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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: Hon Joan B Carey PART 29

Index Number : 110358/2007
O'DEA, TINA
VS.
TERRENCE CARDINAL COOKE
SEQUENCE NUMBER : 002
SUMMARY JUDGMENT

INDEX NO. _____
MOTION DATE _____
MOTION SEQ. NO. _____
MOTION CAL. NO. _____

n this motion to/for Summary Judgmen

	PAPERS NUMBERED
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Cross-Motion: ☐ Yes ☑ No

Upon the foregoing papers, it is ordered that this motion is granted in part and denied in part, in accordance with the attached decision.

Dated: 11/12/09

J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: FINAL DISPOSITION NON-FINAL DISPOSITION

Check if appropriate: DO NOT POST ☐ REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 29

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TINA O'DEA, as administratrix of the estate of JOHN O'DEA, deceased, and TINA O'DEA, Individually,

Plaintiffs, Index No. 110358/2007

-against-

TERENCE CARDINAL COOKE HEALTH CARE CENTER,

Defendant.

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Joan Carey, J.:

This is an action, commenced by Tina O'Dea, the administratrix of the estate of her late husband, John O'Dea (O'Dea), in which it is alleged that, as a patient of defendant nursing home, Terence Cardinal Cooke Health Care Center (the Center), O'Dea fractured his hip and died because of the Center's medical malpractice/negligence and violation of Public Health Law §§ 2801-d and 2803-c, and "applicable ... rules, statutes and ordinances" (Complaint, ¶ 18). The Center now moves for an order granting it summary judgment dismissing the action on the ground that it rendered appropriate treatment to O'Dea, and did not cause him any injury. In addition, the Center seeks dismissal of the lack of informed consent cause of action, because there is no claim or evidence that O'Dea's hip fracture was due to an affirmative violation of his bodily integrity. The Center also seeks dismissal of the wrongful death

cause of action on the ground that O'Dea's death was unrelated to his hip fracture, and was, instead, the result of long-standing conditions which antedated the hip fracture. Finally, since the Center urges that all of the claims brought for O'Dea's conscious pain and suffering must be dismissed, it is urged that Tina O'Dea's loss of services[1] claim must be dismissed.

Background

O'Dea, who was born in 1954, became permanently disabled in 1997, allegedly because of a brittle diabetes condition. He also suffered from severe liver disease, caused by Hepatitis C, which resulted in his being placed on a liver transplant list. His diabetes caused circulatory problems, which led to the amputation of some of his toes, and ultimately, on January 24, 2005, to the below-knee amputation of his left leg. Following the amputation at Beth Israel Medical Center (Beth Israel), O'Dea, who was unable to stand and had not yet been fitted with a prosthesis, was transferred, on March 3, 2005, to the Center for rehabilitation to assist him with his mobility.

On March 5, 2005, the Center created an initial "FALLS/INJURY and RISK FOR" care plan (Barretta aff., ex. F) for O'Dea, as it was required to do. *See* 10 NYCRR 415.11. Pursuant to that plan, the

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[1] Notwithstanding the complaint's allegations that Tina O'Dea will suffer loss of services in the future, such a cause of action ceased at O'Dea's death. *Liff v Schildkrout*, 49 NY2d 622 (1980); *Yuet Ngor Chang v New York City Health & Hosps. Corp.*, 82 AD2d 764 (1st Dept 1981).

Center was to assess O'Dea via its Falls Prevention protocol which set forth the procedures to be followed based on a patient's risk level. Id., ex. G. The Center was also to provide supervision and assistance when the patient was transferring (presumably from bed to the wheelchair), monitor the patient for the correct use of devices and appliances, and was to "reinforce safety precautions." Id., ex. F. In addition, the Center was to complete a Falls Risk assessment every three months. *Ibid.* On March 4, 2005, an ADL (assistance with daily living) Transfer-Impaired Physical Mobility plan was created, which was triggered by O'Dea's need for supervision and limited assistance with transfers. Id., ex. H. Weekly assessments were conducted regarding O'Dea's needs and abilities with regard to eating, transferring and toileting. *Id.*, ex. I. O'Dea required one-person assistance with transferring and toileting.

