To commence the 30-day statutory time period for appeals as of right under CPLR 5513 (a), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

----------X

FLORENCE BENISATTO, Individually, and as Executrix of the Estate of EUGENE BENISATTO, deceased,

Plaintiff,

-against-

Index No. 50475/13
Motion Seq. Nos. 005, 006
Decision and Order

SPRAIN BROOK MANOR NURSING HOME, LLC d/b/a SPRAIN BROOK MANOR NURSING HOME, SPRAIN BROOK MANOR NURSING HOME, LLC, SPRAIN BROOK MANOR NURSING HOME, H. BOOK and R. KLEIN,

Defendants.

----------X

EVERETT, J.

The following papers were read on the motions:

005 Notice of Motion/Aff in Supp/Exhibits A-O/Memorandum of Law

006 Notice of Cross Motion/Affirmation in Supp/Taylor Affidavit/Schwartz Affidavit/ Exhibits 1-12/Memorandum of Law
Aff in Opp/Exhibits A-B
Reply Aff/Exhibits A-B

Upon the forgoing papers, the motions are denied.

The following facts are taken from the pleadings, motion papers, affidavits, documentary evidence and the record, and are undisputed unless otherwise indicated.

Plaintiff Florence Benisatto, Individually, and as Executrix of the Estate of Eugene Benisatto, deceased, commenced the instant action against defendants Sprain Brook Manor Nursing Home, LLC d/b/a Sprain Brook Manor Nursing Home, Sprain Brook Manor Nursing Home, LLC, Sprain Brook Manor Nursing Home (Sprain Brook), and its alleged owners and

operators H. Book (Book) and R. Klein (Klein), by filing a summons and complaint in the Office of the Westchester County Clerk on January 11, 2013, to recover damages stemming from the care, treatment and subsequent death of her husband, Eugene (E. Benisatto, or decedent, as appropriate), while a resident patient at the nursing home owned and operated by Sprain Brook, and located at 77 Jackson Avenue, Scarsdale, New York.

According to the complaint, at approximately 6:00 p.m., on May 10, 2011, another resident in the nursing home's designated dementia/Alzheimer's unit (Unit) with a known history of aggression (Resident X), was at the nurse's station screaming about his television being stolen or missing. It is alleged that the Licensed Practical Nurse (LPN) on duty at the time, Vinnette Fowler (Fowler) tried to calm Resident X in a manner not appropriate for dealing with an agitated dementia/Alzheimer's patient - - by walking him into his room confronting Resident X with the fact that his television was still there - - and was unsuccessful in her efforts, as Resident X walked out of his room, continuing to rage. It is also alleged that, when E. Benisatto, who had been sitting on a chair in the hallway, stood up to intervene and/or stop Resident X, Resident X pushed E. Benisatto, who fell to the floor. Sprain Brook's nursing staff rushed over to take control of the situation.

Sprain Brook arranged for E. Benisatto to be taken by ambulance to St. John's Riverside Hospital (St. John's Riverside), where he was underwent surgery for a hip fracture. On May 18, 2011, E. Benisatto was readmitted to Sprain Brook, where he stayed until June 1, 2011, when he was transferred back to St. John's Riverside with a diagnosis of failing to thrive. On June 8, 2011, E. Benisatto was transferred to Calvary Hospital, where he remained until he died on September 13, 2011.

Thereafter, his wife commenced the instant action for damages, claiming, essentially, that as a result of defendants' failure to properly monitor and handle Resident X, who had a documented history of increasingly aggressive behavior, E. Benisatto was caused to sustain the injuries, which ultimately led to his diagnosed failure to thrive (malnutrition, bedsores and gangrene) and death. The complaint contains six causes of action. The first cause of action alleges that defendants violated Public Health Law §§ 2801-d and 2803-c, based on their actions and/or inactions which resulted in a deprivation of E. Benesatto's rights as a resident of a nursing home and in his sustaining personal injury. The second, third, fourth, fifth and sixth causes of action sound in negligent hiring and supervision, negligence, gross negligence, loss of consortium, and wrongful death, respectively. Issue was joined by service of defendants' joint answer, with 14 affirmative defenses, on or about March 26, 2013. The parties pursued discovery pursuant to the preliminary conference order and several follow-up compliance conference orders, and on February 8, 2016, plaintiff filed a note of issue and certificate of readiness.

