2007 WL 4979183 (La.Dist.Ct.) (Trial Motion, Memorandum and Affidavit)
District Court of Louisiana,
21st Judicial District Court.
Livingston Parish

Geraldine M. SHAW, Donald R. Shaw and Linda J. Varnum,
v.
PLANTATION MANAGEMENT COMPANY, L.L.C. D/B/A Harvest Manor Nursing Home, Reliance Insurance Company, and John M. Rollinson.

No. 90926.
November 30, 2007.

Division "A"

Post-Trial Memorandum

By Attorneys: Guglielmo, Marks, Schutte, Terhoeve & Love, 320 Somerulos Street, Baton Rouge, Louisiana 70802-6129, Telephone: (225) 387-8330, Facsimile: (225) 387-8230, Charles A. Schutte, Jr., Bar Roll Number 11846, Attorneys for Plantation Management Company, LLC d/b/a Harvest Manor Nursing Home.

This matter was tried on November 20, 2007, and Plantation Management Company, L.L.C. ("PMC"), d/b/a Harvest Manor Nursing Home ("Harvest Manor"), submits this memorandum setting forth the findings that the court should make based on the evidence presented, and the duty PMC owed to Ivan Shaw ("Shaw"). The court should dismiss the claims of the plaintiffs, with prejudice, at their costs for the following reasons.

STATEMENT OF FACTS

Ivan Shaw ("Shaw") was admitted to Harvest Manor on the evening of January 3, 2000[1] into the locked unit. The locked unit was provided for residents with Alzheimer's, dementia, and other abnormal behaviors. The residents in the locked unit frequently are restless and wander aimlessly. The doors of the unit are locked to maintain the residents in a confined area. The locked unit was a self-contained area, including ten rooms, a sitting room, patio, dining room, and shower area. The residents were assigned to rooms based upon gender (men and women), and compatibility.

Shaw was a resident on the locked unit for two days. At approximately 2:00 o'clock a.m. on January 6, 2000, Shaw was found on the floor of his room where he had fallen. The incident report prepared by Betty Carney, LPN, the nurse on duty in the locked unit at the time of the incident, stated simply that Shaw got up to go to the bathroom and slipped and fell on the floor. The incident report[2] further shows that Shaw was 83 years old and confused at the time of the incident. The nurse's note[3] states that Shaw was found on the floor of his room near the bathroom door. Shaw stated that he fell after slipping in urine on the floor on his way to the bathroom. Shaw immediately stated that the urine on the floor was not from him. Shaw complained of severe pain to the right hip, but he was alert, awake, and responding verbally. The incident was immediately reported to Shaw's physician, Dr. Susan Nelson, and Shaw was transported by ambulance to the Baton Rouge General Medical Center on Bluebonnet Boulevard.

Prior to his admission to Harvest Manor, Shaw had the following relevant past medical history. Shaw had a benign prostatic hypertrophy. This condition caused an enlargement of the prostate gland attributed to the aging process rather than inflammation or blastoma. The condition is benign, but if enlargement progresses to cause obstruction of the urethra surgical intervention is

required. Shaw had undergone a procedure commonly referred to as a TURP, [4] a transurethral resection of the prostate. Peter Green, RN ("Green"), Director of Nursing at Harvest Manor described the procedure. The prostate is resected or cut and a tube is placed through the prostate and into the bladder to allow urine to drain. The tube runs from the bladder through the prostate and into the penis. Because of the procedure, Shaw would have abnormal urination requiring that he take Flomax, to regulate urination.

Shaw also suffered with chronic obstructive pulmonary disease, a condition which impaired the exchange of air in the lungs. The COPD was caused by a long term exposure to smoke from years of smoking. COPD had existed for many years.

