At an IAS Term, Part 80 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 24th day of September 2023.

PRESENT:

HON. GENINE D. EDWARDS,
Justice.

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LAURA AGOLA, as the Administratrix of the Estate of LEONARD MAIETTA, Deceased,

Plaintiff,

-against-

CALOGERO TUMMINELLO, M.D., WYCKOFF HEIGHTS MEDICAL CENTER, and DRY HARBOR NURSING HOME,

Defendants.

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WYCKOFF HEIGHTS MEDICAL CENTER,

Third-Party Plaintiff,

-against-

JIGAR PATEL, M.D.,

Third-Party Defendant.

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WYCKOFF HEIGHTS MEDICAL CENTER,

Second Third-Party Plaintiff,

-against-

GEORGE WRIGHT, M.D.,

Second Third-Party Defendant.

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DECISION, ORDER, AND JUDGMENT

Index No. 6883/14

Mot. Seq. No. 27-30

The following e-filed papers read herein: NYSCEF Doc No.:

Notice of Motions, Affirmations, Affidavit and Exhibits.....84-98; 101-132; 133-159; 160-165
Affirmations in Opposition and Exhibits.....172-175; 178-181
Reply Affirmations.....183-184; 186, 187, 188

In this action to recover damages for, among other things, medical malpractice and wrongful death, defendant Calogero Tumminello, M.D. ("Dr. Tumminello"), defendant Dry Harbor Nursing Home ("DHNH"), second third-party defendant George Wright, M.D. ("Dr. Wright"), and defendant/third-party plaintiffs Wyckoff Heights Medical Center ("Wyckoff"), separately move for summary judgment, pursuant to CPLR 3212, dismissing: (1) the verified complaint, dated April 29, 2014 (the "complaint"), as against Dr. Tumminello; (2) the complaint as against DHNH; (3) the second third-party complaint as against Dr. Wright; and (4) the complaint as against Wyckoff.

Plaintiff Laura Agola, as the administratrix of her late father Leonard Maietta's estate ("plaintiff"), while objecting to DHNH's and Wyckoff's respective motions, does not object to Dr. Tumminello's motion. Nor does Wyckoff object to Dr. Wright's motion for dismissal of its second third-party complaint as against him.[1] Accordingly, the respective motions of Dr. Tumminello and Dr. Wright are each granted without opposition, as more fully set forth in the decretal paragraphs below. The remainder of this decision/order/judgment addresses DHNH's care for plaintiff's decedent during his ten-day residence at DHNH from February 3, 2012 to February 13, 2012, and Wyckoff's treatment and care of plaintiff's decedent during his approximately 15-week hospitalization from February 13, 2012 until his death at Wyckoff on May 25, 2012. The remaining part of this litigation – Wyckoff's third-party action against Jigar Patel, M.D. – was discontinued by stipulation, dated March 2, 2023 (NYSCEF Doc. No. 167).

[1] Dr. Wright is a third-party (rather than a direct) defendant.

Summary of Events

On December 29, 2011,[2] Leonard Maietta (the "patient"), then age 81, was admitted to Wyckoff with a spine-compression fracture following a fall at home. His co-morbidities, at the time, included diabetes, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease ("COPD"). On January 12th, the patient underwent, in a single operative session, C3-C7 decompressive laminectomies, as well as C3-C6 (on the right) and C3-C5 (on the left), internal spinal fixation with "lateral mass screws and rods." The "cervical spinal canal stenosis" and the "compressive cervical myelopathy" were his pre- and post-operative diagnoses. On January 31st, the patient received a ventriculoperitoneal shunt to alleviate his hydrocephalus.[3]

Meanwhile on January 11th, the patient was identified as suffering from a high lumbar decubitus ulcer, measured at 1.5 cm by 1.0 cm by 0.4 cm, and described as a full thickness stage III ulcer that was 80% slough and 20% red wound tissue with slight serous drainage, a necrotic tissue base, but without an odor. On January 17th, the ulcer was healing, as it was then measured at 1.5 cm by 1.0 cm by 0.0 cm, with an 80% fibrotic wound base to 20% slough. On February 2nd, the high lumbar decubitus ulcer was completely healed.

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[2] All references in this decision/order/judgment are to year 2012, unless otherwise indicated.