Currently before the Court are defendants' joint motion for an order, pursuant to CPLR 3212, granting a summary judgment dismissal of the complaint, and plaintiff's cross motion for an order, pursuant to CPLR 3212, granting summary judgment against defendants, which defendants oppose both on the merits and on procedural grounds. The motions, under motion sequence numbers 005 and 006, are consolidated for disposition.

It is well settled that:

> "the proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact. Failure to make such

> prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers. Once this showing has been made, however, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action"

(*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 [1986] [internal citations omitted]).

Steadfastly denying any wrongdoing, defendants insist that they had no notice that Resident X was predisposed to violent behaviors, and assert that there is no basis for plaintiff's deprivation of rights and dignity claims (Public Health Law §§ 2801-d, 2803-c), as Resident X's actions were spontaneous, and the altercation occurred between facility residents, and did not involve Sprain Brook or an of its staff. Defendants dispute plaintiff's claims that the incident was a substantial factor in causing the injury (hip fracture) that led to E. Benisatto's subsequent failure to thrive and gangrene diagnoses and death, pointing out that he suffered gangrene while at Calvary Hospital, and not during his residency at Sprain Brook. Defendants also argue that the allegations against Book and Klein are groundless, and must be summarily dismissed.

To demonstrate prima facie entitlement to summary judgment, defendants submit copies of: the requisite pleadings and bills of particulars; Sprain Brook's records, assessments and facility charts for E. Benisatto (notice of motion, exhibits G); the Resident to Resident Altercation report (*id.* exhibits H); the St. John's Riverside record for E. Benisatto (*id.* exhibit I); plaintiff's deposition transcripts (*id.* exhibits J); the deposition transcripts of plaintiff, Amelia (Mendizabal), Fowler, certified nursing assistants (CNAs) Jacqueline Jackson (Jackson) and Monica Murphy (Murphy) (*id.* exhibits J, K, L, M, and N, respectively); the Calvary Hospital records for E. Benisatto (*id.* exhibits O); and the expert affirmation of Dr. Harold Milstein, a licensed physician with 36 years of practice in internal medicine, and in long-term care in nursing

and rehabilitation facilities. They contend that this evidence establishes, as a matter of law, that Sprain Brook did not depart from good and accepted medical and nursing home practice care in its supervision and handling of Resident X, and in its monitoring and care for its residents, including E. Benisatto, because: (1) Sprain Brook's staff was adequately trained and qualified in safety protocol and care; (2) the Unit was adequately staffed; (3) Sprain Brook's staff was properly supervising the residents before, during and after the incident; (4) at the time of the altercation, Fowler was supervising Resident X, and E. Benisatto was within close proximity to another nurse, Monica Murphy (Murphy); (4) Fowler was handling Resident X in an appropriate manner; (5) Resident X's push of E. Benisatto was sudden, spontaneous and unexpected; and (6) when the altercation occurred, Sprain Brook's staff immediately intervened, separated, assessed and monitored them, notified the appropriate parties and took the appropriate actions.

As indicated above, defendants offer and rely upon the affirmed statement of Dr. Milstein regarding the care and treatment provided by Sprain Brook to the Unit residents on May 10, 2011, during the 3:00 p.m. to 11:00 p.m. shift (3-11 shift). Dr. Milstein states that his opinions are based on his review of: the pleadings; the relevant Sprain Brook, St. John's Riverside Hospital, and Calvary Hospital records; the deposition transcripts of parties and nonparties; the state and federal statutes allegedly violated; and the medical literature related to the good and accepted standards of medical and nursing home practice care between 2007-2011 (notice of motion, exhibit A). Dr. Milstein provides a summary of the incidents of May 10, 2011, stating that, as soon as Resident X knocked E. Benisatto to the floor, Sprain Brook's staff took the immediate and appropriate steps of separating the two residents, placing them on one to one observation, assessing them for injury, transferring them to separate hospitals and notifying their

families and primary physicians. He opines that the staff's immediate response was consistent with good and accepted standards of medical and nursing care.

