Hernandez v Amsterdam Nursing Home Corp. (1992)
2019 NY Slip Op 32815(U)
September 16, 2019
Supreme Court, New York County
Docket Number: 805362/15
Judge: Joan A. Madden

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 11

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MICHELLE HERNANDEZ, as Administrator of the Estate of SONIA HERNANDEZ, Deceased, INDEX NO. 805362/15

Plaintiff,

-against-

AMSTERDAM NURSING HOME CORPORATION (1992) and EDWARD PHILLIPS, M.D., PARK AVENUE MEDICAL ASSOCIATES, P.C. and INPATIENT HOSPITALIST SERVICES OF NEW YORK, P.C., now known as HOSPITALIST HEALTHCARE SERVICES, PLLC,

Defendants.

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JOAN A. MADDEN, J.:

In this action for nursing home and medical malpractice, defendant Amsterdam Nursing Home Corporation ("nursing home"), moves for summary judgment dismissing the complaint as against it. Plaintiff opposes the motion. None of the co-defendants has responded to the motion.

On July 8, 2014, plaintiff's decedent was admitted to defendant nursing home for rehabilitation; at the time she was 67 years old. While at the nursing home, she fell on three separate occasions, on July 8, July 22 and August 16, 2014. As a result of the third fall on August 16, the decedent suffered a laceration to the occipital area at the back of her head/skull measuring approximately 4.5 cm, and a subdural hematoma. She was transferred to Mount Sinai Hospital, and after surgical evacuation of the subdural hematoma on August 17, her condition deteriorated and she died in the hospital on August 22, 2014.

Based on the affirmation of Dr. Perry Starer, who is board certified in Internal Medicine and Geriatrics, and the affidavit of Eleanor Tache, R.N., plaintiff alleges defendant nursing home

departed from the standard of care by failing to provide the following safety precautions and interventions that would have prevented the decedent from falling on August 16, 2014: 1) a bed tab alarm and/or a functioning bed tab alarm on August 16; 2) monitoring the decedent every 30 minutes at night from 11p.m. to 7a.m. on August 15 and 16; 3) checking her toileting needs every two hours on August 16, 2014; 4) updating the Fall/Safety Care Plan to reflect the use of Ambien and Lasix; 5) and advising staff that she had been given Ambien the night of August 15, 2014. The experts opine that foregoing departures were "substantial causative factors" of the decedent's fall on August 16, 2014, and the resulting injuries, including a 4.5 cm laceration with hematoma and bleeding, a subdural hematoma, surgery and death.

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing that "in treating the plaintiff, there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy the burden, defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific and factual in nature. Id; see Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2nd Dept 2008). Expert opinion must be based on facts in the record or those personally known to the expert, and the opinion of defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hospital, 69 AD3d 403, 404 (1st Dept 2010). Defendant's expert opinion must "explain 'what defendant did and why.'" Id (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

"[T]o avert summary judgment, plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries." Roques v. Nobel, supra at 207. To meet this burden, "plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." Id. Where the parties' conflicting expert opinions are adequately supported by the record, summary judgment must be denied. See Frye v. Montefiore Medical Center, 70 AD3d 15 (1st Dept 2009); Cruz v. St Barnabas Hospital, 50 AD3d 382 (1st Dept 2008).

Defendant nursing home has established prima facie entitlement to judgment as a matter of law based on the expert affirmation of Dr. Barbara Tommasulo, who is board certified in Internal Medicine and Geriatrics. She reviewed the pleadings and the bills of particulars, the depositions, and the decedent's records from the nursing home, including her medical chart, the fall investigations and the call bell log. She opines that at all times, the nursing home and its staff "conformed" to accepted medical and nursing practices, including but not limited to fall assessment and precautions, and "nothing that they did or failed to do," was proximate cause of any injury sustained by the decedent.

