King v Menorah Nursing Home Inc.
2015 NY Slip Op 30292(U)
March 3, 2015
Supreme Court, Kings County
Docket Number: 500110/2013
Judge: Karen B. Rothenberg
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At an IAS Term, Part 35 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 19th day of February, 2015.

PRESENT:

HON. KAREN B. ROTHENBERG,
Justice.

- -X

OLIVER KING, AS GUARDIAN AD LITEM OF MARGARET KING,

Plaintiff,

- against -

Index No. 500110/2013

MENORAH NURSING HOME INC., D/B/A MENORAH CENTER FOR REHABILITATION AND NURSING CARE, ET AL.,

Defendants.

- -X

The following papers numbered 1 to 12 read herein:

	Papers Numbered
Notice of Motion/Order to Show Cause/ Petition/Cross Motion and Affidavits (Affirmations) Annexed	1-4
Opposing Affidavits (Affirmations)	5-7
Reply Affidavits (Affirmations)	8-10; 11-12
____ Affidavit (Affirmation)	
Other Papers	

Upon the foregoing papers, defendant Menorah Nursing Home, Inc. (Menorah) moves, pursuant to CPLR 3212, for an order granting summary judgment dismissing the complaint and any cross claims.

[* 2]

This action concerns allegations of malpractice and/or negligence in the care rendered to Margaret King (Mrs. King), while she was a resident at Menorah Center for Rehabilitation and Nursing Care (Menorah). Subsequent to commencement of the action, on February 9, 2014, plaintiff Oliver King, Mrs. King's son, was appointed her Guardian Ad litem pursuant to order of this court.

Plaintiff alleges that at some time between May 10, 2012 and May 14, 2012, Mrs. King fell and fractured her right hip. In her Verified Bill of Particulars and Supplementary Verified Bill of Particulars, it is alleged, among other things, that defendants were reckless, careless and negligent in failing to have proper and sufficiently trained personnel; in failing to properly supervise and/or monitor Mrs. King; in causing and/or permitting her to fall; in failing to use proper equipment, including non-tipping devices on her wheelchair, bed and chair alarms and floor mats; in failing to prepare, amend or update Mrs. King's care plan regarding her fall risk; in failing to follow proper procedures; in failing to comply with internal rules and regulations and the guidelines of the "Health Department"; in failing to consider Mrs. King a "falling star," in failing to inform other medical providers of Ms. King's alleged fall; and in seeking to conceal what had occurred through changing and/or falsifying Mrs. King's records. In addition, plaintiff indicates that he will rely on the doctrine of *res ipsa loquitur*.

In the present motion, relying on the expert affirmation of Scott S. Coyne, M.D. and

the affidavit of Marvette Lowrie-Morris, R.N.,[1] defendant contends that plaintiff can neither establish by evidence in admissible form that any departures from good and accepted medical practice occurred, nor that any such departures as might have been committed were the proximate cause of Mrs. King's injuries.

Dr. Coyne states that he is a board certified Radiologist, licensed to practice in the state of New York since 1981. Upon review of all relevant materials, including the pleadings, hospital and nursing home records and transcripts of the deposition testimony, Dr. Coyne opines that Mrs. King suffered a non-displaced subcapital impacted fracture that was caused by her severe chronic osteoporosis in conjuncture with normal activities of daily living, or otherwise occurred spontaneously, and that within a reasonable degree of medical certainty, her injury was not caused by any act of negligence on the part of Menorah.

Dr. Coyne states that Mrs. King had advanced osteoporosis in her right hip and that the fracture healed well with conservative treatment. He further opines that: (1) the care and treatment rendered by Menorah is well-documented and there is no supporting history that Mrs. King suffered a fall while there between May 10, 2012 and May 14, 2012; (2) neither the Verified Bill of Particulars nor the supplemental Verified Bill of Particulars provide any information as to when or how such fall occurred; (3) his findings are consistent with those of orthopedic surgeon Dr. Robert Copulsky who performed a consultation on Mrs. King; (4)

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[1]Although the notarization stamp was omitted from the original affidavit of Lowrie-Morris, and plaintiff, in opposition, objects to the introduction of the document, the omission was duly cured by defendant's annexing an affidavit in proper form in their reply papers, rendering said document admissible (*see Matos v Schwartz,* 104 AD3d 650, 653 [2013]).

the absence of bruising supports a finding that the fracture was the result of osteoporosis and not a traumatic event; (5) there is no merit to any claim that she sustained injuries to her right knee and neck, as there is no reference in the hospital records of same.