Shaw had mandibular carcinoma many years prior to his admission to Harvest Manor, as well as a resection of the lymph node in his anterior cervical triangle. In simple terms, surgery was performed to remove a tumor in the throat and/or mouth. A prior surgery caused weakening and progressive loss of tone in the muscles at the back of the throat and neck used to maintain the airway required for breathing. [5]

Shaw's mental condition prior to admission to Harvest Manor is described in the handwritten notes [6] of his granddaughter. Most importantly, he was very unstable and loses his balance often and easily. [7] Shaw would lose his way even while walking down the hallway of his house. He had prior temper flare-ups where he struck and threatened his wife. His wife was terrified of him and the family feared that he might injure her. He could not get along with members of his family. He had difficulty dressing himself. He often would be naked or partially dressed. He often lost items that were given to him to hold and misplaced things. If he leaves his yard, then he cannot find the gate to re-enter his yard. He moves the furniture in the house and empties everything out of the dressers and drawers in the house. When in his shop in the back yard, he cannot find the door to exit. Donald Shaw testified that his *father* Shaw did fall at times.

The Social Service Notes [8] at Harvest Manor prepared upon admission state that Shaw was admitted from home. Mrs. Shaw had been admitted to the hospital and Shaw was residing at home. Shaw was found outside beating on the garbage cans, chasing cats, and stripped off his clothes at 3:00 A.M. His granddaughter who lived next door had to redirect him inside and get him dressed. Shaw was attending a daytime program at Oakhaven in Baker, LA and the records contained the same history. [9] Upon admission Shaw had both short term and long term memory deficits.

Shaw was admitted to the behavioral unit at the Baton Rouge General - Mid-City from December 8, 1999 through December 22, 1999, [10] because he threatened to kill his wife. A neuropsychological evaluation was performed on December 17, 1999 during this admission. [11] In his conclusions, Dr. Klusmen determined that Shaw had impairment and memory, language and motor skills consistent with dementia. Dr. Klusmen believed that the recent decline had a vascular cause and there was a history of a number of small strokes with infarcts confirmed by neuroimaging studies. Finally, his short term memory was significantly impaired.

THE DUTY OWED BY PMC TO SHAW

PMC contends that the plaintiffs seek to apply the wrong duty in this case, since Shaw was not a guest or invitee, Shaw did not fall in a public area or regular room, and the fall did not occur due to any defect or condition in the premises. For this reason, the cases cited by plaintiffs are clearly not applicable in the case sub judice.

I. *General Standard of Care.*

With respect to the nursing services and care, the staff at Harvest Manor had a duty to provide a reasonable standard of care, taking into consideration Shaw's *known* mental and physical condition. The following statement of the law as to the standard of care is set forth in *Booty v. Kentwood Manor Nursing Home, Inc.*, 483 So.2d 634 (La. App. 1st Cir. 1985):
"It is true that a nursing home is not the insurer of the safety of its patients." *Murphy v. Allstate Insurance Company*, 295 So.2d 29 (La.App. 2d Cir. 1974), *writ denied* 299 So.2d 787 (La. 1974); *Milton v. State (Health and Social and Rehabilitation Services Administration)*, 293 So.2d 645 (La.App. 1st Cir. 1974); *Nichols v. Green Acres Rest Home, Inc.*, 245 So.2d 544 (La.App. 3rd Cir.1971). *The duty of care owed by a nursing home to its patients* is to provide a reasonable standard of care, taking into consideration *each* patient's *known* mental and physical condition. *Hinson, et al, v. The Glen Oak Retirement System*, 37-550 (La.App. 2 Cir. 8/20/03), 853 So.2d 726, *rehearing denied* 9/18/03, *writ denied* (La. 12/19/03), 861 So.2d 572. (emphasis provided)

PMC's duty to Shaw cannot be considered independent of its duties to the other residents in the locked unit. PMC owed the same duty to each resident while granting the other residents freedom to exercise his resident rights in accordance with federal and state laws and regulations. The nursing care and services required for each resident may vary and was determined by his mental and physical condition at that point in time. Due to dementia and impaired mental status, a resident's behavior or conduct could vary widely from day to day, hour to hour, or even minute to minute. Due to his impaired cognition, Shaw presented an increased risk of harm to himself and to others. Shaw was also exposed to additional risks or hazards due to the unpredictable behavior or conduct of the other residents in the locked unit, and Shaw's family was notified of the increased risks or hazards. [12]

