Turner v Northern Manhattan Nursing Home, Inc.
2018 NY Slip Op 30406(U)
March 9, 2018
Supreme Court, New York County
Docket Number: 161278/15
Judge: Lynn R. Kotler

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON.LYNN R. KOTLER, J.S.C. PART 8

BETTY TURNER, as Administrator of the Estate of SARAH LOUISE DRAYTON, Deceased

- v -

NORTHERN MANHATTAN NURSING HOME, INC. et al.

INDEX NO. 161278/15

MOT. DATE

MOT. SEQ. NO. 004

The following papers were read on this motion to/for summary judgment, x-mot sj and spoliation sanctions

Notice of Motion/Petition/O.S.C. — Affidavits — Exhibits NYSCEF DOC No(s). 50-77

Notice of Cross-Motion/Answering Affidavits — Exhibits NYSCEF DOC No(s). 79-92

Replying Affidavits NYSCEF DOC No(s). 96, 97

This action arises from defendants' alleged negligence while transferring Sarah Louise Drayton ("Drayton"), a long-term nursing home resident, from her bed to a wheelchair using a Hoyer Lift. Defendants, the nursing home where Drayton resided, move for summary judgment. Plaintiff, the representative of Drayton's estate, opposes the motion and cross-moves for summary judgment or alternatively, spoliation sanctions. Issue has been joined and note of issue has been filed. The motion is timely, and while the cross-motion for summary judgment is not timely, it is directly related to the motion-in-chief, contrary to defendants' argument. Therefore the cross-motion will be considered by the court. The court's decision follows.

Many of the relevant facts are not in dispute. Defendants operate a nursing home located at 116 East 125th Street, New York, New York. Drayton had been a resident at the nursing home for approximately ten years. On February 18, 2015, Drayton sustained injuries when she fell to the ground while two certified nursing attendants ("CNA") were transferring her from her bed to a wheelchair using a Hoyer lift. Drayton fell when the strap portion of a pad (sometimes "sling" or "canvas"), which the CNAs placed underneath Drayton and then connected to the lift, broke. After she fell, Drayton was transferred to Mount Sinai St. Luke's Hospital (the "hospital"), where she was diagnosed with subdural hematoma, bilateral nasal fractures, a vertebral fracture and severe facial bruising. On March 7, 2015, Drayton passed away at the hospital. According to her death certificate, Drayton's immediate cause of death was hypertensive and atherosclerotic cardiovascular disease. Other conditions contributing to her death listed on the death certificate include Diabetes Melititus; end-stage dementia of unknown type and immobilization following blunt head trauma.

During her deposition, Marie Paula Fluerant, one of the two CNAs involved in the transfer, described the steps she took prior to the accident as follows. That morning, Fleurant cleaned and dressed Drayton. Then, with the help of another CNA, Ivonne Parker, Fleurant positioned Drayton onto a pad which was then connected to the lift via straps. Each resident of defendants' nursing home that utilizes

Dated: 3/9/18

HON. LYNN R. KOTLER, J.S.C.

1. Check one: ☐ CASE DISPOSED ☒ NON-FINAL DISPOSITION

2. Check as appropriate: Motion is ☐ GRANTED ☒ DENIED ☒ GRANTED IN PART ☐ OTHER

3. Check if appropriate: ☐ SETTLE ORDER ☐ SUBMIT ORDER ☐ DO NOT POST

☐ FIDUCIARY APPOINTMENT ☐ REFERENCE

the Hoyer lift has their own pad, which is kept in the resident's room. Fleurant testified that the same pad had been used before to transfer Drayton via the lift, but did not know how many times or for how long prior to the accident. Fleurant further stated that the pads would be washed if they became dirty.

