2016 IL App (4th) 150129-U

NO. 4-15-0129

IN THE APPELLATE COURT

OF ILLINOIS

FOURTH DISTRICT

FILED
June 6, 2016
Carla Bender
4th District Appellate
Court, IL

In re: the ESTATE of MARY ELLENA, Deceased,	)	Appeal from
RICHARD A. ELLENA, as Special Administrator,	)	Circuit Court of
Plaintiff-Appellant,	)	Macoupin County
v.	)	No. 06L22
HERITAGE ENTERPRISES, INC., an Illinois	)	
Corporation, d/b/a HERITAGE MANOR,	)	Honorable
Defendant-Appellee.	)	Joshua A. Meyer,
	)	Judge Presiding.

JUSTICE HOLDER WHITE delivered the judgment of the court.
Justices Harris and Pope concurred in the judgment.

ORDER

¶ 1 *Held*: The appellate court affirmed, concluding the trial court properly denied plaintiff's motion for judgment notwithstanding the verdict where the evidence did not so overwhelmingly favor plaintiff that no contrary verdict could stand.

¶ 2 In April 2004, decedent, Mary Ellena, fell and broke her hip while residing in defendant nursing home, Heritage Enterprises, Inc., an Illinois corporation doing business as Heritage Manor. Decedent eventually passed away in May 2005.

¶ 3 In April 2006, plaintiff, Richard Ellena, decedent's son, and special administrator of decedent's estate, filed a negligence claim against defendant, claiming, in part, defendant was negligent in failing to prevent decedent's fall. In November 2014, the case proceeded to a jury trial, where the jury found in defendant's favor. In December 2014, plaintiff filed a motion for judgment notwithstanding the verdict, which the trial court denied the following month.

¶ 4 Plaintiff appeals, asserting the trial court erred in denying his motion for judgment notwithstanding the verdict because the evidence so overwhelmingly favored plaintiff that no contrary verdict could stand. We affirm.

¶ 5 I. BACKGROUND

¶ 6 A. General Information

¶ 7 In December 2003, decedent lived at home with plaintiff. On the morning of December 29, 2003, shortly after plaintiff left for work but before decedent's home-health provider arrived, decedent wandered outside and fell in a ditch in front of the home.

¶ 8 As a result of this incident, Dr. Manish Mathur, decedent's primary-care physician, recommended plaintiff place decedent permanently in a nursing home. Decedent, then 89 years old, had previously stayed in defendant nursing home in Staunton, Illinois, three to four different times for rehabilitation. Plaintiff decided to place decedent in defendant nursing home due to its convenient location to plaintiff, the hospital, and the doctor's office. Prior to entering defendant nursing home, decedent had suffered through a host of medical conditions, including hypertension, dementia, pneumonia, urinary-tract infections, osteoporosis, heart disease, myocardial infarction, colitis, and numerous falls. She also had weakness on her right side due to suffering a stroke, which required her to utilize a walker and increased her likelihood of falling.

¶ 9 In February 2004, decedent suffered a minor fall while in defendant's care. At that point in time, Dr. Mathur diagnosed decedent as fairly guarded with no realistic chance for a meaningful recovery. He spoke with plaintiff, who held power of attorney over decedent, about end-of-life planning due to decedent's declining health, at which time plaintiff determined decedent should not be resuscitated or provided a feeding tube. By this time, decedent had

developed severe aortic stenosis due to poor circulation and was also receiving speech therapy to aid her with swallowing.

¶ 10 On April 15, 2004, sometime between 9:45 a.m. and 11 a.m., decedent was in her room at defendant nursing home when she attempted to stand without assistance. She fell and was subsequently discovered on the floor of her room. At the hospital, decedent was diagnosed with a fracture of her right hip, which was a fracture of the femoral neck.

