Yerkes v Parkview Care & Rehabiitation Ctr., Inc.
2020 NY Slip Op 34816(U)
December 14, 2020
Supreme Court, Nassau County
Docket Number: Index No. 604044-18
Judge: Jeffrey S. Brown
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

PRESENT: HON. JEFFREY S. BROWN, J.S.C.

----------X	**TRIAL/IAS PART 9**
CAROL YERKES as Executor of the Estate of JOSEPHINE WALKOWIAK, deceased,	**INDEX NO. 604044-18**
Plaintiff,	**MOT. SEQ. 01**
-against-	**SUBMIT DATE:10.20.2020**
PARKVIEW CARE AND REHABIITATION CENTER, INC. and SENTOSACARE, LLC.,	
Defendants.	
----------X	

The following papers were read on this motion	DOCS NUMBERED
Notice of Motion, Affirmations, Exhibits.....	27
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Defendants Parkview Care and Rehabilitation Center, Inc. (Parkview) and Sentosacare, LLC (Sentosacare) move by notice of motion pursuant to CPLR 3212 for an order granting summary judgment in their favor and dismissing the complaint in its entirety or, in the alternative, dismissing plaintiff's claims for punitive damages.

Plaintiff's decedent Josephine Walkowiak was a resident of Parkview from December 31, 2015 to March 8, 2016. During this time period, she suffered falls on five occasions. The fifth and final fall resulted in a hip fracture requiring hospitalization and surgery. Ms. Walkowiak died on April 11, 2016, about one month after being discharged back to Parkview from South Nassau Communities Hospital. Plaintiff commenced this action on March 28, 2018 alleging wrongful death, negligence, and negligence per se, as well as violations of Public health Law §§ 2801-d and 2803-c. Specifically, by her bill of particulars, plaintiff alleges that defendants failed to complete a proper fall risk assessment; failed to order proper fall prevention care; failed to reassess and modify care plans as falls, events, and conditions changed; and failed to follow the assessment for a resident that is high risk for falls. Plaintiff further alleges that defendants failed to implement proper safety interventions such as alarms, placing safety mats and/or cushions next to the decedent's wheelchair, provide her with access to the call button, and provide her with a wheelchair seatbelt. Plaintiff seeks compensatory and punitive damages.

> "It is well established that 'the proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact.' (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 [1986]; *see also William J. Jenack Estate Appraisers & Auctioneers, Inc. v. Rabizadeh*, 22 N.Y.3d 470, 475-476 [2013]; CPLR 3212[b]). Once the movant makes the proper showing, 'the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action' (*Alvarez*, 68 N.Y.2d at 324). The 'facts must be viewed in the light most favorable to the non-moving party' (*Vega v. Restani Constr. Corp.*, 18 N.Y.3d 499, 503 [2012] [internal quotation marks omitted]). However, bald, conclusory assertions or speculation and '[a] shadowy semblance of an issue' are insufficient to defeat summary judgment (*S.J. Capelin Assoc. v. Globe Mfg. Corp.*, 34 N.Y.2d 338, 341 [1974]), as are merely conclusory claims (*Putrino v. Buffalo Athletic Club*, 82 N.Y.2d 779, 781 [1993])."

(*Stonehill Capital Management, LLC v. Bank of the West*, 28 NY3d 439 [2016]; *see also Fairlane Financial Corp. v. Longspaugh*, 144 AD3d 858 [2d Dept 2016]; *Phillip v. D&D Carting Co., Inc.*, 136 AD3d 18 [2d Dept 2015]).

In addition to claims for common law negligence in an action such as this, Article 28 of the Public Health Law allows patients of residential care facilities to bring an action for the deprivation of any right or benefit enumerated in Section 2803-c of the statute. (*Gold v. Park Avenue Extended Care Center Corp.*, 90 AD3d 833 [2d Dept 2011]; *Zeides v. Hebrew Home for the Aged at Riverdale*, 300 AD2d 178 [1st Dept 2008]). The basis for liability under Public Health Law § 2801 is '"neither deviation from accepted standards of medical practice nor breach of a duty of care. Rather, it contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule' (*Zeides v. Hebrew Home for Aged at Riverdale*, 300 AD2d 178,179)." (*Novick v. S. Nassau Communities Hosp.*,136 AD3d 999, 1001 [2d Dept 2016]). Accordingly, an action pursuant to the Public Health Law is distinct from claims of negligence.