On March 4, 2005, O'Dea was evaluated for physical therapy, which he began on March 7, 2005, attending five to six times a week for bed mobility, gait training, use of his prosthetic device, transfers, balance and exercise. *Id.*, ex. K. As is relevant, O'Dea's initial sitting balance was "F-/P+" (fair-/poor+), and his standing balance was "P/P." *Ibid.* The long-term physical therapy goal was to improve O'Dea's sitting balance to "G+/G" (good+/good) and his standing balance to "F+/F." *Ibid.* Physical therapy continued until December 15, 2005, when it was determined that

O'Dea had reached his maximum potential. *Ibid.* At that time, O'Dea's sitting balance had improved to G/F+, and his standing balance had improved to F-/P. *Ibid.* At that time, O'Dea was independent in bed mobility, could walk 50 feet with his prosthetic device with a cane and contact guarding, and required close supervision while transferring between his wheelchair and bed. *Ibid.*

O'Dea was also evaluated for occupational therapy on March 4, 2005, which he underwent five to six times a week from March 7, 2005 until May 23, 2005, when it was determined that he had reached his maximum potential. *Id.*, ex. L. On April 8, 2005, during the period when O'Dea was undergoing occupational and physical therapy, he was evaluated for fall risk, and was found to be at moderate risk. His fall risk was periodically reassessed, and he remained at moderate risk for falls. *Id.*, ex. J.

Meanwhile, on April 20, 2005, shortly after he had begun physical therapy, nursing responded to the call light above the door outside of O'Dea's room, and found him on his knees on the floor. O'Dea, who was not injured, reported that he had slid off his wheelchair, while attempting to move it near the wall. This was noted in the falls/injury care plan, which recited "will continue to monitor for safety." *Id.*, ex. F. An incident report was filled out (*id.*, ex. M), as was required with respect to any fall. Jones ebt, at 51. The patient was told to be more careful

and to call for help if he needed it. Barretta aff., ex. M. A May 6, 2005 note recited, "continue to assess that placement of chair is close to patient." *Ibid.*

On June 6, 2005, O'Dea was found by nursing on the floor next to his bed. He reported that he fell while reaching for his chair. *Id.*, ex. N. O'Dea evidently had not sought and/or obtained the necessary assistance he required for transferring. O'Dea suffered no injury as a result. The falls/injury plan was updated that day, and included O'Dea's statement that he was reaching for his chair, and "let himself to ground," but denied falling. *Id.*, ex. F.

Several weeks later, on June 29, 2005, O'Dea reported that he fell while transferring from his wheelchair to his bed, and suffered a laceration to his leg stump. *Id.*, ex. O. The laceration was treated, and he was counseled on calling for and waiting for help before transferring, and agreed to comply. *Ibid.*; *Id.*, ex. F.

On December 16, 2005, the day after O'Dea concluded physical therapy, a nurse's aid responded to O'Dea's call light, and found him sitting on the floor in front of his bed. O'Dea reported that he had been sitting on the edge of his bed, changing his underwear, and slid off, but did not fall. *Id.*, ex. P. He suffered no injuries. His falls/injury plan was updated that day to reflect the incident. *Id.*, ex. F.

