent was documented with a posterior vascular wound measuring 7 x 5 cm and a left lateral ankle vascular ulcer measuring 4 x 1.8 cm. On January 29, 2016, the vascular surgeon removed the Unna boot. On February 2, 2016, decedent was noted to have a left heel unstageable ulcer, 3.0 x 3.0 cm with necrotic tissue,

and a vascular wound on the left ankle measuring 11.0 x 9.0 x 0.4 cm. On February 3, 2016, the left heel ulcer was noted to be 3 x 3 cm (unstageable), the left lateral ankle vascular/areterial wound measured at 4 x 3 X 0.3 cm, and the left lower extremity posterior vascular/arterial wound measured at 9.8 x 5.8 x 0.3 cm. Two weeks later, Medcena Wound Management (Medcena), defendant facility's wound care provider, measured the left ankle vascular wound at 10 x 5 x 0.3 cm, a separate left lateral ankle wound at 3.5 x 3.0 x 0.3 cm, a left anterior foot wound measuring 2 x 2 x 0.3 cm and the left heel pressure ulcer at 3 x 3.2 cm. According to defendant's expert, the left heel ulcer resolved as of February 24, 2016, and decedent continued to be treated for his two left lower extremity vascular/arterial wounds.

On March 15, 2016, decedent had a plastic surgery consult for evaluation of his wounds on his left posterior Achilles tendon and left dorsum. It was noted that decedent's left ankle wound had full thickness with exposed necrotic Achilles tendon, malodorous drainage, and limited range of motion. The surgeon diagnosed chronic venous hypertension with ulcer and inflammation of the left lower extremity and atherosclerosis of native arteries of the left leg with ulceration of the ankle. The surgeon found that the wound was not likely to heal and amputation was considered. Decedent's family ultimately decided against amputation.

Thereafter, weekly skin assessments in May and June of 2016 indicated that decedent's exterior and posterior wounds increased in size. In July of 2016, decedent's son expressed concern over decedent's right hand swelling and lower left extremity edema, which was explained as being secondary to vascular issues. On August 11, 2016

and November 5, 2016, decedent was still assessed as a "mild risk" on the Braden Scale for developing pressure ulcers.

On December 5, 2016, it was noted that decedent had a sacral wound measuring 1 x 1 cm, which, by December 14, 2016, had deteriorated to a Stage II wound measuring 4.5 x 5.5 x 0.2 cm by December 14, 2016. On December 14, 2016, decedent was given a "Supreme Air" mattress. On December 15, 2016, decedent was seen by a wound care doctor secondary to his nonhealing vascular wounds, and was discharged from defendant facility and admitted to New York Community Hospital for treatment of those wounds. Upon admission, decedent was diagnosed with a Stage IV necrotic sacral wound measuring 7 cm x 9 cm and a Stage II pressure ulcer on his buttock measuring 5 x 2 cm, as well as additional vascular wounds. Decedent's left leg had extensive dry gangrene of the foot and lower leg through his calves. Extensive tissue loss and the need for an above knee amputation of the left leg were noted. On December 30, 2016, a podiatric surgery specialist noted that decedent's foot and ankle wounds were gangrenous and infected, and the wounds were malodorous and wet. Decedent's family ultimately refused to consent to an above the knee amputation and the amputation recommendation was later discontinued as decedent's condition became more unstable.

On January 3, 2017, decedent was discharged to Four Seasons Nursing and Rehab. Upon admission, his gangrenous left foot, and vascular ulcers on this left posterior leg and dorsal left foot were noted. Decedent expired on January 13, 2017.

Pamela Delacuadra (Delacuadra), director of nursing at defendant facility,

testified that the facility had nursing policies and procedures relating to pressure ulcer prevention and management and for comprehensive care plan development. Delacuadra testified that according to the defendant's comprehensive care plan, facility residents were to be assessed for pressure ulcer risk upon admission, readmission, or upon significant changes to their condition, as needed. Delacuadra testified that according to facility policy and procedure, the recognized standard of practice for turning and positioning a resident in bed is every two to three hours and every two hours in a chair. According to Delacuadra, someone like decedent with a moderate risk of developing pressure ulcers, or someone with a Stage II pressure ulcer, would get an "air overlay" mattress as opposed to a "Supreme Air" mattress. She also testified that if someone with decedent's wounds and comorbidities was not turned and positioned within two to three hours, it would be a violation of policies and procedures. Delacuadra further testified that the facility policy was to assess wounds weekly.

