

Lazo v St. Barnabas Nursing Home, Inc.

2014 NY Slip Op 32630(U)

September 11, 2014

Supreme Court, Bronx County

Docket Number: 301087/09

Judge: Stanley B. Green

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This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6M

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FLOR MARIA LAZO, as the Administratrix of the
ESTATE OF FRANCISCA ACEVEDO, Deceased,
and FLOR MARIA LAZO, Individually,
Plaintiff(s),

INDEX NO.: 301087/09

-against-
ST. BARNABAS NURSING HOME, INC.,
Defendant(s)

DECISION

-----X
HON. STANLEY GREEN:

The motion by St. Barnabas Nursing Home, Inc. (SBNH) i/s/h/a St. Barnabas Nursing Home, Inc. for an order pursuant to CPLR §3025(b) granting permission to assert an additional affirmative defense responding to plaintiff's claims under the NY Public Health Law and upon such leave, an order pursuant to CPLR §3212 dismissing all claims and causes of action against SBNH is granted only to the extent that SBNH may serve an amended answer in the form annexed as Exhibit "11". The cross-motion by plaintiff for an order pursuant to CPLR §3126 and §3212 striking SBNH's answer for spoliation for its failure to provide accident and incident reports of four documented and two undocumented falls and upon striking the answer, for a grant of summary judgment against SBNH or, in the alternative, an order deeming SBNH to have notice/knowledge that decedent was at high risk for falls and that any fall precautions that had been previously initiated where wholly inadequate, is denied.

Plaintiff claims that as a result of SBNH's negligent care and treatment, decedent Francisca Acevedo, suffered a fall on February 9, 2007 and injuries that led to her death on April 23, 2007.

Decedent, age 85, was admitted to SBNH in August 2001. Her admitting diagnosis was progressive dementia from Alzheimer's, depression and dizzy episodes secondary to anemia. At the time she was admitted, decedent was ambulatory with a cane. By December 2001, she was ambulating independently via a wheelchair and her care plan called for her to be out of bed to wheelchair "as tolerated." Decedent's care plan was subsequently modified to address changes in her medical condition, including her ambulation and toileting plan. However, decedent suffered four falls during her admission, including the fall on February 9, 2007, which is the subject of this lawsuit. (Plaintiff also contends that there were two "undocumented" falls, based on injuries noted to decedent's left wrist in February 2005 and to her right knee in March 2005, but there is no evidence that the injuries were due to a fall and decedent, when questioned about the knee injury, denied that she had suffered a fall).

The first documented fall was noted on October 20, 2003, when decedent was found by an LPN on the floor near the nurses' station. The second fall was noted on May 29, 2004, when decedent was found sitting on the floor in the corridor between the dining room and smoking area. The third fall occurred on November 14, 2006, when decedent fell from a wheelchair as she was being transported to the bathroom by a CNA and the last fall was noted on February 9, 2007, when decedent was found on the bathroom floor.

At the time of decedent's fall on February 9, 2007, her toileting plan called for her to be taken to the bathroom, with the assistance of one person, every two to four hours during the day and "as required" at night. The Toileting Record shows that a SBNH nurse or staff member took decedent to the bathroom at 9:30 p.m. According to the Progress Notes, less than 25 minutes later, decedent was found sitting on the bathroom floor, complaining of pain in her left hip. She

was taken to St. Barnabas Hospital (SBH) emergency room, where she was diagnosed with a fracture of the left femoral head. Decedent was treated at SBH until February 12, 2007, when she was re-admitted to SBNH. She remained at SBNH until April 23, 2007, when she died.

Plaintiff alleges that SBNH departed from good and acceptable medical practice in its care and treatment of decedent by, inter alia, failing to properly assess her as a high fall risk resident and by failing to provide appropriate fall prevention measures, including evaluation for a change of room assignment closer to the nursing station, use of a bed alarm and constant supervision. Plaintiff claims that as a result of these departures, decedent fell and suffered injuries that led to her death.

SBNH seeks permission to amend its answer to include an affirmative defense responding to plaintiff's claims under the Public Health Law and, upon granting the amendment, summary judgment dismissing all claims against it on the ground that there are no questions of fact, no deviations from the standard of care, and no violations of the Public Health Law.

SBNH contends that there is no prejudice in allowing the proposed amendment because it is essentially the equivalent of its denial of paragraph 27 of the complaint, which alleges a violation of the PHL §§ 2801-d and 2803©. In support of the motion for summary judgment, SBNH submits the affirmation of Dr. Jeffrey Levine, who opines that the care and treatment rendered by SBNH was appropriate in all respects, complied with accepted standards of care in geriatric medicine and with all relevant Public Health Law statutes. Dr. Levine notes that after decedent's fall in November 2006, a staff physician ordered that an alarm be placed on decedent's wheelchair and a modified floor ambulation plan was ordered in which decedent was only permitted to ambulate with a rolling walker for 20 feet with supervision. He also notes that

in January 2007, a Fall Risk Assessment was conducted and decedent was identified as a moderate risk for a subsequent fall. He notes that, at that time, decedent ambulated solely with the use of a wheelchair with bilateral leg rests and that she was able to make her needs known. He opines that the attending physicians regularly and properly determined decedent's safety precautions and care plans, that SBNH staff properly identified decedent as a moderate risk for falls and that no act or omission by SBNH caused decedent's fall on February 9, 2007, as that was an unexpected event that could not have been anticipated based on decedent's medical condition. Dr. Levine acknowledges that decedent suffered falls prior to February 9, 2007, but states that this does not alter his opinion regarding the appropriateness of SBNH's care of decedent, because "the subject fall" involved different circumstances from the prior falls. "That is, according to the records, the subject fall occurred because Acevedo unilaterally got out of her bed and walked to the bathroom, and not because she fell out of her wheelchair."

