SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2267-20

JAMIE VALENTINE,[1]
ADMINISTRATOR AND
ADMINISTRATOR AD
PROSEQUENDUM OF THE
ESTATE OF JAMES PATTERSON,
DECEASED,

Plaintiff-Appellant,

v.

CARE ONE AT MOORESTOWN,
LLC d/b/a CARE ONE AT
MOORESTOWN, CARE ONE
MANAGEMENT, LLC,
HEALTHBRIDGE MANAGEMENT,
LLC, VIRTUA MEMORIAL
HOSPITAL, VIRTUA MARLTON
HOSPITAL, and VIRTUA HEALTH,
INC.,

Defendants-Respondents.

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[1] The complaint was originally filed by Dorothy Patterson, Administrator ad Prosequendum of decedent's estate. In the interim between the complaint's filing and this appeal, plaintiff was appointed the estate's Administrator ad Prosequendum and is the substituted party in the matter.

Argued April 25, 2022 – Decided May 4, 2022

Before Judges Fasciale and Sumners.

On appeal from the Superior Court of New Jersey, Law Division, Burlington County, Docket No. L-0190-16.

Matthew E. Gallagher argued the cause for appellant (Swartz Culleton, PC, attorneys; Matthew E. Gallagher, on the briefs).

Anthony Cocca argued the cause for respondents Care One at Morrestown, LLC d/b/a Care One at Morrestown, Care One Management, LLC and Healthbridge Management, LLC (Cocca & Cutinello, LLP, attorneys; Anthony Cocca and Katelyn E. Cutinello, of counsel and on the brief).

Andrew S. Winegar argued the cause for respondents Virtua Health, Inc., Virtua-Memorial Hospital of Burlington County, Inc., and Virtua-West Jersey Health System, Inc. (Parker McCay PA, attorneys; Carolyn R. Sleeper and Andrew S. Winegar, on the brief).

PER CURIAM

In this nursing home malpractice case, plaintiff, Administrator Ad Prosequendum of her father James Patterson (decedent)'s estate, appeals from two orders dated March 8, 2021 granting summary judgment in favor of Care One at Moorestown, LLC d/b/a Care One at Moorestown, Care One Management, LLC, and Healthbridge Management, LLC (Care One defendants) and Virtua-Memorial Hospital, Virtua-West Jersey Health System, and Virtua

Health, Inc. (Virtua defendants) (collectively defendants). Because there are genuine issues of material fact as to whether defendants deviated from the standard of care and whether that deviation increased the risk of harm to decedent, we reverse.

A motion judge should grant summary judgment when the record reveals "no genuine issue as to any material fact" and "the moving party is entitled to a judgment or order as a matter of law." R. 4:46-2(c). We review a ruling on summary judgment de novo. Branch v. Cream-O-Land Dairy, 244 N.J. 567, 582 (2021). We apply the same standard as the motion judge and consider "whether the competent evidential materials presented, when viewed in the light most favorable to the non-moving party, are sufficient to permit a rational factfinder to resolve the alleged disputed issue in favor of the non-moving party." Brill v. Guardian Life Ins. Co. of Am., 142 N.J. 520, 540 (1995). We also give the non-moving party "the benefit of the most favorable evidence and most favorable inferences drawn from that evidence." Gormley v. Wood-El, 218 N.J. 72, 86 (2014).

I.

We look at the pertinent facts in the light most favorable to plaintiff. Decedent was a patient at Virtua-Memorial Hospital and Virtua-Marlton

Hospital and a resident at Care One at Moorestown during several admissions from September to November 2014. Decedent was admitted to Care One on September 3, 2014, at the age of eighty-three years old, with diagnoses of cerebrovascular accident/stroke (CVA), atrial fibrillation (irregular heart beat), pacemaker, cardiac stents, tube feeding, anemia, hypertension (HTN), coronary artery disease (CAD), tachycardia (rapid heart rate), dysphagia (difficulty swallowing), congestive heart failure, lung cancer, end-stage kidney disease on hemodialysis, and generalized muscle weakness.