Discussion

A party moving for summary judgment bears the burden of making a prima facie showing of entitlement to judgment as a matter of law and must tender sufficient evidence in admissible form to demonstrate the absence of any material factual issues (*see* CPLR 3212 [b]; *Alvarez v Prospect Hospital*, 68 NY2d 320, 324 [1986]; *Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]; *Korn v Korn*, 135 AD3d 1023, 1024 [3d Dept 2016]). Failure to make this prima facie showing requires denial of the motion (*see Alvarez*, 68 NY2d at 324; *Winegrad v New York University Medical Center*, 64 NY2d 851, 853 [1985]). Once this showing has been made, the burden shifts to the party opposing

the motion to produce evidence in admissible form sufficient to establish an issue of material fact requiring a trial (*see* CPLR 3212; *Alvarez*, 68 NY2d at 324; *Zuckerman*, 49 NY2d at 562). "[A]verments merely stating conclusions, of fact or of law, are insufficient to defeat summary judgment" (*Banco Popular North America v Victory Taxi Management, Inc.*, 1 NY3d 381, 383 [2004] [internal quotations omitted]). The court must view the totality of evidence presented in the light most favorable to the nonmoving party and accord that party the benefit of every favorable inference (*see Fortune v Raritan Building Services Corp.*, 175 AD3d 469, 470 [2d Dept 2019]; *Emigrant Bank v Drimmer*, 171 AD3d 1132, 1134 [2d Dept 2019]).

Summary judgment is a "drastic remedy" that "should not be granted where there is any doubt as to the existence of such issues or where the issue is 'arguable'; issue-finding, rather than issue-determination, is the key to the procedure" (*Sillman v Twentieth Century-Fox Film Corp*, 3 NY2d 395, 404, *rearg denied* 3 NY2d 941 [1957] [internal citations omitted]). "The court's function on a motion for summary judgment is 'to determine whether material factual issues exist, not resolve such issues'" (*Ruiz v Griffin*, 71 AD3d 1112, 1115 [2d Dept 2010], quoting *Lopez v Beltre*, 59 AD3d 683, 685 [2d Dept 2009]).

A. Liability Under the Public Health Law and Federal and State Regulations

Public Health Law § 2801–d confers a private right of action on a patient in a nursing home for injuries sustained as the result of the deprivation of specified rights (Public Health Law § 2801–d [1]; *Henry v Sunrise Manor Ctr. for Nursing & Rehab.*, 147 AD3d 739, 741 [2d Dept 2017]; *Moore v St. James Health Care Ctr., LLC*, 141 AD3d

701, 703 [2d Dept 2016]; *Zeides v Hebrew Home for Aged at Riverdale*, 300 AD2d 178, 179 [1st Dept 2002]). Claims to recover damages for deprivation of rights under the Public Health Law are separate and distinct and involve considerations different from those sounding in medical malpractice and/or negligence (*see Sullivan v Our Lady of Consolation Geriatric Care Ctr.*, 60 AD3d 663, 665 [2d Dept 2009]; *Zeides*, 300 at 179; *Butler v Shorefront Jewish Geriatric Center, Inc.*, 33 Misc 3d 686, 693 [Sup Ct, Kings County 2011], Steinhardt, J.). "Liability, however, is limited to 'injuries suffered as a result of said deprivation'" (Public Health Law § 2801-d [l]; *Burns v Rockville Skilled Nursing & Rehabilitation Center, LLC*, 2012 NY Slip Op 31176[U] [Sup Ct, Nassau County 2012]). Under section 2801-d, a patient may obtain compensatory damages upon a finding that he or she has been injured as the result of a deprivation of a specified right unless there is a finding that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient (Public Health Law § 2801-d [2]).

The relief sought here is predicated upon Public Health Law regulations regarding the rights of patients in certain medical facilities, which states, in pertinent part, that "[e]very patient shall have the right to receive adequate and appropriate medical care" (Public Health Law § 2803-c). Plaintiff contends that defendant's failure to adequately assess decedent's condition, to institute a proper comprehensive plan of care, and to treat his pressure ulcers, including the failure to adequately turn and position him and to provide him with an appropriate quality air mattress, caused decedent's injuries.

Of relevance here, the Code of Federal Regulations directs nursing homes to provide residents with a quality of care, based on a comprehensive assessment of a resident, in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices (*see* 42 CFR § 483.25). With regard to development of pressure ulcers:

> "[b]ased on the comprehensive assessment of a resident, the facility must ensure that . . . (i) [a] resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) [a] resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing" (42 CFR § 483.25 [b] [1]).