[3] Hydrocephalus is an excessive accumulation of cerebrospinal fluid within the head caused by a disturbance of formation, flow, or absorption. Normal pressure hydrocephalus is a condition in older adults of low-grade hydrocephalus with the intermittently raised intracranial pressure causing the classic triad of gait dyspraxia (slow, hesitant, shuffling gait), incontinence, and dementia. A ventriculoperitoneal shunt is a device that is surgically inserted into the brain to drain excess cerebrospinal fluid into the abdominal cavity.

In the interim on January 19th, the patient was noted to suffer from a partial-thickness skin tear on the right side of his mid-back, measuring at 2.0 cm by 5.0 cm by 0.1 cm. By January 24th, the mid-back wound was completely healed. At the February 2nd skin examination, no skin breakdowns were noted.

On February 3rd, the patient was transferred from Wyckoff to DHNH for post-operative rehabilitation. Upon admission to DHNH, no skin ulcers, wounds, tears, or similar problems were noted, with the exception of the stitches on the back of his head from the cervical laminectomy and the surgical wound on his lower front abdomen from the shunt placement.

On the day of his transfer to DHNH (February 3rd), DHNH prepared the patient's Comprehensive Care Plan (the "CCP"). The CCP required a daily inspection of the patient's skin and the avoidance of prolonged periods of immobilization. To that end, the patient was started on physical therapy on February 5th. The CCP also addressed the patient's bowel/bladder incontinence and called for regular skin assessment/care to prevent its breakdown. The CCP further called for the assessment of skin-breakdown factors, the skin-care interventions, the establishment of a skin-care protection routine, the use of pressure-relieving devices, turning/positioning every two hours, and adequate nutrition.

Ten days later, on February 13th, the patient was returned to Wyckoff from DHNH with complaints of increasing (and severe) shortness of breath since that morning (with no then-recent history of fever, nausea, vomiting, or diarrhea reported). On re-admission, the patient required total care (as noted, he was incontinent of bowel and bladder), was

confused with unclear speech, as well as combative. A chest x-ray discovered a new right lower lobe infiltrate. An electrocardiogram noted sinus tachycardia and right bundle-branch block. A CT scan of the chest, abdomen, and pelvis noted an irregular mass in the left upper lobe, multiple small nodules in the left lower lobe, a 3 mm right lower lobe nodule that was highly suspicious for carcinoma,[4] extensive cystic pulmonary disease changes, and an abdominal aortic aneurysm.

At Wyckoff, the patient was admitted to the intensive care unit where he was intubated and placed on mechanical ventilation with a two-point restraint. His primary diagnosis was an acute respiratory failure that was likely secondary to the exacerbation of his COPD.

No pressure ulcers were noted upon admission to Wyckoff, as his skin appeared grossly normal and was warm to the touch. No plan to treat skin wounds was in place at the time because the patient exhibited no skin wounds.

One day later, on February 14th, however, a stage II bedsore, measuring 2.5 cm by 0.25 cm, was noticed for the first time on the patient's sacral area (the "sacral ulcer"). The patient was placed on intravenous antibiotics and contact isolation for the MRSA (methicillin-resistant Staphylococcus aureus) of the sacral ulcer.

The following day, February 15th, the patient was noted to have "multiple decubitus ulcer[s] to heels and sacrum," including the sacral ulcer was characterized by the wound-care team as being stage III and measuring at 3 cm by 3 cm by 0.3 cm with the

[4] The lung mass was not biopsied because of the patient's generalized weakness and his inability to tolerate oncology therapy.

necrotic-wound base and slight drainage. The sacral ulcer was cleaned and dressed in the course of that day.

Wyckoff's plan of action for the patient was debridement of the sacral ulcer with the post-debridement vacuum application to the wound, off-loading of the heels with the pillows and an air mattress, administration of nutritional supplements, continuing evaluation and monitoring of his albumin and prealbumin levels (signs of malnutrition if low), infectious-disease consultation, and wound-culture samplings. While the patient was initially supplied with a low air-loss mattress, he was upgraded to a "Turn Q" mattress on February 22nd, following his extubation (and ventilator weaning) on February 20th. In addition to the mechanical turning provided by the Turn Q mattress,[5] the patient was manually turned and positioned every two hours during his hospitalization at Wyckoff.

