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 20th day of May 2024.

PRESENT:

HON. GENINE D. EDWARDS,
Justice.

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JANEEN ARSHAN as Administratrix of the Estate of DOLLY ARSHAN, and JANEEN ARSHAN, Individually,

Plaintiffs,

-against-

BROOKDALE UNIVERSITY HOSPITAL MEDICAL CENTER, NEW YORK-PRESBYTERIAN BROOKLYN METHODIST HOSPITAL, and PARKSHORE HEALTH CARE, LLC, d/b/a FOUR SEASONS NURSING AND REHABILITATION CENTER,

Defendants.

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DECISION, ORDER, AND JUDGMENT

Index No. 513164/19

Mot. Seq. No. 5, 6, 7

The following e-filed papers read herein: NYSCEF Doc Nos.:

Notice of Motion, Affirmations, and Exhibits.....110-125; 126-138; 139-157
Affirmations (Affidavits) in Opposition, and Exhibits.....162-169; 170-178; 179-186
Reply Affirmations and Exhibits.....187-189; 196-197; 198-199

In this action to recover damages for negligence, medical malpractice, wrongful death, and violation of Public Health Law § 2801-d, defendants Brookdale University Hospital Medical Center ("Brookdale"), Parkshore Health Care, LLC, doing business as Four Seasons Nursing and Rehabilitation Center ("Parkshore"), and New York-Presbyterian Brooklyn Methodist Hospital ("Methodist"), each separately moved for an order, pursuant to CPLR 3212, granting each defendant summary judgment. Plaintiffs Janeen Arshan, individually and as the administratrix of the Estate of her late mother, Dolly Arshan (collectively, "plaintiff"), opposed all three motions.

Background

The events underlying this action spanned a period of approximately four months from November 2, 2016 through March 23, 2017 (the "treatment period").[1] During the treatment period, plaintiff's mother, Dolly Arshan (the "patient"), was hospitalized at (or was a resident of) on a total of four consecutive occasions: (1) at Brookdale, from November 2 through November 12 (the "Brookdale hospitalization"); (2) at Methodist, from November 12 through December 14 (the "Methodist initial hospitalization"); (3) at Parkshore, from December 14 through March 18 (the "Parkshore residence"); and (4) again at Methodist, from March 18 through March 23 (the "Methodist subsequent hospitalization").

The Events *Preceding* the Treatment Period

Immediately before the inception of the treatment period, the patient, then age 72, was residing in nonparty Spring Creek Rehabilitation & Nursing Care Center ("Spring Creek") to which she had been transferred following her hospitalization at Brookdale from September 9 to September 16 for status epilepticus, confusion, and convulsions (the "prior Brookdale hospitalization").[2] A summary of the prior Brookdale hospitalization (as reproduced below) reflected the patient's poor health in the months preceding the treatment period:

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[1] Unless otherwise indicated, all references to the months of September, October, November, and December are in the year 2016, whereas all references to the months of January, February, March, and thereafter are in the year 2017. For the sake of consistency and ease of reference, when military time was used in the patient's records, the Court converted it to standard time. When quoting from the medical records, the Court spelled out all abbreviations and corrected typographical errors.

[2] Brookdale's records, page 749 ("Physician Discharge Summary," dated September 13 and timed at 5:02 pm, summarizing the patient's admission diagnoses).

"72-year-old female with presenting medical history of hypertension, hyperlipidemia[.] Cerebrovascular accident (December 2015 and on MRI [of] August 2016[,] a 4 mm acute infarct in [the] right caudate nucleus), atrial fibrillation on [anticoagulant] Apixaban, dementia and *a recent admission for altered mental status after she was found roaming the streets.*

[W]as admitted [to Brookdale] on September 9, 2016 with generalized tonic-clonic seizure.[3] As per [the patient's] home-health aide[,] *she had [a] seizure [lasting] for 15 minutes*. [On] arrival [at] the emergency department, she was not responding to verbal stimuli. *Left sided gaze preference* [a symptom of left-hemisphere stroke] *and nystagmus*.[4]

CT head did not show hemorrhagic stroke. Ativan vas given. Patient then had another seizure and was loaded with [anticonvulsant] Keppra. Patient was admitted to ICU. *MRI brain showed marked diffuse cerebral atrophy, extensive microvascular ischemic white matter changes, old infarcts in [the] right frontal, right temporal, right parietal and right occipital lobes[,] and [in] the right basal ganglia/caudate nucleus. . . .*

Patient was seen by neurology on admission, recommended Keppra and EEG. She had a prolonged post-ictal state[,] but she is making a gradual recover[y]. *[S]he declined anticoagulation for atrial fibrillation due to risk of fall with head trauma, but [was] commenced on daily aspirin 81 mg.*

Patient will be discharged to [a] short term rehabilitation [facility, *i.e.*, Spring Creek] to continue with physical rehabilitation and follow-up with outpatient clinic."[5]

On discharge from the prior Brookdale hospitalization to Spring Creek on September 16, the patient's neurology team noted that while "[i]nitially, [she] needed

[3] In the opinion of Methodist's neurologist, the patient developed seizures as the consequence of her second cerebrovascular accident in August 2016. Methodist's records, page 250 of 2,824 ("Neurological Consult Follow-Up," neurologist attending physician's note, dated December 12 and timed at 8:57 pm, pages 248-251 of 2,824) (footnote by the Court).

[4] "Nystagmus" is defined as an "[i]nvoluntary rhythmic oscillation of the eyeballs, either pendular or with a slow and fast component." Stedman's Medical Dictionary, entry 619540 (footnote by the Court).