¶ 11 Due to decedent's age and frailty, doctors determined she could not successfully undergo surgery to repair the fracture. As a result, decedent would never be able to walk again, which left her bedridden. She was also in significant pain that required sedation. After recovering at the hospital, decedent again returned to defendant nursing home. She passed away in May 2005.

¶ 12 B. Procedural History

¶ 13 In April 2006, plaintiff filed a complaint against defendant, alleging, in general, defendant was negligent in its care for decedent. Specifically, plaintiff asserted defendant failed to (1) properly monitor decedent; (2) instruct its agents, servants, and employees concerning the care and treatment of decedent; (3) assess decedent's condition; (4) follow required charting procedures when documenting the condition and treatment of decedent; (5) assist decedent, thus allowing her to fall; (6) provide adequate safeguards to prevent decedent from being injured on the premises; and (7) obtain sufficient and properly trained personnel who could attend to decedent. Plaintiff asserted that the negligent acts of defendant resulted in decedent suffering and, ultimately, dying in May 2005.

¶ 14 The case proceeded through discovery and other pretrial proceedings. In April 2009, plaintiff filed his fourth amended complaint. The fourth amended complaint, in general,

alleged defendant, as a nursing facility subject to federal regulations, was negligent in its care of decedent.

¶ 15 C. The Trial

¶ 16 In November 2014, the jury trial commenced. Because plaintiff's appeal focuses solely on defendant's negligence regarding decedent's fall, we will summarize only the evidence necessary to the disposition of this case.

¶ 17 1. *Plaintiff*

¶ 18 Plaintiff testified he was the son of decedent. Prior to decedent's stay in the nursing home, plaintiff testified she used a walker and a home-health provider cared for her every day. Plaintiff agreed decedent had some health issues, but he said she was "doing okay" prior to her admission to defendant nursing home.

¶ 19 In April 2004, after decedent's admission into defendant nursing home but prior to her hip fracture, plaintiff described decedent as mentally sharp, asking about her pets and plaintiff's job. Plaintiff said decedent was getting along well with her walker.

¶ 20 Plaintiff noted some dissatisfaction with the facility, such as nurses taking 30 minutes to answer decedent's call button or not helping decedent or her roommate out of bed before noon. He testified he overheard a nurse berating a patient who had asked for a drink. Plaintiff said he was afraid to report any dissatisfaction for fear the nursing staff would take their anger out on decedent. In fact, plaintiff admitted he provided paperwork to staff prior to care plan meetings, writing he was "very satisfied" with their work. He also wrote she was receiving "good care." When asked if decedent's call lights had been answered promptly, he circled "yes." He marked the room was clean, though he felt the rooms smelled of urine and excrement. He

also marked "no" to the question asking whether he had any suggestions for defendant to improve.

¶ 21 On April 15, 2004, plaintiff arrived at defendant nursing home to discover decedent had been admitted to the hospital. The staff said they "didn't know" what happened to decedent. Plaintiff later learned from the doctor that decedent had fallen and broken her hip. Afterward, despite plaintiff's concerns, he moved his mother back into defendant nursing home. He said he believed no other feasible options existed.

¶ 22 Once she returned to defendant nursing home, plaintiff observed decedent's condition worsening. He said the nursing staff overdosed decedent on morphine until she nearly died, and she was in constant pain. Plaintiff noticed decedent became depressed, stopped talking, and was no longer able to walk. She was confined to her bed and began losing a significant amount of weight.

¶ 23 Plaintiff testified he believed defendant abused or neglected decedent. He thought defendant would provide 24-hour nursing to ensure decedent's safety. Plaintiff stated he was never told how decedent fell, nor was he shown any records regarding the fall. He therefore did not know how long decedent had been left unattended before or after her fall, or the circumstances that led to her fall. He reiterated he never raised any concerns with staff because he was afraid it would lead to staff abusing decedent.

¶ 24 2. *Carla Lounsbury*

¶ 25 Carla Lounsbury testified she was the administrator of defendant nursing home at the time decedent resided there. She explained she was responsible for everything that happened in defendant nursing home.

