Zalewska v Gredysa
2016 NY Slip Op 31821(U)
April 22, 2016
Supreme Court, Suffolk County
Docket Number: 08-27931
Judge: W. Gerard Asher
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[* 1]

SHORT FORM ORDER

INDEX No. 08-27931
CAL. No. 14-01982MM

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 4-24-15 (002 & 004)
MOTION DATE 4-28-15 (003)
ADJ. DATE 6-23-15
Mot. Seq. #002- MG
#003- MG
#004- MD

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ANETA ZALEWSKA, as the Administratrix of the estate of RYSZARD ZALEWSKI and STANISLAW A ZALEWSKI,

Plaintiffs,

- against -

LESLAW J. GREDYSA, M.D., AGOSTINO CERVONE, M.D., PECONIC BAY MEDICAL CENTER, RAKESH PATEL, M.D., JOHN LABIAK, M.D., FARIH SANJI, M.D., ARTHUR KLEIN, M.D., STEVEN LEON, M.D., and ST. CHARLES HOSPITAL,

Defendants.

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Upon the following papers numbered 1 to 80 read on these motions summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 -17; 18-48; 49-67; Notice of Cross Motion and supporting papers ____;

Answering Affidavits and supporting papers 68-73 ; Replying Affidavits and supporting papers 74-75;; 76-77; 78-80 ; Other ____; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the unopposed motion (#002) by defendant Arthur Klein, M.D., the unopposed motion (#003) by defendants Leslaw Gredysa, M.D. and Agostino Cervone, M.D., and the motion (#004) by defendant St. Charles Hospital, hereby are consolidated for the purposes of this determination; and it is

ORDERED that the unopposed motion by defendant Arthur Klein, M.D. seeking summary judgment dismissing the complaint against him is granted; and it is

ORDERED that the unopposed motion by defendants Leslaw Gredysa, M.D. and Agostino Cervone, M.D. seeking summary judgment dismissing the complaint against them is granted; and it is further

ORDERED that the motion by defendant St. Charles Hospital seeking summary judgment dismissing the complaint against it is denied.

Plaintiff Aneta Zalewska, as the administratrix of the estate of Ryszard Zalewksi, and plaintiff Stanislaw Zalewksi commenced this action against defendants Dr. Leslaw Gredysa, Dr. Agostino Cervone, Peconic Bay Medical Center, Dr. Rakesh Patel, Dr. John Labiak, Dr. Farih Sanji, Dr. Arthur Klein, Dr. Steven Leon, and St. Charles Hospital to recover damages for medical malpractice, wrongful death and lack of informed consent. Dr. Farih Sanji, despite being named as a defendant in the action, has not interposed an answer or appeared in the action, and he was never deposed. A stipulation of discontinuance dismissing Dr. Steven Leon from the instant matter was executed. By their complaint, plaintiffs allege, among other things, that defendants' negligent failure to diagnose plaintiff's decedent Ryszard Zalewski, with metastatic cancer resulted in his wrongful death. Plaintiffs allege that the defendants' negligence also resulted in Ryszard Zalewski undergoing an unnecessary surgical decompression of the lumbar spine; and that defendants failed to properly evaluate the decedent's right leg and foot pain. Plaintiffs further allege defendants failed to properly assess the decedent's risk of falling, failed to timely investigate the decedent's complaints and test results, and failed to prevent the decedent from falling, causing him to sustain a subarachonid cerebral hemorrhage, which substantially contributed to his death on March 13, 2007.

Dr. Arthur Klein now moves for summary judgment on the basis that he did not deviate from the acceptable standards of medical practice in his treatment of Ryszard Zalewski, and that his treatment of the decedent was not a proximate cause of the decedent's injuries. In support of the motion, Dr. Klein submits copies of the pleading, certified and uncertified copies of the decedent's medical records, the parties' deposition transcripts, and the affidavit of his expert, Dr. Irwin Ingwer. Dr. Leslaw Gredysa and Dr. Agostino Cervone also move for summary judgment on the grounds that they did not depart from the good and acceptable standard of medical care during their treatment of the decedent, and that their treatment of plaintiff's decedent was not a proximate cause of his injuries or death. In support of the motion, Dr. Gredysa and Dr. Cervone rely on the same evidence as Dr. Klein. They also submit the affidavits of their experts, Dr. Larry Scher and Dr. Ronald Primis, and certified copies of the decedent's medical records from Peconic Bay Medical Center, and Stony Brook University Hospital, their own office medical records for the decedent, and a copy of the medical examiner's report for the decedent. Plaintiffs do not oppose the motion made by Dr. Klein or the motion made by Dr. Gredysa and Dr. Cervone.