As to Sentosacare, defendants present the affidavit of Bent Philipson. As a member of that entity, he states that he is fully familiar with the "Agreement to Provide Consulting Services" with Parkview. Sentosacare maintains that although it provides consulting services to Parkview with regard to regulatory and compliance matters, financial management, implementation of Parkview's Rehabilitation Program, pre-admission screening, group purchasing, and marketing, it does not own or operate the Parkview facility, and therefore cannot be subject to liability in this action. Plaintiff does not oppose this aspect of defendants' motion and, accordingly, raises no issue of fact as to whether Sentosacare undertook any duties relating to patient care. Therefore, summary judgment in favor of Sentosacare must be granted.

Defendants also submit the expert affirmation of Alan J. Weider, M.D., a physician trained in the standards of care applicable to geriatrics and internal medicine. Upon review of the relevant materials and records, Dr. Weider opines that there were no failures to exercise reasonable care by Parkview, its staff, agents, servants, and/or employees in connection with its treatment of Josephine Walkowiak, that proximately caused and/or contributed to her alleged injuries and death. Additionally, Dr. Weider opines with regard to plaintiff's Public Health Law § 2801-d cause of action, that there were no deprivations of any nursing home resident "rights or benefits" or the failure to provide adequate and appropriate medical care which proximately caused and/or contributed to Ms. Walkowiak's injuries and death. Further, Dr. Weider opines that there is no evidence of intentional or reckless conduct by Parkview with respect to its care of Ms. Walkowiak and there was no intentional or reckless disregard of her rights as a nursing home resident.

Dr. Weider recounts the details of the decedent's admission at Parkview, with particular focus on the falls that she sustained on January 3, 2016, January 13, 2016, February 23, 2016, February 29, 2016, and March 8, 2016. He explains that the decedent presented to Nassau University Medical Center on December 15, 2016 with increasing agitation secondary to dementia and a urinary tract infection. A fall risk assessment performed at NUMC yielded a score of "8," placing her at a high risk for falls due to confusion, disorientation and gait disturbances. On December 31, 2015, decedent was admitted to Parkview from Nassau University Medical Center and was described as alert and oriented to time, place, and person, but not situation. It was further noted upon admission that she was bowel and bladder incontinent; required extensive assistance with bed mobility, transfers, locomotion, and eating; and was totally dependent with dressing, toileting, hygiene and bathing. The initial nursing note indicates that Ms. Walkowiak was confused at times with a primary diagnosis of altered mental status. Moreover, because she had tried to get out of bed on the date of admission, a bed alarm was ordered.

An initial fall risk assessment noted Ms. Walkowiak was confused and debilitated/weak and had osteoporosis. Additionally, she reportedly had mobility, communication, and visual sensory deficits and used anti-hypertensive medication. Safety measures included (1) orienting her to the room and unit and safety precautions and call bell usage; (2) the call bell and frequently used items were to be kept within reach and (3) psychiatric evaluation.

On January 2, 2016, Ms. Walkowiak was found on the floor in her room by her wheelchair with the wheelchair alarm sounding. She had no apparent injuries. Her family had come for a visit, after which she was left alone in her room. Plaintiff, Carol Yerkes, was notified of the incident and the family was instructed to alert staff when leaving Ms. Walkowiak in her room following a visit. Neuro-monitoring was to be performed every four hours for seventy-two hours. A care plan for falls instituted in light of decedent's risk factors, including impaired balance, impaired gait, gait disturbance, limited endurance, debility and weakness, visual impairment, impulsivity and poor safety awareness, cognitive impairment, dementia, arthritis, osteoporosis, incontinence, anemia, and TIA. The care plan called for keeping Ms. Walkowiak's room well-lit, PT/OT screenings every three weeks, placing the call bell within easy reach at all times, providing assistance with ADLs, continued use of a wheelchair and bed alarms, and placing the decedent's bed in the lowest position.

After additional similar incidents, Ms. Walkowiak was moved to a room near the nurses' station, which seemed to exacerbate her confusion. On February 23, 2016 and February 29, 2016, Ms. Walkowiak was found on the floor near her wheelchair and activity monitoring every thirty minutes for 48 hours was ordered. She continued to require extensive assistance for transfers from bed to wheelchair and it was recommended that she continue with skilled PT/OT, use of bed and wheelchair alarms, and frequent rest periods as needed.