Plaintiff alleges that during decedent's several admissions to defendants' nursing facilities from September to November 2014, he developed severe pressure ulcers due to a lack of proper nursing care. Upon admission to Care One at Moorestown on or about September 3, 2014, decedent's skin was intact. On September 19, during decedent's admission to Virtua-Marlton Hospital due to shortness of breath and anemia, a stage 1 wound was first identified on his sacrum. Decedent returned to Care One on September 19 and remained there until being admitted to Virtua-Memorial Hospital on October 7 with shortness of breath. Decedent was then readmitted to Care One on October 10 and it was at this time that staff noted a stage 2 pressure ulcer on his left upper buttock, a stage 2 sacral pressure ulcer, and redness on his right ankle. When decedent

returned to Virtua-Marlton Hospital on October 14 because of a clogged dialysis catheter, providers found another unstageable sacral wound. Decedent stayed at Virtua-Marlton until October 17 before returning to Care One at Moorestown. Decedent returned to Virtual-Marlton from October 23 to October 30 for another catheter issue. On October 30, decedent's sacral pressure ulcer was documented as stage 3. Decedent died on November 11, 2014.

Plaintiff filed her complaint alleging nursing negligence, noncompliance with the New Jersey's Nursing Home Responsibilities and Rights of Residents Act[2] (NHA), and other related claims including wrongful death,[3] against defendants on January 26, 2016. Plaintiff supplied an expert report prepared by registered nurse Darlene Parks on November 7, 2019. Parks opined that Care One's staff "failed to render proper wound care/management/monitoring/treatment and pressure redistributing support" to prevent the development and deterioration of decedent's pressure ulcers. Specifically, Parks opined Care One failed to ensure decedent received proper care for bed mobility, turning and repositioning, pressure distribution, weight

[2] N.J.S.A. 30:13-1 to -19.

[3] Plaintiff did not object to dismissal of the wrongful death claim in the trial court and does not oppose its dismissal on appeal.

shifting, off-loading heels, and toileting. As a nurse herself who was personally familiar with general nursing standards accepted in the industry, she concluded that it is inadequate to document turning and repositioning once per shift for turning and repositioning that actually occurred every two hours.

To prove causation, plaintiff offered Dr. Erik I. Soiferman as an expert on decedent's medical conditions. Dr. Soiferman noted decedent "was at a severe high risk for the development of pressure wounds" that required "all possible preventive measures be put into place" to avoid further complications. Dr. Soiferman further opined that Care One did not provide adequate documentation about turning and repositioning, only reflecting one signature per shift to document this care. Dr. Soiferman also opined that Care One did not act in a timely manner to provide wound care, as there was no documentation that an "air mattress" was used to treat an identified wound. Dr. Soiferman concluded Care One deviated from accepted standards because decedent's wounds were not unavoidable but were rather caused by the failures referenced in his report.

On November 20, 2020, after extensive discovery—including the depositions of Dr. Soiferman and Parks—defendants moved for summary judgment on the basis that plaintiff failed to establish a prima facie case of negligence, mainly because plaintiff's experts withdrew most of the criticisms

from their expert reports during their deposition testimony. The judge conducted oral argument on March 5, 2021, and subsequently entered two orders granting summary judgment in favor of defendants and dismissing plaintiff's claims.

On appeal, plaintiff argues that the judge erred in granting summary judgment to Virtua defendants and Care One defendants because plaintiff provided "sufficient evidence that the deviations in the standard of care by the nursing staff" at the respective facilities "increased the risk of harm to . . . decedent, and that the increased risk of harm was a substantial factor in causing deterioration of his pressure injuries." Giving plaintiff every favorable inference, as we must, we agree with plaintiff that summary judgment was inappropriate because there are genuine issues of material fact regarding breach and proximate cause.