To make a prima facie showing of entitlement to summary judgment in an action to recover damages for medical malpractice, a defendant physician must establish through medical records and competent expert affidavits that he or she did not deviate or depart from accepted medical practice in the treatment of the plaintiff or that he or she was not the proximate cause of plaintiff's injuries (*see* ***Castro v New York City Health & Hosps. Corp.***, 74 AD3d 1005, 903 NYS2d 152 [2d Dept 2010]; ***Deutsch v Chaglassian***, 71 AD3d 718, 896 NYS2d 431 [2d Dept 2010]; ***Plato v Guneratne***, 54 AD3d 741, 863 NYS2d 726 [2d Dept 2008]; ***Jones v Ricciardelli***, 40 AD3d 935, 836 NYS2d 879 [2d Dept 2007]; ***Mendez v City of New York***, 295 AD2d 487, 744 NYS2d 847 [2d Dept 2002]). To satisfy this burden, the defendant must present expert opinion testimony that is supported by facts in the record and addresses the essential allegations in the bill of particulars (*see* ***Roques v Noble***, 73 AD3d 204, 899 NYS2d 193 [1st Dept 2010]; ***Ward v Engel***, 33 AD3d 790, 822 NYS2d 608 [2d Dept 2006]). Conclusory statements that do not address the allegations in the pleadings are insufficient to establish entitlement to summary judgment (*see* ***Garbowski v Hudson Val. Hosp. Ctr.***, 85 AD3d 724, 924 NYS2d [2d Dept 2011]). A physician owes a duty of reasonable care to his or her patients and will generally be insulated from liability where there is evidence that he or she conformed to the acceptable standard of care and practice (*see* ***Spensieri v Lasky***, 94 NY2d 231, 701 NYS2d 689 [1999]; ***Barrett v Hudson Valley Cardiovascular Assoc., P.C.***, 91 AD3d 691, 936 NYS2d 304 [2d Dept 2012]; ***Geffner v North Shore Univ. Hosp.***, 57 AD3d 839, 871 NYS2d 617 [2d Dept 2008]). A doctor is not a guarantor of a correct diagnosis or a successful treatment, nor is a doctor liable for a mere error in judgment if he or she has considered the patient's best interest after careful evaluation (*see* ***Nestorowich v Ricotta***, 97 NY2d 393, 740 NYS2d 668 [2002]; ***Oelsner v State of New York***, 66 NY2d 636, 495 NYS2d 359 [1985]; ***Bernard v Block***, 176 AD2d 843, 575 NYS2d 506 [2d Dept 1991]).

Failure to demonstrate a prima facie case requires denial of the summary judgment motion, regardless of the sufficiency of the opposing papers (*see* ***Alvarez v Prospect Hosp.***, 68 NY2d 320, 5088 NYS2d 923 [1986]). Once the defendant makes a prima facie showing, the burden shifts to the plaintiff to produce evidentiary proof in admissible form sufficient to establish the existence of triable issues of fact which require a trial of the action (*see* ***Alvarez v Prospect Hosp.***, *supra*; ***Kelley v Kingsbrook Jewish Med. Ctr.***, 100 AD3d 600, 953 NYS2d 276 [2d Dept 2012]; ***Fiorentino v TEC Holdings, LLC***, 78 AD3d 911 NYS2d 146 [2d Dept 2010]). Specifically, in a medical malpractice action, a plaintiff opposing a motion for summary judgment need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's prima facie showing (*see* ***Bhim v Dourmashkin***, 123 AD3d 862, 999 NYS2d 471 [2d Dept 2014]; ***Hayden v Gordon***, 91 AD3d 819, 937 NYS2d 299 [2d Dept 2012]; ***Stukas v Streiter***, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]; ***Schichman v Yasmer***, 74 AD3d 1316, 904 NYS2d 218 [2d Dept 2010]).

Here, Dr, Klein established his prima facie burden of entitlement to judgment as a matter of law by proffering the affidavit of Dr. Irwin Ingwer, who is board certified in internal medicine with a sub-certification in infectious disease, and who opines to a reasonable degree of medical certainty, that the care and treatment that Dr. Klein provided to Ryszard Zalewski did not depart from good and accepted medical practice (*see* ***Muniz v Mount Sinai Hosp. of Queens***, 91 AD3d 612 [2d Dept 2012]; ***Belak-Redl v Bollengier***, 74 AD3d 1110, 903 NYS2d 508 [2d Dept 2010]; ***Tuorto v Jadali***, 62 AD3d 784, 878 NYS2d 457 [2d Dept 2009]). Dr. Ingwer states that Dr. Klein, at all times, acted within the appropriate standard of care in providing care and treatment to the decedent, and that no act or omission on Dr. Klein's behalf

contributed or proximately caused the decedent's injuries or death. Dr. Ingwer states that Dr. Klein's care and treatment of the decedent was appropriate and conformed with good and acceptable medical practice for an infectious disease specialist, that Dr. Klein ordered the appropriate tests and studies for the decedent, that an appropriate work-up and assessment of a potential infection were made, and that the results of such tests did not reveal that the decedent had an infection process.