[5] Brookdale's records, page 750 ("Brookdale's Discharge Summaries, dated September 13 and timed at 5:02 pm) (paragraphing and emphasis added).

tactile stimuli to react, . . . [she] then became more awake, answered [a] few words (ok, yes etc.) and followed simple commands (squeezing hand, lifting hand)."[6]

The Brookdale Hospitalization from November 2 to November 12

After the patient experienced two seizures while residing at Spring Creek,[7] she was returned to Brookdale on November 2 at 2:02 pm. Two hours later in Brookdale's emergency department ("ED"), the patient was observed as "having [a break-through] seizure involving her face and left side arm for about 1 minute."[8] The course of the Brookdale hospitalization from November 2 through November 12 was concisely summarized by the patient's attending physician in his note, dated November 12 and timed at 2:47 pm, as follows:

> "In the ED[,] patient was loaded with Keppra . . . and was also given [another anticonvulsant] Ativan. Patient [was] seen and examine[d] at bedside. Patient is sleeping, not arousable with verbal commands[;] only [arousable] with tactile stimuli. Breathing [is] comfortable, no seizure[-]like activity. Patient was admitted to the medical floor.
>
> *Patient went into status epilepticus that required sedation and intubation for airway protection. Patient was transferred to the Medical Intensive Care Unit for further management. Patient coded at 7:00 am on November 5, 2016 and [a] return of spontaneous circulation [to her heart] was achieved within 8 minutes.* [An] MRI of brain was done and did not show any acute changes, though showed old strokes. Patient was on and off [sedative] Versed. . . . Patient is on Keppra . . . and [on another convulsant] Valproic Acid. . . .
>
> Patient was found to have pulmonary embolism and [was] started on full dose of [anticoagulant] Lovenox [in lieu of the previously administered Apixaban]. *Seizures are still not controlled*[.] [An additional

[6] Brookdale's records, page 751.

[7] Brookdale's records, pages 778 and 781.

[8] Brookdale's records, page 777.

> anticonvulsant] Phenytoin was added. . . . . Patient was found to have acute right leg deep vein thrombosis. [An] inferior vena cava filter was placed on November 9. Patient needs further anticoagulation for now.
>
> *Seizure medications advanced. Mental status did not improve*[.] EEG [was] done and [was] suggestive of diffuse encephalopathy of [the] metabolic, degenerative[,] or vascular origin. *Patient has anoxic brain injury, status post-cardiac arrest [on] November 5, 2016.*
>
> [Plaintiff] wants to transfer [the] patient to . . . Methodist. . . . [Plaintiff is] telling [the Brookdale medical team] that Dr. Din[ ] will take care of [the] patient in . . . Methodist. . . . [The Brookdale attending physician in charge of the patient's care] personally spoke with Dr. Din[ ] on phone and was told that he is not accepting [the] patient as [an] 'in[-]hospital to in[-]hospital transfer' but he will see [the] patient if she [is] brought to the ER of Methodist. . . .
>
> *Patient's daughter insists on discharge [of] patient against medical advice* ["AMA"]. I have talked to the daughter multiple times and told [her] that it is not safe to discharge patient if nobody accepts patient in . . . another hospital. She still insists on discharging [the patient] AMA.
>
> [Plaintiff] is signing AMA. As per [plaintiff,] [she and the patient] will go to the ER of . . . Methodist. . . . She arranged [for] private transportation."[9]

At 2:02 pm on November 12, a private ambulance arrived at Brookdale to transport the patient to Methodist.[10] At 3:00 pm, the patient's skin was last checked at Brookdale as being clear and without any evidence of pressure ulcers ("PUs").[11] At 3:56 pm, the patient was discharged from Brookdale's medical intensive care unit and taken by ambulance to Methodist's emergency department.[12]

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[9] Brookdale's records, page 781 ("Discharge Summaries," dated November 12 and timed at 2:47 pm) (paragraphing and emphasis added). Brookdale's records, pages 1647-1650 (Discharge against AMA).

[10] Brookdale's records, page 773.

[11] Brookdale's records, pages 1560 and 1573 ("Wound Prevention and Management" entries).

[12] Brookdale's records, page 773.

The Methodist Initial Hospitalization from November 12 through December 14

At 4:37 pm on November 12, the patient was triaged in Methodist's emergency department.[13]

At 7:32 pm on November 12, the Methodist ED staff found that the patient had three PUs – all of the Stage 1 type[14] – one on her sacrum, another on her left heel, and the final one on her right heel.[15]

At 8:57 pm on November 12, the patient was admitted to Methodist by way of its ED. Her principal admitting diagnosis was "acute respiratory failure with hypoxia."[16]

In connection with her admission, her PUs were reassessed at 8:58 pm. Her sacral and right-heel PUs were measured at 8 cm by 5 cm and 1 cm by 1 cm, respectively, with zero depth in each instance.[17] At 10:00 pm, her left heel PU was measured at 1 cm by 1 cm, likewise with zero depth.[18]

The patient's hospital course at Methodist, as summarized below, reflected that her condition had deteriorated:

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[13] Methodist's records, page 72 of 2,824.

[14] During the relevant time period, a Stage 1 pressure ulcer (also known as a "Stage 1 Pressure Injury") was defined as an "[i]ntact skin with a localized area of nonblanchable erythema, which may appear differently in darkly pigmented skin." *See* Laura E. Edsberg, Joyce M. Black, Margaret Goldberg, Laurie McNichol, Lynn Moore, & Mary Sieggreen, *Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System*, J WOUND OSTOMY CONTINENCE NURS., 2016;43(6):585-597, page 589 (hereafter, the "2016 PU Staging Guidelines"). The 2016 PU Staging Guidelines, which were designated as "open access" to the public, are available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5098472/ (last accessed May 10, 2024).