Marvette Lowrie-Morris, RN states that she is licensed to practice in New York State, a licenced Nursing Home Administrator, and a certified Legal Nurse Consultant. Following her review of the same documents as those reviewed by Dr. Coyne, she renders opinions regarding the instant matter, all of which are stated to be within a reasonable degree of nursing certainty.

Ms. Lowrie-Morris reports that on February 8, 2012, Mrs. King complained of bilateral extremity pain and was placed on Neurontin for her diabetic neuropathy. She further reports that (1) on February 16, 2012, fall precautions were instituted including bed/chair alarms (because she was non-compliant with instructions to call for assistance in making transfers and was seen tying to ambulate and make transfers without assistance), physical therapy, and a call bell; (2) on March 14, 2012, shortly after she was diagnosed with Alzheimer's dementia, a physical examination of Mrs. King revealed multiple joint deformities secondary to osteoarthritis in her hands and knees, and on March 26, 2012, side rails for her bed were ordered; (3) on April 29, 2012, a fall risk assessment was performed and Mrs. King scored a 22, indicating that she was at risk for falls; and (4) on May 8, 2012, the chair and bed alarm was removed as Mrs. King was being monitored closely.

Subsequently, as reported by Ms. Lowrie-Morris: on May 10, 2012, Mrs. King, after

experiencing a vomiting episode, was twice walked 100 yards with a nurse; on May 11, 2012, she tolerated range of motion testing.

As additionally reported on May 13, 2012, Oliver, who had not seen Mrs. King since March of 2012, visited Mrs. King, who allegedly told him that she fell when her wheelchair rolled out from underneath her. Menorah's records indicate that on the morning of May 14, 2012, CNA Ramnath and Dr. Yatcha saw Mrs. King who told Dr. Yatcha that she had fallen either on May 11, 2012, or May 12, 2012, and Dr. Yatcha, after conducting his examination, had her transferred to Coney Island Hospital.

Based upon her review, Ms. Lowrie-Morris opines within a reasonable degree of nursing certainty that the care and treatment rendered by Menorah to Mrs. King between May 10, 2012 and May 14, 2012, was within the accepted standards of nursing practice, that Mrs. King was properly assessed as a fall risk, properly monitored and equipped with appropriate mechanisms and appropriately sent to Coney Island Hospital for diagnostic testing once her complaints of a fall became known. Further, she opines that it is undeniable that Mrs. King suffered from osteoarthritis and osteoporosis for many years, and that the hip fracture healed with conservative treatment. She opines that the care and treatment of Mrs. King was well-documented and the records do not contain any evidence of a fall. She opines that Mrs. King's hip fracture was not caused by trauma or fall, as there was no evidence of bruising upon Dr. Yatcha's examination, nor is there any record of Mrs. King being found on the floor or that she was helped to her feet, and Mrs. King could not have

gotten up from the floor on her own, given her age and need for assistance. Opining that the standard of care does not require bed and chair alarms for patients who are compliant with the instructions given by the staff and who utilize the call bell, she notes that a bed and chair alarm was implemented for Mrs. King on February 16, 2012 due to non-compliance with use of the call bell, but Menorah's records of May 8, 2012 indicate that since the implementation of the alarm and reeducation, she had become compliant, and the alarms were no longer required, and, in her opinion, their discontinuance was reasonable. She further opines that floor mats posed a potential tripping hazard and were inappropriate here, given Mrs. King's partial mobility. Finally, rejecting any allegations of improper care or equipment having been provided or having failed to be provided, she opines that Mrs. King's allegations that Menorah failed to have non-tipping devices on her wheelchair is devoid of relevance, as there is no allegation in any bill of particulars that Mrs. King's wheelchair tipped over.