II.

To establish a claim of medical malpractice, "a plaintiff must present expert testimony establishing (1) the applicable standard of care; (2) a deviation from that standard of care; and (3) that the deviation proximately caused the injury." Nicholas v. Mynster, 213 N.J. 463, 478 (2013) (quoting Gardner v. Pawliw, 150 N.J. 359, 375 (1997)). The burden of proof on all elements of an

ordinary or medical negligence claim—which includes that the defendant's conduct proximately caused the plaintiff's injury—is normally on the plaintiff. Komlodi v. Picciano, 217 N.J. 387, 409 (2014).

"The general rule in malpractice cases is that 'evidence of a deviation from accepted medical standards must be provided by competent and qualified physicians.'" Est. of Chin by Chin v. St. Barnabas Med. Ctr., 160 N.J. 454, 469 (1999) (quoting Schueler v. Strelinger, 43 N.J. 330, 345 (1964)). Typically, in these types of cases, the plaintiff is "required to establish that the defendant's treatment or care fell below the standard established and recognized by the medical profession for the indicated condition of the patient, and the standard must be proven by expert medical testimony." Terhune v. Margaret Hague Maternity Hosp., 63 N.J. Super. 106, 111 (App. Div. 1960). Only a nurse may opine on the standard of care in a nursing negligence action, State v. One Marlin Rifle, 319 N.J. Super. 359, 369-70 (App. Div. 1999), but opining as to a medical diagnosis is beyond the authority of a nurse under N.J.S.A. 45:11-23(b). An expert witness may make conclusions based on his or her qualifications and what has been learned from personal experience, without sole reliance on academic literature or treatises. See Rosenberg v. Tavorath, 352 N.J. Super. 385, 403 (App. Div. 2002). It is well known, and pertinent to the expert testimony of

Parks, that the requirements for expert qualifications are in the disjunctive; one's qualifications "can be based on either knowledge, training or experience." Ibid. (emphasis added) (quoting Bellardini v. Krikorian, 222 N.J. Super. 457, 463 (App. Div. 1988)).

In her expert report, Parks opined that Care One staff failed on several levels to prevent and care for decedent's pressure ulcers, but that most importantly, Care One's records only included one entry per eight-hour shift to document that staff had turned and repositioned decedent every two hours. In her report, Parks asserted that the documentation "did not suffice to reflect the standard every two hour[s] at minimum task." Parks pointed to the deposition of Maryann Berry, a registered nurse at Care One, who conceded "there were situations where turning and repositioning wasn't documented every shift for a given patient." Parks similarly concluded Virtua's records fail to demonstrate that staff turned and repositioned decedent at least every two hours.

Defendants urge us to consider that Parks withdrew most of the assertions in her report when questioned. Specifically, Parks withdrew part of her opinions regarding deviation from the standard of care by conceding that Care One had records of a care plan for skin integrity, orders for a pressure-reducing mattress and chair, and physician communication and medication orders for decedent's

toileting issues. The sole remaining deviation opinion from Parks's expert report was that both Care One defendants and Virtua defendants failed to turn and reposition decedent properly.

At her deposition, Parks testified that the standard of care for nursing was to turn and reposition the patient "[e]very two hours and more often as needed based on tissue tolerance" to avoid the patient suffering from a skin breakdown. When questioned on whether a patient is harmed when the patient is turned every two hours, but the care provider does not document the turning, Parks responded that "[w]ithout the documentation I cannot assume that [the patient] received that level of care." Parks conceded that it is possible for nursing staff to comply with the standard of care by documenting turning and positioning only once per shift.