Dr. Tommasulo states that when the decedent was admitted to the nursing home on July 8, 2014, she required the use of a wheel chair and walker, and a "one-person" assistance for "transfers and locomotion," but was fully able to understand and communicate with staff. She opines that on admission the decedent was "appropriately scored and assessed as a moderate risk for falls," and given a care plan for falls and safety that provided for the following precautions: a call bell in easy reach at all times; reminders to use "assistive device" when ambulating;

encouraging the decedent to ask for assistance as needed and teaching her safety techniques; providing adequate lighting; minimizing glare from lights and floor; eliminating clutter; installing nonskid strips at bedside; and keeping the bed at the lowest position. The expert opines that decedent was also assessed for bed-rails, and left and right top/upper half bed rails were ordered and installed. The expert opines that a care plan was also established for Bowel and Bladder Incontinence/Continence Management, which called for 72 hour bladder and bowel monitoring and a toileting schedule that included checking the decedent every two hours.

Dr. Tommasulo opines that when the decedent fell on July 8, 2014, as she was attempting to reach for her slippers and slipped to the ground, she failed to call for assistance, even though the call bell was in reach and she had previously been using the call bell. The expert states that according to the investigation report, the decedent did not suffer any injures, and the nursing home staff responded by "reinforcing" the use of the call bell. The expert opines that after that fall, the nursing home "re-assessed" the decedent for fall risk and safety measures, "educated" her again as to the use of the call bell for assistance, and implemented the following precautions: a low bed; a tab bed alarm; safe environment including non-skid strips on the floor; non-slip socks and non-skid slippers; call bell within easy reach; and monitoring the decedent every 30 minutes. The expert opines that the nursing home's response and re-assessment were "entirely appropriate and proper."

Dr. Tommasulo states that on July 11, 2014, at approximately 12:35 a.m., the decedent's bed alarm sounded and she was found sitting on the floor on the right side of her bed; the decedent said she had fallen while reaching for the light switch; she did not sustain any injuries

and was helped back into bed. The expert opines that the nursing home staff again reinforced the need to use the call bell for assistance, and the decedent "verbalized understanding"; the decedent was placed on 30 minute monitoring at night; and after re-assessing her fall risk, she was given a score of 12, a moderate risk for falls. The expert opines that the decedent's care plan was updated as to the new fall risk score, and that the prior safety and fall precautions continued, including the call bell within easy reach at all times, a tab bed alarm and reminding the decedent to ask for assistance as needed. The expert opines that the interventions and fall risk re-assessment were "appropriate and proper and conformed with the standard of care."

Dr. Tommasulo opines that the decedent did not have another fall until August 16, 2014, when she attempted to go to the bathroom alone, and that prior to that day, she had been "consistently utilizing the call bell to summon assistance, which demonstrates that she had been educated on the use of the call bell and understood the necessity and function of that system." The expert opines that prior to the fall on August 16, the decedent's bed alarm "was attached and working." The expert opines that on August 16, at approximately 6:25 a.m., the decedent was heard calling for help and found on the floor; she sustained a 4.5 cm. linear laceration with hematoma to the occipital area at the back of the head/skull, with moderate bleeding; she was helped back into bed, a pressure dressing was applied to the laceration; an ice pack was applied to the occipital area; and she was reminded to call for assistance when she needed to use the toilet. The expert states that after the nursing home notifying Dr. Bassey, the decedent was transferred to the emergency room at Mount Sinai Hospital.

Dr. Tommasulo opines that the nursing home appropriately and properly responded to the decedent's August 16 fall, by administering first aid, notifying Dr. Bassey, and transferring her to

the emergency room. The expert also opines that the "condition of the environment" at the time of the decedent's fall was "entirely appropriate" and in conformance with the fall precautions in place, as the nursing home's investigation report noted as follows: "Equipment with walker at the side of resident. Lighting with adequate light. Floor, no spills, Furniture clutter-free." The expert opines that it is "significant" the decedent did not call for assistance, as she had previously used the call bell to summon assistance on August 15 at 11:25 p.m., and on August 16 at 2:49 a.m., which shows that she "knew how to use the call bell when she required assistance."