In opposition to defendant's motion, Oliver alleges he visited his mother on May 13, 2012, and saw that his mother had not been bathed in days, had only been dressed in her hospital gown, was in visible pain, and complained of pain in her backside. He asked his mother what caused her pain, and his mother informed him that she had fallen a few days prior, explaining that she had been given a bath and was left sitting in her wheelchair near her bed. Mrs. King attempted to get out of the wheelchair unassisted, causing the wheelchair to roll out from underneath her. She told him she landed on her backside, and remained on the floor for some time until an employee by the name of "Pat" found her and placed her

back in bed. She told her son that the fall occurred after dinner.

Upon being so informed, Oliver notified the staff of Menorah. A doctor was called in to examine Mrs. King, and she was sent to Coney Island Hospital the following day. Menorah commenced its investigation and began preparing an Incident/Occurrence Report.

According to plaintiff, the Coney Island Hospital emergency department records contain a statement of Mrs. King that she had a fall "the day before yesterday while getting on the bed from chair." The recorded notes of other doctors at Coney Island Hospital are alleged to contain similar statements.

In a redacted affirmation, plaintiff's expert in the field of radiology, after reviewing all relevant documents and hospital records, opines that Mrs. King sustained an acute subcapital fracture with superior displacement of the right femoral neck and that within a reasonable degree of medical certainty, it occurred within the month of May of 2012 and was caused by a fall or other trauma. Expressly disagreeing with Dr. Coyne, the radiologist opines that even a person with osteoporosis such as Mrs. King would not sustain a spontaneous fracture to the femur that did not involve a fall or other trauma.The radiologist further disagrees with Dr. Coyne's opinion that there was no displacement, asserting that the x-rays of May 14, 2012 of the right hip and pelvis indicated that the fracture had superior displacement, and that the displacement was indicated within Coney Island Hospital's records, such as Dr. Qasim Sheikh's May 14, 2014 radiology reports. The expert further opines that the fracture could not have resulted from a "normal activity of daily living,"

suggesting that Mrs. King lacked the strength to turn herself in bed without assistance. The lack of bruising is discounted, as the expert opines that a fracture of a femur can result from a fall or trauma that does not result in visible bruising. Thus, within a reasonable degree of medical certainty, plaintiff's expert radiologist opines that Mrs. King's fracture of her right femur was due to a fall or trauma that she sustained while in Menorah's care, and that the fracture occurred in May of 2012 while she was under its care and prior to her hospitalization in Coney Island Hospital.

In further opposition to defendant's motion, plaintiff proffers the affidavit of Jeannine Lurie, RN. However, as a threshold matter, defendant, in its reply states that according to the New York State Board of Regents, on April 19, 2010, Ms. Lurie's licence was suspended and she was placed on professional probation based upon uncontested charges that she stole prescription-only drugs from her employer. According to defendant, the New York State Office of the Professions indicates that her licence has not been renewed and she is no longer allowed to practice within New York State. Defendant contends that Ms. Lurie has committed perjury, by swearing to be a licensed registered nurse, and lacks the qualifications to render an expert opinion regarding the standard of care, and that without a nursing expert, plaintiff cannot make out a prima facie case, mandating summary judgment in defendant's favor.

In sur-reply, plaintiff, asserting that Ms. Lurie is now retired from the clinical practice of nursing, provides an affidavit from her which purports to address the circumstances of her

disciplinary issues, and where she states that never intended to misrepresent her status with the court, and as the proceedings and the results were a matter of public record, she did not believe that disclosure was required.