New York State Department of Health regulations concerning the minimum quality of care applicable to nursing homes directs:

> "(c) *Pressure sores*. Based on the comprehensive assessment of a resident, the facility shall ensure that: (1) 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 despite every effort to prevent them; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing" (10 NYCRR § 415.12 [c]).

Defendant contends that decedent's pressure ulcers were not a result of any failure on its part of following the statutory guidelines but due to decedent's own comorbidities. In that regard, defendant submits that it has made a prima facie showing of its entitlement to summary judgment by submitting decedent's medical records, deposition testimony, as

well an affidavit from its expert, Garbitelli, opining the treatment provided to decedent comported with good and accepted standards of medical practice and was not a proximate cause of his injuries. In opposition, plaintiff contends that defendant failed to provide statutorily mandated treatment and services, depriving plaintiff of his rights and causing neglect and injury. Plaintiff argues that the failures began upon admission when decedent was not properly assessed, resulting in failure to implement proper interventions to avoid pressure ulcers. The failures were allegedly systemic, as they ranged from the initial assessment, to the failure to monitor and modify interventions, to the failure to re-evaluate decedent and to promote healing of the pressure ulcers once they developed.

Here, defendant has established its prima facie entitlement to summary judgment as a matter of law by submitting decedent's medical records from the facility as well as Garbitelli's affidavit, which concludes that defendant followed all statutory guidelines (*see Alvarez*, 68 NY2d at 324; *Zuckerman*, 49 NY2d at 562). Garbitelli opines that defendant's compliance with all applicable statutory requirements is evidenced by the care and treatment documented in the records from defendant facility and testified to by Delacuadra. Garbitelli states that upon admission to the facility, decedent was assessed, and then started receiving physical and occupational therapy services. Decedent was allegedly turned and positioned every two to three hours on a regular basis, and his wound was treated per physician's orders. Garbitelli opines that there is nothing in the evidence, testimony or medical records that defendant or its staff caused or contributed to decedent's injuries or death.

Garbitelli notes that decedent was admitted to defendant facility with compromised skin integrity, comorbidities and multiple risk factors for developing pressure ulcers, and that and the worsening of those ulcers was unavoidable despite appropriate care from defendant facility. According to Garbitelli, decedent's fragile skin correlated with his history of diabetes and hypertension, which reduce blood flow to skin, causing tissue to be poorly oxygenated and failing to deliver adequate nutrients to maintain skin integrity. He opines that decedent's anemia reduced oxygen to the skin and reduced the ability of decedent's skin to heal. Garbitelli further opines that all decedent's wound care plans and cleansing orders were appropriate, and appropriately altered as necessary.

In addition, Garbitelli opines that decedent was appropriately turned every two to three hours, which is consistent with the standard of care to assist with prevention of and reduction of worsening of pressure ulcers. With regard to decedent's treatment in December of 2015 of his Stage II left lateral ankle wound, Garbitelli contends that the treatment complied with the standard of care despite the fact that the wound progressed to Stage III. He opines that defendant facility appropriately relied on the vascular surgery consult and the recommendation to place decedent in an Unna boot in an attempt to increase blood flow to decedent's lower left extremity. Garbitelli also opines that the worsening of the left ankle wounds, to the extent that an above the knee amputation was recommended, was also unavoidable and caused by decedent's worsening diabetes and other comorbidities and not caused by any deficient care.

Garbitelli states that the appropriateness of defendant's care for decedent was evidenced by the fact that decedent's wounds were relatively stable and only gradually increased in size at times despite his numerous comorbidities. He also opines that defendant responded promptly and adequately to decedent's signs of infection and timely transferred him to acute care facilities when necessary, and that a proper vascular consult was obtained for decedent's wounds. Garbitelli notes that the death certificate provided by the City of New York for decedent, which indicated that decedent died of natural causes, rather than by any negligent care or treatment by defendant facility or its staff, further evidences that defendant provided adequate care within the appropriate standard of care.