¶ 26 Lounsbury testified, when decedent fell on April 15, 2004, she was found on the floor at the foot of her bed in her room. Because the first Lounsbury learned of plaintiff's complaint was in 2008, she was unaware of how many staff members were on duty the day decedent fell.

¶ 27 Lounsbury agreed defendant nursing home provided 24-hour nursing care. However, no patients were visually and physically monitored 24 hours a day absent doctor's orders. At the time decedent was in defendant nursing home, decedent's needs did not change such that defendant could no longer meet her needs.

¶ 28 In examining defendant's safety disclosure given to plaintiff, Lounsbury noted defendant would not restrain or use bed rails for a patient unless directed to do so by a physician or person holding power of attorney. Lounsbury acknowledged plaintiff signed a consent form for defendant to place side rails on decedent's bed. Lounsbury also stated decedent's general demeanor did not suggest the need to further restrain decedent. However, Lounsbury noted decedent was sometimes disoriented, confused, and unsteady on her feet.

¶ 29 According to Lounsbury, the incident report for decedent's fall stated, on April 15, 2004, decedent was found sitting on the floor next to her bed. Decedent was then admitted to the hospital. According to the report, decedent said, "I was tired of sitting and I got up and fell." A nurse's report indicated at 9:45 a.m., a nurse checked decedent's vital signs and determined her skin was dry, color fair, and respiration even and unlabored. At that time, decedent had to be reminded to swallow, and she was provided assistance in transferring to another seat. The note does not clarify whether she was transferred to her wheelchair, another chair in her room, or her bed. At 11 a.m., a physical therapy assistant went to decedent's room for therapy and discovered decedent on the floor. Lounsbury acknowledged the reports did not indicate what time decedent

awoke, whether nurses took her to breakfast, or whether she had been bathed. However, the records indicated decedent had food in her mouth during the nurse's 9:45 check of decedent's vitals.

¶ 30 3. *Dr. Robert Holstein*

¶ 31 Dr. Robert Holstein testified on behalf of plaintiff via a recorded evidentiary deposition. Although the recording is not contained in the record on appeal, plaintiff provided a transcript of the deposition. Dr. Holstein practiced internal medicine from 1976 until his retirement in 2014. He had provided his services as an expert witness since the mid-1980s. In approximately 95% of the estimated 600 cases in which Dr. Holstein acted as an expert, he was retained by plaintiffs' attorneys. In many of those cases, he offered testimony on behalf of a patient to whom he provided treatment.

¶ 32 Dr. Holstein reviewed decedent's medical records, both before and after her admission to defendant nursing home. Dr. Holstein noted, after her fall, decedent's hip fracture would have caused her significant pain, probably for the rest of her life, as the fracture could not be properly addressed through surgery. Additionally, without repairing the fracture, decedent would be unable to walk or stand on the hip. Dr. Holstein testified decedent's pain would require sedation, and for someone with dementia, that would result in deteriorating thinking.

¶ 33 Dr. Holstein opined decedent's fall affected her mental health, as documented through her lack of alertness, confusion, and difficulty speaking following the fall. The prescribed drugs and painkillers would also impact her mental health. Dr. Holstein then opined decedent's fall and resulting fracture hastened her death, as her condition deteriorated rapidly after the fall.

¶ 34 On cross-examination, Dr. Holstein testified he did not review defendant's occupational therapy, speech therapy, or physical therapy records to determine what services had been provided to decedent. He also did not review doctor or nurse progress notes, treatment administration records, or care plans. He did, however, rely on hospital records related to decedent's fall, including radiology reports. He reviewed the deposition of Dr. Mathur, who determined decedent's cause of death was due to ischemic colitis. Though Dr. Holstein disagreed as to the cause of decedent's death, he otherwise agreed with Dr. Mathur's assessment that decedent's condition had deteriorated. Dr. Holstein also agreed decedent had clostridium difficile, a form of colitis that was likely a major contributor to her death.