According to federal and state regulations and Harvest Manor's admission policy, admission to the locked unit required an assessment to determine if Shaw met the admission criteria. Admission required the consent of Shaw's family and the treating physician. Dr. Susan Nelson was the treating physician and entered the order for admission to the locked unit. [13] Shaw was evaluated by Wanda Crawford ("Crawford"), the social worker at Harvest Manor, for admission to the locked unit. Crawford testified that based upon his history of dementia and other circumstances, Shaw met the criteria for admission. Crawford met with Donald Shaw (Shaw's son and plaintiff), and explained to him the conditions in the locked unit and showed him the locked unit and Shaw's room. Donald Shaw approved the admission and the room, and signed the consent forms, including the form for acknowledging the admission criteria. [14] The admission criteria clearly state that there is increased risk to the resident upon admission to the locked unit, because of the unpredictable behavior of the residents in the locked unit. The admission criteria expressly stated that residents in the locked unit engage in behavior that makes them a danger to themselves and others. The residents can engage in behavior which causes them or other residents to react or respond violently. The residents also display and engage in socially inappropriate behavior such as screaming for no apparent reason, rude and inappropriate sexual behavior, self-**abusive** acts, spitting at or striking out at others for no apparent reason, or in the past demonstrated acts which require a secured unit at the family's request and the doctor's order. Shaw's family was notified in detail regarding the additional risk presented by Shaw residing on the locked unit. Finally, the admission criteria made it clear that the staff on the locked unit makes a concerted effort to minimize the conditions which may agitate or cause abnormal behavior in the residents.

The residents on the locked unit also exhibited behaviors that made them more difficult to supervise and monitor. According to the testimony of Harvest Manor's staff, almost all of the residents were incontinent at times, and most were incontinent 24/7. A bowel and bladder program was not effective, because the residents were not cognizant of the urge to void. Most of the residents were on pads and briefs to control incontinence episodes.

II. *Standard of Care for Accident Prevention.*

The federal regulations applicable to Harvest Manor expressly set forth the standard of care for preventing accidents, recognizing the difficult position of a licensed nursing facility responsible for meeting the needs of each resident when those needs are in conflict with the needs or rights of another resident. 42 C.F.R. §483.25 provides in pertinent part:

> (h) Accidents. The facility must ensure that- (1) The resident environment *remains as free* of accident hazards *as is possible;* and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The evidence demonstrates that the Harvest Manor staff provided Shaw with an environment as free of hazards as possible, adequate supervision, and assistance devices. PMC, however, is not responsible for the conduct of the locked unit residents every minute of the day. The standard recognizes that even in the most controlled setting accidents will occur. The risk of falling cannot be eliminated when the standard by law is to allow residents to remain as free to move about as possible. The risk of an **elderly** resident falling is an accepted risk in exchange for providing the greatest freedom possible to each resident.

III. ***Standard of Care Relating to Physical and Chemical Restraints.***

With respect to the use of physical and chemical restraints to prevent falls and regulate behavior, the Louisiana Resident Bill of Rights [15] provides:

A. All nursing homes shall adopt and make public a statement of the rights and responsibilities of the residents residing therein and shall treat such residents in accordance with the provisions of the statement. The statement shall assure each resident the following:

(6) The right to be adequately informed of his medical condition and proposed treatment, unless otherwise indicated by the resident's physician; to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to be informed of the consequences of such actions.

(7) The right to receive adequate and appropriate health care and protective and support services, including services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules promulgated by the Department of Health and Hospitals.

(10) The right to be free from mental and physical **abuse** and from physical and chemical restraints, except those restraints authorized by a physician for a specified and limited period of time or those necessitated by an emergency. In case of an emergency, restraint may only be applied by a qualified licensed nurse, who shall set forth in writing the circumstances requiring the use of the restraint, and, in case of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints shall not be used in lieu of staff supervision or merely for staff convenience or resident punishment, or for any reason other than resident protection or safety.

With respect to the use of physical or chemical restraints to avoid falls and prevention of **abuse**, 42 C.F.R. §483.13 provides in pertinent part:
(a) Restraints. The resident has 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.

(b) **Abuse**. The resident has the right to be free from verbal, sexual, physical, and mental **abuse**, corporal punishment, and involuntary seclusion.

The risk of an **elderly** resident falling is an accepted risk in exchange for providing the greatest freedom possible to each resident. Due to their medications and frail condition residents were often at an increased risk of falling. PMC's duty is simply

to avoid conditions presenting unreasonable risks of harm within its control. PMC has no duty to eliminate the risk of a resident in the locked unit from falling.