In opposition, however, plaintiff has raised questions of fact regarding whether the care provided to decedent with respect to assessing his condition, turning and positioning him, and providing him with and adequate air mattress complied with the applicable statutory guidelines (*see Alvarez*, 68 NY2d at 324; *Zuckerman*, 49 NY2d at 562). To that end, plaintiff's expert, Ronald Roth, M.D. (Roth), opines that upon admission to defendant facility, decedent was incorrectly assessed as mild risk for the development of pressure ulcers in violation of 42 CFR § 483.25 (b) (1). Roth asserts that decedent should have been assessed as high risk because he required extensive assistance for bed mobility and had multiple comorbidities. Roth claims that as a result of this improper assessment, decedent was not provided with proper interventions and basic preventive measures designed to prevent the development of pressure ulcers and turning and

positioning decedent pursuant to the state and federal regulations.[1] Roth opines that decedent presented a high risk of developing pressure ulcers and that the failure to properly assess him was the causation or contributing factor to the development and worsening of his wounds. In that regard, Roth points to the fact that decedent received an "air overlay" mattress, appropriate for a moderate risk patient, rather than a "Supreme Air" mattress, which a patient assessed as high risk would receive. Roth notes that decedent only received a Supreme Air mattress in December of 2016 after he developed multiple pressure ulcers and vascular wounds that put decedent in danger of leg amputation. Roth observes that despite the fact that the decedent's wounds noted in February of 2016 were getting progressively larger, deeper and more numerous, decedent was again assessed as mild risk on the Braden Scale on August 11, 2016 and November 5, 2016, and no new interventions were taken.

Roth also disputes Garbitelli's claim that decedent's ulcers were unavoidable. Roth contends that the federal regulations define an unavoidable ulcer as one that developed even though the facility had evaluated decedent's condition and risk factors, defined and implemented interventions consistent with his needs, goals and professional standards of practice, and monitored and evaluated the impact of the interventions and revised as appropriate.

Roth further opines that the turning and positioning regimen of two to three hours was inappropriate and violated the guidelines. In that regard, Roth opines that

[1] While plaintiff and Roth contend that specific interventions, such as an adequate pressure relieving mattress, is mandated by 42 CFR § 483.25 (b) (6), the current statute does not contain this subsection.

Delacuadra's testimony that a turning regimen of every three hours was in line with the facilities' policies and procedures show a lack of knowledge of the federal and state guidelines, as 42 CFR § 483.25 (b) (1) states that repositioning should occur at least every two hours,[2] depending on the resident's condition and specific needs, and 10 NYCRR § 415.12 (c) (2) directs the facility to provide a resident with pressure sores the necessary treatment and services to promote healing. Roth contends that, contrary to defense expert's opinion that the standard industry practice is that residents with bed mobility issues be turned and positioned every two or three hours, the current accepted guideline for care is to turn the patients every two hours at a minimum. Roth states that Garbitelli is unfamiliar with the federal and state regulations, and that, therefore, summary judgment is not warranted. Roth also claims that the policy of turning and repositioning a resident at risk for development of pressure ulcers every three hours violated the regulations as well as placed vulnerable residents at risk, and caused or contributed to decedent's injuries.

Roth points out that, here, not even a three hour turning and positioning regimen was adhered to, since the documentation of decedent's turning and positioning show that in August of 2014, decedent was not turned and positioned at all during the night shifts from 11:00 p.m. to 7:00 a.m. for more than half of that month, and that sometimes he was not repositioned for over 16 hours. Plaintiff further points to decedent's medical record,

[2] While the language of 42 CFR § 483.25 (b) (1), quoted *supra*, does not mandate repositioning at least every two hours, Roth clearly opines that a turning regimen of three hours for decedent was inadequate, and that decedent should have been turned and repositioned at least every two hours, thereby creating a question of fact.

which demonstrates that decedent's development of pressure ulcers coincides with the failure of decedent facility staff to turn and reposition decedent, which could have been avoided if preventative measures were used. For example, on November 12, 2015, decedent was placed in his wheelchair for nine hours (from 10:15 a.m. to 7:15 p.m.), and was later positioned on his back, where he remained for another six hours. The next morning, on November 13, 2015 at 10:15 a.m., decedent was again placed in his wheelchair where he remained for another six hours. Later on November 13, 2015, a nurse noted in decedent's chart that he had left ischium redness measuring 5 x 3 cm.

In another such instance, on December 9, 2015, decedent was placed on his back at 10:15 p.m. and was not turned until December 10, 215 at 4:15 a.m. Later on December 10th at 10:15 a.m., decedent was in his wheelchair for nine hours until 7:15 p.m., and later that evening, was repositioned on his right side for another nine hours. Thereafter, on December 10, 2015, decedent's record noted an open wound on the left malleolus measuring 4 x 2.5 x 0.3 cm, and on December 14, 2015, a left heel pressure ulcer was noted on the ankle measuring 2 x 2 cm, which was noted as a Stage II wound. In addition, a pressure wound was noted on the left lateral ankle and was assessed as a Stage II wound.