The court rejects Ms. Lurie's reasons for not disclosing these matters of extreme significance, and notes that in lieu of stating that she is "duly licenced" in New York, only disingenuously and somewhat ambiguously states that "I am a registered nurse and have been licensed to practice nursing in New York State since 1981. . . . ." However, for the purposes of resolving this issue, the court, after giving defendant's arguments full consideration, nevertheless, and with some reluctance, declines to find Ms. Lurie's affidavit wholly inadmissible(*see Williams v Halpern,* 25 AD3d 467 [2006] ["...any prior immoral acts or suspensions of (the expert's) license bear on his credibility but do not preclude him from testifying as an expert"]; *but see Howard v Stanger,* 122 AD3d 1121 [2014] ["(C)ontrary to plaintiff's assertion, the fact that (defendant) Stanger's license was under a stayed suspension at the time he prepared the subject affidavit does not render his affidavit inadmissible for purposes of the underlying (summary judgment) motions...That said, we nonetheless are troubled by the fact that Stanger failed to disclose the status of his medical license when he prepared his affidavit in support of defendants' motions for summary judgment. . . . This glaring omission is entirely inconsistent with Stanger's ethical obligations as a practicing physician and, in our view, seriously calls into question the medical opinion he has rendered regarding his diagnosis, care and treatment of decedent. . .[and] we do not find Stanger's

affidavit to be sufficient to satisfy defendants' initial burden on the motions for summary judgment, thereby warranting the denial thereof"]).

Turning to the contents of her affidavit, Ms. Lurie provides a lengthy sworn document wherein she sets forth the materials she reviewed prior to preparing the instant affidavit, which include the affirmations and affidavits submitted by other experts herein and Mrs. King's medical records. Describing, in detail, Mrs. King's history since her admission to Menorah, including all events and examinations which led to her being designated as being at high risk for falls, and her placement in two physical therapy programs (range of motion therapy and walking therapy). Noting that walking therapy was discontinued as of May 11, 2012, she asserts that the records only state that she refused or was sick, and speculates that this was "likely due to the fact that she sustained a fall and fractured her femur."

Ms. Lurie asserts that it was a deviation when Dr. Yatcha failed to examine Mrs. King's hip or joints on May 13, 2012, and his note of May 13, 2012 suggests that a pain assessment was never performed, also a deviation. Further disagreeing with defendant's expert that there is no indication in the occurrence report that Menorah was aware of Mrs. King's complaints of a fall prior to May 14, 2012, she refers to a note prepared by RN Maria Zuckerman on May 14, 2013, which purportedly states that Mrs. King told her that she "fell two days ago and two girls picked her up," and to Menorah's occurrence report, under Physician's/NP Assessment, singed and dated May 13, 2012, that an unidentified source reported a fall on 5/11/12 or 5/12/12.

Ms. Lurie opines that Menorah failed to comply with the standard of care of a nursing home and with its own rules and regulations, including, among other things, in failing to: take and maintain proper records; undertake a complete investigation; update a care plan; provide proper assistance in transferring Mrs. King; and provide proper safety equipment including bed rails, call bells, anti-tipping devices and floor mats. All are described as deviations. She further charges that Menorah failed to ensure that Mrs. King was not being abused by its employees. She concludes by stating that "[a]s a result of Menorah's negligent care and malpractice, Ms. King sustained a fall and/or trauma that resulted in her femur fracture which would have been prevented had Menorah complied with the standard of care and its own rules and regulations.

Defendant's Reply

In reply, defendant contends that plaintiff's opposition, including the affirmation of his radiologist and the affidavit of Ms. Lurie, are based on inadmissible hearsay statements which allege that Mrs. King suffered a fall or trauma between May 10, 2012 and May 14, 2012. It further contends that Mrs. King's incapacity renders her deposition testimony inadmissible, and precludes her testimony at trial, and that Mrs. Kings's medical records, as prepared and maintained by Coney Island Hospital, contain inadmissible hearsay in the history portions of said documents; and therefore, plaintiff cannot meet his burden on this motion, nor does the theory of *res ipsa loquitur* apply.

Also in reply, in addition to providing the afore-mentioned affidavit of Lowrie-Morris

in admissible form, defendant annexes a supplemental affirmation of Dr. Coyne, who disputes the findings and opinions of plaintiff's expert radiologist.