Dr. Tommasulo further opines that the August 2014 "Habit/Prompt training schedule" shows that the decedent's toileting schedule, which called for checking her toileting needs every two hours, was followed on August 16, as she was checked at 12:00 a.m., 2:00 a.m. and 4:00 a.m.; and at 5:45 a.m., Claudia Hayes, C.N.A., assisted her to the bathroom and she voided, which was less than one hour prior to her fall at approximately 6:25 a.m. The expert states that when the decedent was asked why she did not call for assistance at 6:25 a.m., she answered that she "didn't want to." Defendant's expert opines that the August 16 fall was "caused by the plaintiff decedent's decision not to use the call bell . . . [as] she attempted to go to the bathroom on her own, despite the fact that she had been assisted to the bathroom less than one hour earlier and clearly knew that she was supposed to call for assistance." The expert opines that "overall," the nursing home "properly assessed" the decedent's fall risk, and implement the fall and safety interventions that were "appropriate for someone in her condition," and nothing the nursing home and its employees "did or failed to do caused or contributed to the plaintiff's injuries."

Addressing any allegations as to violations of the Public Health Law, Dr. Tommasulo opines that the nursing home and its employees "exercised all care reasonably necessary to

prevent and limit any alleged deprivation or injury," by implementing "all fall precautions and prevention measures reasonably necessary for a patient situated such as the plaintiff-decedent," as evidenced by the nursing home records and deposition testimony as to the "extensive assessments, monitoring, re-assessment, fall precautions and safety measures implemented."

Addressing plaintiff's allegations that the administration of Ambien on August 15 caused or contributed to the decedent's fall on August 16, defendant's expert opines that the nursing home and its employees were not involved in the decision to prescribe that drug, which was prescribed by Dr. Phillips, who is not employed by the nursing home. The expert opines that Nurse Eileen Zabala "appropriately and properly relied on the expertise of a physician" in administering Ambien and "simply followed the doctor's order"; it is not "within the purview" of the nursing home or its staff to "determine how a medication prescribed by a physician may or may not affect a patient's fall risk status"; and regardless of any side effects of Ambien, "all appropriate fall risk and safety precautions were in place both prior and subsequent to the administration of Ambien."

Based on the foregoing, defendant nursing home has made a sufficient showing to establish prima facie entitlement to summary judgment, and the burden shifts to plaintiff.

In opposition to the motion, plaintiff submits the affirmation of Dr. Perry Starer, who is board certified in Internal Medicine and Geriatric Medicine, and the affidavit of Eleanor Tache, a Certified Registered Nurse and a New York State Licensed Nursing Home Administrator. The experts reviewed the bills of particulars, the nursing home records and protocols, the depositions of nursing home employees and co-defendant Dr. Phillips, Mount Sinai Hospital records, the

decedent's death certificate, the affirmation of the nursing home's expert Dr. Tommasulo, and state and federal statutes and rules governing nursing home patient care in effect in 2014.

The Court finds that the opinions of plaintiff's experts are sufficient to raise material issues of fact as to the alleged departures. Plaintiff's experts opine that the nursing home failed properly and adequately to implement the safety precautions it had determined were necessary to prevent plaintiff from falling. The Court notes that plaintiff's experts neither object to the nursing home's fall risk assessments nor opine that additional precautions should have been implemented.