[15] Methodist's records, page 69 of 2,824.

[16] Methodist's records, page 3 of 2,824.

[17] Methodist's records, pages 2,744-2,745 of 2,824.

[18] Methodist's records, page 2,746 of 2,824.

> "72-year-old female with presenting medical history of hypertension, hyperlipidemia, atrial fibrillation (not on anticoagulation), dementia, cerebrovascular accident (08/2016), and new onset seizures (09/2016) who was transferred to [Methodist] from Brookdale where she was admitted for status epilepticus [that was] complicated by [a] cardiac arrest on 11/02 [at Brookdale]. Transferred [to Methodist] at family request. *Patient likely suffered from anoxic brain injury and no longer exhibits purposeful movement as per [the] [n]eurology [attending physician in charge of the patient's care].*
>
> [At Methodist, the patient] had an RRT [a tracheostomy culture testing for bacteria] on 12/4 and was found to be septic from Klebsiella [Pneumoniae] bacteremia and is being treated with [antibiotic] Ceftriaxone.
>
> *Tracheostomy [tube] placed [on] 12/6, PEG [tube] placed on 12/9. . . .*
>
> Discharge planning and . . . complete [a] two-week course of Ceftriaxone until 12/21."[19]

The patient was discharged from Methodist to Parkshore on December 14. **Her** overall prognosis on discharge (as reiterated throughout her Methodist chart) was "poor," with "dismal chances of meaningful recovery."[20] The patient's last skin check at Methodist, performed at 10:11 am on December 14 reflected that she was not suffering from any PUs at the time of her discharge.[21]

The Parkshore Residence from December 14 through March 18

The patient resided at Parkshore from December 14, 2016 to March 18, 2017. By way of a skin assessment that was "created" on December 14 and "completed" on December 16, Parkshore found that the patient was suffering from three PUs (which it initially characterized as deep-tissue injuries): (1) a sacral PU of 3 cm by 3 cm;

[19] Methodist's records, pages 48-49 of 2,824 (paragraphing and emphasis added).

[20] Methodist's records, pages 324, 328, 331, 344, 347, 350, 354, 359, 368, 373, 378, and 382 of 2,824.

[21] Methodist's records, page 2,803 of 2,824.

(2) a right-heel PU of 1 cm by 1 cm; and (3) a left-heel PU of 2 cm by 2 cm, in each instance, without depth.[22] On December 16, a wound-care specialist assessed the patient's sacral and heel PUs, describing them as 100% dark brown-maroon discoloration without exudate. On December 23, all PUs were documented as healed.[23]

On January 19, the patient's sacral PU reopened and was characterized at the time as an unstageable "deep-tissue pressure injury" (or "DTPI") of 1 cm by 1 cm.[24] A skin-protecting ointment (Dermamed) was applied until February 3, when wound care was changed to a combination of normal saline and a more moisture-protective skin ointment (Dermagran-B), with the sacral PU to be covered by a dry sterile dressing. One week later, February 10, when the sacral PU was measured at 3 cm by 3 cm, the level of wound care was elevated from a Dermagran B skin ointment to a Hydrogel dressing.

Notwithstanding the application of a variety of moisture-protective skin ointments and wound dressings, the patient's sacral PU persisted. On March 2, the patient underwent bedside debridement of her sacral PU. The following day, March 3, the Hydrogel wound dressing was upgraded to Silver Collagen. On that day, March 3, the sacral PU was classified as Stage 4 with 50% granulation (healthy tissue), which progressed to 80% granulation on March 10. One week later on March 17, the patient's

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[22] Parkshore's records, pages 12-13 of 17 ("Nursing Admission Assessment").

[23] Parkshore's records, page 17 of 42 ("Care Plan Activity Report").

[24] Parkshore's records, page 38 of 42 ("Care Plan Activity Report"). The 2016 Staging Guidelines (at page 594) defined a "deep tissue pressure injury" as "[i]ntact or nonintact skin with localized area of persistent nonblanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or bloodfilled blister. . . . This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss."

sacral PU, still at Stage 4, was measured at 6 cm by 6 cm by 2 cm.[25] On that day, the Silver Collagen was discontinued and was replaced with a combination of a Metrogel (metronidazole) cream and a Calcium Alginate dressing. On the same day, Parkshore informed plaintiff that the healing prospects of her mother's sacral PU were poor in view of (among other things) her ongoing sepsis. The following day, March 18, the patient was re-admitted to Methodist at plaintiff's instigation.[26]

The Methodist Subsequent Hospitalization from March 18 through March 23

On re-admission to Methodist on March 18, the patient was suffering from multiple infections. Her white blood cell count was elevated to 12.7 (normal range of 3.8-10.8) which, coupled with shortness of breath and cough, suggested a possible sepsis.[27] In the ED, plaintiff complained to the staff that the patient had been abused in Parkshore, pointing to the "new bruising on her mother's bilateral shoulders."[28]

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[25] Parkshore's records, page 40 of 42 ("Care Plan Activity Report").