The sacral ulcer underwent multiple surgical debridements. On February 22nd, a sharp excisional debridement removed a portion of the fat and muscle at (or near) the sacral ulcer, with the post-debridement wound measuring 7 cm by 10 cm by 13 cm. By February 24th, the sacral ulcer progressed from stage III to stage IV. On February 28th, the sacral ulcer received a wound-vacuum treatment. On March 2nd, the sacral ulcer underwent another sharp excisional debridement with the removal of necrotic skin, subcutaneous tissue, and muscle. The post-debridement wound measured 13 cm by 11 cm by 2 cm.

[5] According to its manufacturer, a "Turn Q" mattress is a powered lateral turning mattress that automatically turns the user up to 30° bilaterally at the preset intervals of 30, 60, or 90 minutes.

On March 6th, a gastroenterology consultation was obtained to address the patient's ongoing malnutrition and to consider the placement of a percutaneous tube ("PEG") for feeding. The patient's low-range albumin and pre-albumin levels confirmed his poor nutritional status. Ten days later, on March 16th, the patient received a PEG tube.

On March 8th, the sacral ulcer underwent its third surgical debridement, with the post-debridement wound measuring (as was reported on the following day) at 12 cm by 15 cm by 2.5 cm, with undermining.

On March 14th, hyperbaric oxygen therapy was ruled out on account of the patient's COPD. On the same day, the sacral ulcer was described as showing an open tendon, with undermining, but without odor or tunneling.

On March 19th, the sacral ulcer was described as containing 80% necrosis, with undermining and depth. On March 22nd, a wound culture from the sacral ulcer tested positive for pseudomonas, proteus and MRSA, indicating that the sacral ulcer had become infected. On March 23rd, the sacral ulcer was described as a combination of 40% slough/eschar and 60% red tissue, whereas the other ulcers remained stable. To make matters worse, the patient tested positive for C-difficile (a diarrhea-causing) infection, on March 28th.

On April 4th, the sacral ulcer underwent its fourth surgical debridement. An operative progress note reflected that the patient was then suffering from multiple medical problems, including anemia, elevated white blood cell count, COPD, diabetes, and (despite the prior placement of the PEG tube) severe hypoalbuminemia.

On April 7th, the patient was started on hemodialysis because of his electrolyte imbalance, acute renal failure, and extremity edema.

On April 27th, intravenous antibiotics were re-started due to the infection of the sacral ulcer and the presence of septicemia. The patient continued to have the wound-vacuum treatment for his sacral ulcer.

On May 4th, a progress note described the sacral ulcer as having both exposed bone and tendon. On May 9th, the patient was re-intubated (and again placed on a ventilator) because of the respiratory distress. A progress note documented acute kidney insufficiency.

On May 10th, the medical notes reflected the patient was in septic shock, acute respiratory failure, and polymicrobial sepsis. On May 11th, a progress note documented the sacral ulcer wound base with additional necrosis. On May 18th, the sacral ulcer was noted to be 40% necrotic. On that day, the patient was in critical condition, including acute renal failure, acute respiratory failure, fluid overload, hemorrhagic anemia, sepsis, respiratory acidosis, tachyarrhythmia, urinary tract infection, and malnutrition. On May 21st, the patient was noted with fever; a urinalysis and cultures were obtained with the findings of the staph and gram-negative rods, despite the prior massive administration of antibiotics.

On May 25th, the patient suffered a cardiac arrest and was unable to be resuscitated. The immediate cause of his death, as listed on his death certificate, was a "cardio[-] pulmonary arrest" due to, or as a consequence of, the "sacral ulcers stage

four with osteomyelitis." At the time of his death at Wyckoff, on May 25, 2012, the patient was 82 years old.

On May 7, 2014, plaintiff commenced the instant action against DHNH and Wyckoff (among others) alleging causes of action sounding in medical malpractice, violations of Public Health Law §§ 2801-d and 2803-c (as to DHNH only), negligent hiring/retention, and wrongful death.[6] After DHNH and Wyckoff (among other defendants) separately answered the complaint, the parties engaged in discovery, culminating with plaintiff's filing a note of issue and certificate of readiness on February 1, 2023. DHNH and Wyckoff timely moved for summary judgment on March 16, 2023 and March 30, 2023, respectively.

Plaintiff opposed by way of (among other submissions) Terrance Baker, M.D.'s ("Dr. Baker") affidavit,[7] who is a Maryland-licensed physician who is board-certified in family medicine with sub-certifications in geriatrics and emergency medicine (NYSCEF Doc. No. 175). On July 14, 2023, DHNH's and Wyckoff's respective motions were marked submitted for determination. The well-established standard of summary judgment is omitted from this decision/order/judgment in the interest of brevity. Additional facts are stated when relevant to the discussion below.