Specifically, plaintiff's experts opine that the nursing home departed from the standard of care on August 16, 2014, by failing to provide the decedent with a bed tab alarm or a functioning bed tab alarm. The experts state that a bed tab alarm consists of a short lead that is clipped to the patient's clothing on one end and the other end is connected to an alarm, and when a patient attempts to move or get out of bed, the alarm sounds and alerts nursing staff. Noting that as of July 8, 2014, the decedent's Care Plan for Falls/Safety required the use of a bed tab alarm, plaintiffs' experts opine that based on the decedent's chart, the testimony of Cheryl Ancog and Claudia Hayes, the call bed log for the decedent's room on August 16 and the Fall Investigation report for the incident, no bed alarm was in use or functioning when the decedent fell on August 16. Specifically, the experts opine that the August 16 nursing notes do not mention a bed alarm was in use or ringing at the time the decedent fell; Hayes testified that a "co-worker was passing" the decedent's room and heard her yelling for help, which is consistent with the description of the "occurrence" in the Fall Investigation Report; Hayes and Ancog testified that they did not hear

an alarm when they entered the decedent's room; and the call bed log for August 16 does not indicate that the bed alarm was activated at the time the decedent fell. The contrary opinion of defendant's expert that the decedent's bed alarm "was attached and working" on August 16, raises issues of fact and credibility for the jury. Notably, counsel for the nursing home acknowledges in his reply papers that the "alarm did not sound," but asserts that the decedent "removed it [the alarm] before going to the bathroom."

Plaintiff's experts additionally opine that the nursing home departed from the standard of care by failing to monitor the decedent every 30-minutes from 11 p.m to 7 a.m, on the night of August 15 to 16, as required in the Care Plan for Falls/Safety. Noting that the decedent's fall risk assessment was "updated" after her second fall on July 11, 2014, to require "30-minute monitoring at night," plaintiff's experts opine that this safety intervention was implemented to prevent the decedent from falling and was not "discontinued . . .at any time after July 11." They opine that there is "no evidence" in the decedent's chart that the nursing staff performed such monitoring on August 16, and point out that the only records in her chart as to 30-minute monitoring are for July 8 and July 9. Plaintiff's experts further opine that 30-minute monitoring at night was "especially important" during the night of August 15-16, as on August 15, at 6:00 p.m., the decedent was administered Lasix (a diuretic that causes frequent urination) and at 9:00 p.m., she was administered Ambien (a sedative that causes "grogginess"), and both medications increased the decedent's risk of falling. With respect to the effects of Ambien, plaintiff's experts point to the August 16 nursing note that quotes the decedent as stating: "I was about to go to the bathroom when I fell. I was sleeping while walking." The experts opine that the

decedent's fall on August 16 was "entirety preventable" had the nursing home performed the 30-minute monitoring as required by the Care Plan for Falls/Safety.

Plaintiff's experts further opine that the nursing home departed from the standard of care on August 16, by failing to comply with the Care Plan for Bowel and Bladder Incontinence/Continence Management, which required that the decedent be checked every two hours for toileting needs, especially since the night before she had been administered Lasix, which would have increased her need to urinate and thereby increased her risk of falling. The experts' opinion is based on the handwritten entries on the "Habit/Prompt training schedule" for August 16, which indicate that the decedent was checked for toileting needs at 2:00 a.m. and 4:00 a.m.,when she reported as "dry"; the experts opine that the next time written on the schedule is "not reliable" as it arguably reads as either 5:45 a.m. or 6:45 a.m. While the nursing home witnesses testified that the time written on the schedule is 5:45 a.m, plaintiff's experts opine that the time was "possibly altered" and changed from 6:45 am to 5:45 am, and that the decedent was not actually checked for toileting until 6:45 am, after she had fallen. Plaintiff's experts opine that since the decedent fell at 6:25 a.m, her fall was "entirely preventable," as had the nursing home complied with the two-hour schedule required in the Care Plan, the decedent would have been toileted at 6 a.m., and not fallen 25 minutes later while attempting to walk to the bathroom on her own.

