Salandy v Bishop Henry Hucles Episcopal Nursing Home
2025 NY Slip Op 31305(U)
April 7, 2025
Supreme Court, Kings County
Docket Number: Index No. 521677/17
Judge: Ellen M. Spodek

At an IAS Term, Part 63 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at Civic Center, Brooklyn, New York, on the 7th day of April, 2025.

PRESENT:

HON. ELLEN M. SPODEK,
Justice.

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ANNETTE SALANDY, as Administrator of the Estate of RITA SALANDY,

Plaintiff,

- against -

BISHOP HENRY HUCLES EPISCOPAL NURSING HOME and ST. MARKS BROOKLYN ASSOCIATES, LLC, d/b/a CROWN HEIGHTS CENTER FOR NURSING AND REHABILITATION,

Defendants.

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DECISION AND ORDER

Index No. 521677/17

Mot. Seq. No. 7-8

The following e-filed papers read herein:	NYSCEF Doc Nos.:
Notice of Motion/Cross Motion, Affirmations (Affidavits), and Exhibits Annexed	26-42
Affirmations (Affidavits) in Opposition and Exhibits Annexed	49-55
Reply Affirmations and Exhibit Annexed	56-57

In this action to recover damages for negligence, medical malpractice, and violation of Public Health Law § 2801-d, defendant Bishop Henry Hucles Episcopal Nursing Home ("BHH") and defendant St. Marks Brooklyn Associates, LLC, doing business as Crown Heights Center for Nursing and Rehabilitation ("CHC"; and collectively with BHH, "defendants"), each moved for summary judgment dismissing all claims as against such defendant. Plaintiff Annette Salandy, as the administrator of the estate of her late mother Rita Salandy ("plaintiff"), opposed both motions.

On March 12, 2016, plaintiff's decedent, Rita Salandy (the "patient"), age 96 and living alone in her apartment, fell and hit her head on the floor. The following day, March 13th, the patient was hospitalized at nonparty Kingsbrook Jewish Medical Center ("Kingsbrook") for a "[f]all with stigmata of head trauma and local neurologic deficits suggesting a preceding left middle cerebral artery territory cardiovascular accident" (Kingsbrook, page 0536). The patient's head CT scan, performed the same day, was significant for an "[a]cute subdural hematoma overlying the left cerebral hemisphere measuring 0.6 cm [or 6 mm] in thickness," without evidence of a "midline shift" (Kingsbrook, page 0536). The admitting physicians' impression was that the patient had suffered a moderate stroke on the score of 6 on the National Institutes of Health Stroke Scale from 1 to 42. Her principal admitting diagnosis to Kingsbrook's Critical Care Unit was "traumatic subdural hemorrhage without loss of consciousness" (Kingsbrook, page 0546). Her secondary admitting diagnoses were "hemiplegia . . . affecting right dominant side," "essential (primary) hypertension," "dementia without behavioral disturbance," "atrial fibrillation," and "epilepsy . . . without status epilepticus" (Kingsbrook, page 0526). Nonetheless, her Glasgow Coma Score was 15 on the scale from 3 to 15, indicating that: (1) the patient was oriented to time, place, and person; (2) her speech was clear and oriented; (3) her affect was normal; and (4) she responded to questions appropriately.

A repeat CT scan, performed on March 14th, confirmed the presence of "the subdural hematoma overlying the left cerebral hemisphere. Laterally[,] this is decreased in

thickness. However[,] medially along the posterior aspect of the falx [cerebri],[1] this is mildly increased which may represent redistribution of subdural hematoma" (Kingsbrook, page 0548). There was "[n]o evidence of midline shift. No significant mass effect" (Kingsbrook, page 0548).

Upon admission to Kingsbrook, the patient was assessed to be at a high risk for falls. During her hospitalization at Kingsbrook, the patient was restrained with a chest vest and **wrist** restraints as a "fall precaution" because of her confusion, restlessness, and disorientation. During her hospitalization at Kingsbrook, she received prophylaxis against deep-vein thrombosis ("DVT") with sequential compression devices (known as the Venodyne boots) that were placed on both of her ankles. On March 14th, the patient passed a swallowing evaluation with the diagnosis of "functional oropharyngeal swallow" (Kingsbrook's page 0610). The evaluator's recommendation was to "initiate modified solids and thin liquids as tolerated" (Kingsbrook, page 0610). On March 15th, the patient was transferred from the Critical Care Unit to a general floor. On March 22nd, the patient was discharged from Kingsbrook to BHH for rehabilitation. Her medications upon discharge to BHH were Buspar (an anxiolytic), Cozaar (an ARB-type antihypertensive), Keppra (an antiepileptic), and Metoprolol Tartrate (a beta-blocker to maintain heart rhythm).