Next, Dr. Milstein notes that, when E. Benisatto was transferred, on May 18, 2011, from St. John's Riverside back to Sprain Brook for long-term care, with admitting diagnoses of right hip fracture, severe osteoporosis, gout, depression, demential B PTT, and decline in function, E. Benisatto exhibited some confusion, and was fully dependent in transferring, toileting and locomotion. Sprain Brook then took the appropriate step of transferring E. Benisatto back to St. John's Riverside on June 1, 2011, because he was then suffering from dysphagia and was failing to thrive.

With respect to the altercation, Dr. Milstein opines that, at the time of the incident, both Resident X and decedent were being appropriately supervised, noting that Fowler was in the hallway and able to observe the interaction. He opines that Fowler's decision to address Resident X's behavior, when he was screaming about his missing possession, by attending to him in his room, by trying to calm him down and by requesting assistance, was consistent with good and accepted standards of medical and nursing care. Furthermore, when Resident X walked out of his room and in a "split second" (quoting from Fowler's deposition testimony at 37), knocked down E. Benisatto, Sprain Brook's nursing staff's immediate response was also consistent with good and accepted standards of medical and nursing care. Dr. Milstein references and quotes from the information contained the Resident on Resident Altercation Report prepared by Mendizabal, Sprain Brook's Director of Nursing, stating, in relevant part, that the:

> "22. . . . 'incident could have been attributed to the impaired cognition and behavioral disturbance of these two residents.' [Mendizabal] further notes the residents' behavior could be unpredictable. Additionally, the record reflects that

> both residents' Care Plans were in place and were followed when the incident took place. I support this assessment. While Decedent may have been pushed to the ground during the incident, he and the other resident were at the time being monitored and had received proper care that day. Therefore, it is my opinion, within a reasonable degree of medical certainty that Sprain Brook was properly monitoring and attending to Decedent and the other residents on the floor. The Sprain Brook staff was properly observing the facility's policy and procedures, including the number of nurses on the floor at all times before, during and after the incident. Both have diagnosis of Dementia. Both Resident's Care Plan was in place and being followed when the incident took place' at the time of the incident.
>
> 23. Based on the pertinent medical records, it is also my opinion, within a reasonable degree of medical certainty that throughout his residency, Decedent was properly cared for and did not experience any such 'deprivation of rights' that Plaintiff alleges"

(Milstein aff, ¶¶ 22, 23).

Dr. Milstein states that decedent did not suffer gangrene as a result of his care at Sprain Brook, because he did not develop gangrene until he was a patient at Calvary Hospital. He further states that, not only was the care and treatment rendered at Sprain Brook within the acceptable standards of medical and nursing home care, but such care did not cause, nor was it related to, decedent's hip fracture or gangrene, and it did not proximately cause decedent's death, and none of these occurrences or diagnoses provide a basis for the claimed statutory violations. As to those of plaintiff's claims that relate to E. Benisatto's failure to thrive, Dr. Milstein states that E. Benisatto "received dietary evaluations, multiple physician assessments, and administrative intervention . . . Decedent actually experienced significant functional improvement pursuant to the physical therapy and rehabilitative services that he received at the time of admission" (*id.* ¶ 28).

As to Book and Klein, Dr. Milstein asserts that, because he has found "zero indication of either an 'H. Book' or an 'R. Klein' being involved in the clinical management of this resident,"

he can find no basis for finding that either defendant deviated from the appropriate standards of medical and nursing care (*id.* ¶ 26).

Defendants also rely on the testimony of Mendizabal, Fowler and of CNAs Jackson and Murphy to establish that, at the time of the altercation, nurses were present at the nurses station, that Murphy was supervising residents in the dayroom, that Resident X was yelling and was the person who pushed E. Benisatto to the floor, that an emergency announcement was made over the loudspeaker, and that nursing staff quickly arrived to assist Resident X and E. Benisatto (Murphy tr at 24, 29-30, 36, 39).