On January 24, 2006, nursing again found O'Dea sitting on the

floor beside his bed. *Id.*, ex. F. He reported that he had slid off the bed. *Id.*, ex. Q. O'Dea was not injured, and the falls/injury plan was updated to reflect the occurrence. Id., ex. F. A note of January 31, 2005 contained in that plan indicated that O'Dea had been free of falls since January 24, and that safety precautions had been observed. *Ibid.*

According to Tina O'Dea, at some unspecified time before her husband broke his hip, there was a problem with the mattress on her husband's bed at the Center, which would cause the mattress to slide off the springs and caused her husband to slide off the bed onto the floor on at least one occasion. T. O'Dea ebt, at 116-118. She was aware of the mattress problem, tried to remedy it herself, by anchoring the mattress to the frame using the sheets, and complained about the problem "all the time." Id. at 116. She allegedly informed a "[n]urse manager, chief of nursing," and complained at various meetings at the Center. Id. at 116-117. Tina O'Dea essentially claims that she was told that other floors, which were getting renovated, were receiving new beds; thus, she had to keep petitioning for a new bed for her husband. Id. at 117-118.

On the evening of June 20, 2006, CNA (certified nurse's aide) Jeanette Headley (Headley) was on duty on the corridor where O'Dea's room was situated. Headley was responsible for about 10 to 11 patients. Headley ebt, at 11. At approximately 8:15 P.M., she

heard O'Dea crying out for help, went to his room, which did not have the call light on, and found him lying on the floor near the side of his bed. Id. at 15-16, 42. Headley immediately shouted from O'Dea's room for the nurse to come, and the nurse, Joyce Jones (Jones), arrived within seconds. Id. at 17-18.

Jones, a licensed practical nurse, who was assigned to O'Dea's corridor and another, saw O'Dea lying on the floor, between his wheelchair and the bed. Jones ebt, at 22. The wheelchair was facing and parallel to the bed, and had its brakes on. Id. at 23-24, 32. Jones asked O'Dea what happened, and he replied that he had fallen on the floor. Id. at 25. Jones did not ask O'Dea about the circumstances of the fall, and O'Dea did not volunteer that information to her, other than to say that he fell from the wheelchair. Id. at 25-26. O'Dea complained of pain, and Jones immediately called the doctor. Id. at 26. Jones filled out part of an incident report, which indicated that, when she entered O'Dea's room, he was lying down on his right side on the floor, complaining of pain in his right leg. Barretta aff., ex. R. The doctor came to see O'Dea, and wrote in that report, "R/O fractured right hip." *Ibid.* The description of the incident contained in that report, as described by the patient was, "I was trying to get something from the floor, and I fell down. I have pain in my right leg." *Ibid.*

Tina O'Dea, who never actually witnessed her husband falling

out of his wheelchair onto the floor on any occasion (T. O'Dea ebt, at 129-130), testified (*id.* at 139-140) that her husband told her that on June 20, 2006, he was trying to pick up "crackers or something" from the floor. While her deposition testimony is not entirely clear, he evidently also told her that his wheelchair tipped forward, causing him and his wheelchair to fall over. Id. at 138-139. Tina O'Dea claimed that her husband did not lose his balance, but that he fell because the wheelchair did not have front anti-tipping devices. Id. at 140. She asserted that, because there was a mouse problem in the room, her husband called to have someone come and clean up the crackers, but that they did not come, so he attempted to pick them up himself. Id. at 139-140.

She also claimed that, before her husband broke his hip, she had seen the wheelchair start to tip forward "a couple of times," perhaps five or six times, but she did not know how many times. Id. at 123-125. This allegedly occurred when her husband was putting on his shoes and/or heavy prosthesis, and was bending or sitting forward. Ibid. Tina O'Dea also believed that her husband's large size (he was six feet, two inches tall) was a contributing factor. Id. at 139. She allegedly told "[w]hoever the nurse manager was on the floor," the "nursing supervisor" and/or O'Dea's nurse on duty for a shift, and a physical therapist, who she thought was a male, about the wheelchair tipping issue. Id. at 123-128. Tina O'Dea could not identify any of these individuals by name. Id. at 123,

126. When asked how the physical therapist responded, Tina O'Dea asserted that "[t]hey" told me that "they would see what they could do to either modify the wheelchair or get a new wheelchair and we would have to wait." Id. at 126. The physical therapist allegedly told her that what was wrong with the wheelchair was that it lacked anti-tipping devices. Id. at 126-127. Tina O'Dea also claimed that individuals from the Center told her that "they wanted to take the chair down to engineering to see if they could devise some kind of attachment," but that one was never put on. Id. at 128.