Fleurant claimed that Drayton began moving while she was approximately three feet in the air right before the strap portion of the pad broke. Fleurant explained as follows:

> Q. Can you describe how the strap broke? Did it rip? Tell me what you observed.
>
> A. It was when she fell and I see the strap came off and broke, you know when the incident happened and you see that, right away you call – I rant the bell, and the charge nurse is coming to see what happened.
>
> ...
>
> Q. Did you see that one of the straps became torn or ripped or something else?
>
> A. No.
>
> Q. What did you mean when you said that the strap broke?
>
> A. Because that's what happened.
>
> Q. Did the strap – when you say that it broke, do you mean that it became disconnected or did it actually – did the material rip?
>
> A. The material ripped.

Fluerant claimed that she inspected the pad before the accident. When asked what she observed in connection with the pad, Fleurant stated "I don't expect nothing." Meanwhile, Parker testified at her deposition that she did not inspect the pad prior to Drayton's fall. Both Fleurant and Parker claimed that they had never been involved in a prior incident where a patient was dropped.

Defendants have provided a "Resident Occurrence Report" to the court, which states in pertinent part:

> At around 8:30am, CNA reported that while transporting resident from bed to wheelchair using mechanical lifter, resident fell. Observed resident lying on right side next to her bed. Hematoma with superficial skin break to forehead noted. Moderate bleeding noted from both nostrils.

Another section of the report, completed by a Ms. Mitchell, who is the nursing supervisor for the unit, states:

> Resident has history of involuntary jerking movement. It appears the mechanical lift strap was not securely in place and with the jerking movement, resident fell. No abuse nor neglect noted.

Another section of the report which is signed by Dorret Chambers, defendants' then Director of Nursing, provides:

> Today I was interviewed by the Surveyor to provide clarification of staffs' statements regarding how the strap became loose from the canvas. I informed her that upon re-interviewing of staff, it was clear that the strap came off the hook because the canvas strap was broken.

There was noted to be loose threads where the strap was connected to the canvas.

Based on these findings, all canvasses were removed and examined for wear and tear and replaced as appropriate. Staff re-inserviced regarding proper usage of canvas and lifter.

Chambers further testified as follows:

Q. Did you determine that the cause of the breakage of the strap here was a result of wear and tear?

A. That is what I though, yes, at the time.

Q. How did you make that determination?

A. Because I could see where it was frayed, it was compromised and it came out and just broke.

...

Q. Did you determine that the wear and tear on the sling that you observed here was a condition that occurred over time or something else?

A. Yes, I thought so.

Q. The plan on the second page of your report calls for discarding canvasses upon any sign of wear and tear or after six months of issuing. Do you know if either of those directives were in place prior to the date of this incident?

A. Well, specifics, no.

...

Q. Do you know if there was any directed to date the canvasses prior to the date of this incident?

A. Yes, we had a date, there was a date.

Q. Was there any date noted on this particular canvass that was involved in this incident?

A. I can't recall.

...

Q. Did the facility as far as you know maintain any records that reflected the date of purchase of the particular sling involved here or canvass?

A. No.

Q. You don't know or there were no records?

A. There were no records.

...

Q. Other than the aids was there anyone else in the facility that was responsible for maintenance of the canvasses?

A. No.

...

Q. Would you agree that the aids involved in this transfer failed to properly ensure Ms. Drayton's safety by using a sling that was in such condition that it broke during the transfer?

A. The aids were not as thorough as they needed to have been.

Q. What do you mean by that?

A. To check a sling more carefully.

Q. Was anyone disciplined or admonished for this incident?

A. They were all admonished for being in service.

Q. When you say all, just those two aids or anyone?

A. The entire facility.

Further, Chambers admitted that after the accident, she gave the pad to housekeeping to be discarded. Chambers stated that she had the pad thrown out because she "didn't want it to come back into circulation." When asked if she thought anyone might want to inspect the pad, Chambers stated "[n]o, I didn't think anybody else because it was obvious (sic)."