Defendants contend the above-referenced charts, records, reports and deposition testimony conclusively establish their entitlement to a summary judgment dismissal of the complaint. They contend that the complaint should also be dismissed, because nursing homes cannot be held liable for resident-on-resident assaults where a facility does not have notice of a resident's predisposition to violent behavior (*Rodriguez v Terence Cardinal Cooke Health Care Ctr.*, 4 AD3d 147 [1st Dept 2004]), and they had no notice that Resident X had this predisposition.

Plaintiff's opposition, which is submitted together with her cross motion, includes competent evidence to rebut defendants' proof, and notes that defendants incorrectly predicate their entire motion on a medical malpractice standard – that being their alleged departure from accepted standards of care – when the complaint alleges violations of Public Health Law, and common law negligence and wrongful death causes of action, rather than medical malpractice. The difference, according to plaintiff's argument, is that, where, as here, the allegations sound in common law negligence and are not premised on "incompetence . . . of a specialized medical

nature, deriving from the physician-patient relationship . . . substantially related to medical diagnosis and treatment" (*Spatafora v St. John's Episcopal Hosp.*, 209 AD2d 608, 609 [2d Dept 1994]), the standard of proof is whether defendants owed a duty to plaintiff, whether defendants breached that duty, and whether defendants' breach was the proximate cause of harm sustained by plaintiff (*Basso v Miller*, 40 NY2d 233 [1976]). Plaintiff asserts that the competent evidence not only fails to support defendants' motion, but it constitutes evidence of defendants' liability on her causes of action sounding in negligence, as well as statutory violation.

In support of her cross motion for summary judgment, plaintiff relies on many of the same records, charts, reports and deposition transcripts, and supplements this evidence with copies of: Sprain Brook's post-incident reports; the Unit's staffing schedule for May 10, 2011; the facility's daily chart containing the nurses' and social workers' notes on Resident X's behavior problems occurring on September 28, 2010, on October 8, 11, 12, and 19, 2010, on February 15, 2011, March 8, 14, 26 and 30, 2011, on April 5, 16, 26, 28, 29, 2011 and on May 10, 2011, and the steps taken to address these problems, including therapies and medications; and the sworn statements of a physician, Ronald Jeffrey Schwartz, M.D. (Dr. Schwartz), and a register nurse (RN), Kara Taylor (Taylor), with expertise in the fields of nursing home care, Alzheimer's and dementia.

Plaintiff offers the facility's staffing schedule to show that, during the 3-11 shift on May 10, 2011, there was one LPN (Fowler) and four CNAs assigned to the Unit, but no RN (notice of cross motion, exhibit 3). Plaintiff offers the document titled "incident/accident post investigation," to show that Fowler is listed as the Unit's Charge Nurse at the time of the incident (*id.* exhibit 5), and the facility's daily chart to show that defendants had documented Resident

X's aggressive behaviors, which range from yelling and screaming in September 2010, to an argument between Resident X and another resident on October 19, 2010, which was noted on the chart as "argument became almost physical" causing a CNA "to separate resident" and call for assistance. Resident X's behaviors occurring: on February 15, 2011 was described as "loud, insistent & distressed;" on March 8, 2011 was "defiant" and "verbally abusive. Psych f/u needed. Discussed with RN;" on April 26, 2011 was "showing aggressive behavior [illegible] fists;" on April 28, 2011 "resident was reported physically aggressive towards staff, tapping overhead desk of nurses station with cane, almost hit the dietician;" and later on April 28, 2011 "became physically aggressive once again w/cane . . . will f/u as needed. Psych to f/u" (*id.* exhibit 5). Plaintiff contends that these notations constitute prima facie evidence that defendants had the requisite notice of Resident X's aggressive predisposition prior to his altercation with E. Benisatto on May 10, 2011 (*Rodriguez v Terence Cardinal Cooke Health Care Ctr.*, 4 AD3d 147 [1st Dept 2004]).