O'Dea was then transferred at 9:30 on the evening of his fall to Mt. Sinai Hospital to rule out a fractured right hip. A right hip fracture was diagnosed and surgically repaired. O'Dea returned to the Center on July 17, 2006.

He was transferred, on November 11, 2006, to Beth Israel for acute renal failure. Beth Israel's records indicate that O'Dea was awaiting a liver transplant. Barretta aff., ex. T. He was found to have end-stage liver disease, secondary to Hepatitis C, his prognosis was poor, and he "was made 'DNR/DNI'." *Ibid.*

On December 22, 2006, O'Dea was transferred back to the Center. On January 24, 2007, he was readmitted to Beth Israel to treat abdominal fluid collection, caused by his Hepatitis C-induced liver cirrhosis. O'Dea then returned to the Center on February 10, 2007. On February 15, 2007, O'Dea was seen by the Center's medical director and a Dr. Taitt of the Center, who discussed end-of-life

measures. O'Dea was put on palliative/ hospice care on February 20, 2007, and passed away at the Center on March 30, 2007. His death certificate listed his cause of death as cardiopulmonary arrest, caused by hepatic cirrhosis and Hepatitis C. Diabetes was listed as a contributing factor. Barretta aff., ex. W.

The Instant Action/Motion

Tina O'Dea commenced this action, asserting claims on behalf of her late husband's estate and a loss of services claim on behalf of herself. The first cause of action sounds in malpractice/negligence. The second cause of action is for lack of informed consent, and is apparently based on a claim that O'Dea did not consent to "the negligent and careless institution of fall prevention protocols" (Bill of Particulars, ¶¶ 22-23). The third cause of action alleges a deprivation of appropriate medical and nursing care under Public Health Law §§ 2801-d and 2803-c. The fourth cause of action alleges that the Center violated applicable rules, statutes and ordinances by failing to provide O'Dea with a proper plan of care. The fifth cause of action asserts a claim for wrongful death, and the sixth cause of action asserts a claim for past and future loss of services and society.

The plaintiff's bill of particulars alleges, in relevant part, that the Center was negligent in failing to give appropriate orders for O'Dea's safety; in failing to order appropriate safeguards to prevent him from falling; in failing to implement an appropriate

nursing plan in accordance with the Public Health Law; and in allowing O'Dea to use a wheelchair that lacked tipping guards, despite his history of falls and foot amputation.

The Center now moves for an order granting it summary judgment on the ground that there are no triable issues of fact. Specifically, it claims that the lack of informed consent cause of action must be dismissed since this is not a case which arises from the affirmative violation or disruption of O'Dea's bodily integrity. Levine aff., ¶ 5. The Center also maintains that the wrongful death cause of action cannot be sustained because O'Dea's death was unrelated to his fractured hip, and was instead the result of serious preexisting medical conditions, including his end-stage liver disease. Levine aff., ¶¶ 17-20.

The Center seeks dismissal of the balance of plaintiff's claims on the grounds that the care rendered was in conformity with accepted medical standards, that the Center was not negligent and that it appropriately implemented the required interventions to prevent and protect O'Dea from injuries from falling. The Center further asserts that O'Dea did not meet the criteria for wheelchair front anti-tipping devices, the decedent had made no prior complaints of his wheelchair tipping, none of his prior falls involved his wheelchair tipping, and that there was no evidence that on the day in issue, O'Dea's wheelchair tipped.

