

**Diana v Broadlawn Manor Nursing & Rehabilitation  
Ctr.**

2013 NY Slip Op 31637(U)

July 12, 2013

Sup Ct, Suffolk County

Docket Number: 11-10355

Judge: W. Gerard Asher

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SUPREME COURT - STATE OF NEW YORK  
I.A.S. PART 32 - SUFFOLK COUNTY

**PRESENT:**

Hon. W. GERARD ASHER  
Justice of the Supreme Court

MOTION DATE 12-17-12  
ADJ. DATE 4-16-13  
Mot. Seq. # 001 - MD

-----X  
CHARLES DIANA and GERALDINE  
DEMPSEY, as Co-Executors of the Estate of  
ANGELA DIANA a/k/a ANGELINA DIANA,  
deceased,

Plaintiffs,

- against -

BROADLAWN MANOR NURSING &  
REHABILITATION CENTER,

Defendant.  
-----X

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Upon the following papers numbered 1 to 38 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (001) 1 - 16; Notice of Cross Motion and supporting papers    ; Answering Affidavits and supporting papers 17-32; Replying Affidavits and supporting papers 33-36; 37-38; Other    ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

**ORDERED** that motion (001) by defendant Broadlawn Manor Nursing & Rehabilitation Center pursuant to CPLR 3213 for summary judgment dismissing the complaint is denied.

On April 2, 2010, the plaintiffs' decedent, Angelina Diana, was a patient at Broadlawn Manor Nursing & Rehabilitation Center. It is alleged that due to the negligence, reckless conduct, and abuse of the decedent, she suffered fractures to the right and left tibias and fibulas, blunt impact injuries to the lower extremities, with ecchymosis on the lower knees and skin of the right and left anterior tibias. At the time the injuries were allegedly sustained, the decedent was using a walker and was being escorted to the bathroom by a nurse's aide, Althea Blearie, who caught the decedent as she was falling, preventing her from falling onto the floor. She was taken to New Island Hospital where she was admitted from April 2, 2010 through April 12, 2010. She died on April 14, 2010.

The note of issue and certificate of readiness were filed in this action on July 27, 2012. Pursuant to CPLR 3212, the last day in which this motion for summary judgment was permitted to be filed was on November 24, 2012. This motion was not served until November 26, 2012, beyond the statutory limitation,

and without explanation by counsel for the defendant, except his statement in his affirmation that the motion is timely filed. “Good cause” under CPLR 3212 (a) requires a showing for the delay in making the motion—a satisfactory explanation for the untimeliness—rather than simply permitting meritorious, non-prejudicial filings, however tardy. No excuse at all, or a perfunctory excuse, cannot be “good cause” (*see Brill v City of New York*, 2 NY3d 648, 781 NYS2d 261 [2004]; *First Union Auto Finance, Inc.*, 16 AD3d 372, 791 NYS2d 596 [2d Dept 2005]; *Tucci v Colella*, 26 Misc 3d 1234A, 907 NYS2d 441 [Sup Ct, Kings County 2010]). Based upon the failure of counsel to offer any excuse for the delay in filing, good cause has not been demonstrated. Because this motion was not filed within the 120 days following the filing of the note of issue and certificate of readiness, and good cause has not been demonstrated, this motion is deemed untimely.

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 eliminate any material issues of fact from the case (*Friends of Animals v Associated Fur Mfrs.*, 46 NY2d 1065, 416 NYS2d 790 [1979]). To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (*Sillman v Twentieth Century-Fox Film Corporation*, 3 NY2d 395, 165 NYS2d 498 [1957]). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form . . . and must “show facts sufficient to require a trial of any issue of fact” CPLR 3212 [b]; *Zuckerman v City of New York*, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (*Castro v Liberty Bus Co.*, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this application the defendant has submitted, inter alia, an attorney’s affirmation; copies of the summons and complaint, defendant’s answer, and plaintiff’s verified bill of particulars; the signed and certified transcripts of the examinations before trial of Charles G. Diana and Geraldine Mary Dempsey, each dated April 12, 2012; the unsigned but certified transcripts of the examinations before trial of Karen Montalvo dated June 28, 2012, and Althea Blearie dated June 29, 2012, both employees of the defendant; an uncertified copy of the decedent’s medical record from defendant facility which fails to comport with CPLR 3212 and 4518 (*see Friends of Animals v Associated Fur Mfrs.*, 46 NY2d 1065, 416 NYS2d 790 [1979]; *Sillman v Twentieth Century-Fox Film Corporation*, 3 NY2d 395, 165 NYS2d 498 [1957]); and the affidavits of Althea Blearie, Lorraine Domaradzki, R.N., and affirmation of Lawrence Diamond, M.D.; and photographs.