¶ 35 Dr. Holstein admitted Dr. Mathur's February 2004 meeting with plaintiff was for the purpose of helping to prepare the family for end-of-life scenarios. However, he noted decedent showed some improvement after this discussion when she was released from the hospital and began to regain some mobility.

¶ 36 4. *Dr. Deborah Chisholm Karas*

¶ 37 Deborah Chisholm Karas, a nurse practitioner and registered nurse with a doctorate in clinical nursing, testified as an expert regarding the appropriate standard of care for medical facilities. Approximately 95% of the 300 cases in which she provided her expert services were on behalf of plaintiffs. However, her expert opinion did not always favor the various plaintiffs' cases.

¶ 38 In rendering her opinion as to whether defendant deviated from the standard of care, Dr. Karas considered weekly progress notes from defendant regarding decedent's health. From March 25 to March 31, 2004, the weekly progress notes indicated decedent was eating fairly well and producing phrases almost every day. On March 31, 2004, an assessment stated

decedent was alert and responsive, engaging in more participation and verbalization. She continued to eat between half and all of her meals. In an April 1 to April 7, 2004, assessment, decedent had been holding her breath until she gasped for air. However, her food intake remained good. Decedent also occasionally volunteered information, but she needed intermittent prompting and had a hoarse voice with slurred speech. The day before her fall, decedent was better with her verbal cues, participated in short conversations, and continued to eat at least half of her meals. Dr. Karas testified these assessments indicated an improvement since her admission to defendant nursing home.

¶ 39 After decedent's fall, a May 2014 follow-up by Dr. Mathur indicated decedent's health was in decline. Decedent was readmitted to the hospital for overall decline, lethargy, and poor oral intake. She would become disoriented and occasionally stop breathing.

¶ 40 After reviewing decedent's records, Dr. Karas opined defendant deviated from the nursing standard of care. She testified defendant failed to implement an appropriate care plan developed to decedent's needs. Dr. Karas further opined defendant failed to provide a safe environment, which led to decedent's fall and subsequent decline of quality of life.

¶ 41 Dr. Karas pointed out the care plan in place at the time of decedent's fall noted decedent's risk for falls, need for assistance with walking, and poor safety awareness. According to Dr. Karas, the standard of care for nursing required defendant to implement a care plan to address her fall risk. This would include more frequent contact with the resident, providing the resident with simple instructions, and ensuring the resident had a call button within reach. Dr. Karas also noted the care plan was not followed because decedent suffered an injury, no documentation was made of her toileting, and the plan did not show defendant followed an ambulation-restorative program.

¶ 42 In February 2004, defendant's notes indicated decedent had fallen while trying to rise without her walker or other assistance. Yet, despite this earlier fall, defendant failed to take protective measures to ensure such a fall would not occur again. According to Dr. Karas, the plan also indicated decedent was to be kept in high-traffic areas so she would be more easily supervised. In other words, if decedent was in her wheelchair, she should be in a high-traffic area. However, her bed would not be moved if she remained awake in bed.

¶ 43 Dr. Karas agreed with Dr. Mathur's February 2004 assessment that decedent would never become healthy; rather, she was going into a steady decline. She acknowledged Dr. Mathur determined, even before the fall, decedent had only a slim chance of being able to walk on her own again. She also agreed a patient like decedent would not have been placed on "comfort care" if she had any significant chance of rehabilitation.

¶ 44 In assessing decedent's April 2004 fall, Dr. Karas assumed decedent was not in her bed when the nurse checked her vitals at 9:45 a.m. because the care plan required her to be upright in order to eat. Decedent's statement that she was tired of sitting also indicated to Dr. Karas she had been in a seat, such as a wheelchair, rather than bed. She also found support for this conclusion in the hospital records, which noted decedent fell when trying to rise from her wheelchair. Dr. Karas noted defendant's report did not check the box indicating decedent had fallen within the last 90 to 180 days.