The Center's motion is supported by medical records, the

affirmation of its expert internist/geriatrician, Dr. Jeffrey Levine (Levine), and the affidavit of its expert physical therapist, Herbert Doerr, P.T. (Doerr). Doerr opines that front anti-tippers are only installed if there are center-of-balance deficits, there is decreased strength or extended leg supports or if the patient had suffered a stroke, none of which applied in the instant case. Doerr aff., ¶ 6. Doerr asserts that physical therapy assessments showed that O'Dea had good sitting balance and independent bed mobility when he was discharged from physical therapy in December 2005. Doerr adds that there is no evidence that O'Dea's wheelchair had ever tipped forward in the past or that tipping caused any of the five prior incidents; thus, front anti-tippers were not warranted, and that, in any event there is no evidence that his wheelchair tipped forward on June 20, 2006, since he made no such complaint to the Center's staff.

Levine maintains that an appropriate and well-documented fall/injury plan was implemented and updated and that O'Dea's risk for falling was continuously evaluated. Levine further observes that none of O'Dea's falls, prior to June 20, 2006, involved a tipping wheelchair, or the lack of necessary fall prevention measures. Rather, Levine asserts that O'Dea's prior falls were the result of his failing to seek the requisite assistance when transferring. Levine asserts that O'Dea never complained to the Center's personnel before June 20, 2006 of his wheelchair having

tipped. Levine also notes that there is no evidence that O'Dea sought help from the staff or used his call bell for assistance before he fell on June 20, or that he reported that his wheelchair had tipped. Based on the foregoing, Levine concludes that the Center acted appropriately and in accordance with the regulations governing long-term-care facilities in implementing its fall prevention protocols and in thereafter continuously monitoring O'Dea's fall risk after each incident.

Tina O'Dea opposes the motion, but neither she nor her expert internist/geriatrician[2] offers any substantive opposition to the branches of the motion which seek dismissal of the lack of informed consent and wrongful death causes of action.

As to the balance of the action, plaintiff's counsel asserts that, in light of O'Dea's five prior falls, the Center committed medical malpractice and violated Public Health Law §§ 2801-d and 2803-c by failing to institute an appropriate and updated care plan that provided for a wheelchair with front "anti-tipping devices or pillows or [a] dycem" (a non-slip cushion) to prevent O'Dea from slipping out of or tipping over in his wheelchair. Wolinetz aff., ¶ 32. Plaintiff's counsel asserts that when O'Dea slipped on three prior occasions, once from his wheelchair and twice from his bed, the Center did not take any steps to assess the reason for these

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[2] Tina O'Dea provided a redacted affidavit from her expert. I inspected the original unredacted version in camera.

incidents, the latter two of which occurred after the Center had terminated physical therapy, and did not take appropriate steps to amend his care plan. Additionally, plaintiff's counsel maintains that prior to the fall in issue, Tina O'Dea had complained to the Center's staff that the wheelchair had tipped. It is counsel's position that regardless of whether O'Dea slipped or tipped forward, had a dycem, pillows and front anti-tipping devices been provided, O'Dea's injuries would have been averted. Plaintiff's counsel also claims that the Center was negligent in failing to maintain a clean environment and provide a sufficient number of personnel to respond to patients' calls, and that, as a result of such negligence, O'Dea was compelled to pick up the crackers, thereby leading to his fall and hip fracture.

Plaintiff's counsel's opposing affirmation is supported by an expert's affidavit. That expert asserts that the Center departed from accepted standards of care when it failed to adequately reassess O'Dea's safety needs after his slips and falls, particularly those which occurred after he ceased going to physical therapy. The expert asserts that the Center failed to investigate the cause of O'Dea's slipping. The expert observes that the Center's updated plan, on several occasions, consisted merely of noting the incident. Plaintiff's expert further observes that, although Tina O'Dea notified the staff that the wheelchair had tipped, the Center failed to install anti-tipping devices. The

expert charges the Center with departures from accepted medical practice and violations of the Public Health Law in failing to institute and update an appropriate fall prevention care plan, in failing to provide a wheelchair with anti-tipping devices, and in failing to provide a dycem and pillows to assist in balance and to prevent slipping. The expert also charges the Center with negligence in failing to maintain a clean facility, understaffing O'Dea's floor, and in not responding to O'Dea's calls when he used his call button. The expert alleges that these departures were a proximate cause of O'Dea's injuries.