IV. ***Standard of Care for Quality of Care.***

With respect to quality of care to be provided to each resident, 42 C.F.R. §483.25 provides in pertinent part:
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to-- (i) Bathe, dress, and groom; (ii) Transfer and ambulate; (iii) Toilet; (iv) Eat; and (v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section;...

PMC created a safer environment for the general population at Harvest Manor by moving residents with identified behavioral problems into the locked unit where they could be confined and more closely monitored and supervised. The residents in the locked unit did receive a higher standard of care with additional staff; nonetheless, this did not make PMC the insurer of every resident's safety at all times. The residents (and their families) admitted to the locked unit were informed of the increased risks presented by other residents during the admission process and accepted those risks regardless of how the risks may materialize.

In her deposition, Dr. Susan Nelson expressed her opinion as Shaw's treating physician that PMC provided nursing services and care to Shaw that exceeded the applicable standard of care. [16]

PLAINTIFFS FAILED TO MEET THEIR BURDEN OF PROOF ON THE ISSUE OF PMC'S FAULT

Plaintiffs have failed to meet their burden of proving that PMC was at fault in causing the fall and injury to Shaw. Plaintiffs further are not entitled to a presumption of fault to shift the burden of proof to PMC for the following reasons.

The evidence demonstrates that Shaw was found at approximately 2:00 A.M. on the floor near the bathroom in his room. Plaintiffs allege that Shaw was on his way to the bathroom when he slipped and fell in urine on the floor. There is absolutely no evidence that the liquid on the floor noted by the nurse was urine from Rollinson, or that the liquid came from any other resident. If one assumes the facts alleged, then Shaw had the urge to urinate when he got out of bed, but never made it to the bathroom. He apparently fell on the floor and was unable to void. Given Shaw's TURP and urge to void, it is unreasonable to assume that Shaw never voided after he fell. When did Shaw satisfy his urge to urinate and could Shaw control the urge with the TURP? When found, Shaw immediately stated to Carney that the urine was not his, but his statement is not reliable. It is more probable that Shaw fell and urinated on himself. Given his demented state, Shaw's child like immediate voluntary statement to the nurse that the urine was not his (in other words - I did not urinate on myself) is very predictable. The evidence demonstrates that Shaw was very unsteady on his feet and had fallen numerous times. Having gotten out of bed to walk to the bathroom, there is no reason to assume that Shaw slipped as opposed to falling due to lost balance or for some other reason, including the stupor that a person has when waking up to urinate at night. Shaw did not state that the liquid was Rollinson's urine, nor is there any reason to assume that it was, especially since there is no evidence that Rollinson was up and/or wandering about at that time of night, and the court cannot make that assumption.

At best, Plaintiffs have proven that there was a risk of Shaw slipping in urine, if Rollinson urinated on the floor. However, there is no proof that the risk of harm presented by Rollinson urinating on the floor actually caused Shaw's fall on January 6, 2000.

To establish that the liquid on the floor was Rollinson's urine, plaintiffs rely solely upon a nurse's note [17] made by Susan Hicks, L.P.N. (“Hicks”) three days prior to Shaw's fall. Hicks made her note at 9:30 P.M. just prior to the end of her shift. The reference Hicks makes to Shaw getting up at night cannot be from her actual experience with Rollinson during the night, and can only make reference to Rollinson's behavior prior to the end of her shift. Hicks worked the 2:00 P.M. to 10:00 P.M. shift each day, and she never worked the 10:00 P.M. to 6:00 A.M. shift when the accident occurred. Hicks worked the period from 4:00 P.M. until 7:00 P.M. when behavior of the residents in the locked unit was at its worst due to the sundowner effect as described by Green and Crawford. A reading of Hicks' nurse's note shows that Rollinson was more agitated during the day and early evening, but she notes that he was stable at the end of her shift which would be consistent with the expected pattern.