The burden on a motion for summary judgment rests initially upon the moving party to come forward with sufficient proof in admissible form to enable a court to determine that it is entitled to judgment as a matter of law. If this burden cannot be met, the court must deny the relief sought (CPLR 3212; *Zuckerman v City of New York,* 49 NY2d 557 [1980]). However, once a moving party has made a prima facie showing of its entitlement to summary judgment, "the burden shifts to the opposing party to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (*Garnham & Han Real Estate Brokers v Oppenheimer*, 148 AD2d 493 [1989]; *see also Zuckerman,* 49 NY2d at 562). Mere conclusory statements, expressions of hope, or unsubstantiated allegations are insufficient to defeat the motion (*Gilbert Frank Corp. v Federal Ins. Co.*, 70 NY2d 966 [1988]).

Here, while plaintiff, in the Amended Verified Complaint, alleges causes of action in negligence and medical malpractice, the proof presented herein is consistent with a claim for the latter, which is set forth in somewhat tentative language. The essential elements of medical malpractice are a deviation or departure from accepted medical practice (*see Holbrook v United Hosp. Med. Ctr.*, 248 AD2d 358, 359 [1998]) and (2) evidence that such departure was a proximate cause of injury (*Id.*). Although for a plaintiff to prevail on a

malpractice claim, "(e)xpert testimony is necessary to prove a deviation from accepted standards of medical care and to establish proximate cause" (*Nichols v Stamer*, 49 AD3d 832, 833 [2008], quoting *Lyons v McCauley*, 252 AD2d 516, 517 [1998]), "[o]n a motion for summary judgment dismissing the complaint in a malpractice action, the defendant...has the initial burden of establishing the absence of any departure from good and accepted [nursing] practice or that the plaintiff was not injured thereby" (*Chance v Felder*, 33 AD3d 645, 645 [2006] [internal quotation marks and citations omitted]; *see Hernandez-Vega v Zwanger-Pesiri Radiology Group*, 39 AD3d 710, 711 [2007]). In opposition, a plaintiff must submit material or evidentiary facts to rebut the defendant's *prima facie* showing that it was not negligent (*Langan v St. Vincent's Hosp. of New York,* 64 AD3d 632, 633 [2009]). Moreover, it is well-settled that unless such evidence is found to be speculative or conclusory (*see Callistro v Bebbington,* 94 AD3d 408 [2012], *aff'd* 20 NY3d 945 [2012]), "[s]ummary judgment may not be awarded in a malpractice action where the parties adduce conflicting opinions of medical experts. When experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution" (*Shields v Baktidy,* 11 AD3d 671, 672 [2004] [citations omitted]; *see also Feinberg v Feit,* 23 AD3d 517, 519 [2005]; *Barbuto v Winthrop Univ. Hosp.,* 305 AD2d 623, 624 [2003]). However, it is equally well-settled that "[w]here the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation...the opinion should be given no probative force and is insufficient to withstand summary judgment" (*see Romano v Stanley*, 90 NY2d 444, 451–452 [1997]; *Amatulli v Delhi*

Constr. Corp., 77 NY2d 525, 533–534 n. 2 [1991]).

A nursing home "has a general duty to exercise reasonable care and diligence in safeguarding a [resident], based in part on the capacity of the [resident] to provide for his or her own safety" (*D'Elia v Menorah Home and Hosp. for Aged & Infirm*, 51 AD3d 848, 850 [2008]; *see also Alexander v American Med. Response*, 68 AD3d 1026, 1027 [2009]; *Yamin v Baghel*, 284 AD2d 778, 779 [2001]). Nevertheless, such duty is "measured by the capacity of the patient to provide for his or her own safety" and is "circumscribed by those risks which are reasonably foreseeable"; the "sliding scale of duty . . . does not render [the facility] an insurer of [resident] safety or require it to keep each [resident] under constant surveillance." (*see N.X. v Cabrini Med. Ctr.*, 97 NY2d 247, 252–53 [2002]; *see also Dawn W. v State of New York*, 47 AD3d 1048, 1050 [2008]; *Borillo v Beekman Downtown Hosp.*, 146 AD2d 734, 735 [1989]).