In her complaint, plaintiff has asserted the following causes of action: [1] defendants deprived Drayton of her rights pursuant to Public Health Law § 2801-d and 2803-c, as well as 10 NYCRR Part 415, thereby seeking damages, attorneys fees and punitive damages; [2] defendants were negligent when they dropped Drayton while transporting her on the date of the accident; and [3] wrongful death. According to her bill of particulars, plaintiff also alleges that defendants violated the Public Health Law and were negligent in failing to ensure that Drayton did not develop pressure sores and receive necessary treatment for same.

Parties' arguments

Defendants argue that summary judgment is warranted because they were not negligent in providing care and treatment to Drayton. Specifically, they contend that Drayton's fall was just an accident. Defendants have provided the affirmation of Luigi M. Capobianco, who supports this conclusion. He claims that the CNAs were appropriately trained and that Drayton's fall was "not foreseeable." Defendants further argue that they did not have notice of a defect with the pad. Defendants also maintain that they did not violate any of the statutes or regulations listed in plaintiff's bill of particulars. Finally, defendants seek dismissal of the punitive damages claim because they are not warranted in this case.

In turn, plaintiff contends that the defendants have not met their burden on this motion and that plaintiff is entitled to summary judgment on the issue of defendants' liability with respect to the negligence cause of action. Plaintiff also argues that she is entitled to summary judgment on the cause of action based upon defendants' violations of Public Health Law § 2801-d. Lastly, plaintiff opposes dismissal of the punitive damages claim.

Plaintiff points to defendants' Policies, Procedures and Information manual regarding mechanical lifts. The manual provides in pertinent part that "[p]rior to using the lifter, the sling will be checked by

both CNA's (sic) for wear and tear, rips, bleached areas, loose threads, frayed edges, holes, broken seams, loose straps, any abnormalities."

Plaintiff has also provided the affirmation of Doctor Perry J. Starer, who opines that the defendants "deprived, violated and/or infringed upon MRs. Drayton's rights as a nursing home resident." Dr. Starer bases this opinion on his conclusion that the defendants violated applicable standards of care in using the Hoyer lift to transport Drayton when the pad failed because of "excessive wear and tear." Dr. Starer states that defendants' use of the pad in an unsafe condition and the CNAs failure to detect observable signs of excessive wear and tear on the strap that broke violated 10 NYCRR 415.12(h) and 42 CFR 483.25(h).

Plaintiff also points to Drayton's medical records which indicate she developed a Stage IV pressure ulcer on her sacral area while a resident at defendants' nursing home. Dr. Starer claims that the defendants violated Drayer's rights as a nursing home resident under 10 NYCRR 415.12(c) and 42 CFR 483.25 by failing to timely observe, note and intervene in the worsening status of the pressure ulcer. In reply, defendants contend that plaintiff's negligence claim arising from pressure ulcer are "moot" because "[t]he records are certain that the pressure ulcer was healed at the time of [Drayton's] fall." Further, defendants' expert opines that appropriate wound care and skin care treatment was implemented.

Meanwhile, in his affirmation, Dr. Starer states that the defendants violated the following regulations in their care of Drayton: 10 NYCRR 415.3, Residents' rights; 10 NYCRR 415.5, Quality of life; 10 NYCRR 415.12, Quality of care; 42 CFR 483.25, Quality of care; 42 CFR 483.13, Resident behavior and facility practices; 42 CFR 483.35, Nursing services; and 42 CFR 483.70, Administration.

Plaintiff has also provided a letter from the New York State Department of Health ("DOH") dated July 12, 2017, wherein the DOH concluded that defendants violated 42 CFR 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) in connection with a complaint made by plaintiff under Case # NY00167359.

Lastly, plaintiff contends that if she is not awarded summary judgment, defendants' answer should be stricken due to their spoliation of the pad. Defendants argue that they did not "deliberately discard[] the frayed sling" because "Chambers had no reason to believe that a lawsuit would later be initiated" because "[a]t the time that the strap was discarded there was no indication as to the type or severity of [Drayton's] injuries or indication that she would not return to the facility."