Addressing the issues related to the adequacy of the training and supervision provided by the sole LPN and four CNAs assigned to the Unit during the 3-11 shift, plaintiff references aspects of Fowler's deposition testimony in which she states that she became an LPN in December 2010, began working at Sprain Brook in March or April of 2011, and had no prior experience working in a nursing home, or with Alzheimer's or dementia patients, until she came to Sprain Brook (Fowler tr at 14-16). Fowler denied being a Charge Nurse at Sprain Brook, did not know what a Charge Nurse was, and stated that her assigned duty during her shift on May 10, 2011, was to dispense medications to the residents (*id.* at 13, 27). Fowler could not recall whether she had been given any policy and procedure manuals at Sprain Brook relating to

Alzheimer's and dementia patients, or educating her on how to calm down Alzheimer's and dementia patients who are in an agitated state (*id.* at 19). She also acknowledged being unaware, back in May 2011, that behaviors such as pacing around, screaming and swinging a cane were examples of an agitated patient (*id.* at 24-25). When asked to describe the subject altercation, Fowler stated that, when Resident X started screaming that his television was missing, she walked him into his room to show him that his property was still there. Fowler stated that Resident X would not calm down, and walked out screaming. When E. Benisatto "sat up to talk to him and in that split second, like less than a second, he pushed him to the floor" (*id.* at 35-36). When asked, Fowler could not recall whether she had called for assistance when she walked Resident X to his room (*id.* at 54).

Plaintiff supports her motion with the sworn affidavit of Taylor, an RN, MHA, with approximately 30 years experience of working in nursing homes (notice of cross motion). Taylor asserts, that, based upon her review of the pleadings, the accident, incident and investigation reports generated as a result of this incident, the daily staffing sheet for May 10, 2011, the facility chart containing notes on Resident X's behavior, and the deposition transcripts, it is her opinion, to a reasonable degree of nursing certainty, that defendants violated E. Benisatto's rights and acted in total disregard for his and other residents' health, well-being and safety. Taylor states that Fowler was unqualified to be the Charge Nurse for the dementia/Alzheimer's Unit and lacked the experience necessary for dealing with dementia and Alzheimer's patients in an agitated state, and should not have been assigned to that Unit. She opines that the appropriate method for dealing with an agitated dementia or Alzheimer's patient is to use a validation technique and not, as Fowler described, a more confrontational method of showing the patient

that he was wrong. Taylor also states that the records confirm that Resident X had a history of verbal and physically aggressive behavior that made him a known risk to the staff and to other residents in the Unit, that the records do not indicate that Sprain Brook had implemented proper interventions and care planning for this resident, and that in the absence of such interventions and care planning, Resident X should have been removed from the Unit. Taylor describes the failings as both administrative and institutional, and that they are consistent with the allegations contained in the complaint, including the alleged statutory violations.

Similarly, in his affirmation, Dr. Schwartz highlights the multiple incidents of aggressive behavior documented in the chart for Resident X, in which the nurses and/or social workers described him as verbally abusive and aggressive, with incidents of cane banging, swinging, and/or throwing, described an altercation with his roommate that almost resulted in a physical altercation, and the repeated references made by the nurses and/or social workers for psychiatric evaluation and consult. Dr. Schwartz states that the nurses and/or social workers' documented notes establish that defendants knew of Resident X's severe cognitive limitations and predisposition to agitated and aggressive behaviors prior to his altercation with E. Benisatto on May 10, 2011.

Dr. Schwartz explains why the Fowler's handling of Resident X, by confrontation rather than validation, was contrary to accepted standards of medical and nursing care for agitated residents with dementia or Alzheimer's. Dr. Schwartz reviews Fowler's work history and education, and opines that defendants should not have assigned, or permitted, Fowler, who lacked experience and training with dementia and Alzheimer's patients to be in charge of the Unit, and by doing so, defendants understaffed the Unit, and placed the residents at risk.