One reason for the change in behavior (stabilizing) at the end of Hicks' shift was the medications that she administered to Rollinson at 8:00 P.M. and 9:00 P.M. as documented in the physician's orders and medical administration records [18] for Rollinson. Green testified about the heavy dosages of medications administered to Rollinson at night, including Aricept, Trazadone, Ambien, Seroquel, and Ativan. There is no evidence that the medications did not have the desired effect of causing Rollinson to rest or sleep at night. There is no evidence whatsoever that Rollinson's behavior (urinating on the floor) Hicks documented on her shift during the afternoon and evening on January 3, 2000, continued into the night, much less during the night three days later.

Plaintiffs have failed to present sufficient evidence to prove the allegations that Shaw slipped and fell in Rollinson's urine as alleged in the Petition and their claims should be dismissed with prejudice.

PLAINTIFFS ARE NOT ENTITLED TO A PRESUMPTION THAT PMC WAS AT FAULT

Plaintiffs contend that they met their burden of proof once they demonstrated that there was a foreign substance on the floor in Shaw's room, and that the burden of proof shifts to PMC to exculpate itself from the presumption of negligence. Plaintiffs argue that PMC must show that “it acted reasonably to discover and correct the dangerous condition reasonably anticipated in its business activity.” PMC contends that this is not the correct rule of law to apply in this case, as is evident if one reviews the cases cited which are clearly distinguishable from this case.

Plaintiffs are not entitled to a presumption that PMC was at fault, using the cases in which the courts have applied a presumption of fault to shift the burden of proof to a hospital in the public areas of a hospital or under circumstances when a condition exists that the hospital can control. For example, Plaintiffs cite the line of cases dealing with the duty owed by a hospital to a patient stating that, “It is the hospital's duty to protect a patient from dangers that may result from the patient's physical and mental incapacities *as well as from external circumstances peculiarly within the hospital's control.*” [19] Imposing this duty upon PMC with regard to residents within the locked unit at night is inappropriate with regard to any risks presented by the conduct of other residents, since the conduct or behavior of the other residents is not a circumstance “peculiarly within the hospital's control.” The behavior or conduct of the residents are circumstances that can only be *monitored and managed,* because the behavior and conduct of residents cannot be controlled as a matter of law. PMC was limited in the measures it could take (if not prevented entirely) to manage the conduct or behavior of Shaw and the other residents, especially with respect to activities of daily living such as incontinence of bowel and bladder. For example, PMC could have restrained Shaw and/or Rollinson in bed to insure that they did not get up without assistance at night, or urinate on the floor, but restraints are not permitted for this purpose. Plaintiffs contend that a room change was warranted, but a room change would not insure that a resident would not wander into another room and engage in behavior creating a risk or hazard for another resident, especially when the men's bedrooms shared a bathroom and none of the rooms could be locked. There is no evidence that a room change was possible due to high occupancy rates in the locked unit. The risks presented by Rollinson urinating on the floor could not be eliminated, and the circumstances were not peculiarly within PMC's control as were the circumstances in the cited cases.

In *Williams v. Finley, Inc.*,[20] a visitor brought a claim against a nursing home owner after slipping in a public hallway of the nursing home at 6:00 P.M. Allegedly, a liquid substance was on the floor and caused the slip and fall. It was believed that a resident spilled the substance on the floor, which was not an uncommon occurrence during the day. The court stated that the accident occurred in a main corridor at 6:00 P.M. while residents are milling about and might spill a liquid on the floor. The nursing home failed to demonstrate that it had personnel checking the main hallway on a regular basis, and it had no custodial staff on duty to perform clean up after 3:00 P.M.

The circumstances in *Williams* are very different from the circumstances in this case. Shaw fell at night in his room in a locked unit not open to the public. At the time of the fall, the residents were asleep and many were under heavy sedation. While some residents may get out of bed during the night to use the bathroom, this was the exception and not the rule. Call buttons were provided for each resident to call for assistance at night, but calls for help were rare because the cognitive problems of the residents in the locked unit made them unable to remember to call for assistance to go to the bathroom. The evidence demonstrates that the staffing was adequate and met all applicable standards. The monitoring of each resident was not one on one, which was known to Shaw's family and not required. At night the CNA's and/or nurse checked each resident at least every two hours and more often if necessary. Residents were changed if necessary at least every two hours, because there was a resident rights or dignity issue if regular checks and changes were not performed on each resident. There is no evidence that the CNA's and nurses were not vigilant in checking the floors for foreign substances when checking the residents. There is certainly no reason to believe that the staff would voluntarily expose themselves to the hazard of slipping in urine or any other liquid on the floor in a room during the night. Since residents in the locked unit were medicated and asleep at night, not having more regular checks of the floors was not unreasonable. Turning on the lights to make comprehensive floor checks would also disturb the sleep of the locked unit residents, which presented even more problems due to the importance of sleeping at night to the residents. PMC clearly provided a “resident environment that *remained as free* of accident hazards *as is possible*” in accordance with 42 C.F.R. §483.25.