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[6] The second through fifth causes of action as pleaded in the complaint (NYSCEF Doc. No. 86).

[7] Although the name of plaintiff's expert is redacted in the body of the affidavit, his name appears in full and is not redacted in the accompanying certificate of conformity (NYSCEF Doc. No. 175). Although a plaintiff may redact the name of his/her expert in opposing summary judgment in a medical malpractice action, such redaction is optional (*see* CPLR 3101 [d] [1] ["In an action for medical . . . malpractice, a party, in responding to a request, *may* omit the names of medical . . . experts. . . ."] [emphasis added]).

Discussion

DHNH and Wyckoff each established its respective prima facie entitlement to judgment as a matter of law by way of, among other submissions:

(1) *in the case of DHNH*, the expert affirmation of Lawrence N. Diamond, M.D. ("Dr. Diamond"), a New York-licensed physician who is board-certified in family medicine with sub-certification in geriatrics (NYSCEF Doc. No. 132); and

(2) *in the case of Wyckoff*, the expert affidavit of Patricia Mead, R.N. ("Nurse Mead"), a New York-licensed registered nurse and the assistant vice president of nursing operations at Wyckoff (NYSCEF Doc. No. 162), as supplemented by (and expanded on): (a) the expert affirmation of Vincent Garbitelli, M.D. ("Dr. Garbitelli"), a New York-licensed physician who is board-certified in internal medicine (NYSCEF Doc. No. 97);[8] and (b) the expert affirmation of Dan Seth Reiner, M.D. ("Dr. Reiner"), a New York-licensed physician who is board-certified in surgery with sub-certification in surgical critical care (NYSCEF Doc. No. 136).[9] Nurse Mead, Dr. Garbitelli, and Dr. Reiner are collectively referred to as the "Wyckoff experts."

In addressing plaintiff's claims *against DHNH*, Dr. Diamond opined that: (1) DHNH did not deviate or depart from accepted community standards with respect to the prevention and treatment of the patient's decubitus ulcers; (2) DHNH did not violate

[8] Dr. Garbitelli offered his expert affirmation on behalf of defendant Dr. Tumminello who was involved in the patient's care at Wyckoff during the relevant time period.

[9] Dr. Reiner offered his expert affirmation on behalf of second third-party defendant Dr. Wright who (like Dr. Tumminello) was also involved in the patient's care at Wyckoff during the relevant time period.

the Public Health Law; (3) at the time of the patient's return to Wyckoff from DHNH on February 13th, he was not then suffering from the sacral ulcer; and (4) in any event, any alleged departures during the patient's ten-day stay at DHNH did not proximately cause the patient's subsequent injuries and death at Wyckoff. *See Russell v. River Manor Corp.*, 216 A.D.3d 827, 188 N.Y.S.3d 191 (2d Dept., 2023); *Rosario v. Our Lady of Consolation Nursing & Rehabilitation Care Ctr.*, 186 A.D.3d 1426, 128 N.Y.S.3d 906 (2d Dept., 2020).

Next, in addressing plaintiff's claims *against Wyckoff*, the Wyckoff experts opined (individually and collectively) that: (1) Wyckoff did not deviate or depart from accepted community standards with respect to the prevention and treatment of the patient's sacral ulcer (among his other ulcers); (2) the patient's sacral ulcer (among his other ulcers) was unavoidable because of his poor medical condition, his multiple comorbidities, and the necessary measures undertaken to maintain his life; and (3) the sacral ulcer did not contribute to his death, as more fully set forth in the margin.[10] *See Russell*, 216 A.D.3d