On March 8, 2016, while approaching the nurses' station at approximately 2:10 p.m., Director of Recreation, Jennifer Fried, observed the decedent toward the edge of her wheelchair with the alarm bell sounding. Ms. Fried ran to assist the decedent, who fell forward before Ms. Fried could reach her. Ms. Fried called for assistance. Moments prior to the March 8, 2016 fall, MDS Coordinator, Ephrem Ozaraga, RN observed the decedent in her wheelchair by the nurses' station in an "unsafe" position. He repositioned Ms. Walkowiak, who had no complaints of pain or discomfort, and confirmed that the alarm in place. Mr. Ozaraga then proceeded down the hallway to return to the office and received a page, which prompted him to return to where he had last seen the decedent, this time on the floor, where other staff members were present. According to the signed "Investigation Statement - CNA Assigned to Resident" of Shirley Brooks, CNA, she had last seen the decedent at 1:45 p.m. at the nurses' station and was retrieving supplies to toilet and change the decedent when she fell. Lacerations were noted to the top of the decedent's head and left eyebrow and she was transferred to South Nassau Communities Hospital at 3:01pm where it was determined that she had a right femoral neck fracture. On March 14, 2016, a right hip hemiarthroplasty was performed and on March 17, 2016, she was discharged back to Parkview in stable condition.

On March 18, 2016, plaintiff Carol Yerkes agreed to the use of an alarmed seatbelt. The decedent was then seen for a rehabilitation evaluation but was unable to self-release the seatbelt upon command. The safety measures in place consisted of an ultra-low bed with bilateral floor mats, a bed alarm, an alarmed seatbelt, checks every fifteen minutes, and maintaining the decedent in high visibility/increased supervised areas when out of bed. At a March 21, 2016 meeting, the circumstances of the fall were discussed and, according to Dr. Weider, because of the Ms. Walkowiak's frequent falls, non-compliance with safety, poor safety awareness, and cognitive deficits related to dementia, the option of utilizing a seatbelt restraint was further discussed.

Dr. Weider explains that the determination of the particular fall prevention measures to be used in the nursing home setting involves a multi-factorial assessment of the resident, including their history of falls, underlying illnesses and medical problems, medications, functional status, sensory status, psychological status, toileting needs and the status of their surrounding environment. In this case, interdisciplinary assessments of decedent's risk for falls were undertaken, her risk factors for falls and injuries from falls were assessed, as described above, which resulted in the creation of a reasonable plan of care to address her risk for falls. Dr. Weider states that these interventions were properly implemented during Ms. Walkowiak's Parkview admission, including multiple interventions to help prevent a fall from occurring or decreasing the extent and severity of injury from falls.

In addition, Dr. Weider contends that restraints are generally prohibited and run afoul of the governing regulations. In particular, 42 C.F.R. §483.13(a), in effect at the time, provided that nursing home "resident[s] ha[ve] the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." Other regulations similarly prohibit restraining residents. And, contrary to plaintiff's contentions, a chair alarm was in place. Further, Dr. Weider indicates that the standard of care does not ordinarily require nursing homes to provide 1:1 supervision of residents, stating that to require a nursing home staff member to be present with a resident at all times is impracticable and not required by either state or federal law.

In opposition, plaintiff submits the expert affirmation of Perry Starer, M.D., a physician board certified in the field of internal medicine with a subspecialty in geriatric medicine. He expressly does not address liability on the part of Sentosacare. Upon his review of the record, Dr. Starer finds that the personnel at Parkview departed from good and accepted nursing home practice in the care and treatment rendered to the decedent, and that each such departure, including violations of the New York State Public Health Law § 2801-d and § 2803-c, was a substantial factor and proximate cause of the injuries sustained by Josephine Walkowiak and her eventual death.

Dr. Starer begins by noting that Ms. Walkowiak was high risk for falls due to confusion/disorientation, altered elimination, and altered mobility when she was admitted to Nassau University Medical Center between December 15, 2015 and December 31, 2015. Due to her fall risk and attempts to get out of bed unattended, Nassau University Medical Center instituted 15-minute observation. Even when she did not attempt to get out of bed unattended, 15-minute checks were continued due to her senile dementia and confusion. This heightened observation was continued throughout her admission for safety. She did not fall at Nassau University Medical Center.

Dr. Starer also reviews the record of decedent's admission to Parkview, with special emphasis on the four falls preceding March 8, 2016. He notes that on January 2, 2016, shortly after the decedent's admission, she was assessed high risk for falls due to impaired balance, impaired gait, gait disturbance, limited endurance, debilitated/weak, visual impairment, impulsive or poor safety awareness, cognitive impairment, other dementia, arthritis, osteoporosis, incontinence, anemia, and TIA. "Noncompliance with safety measures" is not checked on this assessment. In addition, a Cognitive Loss and Decision Making Ability care plan was initiated on January 5, 2016, indicating that Ms. Walkowiak had "severely impaired" decision making and "short term memory impairment; cannot recall after 5 minutes."