Dr. Ingwer further explains that it was appropriate for Dr. Rakesh Patel, the surgeon who would be performing the lumbar laminectomy, to request that the decedent be followed by a hospitalist and to receive a consultation from an infectious disease physician, Dr. Klein, due to an elevated white blood cell count, upon transfer from Peconic Bay Medical Center to St. Charles Hospital for the performance of a lumbar laminectomy. Dr. Ingwer states that, as requested, Dr. Klein treated Ryszard Zalewski on two occasions, February 4, 2007 and February 26, 2007. He states that Dr. Klein noted that the decedent had complaints of right hip and thigh pain, and that an MRI previously taken showed disc bulges at levels L3 through L5. As a result, Dr. Klein determined that the increased white blood cell count probably was not infectious, and recommended that if the patient did not have a fever, had a negative urinalysis and negative cultures for 24 hours then the surgery could proceed using prophylactic antibiotics. Dr. Ingwer opines that this was an appropriate determination by Dr. Klein, based on his examination of the decedent and the test results, since operating on a patient with an active infection increases the chance of an infection at the surgical site, and especially in this case, where Dr. Patel was going to implant metal during the spinal fusion, which could become infected if there was an active infection. Moreover, Dr. Ingwer states that the decedent was cleared for surgery by a hospitalist physician.

In addition, Dr. Ingwer opines that Dr. Klein correctly diagnosed the decedent with spinal stenosis, because all cultures taken during his hospitalization at St. Charles Hospital and at Peconic Bay Medical Center were negative for bacterial pathogens, and that the evaluation of the surgical pathology subsequent to the decedent's spinal surgeries and bone biopsies did not reveal any evidence of infection. Dr. Ingwer states that once the decedent's condition began to deteriorate he was appropriately treated with "empiric intravenous antibiotics" until confirmation was received that he did not have an infection. He explains that following the decedent's second lumbar spine surgery on February 19, 2007, and his placement in the intensive care unit due to, among other things, increased confusion and white blood cell count, an oncology consultation determined that the abnormal laboratory tests, including the elevated white blood count was secondary to metastatic cancer.

Furthermore, Dr. Ingwer opines that the treatment rendered by Dr. Klein did not proximately cause any of the injuries allegedly sustained by the decedent. Dr. Ingwer states that Dr. Klein performed an appropriate evaluation when he was consulted to evaluate the decedent for an elevated white blood count, which may have been an infectious process, because of the concern of operating on a patient with an active infection, since there was no postoperative wound infection or seeding of bacteria on the metal rods that were used during the fusion. Additionally, Dr. Ingwer states that the decedent's metabolic encephalopathy was not caused by any treatment rendered by Dr. Klein, since Dr. Klein's involvement was limited to treating an infectious process, and, as an infectious disease physician, Dr. Klein would not manage the electrolyte levels in a patient. Similarly, Dr. Ingwer explains that plaintiffs' claims of failure to properly evaluate the decedent for leg pain and lower back pain prior to recommending surgical intervention, of negligently allowing Zalewski to undergo back surgery, and of improperly diagnosing the decedent are

outside the scope of an infectious disease specialist, and, therefore, Dr. Klein would not have been making a diagnosis, recommendations or treatment plan regarding these matters.

Likewise, Dr. Gredysa and Dr. Cervone have established a prima facie case by submitting the affidavit of Dr. Larry Scher, a board certified vascular surgeon, who opined that the care and treatment rendered to the decedent did not deviate or depart from good and acceptable standards of medical care, and that their treatment of him was not the proximate cause of his injuries or death (*see* ***Ellis v Eng***, 70 AD3d 887, 895 NYS2d 462 [2d Dept 2010]; ***Adjetey v New York City Health & Hosps. Corp.***, 63 AD3d 865, 881 NYS2d 472 [2d Dept 2009]; ***Tuorto v Jadali***, 62 AD3d 784, 878 NYS2d 457 [2d Dept 2009]). Dr. Scher states in his affidavit, to a reasonable degree of medical certainty, that the care and treatment rendered to the decedent by Dr. Gredysa and Dr. Cervone was appropriate, timely and met all relevant standards of medical care and practice, and that there was no delay in diagnosing the decedent's condition by either doctor, or any act or omission on the part of either doctor that proximately caused the decedent's injuries.

Dr. Scher states that neither Dr. Gredysa or Dr. Cervone treated or cared for the decedent during his admission to St. Charles Hospital, nor did either doctor perform spinal surgery on the patient or get involved in his postoperative care. Dr. Scher states that the decedent was last treated and examined by Dr. Gredysa and Dr. Cervone during his admission to Peconic Medical Center from January 22, 2007 to February 3, 2007. Dr. Scher explains that Dr. Gredysa first began treating the decedent on September 15, 2006 for an evaluation of pain in the right leg and right toe and that, upon examination, Dr. Gredysa observed erythema and a superficial ulceration of the fourth and fifth toes. As a result, Dr. Gredysa recommended that the decedent continue taking the antibiotics, which he had begun three days before his appointment with him, and to apply an antibiotic ointment to his toes. He also recommended that, if the infection continued, the decedent would be hospitalized, and he advised the decedent to stop smoking. Following his admission to Peconic Bay Medical Center on September 19, 2006, the decedent was diagnosed with peripheral vascular disease and an infection of the right fifth toe, and testing was performed to rule out arterial emboli of the right fifth toe. The carotid and abdonimal sonogram as well as all other diagnostic tests performed while the decedent was a patient at Peconic Bay Medical Center were within normal limits.