[10] *See* Dr. Garbitelli's expert affirmation, ¶ 10 ("*[T]he source of the patient's sepsis was not a decubitus [i.e., the sacral] ulcer, but rather was a result of pneumonia, urinary tract infection and an indwelling vascular catheter*. [The patient] was in very poor medical condition on admission and had been on a downhill course prior to, and leading up to, his [re-]admission to [Wyckoff]. [The patient] was at the beginning of a terminal condition in view of the need for ventilatory support in a patient with chronic lung disease and pneumonia.") (emphasis added). *See also* Dr. Roth's expert affirmation, ¶¶ 26-27 ("The [patient] had end stage COPD with multiple co-morbidities[,] including pneumonia, respiratory failure, diabetes and hypertension. He also had sinus tachycardia and right bundle branch block. He also had a right lower lobe nodule highly suspicious for carcinoma, extensive cystic pulmonary disease changes and abdominal aortic aneurysm. He had recent repeated urinary tract infections and was total care, incontinent of bowel and bladder[,] and confused with unclear speech. In light of these multiple co-morbidities[,] the prognosis for the wounds was very poor with almost no expectation they would heal. Thus, the primary goal [at Wyckoff] was to attempt to avoid infection and prompt treatment of infection once it occurred. *[G]iven the [patient's] clinical picture, the development of pressure ulcers and worsening of the existing ulcers was clinically unavoidable*. . . . Indeed, for skin to heal it requires

(footnote continued)

827; *Cerrone v. North Shore-Long Is. Jewish Health Sys., Inc.*, 197 A.D.3d 449, 152 N.Y.S.3d 147 (2d Dept., 2021); *Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902, 48 N.Y.S.3d 420 (2d Dept., 2017).

In opposition to DHNH's and Wyckoff's respective prima facie showing, plaintiff failed to raise a triable issue of fact as to either defendant. As DHNY and Wyckoff correctly pointed out, the five-page affidavit of plaintiff's expert, Dr. Baker, failed to lay the requisite foundation for his asserted familiarity with the applicable standards of care in the fields of geriatric medicine and wound care, as indicated in the margin.[11] *See Korszun v. Winthrop Univ. Hosp.*, 172 A.D.3d 1343, 101 N.Y.S.3d 408 (2d Dept., 2019); *see also Montanari v. Lorber*, 200 A.D.3d 676, 157 N.Y.S.3d 102 (2d Dept., 2021).

In any event, Dr. Baker's affidavit was conclusory and speculative, failed to address the significance of the patient's multiple comorbidities, and was silent on the

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oxygen. The [patient] had multiple medical conditions[,] including COPD, anemia, hypertension and diabetes[,] all of which impair the flow of oxygen to the skin. In such a clinical situation ulcers would develop absent a departure and those that exists will worsen absent a departure.") (emphasis added). *See further* Nurse Meade's affidavit, ¶¶ 7-88 ("[W]hen a patient is as ill as [plaintiff's decedent was], wounds can develop and progress despite appropriate interventions. . . . The . . . progression of the sacral ulcer was secondary to the patient's underlying co-morbidities, which included pneumonia, diabetes, anemia, hypertension, intubation with ventilation, probable cancer with a lung mass, and malnourishment.").

[11] Dr. Baker's assertion (in ¶ 4 of his affidavit) that he "base[d] [his] opinions upon [his] training, skill, and expertise in the fields of geriatric, family, and emergency medicine[,] and upon [his] review of the relevant records," was inadequate to form the requisite foundation for his asserted familiarity with the applicable standards of care in the fields of geriatric medicine and wound care. Further, Dr. Baker failed to allege to have: (1) familiarity with the standards of care for short- and long-term care facilities in 2012, the time at issue in the complaint; and (2) knowledge of the relevant New York standards of care for hospitals and nursing homes. *Compare Cummings v. Brooklyn Hosp. Ctr.*, 147 A.D.3d 902, 48 N.Y.S.3d 420 (2d Dept., 2017) ("*The plaintiff's expert* affirmed that she was 'thoroughly familiar with the standards for the prevention and treatment of decubitus ulcers and skin ulcers existing for the dates of the admissions to the hospitals in this action' and *supported her statements as to the standard of care applicable in this case with numerous medical journals and textbooks, excerpts from which were attached to her affirmation as exhibits*.") (emphasis added).

essential element of proximate cause. *See Russell,* 216 AD3d 827; *Losak v. St. James Rehabilitation & Healthcare Ctr.*, 199 A.D.3d 671, 156 N.Y.S.3d 406 (2d Dept., 2021), *rev'g* 2018 WL 11351138 (Sup. Ct., Suffolk County 2018); *Lowe v. Japal*, 170 A.D.3d 701, 95 N.Y.S.3d 363 (2d Dept., 2019); *Novick v. South Nassau Communities Hosp.*, 136 A.D.3d 999, 26 N.Y.S.3d 182 (2d Dept., 2016).