In reply, the Center sets forth a new ground for dismissal of part of the action, namely, that all medical malpractice claims arising out of a failure to provide an adequate fall prevention plan should be dismissed because any such planning was done by a nurse or physical therapist, rather than by a medical doctor, and, thus, such alleged failures are not applicable to medical malpractice. The Center also maintains that since there is no evidence that, on June 20, 2006, O'Dea slid off his wheelchair or that it tipped over, and because the plaintiff's expert did not address the claim that, since the therapy records showed that O'Dea had good sitting balance, front anti-tipping devices were not required, the balance of the action should be dismissed. The Center asserts that plaintiffs have failed to prove that there were crackers on the floor, or that the number of staff on the floor had

anything to do with O'Dea's fall on June 20, 2006. The Center also observes that such claim was not set forth in the pleadings.

Discussion

The branch of the motion which seeks dismissal of the lack of informed consent cause of action is granted. The right to recover for medical malpractice based on a lack of informed consent is limited to those cases involving non-emergency surgery, treatment or procedures, or diagnostic procedures in which the body is invaded or its integrity is disrupted. Public Health Law § 2805-d. The plaintiff's bill of particulars is devoid of any such claim. Since it is undisputed that this case does not arise out of a procedure, surgery or treatment which involved the invasion or disruption of the integrity of O'Dea's body, the second cause of action, which sounds in the lack of informed consent, must be, and hereby is, dismissed. *Karlsons v Guerinot*, 57 AD2d 73, 82 (4th Dept 1977) (the doctrine of lack of informed consent is "limited to those situations where the harm suffered arose from some affirmative violation of the patient's physical integrity such as surgical procedures, injections or invasive diagnostic tests"); *see also Janeczko v Russell*, 46 AD3d 324 (1st Dept 2007); *Sample v Levada*, 8 AD3d 465 (2d Dept 2004); *Keselman v Kingsboro Med. Group*, 156 AD2d 334 (2d Dept 1989).

The branch of the motion which seeks an order dismissing the fifth cause of action, which asserts a wrongful death claim, is

granted, and that cause of action is dismissed. The Center has the prima facie burden of establishing its entitlement to dismissal of this cause of action. *Alvarez v Prospect Hosp.*, 68 NY2d 320, 324 (1986). It has met its burden through the affirmation of its expert physician, who reviewed O'Dea's medical records from the Center, Mt. Sinai Hospital and Beth Israel, as well as his death certificate, and opined that O'Dea's death was unrelated to his hip fracture, but was instead due to cardiopulmonary arrest, resulting from O'Dea's long-standing, preexisting, severe medical conditions, including end-stage renal disease, cirrhosis of the liver caused by Hepatitis C, and diabetes mellitus. Tina O'Dea's expert wholly fails to rebut this showing, and neither that expert nor Tina O'Dea's counsel addresses the wrongful death cause of action in the opposition papers. Accordingly, the wrongful death cause of action is dismissed.

This leaves plaintiff's claims under the first cause of action alleging negligence/medical malpractice, her claims under the third and fourth causes of action asserting violations of the Public Health Law and applicable regulations, and her sixth cause of action for loss of services and society, which hinges on the viability of her other causes of action.