Discussion

On a motion for summary judgment, the proponent bears the initial burden of setting forth evidentiary facts to prove a prima facie case that would entitle it to judgment in its favor, without the need for a trial (CPLR 3212; *Winegrad v. NYU Medical Center*, 64 NY2d 851 [1985]; *Zuckerman v. City of New York*, 49 NY2d 557, 562 [1980]). The party opposing the motion must then come forward with sufficient evidence in admissible form to raise a triable issue of fact (*Zuckerman, supra*). If the proponent fails to make out its prima facie case for summary judgment, however, then its motion must be denied, regardless of the sufficiency of the opposing papers (*Alvarez v. Prospect Hospital*, 68 NY2d 320 [1986]; *Ayotte v. Gervasio*, 81 NY2d 1062 [1993]).

Granting a motion for summary judgment is the functional equivalent of a trial, therefore it is a drastic remedy that should not be granted where there is any doubt as to the existence of a triable issue (*Rotuba Extruders v. Ceppos*, 46 NY2d 223 [1977]). The court's function on these motions is limited to "issue finding," not "issue determination" (*Sillman v. Twentieth Century Fox Film*, 3 NY2d 395 [1957]).

The court's analysis of the negligence claim and cause of action for violations of Public Health Law §§ 2801-d and 2803-c is similar. Pursuant to Public Health Law § 2801–d, liability arises from an injury to the patient "caused by the deprivation of a right conferred by contract, statute, regulation, code or rule, subject to the defense that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient" (*Moore v. St. James Health Care Center, LLC*, 141 AD3d 701

[2d Dept 2016]). Public Health Law § 2803-c enumerates certain rights and responsibilities afforded to patients who are receiving care in every nursing home and facility providing health related service. Relevant to this action, subsection "e" provides that "[e]very patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated..."

Here, although defendants claim that they have established as a matter of law that they were not negligent in transporting Drayton, and that her fall was the result of a simple accident, the court disagrees. Indeed, defendants' director of nursing concluded that the CNAs were not as thorough as they needed to be in ensuring that the pad was in a safe condition. Further, Parker admits that she did not check the pad before it was placed under Drayton in violation of defendants' policy with regards to the lift. While Fleurant claimed that she checked it prior to the accident in her deposition, defendants have not come forward with any facts to support this claim or support the conclusion that Fleurant was not negligent in checking the pad, in light of Chambers' testimony that fraying was readily observable. Accordingly, defendants' motion for summary judgment dismissing plaintiff's claims arising from Drayton's fall is denied.

Defendants have, however, made a *prima facie* showing that Drayton's pressure ulcer was unavoidable and the result of preexisting conditions and other risk factors (see i.e. *Craig v. St. Barnabas Nursing Home*, 129 AD3d 643 [1st Dept 2015]). In turn, plaintiff has raised triable issues of fact on this point based upon the affirmation of her own expert, who opines that the ulcers were not properly noted or treated for an extended period of time until they because Stage III or IV, and then were not properly treated thereafter. Accordingly, defendants' motion for summary judgment dismissing plaintiff's claims arising from the pressure ulcers is also denied.

Assuming *arguendo* that plaintiff met her burden with respect to the negligence claim, defendants have raised triable issues of fact sufficient to defeat the motion. Fleurant clearly testified that she checked the pad before she placed it under Drayton and affixed it to the lift. Plaintiff's counsel claims in his affirmation that when he conducted Fleurant's deposition, the response "I don't expect nothing" from Fleurant was actually "I don't inspect nothing." Plaintiff's counsel therefore claims that Fleurant therefore admitted that she did not conduct any inspection.

Accepting plaintiff's counsel's claim would result in a substantive change to Fleurant's deposition testimony. Indeed, from one question to the next, Fleurant would have completely contradicted her own testimony. That plaintiff's counsel did not ask a follow-up question to clarify whether or not Fleurant inspected the pad prior to the accident is unfortunate, because had such an exchange taken place, the court would not be in this position. Defense counsel claims that Fleurant did inspect the pad prior to the accident. Plaintiff's counsel acknowledges that Fleurant spoke in a heavy accent, and perhaps she misspoke during her deposition. To resolve this factual issue in favor of plaintiff, however, is not warranted. Summary judgment is drastic relief, and this court cannot conclude on this motion that Fleurant did not observe the pad prior to its placement.