[1] Lying in the midline of the brain, "falx cerebri" is a thin dural fold that forms a vertical sickle shape in the midsagittal plane in the longitudinal groove (or fissure) separating the cerebral hemispheres.

Despite her advanced age of 96, the patient was not suffering from diabetes, kidney disease, or respiratory ailments. She was breathing on room air without supplemental oxygen. Her left ventricular ejection fraction – a key measure of heart function – was within the normal limit of 50-55%.

Upon admission to BHH on March 22nd, the patient was noted to be suffering from a cardiovascular accident, a subdural hematoma with right-side hemiparesis, hypertension, and dementia. She was oriented only as to "person," but not as to time or place. Although she was alert and able to express herself, her perception was altered, her memory was impaired, and her judgment was also impaired. She was incontinent as to both bowl and bladder. She was on a "mechanical soft" diet (BHH, page 119).

The patient was assessed at a high risk of falls, with the fall score of 21 within the high risk of 17 to 35. She was recommended to be "in close observation of staff once [she was awake and] out of bed [to a] wheelchair" (BHH, pages 056 and 060).

Two comprehensive nursing-care plans specifically addressing the subject of fall protection were prepared for the patient: (1) the March 22nd plan which was prepared before the patient's fall (the "pre-incident fall-protection plan"); and (2) the March 26th plan which was prepared shortly after the patient's fall on the morning of March 26th (the "post-incident fall-protection plan"). Both plans emphasized that the patient was at an "actual" risk of falls.

The pre-incident fall-protection plan included a handwritten, patient-tailored list of specific nursing/CNA interventions to prevent and/or minimize the risk of her falls. Those

interventions required that the patient: (1) " be frequently "orient[ed] to surroundings and reality . . . with each contact"; (2) "be out of bed to wheelchair in close observation of staff once awake"; and (3) be "frequent[ly] round[ed] [the by staff] to monitor [her] activities" (BHH, page 076). The patient's post-incident fall-protection plan directed close monitoring and providing her with a gerichair when out of bed.

On Thursday, March 24, a nursing note indicated that the patient was encouraged to be out of bed and onto a recliner, with a two-person assistance. On Saturday, March 26th, at 10:15 a.m., the patient was out of bed and in a gerichair/recliner[2] when she fell onto the floor on her right lateral side (the "fall incident"). A resulting hematoma to the right frontal region of her skull was observed. The patient, when questioned, was unable to recall how she fell. Approximately thirty-minutes later, she was picked up by a 911-summoned ambulance for transfer from BHH to nonparty Interfaith Medical Center ("Interfaith").

At 11:42 a.m. on March 26th, the patient was triaged at Interfaith. At the time, the patient was "oriented only to person," her speech pattern was "delayed," and her Glasgow Coma Score was 12 on the scale of 3 to 15.

The initial CT scan report of the patient's head (finalized at 1:24 p.m.) showed: (1) a 13 mm hyperdense left subdural hematoma, (2) with a 7 mm midline shift to the right, and (3) with a subfalcine herniation. The subsequent CT scan report of her head (finalized two hours later at 3:06 p.m.) showed that the patient had marginally improved: (1) her 13

[2] The patient was not strapped to the recliner or wheelchair because no physician order to that effect had been entered. *See* EBT transcript of Nurse Grace Nmecha, page 33, lines 20-21.

mm hyperdense subdural hematoma was stable, (2) with a 6 mm (rather than a 7 mm) midline shift to the right, and (3) with a subfalcine herniation.

In between the two CT scans, the patient became agitated and restless, was intubated and placed on mechanical ventilation, and received a single dose of Mannitol to reduce intracranial pressure, as well as multiple doses of Versed for agitation, pending her inter-hospital transfer at approximately 6 p.m. to nonparty New York-Presbyterian Hospital, Columbia Presbyterian Medical Center ("NYP-Columbia") as an acute-care facility.