To the extent that the Center raises for the first time in its reply affirmation a new ground for dismissal, i.e., that there was no medical malpractice because any fall prevention plan was

determined by a nurse or physical therapist, as opposed to a medical doctor, such ground for dismissal cannot be considered by this Court. *See Dannasch v Bifulco*, 184 AD2d 415 (1st Dept 1992). In any event, the mere fact that any plan may have been created by a nurse or physical therapist, rather than a physician, is not determinative of whether plaintiff's claims sound in medical malpractice or ordinary negligence. *See Bleiler v Bodnar*, 65 NY2d 65 (1985); *Meiselman v Fogel*, 50 AD3d 979 (2d Dept 2008) (which respectively hold that a nurse and a physical therapist can be liable for medical malpractice where the services provided amount to, or are substantially related to, medical treatment). Further, 10 NYCRR 415.11 (c) (2) (ii), which deals with comprehensive care plans for residents of nursing homes, provides, in relevant part, that such plans "shall be ... prepared by an interdisciplinary team that includes *the attending physician*, a registered professional nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs ..." (emphasis added).

Plaintiff's claims regarding the Center's negligence with respect to keeping the premises clean and not providing enough staff to answer calls are unavailing. No such claims were pleaded in the complaint or in the bill of particulars. *See Abalola v Flower Hosp.*, 44 AD3d 522 (1st Dept 2007) (in response to a summary judgment motion, plaintiff's expert in a medical malpractice action

could not raise a new theory of liability which was absent from the complaint and bill of particulars). In addition, to the extent that Tina O'Dea claims that her husband's fall was caused by his picking up crackers, that assertion is based only on hearsay, i.e., that her husband allegedly told her that. The only thing that he reported to the Center's staff, as reflected in the incident report, was that he was trying to pick up something. Thus, there is no admissible evidence that O'Dea's injuries were due to a lack of good housekeeping.

Further, the evidence shows that O'Dea's call bell light was not on when Headley responded to his cry for help. So, O'Dea did not seek any assistance in picking up the item, and there is no admissible evidence to the contrary. Moreover, that Headley responded to O'Dea's cry for help, and that Jones came in within seconds after Headley immediately called for her, show that there was adequate staff to assist him in retrieving the item, had he sought help. Therefore, plaintiff has not demonstrated that O'Dea's fall was attributable to a lack of staff, or to an unresponsive staff.

The balance of the motion deals with the alleged failures to implement an adequate falls prevention plan and to order appropriate safeguards to prevent O'Dea from falling, under the first, third and fourth causes of action. It appears that plaintiff is claiming that, under the first cause of action, the

Center departed from accepted standards of care, and that, under the latter two causes of action, she is claiming that the Center is liable under Public Health Law § 2801-d for violating Public Health Law § 2803-c and applicable regulations by depriving O'Dea of an adequate falls prevention plan and appropriate safety devices.

Public Health Law § 2801-d (1) provides, as is relevant, that "[a]ny residential health care facility that deprives any patient ... of any right or benefit ... shall be liable ... for injuries suffered as a result of said deprivation ... ." "Right or benefit" under that statute is defined as "any right or benefit created or established for the well-being of the patient by the terms of any contract, [or] by any state [or federal] statute, code, rule or regulation ... ." *Ibid.* Public Health Law § 2801-d provides for the assessment of damages and counsel's fees, as well as other relief. The remedies provided by that statute are cumulative with any other available remedies. Id., subsection 4.

Under Public Health Law § 2803-c (3) (e) every nursing home patient is entitled "to receive adequate and appropriate medical care ... ." *See also* 10 NYCRR 415.3 (e) (1) (i) (which requires each resident of a nursing home to have "adequate and appropriate medical care ..."). It is apparently plaintiff's position that this statute was violated when the Center failed to have an adequate care plan in place for O'Dea, and that such violation constituted a deprivation of O'Dea's rights under Public Health Law