Care One's counsel further questioned Parks about whether there was any authoritative written source requiring the care of turning and repositioning to be documented in a certain way. Parks responded no but, relying on her extensive experience, later noted that she had never practiced at a facility or led a care team that only documented turning and repositioning once per shift when the care providers were actually doing it every two hours. Parks reiterated when questioned on this point several times:

> [I]t goes back to evidence as to something being done. Our documentation is proof that we provided the care and without that documentation at a specific time interval it can't be assumed that it was every two hours. So for me that's not acceptable and the standard is to document the care that we provide.

For example, Care One's documentation showed a staff nurse on September 3, 2014, initialed once to indicate that she turned and repositioned decedent every two hours and as needed during her 11 a.m. to 7 p.m. shift. Parks stated that she did not have any evidence that nurses did in fact not turn and reposition decedent every two hours during an eight-hour shift.

Viewing the evidence in a light most favorable to plaintiff, there is a genuine question of material fact regarding whether—based only on one documentation per eight-hour shift—defendants actually turned and repositioned decedent every two hours to prevent the deterioration of the pressure wounds. Care One alleges that Parks failed to even establish a standard of care because her opinions were based on an industry "guideline" rather than being established by an authoritative source. As a qualified expert, Parks was not required to solely point to an academic treatise to support her opinions and instead may rely on applicable industry standards as observed by her personal experience as a nurse that nursing home staff usually documented every single

instance they turned and repositioned a patient. See Rosenberg, 352 N.J. Super. at 403.

Although Parks opined it was possible for nursing staff to administer the proper care and fail to document it every two hours, it is for the jury to determine whether there was a deviation from accepted standards by considering all the evidence, including the testimony of staff who administered the care to decedent or decedent's family who may have witnessed the care. And the jury is responsible for determining whether those witnesses are credible when there is inadequate documentation. Thus, genuine issues of material fact remain and preclude summary judgment.

III.

In a medical malpractice action, generally "the causation element . . . is the most complex." Verdicchio v. Ricca, 179 N.J. 1, 23 (2004). Instead of the but for standard, "New Jersey courts apply the substantial factor test in medical malpractice cases involving preexisting conditions." Reynolds v. Gonzalez, 172 N.J. 266, 280 (2002). "Evidence demonstrating within a reasonable degree of medical probability that negligent treatment increased the risk of harm posed by a preexistent condition raises a jury question whether the increased risk was a substantial factor in producing the ultimate result." Scafidi v. Seiler, 119 N.J.

93, 108 (1990). In a Scafidi situation, "there is a likelihood of adverse consequences based on the preexisting condition alone, and the [defendant's] negligence hastens or otherwise fails to stem the patient's downward course caused by the preexisting condition." Holdsworth v. Galler, 345 N.J. Super. 294, 300 (App. Div. 2001). "Proximate cause is a factual issue, to be resolved by the jury after appropriate instruction by the trial [judge]." Scafidi, 119 N.J. at 101.

The plaintiff maintains the burden of demonstrating the "defendant's negligence was a substantial contributing cause of the injury." Koseoglu v. Wry, 431 N.J. Super. 140, 158 (App. Div. 2013). And "[a] party's burden of proof on an element of a claim may not be satisfied by an expert opinion that is unsupported by the factual record or by an expert's speculation that contradicts that record." Townsend v. Pierre, 221 N.J. 36, 55 (2015).

Per Scafidi, we must determine whether plaintiff's medical expert Dr. Soiferman provided sufficient evidence demonstrating "within a reasonable degree of medical probability" that defendants' alleged negligence increased the risk of harm posed by decedent's preexisting conditions to create a genuine issue of material fact as to proximate cause. Highlighting disputed material issues of fact, defendants argue that he did not, as there were several instances during Dr.

Soiferman's deposition that he walked back from the opinions in his expert report. Like Parks, Dr. Soiferman conceded that it was impossible to say conclusively whether defendants failed to turn and reposition decedent every two hours because it was only documented once per eight-hour shift.