As Dr. Baker conceded (in ¶ 12 of his affidavit), the patient "was [at] an elevated risk for pressure ulcer development" because of (among other conditions) "his immobility, vascular disease, and his diminished mental state." To that end, Dr. Baker opined (in ¶¶ 15 and 12 of his affidavit) that the patient should have been turned *hourly* at both DHNH and Wyckoff, as well as placed on the "*gel-filled foam mattresses*." In particular, Dr. Baker failed to explain: (1) how the turning/repositioning of the patient every *hour* (rather than every *two hours* as had been performed at both DHNH and Wyckoff) would have made a difference; and (2) why (in his opinion) the *non-mechanized* "gel-filled foam mattress" were preferable to the *mechanized* (or the automatically preset) low air-loss mattresses and the Turn Q mattresses.

Equally important, Dr. Baker failed to raise a triable issue of fact on the element of proximate cause. Dr. Baker's opinion on causation was based on his oversimplified assumption (in ¶ 16 of his affidavit) that "[a] pressure ulcer that is treated appropriately should and will heal." However, no inference of negligence could be premised from the mere development and/or worsening of a bedsore. As a general matter, "[t]he presence of an injury does not mean that there was negligence." *Landau v. Rappaport*, 306 A.D.2d 446, 761 N.Y.S.2d 325 (2d Dept., 2003). Indeed, 42 CFR § 483.25 (b) (1) (i) (on the

federal level) and 10 NYCRR § 415.12 (c) (1) (on the state level) exempt nursing homes (such as DHNH) from liability where "the individual's clinical condition demonstrates that [pressure ulcers] were unavoidable," as was the case here. *See Russell*, 216 A.D.3d 827; *Korszun*, 172 A.D.3d 1343. *See also Rubin v. KFC Operating Two*, 2021 WL 3264279 (Sup. Ct. Kings County 2021).

Lastly, Dr. Baker opined (in ¶ 11 of his affidavit) that "*[p]ressure ulcers* should never develop or worsen absent a failure on the part of the medical facility in their *fall prevention plan*" (emphasis added). DHNH and Wyckoff both asked, "How is a fall prevention plan relevant to pressure ulcers?"[12] To answer the puzzle, it is necessary to review a recent decision from Supreme Court, New York County, which considered (and rejected) Dr. Baker's expert opinion in a nursing-home liability case involving a resident's *fall* (rather than her development of a bedsore). *See Martinez v. New York City Health & Hosps. Corp.*, 2023 N.Y. Slip Op. 31104(U) (Sup. Ct., NY County, April 10, 2023). In *Martinez*, Dr. Baker, as the expert for the plaintiff in that case, submitted a similarly terse, five-page affidavit opining (among other things) as to the proper steps for implementing a *fall prevention plan*.[13] It appears that Dr. Baker's two affidavits (one in *Martinez* and the other one here) inadvertently "crossed wires" because the patient in each case was (or, at least, at one point, had been) a nursing-home resident.

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[12] *See* Wyckoff's reply affirmation, ¶ 6; DHNH's reply affirmation, ¶ 9 (NYSCEF Doc Nos. 186 and 188, respectively).

[13] *See* NY St Cts Elec Filing (NYSCEF) Doc No. 94, Dr. Baker's affidavit, in *Martinez v. New York City Health & Hosps. Corp.*, Sup. Ct., NY County, index No. 450082/16.

Conclusion

Accordingly, it is

ORDERED that, in mot. seq. 27, the motion of defendant Calogero Tumminello, M.D., is *granted without opposition*, and the complaint as against him is dismissed without costs or disbursements, and it is further

ORDERED that, in mot. seq. 28, the motion of defendant Dry Harbor Nursing Home is *granted*, and the complaint as against it is dismissed without costs or disbursements and it is further

ORDERED that, in mot. seq. 29, the motion of second third-party defendant George Wright, M.D., is *granted without opposition from Wyckoff Heights Medical Center*, and the second third-party complaint is dismissed as against him without costs or disbursements and it is further

ORDERED that, in mot. seq. 30, the motion of defendant/third-party plaintiffs Wyckoff Heights Medical Center is *granted*, and the complaint is dismissed as against it without costs and disbursements and it is further

ORDERED that DHNH's counsel is directed to electronically serve a copy of this decision/order/judgment with notice of entry on the other parties' respective counsel and to electronically file an affidavit of service thereof with the Kings County Clerk.

This constitutes the decision/order/judgment of this Court.

E N T E R,

J. S. C.

15 **HON. GENINE D. EDWARDS**