At 7:18 p.m. on March 26th, the patient was admitted to NYP-Columbia with acute diagnoses of intracranial subdural hemorrhage and traumatic subdural hematoma. Shortly after her admission to NYP-Columbia, the patient scored 31 on the National Institutes of Health Stroke Scale from 1 to 42, with the score of 25 or higher indicating a very severe stroke. In addition, the patient scored 5 (down from her score of 12 at Interfaith earlier that day) on the Glasgow Coma Scale from 3 to 15, with the score of 5 falling within the range of 3 to 8 indicating a severe traumatic brain injury.

The initial CT scan report of the patient's head (performed at approximately 9 p.m.) found, in relevant part: (1) a left holohemispheric (*i.e.*, affecting the entire hemisphere of the brain) subdural hematoma extending to the posterior tentorium (a fold of the dura mater forming a partition between the cerebrum and cerebellum) and the left posterior falx[,] which measured maximally 13 mm in thickness; (2) the subdural hematoma was of mixed density with more acute hemorrhage within the superior portions; and (3) a mass effect with the right-to-left midline shift of 4 mm, accompanied by the compression on the left

lateral and the third ventricles. The patient's admitting neurologist's own interpretation of the initial CT scan films "show[ed] left subdural hyperdense lesion consistent with acute blood [bleeding], about 12 mm thick; positive for a midline shift of about 4 mm to the right; effacement of sulci[,] especially on [the] left[,] and effacement of [the] left lateral ventricle; also hypodensity in [the] right cerebellum consistent with prior ischemic stroke" (NYP-Columbia, page 110). A repeat CT scan report of the patient's head performed the following morning at 5:58 a.m. revealed, in relevant part: (1) a stable left holohemispheric acute subdural hematoma extending to the posterior tentorium and the left posterior falx, once again measuring 13 mm in maximal thickness; and (2) a mass effect with the right-to-left midline shift of 4 mm, once again accompanied by the compression on the left lateral and the third ventricles.

In between the two CT scans, the patient once again became agitated and restless. She was intubated and placed on ventilator support at approximately 2 p.m. on March 26th, and shortly thereafter received Mannitol and Keppra, as well as was a Versed drip.

A neurosurgery consultation note of March 26th at 10:25 p.m., concluded that the "[b]edside burr holes [would be] unlikely to benefit [the patient] based on [the] density of [her] blood. Large craniotomy/craniectomy would be extremely morbid given [the] patient's advanced age" (NYP-Columbia, pages 112-113).

During the patient's stay at Columbia's neurology intensive care unit ("Neuro ICU") from March 26th to March 30th, the patient was diagnosed with: (1) an acute left subdural hematoma with an about 5 mm midline shift; (2) the old right cerebellar stroke; (3) the

residual right hemiparesis; (4) history of old subdural hemorrhage; (5) baseline dementia; and (6) structural encephalopathy. The patient was assessed at a high risk for fall injuries with the score of 14, where the score of 7 or higher indicated a "high fall-injury risk" (NYP-Columbia, pages 465 and 469). Throughout her stay at the Neuro ICU, the patient was restrained.

Nonetheless, the patient was recovering without a neurosurgical intervention. On March 28th, the patient pulled out her breathing tube. The following day, March 29th, the patient was transferred from the Neuro ICU to the general neurology floor. On March 30th, she scored 4 on the National Institutes of Health Stroke Scale, indicating a mild stroke, which was a significant improvement from her high stroke score of 31 at the time of her admission to the Neuro ICU four days earlier. On March 31st, she achieved a score of 14 (equivalent to a mild traumatic brain injury) on the Glasgow Coma Scale from 3 to 15. Nonetheless, her risk of falls was consistently documented as high at the score of 18, with the score of 7 or higher representing a "high fall-injury risk".

On March 30th, the patient's tube feedings were supplemented with assisted oral feedings initially on the "dysphagia I diet" (nectar-thick liquids) (NYP-Columbia, pages 161 and 165-166) and subsequently on the "puree and thin liquids" (NYP-Columbia, page 167). From March 30th through April 2nd, the patient received DVT prophylaxis in the form of once-per-day injections of Lovenox 40 mg (NYP-Columbia, pages 091 and 098). The Lovenox was in lieu of the Venodyne boots, which had been used at Kingsbrook for the patient's DVT prophylaxis.