In Mosley v. Methodist Health System Foundation, Inc.,[21] the court found that the hospital was at fault when a visitor slipped in urine leaking from a catheter or collection bag while visiting her grandmother and fell. The court found that it was reasonably forseeable that urine might leak from a catheter and bag, and the hospital had not acted reasonably in discovering and correcting the hazard. The hospital had a duty to monitor the catheter and bag to make sure it did not leak. The facts in this case are significantly different, since the urine did not leak from a catheter or bag, but rather allegedly from a resident that could not be controlled and who might urinate on the floor even with close monitoring and supervision. The circumstances are obviously different.

In *Delaune v. Medical Center of Baton Rouge, Inc.*,[22] a patient slipped and fell on the shower entrance ramp used by residents to enter the shower while in a wheel chair. The hazardous condition in *Delaune* was not a liquid on the floor, and the fall did not occur due to a slip caused by a liquid. The shower entrance ramp was a condition in the room that was installed by the hospital and that the hospital should have considered in assigning Delaune a room, since she was ambulatory. The facts in *Delaune* are obviously very different from the case at hand, because the condition that caused the fall was permanently attached to the building and not a transient condition such as urine or a spilled liquid. *Delaune* does not support plaintiffs' contention that a presumption of fault on the part of PMC is appropriate in this case.

Plaintiffs have failed to cite any case supporting their contention that they are entitled to a presumption that PMC was at fault in causing the accident simply because there was a liquid on the floor of Shaw's room at the time he was discovered on the floor. The other circumstances of the case do not support a presumption of fault on the part of PMC. There is no evidence that the liquid was there prior to Shaw's fall or that the liquid caused the fall. PMC has been unable to find any cases that address PMC's duty for *alleged* conduct of another resident that creates a risk of harm under the circumstances similar to this case. In the alternative, PMC contends that it has demonstrated that it acted reasonably under the circumstances and exercised reasonable care in preventing hazards. PMC provided “a resident environment that *remained as free* of accident hazards *as is possible*” in accordance with 42 C.F.R. §483.25. PMC owed no other duty to Shaw under the circumstances in this case.

PLAINTIFFS FAILED TO PROVE THAT THE FALL WAS A CONTRIBUTING CAUSE OF SHAW'S DEATH

Exhibit 5 is the certificate of death, which shows the primary cause of death as obstructive apnea. Secondary causes of death were chronic obstructive pulmonary disease, dementia and delirium. There is no indication in the death certificate or medical records from Baton Rouge General Medical Center-Mid City [23] that the fractured hip or the surgery were a contributing cause of Shaw's death.

During the admission to Baton Rouge General Medical Center on December 8, 1999, there was a secondary diagnosis of chronic airway obstruction, not elsewhere classified; and therefore, there was some chronic airway obstruction noted prior to the fall at Harvest Manor. [24] The same secondary diagnoses was made during the January 13, 2000 admission after the fall. [25]

Dr. Slataper performed Shaw's history and physical upon admission to the Skilled Nursing Unit. Dr. Slataper testified that the obstructive apnea was caused by the collapse of the airway in the throat. He attributed the collapse to a lack of muscle tone, caused by aging, dementia, and the prior surgery performed on the throat or neck for cancer. [26] The prior surgery substantially affected the muscles and tissue in the neck and throat. As Shaw aged, the muscles became incapable of maintaining the airway. There was no evidence that there was any damage to the airway as a result of the anesthesia administered during the surgery to repair the hip fracture. Shaw did well after the surgery for almost a week before developing the airway obstruction. At first the obstruction was intermittent and became progressively worse.