Additionally, Dr. Scher states that Dr. Cervone first treated the decedent on December 27, 2006, after he had been to the emergency rooms at Stony Brook University Hospital and Peconic Bay Medical Center for complaints of swelling of the right leg. Following the performance of a physical examination and noting that the decedent had difficulty walking because of the edema, and that he had been taken off of the medications Pletal and Plavix for vascular disease because of the development of a large hematoma on his posterior thigh through his posterior calf, Dr. Cervone determined that the patient had a large hematoma of the right thigh without neurovascular compromise. Dr. Cervone instructed him to keep his leg elevated, to apply ice and to stop his medications for two weeks and to return for a follow-up evaluation. When the decedent returned to Dr. Gredysa for a follow-up appointment on January 5, 2007, after performing a physical examination of him, which revealed the right leg was improving and the edema had decreased, he determined there were no signs of deep vein thrombosis or acute arterial insufficiency, and advised him not to travel and to return for a follow-up appointment. Thus, Dr. Scher opines that the care and treatment received by the decedent by Dr. Gredysa and Dr. Cervone, based upon his complaints, clinical presentations, physical examinations, and the results of the diagnostics tests that were performed, was appropriate, reasonable and well within the standards of medical care, and did not constitute a depart or deviation from

such standards. Dr. Scher further explains that it was appropriate for Dr. Gredysa and Dr. Cervone to continue to monitor the decedent for a period of time to see if his complaint would resolve; however, the decedent did not return to either doctor's office after January 12, 2007.

Further, Dr. Scher states, within a reasonable degree of medical certainty, that the care and treatment rendered to the decedent by Dr. Gredysa and Dr. Cervone as general and vascular surgeons was appropriate and timely, and that he was appropriately monitored and treated by both doctors. He states that the decedent's right foot and leg pain were properly and timely evaluated from a vascular surgery standpoint, and that it was appropriate for Dr. Gredysa and Dr. Cervone to defer to the orthopedic surgeon, as well as the variety of other physicians and specialists that the decedent already had seen prior his admittance into Peconic Baby Medical Center on January 22, 2007, who determined that the etiology of the patient's complaints were orthopedic and neurologic in nature. In addition, Dr. Scher states that there was no delay in diagnosing the decedent with metastatic cancer by either Dr. Gredysa or Dr. Cervone, which proximately caused any injury to him. Dr. Scher explains that the decedent's prognosis was not changed or altered by any alleged delay in diagnosing him with metastatic cancer, nor was he deprived of a cure or treatment, since he had incurable stage 4 metastatic cancer, and he underwent palliative radiation and was unable to tolerate such treatment.

Finally, Dr. Scher opines, within a reasonable degree of medical certainty, that plaintiffs' claims, including the alleged failure to address or be aware of the decedent's social or medical history, the failure to appreciate the patient's symptoms prior to recommending spinal surgery, and the lack of informed consent, are without merit, since neither Dr. Gredysa nor Dr. Cervone recommended, performed or cleared the decedent for spinal surgery.

Additionally, the affidavit of Dr. Ronald Primis, a board-certified internist, hematologist and oncologist, demonstrates Dr. Gredysa and Dr. Cervone's prima facie entitlement to judgment as a matter of law that they did not deviate from acceptable standards of medical care in the treatment rendered to the decedent, and that their treatment did not proximately cause his injuries (*see* ***Muniz v Mount Sinai Hosp. of Queens***, 91 AD3d 612 [2d Dept 2012]; ***Ellis v Eng***, 70 AD3d 887, 895 NYS2d 462 [2d Dept 2010]; ***Adjetey v New York City Health & Hosps. Corp.***, 63 AD3d 865, 881 NYS2d 472 [2d Dept 2009]). Dr. Primis states, within a reasonable degree of medical certainty, that Dr. Gredysa and Dr. Cervone rendered appropriate and timely medical care to the decedent, and that the care rendered by either doctor did not proximately cause the injuries sustained by the decedent. Dr. Primis further states that, within a reasonable degree of medical certainty, there was no delay in the diagnosis of the decedent's medical condition by either Dr. Gredysa or Dr. Cervone that proximately caused the decedent's injuries. Moreover, Dr. Primis states that the medical records clearly demonstrate that neither Dr. Gredsya nor Dr. Cervone were involved in making any decisions in regards to the decedent's medical care, including the decision to perform spinal surgery, while he was admitted to St. Charles Hospital. He states that neither Dr. Gredysa nor Dr. Cervone determined the type of testing to be performed prior to the surgery, and that they were not involved in the decedent's postoperative care and treatment. In fact, Dr. Primis states that the last time Dr. Gredysa or Dr. Cervone treated or examined the decedent was during his admission to Peconic Bay Medical Center from January 22, 2007 to February 3, 2007. Dr. Primis additionally states it is his opinion, within a reasonable degree of medical certainty, that it was appropriate for Dr. Gredysa and Dr. Cervone, who are general and

vascular surgeons, to defer to the opinions of various specialist, who examined, evaluated and treated the decedent during his admission at Peconic Bay Medical Center.

Dr. Primis further opines, within a reasonable degree of medical certainty, that the care and treatment rendered by Dr. Gredysa and Dr. Cervone during the decedent's admission to Peconic Bay Medical Center in September 2006, and during his visit to their offices, based upon the decedent's reported conditions, medical history, clinical presentation, physical examinations, the results of available diagnostic studies that had been performed and available at the time, was appropriate, and reasonable. Dr. Primis concludes that plaintiffs' claims against Dr. Gredysa and Dr. Cervone, such as failure to address or be aware of the patient's medical or social history, failing to diagnose an infection, permitting the decedent to undergo spinal surgery, allowing the decedent to fall and deteriorate at St. Charles Hospital, and lack of informed consent are without merit, since neither physician performed spinal surgery on the decedent and both are general and vascular surgeons. Accordingly, the motions by Dr. Klein, Dr. Gredysa, and Dr. Cervone seeking summary judgment dismissing the causes of action against them are granted.

St. Charles Hospital also moves for summary judgment in its favor, arguing that its staff did not deviate from any standards of good and acceptable medical care when it rendered care to Ryszard Zalewski during his admission at its facility from February 3, 2007 through March 1, 2007, and that the care provided by its staff did not, in any way, proximately cause the injuries allegedly sustained by him. In support of the motion, St. Charles Hospital submits copies of the pleadings, certified copies of Ryszard Decedent's medical records, and the affidavit of its expert, Lynn Wilson, R.N.

It is fundamental that the primary duty of a hospital's nursing staff is to follow the physician's orders, and that a hospital, generally, will be protected from tort liability if its staff follows the orders (***Toth v Community Hosp. at Glen Cove***, 22 NY2d 255, 265, 292 NYS2d 440 [1968]; *see* ***Sledziewski v Cioffi***, 137 AD2d 186, 538 NYS2d 913 [3d Dept 1988]). "A hospital may not be held vicariously liable for the malpractice of a private attending physician who is not an employee and may not be held concurrently liable unless its employees committed independent acts of negligence or the attending physician's orders were contraindicated by normal practice such that ordinary prudence required inquiry into the correctness of the same" (***Toth v Bloshinsky***, 39 AD3d 848, 850, 835 NYS2d 301 [2d Dept 2007]; *see* ***Sela v Katz***, 78 AD3d 681, 911 NYS2d 112 [2d Dept 2010]; ***Cerny v Williams***, 32 AD3d 881, 882 NYS2d 548 [2d Dept 2006]). "A hospital may also be held liable on a negligent hiring and/or retention theory to the extent that its employee committed an independent act of negligence outside the scope of employment, where the hospital was aware of, or reasonably should have foreseen, the employee's propensity to commit such an act" (***Doe v Gutherie Clinic, Ltd.***, 22 NY3d 480, 485, 982 NYS2d 431 [2014]; *see* ***Sieden v Sonstein***, 127 AD3d 1158, 7 NYS3d 565 [2015]). However, "an exception to the general rule exists where a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the of the patient's choosing" (***Schultz v Shreedhar***, 66 AD3d 666, 666, 886 NYS2d 484 [2d Dept 2009], *quoting* ***Salvatore v Winthrop Univ. Med. Ctr.*** 36 AD3d 887, 888, 829 NYS2d 183 [2d Dept 2007]; *see* ***Sampson v Contillo***, 55 AD3d 588, 865 NYS2d 634 [2d Dept 2008]).

Moreover, "not every negligent act of a nurse [is] considered medical malpractice, but a negligent act or omission by a nurse that constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician constitutes malpractice" (***Bleiler v Bodnar***, 65 NY2d

65, 72, 489 NYS2d 885 [1985]; *see* ***Spiegel v Goldfarb***, 66AD3d 873, 889 NYS2d 45 [2d Dept 2009]). This conclusion is no different with respect to the emergency room nurse, functioning in that role as an integral part of the process of rendering treatment to a patient (***Bleiler v Bodnar***, *supra* at 72, 489 NYS2d 885)].

Upon review of the affidavit of St. Charles Hospital's expert, Lynn Wilson, R.N., and the additional exhibits submitted in support of the motion, the Court finds that St. Charles Hospital has established, as a matter of law, that its nursing staff did not deviate from good and acceptable medical practice in rendering nursing care to Ryszard Decedent during his admission to its facility from February 3, 2007 through March 1, 2007, and that the treatment provided by its nursing staff was not the proximate cause of the alleged injuries sustained by him (*see* ***Shahid v New York City Health & Hospitals Corp.***, 47 AD3d 800, 850 NYS2d 519 [2d Dept 2008]; ***Mattis v Keen***, 54 AD3d 610, 864 NYS2d 6 [1st Dept 2008]; ***Fernandez v Elemam***, 25 AD3d 752, 809 NYS2d 513 [2d Dept 2006]; ***Ericson v Palleschi***, 23 AD3d 608, 806 NYS2d 667 [2d Dept 2005]).

In her affidavit, Lynn Wilson states that she is a licensed professional nurse within the state of New York, and that she is fully familiar with the nursing standard of care in effect in 2007 with regard to fall risk assessment and fall prevention. Nurse Wilson states, within a reasonable degree of nursing certainty, that the care and treatment rendered to Ryszard Zalewski by St. Charles Hospital's nursing staff during his admission in February 2007 did not deviate from the confines of good and acceptable nursing practice. Nurse Wilson explains that when a patient's score is 25 or more on the risk of fall assessment, the patient is identified as being at risk for falling and is continuously assessed for fall risk on odd calendar days, and that when a patient's score is higher than 25, a wrist band is placed on the patient and the nursing notes will denote any possible intervention and/or response to the patient's risk of fall. She states that the decedent had a score of 40 on the initial risk of fall assessment when he was transferred to St. Charles Hospital from Peconic Bay Medical Center, and that the score was premised upon the fact that the decedent, who spoke Polish, had a language barrier; that he had a recent change in environment and reported intermittent confusion; his medication regiment and unsteady gait; and his requirement of assistance with transfers. Nurse Wilson also states it was noted that the decedent was alert at the time of the interview and ambulatory with assistance, and that when he was reassessed for the risk of falling after arriving on the hospital floor, his score was 20, a low risk of fall. She states that the record is unclear as to how much time elapsed between the initial assessment and the medical floor assessment, but that the record does state that the decedent, although he was a native speaker of Polish, was able to communicate his needs, that there was a interpretation phone available at the decedent's bedside to assist the healthcare professionals and the patient, and that the decedent's family acted as interpreters.

Additionally, Nurse Wilson states that, although the decedent initially was noted to have an unsteady gait, once he was reassessed on the medical floor there was no indication that his gait was unsteady and he was permitted to ambulate as tolerated with assistance until there was an exhibited change in his cognitive status. According to Nurse Wilson, the decedent's report indicates that he was alert and "oriented times three." She further explains that the decedent underwent a surgical decompression of the lumbar spine on February 3, 2007, and that between February 3 through February 11, 2007, the record reflects no change in the decedent's fall risk assessment, and there are no orders requiring him to be on complete bed rest. In fact, Nurse Wilson states that the patient was reported to be alert, calm, verbal, cooperative, and ambulating with a walker and staff assistance on February 9, 2007, and that fall precautions were maintained.

Nurse Wilson states, within a reasonable degree of nursing certainty, that the nursing staff acted appropriate and within the standard of care when the decedent was discovered on the bathroom floor on his right side after having fallen while attempting to go to the bathroom with his walker on February 11, 2007. She states that a physician's assistant immediately ordered an X-ray, which revealed there were no injuries, and that the decedent's vital signs were stable. In addition, Nurse Wilson states that there was no indication that the decedent incurred any trauma to his head, that his primary complaint was right knee pain, and that he was able to walk back to his bed. More importantly, she states that the nursing staff informed the decedent's physician of the events of the prior evening, that he was alert and "oriented times three," that he was able to communicate his needs, that he was able to ambulate, and that a bed alarm was put in place. And that following the placement of the bed alarm, the decedent's cognitive status did not change, and that the fall risk assessment remained the same from February 11, 2007 through February 15, 2007.

Nurse Wilson also states that when the decedent was discovered on his knees with urine on the floor after having fallen out of his bed on February 17, 2007, the nursing staff acted appropriately, timely, and in accordance with the acceptable nursing standard of care, by promptly informing the physician's assistant, who examined the decedent and found that he exhibited no bruises or marks. Moreover, she states that the decedent denied having any injury and only complained about pain in his right knee and leg, which was consistent with his complaints prior to the fall. In addition, the neurological assessment that was performed indicated that the decedent was alert, awake, and followed commands, and the assessment was that the fall was atraumatic and the patient would continue to receive observation and fall precautions.

Furthermore, Nurse Wilson states that there is a five-prong approach to assessing a patient's risk of fall, which includes taking the patient's pertinent history, including any history of falls; change in environment; language barrier; patient's mobility; visual impairment; continence; the patient's medication regimen; and the patient's cognitive ability. Nurse Wilson states that the nursing standard of care does not require the nurse to note all findings, just the pertinent positive findings that will advance the clinical care of the patient. She states that with respect to the decedent, he was properly assessed for his risk of falls when he was first transferred to St. Charles Hospital, that he was properly reassessed when he was transferred to the medical floor, that the nursing staff correctly and appropriately entered notations concerning his care and treatment regarding his fall risk, that he was appropriately evaluated after his falls for trauma, and that he was correctly assessed for any future risks of falls. Nurse Wilson states that the record is devoid of any indications or notations of the decedent having sustained a head trauma, and that after the first fall he continued to receive physical therapy, to display the ability to ambulate with a walker, and to transfer from the bed with assistance. She states that a "1:1 observation" was correctly and appropriately ordered once the decedent was observed to have a change in cognitive status and an altered mental state, and his risk of falling was increased to "high" risk, and that his transfer to the intensive care unit as a result of his altered mental status was appropriate. Nurse Wilson concludes that there was no departure by the nursing staff at St. Charles Hospital from the nursing standard of care, that no act or omission by the staff proximately caused the injury sustained by the decedent.

In opposition to St. Charles Hospital's motion, plaintiffs argue that there are material issues of fact as to whether St. Charles Hospital's nursing staff deviated from good and accepted standards of nursing practice in its treatment of the decedent, and whether such deviations were a proximate cause of the injuries suffered by the decedent. In opposition to the motion, plaintiffs submit the affidavit of Diane Marangelo,

R.N., and Dr. Stephen Bloomfield; certified copies of the decedent's discharge summary for Stony Brook University Hospital; and the certified report of the medical examiner, Stuart Dawson.

Plaintiffs have raised a triable issue of fact in opposition to St. Charles Hospital's prima facie showing (*see* ***Lesniak v Stockholm Obstetrics & Gynecological Servs, P.C.***, 132 AD3d 959, 18 NYS3d 689 [2d Dept 2015]; ***Smith v Agnant***, 131 AD3d 463, 15 NY3d 387 [2d Dept 2015]; ***Farrell v Herzog***, 123 AD3d 655, 998 NYS2d 202 [2d Dept 2014]). Plaintiffs have submitted the affidavit of their medical expert, Diane Marangelo, R.N., who opines within a reasonable degree of nursing certainty that the nursing staff at St. Charles Hospital departed from the nursing standard of care in regards to the fall risk assessment and fall prevention of Ryszard Zalewski during his admission to its facility in February 2007. Nurse Marangelo states that the following factors are to be considered when assessing a patient's risk of falling: the patient's history of falls; the patient's medications or combinations of medications that could predispose him or her to falls; the patient's underlying medical conditions; the patient's functional status, including levels of mobility; assessing the patient's neurological status; the patient's psychological status; and the environmental factors that could cause or contribute to falls. Nurse Marangelo states that the decedent's initial fall risk assessment, which occurred the day he was transferred to St. Charles Hospital, was 40, based upon his language barrier, a recent change in environment, reported intermittent confusion, an unsteady gait, and medication regimen. She explains that a fall risk score of 40 indicates a moderate risk of falling as per the fall risk screening sheet. Nurse Marangelo states that later that same day, when the decedent presented to the hospital floor, a second fall risk assessment was conducted by the nursing staff and he was given a score of 20. Nurse Marangelo states that the score of 20 was attributable to the decedent's change in environment, his need for assistance with transfers and his medication regimen, but that absent from the assessment was his language barrier, unsteady gait and intermittent confusion. Nurse Marangelo states that, based upon the decedent's medical records, there was no reason for not including the assessment factors of language barrier, unsteady gait, or intermittent confusion in the second assessment. As a result, Nurse Marangelo concludes that the nurse on staff at St. Charles Hospital who conducted the second fall assessment on February 3, 2007 failed to properly perform the fall risk assessment, which resulted in the decedent being classified as a low risk for falling instead of the moderate risk, as was previously assessed upon his transfer to the hospital.

In addition, Nurse Marangelo states that the decedent underwent a surgical decompression of his lumbar spine on February 7, 2007, and that the record reflects he was agitated, yelling, angry, and unable to communicate his needs, since he only speaks Polish, when he returned to the hospital floor from the post anesthesia care unit following the surgery on February 8, 2007. Nurse Marangelo states that the interpretation phone next to his bedside was broken and unavailable, and that this change in mental status was not included in any fall risk assessment of the decedent. In fact, Nurse Marangelo states that there was no change in the decedent's score of 20 on the fall risk assessment scale from February 3 through February 11, 2007, and that the only fall risk intervention taken by the nursing staff was the placement of a call bell within his reach. She further states that when the decedent first fell in the bathroom while attempting to void on February 11, 2007, at approximately 2:45 a.m., the record does not indicate that anyone observed his fall or that he did not strike his head when he fell. Instead, the record only contains a notation that the housing staff found the decedent on the bathroom floor on his right side after turning around with his walker to use the bathroom. Thus, Nurse Marangelo opines, within a reasonable degree of nursing certainty, that the decedent was not properly assessed for his risk of falling, and that such failure constituted a departure from

good and acceptable standards of nursing practice. She explains that once the decedent was assessed as having a risk fall score of 40, a yellow wrist band should have placed on his wrist to inform the staff that he was at a moderate risk of falling, and that a bed alarm, which would have alerted the nursing staff if the patient left the bed, should have also been instituted. Nurse Marangelo states that a bed alarm was not instituted for the decedent until after he fell on February 11, 2007. She states that it is her opinion that if he had been classified as a moderate fall risk and a bed alarm had been instituted, the nursing staff would have been on alert as to the decedent's moderate risk for fall whenever he attempted to leave the bed. Nurse Marangelo states that in her opinion the failure to provide the decedent with a yellow wrist band, as per hospital protocol, and the failure to place a bed alarm prior to February 11, 2007 were substantial factors in causing the decedent's injuries.

Nurse Marangelo further states, within a reasonable degree of nursing certainty, that the nursing staff at St. Charles Hospital departed from good and acceptable nursing practice when they failed to follow a protocol of observing of the decedent for neurological signs for three days post fall, and to document every shift post fall for those three days. Nurse Marangelo explains that from February 11, 2007 through February 15, 2007, the decedent's fall risk assessment remained the same score of 20. On February 15, 2007, a nurse recording the fall risk assessment indicated factors of environment change, unsteady gait, assistance with transfers, and narcotic use, which totaled 30 on the fall risk assessment scale; despite these findings, plaintiffs' decedent was mistakenly assigned a scored of 20. Nurse Marangelo states that, according to the St. Charles Hospital Fall Risk Assessment sheet, a score of over 24 indicates a patient has a moderate fall risk score, which requires a yellow wristband, and that the purpose of the wristband is to alert the nursing staff of the patient's fall risk status in order to institute the necessary interventions if the patient is out of bed unsupervised. However, Nurse Marangelo states that there is no indication in the hospital records that this action was taken for the decedent.

Nurse Marangelo states that after the decedent's fall on February 11, 2007, his fall risk assessment should have been 50 or higher, which would have classified him as a "high" fall risk, requiring not only a yellow wrist band, but the placement of a falling leaf outside of his room to alert the staff of his high risk of falling, along with the implementation of the appropriate fall risk interventions for high risk of fall patients. She explains that the decedent should have been reassessed after his first fall, and that an additional 30 points should have been added to his fall risk assessment score of 20: 10 points for the actual fall, 10 points for his unsteady gait, 5 point for his language barrier, and 5 points for taking more than 4 types of medications. Nurse Marangelo states that once a patient is classified as a high risk for falling, hospital precautions require that the patient is frequently observed and a schedule to assist the patient to the bathroom is implemented. Nurse Marangelo further states that had these precautions been implemented, the decedent's second fall on February 17, 2007 may have been prevented, and that the failure to properly reassess him after his first fall was a substantial factor in the occurrence of his second fall from his bed. She notes that each fall occurred when the decedent attempted to go to the bathroom, which indicates that he left the bed unassisted to void. Nurse Marangelo further states that, although he was seen by a nurse practitioner, who indicated that he was alert, awake and followed commands, there was no indication in the hospital chart that anyone witnessed the decedent's fall or that he did not hit his head when he fell on February 17, 2007.

Furthermore, Nurse Marangelo states that from February 17, 2007 through February 19, 2007, the decedent's fall risk assessment score remained at 20, even though he had fallen twice. She states that the

decedent's fall risk score only was increased to 45 and "1:1 observation" was initiated on February 21, 2007, although the hospital record indicates that beginning on the evening of February 19, 2007 through the morning of February 20, 2007, the decedent had a change in cognitive status, that his family indicated he was confused, and that he attempted to get out of bed unassisted. Additionally, Nurse Marangelo states that Dr. Leon, a neurosurgeon, noted that the decedent had fallen on February 11, 2007 and, February 17, 2007, and, following the performance of a computerized tomography ("CT") scan, diagnosed him with a traumatic subarachnoid hemorrhage on February 26, 2007. She further states that no explanation has been provided as to why the decedent's fall risk assessment remained at 20 after his initial fall on February 11, 2007 or as to why his fall risk score was never corrected after the miscalculation on February 15, 2007. Thus, Nurse Marangelo concludes that the decedent, after having been given an initial fall risk assessment score of 40 upon arrival at St. Charles hospital, was not properly reassessed once he was transferred to the hospital floor, and that such failure to properly assess him was a substantial contributing factor in causing his two falls at the hospital and subsequent injuries.

Moreover, triable issues of fact as to whether St. Charles Hospital's nursing staff departed from good and acceptable nursing practices and, if so, whether such departure was the proximate cause of plaintiffs' decedent's injuries is raised by the affidavit of Dr. Stephen Bloomfield and the medical report of Dr. Stuart Dawson. Dr. Bloomfield, a neurosurgeon, who, based upon his review of the decedent's medical records, opines, within a reasonable degree of medical certainty, that the decedent suffered a traumatic subarachnoid hemorrhage as a result of his falls at St. Charles Hospital on February 11, 2007 and February 17, 2007, and that such falls resulted in his death at Stony Brook University Hospital on March 13, 2007. In addition, the May 3, 2007 medical report of Dr. Dawson, a medical examiner at Suffolk County Medical Examiner's Office, states that the decedent's cause of death was blunt force head trauma, that metastatic cancer of unknown primary site was a contributing cause of death, and that the manner of death was accidental.

As a consequence, summary judgment in favor of St. Charles Hospital is not appropriate in the instant matter, since the parties have presented conflicting medical expert opinions on whether the nursing staff at St. Charles Hospital departed from the acceptable standards of nursing practice and whether such deviation resulted in plaintiffs' decedent's injuries and death (*see* ***Wexelbaum v Jean***, 80 AD3d 756, 915 NYS2d [2d Dept 2011]; ***Darwick v Paternoster***, 56 AD3d 714, 868 NYS2d 698 [2d Dept 2008]; ***Shields v Bakitdy***, 11 AD3d 671, 783 NYS2d 654 [2d Dept 2004]). "Such credibility issues can only be resolved by the jury" (***Feinberg v Feit***, 23 AD3d 517, 519, 806 NYS2d 661 [2d Dept 2005]).

Accordingly, the motion by St. Charles Hospital for summary judgment dismissing the causes of action against it is denied. Further, having granted summary judgment plaintiffs' claims against Dr. Klein, Dr. Gredysa and Dr. Cervone, the case is severed and continued as against Peconic Bay Medical Center, Dr. Rakesh Patel, Dr. John Labiak, Dr. Farih Sanji, and St. Charles Hospital.

Dated: April 22, 2016

W. Gerard Asher
J.S.C.
HON. W. GERARD ASHER

____ **FINAL DISPOSITION** __x__ **NON-FINAL DISPOSITION**