[26] Parkshore's nursing note described how plaintiff had her mother transferred to Methodist from Parkshore:

> "Around 8:45 am [on March 18, Nurse Faith Mancenido at Parkshore] noticed a 911 EMS ambulance on the unit at room 523A, [Nurse Mancenido] asked [plaintiff] and [she] verbalize[d] that [she] called 911 and [she] want[ed] to transfer [the patient] to the hospital to get evaluated. [Nurse Mancenido] [e]xplained that [the] resident is on [a] ventilator machine and ALS need[ed] to be called. Resident-care coordinator [was] made aware [by Nurse Mancenido]. Offered to [plaintiff] if [the Parkshore] staff can clean and change [the] resident but [plaintiff] refuse[d]. 911 ALS [took] over and left the unit [with the patient] at 9:25 am [on the way] to Methodist Hospital."

Parkshore's records, page 00734 (nursing note, dated March 18, and timed 9:29 am).

[27] Methodist's records for the patient's subsequent hospitalization, page 85 of 645.

[28] Methodist's records for the patient's subsequent hospitalization, page 85 of 645 ("3/18/2017 10:17 am EDT[.] Chief Complaint[:] Brought in by ambulance[.] As per EMS[,] [the patient was] being abused at nursing home[;] ventilator dependent with tracheostomy and PEG. Bruises to [the patient's] both arms[;] sacral ulcers[.]) (unnecessary capitalization omitted).

The patient's hospital course during her subsequent stay at Methodist was summarized in the following progress note:

> "[The patient] had a systemic inflammatory response likely to a possible pneumonia as opposed to a soft tissue infection due to her sacral ulcer which was present on admission. She is to complete 14 days of therapy with vancomycin and tobramycin (due to the presence of multi drug resistant pseudomonas) in her tracheal aspirate. She underwent a bedside surgical debridement of her ulcer. Patient also had multiple attempted weaning trials [off the ventilator] without success."[29]

At discharge on March 23, the patient's sacral PU was measured at 7 cm by 4 cm by 3.5 cm. The wound-care protocol was to apply Hydrogel, to cover the sacral PU with bordered gauze, and to change the dressing daily.

The Events *Following* the Treatment Period

From March 23, 2017 to April 28, 2017, the patient was hospitalized at nonparty CareOne/Trinitas Regional Medical Center in New Jersey ("CareOne") for further treatment and weaning off the ventilator. On admission to CareOne, the patient was noted to have "been diagnosed [with] anoxic encephalopathy and ha[d] been in a persistent vegetative state."[30] On April 3, she was noted to have a single PU, which was Stage 4 on her sacrum, measuring at 6 cm by 3 cm by 4 cm.[31]

From April 28, 2017 to July 16, 2017, the patient resided at nonparty Resort Nursing Home in Queens, New York ("RNH"). One day after her admission to RNH, the

[29] Methodist's records for the subsequent hospitalization, page 12 of 645.

[30] CareOne's records, page 2 of 4 ("Pulmonary Consultation Report").

[31] CareOne's records, page 1 ("Weekly Wound Care" for the period from April 3 to April 24).

patient was noted to have a Stage 4 sacral PU, measuring 4.5 cm by 6.0 cm by 4.0 cm.[32] The sacral PU appeared stable (unchanged) through June 22.[33] The Court was not provided with any records from RNH for the remainder of the patient's stay.

From July 16, 2017 and until her death on July 21, 2017, the patient was hospitalized at nonparty Mount Sinai-Brooklyn for sepsis and pneumonia.[34] At the inception of her terminal hospitalization at Mount Sinai-Brooklyn, the patient was suffering from three PUs: (1) a Stage 4 sacrum PU of 7 cm by 7 cm with moderate exudate; (2) a Stage 2 right buttock PU of 5 cm by 5 cm with light exudate; and (3) a Stage 1 bilateral buttock PU of 10 cm by 10 cm without exudate.[35] On July 21, 2017, the patient passed away at the age of 73 from a cardiopulmonary arrest caused by a combination of pneumonia, anoxic encephalopathy, seizures, and myocardial infarction.[36]

Litigation

On June 13, 2019, the patient's daughter, individually and as the administratrix of her Estate, commenced this action against defendants. The crux of plaintiff's claims – whether denominated as negligence, medical malpractice, wrongful death, or (in the case of Parkshore) a violation of the Public Health Law – lay in the alleged independent failure of each defendant (separately from the other defendants): (1) to prevent the patient

[32] RNH's records ("Evaluation of Comprehensive Care Plan"; April 29 entry).

[33] RNH's records ("Evaluation of Comprehensive Care Plan"; June 22 entry).

[34] Mount Sinai-Brooklyn's records, unnumbered page (NYSCEF Doc No. 166).

[35] Mount Sinai-Brooklyn's records, page 7 of 74.

[36] Mount Sinai-Brooklyn's Mortality Final Progress Note, dated July 21, 2017 (NYSCEF Doc No. 138).

from developing the sacral and other PUs; and (2) to provide appropriate medico-nursing care for her sacral and other PUs by way of: (i) properly documenting and sizing the patient's PUs as well as by keeping a detailed repositioning schedule for the patient; (ii) turning/repositioning the patient at least every two hours, or more frequently if necessary; and (iii) taking other steps to prevent the PUs from deteriorating.

After discovery was completed and a note of issue was filed, each defendant timely moved for summary judgment. On March 1, 2024, the motions were fully submitted, and the Court reserved decision.