In response, defendants submit a supplemental expert affirmation from Dr. Milstein, and an expert affidavit from Marirose Kaufman (Kaufman), an RN with experience in nursing home care and treatment (aff in opp, exhibits A-B). In responding to plaintiff's evidence, Dr. Milstein challenges Dr. Schwartz's claim that Fowler was unqualified to be a Charge Nurse (without addressing the fact that Fowler was unaware that she was the designated Charge Nurse, or that she did not know what that position entailed) (*id.* exhibit A). Dr. Milstein disagreed with Dr. Schwartz's opinions that the intervention technique used by Fowler in attempting to calm Resident X was improper, and that it was inappropriate to house Resident X with the other dementia/Alzheimer's residents (*id.*). Dr. Milstein then explains that, because dementia is a progressive illness, the ultimate deterioration of E. Benisatto's health is consistent with that diagnosis, and also, that it is likely that his co-morbidities also contributed to his deterioration, failure to thrive and gangrene diagnoses, and death (*id.*).

In her sworn affidavit, Kaufman unequivocally states that Fowler's certification as an LPN qualifies her to be a Charge Nurse and to care for Alzheimer's patients (*id.* exhibit B). Kaufman disagrees with plaintiff's description of the intervention technique Fowler used with Resident X as a "reality intervention," stating that Fowler's technique was actually one of validation, and that, because Alzheimer's is a progressive disease, different methods must be used with each patient during different stages of the disease (*id.*). Kaufman criticizes Taylor's affidavit for omitting any reference to any policies and procedures which were not implemented by Sprain Brook's staff, and points to the sudden nature of Resident X's reaction to E. Benisatto's unexpected instigation as the cause of the claimed injuries, rather than the alleged inadequate or unqualified staffing (*id.*).

That aspect of defendants' motion that seeks a judgment dismissing the causes of action as against Book and Klein is granted. Insofar as neither the pleadings, nor any evidence in the record suggest any basis for the personal liability of Sprain Brook's alleged owners and operators Book and Klein, and insofar as plaintiff makes no meaningful argument in favor of assessing liability against them, the action must be dismissed as against them.

Addressing next, defendants' procedural argument that the cross motion must be denied as untimely, defendants' argument is unavailing, as it is appropriate for the Court to consider plaintiff's cross motion for summary judgment because she seeks relief based on the same issues on which defendants timely moved for summary judgment (*Filannino v Triborough Bridge & Tunnel Auth.*, 34 AD3d 280, 281 [1st Dept 2006], *appeal dismissed* 9 NY3d 862 [2007]).

As to the merits of the instant motions, given that, under CPLR 3212 (b), a court may only grant summary judgment when it finds that a movant's motion papers demonstrate, as a matter of law, that "there is no defense to the cause of action or that the cause of action or defense has no merit," and the evidence submitted in support of that movant must be viewed "in the light most favorable to the party opposing the motion" (*Lakeside Constr. v Depew & Schetter Agency*, 154 AD2d 513, 514 [2d Dept 1989 [internal citation omitted]), the balance of defendants' motion and plaintiff's cross motion must be denied.

Dr. Milstein's expert affidavit in support of defendant's motion is not only conclusory, but neither the records, charts, reports on which he relies, nor the deposition testimony to which he refers, establish, as a matter of law, that defendants: were not negligent in their supervision, care and treatment of E. Benisatto or any other resident, including Resident X; did not deviate

from relevant industry standards of care in their supervision, care and treatment of E. Benisatto; did not deprive E. Benisatto of any of his rights as a patient in a nursing home; and/or did not cause any of the injuries alleged in the complaint.

To the extent Dr. Milstein relies on the Resident-to-Resident Altercation Report prepared by Mendizabal for his assessment of what occurred on May 10, 2011, why it occurred, and how it was handled, his reliance is misplaced, as it is clear from her deposition testimony that she did not witness the incident, was not present at the facility during the 3-11 shift, and that she obtained her information afterwards.

It is also clear from Mendizabal's testimony that, despite plaintiff 's demand for Sprain Brook's policies and procedures, defendants did not produce the policy and procedures materials for counsel's use during her deposition. A review of the transcript reveals that, even after acknowledging that it was part of her duties as Sprain Brook's Director of Nursing to write and update its policies and procedures, Mendizabal provided no information in this regard, as either she could not recall any of the relevant policies and procedures, or defense counsel interrupted or blocked questions related to the policies and procedures in place for handling dementia residents with cognitive, agitative and/or behavioral issues. Defense counsel's constant interference also prevented discovery into many of the other issues, including whether there was adequate staffing in the Unit at the time of the incident, whether defendants were on notice of Resident X's aggressive behaviors, and what steps defendants took to address his behavior and to protect the other residents. Other than allowing his witness to state that the level of monitoring deemed necessary for any given resident is based on the staff's knowledge of that particular resident's

background and history, defense counsel deemed the majority of plaintiff counsel's questions to be improper on one basis or another.[1]

Based on this evidence, Sprain Brook has failed to demonstrate entitlement to summary judgment. Dr. Milstein's conclusory affirmation, which is based, in large part, on Mendizabal's conjecture that the incident could be attributed to the residents' impaired cognition and behavioral disturbances due to their dementia, without addressing whether any of the behaviors noted in Resident X's chart placed defendants on notice of a need for increased monitoring and/or the likelihood that he might cause injury to another resident. Dr. Milstein also failed to meaningfully address Fowler's acknowledged lack of training and experience with dementia patients, whether showing Resident X that the television was still in his room was the appropriate method for handling an agitated dementia patient, and why, or to what medical extent, E. Benisatto's decline following his hip fracture is not attributable to the subject incident. The limited disclosure is also inadequate to establish, as a matter of law, that the nursing staff on duty had, as a matter of law, adequate training and qualifications, nor does its demonstrate that defendants complied with all policies and procedures, and were providing adequate supervision for Resident X and E. Benisatto during the 3-11 shift on May 10, 2011. In fact, defendants offer no evidence of the policies and procedures in place at the time of the incident, which, in turn, precludes a grant of summary judgment as to any of plaintiff's claims involving compliance with Sprain Brook's policies and procedures.

However, while his initial affirmation is woefully inadequate, Dr. Milstein's

[1] Defense counsel similarly interfered with the depositions of the CNAs, allowing only basic information about their work histories and job duties to be disclosed.

supplemental affirmation does raise questions of fact precluding summary judgment in favor of plaintiff. The voluminous deposition transcripts, medical records, facility charts, investigation reports, RN affidavits and physician affirmations do not eliminate all material issues of fact as to whether defendants violated E. Benisatto's rights under the Public Health Law, and whether Sprain Brook was negligent and/or grossly negligent by: (1) failing to provide sufficient, qualified staffing in the Unit for the 3 to 11 shift on May 10, 2011; (2) failing to appreciate that Resident X's previously documented behavioral problems presented a risk to the other residents, including E. Benisatto; (3) taking appropriate precautions with respect to Resident X and the other residents, including E. Benisatto, to ensure their safety and freedom from abuse; and (4) Fowler's manner of handling Resident X during his state of agitation, which failed to produce a calm state before permitting him to interact with other residents. There also remain questions of material fact as to whether E. Benisatto's failure to thrive, gangrene diagnoses and death were the unavoidable result of his preexisting medical condition and risk factors, or the proximate result of specific departures by Sprain Brook (*Negron v St. Baranabas Nursing Home*, 105 AD3d 501, 501-502 [1st Dept 2013]).

Accordingly, it is

ORDERED that defendants' motion for summary judgment is granted only to the extent that the action is dismissed as against defendants H. Book and R. Klein with costs and disbursements to said defendants as taxed by the Clerk upon the submission of an appropriate bill of costs; and it is further

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

ORDERED that defendants' motion for summary judgment is otherwise denied; and it is further

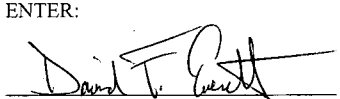
ORDERED that plaintiff's motion for summary judgment is denied; and it is further

ORDERED that counsel appear in the Settlement Conference Part in courtroom 1600, on Tuesday, November 1, 2016, at 9:15 a.m.

This constitutes the decision and order of the Court.

Dated: White Plains, New York
October 21, 2016

ENTER:



HON. DAVID F. EVERETT, A.J.S.C.

To:

Parker Waichman LLP
6 Harbor Park Drive
Port Washington, New York 11050

Caitlin Robin & Associates, PLLC
120 Broadway - 11th Floor
New York, New York 10271