Plaintiff cross-moves to strike SBNH's answer for failure to provide accident and incident reports for four documented and two "undocumented" falls and, upon striking the answer, for summary judgment on her claims against SBNH because all further issues of fact are eliminated. In the alternative, plaintiff seeks an order deeming SBNH to have notice/knowledge that decedent was at high risk for falls and that any fall precautions that had been previously initiated were wholly inadequate.

Plaintiff contends that SBNH was required by statute to maintain any accident and unusual incident reports relative to decedent and that SBNH's failure to preserve the incident reports has severely injured her ability to pursue her claims in this action. She contends that the reports are "crucial pieces of evidence" that go to the very heart of this action and loss of the

reports "fatally compromises" her ability to prosecute the action.

Plaintiff contends that SBNH's motion for summary judgment must be denied because the affirmation of Dr. Levine is speculative and conclusory and fails to address many issues raised in her bill of particulars. She also contends that the affirmation of her expert raises triable issues of credibility and fact which preclude a grant of summary judgment.

Plaintiff's expert, who is board certified in Geriatric Medicine and the Medical Director of a nursing home in New York State, opines that SBNH physicians departed from good and accepted standards of medical and geriatric care by, inter alia, failing to properly assess decedent as a high risk resident, by failing to provide appropriate treatment for a high risk patient, including a bed alarm, placing her in a room near the nurses's station and by leaving her in the bathroom unattended, without constant supervision. He opines that SBNH violated PHL §2803-c by failing to ensure that decedent received adequate and appropriate medical care, failing to ensure that her abilities in activities of daily living and her range of motion did not diminish and by failing to have sufficient nursing staff and that all of these deviations were the direct cause of decedent's fall and subsequent injuries. The expert also opines that SBNH's expert "engages in complete speculation" when he states that decedent "unilaterally and without assistance got out of bed and walked to the bathroom" as there is no proof that an investigation was ever completed regarding the fall and the testimony of Nurse Sharpe shows that she could not testify as to the facts and circumstances around the fall. He opines that "it is much more reasonable to surmise that a CNA took her to the bathroom, went to do something else, and later returned to find her on the floor."

In response to plaintiff's cross-motion, SBNH contends that the cross-motion should be

denied as there is no evidence that SBNH possessed or destroyed the missing incident reports and, during a more recent search, incident reports for the May 29, 2004 fall and the November 14, 2006 falls were located and provided to plaintiff. With permission of the court, SBNH also submitted the affidavit of the Debra Kramer, R.M., Vice President of Quality and Clinical Services at SBNH. Ms. Kramer explains that the failure to locate these incident reports in prior searches was apparently due to confusion of the former risk manager as to whether she was to search for an incident report for the alleged date of loss only or for all incident reports. However, the search for the February 9, 2007 incident report is continuing.

Leave to amend is freely given absent prejudice or surprise resulting from the delay (CPLR §3025(b)). Plaintiff has not opposed SBNH's motion insofar as it seeks to amend the answer. Accordingly, SBNH may serve an amended answer in the form annexed as Exhibit "11".

Insofar as SBNH seeks an order granting for summary judgment, the motion is denied. While SBNH has submitted the affirmation of an expert who opines that SBNH's care and treatment was proper and that no act or omission by SBNH caused decedent's fall, the expert fails to address the alleged violations of the Public Health Law, other than in a conclusory statement that "St. Barnabas Nursing Home fully complied with the relevant Public Health Law statutes and Acevedo was never deprived of any right at any time." In addition, Dr. Levine's opinion that the February 9th fall is different from decedent's prior falls because it involves different circumstances is based, in part, upon conjecture as to how the accident occurred. He indicates that his belief that decedent "unilaterally and without assistance got out of bed and walked to the bathroom" is supported by a note in the record dated 2/12/14. However, no copy of the note was attached to his affirmation or the motion papers and, upon review of the record,

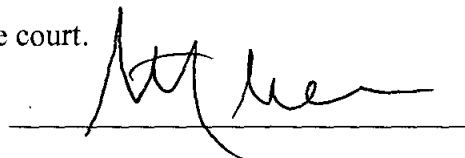
there is a note on an "Evaluation/Summary" sheet dated "2/10/07," which indicates that:

"Probably resident got out from bed to the w/c or from the w/c with out calling for help, wheeled self to bathroom door got out from w/c and tried/went to go ... & fell... & staff observed resident sitting in [sic] the bathroom floor." These varying descriptions of decedent's fall on February 9, 2007, coupled with the conflicting expert affidavits, raise material issues of fact and credibility that cannot be resolved on a motion for summary judgment (Cregan v. Sachs, 65 AD3d 101; Bradley v. Soundview Healthcenter, 4 AD3d 194). Accordingly, SBNH's motion for summary judgment is denied.

As to plaintiff's cross-motion to strike SBNH's answer, discovery sanctions are inappropriate because plaintiff filed the note of issue without reserving her rights or preserving objections (Rivera Irby v. City of NY, 71 AD3d 482) and spoliation sanctions are not warranted (cf. Squittieri v. City of New York, 248 AD2d 202). While Ms. Kramer is not the person who conducted the search for the incident reports, her affidavit shows that there was no willful or contumacious conduct on the part of SBNH or intentional destruction of the reports. Also, the record contains many notes regarding the February 9, 2007 incident and plaintiff's expert's opinion is primarily based upon assessments, evaluations and notes that exist in the SBNH record. Accordingly, the cross-motion by plaintiff to strike SBNH's answer and thereupon for summary judgment or, in the alternative, to deem it to have notice or knowledge that decedent was at high risk for falls is denied.

This constitutes the decision and order of the court.

Dated: September 11, 2014



STANLEY GREEN, J.S.C.