Dr. Mary Kendall performed an otolaryngology consultation on January 13, 2000. [27] Dr. Kendall's assessment was that Shaw was suffering from obstructive apnea while he is awake because of his decreased mental status. Dr. Kendall noted that a tracheotomy was not indicated for the gentleman, considering his wish not to be maintained on life support, his poor mental status, and the need for a probable gastrostomy feeding tube, as Shaw would be unable to eat.

Shaw had indicated to his family that he did not want tubes or artificial life support used to extend his life. After the consultation by Dr. Kendall, a decision was made to make Shaw as comfortable as possible to see if he would recover without any intervention. Shaw was positioned in a manner that maximized airway patency. While it was hoped his condition might improve spontaneously, his condition continued to deteriorate until his death on January 14, 2000 at 7:50 P.M. Narcotic analgesics were used to provide comfort until he expired.

The evidence demonstrates that Shaw had pre-existing medical conditions that could cause the collapse of his airway without the hip fracture being a contributing factor, including his dementia, age, and prior surgery on his neck and throat. Defendants are not liable for any damages that are a natural and normal result of Shaw's pre-existing conditions. [28] To recover, plaintiffs must prove at trial both the pre-existing condition and the extent of the aggravation of that condition. Even if there were an aggravation of a pre-existing condition by the hip injury and surgery, plaintiffs are not entitled to the *Housely* presumption, since Shaw was suffering with obstructive apnea prior to the fall on January 6, 2000, according to the undisputed testimony of Dr. Slataper and Dr. Nelson, his treating physicians.

The *Housely* presumption is used under certain circumstances to prove causation, and it provides that a "claimant's disability is presumed to have resulted from an accident, if before the accident the injured person was in good health, but commencing with the accident the symptoms of the disabling condition appear and continuously manifest themselves afterwards, providing that the medical evidence shows there to be a reasonable possibility of causal connection between the accident and the disabling condition." [29] The plaintiffs are not entitled to use this presumption because Shaw was not in good health at the time of the fall, and his symptoms manifested at least to some extent prior to the accident. Dr. Slataper testified that the obstructive apnea had existed for some time and Shaw had been compensating for it. The obstructive apnea was completely consistent with Shaw's decline in mental status and cognition over a short period of time due to reduced oxygen levels in the blood and absorption of

carbon dioxide. Under these circumstances, plaintiffs must prove at trial both the pre-existing condition and the extent of the aggravation of the obstructive apnea. Defendants contend that plaintiffs failed to satisfy their burden of proof.

In addition to Dr. Slataper's testimony, Dr. Susan Nelson, who was Shaw's treating physician also testified that Shaw's death was not caused by the hip injury or surgery, agreeing with Dr. Slataper's opinion as to causation of Shaw's death. [30]

The limited evidence that plaintiffs rely upon to prove a causal relationship between Shaw's death and the injury or surgery is the testimony of Dr. Hubbard. Dr. Hubbard saw Shaw on only a few occasions and had released him several days prior to the development of the obstructive apnea. Dr. Hubbard testified without any information regarding the actual circumstances of Shaw's death and based strictly upon comorbidity statistics he was familiar with that showed that ten percent of the octogenarians that undergo hip surgery will die within a month, fifteen percent die within six months, and twenty-two percent will die within a year, acknowledging that it was part of end of life issues. [31] Dr. Hubbard also acknowledged that one could not determine what percentage of the persons would have died anyway, so the statistics did not represent an increase in the number of deaths. [32] A review of the testimony of Dr. Hubbard shows that he never expressed any opinion except that the hip fracture was a comorbidity and a condition that Shaw suffered with at the time of his death. A morbidity is the state of being diseased or suffering with a clinical condition. A morbidity rate is a number of sick persons or cases of disease in relationship to a specific population. Comorbidities, therefore, are morbitities that co-exist. Dr. Hubbard said that the hip surgery was not a direct cause of Shaw's death. When asked if it was a contributing cause of his death, Hubbard did not state more probably than not that the hip fracture was a contributing cause of Shaw's death. In answer to counsel's question, Dr. Hubbard responded that it was a comorbidity never answering the question if the hip fracture was a contributing cause. PMC contends that Dr. Hubbard never testified that the hip fracture was more probably than not a contributing cause of Shaw's death. He merely stated that it was a comorbidity based upon statistics he was aware of. Dr. Hubbard's testimony is not sufficient to meet plaintiffs' burden of proof on the causation issue on the wrongful death claim. Dr. Hubbard never addressed Shaw's actual condition and the circumstances of his death, because he never had that information and was not involved in providing his care at that time.