Standard of Review

In the medical-malpractice context, "[a] defendant moving for summary judgment . . . must demonstrate the absence of any material issues of fact with respect to at least one of the elements of a cause of action alleging medical malpractice: (1) whether the physician deviated or departed from accepted community standards of practice, *or* (2) that such a departure was a *proximate cause* of the plaintiff's injuries" and, where wrongful death is alleged, of wrongful death as well. *See Rosenthal v. Alexander*, 180 A.D.3d 826, 118 N.Y.S.3d 658 (2d Dept. 2020) (internal citation omitted; emphasis added); *Mandel v. New York County Pub. Adm'r*, 29 A.D.3d 869, 815 N.Y.S.2d 275 (2d Dept. 2006). "When a defendant in a medical malpractice action demonstrates the absence of any material issues of fact with respect to at least one of those elements, summary judgment dismissing the action should eventuate unless the plaintiff raises a triable issue of fact in opposition." *Schwartz v. Partridge*, 179 A.D.3d 963, 117 N.Y.S.3d 300 (2d Dept. 2020) (internal citations omitted). "A physician's [expert affirmation] in

opposition to a motion for summary judgment must attest to the defendant's departure from accepted practice, which departure was a competent producing cause of the injury." *Shahid v. New York City Health & Hosps. Corp.*, 47 A.D.3d 800, 850 N.Y.S.2d 519 (2d Dept. 2008). "General and conclusory allegations unsupported by competent evidence are insufficient to defeat a motion for summary judgment." *Id.*

A similar principle governs negligence claims. "Where the evidence adduced reveals the existence of several possible causes of an injury, for one or more of which the defendant is not responsible, a plaintiff cannot recover without proving the injury was sustained wholly or in part *by reason of* the defendant's negligence." *Ramirez v. Sears, Roebuck & Co.*, 286 A.D.2d 428, 729 N.Y.S.2d 503 (2d Dept. 2001) (internal quotation marks omitted; emphasis added).

Further, "[l]iability under the Public Health Law contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule, subject to the defense that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient." *Moore v. St. James Health Care Ctr., LLC*, 141 A.D.3d 701, 35 N.Y.S.3d 464 (2d Dept. 2016) (internal quotation marks omitted). "Thus, the basis for liability under Public Health Law § 2801-d . . . contemplates injury to the patient caused by the deprivation of a right conferred by contract, statute, regulation, code or rule." *Schwartz v. Partridge*, 179 A.D.3d 963, 117 N.Y.S.3d 300 (2d Dept. 2020) (internal quotation marks omitted).

Lastly, "[t]he elements of a cause of action to recover damages for wrongful death are (1) the death of a human being, (2) the wrongful act, neglect or default of the

defendant by which the decedent's death was caused, (3) the survival of distributees who suffered pecuniary loss by reason of the death of decedent and (4) the appointment of a personal representative of the decedent." *Chong v. New York City Tr. Auth.*, 83 A.D.2d 546, 441 N.Y.S.2d 24 (2d Dept. 1981).

Discussion

Brookdale's, Parkshore's, and Methodist's individual motions were supported by the affirmations of their respective expert internists/geriatricians, Lawrence Diamond, M.D. ("Dr. Diamond"), for Brookdale; Lisa A. Honkanen, M.D. ("Dr. Honkanen"), for Parkshore; and Gisele Wolf-Klein, M.D. ("Dr. Wolf-Klein"), for Methodist.

Brookdale's Expert

Brookdale's expert, Dr. Diamond, advanced three principal points on the element of proximate cause. First, according to Dr. Diamond, the patient was not suffering from any PUs at the time of her involuntary (or the AMA-type of) discharge from Brookdale at 3:56 pm on November 12. Second, Dr. Diamond opined that the patient's PUs, which were discovered in Methodist's ED at 7:32 pm on that day, developed (or in Dr. Diamond's words had been "community acquired"[37]) over the span of "three and a half hours since [or following the patient's] discharge from Brookdale," which, in Dr. Diamond's opinion, "was sufficient time for the skin redness at the sacrum and bilateral heels to have developed [in the interim]."[38] Third and finally, Dr. Diamond observed that the patient's newly discovered PUs were merely "Stage I ulcers, or skin

[37] Dr. Diamond's Expert Affirmation, dated August 17, 2023 ("Dr. Diamond's affirmation"), ¶ 17.

[38] Dr. Diamond's affirmation, ¶ 18.

redness[es] without skin breaks,"[39] which (as Methodist's records reflected and as Methodist's expert confirmed) subsequently healed during her initial hospitalization at Methodist.

Parkshore's Expert

Parkshore's expert, Dr. Honkanen, advanced three major points on the element of proximate cause. First, according to Dr. Honkanen, the patient did not develop any new PUs during her stay at Parkshore, but rather experienced the recurrence of her preexisting sacral PU on January 19, whereas her pre-existing bilateral heel PUs had resolved within several weeks of her admission to Parkshore.[40] Second, in Dr. Honkanen's opinion, the recurrence (or the reopening) of the patient's sacral PU was "unavoidabl[e]" because of her "fragile skin and numerous comorbidities," as more fully explained in the margin.[41] Third and finally, Dr. Honkanen emphasized that the patient "was already approaching [the] end of life when she was . . . admitted to [Parkshore] in December . . . 2016" in light

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[39] Dr. Diamond's affirmation, ¶ 18.

[40] Dr. Honkanen's Expert Affirmation, dated August 28, 2023 ("Dr. Honkanen's affirmation"), ¶ 29.