Based upon the expert affirmations of Dr. Coyne and the affidavit of Lowrie-Morris, all of which contain non-conclusory opinions supported by reference to the record, moving defendants have established, prima facie, their entitlement to judgment as a matter of law . Thus, the burden shifts to plaintiff to raise an issue of fact. While plaintiff's reliance on the doctrine of *res ipsa loquitur* is misplaced in the present context, whether viewed as sounding in medical malpractice or ordinary negligence (*see Bucsko v Gordon,* 118 AD3d 653 [2014]; *Clark,* 29 Misc 3d at 1219[A]), the court finds that an issue of fact has nonetheless been so raised.

Based upon the conflicting findings and opinions as stated in the affirmation of his expert radiologist and the affidavit of RN Lurie, which reflect non-speculative differences of opinion, within a reasonable degree of medical and nursing certainty, as to whether departures were committed by defendant, and whether such departures were the proximate cause of Mrs. King's injuries.

Moreover, contrary to defendant's contentions, the court finds that plaintiff supports his opposition with sufficient non-hearsay evidence. In this regard, it is well-settled that "[a]lthough hearsay may be used to oppose a summary judgment motion, such evidence is insufficient to warrant denial of summary judgment where it is the only evidence submitted in opposition" (*Candela v City of New York,* 8 AD3d 45, 47 [2004]). Here, there is direct evidence in the record to support the finding of an issue of fact on the question of the cause of Mrs. King's fracture in the form of Mrs. King's own testimony. While there is authority to support rejection of such confused and tenuous testimony which patently bears the imprint of the effects of dementia (*see Mauskopf v 1528 Owners' Corp.,* 102 AD3d 930 [2013]), the record here clearly demonstrates that Mrs. King consistently maintained that she fell when she was left alone by two attendants, and according to Dr. Yatcha, she reported the incident to him as a fall, prompting him to refer her to Coney Island Hospital for diagnostic testing and treatment for a possible fracture. Thus, while defendant asserts that Mrs. King is an unreliable historian, an inference as to the admissibility of her testimony cannot be drawn without a further inquiry into Mrs. King's mental condition both at the time of the

alleged incident, and the time of her deposition (*see Estate of Ruso,* 212 AD2d 846, 847-848 [1995]). As no such inquiry has been undertaken, any assertion that Mrs. King lacked capacity to accurately recall and report the occurrence of the incident raises an issue of credibility, and her claim that defendant's departures from the standard of care cannot be rejected as a matter of law under the present circumstances (*see In re Estate of Williams,* 13 AD3d 954, 957 [2004] [where issue was testamentary capacity of decedent, Appellate Division found, under circumstances demonstrating that decedent's dementia "waxed and waned," that "mere proof that the decedent suffered from old age, physical infirmity and chronic, progressive senile dementia when the will was executed is not necessarily inconsistent with testamentary capacity and does not alone preclude a finding thereof, as the appropriate inquiry is whether the decedent was lucid and rational at the time the will was made"]).[2] Thus, as it is well-settled that it is not the court's function on a motion for summary judgment to assess credibility and that any conflict in the testimony or evidence presented merely raise[s] an issue of fact (*see Brown v Kass,* 91 AD3d 894 [2012]), an issue of fact has been raised, requiring denial of defendant's motion.

Such being the case, the court finds it unnecessary to examine defendant's additional contention that Mrs. King's statements as contained in Coney Island Hospital's records are inadmissible hearsay. However, were such inquiry found necessary, the court would permit

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Also contrary to anything contained in the record is defendant's statement, in reply, that "Ms. King was deemed to be incapable of testifying as per [this court's] order dated February 9, 2014." No such finding was made.

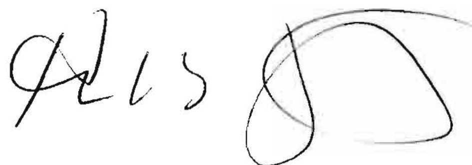
introduction of statements such as "I fell," as made to medical personnel, as such would be relevant to diagnosis and treatment (*see Eitner v 119 W. 71st St. Owners' Corp.*, 253 AD2d 641 [1998]).

The court has considered the parties' remaining contentions and finds them to be without merit.

Based upon the foregoing, the court denies defendant's motion for summary judgment in all respects.

This constitutes the decision and order of the court.

E N T E R,



J. S. C.

Karen B. Rothenberg
Justice, Supreme Court