¶ 45 Dr. Karas testified decedent was not in a high-traffic area as the case plan required. Dr. Karas opined defendant's failure to place decedent in a high-traffic area made it more likely than not that she would suffer a fall due to the lack of supervision. She opined, had defendant followed its care plan, decedent would not have fallen. Dr. Karas also opined defendant was understaffed, which led to decedent being unsupervised.

¶ 46 Dr. Karas agreed the standard of care does not require a nursing home resident to be under one-to-one supervision 24 hours a day. She also agreed decedent's condition did not require around the clock bedside care. When asked whether decedent was an appropriate candidate for restraints, Dr. Karas determined restraints were not appropriate in decedent's case.

¶ 47 5. *Dr. Pamela Brown*

¶ 48 Pamela Brown, a registered nurse who holds a doctoral degree in nursing, testified as an expert on behalf of defendant. She testified decedent was a fall risk after her stroke caused her weakness. She also had osteoporosis, which rendered her bones weak.

¶ 49 Dr. Brown opined defendant took steps to address decedent's risk of falling but noted it was impossible to prevent all falls without tying patients to their beds. Dr. Brown stated, to a reasonable degree of medical certainty, decedent should not have been physically or chemically restrained.

¶ 50 According to Dr. Brown, decedent required long-term care, but that did not equate with 24-hour care. She explained nursing homes are not meant to provide 24-hour physical supervision for each resident. In her experience as a nurse over the course of 40 years, Dr. Brown testified she found no evidence of abuse or neglect in defendant's care of decedent. Dr. Brown also admitted a nursing home should follow the care plan for its residents.

¶ 51 D. Posttrial

¶ 52 Following the presentation of evidence, the jury returned a verdict in favor of defendant and against plaintiff. In December 2014, plaintiff filed a motion for judgment notwithstanding the verdict, arguing the evidence so overwhelmingly favored plaintiff that the jury's verdict could not stand. In January 2015, the trial court denied the motion.

¶ 53 This appeal followed.

¶ 54 II. ANALYSIS

¶ 55 On appeal, plaintiff asserts the trial court erred in denying its motion for judgment notwithstanding the verdict because the evidence so overwhelmingly favored plaintiff that no contrary verdict could stand.

¶ 56 A motion for judgment notwithstanding the verdict should only be granted when, in viewing the evidence in the light most favorable to the nonmovant, the evidence so overwhelmingly favors the movant that no contrary verdict could stand. *Thornton v. Garcini*, 237 Ill. 2d 100, 107, 928 N.E.2d 804, 808 (2010). "Judgment notwithstanding the verdict is not appropriate if 'reasonable minds might differ as to inferences or conclusions to be drawn from the facts presented.' " *McClure v. Owens Corning Fiberglas Corp.*, 188 Ill. 2d 102, 132, 720 N.E.2d 242, 257 (1999) (quoting *Pasquale v. Speed Products Engineering*, 166 Ill. 2d 337, 351, 654 N.E.2d 1365, 1374 (1995)). In reaching its decision, the trial court must not substitute its judgment for that of the jury by reweighing the evidence or determining the credibility of witnesses. See *Mansmith v. Hameeduddin*, 369 Ill. App. 3d 417, 426, 860 N.E.2d 395, 404 (2006). The standard for a judgment notwithstanding the verdict is very difficult to meet and is limited to extreme situations. *Bergman v. Kelsey*, 375 Ill. App. 3d 612, 621, 873 N.E.2d 486, 497 (2007). Our review is *de novo*. *Thornton v. Garcini*, 237 Ill. 2d 100, 107, 928 N.E.2d 804, 808 (2010).