Plaintiff's experts also opine that the nursing home departed from the standard of care by failing to maintain proper and accurate records, and failing to following its own protocols. The experts opine that the nursing home's "CNA/Nurse Assignment" sheets for the decedent for the months of July and August 2014 failed to indicate the necessary safety and fall precautions;

under the category "Safety," only "fragile skin precaution" is checked off, and all the other items are blank, including "bed alarm" and "fall precaution." Plaintiff's experts opine that the nursing home failed to comply with its own protocol for updating the decedent's care plan "as needed," as the Falls/Safety Care Plan was not updated to reflect the administration of Lasix and Ambien as additional risk factors for falls. The experts opine that a result of such departures, the "nursing staff" would not know of the decedent's "increased fall risks and/or to use the safety intervention of a bed alarm."

Plaintiff's expert Dr. Starer states that he "totally disagrees" with the opinion of defendant's expert Dr. Tommasulo that it was not "within the purview" of nursing home staff to determine whether medication prescribed by Dr. Philips would affect the decedent's "fall risk status." Dr. Starer notes that on August 16, after the decedent's fall, the nursing home not only updated her care plan with the handwritten note, "Will Request MD to reassess med (Ambien)," but also performed a new fall risk assessment and "added a score for 'Psychoactive Drugs –includes anti-depressants, sedatives,' which can only have been the Ambien administered the prior night,." Dr. Starer opines that based on his "professional, medical experience in treating geriatric patients in nursing homes," as well as the defendant's own fall risk assessments and care plan, and the testimony of nurses Ancog and Zabala, the applicable medical and nursing standard of care is that nursing staff in a nursing home is "obligated to know how medication, such as Ambien, affects a patient's fall risks and nursing staff must safeguard a patient from increased fall risks due to medication side-effects, and thereby prevent falls."

Finally, plaintiff alleges that the nursing home's departures violated federal and state regulations governing the operation of nursing homes. Plaintiff's expert Nurse Tache, identifies specific regulations, and provides a sufficient factual basis in the record to support plaintiff's

claims of nursing home malpractice based on violations of those regulations.[1]

Based on the foregoing, the Court concludes that the affirmation of Dr. Starer and the affidavit of Nurse Tache establish the existence of triable issues of material fact as to whether defendant nursing home departed from the standard of care by failing to follow its own care plan and provide the safety precautions and interventions it had determined were necessary to prevent the decedent from falling. The experts disagree as to whether the decedent had a bed tab alarm or a functioning bed tab alarm at the time of the accident on August 16, 2014, whether the nursing home staff was monitoring the decedent at half hour intervals during the night, and whether the nursing home staff was checking the decedent's toileting needs every two hours during the evening of August 15 to August 16. Moreover, the experts disagree as to the standard of care applicable to nursing home staff when a patient is administered medications such as Ambien and Lasix, which can increase a patient's the risk of falling. Thus, in view of the conflicting expert opinions that are adequately supported by the record, triable issue of material fact are raised as to the alleged departures, and defendant nursing home is not entitled to summary judgment. See Frye v. Montefiore Medical Center, 70 AD15 (1st Dept 2009); Cruz v. St. Barnabas Hospital, 50 AD3d 382 (1s Dept 2008).

Accordingly, it is

ORDERED that the motion for summary judgment by defendant Amsterdam Nursing

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[1]For example, Nurse Tache opines that the nursing home violated 42 CFR §483.25(h) (2) which requires "adequate supervision . . . to prevent accidents," in that the nursing home failed to provide a bed alarm in use or functioning on August 16, and failed to perform the 30-minute monitoring at night and the two-hour toileting schedule, which were all required by the decedent's care plan. She also opines that the nursing home violated 42 CFR §483.25(1), which prohibits the use of "unnecessary drugs," defined as "any drug when used . . . without adequate monitoring," in that the nursing home failed adequately to monitor the decedent after administering Ambien on the evening of August 15.

Home Corporation (1992) is denied; and it is further

ORDERED that the parties are directed to appear for the pre-trial conference previously scheduled for September 26, 2019 at 11:00 a.m., in Part 11, Room 351, 60 Centre Street.

DATED: September 16, 2019

ENTER:

J.S.C.

HON. JOAN A. MADDEN
J.S.C