Dr. Starer notes that Ms. Walkowiak fell out of her wheelchair for the fourth time on February 29, 2016 despite the fact that she was sitting at the nurses' station. All employees there at the time reported being focused on other duties. There is conflicting information concerning whether the chair alarm was active and sounded at the time. Dr. Starer indicates that the decedent's fall risk was not reassessed after this event and it was attributed to "resident impaired cognition and unawareness of physical boundaries and limitations." He further submits that "[a]fter four falls, at least three of which were from her wheelchair, and two of which were caused by [decedent]

sliding off the wheelchair without the alarm sounding, Parkview never conducted a wheelchair restraint evaluation or even considered an alarmed seatbelt or reclining wheelchair." He further indicates that on the morning of the March 8, 2016 fall, Dr. Abiola Familusi reviewed the plan of care and performed an assessment—inaccurately recording that there were no recent falls in the last 30 days despite Ms. Walkowiak having suffered two falls during that time.

Dr. Starer notes that upon decedent's readmission to Parkview, Ms. Walkowiak was put on 15-minute checks with an alarmed seatbelt when in her wheelchair. She was also given a reclining wheelchair instead of a standard wheelchair. The care plan at that time reflected the use of the alarmed seatbelt due to cognitive impairment/memory loss; unspecified physical impairment (could be unsteady gait, gait disturbance, and/or fractured hip), impaired balance, and weakness of bilateral lower extremities.

Dr. Starer opines that each of the fall assessments performed for decedent were flawed as they failed to address her noncompliance with safety measures and the fact that her cognitive decline made it improbable, if not impossible, for her to remember to use a call bell or ask for assistance. Non-compliance with safety measures was an issue known since at least January 5, 2016 when a Behavioral Symptoms Care Plan noted that she was "unaware of safety, trying to get [out of bed] without calling for assistance." Likewise, Dr. Starer states that the fall risk assessment did not address decedent's obvious restlessness as evidenced by her repeated attempts to get out of bed and her wheelchair both at Parkview and at Nassau University Medical Center. Neither of these factors was added to the fall risk assessment until March 17, 2016.

It is Dr. Starer's opinion that the failure to properly and accurately perform assessments, particularly of decedent's fall risk, resulted in improper interventions and care in violation of 10 NYCRR § 415.11, et seq. and was a proximate cause of Ms. Walkowiak's injuries and death as proper interventions were not in place. He further submits that the alarmed seatbelt and reclining wheelchair, which defendants did not address in their papers, were necessary interventions that should have been initiated well before the March 8 fall. He suggests that Parkview blames Ms. Walkowiak for this fall because she was cognitively impaired, restless and unaware of safety and physical boundaries. All of these factors were there as of admission and Parkview's chart shows actual knowledge of these factors, but, as noted below, their plan was reactive, as opposed to proactive. He notes that the medical symptoms provided as justification for implementing an alarmed seatbelt and reclining wheelchair after the March 8, 2016 fall were the same symptoms noted as early as January 5, 2016 and on Ms. Walkowiak's January 2, 2016 fall risk assessment. Dr. Starer disagrees with Dr. Weider's opinion that using an alarmed seatbelt and reclining wheelchair prior to the March 8, 2016 accident would have been detrimental. Instead, he states that the multiple falls and resulting injuries Ms. Walkowiak suffered were far more detrimental to her physical, mental and psychosocial wellbeing than the alarmed seatbelt and/or reclining wheelchair would have been.

Dr. Starer points out that while the regulations restrict the use of restraints when implemented for "purposes of discipline or convenience, and not required to treat the resident's medical symptoms," in this case restraints were implicated, and ultimately untimely applied, to treat decedent's medical conditions and ensure her safety. Dr. Starer concludes that the use of an

alarmed seatbelt and/or a reclining wheelchair was indicated and these interventions should have been put in place, latest, after the February 23, 2016 fall in order to treat Ms. Walkowiak's dementia and unawareness of physical boundaries/limitations—the same medical diagnoses and symptoms later used to justify their implementation. It is also his opinion that the failure to implement an alarmed seatbelt and/or reclining wheelchair was a proximate cause of Ms. Walkowiak's injuries as it was foreseeable she would either slide out of the wheelchair or fall off the edge as she had done before.

Additionally, Dr. Starer opines that Parkview failed to supervise and monitor Ms. Walkowiak, and this failure was a proximate cause and/or contributed to her injuries and death. He explains that 42 CFR 483.25(h)(2) requires a nursing home to provide adequate supervision and assistive devices to prevent accidents. While defendants imply that by placing Ms. Walkowiak near the nursing station while out of bed, alone, was adequate supervision, Dr. Starer argues that this does not comport with the facts. Rather, decedent was at the nurses' station (or nearby) for three falls (February 23, February 29 and March 8) and two of these falls were unwitnessed and one was witnessed by pure coincidence.

On this record, the court finds that plaintiff's negligence, wrongful death, and Public Health Law claims survive the instant motion. Both experts comprehensively reviewed the record yet they arrive at differing conclusions as to what interventions were implicated by the decedent's contributing conditions and history of falls. Dr. Starer's affirmation raises questions regarding Parkview's evaluation and creation of an appropriate care plan and safety measures. These conflicting medical opinions preclude summary judgment. (*See Carino v. Patel*, 159 AD3d 463 [1st Dept 2018]; *DiGeronimo v. Fuchs*, 101 AD3d 933, 936 [2d Dept 2012]). Finally, Dr. Weider does not directly address the plaintiff's claims concerning the standards set forth in federal and state regulations governing residential care facilities. Finally, contrary to defendant's contention, Dr. Starer's affirmation is neither conclusory nor unsupported by the facts and provides an adequate foundation for his testimony in this case. Whether the failure to implement restraints as suggested by Dr. Starer was a proximate cause of Ms. Walkowiak's injuries is an issued to be determined by the trier of fact.

Next, the applicable law permits punitive damages to be awarded only "where the deprivation of any such right or benefit is found to have been willful or in reckless disregard of the lawful rights of the patient." (Pub. Health L. § 2801-d(2)).

> Punitive damages may be assessed where a defendant's actions evinced a high degree of moral culpability which manifested a conscious disregard for the rights of others or conduct so reckless as to amount to such disregard (*see Welch v. Mr. Christmas,* 57 N.Y.2d 143, 150, 454 N.Y.S.2d 971, 440 N.E.2d 1317; *Walker v. Sheldon,* 10 N.Y.2d 401, 404, 223 N.Y.S.2d 488, 179 N.E.2d 497; *Greenberg v. Meyreles,* 155 A.D.3d 1001, 1003, 66 N.Y.S.3d 297). Such damages may be imposed for wanton or reckless disregard for the safety or rights of others where the conduct is "'sufficiently blameworthy,' and the award of punitive damages ...

> advance[s] a strong public policy of the State by deterring its future violation" (*Randi A.J. v. Long Is. Surgi–Ctr.,* 46 A.D.3d 74, 81, 842 N.Y.S.2d 558, quoting *Doe v. Roe,* 190 A.D.2d 463, 475, 599 N.Y.S.2d 350; *see Giblin v. Murphy,* 73 N.Y.2d 769, 772, 536 N.Y.S.2d 54, 532 N.E.2d 1282; *Serota v. Mayfair Super Mkts., Inc.,* 15 A.D.3d 385, 790 N.Y.S.2d 173). The violation of rights must be "so flagrant as to transcend mere carelessness" (*Zabas v. Kard,* 194 A.D.2d 784, 784, 599 N.Y.S.2d 832). In addition, Public Health Law § 2801–d(2) permits punitive damages against a medical facility where a deprivation of a patient's rights is found to be willful or in reckless disregard to the patient's rights (*see Hairston v. Liberty Behavioral Mgt. Corp.,* 138 A.D.3d 467, 468, 29 N.Y.S.3d 310).

(*Valensi v. Park Ave. Operating Co., LLC*, 169 A.D.3d 960, 961–62 [2d Dept 2019]). Here, plaintiff's claims based upon a reckless disregard for the rights of the decedent must be dismissed. Defendants' expert Dr. Weiber opines that there was no departure from the standard of care, no less one that would rise to the level of recklessness. Plaintiff's expert, though making reference to a reckless disregard of Ms. Walkowiak's health and safety, substantively supports only plaintiff's claims of negligent conduct. Accordingly, there is no factual or expert support for a claim of punitive damages.

For the foregoing reasons, it is hereby

ORDERED, that the branch of defendants' motion for summary judgment on the claims as asserted against Sentosacare, LLC is **granted**; and it is further

ORDERED, that the branch of the defendants' motion for summary judgment on the claims as asserted against Parkview Care and Rehabilitation Center, Inc. is **granted** with respect to plaintiff's claim for punitive damages and is otherwise **denied**.

The foregoing constitutes the decision and order of this court. All applications not specifically addressed are denied.

Dated: Mineola, NY
December 14, 2020

E N T E R:

/s/ Jeffrey S. Brown

Jeffrey S. Brown, J.S.C.