CONCLUSION

For the reason set forth above, Donald Shaw and Linda Varnum, plaintiffs, have failed to meet their burden of proof in this matter. Their petition should be dismissed, with prejudice, at their costs.

By Attorneys:

GUGLIELMO, MARKS, SCHUTTE,

TERHOEVE & LOVE

320 Somerulos Street

Baton Rouge, Louisiana 70802-6129

Telephone: (225) 387-8330

Facsimile: (225) 387-8230

By: <<signature>>

Charles A. Schutte, Jr.

Bar Roll Number 11846

Attorneys for Plantation Management Company, LLC d/b/a Harvest Manor Nursing Home

Footnotes

1 Ex. 1, page 22.
2 Ex. 2.
3 Ex. 1, p. 22.
4 Ex. 1, page 26-27.
5 Deposition of Dr. Richard Slataper, Ex. 25, page 24, line 5.
6 Ex.6,pp. 108-111.
7 Ex. 6, p. 109, note 21.
8 Ex. 1, p. 28A.
9 Ex. 6, pp. 12. 21, 82.
10 Exhibit 1, pp. 8-9; Ex. D2, pp. 302-505..
11 Exhibit 1, pp. 42-45.
12 Ex. 1. p. 38, Locked Unit Admissions Criteria.
13 Ex. D2, pp. 12-13.
14 Ex. 1, page 38.
15 La. R.S. 40:2010.8(A)(6),(7), and (10). Federal regulations applicable to licensed nursing facilities also require that certain rights be insured to Polk. See 42 C.F.R. §483.10. Ex. 1, p. 53, which is the notice of resident rights provided to Shaw's family.
16 Ex. D2, pp. 20-25.
17 Ex. 7, p. 142.
18 Ex. 7, p. 161.
19 *Robin v. Gulf Insurance Company*, 434 So.2d 487 (la. App. 2d Cir. 1983), writ denied, 439 So.2d 1075 (La. 1983); *Murphy v. Allstate Insurance Company*, 295 So.2d 29 (La. App.2d Cir. 1974), writ refused, 299 So.2d 787 (La. 1974); *Lemoine v. Insurance Co. of North America*, 499 So. 2d 1004 (La. App. 3d Cir.), writ denied, 501 So.2d 199 (La. 1986); *Williams v. Finley, Inc.*, 2004-1617 (La. App. 3d Cir. 4/6/05), 900 So. 2d 1040, 1043; *Moore v. Willis-Knighton Medical Center*, 31,203 (La. App. 2d Cir. 10/28/98), 720 So.2d 425, 428; and *Millet v. Evangeline Health Care, Inc.*, 02-1020 (La. App. 5 Cir. 1/28/03), 839 So.2d 357.
20 *Williams v. Finley, Inc.*, 2004-1617 (La. Ap. 3d Cir. 4/6/05), 900 So. 2d 1040, 1043-44
21 *Mosley v. Methodist Health System Foundation, Inc.*, 99-3116 (La. App. 4th Cir. 1/31/01), 776 So. 2d 21.
22 *Delaune v. Medical Center of Baton Rouge, Inc.*, 95-1190 (La. App. 1st Cir. 10/25/96), 683 So. 2d 859, 864, 868
23 Ex. 3 and Ex. 4
24 Exhibit D3, p. 303.
25 Exhibit 3, p. 8.
26 Exhibit D4, p. 10.
27 Exhibit D4, p. 15.
28 *Broussard v. Razden*, 763 So. 2d 644 (La. App. 1st Cir. 1999); and *Hale v. Champagne*, 365 So.2d 55 (La. App. 3rd Cir. 1978).
29 *Housley v. Cerise*, 579 So.2d 973 (La. 1991).
30 Ex. D2, pp. 22-25
31 Ex. 24, pp. 22-23.
32 Ex. 25, pp. 32-33.

End of Document