[41] Dr. Honkanen's affirmation, ¶ 29 ("[The patient's] sacral wound was pre-existing and also healed, but later unavoidably recurred due to [her] fragile skin and numerous comorbidities."); ¶ 30 ("A wound heals through a process of granulation [filling of the wound with connective/scar tissue], contraction [wound margins contract and pull together], and re-epithelialization [covers with epithelial tissue from within wound bed and/or from wound margins]. Once the [PU] has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength."); ¶ 31 ("However, a patient remains at risk of having the site of a closed [PU] open up due to damage, injury, or pressure, because of the reduction in tensile strength of the overlying tissue. *Because the tensile strength of a healed wound is always compromised from its original state, a healed wound bed is significantly more vulnerable to recurrence of the wound. Thus, preventative measures are put into place to mitigate the risk of re-opening of a closed ulcer, but cannot be guaranteed to prevent recurrence.*"), ¶ 30 ("*That the wound reopened is not proof of poor care. [The patient] remained in a minimally conscious state throughout admission. She was status-post CVA, MI and cardiac arrest and had required cardiopulmonary resuscitation. As a result, she suffered anoxic encephalopathy, causing her to be minimally conscious and requiring a ventilator to maintain life.*") (emphasis added).

of her "multiple chronic, irreversible comorbidities, including acute hypoxemic respiratory failure, anoxic brain injury, bacteremia due to Klebsiella, stroke, chronic respiratory failure, epilepsy, and cardiac arrest," as juxtaposed against the background of her ventilator support, tube feedings, and minimally conscious state.[42]

Methodist's Expert

Methodist's expert, Dr. Wolf-Klein, "reminded [the Court] that "the [patient] was twice admitted to [Methodist] and for each admission, the [patient] was transferred to [Methodist] upon the wishes of the plaintiff."[43] Dr. Wolf-Klein next separately opined on the element of proximate cause in connection with the patient's initial and subsequent hospitalizations at Methodist. As to the patient's initial hospitalization at Methodist, Dr. Wolf-Klein opined that:

> "Relative to the first [Methodist] admission, the three community-acquired pressure ulcers (sacrum and bilateral heels) were identified within approximately three hours of the [patient] arriving to the [Methodist] emergency department. . . .
>
> [B]y December 5, 2016, the [patient's] sacrum was healed and remained healed through discharge. Notably, during this admission, the [patient] did not develop any pressure ulcers and the ulcers that were present on admission never opened. The fact that the skin remained intact throughout the [Methodist] one[-]month [initial] admission in a non-responsive[,] bedbound[,] critically ill patient is indeed a testimony to the excellence of the nursing team's concerted efforts."[44]

Addressing the patient's subsequent hospitalization at Methodist, Dr. Wolf-Klein opined that:

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[42] Dr. Honkanen's affirmation, ¶ 9.

[43] Dr. Wolf-Klein's Physician Affirmation, dated August 27, 2023 ("Dr. Wolf-Klein's affirmation"), ¶ 26.

[44] Dr. Wolf-Klein's affirmation, ¶¶ 17, 19.

> "[T]he [patient] was . . . readmitted to [Methodist] on 3/18/2017 with a community-acquired sacral pressure ulcer. . . . Two days into the admission, a bedside surgical debridement was performed on the community-acquired sacral ulcer. The subsequent medical records from [nonparty] CareOne . . . confirm[ed] on admission to that facility and as of March 25, 2017 (two days after being admitted [to CareOne]), [that] the only documented pressure ulcer was the sacral pressure ulcer. Accordingly, the subsequent medical records confirm that during the second [Methodist] admission, [the patient] did not develop additional pressure ulcers. . . ."[45]

Thus, Dr. Wolf-Klein concluded, on the element of proximate cause, that:

> "[T]he evidence demonstrates [that] the [patient's] death, on July 21, 2017, was not caused by or related to the care and treatment she received during the November-December 2016 [Methodist] admission or the March 2017 [Methodist] admission. . . .
>
> . . . Further, there is no evidence to suggest the [patient] suffered and/or sustained any of the claimed injuries during the November through December 2016 admission[,] or the March 2017 admission[,] . . . as a result of any act of negligence by [Methodist]. . . ."[46]

The foregoing expert affirmations, together with defendants' medical records and other submissions, established their respective prima facie entitlement to judgment as a matter of law on the element of proximate cause. *See Campbell v. Ditmas Park Rehabilitation & Care Ctr., LLC*, 225 A.D.3d 835, 208 N.Y.S.3d 220 (2d Dept. 2024); *Van DeVeerdonk v. North Westchester Restorative Therapy & Nursing Ctr.*, 223 A.D.3d 702, 204 N.Y.S.3d 132 (2d Dept. 2024); *Barnaman v. Bishop Hucles Episcopal Nursing Home*, 213 A.D.3d 896, 184 N.Y.S.3d 800 (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).

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[45] Dr. Wolf-Klein's affirmation, ¶ 20.

[46] Dr. Wolf-Klein's affirmation, ¶¶ 27-28.