§ 2801-d. *See* Plaintiff's expert's affidavit, ¶ 13; *Morisett v Terence Cardinal Cooke Health Care Ctr.*, 8 Misc 3d 506, 515 (Sup Ct, New York County 2005) (assertion that the Center failed to ensure that an adequate care plan was created for decedent, stated a claim under Public Health Law § 2801-d); *see also* 10 NYCRR 415.11 (which requires nursing homes to conduct a comprehensive and accurate assessment of each resident's functional capacity on admission and to create and update an individualized care plan to meet that resident's needs); 10 NYCRR 415.11 (a) (3) (which requires comprehensive assessments to be conducted within 14 days of admission, "promptly after a significant improvement or decline in the resident's physical ... status ...," and in all cases no less frequently than once every 12 months); 10 NYCRR 415.11 (a) (4) (which requires the professional staff to examine each resident at least every three months, and, if necessary, revise the resident's assessment); 10 NYCRR 415.12 (h) (1), (2) (which require nursing homes to ensure that the resident's environment stays as accident-free as possible and that "each resident receives adequate supervision and assistive devices to prevent accidents"); *cf. Zeides v Hebrew Home for Aged at Riverdale*, 300 AD2d 178 (1st Dept 2002) (in which relief was sought under Public Health Law § 2801-d, based on a deprivation of the right to receive adequate medical care under Public Health Law § 2803-c, predicated on violations of several subsections of 10 NYCRR 415.12).

Following a review of the motion papers and the applicable law, the Center's motion, seeking to dismiss the balance of the complaint's causes of action, is denied. While it does not appear that the lack of pillows or a dycem was causative of O'Dea's falls, since by all accounts it was claimed, not that O'Dea slipped out of the wheelchair, but that he fell out of it when he bent forward to pick something up off the floor, the evidence raises at least an issue of fact as to the Center's liability in connection with plaintiff's claim regarding the failure to update O'Dea's fall prevention plan and provide front anti-tipping devices on the wheelchair. The Center has failed to meet its burden of establishing its entitlement to dismissal of this claim (*Alvarez v Prospect Hosp.*, 68 NY2d at 324), by demonstrating, in the first instance, that it lacked notice, that before the fall in issue, O'Dea's wheelchair tipped forward on several occasions when he sat or bent forward. The Center's expert, Doerr, left open the possibility that had there been evidence of the wheelchair having tipped and notice of such tipping, via complaints to the Center, anti-tipping devices would have been warranted. Doerr aff., ¶¶ 6, 10.

The Center has not provided the affidavits from anyone with firsthand knowledge, including from O'Dea's physical therapist, or any of the nursing supervisors or managers on his unit, indicating that neither O'Dea nor his wife made any such complaints. The

Center's experts lack any personal knowledge on this issue, and in any event, it was only claimed that O'Dea, himself, made no such complaints. The Center does not present any evidence that Tina O'Dea made no prior complaints of the wheelchair having tipped forward, as she alleged, at her deposition, that she did.

Although there is no direct evidence that on the day in issue, the wheelchair actually tipped forward, if a jury were to find that there were prior complaints of it having tipped when O'Dea sat or bent forward, they could reasonably draw the inference (*Schneider v Kings Highway Hosp. Center*, 67 NY2d 743 [1986]) that O'Dea's bending forward to pick something up from the floor caused the wheelchair to tip and him to fall, thereby resulting in his fractured hip.

The law is well settled that "the remedy of summary judgment is a drastic one, which should not be granted where there is any doubt as to the existence of a triable issue or where the issue is even arguable, since it serves to deprive a party of his day in court [internal citations omitted]." *Gibson v American Export Isbrandtsen Lines*, 125 AD2d 65, 73 (1st Dept 1987). In light of the foregoing, the branch of the Center's motion which seeks dismissal of the first, third, fourth, and sixth causes of action must be, and hereby is, denied.

Accordingly, it is

ORDERED that Terence Cardinal Cooke Health Care Center's motion for summary judgment is granted only to the extent that the second cause of action for lack of informed consent and the fifth cause of action for wrongful death are hereby dismissed, and the motion is otherwise denied; and it is further

ORDERED that the remainder of the action shall continue; and it is further

ORDERED that counsel for all parties are to appear before the Court on December 3, 2009, at 9:30 a.m., at 60 Centre Street, Room 228, Part 29, for a pre-trial conference.

Dated: Nov 12, 2009

ENTER: