Lopez v St. Vincent De Paul Residence
2014 NY Slip Op 33570(U)
October 3, 2014
Supreme Court, Bronx County
Docket Number: 306970/09
Judge: Julia I. Rodriguez
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: PART 27

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JUANA LOPEZ, as Administratrix for the Estate of MARIA VERAS,

Plaintiff,

-against-

ST. VINCENT DE PAUL RESIDENCE and ST. VINCENT DE PAUL NURSING HOME, INC.,

Defendants.

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INDEX NO.: 306970/09

POST-TRIAL DECISION and ORDER

Present:
Hon. Julia I. Rodriguez
Supreme Court Justice

RELIEF REQUESTED:

After a jury trial, Defendants move to set aside the verdict pursuant to CPLR § 4404(a) on the ground that the Jury Verdict is contrary to the weight of the evidence, and to dismiss the award on punitive damages, or, in the alternative, directing a new trial on the issue of punitive damages.

Plaintiff cross-moves for an Order awarding attorney's fees and costs in the amount of $171,708.21 pursuant to Public Health Law § 2801-d (6) which provides, upon the court's discretion, for an award of attorneys fees when a judgment is granted under PHL §2801-d. In the affirmation, a further request is made to set aside the Judgment as inadequate and against the weight of the evidence.

STATEMENT OF FACTS:

The instant case was commenced as a result of Decedent Plaintiff Maria Veras' death while under the care of Defendants' nursing facility. On August 28, 2007, Decedent Plaintiff, born 8-29-1929 and approximately 78 years old, fell at home as she attempted to step out of bed. [Trial transcript (TT) 122]. Decedent sustained a subdural hematoma which is bleeding to the brain.[TT234, 264]. She underwent several surgical procedures and had multiple complications during hospitalization. [TT 123]. She was stabilized and discharged to a rehabilitation facility but continued to suffer medical complications and was transferred back to Lincoln Hospital. [TT 430]. On November 23, 2007, she was again stabilized, discharged and admitted to Defendants' Nursing Home. [TT 114, 351]. Decedent's condition continued to have medical complications. [TT 430, 431]. She had a tracheotomy and feeding tube, required assistance with all of her daily

living activities, was confused, could not walk, talk or sit upright. [TT 430, 431]. Significantly, her own treating neurologist was not optimistic about her recovery prospects. [TT 167, 231, 265]. A note in the St. Vincent De Paul chart indicated that the Decedent's daughter "refuses to accept the facts regarding her mother's condition," and intended on her mother returning home soon, despite her serious condition. [TT 232].

Defendants' records reveal that on November 26, 2007, a care plan was implemented. [TT33]. The care plan reveals that the Decedent has a high risk for falls. [TT 31]. The care plan provides for referral for evaluation with occupational and physical therapy. [TT33]. The plan provides for floor mats next to Decedent's bed. [TT33]. A note in the medical records indicates that on November 27, 2007, a RN indicated that Decedent continued to lean forward in the wheelchair and slide out. [TT36]. A rehabilitation therapist was asked to evaluate Decedent but it was not documented whether the evaluation took place, whether there were recommendations as a result of the evaluation or whether the evaluation and recommendations were made within a 24 hour evaluation / documentation care plan period which would have included the recommendations. [TT 37, 38]. The care plan provided for the implementation of side rails for the bed. [TT40]. The plan included range of motion exercises for the Decedent. [TT 47].

On November 25, 2007, there was no indication in the records whether the active range of motion exercises were performed which is a charting violation of federal and state statutes [TT 47, 49]. A notation on November 28 indicated that Decedent was to be reassessed but it is not known if it was done. [TT49]. A notation on Nov. 28, 2007 also indicated that Decedent is confused; trying to remove trach and GT; mitten restraints on both hands ordered by M.D. and removed every two hours; assess skin regularly. [TT50]. The records reflect that on Dec. 30, 2008, a nurse noted that Decedent made several attempts to take off bilateral mitten. One mitten successfully removed and same replaced without difficulty. [TT 77].

In early January 2008, a Speech Language Pathology Intervention note states "nursing to keep resident out of bed four hours a day." [TT50]. The notation indicated, "The family agreed. They're concerned about her wheelchair safety, as the resident is restless at times." [TT51]. On January 14, 2008, Decedent falls out of the wheelchair and sustains a head and eye hematoma. [TT51]. Defendants implement a lap board to prevent falls and close supervision. [TT53]. Close supervision meant that staff is in close proximity to Decedent when she is out of bed. [TT 54]. However, records did not indicate whether a lap board or close supervision was implemented or

whether it was made part of the Decedent's care plan. [TT 55, 58]. Significantly, safety measures not written in care plan may appear any place in the record as long as its documented. [TT 60, 61]. There was no indication in the record whether the mittens were removed every two hours. [TT 68]. On January 15, 2008, a notation states that Decedent continues to pull off bilateral mittens, pull out trach and disconnect trach collar. [TT 81]. To make it more difficult to remove the mitten, mitten was tightened around her wrist. [TT 353]. Decedent was checked every half-hour by St. Vincent De Paul staff member. [TT 357, 447]. There was no indication in the records whether an intervention meeting or reassessment took place as a result of Decedent's behavior [TT81] or that the interdisciplinary team met to assess the resident. [TT 174]. A lack of intervention would have violated state, federal and Defendants' regulations. [TT 81]. The failure to change mittens as the intervention was a departure from good and accepted nursing practice. [TT 180]. However, Defendants believed that adjusting the restraints on the hands and half- hour monitoring was adequate intervention [TT 357], and that they were not in violation of statutory regulations as long as the safety measures were documented in the resident's records, and not necessarily in the care plan [TT 60].

A weekly behavior note written on January 16, 2008 indicates that "resident continues to pull on trach even with hand mittens on" [TT 81, 82]. A monthly progress note incorrectly indicates that no physical restraints are being used on Decedent and that there were no recurrent falls, skin tears, fractures. [TT 83, 84]. There were other inaccuracies with the charting with respect to whether mittens were worn and/or removed every two hours and safety rails implemented. [TT -87].

On January 20, 2014, at 5:40 a.m., Nurse Cohen noted that Decedent was receiving a nebulizer treatment; also noted to be restless and trying to remove the trach. [TT 386, 405]. Nurse Cohen moved Decedent's hand from the trach and warned Decedent: "Don't do that, Maria. You know, that's not safe. Put your hand down." [TT 387]. Decedent did not succeed in pulling out the trach. [TT 387]. Cohen testified that she left Decedent's room at 5:45 am and returned at 6:10 am. [TT 405]. Cohen did not administer the nebulizer treatment but saw that it was being administered at 5:40 a.m.; the treatment would normally take 15 minutes. [TT 389]. When Cohen returned, she saw that the trach was in Decedent's mitt. [TT 390]. The Decedent was not responsive. [TT 391]. Although Cohen testified that she returned to Decedent's room at

6:10 am, a note in the records written by Cohen states: "[a]t 6:00 am, assisted resident, trach off, mitten restraints was on both hands, called supervisor, vital signs not palpable, CPR started, 911 called, 911 responded at 6:24 am and took over CPR. EMS intubate resident. Resident left the floor at 7:08 am. via ambulance on stretcher with EMS. Family was notified by supervisor at 7:30 am." [TT 390].

Plaintiff Lopez received the call that Decedent was being transported to the hospital and met them at the hospital. [TT140]. When she arrived at the hospital, she observed that Decedent was breathing and moving her arms. [TT 141]. However, Dr. Tommasulo testified that during his review of the emergency hospital records, he did not see whether it indicated if Decedent regained consciousness. [TT 461]. According to the Lincoln Hospital records, Decedent was found in cardiac arrest by EMS. EMS resuscitated Decedent for 40 minutes. She arrived at the hospital at approximately 7:15 am. In the emergency room, Decedent suffered another cardiac arrest. CPR was initiated again at 8:00 am after another cardiac arrest and she was resuscitated. She had a faint pulse and was admitted to critical care at 11:45 am. It was noted that when she arrived at the unit she was unresponsive with eyes closed. At 2:55 pm, Decedent had no pulse and was pronounced dead.

After Decedent's death on January 21, 2008, Defendants' records erroneously indicated that Glucerna, Brimonidine drops, water, feedings and formula were given to Decedent during the 7 am to 3 pm shift. [TT 93-94].

Additional relevant evidence considered in the instant motion included: testimony regarding OBRA section stating that facilities should not tie down residents [TT 171]; where facility had to use restraints, restraints must be the least restrictive measure [TT 171]; Plaintiff Lopez testified she would never have wanted Decedent's hands tied down [TT 149]; that the least restrictive measure was to provide 24 hour supervision which involved financial considerations [TT 203]; there were two incidents that injured or potentially injured Decedent [TT 240]; Decedent's injuries were a result of the fall on January 14, 2008 and the trach removal on January 20, 2008 [TT 240]; that Decedent still managed to pull trach off with the mittens on [TT 249].

On August 26, 2009, Plaintiff commenced the instant action alleging causes of action in negligence, gross negligence, Public Health Law 2801-d and other general violations.

Specifically, Plaintiff alleged that the Decedent's rights were violated by failing to provide proper restraints; failing to provide proper supervision; failing to properly monitor Decedent; failing to prevent Decedent from removing a tracheotomy; failing to provide Decedent with appropriate gloves or mitts to prevent Decedent from pulling, tugging or removing the tracheotomy; failing to implement appropriate standards of care for the Decedent; failing to prevent falls; failing to properly care for Decedent; failing to provide a comprehensive assessment; failing to provide the right to a dignified existence; failing to undertake proper and timely tests; failing to understand such tests so that Decedent could be properly diagnosed, and other duplicative allegations.

RELEVANT LAW:

CPLR §4404(a) states in relevant part:

After a trial, the court may set aside a verdict or any judgment entered thereon and direct that judgment be entered in favor of a party entitled to judgment or it may order a new trial of a cause of action or separable issues in the interest of justice or where the verdict is contrary to the weight of the evidence. Further, in deciding a post-trial motion, a court should set aside a jury verdict "only if there was no valid line of reasoning and permissible inferences which could possibly lead rational men to the conclusion reached by the jury on the basis of the evidence presented." *Cedano v. City of New York*, 35 Misc.3d 1223(A), 2009 WL 8604421 (Sup. Ct. Bx. Co. 2009), quoting *Lolik v. Big v. Supermarkets, Inc.* 86 N.Y.2d 744 (1995).

Public Health Law § 2801-d states, *in relevant part*:

1. Any residential health care facility that deprives any patient of said facility of any right or benefit, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation, except as hereinafter provided. For purposes of this section a "right or benefit" of a patient of a residential health care facility shall mean any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority. No person who pleads and proves, as an affirmative defense, that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury for which liability is asserted shall be liable under this section. For the purposes of this section, "injury" shall include, but not be limited to, physical harm to a patient; emotional harm to a patient; death of a patient; and financial loss to a patient.

> 2. .... In addition, 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, punitive damages may be assessed.
>
> 6. If judgment in an action maintained under this section is rendered in favor of the plaintiff, in its discretion the court may, if justice requires, award attorney's fees to the plaintiff based on the reasonable value of legal services rendered and payable by the defendant.

Inasmuch as the language in *Public Health Law* § 2801-d providing for punitive damages is parallel to the common law standard for punitive damages based on gross negligence, it is appropriate to evaluate cases involving common law claims of gross negligence and punitive damages for a better understanding and clarification of the law. Gross negligence is conduct that evinces a reckless disregard for the rights of others or smacks of intentional wrongdoing. *Platinum Partners Value Arbitrage Fund LP v Kroll Associates, Inc.* 102 A.D.3d 483, 957 N.Y.S.2d 336 (1st Dept. 2013); *Chan v Counterforce Central Alarm Services Corp.,* 88 A.D.3d 758, 930 N.Y.S.2d 680 (2nd Dept. 2010) citing *Colnaghi, USA, Ltd., v Jewelers Protection Services, Ltd,* 81 N.Y.2d 821, 595 N.Y.S.2d 381 (1993).

A party is grossly negligent when he/she fails to exercise even slight care or slight diligence. *Ryan v IM Kapco, Inc.,* 88 A.D.3d 682, 930 N.Y.S.2d 627 (2nd Dept. 2011).

Gross negligence is conduct that is so careless that it shows a complete disregard for the rights and safety of others. *Goldstein v Carnell Associates, Inc.*, 74 A.D.3d 745, 906 N.Y.S.2d 905 (2nd Dept. 2010).

The standard for an award of punitive damages is when a defendant manifests evil or malicious conduct beyond any breach of professional duty. *Dupree v Giugliano,* 20 N.Y.3d 921, 982 N.E.2d 74, 958 N.Y.S.2d 312 (2012).

There must be an aggravation or outrage, such as spite or malice or a fraudulent or evil motive on the part of the defendant, or such a conscious and deliberate disregard of the interests of others that the conduct may be called willful or wanton. *Id.*

Punitive damages are awarded to punish a defendant for wanton and reckless behavior or malicious acts and to protect society against similar acts. *Rivera v City,* 40 A.D.3d 334, 836 N.Y.S.2d 108 (1st Dept. 2007). The conduct of the defendant must evince a high degree of

moral culpability, or the conduct must be so flagrant as to transcend mere carelessness, and it is not necessary that the conduct complained of be intentional. *Shovak v Long Island Commercial Bank,* 50 A.D.3d 1118, 858 N.Y.S.2d 660 (2nd Dept. 2008); *Gerulaitis v Recreational Concepts, Inc.,* 295 A.D.2d 562, 744 N.Y.S.2d 710 (2nd Dept. 2002); *Rey v Park View Nursing Home, Inc.* 262 A.D.2d 624, 692 N.Y.S.2d 686 (2nd Dept. 1999). Further, the court has authority to assess whether the allegations, pleadings, facts and evidence presented by a Plaintiff rise to the level of gross negligence, willful or reckless conduct as a matter of law, thereby determining whether the claim for punitive damages survive. See *Gerulaitis,* supra 295 at 562, 744 at 711; *Dmtryszyn v Herschman,* 78 A.D.3d 1108, 912 N.Y.S.2d 107; *Wing Wong Realty Corp. v Flintlock Construction Services, LLC,* 71 A.D.3d 537, 895 N.Y.S.2d 825 (1st Dept. 2010); *Kraycar v Monahan,* 49 A.D.3d 507, 856 N.Y.S.2d 123 (2nd Dept. 2009); *Giannotti v Mercedes Benz USA, LLC,* 56 A.D.3d 610, 867 N.Y.S.2d 350 (2nd Dept. 2008); *Pellegrini v Richmond County Ambulance Service, Inc.* 48 A.D.3d 436, 851 N.Y.S.2d 268 (2nd Dept. 2008); *Lee v Health force, Inc.,* 268 A.D.2d 564, 702 N.Y.S.2d 108 (2nd Dept. 2000); *Dubecky v S2 Yachts, Inc.,* 234 A.D.2d 501, 651 N.Y.S.2d 602 (2nd Dept. 1996); *Fernandez v Summit House Associates,* 186 A.D.2d 717, 589 N.Y.S.2d 790 (2nd Dept. 1992).

DISCUSSION:

Upon consolidation of Plaintiff's causes of action stated in the complaint, there remained two claims: negligence and violation of Public Health Law 2801-d, which were included in the Verdict Sheet.

With respect to the claim for punitive damages as a result of the alleged violation of Public Health Law 2801-d, the court finds that no reasonable view of the evidence supports a finding that Defendants' actions were willful, motivated by actual malice or were in reckless disregard of the Decedent's rights or safety. Consequently, this court finds that the Jury's award for punitive damages was not based upon "a valid line of reasonable or permissible inferences" garnered from the evidence presented at trial. *Cedano v. City of New York,* supra.

First, it cannot be said that Defendants acted in reckless disregard of Decedent's rights. To be deemed in reckless disregard, the conduct complained of must have been so careless that it showed a complete disregard for the rights and safety of Decedent. See *Goldstein,* supra. Also,

the conduct must have involved the failure to exercise slight care or slight diligence toward Decedent. See *Ryan,* supra. In the instant case, the evidence established that Defendants exercised more than slight care. For example, the Decedent was evaluated on several occasions, albeit not in a formal care plan, and measures were taken to prevent falls and the removal of the trach. The evidence shows that Defendants took progressive steps including placing floor mats, providing side rails, providing rehab, using a seat cushion, providing a lap board, using mittens, tightening the mitten restraints and providing monitoring every half hour. While Plaintiff may have wanted more aggressive measures, the measures taken by Defendants were professional judgment calls. Thus, any injuries sustained by Decedent were a result of mistakes in professional judgment and/or breach of professional duty, but not the result of complete carelessness or complete disregard of Decedent's rights. Moreover, it must be noted that Decedent required assistance with every aspect of living. Her condition required much attention and there are numerous notations in Defendants' records which indicate that Decedent was receiving a lot of care. Thus, it cannot be said that Defendants failed to provide slight care. Indeed, the fact that Defendants monitored Decedent every half hour, which required a significant financial consideration, showed that Defendants did not recklessly disregard or were careless toward Decedent; rather, it evinced significant regard for Decedent's rights and safety.

Further, there was no evidence to show that Defendants acted with malice or that Defendants' actions were willful, i.e., that they willfully, consciously and deliberately intended to deprive Decedent of her rights. See *Dupree,* supra. Although Plaintiff argues that Defendants "willfully disregarded their obligation to assess, re-assess and implement a care plan for restraints," resulting in Decedent's death, Plaintiff overlooks the fact that there were evaluations and progressive measures taken culminating in half hour monitoring. These actions do not constitute a willful and deliberate disregard. Granted, a formal evaluation with the interdisciplinary team and a formal care plan did not take place. However, given the alternatives presented, that is, physically restraining the Decedents' hands or 24 hour supervision, both of which were not viable options, a formal care plan meeting to discuss restraints would not have been productive.

In addition, Plaintiff is misguided in the interpretation of willful. Willful requires the element of intent. To be willful, Defendants' actions must have evinced the intent to deprive

Decedent of her rights. Willful is conduct that is beyond the breach of professional duty. See *Dupree,* supra. It is conduct that goes beyond ordinary negligence and is also known as gross negligence. The evidence established that Defendants breached their professional duty and that those actions constitute ordinary negligence, but do not rise to the level of gross negligence. Although Defendants breached their professional duty, the evidence did not establish that Defendants intended to deprive Decedent of her rights. On the contrary, as discussed above, the evidence of all the steps taken, culminating in half hour monitoring, established that Defendants did not intend to deprive Decedent of her rights. As such, Plaintiff failed to meet her burden on the issue of punitive damages. Therefore, this court must vacate that part of the Verdict which rendered an award of punitive damages as against the weight of the evidence.

Arguments were presented to the court as to whether or not the court should have returned the verdict to the jury for reconsideration. As this issue is now moot, the court shall not entertain those arguments.

With respect to Plaintiff's cross-motion, the evidence established that there were two negligent acts that resulted in injury or potentially injured Decedent. They include the fall on January 14, 2008 and the trach removal on January 20, 2008. None of the other alleged violations or negligent acts resulted in injury to the Decedent, or at least there was no proof of injury established as a result of the other alleged negligent acts. As a result of the fall, Decedent sustained a head and eye hematoma. However, the cat scan and evaluation tests came back normal. In addition, Nurse Cohen last checked Decedent at about 5:45 am and when she returned at 6:10 am, Decedent was not conscious. Thus, the Decedent suffered at most 25 minutes as a result of the removal of the tracheotomy. In light of the evidence and injuries sustained, the court finds that the jury award in the amount of $250,000 is rationally based on the record presented. As such, the court declines to increase the pain and suffering award or grant Plaintiff attorneys' fees and costs.

For the foregoing reasons, it is ORDERED that Defendants' post-trial motion is hereby **granted** *solely* to the extent that the punitive damages award is vacated; and it is further

ORDERED that Plaintiff's post-trial cross-motion is **denied** in its entirety.

Dated: October 3, 2014

J Rod

Hon. Julia I. Rodriguez