¶ 57 Plaintiff asserts the evidence so overwhelmingly favored his position that the jury's verdict to the contrary cannot stand. Specifically, plaintiff argues the evidence demonstrated defendant was negligent for failing to prevent decedent's fall by placing her in a high-traffic area.

¶ 58 In a common-law negligence case, such as the one presented here, the plaintiff must demonstrate the defendant owed the plaintiff a duty, the defendant breached that duty, and that breach proximately caused the plaintiff's injury. *Varela ex rel. Nelson v. St. Elizabeth's Hospital of Chicago, Inc.*, 372 Ill. App. 3d 714, 722, 867 N.E.2d 1, 8 (2006). The burden is on the plaintiff to prove each element by a preponderance of the evidence. *Blue v. Environmental Engineering, Inc.*, 215 Ill. 2d 78, 98, 828 N.E.2d 1128, 1142 (2005).

¶ 59 Plaintiff first argues the evidence, when taken in the light most favorable to defendant, overwhelmingly demonstrates defendant breached its duty to decedent by deviating from the standard of care. In support, plaintiff points to Dr. Karas' expert testimony stating defendant deviated from the standard of care by failing to follow the care plan, which required decedent to be placed in high-traffic areas so she would be supervised while in her wheelchair.

¶ 60 As defendant points out, the care plan on which Dr. Karas relies is not contained in the record on appeal. Regardless, even if we had the document before us, our decision would not change.

¶ 61 This case presents us with differing expert opinions. Dr. Karas opined defendant deviated from the standard of care by failing to place decedent in a high-traffic area so she would be under supervision. However, this opinion is premised on Dr. Karas' presumption that decedent was in her wheelchair at the time of her fall. Though plaintiff argues a nurse's note indicated decedent had been placed in a wheelchair, our review of the record fails to provide such clarity. Rather, Dr. Karas testified the nurse's note was silent as to whether decedent was in her wheelchair, which left Dr. Karas to make presumptions based on speculation. For example, she opined decedent's statement that she was tired of sitting meant she had to be in a chair at the time of her fall. Moreover, the hospital records, which indicated decedent fell from her

wheelchair, failed to indicate the source of that information. Given the fact decedent was found on the floor and no witnesses to her fall were identified, presuming she was in a chair is just speculation. Thus, the jury could have concluded plaintiff failed to present sufficient evidence to show decedent was in a wheelchair at the time of her fall to trigger the care plan's requirement that decedent be placed in a high-traffic area.

¶ 62 Also, the jury had to consider not only whether defendant's failure to place decedent in a high-traffic area violated the standard of care, but also whether that failure proximately caused decedent's injury. Plaintiff raises no argument regarding causation in his brief.

¶ 63 Even if the jury determined defendant breached its duty to decedent by failing to place her in a high-traffic area for supervision, a reasonable jury could have concluded that, despite decedent's location, whether it was in her room or a high-traffic area, defendant could not have prevented her from standing and falling. All of the witnesses testified decedent was an inappropriate candidate for restraints, and the experts all agreed defendant nursing home could not be expected to provide one-to-one supervision, 24 hours a day. None of the experts explained how having a nurse nearby would have necessarily prevented decedent from standing and falling. Consistent with Dr. Brown's opinion, the jury could have determined defendant was unable to prevent decedent's fall, regardless of her location. After hearing the conflicting expert opinions regarding causation, the jury had to determine which expert it found more credible, and it appears to have found Dr. Brown's testimony more credible. See *Barth v. State Farm Fire & Casualty Co.*, 228 Ill. 2d 163, 180, 886 N.E.2d 976, 985 (2008).

¶ 64 Accordingly, we conclude plaintiff has failed to demonstrate this is an extreme situation warranting judgment notwithstanding the verdict, as the evidence does not so overwhelmingly favor plaintiff that no contrary verdict may stand.

¶ 65 III. CONCLUSION

¶ 66 For the foregoing reasons, we affirm the trial court's judgment.

¶ 67 Affirmed.