Plaintiff's Expert

In opposition to defendants' respective prima facie showing on the element of proximate cause, plaintiff's expert, a New York State-licensed physician, who was board-certified in internal medicine with a sub-certification in geriatrics ("plaintiff's expert"), failed to raise a triable issue of fact on the element of proximate cause as to any of plaintiff's causes of action as against any of defendants.[47] Plaintiff's expert's opinions were speculative, conclusory, and nonresponsive to the specific assertions of defendants' respective experts, in that the patient's claimed injuries: (1) were, in substance, either non-existent/minor/inconsequential, or were not proximately caused by the applicable defendant's alleged acts/omissions, in the instances of the Brookdale hospitalization and the Methodist initial hospitalization; or (2) were clinically unavoidable in the instances of the Parkshore residence and the Methodist subsequent hospitalization. *See Campbell*, 225 A.D.3d 835; *Russell v. River Manor Corp.*, 216 A.D.3d 827, 188 N.Y.S.3d 191 (2d Dept. 2023); *Barnaman*, 213 A.D.3d 896; *Losak v. St. James Rehabilitation & Healthcare Ctr.*, 199 A.D.3d 671, 156 N.Y.S.3d 406 (2d Dept. 2021); *Lowe v. Japal*, 170 A.D.3d 701, 95 N.Y.S.3d 363 (2d Dept. 2019); *Ciccotto v. Fulton Commons Care Ctr., Inc.*, 149 A.D.3d 1030, 53 N.Y.S.3d 338 (2d Dept. 2017); *Novick v. South Nassau Communities Hosp.*, 136 A.D.3d 999, 26 N.Y.S.3d 182 (2d Dept. 2016); *DePaso v. Sarah Neuman Ctr. for Healthcare & Rehabilitation*, 119 A.D.3d 727, 989 N.Y.S.2d 310 (2d Dept. 2014).

[47] Plaintiff's expert's separate affirmations in opposition to defendants' summary judgment motions, each dated November 16, 2023.

Plaintiff's expert's opinion on causation as to each defendant was based on the oversimplified assumption that "unrelieved pressure causes pressure ulcers."[48] Plaintiff's expert, while acknowledging that the patient was suffering from multiple comorbidities throughout the treatment period,[49] overlooked that the factors causing the development and persistence of pressure ulcers include not only the external physical forces such as pressure, friction, or shear, but also an interaction between those forces and a multitude of the patient's individual characteristics and her own risk factors. With a higher number of individual risk factors, any patient has a higher likelihood of developing and retaining a pressure ulcer. Plaintiff's expert's assumption that each defendant had (or could have had) a good pressure-ulcer preventive strategy in place that always worked, and that when a sacral pressure ulcer developed and persisted, it must have meant that the strategy was not correctly applied to the patient or that there was some other problem with her care plan, was fundamentally incorrect. Where, as here, the patient's sacral pressure ulcer was not preventable or curable by the repeated medical, surgical, and nursing interventions at a total of six separate facilities,[50] its initial development, subsequent closure, subsequent re-opening, and overall persistence could not be relied on as the key indicator of the quality of care provided (or the lack thereof). Rather, the development and persistence of a pressure ulcer could have been a quality indicator only where (unlike

[48] Plaintiff's expert affirmations, ¶¶ 56 and 59 as to Brookdale; ¶¶ 52-53 as to Parkshore; ¶¶ 55 and 57 as to Methodist.

[49] Plaintiff's expert affirmations, ¶ 7 and ¶¶ 55-56 as to Brookdale; ¶ 7 and ¶¶ 52-53 as to Parkshore; ¶ 7 and ¶¶ 54-55 as to Methodist.

[50] The six facilities were comprised of three defendants Brookdale, Methodist, and Parkshore, as well as of three nonparties CareOne, RNH, and Mount Sinai-Brooklyn.

the case here) a patient was either without risk factors or was at a low risk for developing pressure ulcers.[51]

Here, defendants (viewed collectively) kept the patient alive for a period of four months from November 2, 2016 through March 23, 2017, by successively implementing multiple artificial means of support in the form of tracheostomy, ventilator, and PEG, while concurrently providing the patient with anticonvulsants, anticoagulants, antibiotics, and other medications. Due to their collective efforts, the patient was able to live another four months until July 21, 2017, following the expiration of the initial four-month treatment period that was at issue in this action.

Ultimately, "[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). The development and/or worsening of a pressure ulcer was not a basis, in and of itself, on which an inference of negligence or medical malpractice could be premised against a health-care provider. Plaintiff's expert's contention that "the care rendered to the [patient] . . . by . . . [Brookdale and Methodist] was inconsistent with the applicable [albeit, uncited] state and federal regulations"[52] as well as his/her further contention that Parkshore violated various cited state and federal regulations,[53] ran contrary to the explicit language of 10 NYCRR 415.12 (c) (1) and 42 CFR 483.25 (b) (1) (i),

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[51] Significantly, plaintiff's expert (in his/her detailed review of the patient's chronology of medical events in his/her affirmations as to each defendant) omitted the critical fact that only three days after the inception of the treatment period the patient "coded at [Brookdale]," with a "return of spontaneous circulation [to her heart] . . . within 8 minutes." Brookdale's records, page 781.

[52] Plaintiff's expert's affirmations, ¶ 68 as to Brookdale; ¶ 66 as to Methodist.

[53] Plaintiff's expert's affirmations, ¶¶ 48 and 62-63 as to Parkshore.

respectively, which (in each instance) exempted medical facilities from liability for pressure ulcers where "the individual's clinical condition demonstrate[d] that they were unavoidable," as was the case here.