Further, as defendants point out, Chambers testimony about what the pad looked like after the accident does not establish how it appeared prior to Drayton's fall. Whether defendants knew of should have known that the pad was in an unsafe condition is a triable issue of fact. Further, defendants' expert maintains that the defendants "exercised all care reasonably necessary to prevent and limit the deprivation and injury." On this record, a reasonable fact-finder might conclude that plaintiff's fall was an unfortunate, unforeseeable accident and not the result of the defendants' negligence.

As for plaintiff's claims arising from the pressure ulcer, the court finds that triable issues of fact exist which preclude summary judgment. Accordingly, that portion of the cross-motion which is for summary judgment is denied.

The remaining branch of the motion-in-chief seeks summary judgment dismissing the punitive damages claim. That portion must be denied. As plaintiff correctly points out, Public Health Law

§ 2801-d provides that "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" (see also *Hairston v. Liberty Behavioral Mgt. Corp.*, 138 AD3d 467 [1st Dept 2016]). Here, defendants have not established as a matter of law that they did not violate Drayton's rights in a willful or reckless manner. Therefore, that portion of the motion is also denied.

Turning to the balance of the cross-motion, while defendants indisputably destroyed crucial evidence, the court does not find that the spoliation sanction of striking their answer is warranted. Spoliation is the destruction of evidence (*Kirkland v. New York City Hous. Auth*, 236 AD2d 170 [1st Dept 1997]). The court has broad discretion in providing relief to the party deprived of lost evidence, such as precluding proof favorable to the spoliator to restore balance to the litigation, requiring the spoliator to pay costs to the injured party associated with the development of replacement evidence, or employing an adverse inference instruction at the trial of the action (*Ortega v. City of New York*, 9 NY3d 69 [2007]). In determining the sanction to be imposed on a spoliator, the court must examine the extent that the non-spoliating party is prejudiced by the destruction of the evidence and whether dismissal is warranted as "a matter of elementary fairness" (*Kirkland, supra*).

Spoliation of a key piece of evidence, whether negligent or intentional, may warrant dismissal of an action or the striking of responsive pleadings (*Standard Fire Ins. Co. v. Federal Pac. Elec. Co., 14 AD3d 213* [1st Dept 2004]). Dismissal or striking a responsive pleading is warranted only where the spoliated evidence is the sole means by which a party can establish a claim or defense, where a claim or defense is otherwise "fatally compromised" or a party is "left 'prejudicially bereft' of its ability to defend as a result of the spoliation (*Arbor Realty Funding, LLC v. Herrick, Feinstein LLP*, 140 AD3d 607 [1st Dept 2016]).

Chambers claims that she did not direct that the pad be discarded to hamper plaintiff's claims, and on this record there is insufficient proof to support such a claim. Plaintiff is, however, prejudiced by the fact that the pad is missing. Yet, if plaintiff had the pad, she would still run the problem of proving the condition that it was in prior to the strap breaking. Therefore, the court finds that plaintiff is not sufficiently prejudiced to warrant anything more than the right to apply for an adverse inference charge at the time of trial with respect to the missing pad.

CONCLUSION

In accordance herewith, it is hereby:

ORDERED that defendants' motion is denied in its entirety; and it is further

ORDERED that plaintiff's cross-motion is granted only to the extent that plaintiff may apply for an adverse inference charge at the time of trial with respect to the missing pad; and it is further

ORDERED that the cross-motion is otherwise denied.

Any requested relief not expressly addressed herein has nonetheless been considered and is hereby expressly rejected and this constitutes the decision and order of the court.

Dated: 3/9/18
New York, New York

So Ordered:

Hon. Lynn R. Kotler, J.S.C.