Dr. Soiferman agreed that decedent did not die from his pressure wounds—he died from renal disease and an inability to continue dialysis due to his preexisting conditions. Dr. Soiferman could not say that it was more likely than not that the wound developed when decedent was under defendants' care or when he was being transported to and from and administered dialysis treatment. However, Dr. Soiferman clarified that the wounds would not be unavoidable during the transport to and from dialysis treatment but would stipulate that "if a patient was in a dialysis chair and was hypotensive then wounds that occurred at that point would be unavoidable."

Dr. Soiferman also testified that decedent's multisystem organ failure contributed to the deterioration of the sacral wound but that his organ failure was not the "sole cause" of the wound. Dr. Soiferman acknowledged that without decedent's serious co-morbidities, the development of a sacral wound would have been "much less likely," but he could not definitively say that the skin breakdown would have never occurred.

At the motion hearing, the judge acknowledged cases involving pressure ulcers often contain issues of fact. Nonetheless, the judge stated

> I believe that [plaintiff's] experts, when they were originally hired, they were reviewing the documentation, and once it all sort of came to a head at the deposition they back off on their criticism. The only criticism left from . . . plaintiff's expert, nursing expert, is that they failed to reposition every two hours and she had no way of knowing that. If she testified, frankly, defense counsel, that the standard of care was to have a record every two hours, I would have had a different opinion here, but she basically said you can do it every shift. And the records are pretty clear that they signed off on repositioning every two hours.
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> Then we have the added fact that the nurses are all saying in their dep[ositions] . . . that they did what they did. Certainly, we have a co[-]morbidity problem. We . . . have a problem with renal failure in another facility. That could be explained away in a jury trial saying, well, we recognize that . . . contributing factor . . . look at, understand all that, but it wasn't addressed at all by the experts in their opinions at the depositions. For that reason and that reason alone, I'm going to grant . . . defendants' motion to dismiss the complaint.[4]

The judge noted that following the expert depositions, plaintiff's claim rested on one unabandoned assertion: defendants were allegedly negligent in failing to reposition and turn decedent every two hours based on inadequate

[4] The judge conducted the motion hearing on Zoom, and the transcription includes some phrases that are indiscernible.

documentation. The judge noted that plaintiff's experts have criticized the lack of documentation and that defendants' nursing staff have testified in their depositions that they performed the proper care. This conflict demonstrates a genuine issue of material fact. A jury is responsible for making credibility findings to determine whether defendants' nursing staff turned and repositioned decedent every two hours regardless of only documenting it once per shift. See State v. Nash, 212 N.J. 518, 553 (2013) (noting that a jury is "well-suited to determine each witness's knowledge, bias, consistency, and overall credibility").

Although Dr. Soiferman withdrew several of his critiques as to deviations from the standard of care and conceded the potential unavoidable nature of decedent's sacral wounds, there are genuine issues of material fact that require a jury's determination. Dr. Soiferman acknowledged that decedent's pressure wounds could have developed or deteriorated when he was receiving dialysis treatment. Dr. Soiferman also conceded that decedent's co-morbidities contributed to his pressure injuries, but that his multi-system organ failure was not the "sole cause" of the wound. The exact contribution of decedent's organ failure, and whether his pressure wounds worsened at Care One's facilities, Virtua's facilities, or during dialysis treatment, are disputed issues of material fact. Although Dr. Soiferman testified it would have been "much less likely"

that decedent's skin broke down without his serious co-morbidities, he did not opine that the skin breakdown would never have developed without those underlying conditions.

Importantly, nowhere in Dr. Soiferman's deposition did he rescind his overall opinion that defendants' alleged negligence "caused a continued downward spiral in a patient already at an extreme high risk for developing and healing ulcers." There remains an open question of whether defendants' nursing staff's alleged failures increased the risk of harm posed by decedent's co-morbidities and whether that increased risk was a substantial factor in the deterioration of his pressure wounds. That question of causation is an issue for the jury. See Scafidi, 119 N.J. at 101.

Reversed.