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (*Holton v Sprain Brook Manor Nursing Home*, 253 AD2d 852, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant’s negligence was a substantial factor in producing the alleged injury (*see Derdiarian v Felix Contracting Corp.*, 51 NY2d 308, 434 NYS2d 166 [1980]; *Prete v Rafla-Demetrious*, 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff’s injury (*see Fiore v Galang*, 64 NY2d 999, 489 NYS2d 47 [1985]; *Lyons v McCauley*, 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept

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1998], *app denied* 92 NY2d 814, 681 NYS2d 475; *Bloom v City of New York*, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.*, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; *Domaradzki v Glen Cove OB/GYN Assocs.*, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]).

It is further determined that even if this motion were timely submitted, and all the evidentiary submissions were in admissible form, there are factual issues which preclude summary judgment.

Althea Blearie averred that she has been employed by the Long Island Home as a certified nursing assistant for approximately eleven years. Although she did not know at the time of her deposition, she later learned that the decedent had been a patient at Broadlawn Manor Nursing & Rehabilitation Center (Broadlawn) for at least one year, and that she saw her about five days a week for the purpose of ambulating the decedent every morning to the bathroom. She stated that she was present on September 27, 2012 when certain photographs of a room identical to the plaintiff's was photographed.

Defendant's expert, Dr. Diamond, affirms that he is a physician licensed to practice medicine in New York and is board certified in family practice with a certificate in geriatric medicine. Dr. Diamond has not set forth his education and training to qualify as an expert in this matter, but does state his current employment. He stated that he reviewed the relevant records, including, the record maintained by Broadlawn Nursing & Rehabilitation Center and the affidavit and deposition transcript of Alethea Blearie CNA, but he does not indicate that he reviewed other pertinent medical records, such as the subsequent hospitalization at New Island Hospital and the findings made by the treating physicians thereat. He opined within a reasonable degree of medical certainty that at all times the care and treatment rendered to Angelina Diana by the defendant was within the confines of good and accepted care, and the care provided did not proximately cause or substantially contribute to the decedent's alleged injuries and death.

Dr. Diamond continued that the defendant maintained excellent documentation which reflected frequent monitoring of the decedent. All efforts were made to keep her ambulating as tolerated, and when the decedent demonstrated a reduced capacity to ambulate, physical therapy was commenced, the most recent from December 3, 2009 through January 7, 2010. On March 11, 2010, she was able to walk thirty-nine feet. Dr. Diamond stated that there is nothing in the record to indicate any decline until the date of the incident on April 2, 2010. He continued that no plan of care can possibly serve as a guarantor against incident, and the plan for the decedent was consistent with minimizing risk of incident. Dr. Diamond continued that at the moment of incident, the Broadlawn staff was appropriately caring for the decedent, treating her completely in accordance with the plan of care, and in accordance with the standard of care. She was appropriately labeled as being at risk for falls.

Lorraine Domaradzki averred that she is a registered nurse licensed to practice in New York with twenty years of experience working at rehabilitation/sub-acute facilities as both a staff member as well as in a supervisory/management role. She stated that she reviewed the defendant's record with respect to the

care and treatment rendered to the decedent, and opined that there was a care plan in place which called for the decedent using the rolling walker while ambulating with the assistance of one or two others as needed for up to ten feet. The most recent care plan was completed on March 17, 2010. When the incident occurred, Althea Blearie, CNA, assisted the decedent over the course of one year in ambulating to the toilet approximately seven feet away. There was no weakness noted on March 22, 2010 by the physical therapist. Nurse Domaradzki opined within a reasonable degree of nursing certainty that the care plan was appropriate and that the care and treatment of the decedent on April 2, 2010 was within the accepted standard of care, which Blearie was appropriately following.