Plaintiff highlights that the failure to properly assess decedent continued through to the end of his residency at defendant's facility, as he was assessed at mild risk for development of ulcers on November 5, 2016 despite the presence of multiple vascular wounds. Medcena noted two vascular/arterial wounds and a sacral pressure ulcer on December 14, 2016, and recommended that he be turned and repositioned every two

hours, rather than every three hours. Despite this recommendation, defendant facility continued to turn reposition decedent every three hours, and even that was not adhered to, as on December 13, 2015, decedent was placed in his wheelchair for nine from 1:15pm until 10:15 pm. Thereafter, decedent's wounds deteriorated and he was discharged to New York Community Hospital on December 15, 2016, where, upon admission, he was diagnosed with a Stage IV necrotic sacral wound measuring 5 x 2 cm.

Roth further contends that defendant did not create an appropriate comprehensive care plan for decedent, which should normally be properly developed, reviewed and revised in conjunction with assessments. Roth states that if the assessments were improper, then the care plan will also more likely than not be improper, and the resident will not get the needed and statutorily mandated care. Roth opines that decedent's care plan was not adequately updated to reflect his development of vascular and pressure ulcers, and that he continued to be assessed as mild risk. As a result of the incorrect assessment of mild risk, no interventions were put in place to address the worsening wounds.

In sum, Roth opines that defendant violated good and accepted practices while treating decedent's vascular and pressure wounds by failing to implement preventative measures required by the state and federal regulations, including providing pressure reducing surfaces and the failure to implement a regimen of off-loading pressure on the wounds to promote healing. Roth opines that these failures were the cause and/or contributing factor to decedent's injuries. Roth's affidavit, in conjunction with decedent's records, create questions of fact as to whether the failure to turn and reposition

decedent more frequently than every three hours, or, in some instances, for over six hours, caused or exacerbated his pressure ulcers and wounds. Roth's affidavit also creates a question of fact as to whether decedent was properly assessed so that the appropriate interventions, such as more frequent turning and an earlier prescription of a Supreme Air mattress, could have been prescribed. The court cannot resolve these issues on this motion, as they are for a trier of fact to resolve. Accordingly, defendant's motion to dismiss the Public Health Law claim is denied.

B. Punitive Damages Claim

Defendant contends that punitive damages are not warranted under Public Health Law § 2801-d because plaintiff has not established that decedent was deprived of any rights that resulted in any injury to him at defendant facility. In that regard, defendant notes that Garbitelli opined that defendant complied with all applicable statutory requirements as evidenced by treatment records and deposition testimony of defendant facility's director of nursing. Defendant also argues that the gross negligence claim should be dismissed. To that end, defendant contends that plaintiff has not established that any deprivations were willful or committed in reckless disregard, and notes that Garbitelli opined that there was no evidence of decedent's negligent care or treatment. Moreover, defendant contends that plaintiff's expert did not opine that defendant facility or its staff acted with reckless disregard or willfully deprived decedent of his rights.

Defendant also contends that it is inconsistent for plaintiff to withdraw all negligence claims and yet continue to assert that defendant's actions rose to the level of reckless or willful disregard. Defendant further argues that plaintiff's expert's opinion

must be disregarded because plaintiff's expert states that his practice is limited to family and pediatric medicine, and he does not have any nursing home affiliations on his curriculum vitae, and his academic and hospital appointments have been in family medicine roles, rather than in geriatric medicine or as an internist.

In response, plaintiff contends that punitive damages are expressly allowed under Public Health Law § 2801-d (2), and that the standard for obtaining punitive damages is lower under the statute than under common law. Plaintiff also argues that the failures of the defendant facility were constant and on such a massive scale as to rise to willful and reckless disregard.

Punitive damages may be assessed "where the deprivation of any such right or benefit is found to have been willful or in reckless disregard of the lawful rights of the patient" (Public Health Law § 2801-d [2]; *Butler*, 33 Misc 3d at 695-698 [Sup Ct, Kings County 2011]). Some trial level courts have stated that section 2801-d (2) provides for recovery of punitive damages under a standard that is less stringent than applicable to such damages in the context of a medical malpractice claim (*see Peters v Nesconset Ctr. for Nursing & Rehabilitation*, 47 Misc 3d 1211[A], 2015 NY Slip Op 50555[U], *3 [Sup Ct, Queens County 2015]; *Osborne el rel. Osborne v Rivington House-Nicholas A. Rango Health Care Facility*, 19 Misc 3d 1132[A], 2008 NY Slip Op 50975[U], *6 [Sup Ct, New York County 2008]).

Nevertheless, the language of section 2801-d (2) sets a high bar for the recovery of punitive damages (*see Butler*, 33 Misc 3d at 695-698; *see also Holder v Menorah Home & Hosp. for the Aged & Infirm*, 36 Misc 3d 1210[A], 2011 NY Slip Op 52515[U], *8

[Sup Ct, Kings Count, 2011], Jacobson, J.). This view is reinforced by the Court of Appeals' discussion of punitive damages in its relatively recent decision in *Chauca v Abraham* (30 NY3d 325 [2017]), in which it adopted a standard for the recovery of punitive damages under the New York City Human Rights Law (Administrative Code of City of NY §§ 8-107 [1] [a], 8-502) that is similar to the statutory language contained in section 2801-d (2) (*see Chauca*, 30 NY3d at 334). The Court of Appeals made clear in *Chauca* that a mere statutory violation would not suffice given that punitive damages are generally intended to address "gross misbehavior" (*Chauca*, 30 NY3d at 331, quoting *Thoreson v Penthouse Intl.*, 80 NY2d 490, 497 [1992]), and "'may only be awarded for exceptional misconduct which transgresses mere negligence'" (*Chauca*, 30 NY3d at 331, quoting *Sharapata v Town of Islip*, 56 NY2d 332, 335 [1982]).

In the instant matter, there is no evidence in the record to support a finding that defendant's conduct constituted gross misbehavior, or that its care and treatment of decedent rose to the level of willful, wanton or reckless conduct that transgressed mere negligence (*see Chauca*, 30 NY3d at 331). Rather, decedent's medical records indicate that most of the time, he was turned and repositioned every two to three hours. Decedent was frequently evaluated for his pressure sores, and Medcena provided routine wound care. Decedent was also sent out for consults regarding his wounds. The documentation of decedent's care at defendant facility demonstrates that while there may be a question of fact as to the adequacy of decedent's treatment that might rise to the level of negligence or a statutory violation, there is no evidence at all of any exceptional misconduct that would warrant punitive damages.

Accordingly, defendant's motion to dismiss the gross negligence and punitive damages claims is granted.

With respect to defendant's motion to disallow plaintiff from using res ipsa loquitur to prove his negligence claim, that motion has been rendered moot, as plaintiff has stated that he is withdrawing the negligence claim. Res ipsa loquitur is a rule of circumstantial evidence that allows a factfinder to infer negligence where the actual specific cause of an accident is unknown (*see James v Wormuth*, 21 NY3d 540, 546 [2013]). The doctrine permits an inference of negligence based upon the mere occurrence where a plaintiff has proffered evidence that: (1) the occurrence is not one that ordinarily happens in the absence of negligence; (2) the occurrence is caused by an instrumentality or agency within the defendant's exclusive control; and (3) plaintiff did not contribute to the occurrence (*id.*; *see also States v Lourdes Hosp.*, 100 NY2d 208, 211 [2003]). Since plaintiff has withdrawn his negligence claim, plaintiff cannot use the doctrine of res ipsa loquitur to infer the existence of negligence, as the remaining claims are statutory.

With respect to defendant's motion to essentially convert this case to a medical malpractice case and move it to the medial malpractice part, that motion is denied. Plaintiff has withdrawn the negligence claims and has stated that he is not asserting a malpractice claim, and there is no basis to grant defendant's requested relief.

Defendant further contends that plaintiff's derivative claims for loss of guidance, support and care must be dismissed because his negligence claims are without merit, and a loss of services claim is predicated on the injured party's ability to recover in the direct

cause of action. In his opposition, plaintiff does not address this argument. The court notes that there is no cause of action for loss of services asserted in the complaint. Accordingly, to the extent that plaintiff asserts these claims in his bill of particulars, such claims are dismissed.

The court has considered the parties' remaining contentions and finds them without merit. Accordingly, it is

ORDERED that defendant's motion, mot. seq. two, for summary judgment on the statutory Public Health Law claims is denied; and it is further

ORDERED that plaintiff's negligence, gross negligence, punitive damages, and loss of services claims are dismissed; and it is further

ORDERED that defendant's motion to convert this action to a medical malpractice action is denied.

All relief not expressly granted herein is denied.

This constitutes the decision and order of the court.

ENTER,

J. S. C.

Hon. Dawn Jimenez-Salta
Justice of the Supreme Court