Plaintiff's expert's next contention that the patient should have been turned and repositioned "more frequently than every two hours" was unsupported by citation to any medical authority.[54] Likewise unavailing was plaintiff's expert's additional contention that neither Brookdale nor Parkshore maintained a "detailed written repositioning schedule or chart" "allow[ing] each caregiver to determine when the patient had been positioned and into which position the patient was placed[;] *i.e.*, left side, right side, or back."[55] However, "[a] failure to document each element of the skin care protocol does not equate to a failure to perform each element or to a cause of the [pressure] ulcer itself." *Braunstein v. Maimonides Med. Ctr.*, 161 A.D.3d 675, 78 N.Y.S.3d 344 (1st Dept. 2018) (citing *Topel v. Long Is. Jewish Med. Ctr.*, 55 N.Y.2d 682, 446 N.Y.S.2d 932 (1981). Contrary to plaintiff's expert's further contention,[56] the alleged omissions in the turning and positioning records maintained by defendants were immaterial and (in and of themselves) could not have resulted in injury to the patient. *See Shapiro v. Gurwin Jewish Geriatric Nursing & Rehabilitation Ctr.*, 84 A.D.3d 1348, 923 N.Y.S.2d 894 (2d Dept. 2011). More to the point, though, is that the patient's sacral ulcer persisted, despite the

[54] Plaintiff's expert's affirmations, ¶¶ 51-52 and 67 as to Brookdale; ¶ 46 as to Parkshore; ¶¶ 51 and 65 as to Methodist.

[55] Plaintiff's expert's affirmations, ¶ 52 as to Brookdale; ¶¶ 45-46 as to Parkshore.

[56] Plaintiff's expert's affirmations, ¶¶ 46-48 as to Brookdale; ¶ 43 as to Parkshore; ¶¶ 46-48 and 50 as to Methodist.

extensive, multi-phasic wound-care treatment that she received, whereas her bilateral heel ulcers were healed during her initial hospitalization at Methodist.

In sum, the Court found that plaintiff's expert's opinion as to proximate cause was speculative and factually unsupported. *See Van DeVeerdonk v. North Westchester Restorative Therapy & Nursing Ctr.*, 223 A.D.3d 702, 204 N.Y.S.3d 132 (2d Dept. 2024); *Russell*, 216 A.D.3d 827; *Tsitrin v. New York Community Hosp.*, 154 A.D.3d 994, 62 N.Y.S.3d 506 (2d Dept. 2017); *Wicksman v. Nassau County Health Gare Corp.*, 27 A.D.3d 644, 811 N.Y.S.2d 778 (2d Dept. 2006). Accordingly, dismissal of the complaint against all three defendants is warranted. *See Moore v. St. James Health Care Ctr., LLC*, 141 A.D.3d 701, 35 N.Y.S.3d 464 (2d Dept. 2016); *Gold v. Park Ave. Extended Care Ctr. Corp.*, 90 A.D.3d 833, 935 N.Y.S.2d 597 (2d Dept. 2011).

While the Court considered that the patient might have endured discomfort and pain as a result of her sacral ulcer – which the Court in no way minimized – the explanation offered by defendants' experts as to its development and persistence was record-based, objective, and unemotional, such that the care that was offered and implemented resulted in the outcome that should not result in a finding that any of defendants was negligent, committed malpractice, or violated the Public Health Law.[57]

[57] The Second Judicial Department (at the summary judgment stage) reviewed and rejected potential liability of health-care facilities for their patients/residents' development and persistence of pressure ulcers. *See Campbell v. Ditmas Park Rehabilitation & Care Ctr., LLC*, 225 A.D.3d 835, 208 N.Y.S.3d 220 (2d Dept., 2024); *Russell v. River Manor Corp.*, 216 A.D.3d 827, 188 N.Y.S.3d 191 (2d Dept., 2023); *Korszun v. Winthrop Univ. Hosp.*, 172 A.D.3d 1343, 101 N.Y.S.3d 408 (2d Dept., 2019); *Novick v. South Nassau Communities Hosp.*, 136 A.D.3d 999, 26 N.Y.S.3d 182 (2d Dept., 2016); *Moore v. St. James Health Care Ctr., LLC*, 141 A.D.3d 701, 35 N.Y.S.3d 464 (2d Dept., 2016); *Domoroski v. Smithtown Ctr. for Rehabilitation & Nursing Care*, 95 A.D.3d 1165, 945 N.Y.S.2d 345 (2d Dept., 2012); *Gold v. Park Ave. Extended Care Ctr. Corp.*, 90 A.D.3d 833, 935 N.Y.S.2d 597 (2d Dept., 2011).

The Court reviewed plaintiff's remaining contentions and found them unavailing.[58]

Conclusion

Based on the foregoing, it is

ORDERED that the respective motions of defendants Brookdale University Hospital Medical Center, Parkshore Health Care, LLC, doing business as Four Seasons Nursing and Rehabilitation Center, and New York-Presbyterian Brooklyn Methodist Hospital are each *granted*, and the complaint is dismissed in its entirety as against each defendant without costs or disbursements, and it is further

ORDERED that the clerk is directed to enter judgment in favor of each defendant, and it is further

ORDERED that Methodist's counsel shall electronically serve a copy of this Decision, Order, and Judgment with notice of entry on the respective counsel to plaintiff and the other defendants, and shall electronically file an affidavit of service thereof with the Kings County Clerk, and it is further

[58] The Court disregarded plaintiff's post-deposition affidavit which, in effect, sought to embellish, and expand on, her deposition testimony. *See Saitta v. Marsah Props., LLC*, 211 A.D.3d 1062, 182 N.Y.S.3d 141 (2d Dept. 2022); *Garcia-Rosales v. Bais Rochel Resort*, 100 A.D.3d 687, 954 N.Y.S.2d 148 (2d Dept. 2012), *lv. denied* 20 N.Y.3d 858, 960 N.Y.S.2d 349 (2013).

ORDERED that the Alternative Dispute Resolution Conference scheduled for June 18, 2024 is canceled.

This constitutes the Decision, Order, and Judgment of the Court.

ENTER,

Genine D. Edwards
J. S. C.