Charles Dempsey testified to the extent that the decedent was his mother. She used a walker for ambulating and sometimes a wheelchair. While she was living with him, at age 91, she tripped and injured her hip. She was treated at Brunswick Hospital and after several weeks was transferred to Broadlawn. Prior to this admission, he had not been told that she suffered from Alzheimer or osteoporosis, but was told by staff at Broadlawn that she had dementia. He participated in the care plan and was told that his mother would use the walker for short distances. However, the physical therapist met with him and asked him to witness his mother's legs buckling when she walked. He was told that it was no longer safe for her to walk with a walker, and a wheelchair was suggested. From 2009 through 2010, he did not observe his mother use a walker and never saw one in her room. The wheelchair was used by the aid to toilet his mother. On the day of the incident, he was contacted by Karen from Broadlawn and was told his mother started to fall when being taken to the commode, and Althea grabbed her and his mother came to a rest on Althea's sneakers. When Karen went in to see her after the incident, she noticed that his mother's knees were swollen, and that she wanted permission to send her to the hospital for x-rays. Karen later told him that she noticed a bone protruding under the skin. Charles Dempsey testified that when he spoke to his mother after the incident, she told him that Althea was taking her to the toilet, when she told Althea that her legs would not move. Althea told her "you can do it, we're late." Her legs buckled, she fell and heard a crack. She was taken to New Island Hospital and developed difficulty breathing. CPR was initiated and she revived, but never responded thereafter. On April 12, 2010, she was taken to hospice and died on April 14, 2010 at age 95. He further testified that when his mother first went to New Island Hospital that Dr. Ostrovsky showed him the x-rays and told him that his mother had four broken bones, that her knees were swollen, and he did not believe she fell.

The plaintiffs submitted the affidavit of their expert physician, Sol S. Farkas, M.D. who avers that he is a physician certified in orthopedic surgery. He has not set forth his education and training, or work experience to qualify as an expert in this matter. He set forth the records and materials which he reviewed. Dr. Farkas stated that Ms. Blearie testified that as the decedent was falling, she lowered her down onto her (Blearie's) shoe tops, and that the decedent never hit the floor. Dr. Farkas stated that the x-rays from New Island Hospital revealed that the decedent has bilateral proximal tibia and fibular fractures. He is in total agreement with the emergency room physician at New Island Hospital that the injuries sustained by the decedent could not have possibly happened in the manner described by Blearie. He opined that the injuries sustained by the decedent were inconsistent with the version of the events testified to by Blearie and that such injuries could not have possibly have happened in the manner described by Blearie. He further opined that the plaintiff did not receive adequate supervision and assistive devices to prevent this accident.

Geraldine Dempsey, daughter of the decedent, set forth in her affidavit that she personally observed that her mother could not transfer and ambulate with the assistance of only one aide. Her mother had tremors while standing, her ambulation was inconsistent and not functional at times, and she needed the assistance of two staff members for transfers and ambulation. When she spoke to the staff at the nursing home, they agreed that her mother should be confined to a wheelchair when not in bed. The use of a walker was discontinued on January 20, 2009. After that date, she never saw a walker in her mother's room, and her mother used the wheelchair when out of bed or to use the commode.

Based upon the forgoing, even if the defendant's motion had been timely submitted, there are triable factual issues which require the denial of summary judgment.

It is noted that the emergency room record at New Island Hospital contains a physician note which states that "[t]he findings are not supported by the NH history of the events 'Pt did not hit the ground when fell' Suspicion warrants further investigation for abuse or neglect."

In view of the foregoing, the defendant's motion for summary judgment dismissing the complaint is denied.

Dated: July 12, 2013

W. Gerald Arle  
J.S.C.

           FINAL DISPOSITION   X   NON-FINAL DISPOSITION