On April 2nd, the patient was discharged from Columbia to CHC on the pureed diet and oral supplementation as needed. The patient's discharge medications (in addition to the Lovenox) were: (1) multiple oral vitamins in liquid form; (2) senna oral liquid (a laxative); (3) docusate sodium (a stool softener); (4) polyethylene glycol (another laxative); (5) acetaminophen for pain; (6) Metoprolol Tartrate (her pre-existing beta-blocker); and (7) Buspar (her pre-existing anxiolytic). Two of her former prescription medications – Cozaar (an ARB-type antihypertensive) and Keppra (an antiepileptic) – were discontinued upon discharge from NYP-Columbia.

On April 2nd, the patient was admitted to CHC from NYP-Columbia for long-term care. The patient's primary admitting diagnosis was "intracranial subdural hemorrhage," and her presenting medical history was significant for "stroke, Alzheimer's, dementia, [and] chronic embolism (CHC, page 010). The comprehensive nursing-care plan (prepared on the day of her admission to CHC) additionally noted the patient's "difficulty in walking," "muscle weakness," and "cognitive deficit[s]" (CHC, page 012). The patient's confused state upon admission was also noted. The patient's chart at admission to (and throughout her residence at) CHC consistently reflected that the patient must be monitored closely because she got out of bed unattended. The patient's degree of physical activity was assessed as "chairfast," and her mobility was assessed as "very limited" (CHC, page 032). The patient's fall risk was assessed as "at risk" with the score of 13, with the score of 10 or higher representing "at risk". She could not walk in the corridor on her floor, either with or without assistance, and she required one-person physical assistance at all times with her locomotion on the unit, with the "total dependence – full staff performance of [her

locomotion on the unit]" (CHC, page 045). A night-shift nurse (in a note, dated April 3rd and timed at 4:01 a.m.) evaluated the patient as requiring "total assistance for activities of daily living" (CHC, page 109). Further, CHC's chart for the patient includes an occupational therapy assessment that was performed at Columbia on March 30th reflecting her raw score of 8 on the Activity Measure Post-Acute Care scale, with the lowest range of 6 to 9 representing the maximum assistance which she required for most tasks.

Throughout her stay at CHC, the patient received the Lovenox daily, in addition to the other medications which she was prescribed at NYP-Columbia. Her status as being on the anticoagulant therapy was reflected in the nursing note that was dated April 3rd and timed at 4:20 a.m.

On April 4th, CHC's physician on call, internist Muhammad Fahimmudin, M.D. ("Dr. Fahimmudin"), examined the patient at bedside. His assessment of the patient was significant for: (1) "status post-fall and left subdural hematoma – stable on follow-up CT scan at [Columbia]"; (2) "history of right cerebellar cardiovascular accident with right hemiparesis"; (3) "old small right subdural hematoma"; (4) "dementia"; and (5) "anxiety disorder" (CHC, page 011). His plan for the patient required (in relevant part): (1) "continue current management"; (2) "continue current medications [, including the Lovenox]"; (3) "neurosurgery follow-up"; and (4) "fall precautions" (CHC, page 011). A nursing assessment performed earlier the same day was notable for the patient's "confusion," as well as her "impaired expressive and receptive language" (CHC, page 119).

A separate nursing note of the same day warned that the patient was "at risk for abuse due to cognitive decline as a result of dementia" (CHC, page 123).

From April 3rd to April 7th, the patient was receiving physical therapy at CHC. The evaluating physical therapist's clinical impression was that "[the patient] present[ed] with difficulty in all her functional mobilities such as bed mobility skills, transfer skills[,] and ambulation. In addition, [the patient] . . . present[ed] with poor balance in all levels, poor coordination[,] and endurance" (CHC, page 158). Throughout the course of her physical therapy, she was assessed as unable to walk on her own and with total dependence on others and without attempts to initiate (CHC, page 062). She was able, at most, to "perform[ ] approximately 2-3 steps, with maximum assistance of 2 [therapists] and [a] wheelchair to follow" (CHC, page 062). The evaluating physical therapist stressed the need to "focus interventions on stability and static standing balance" (CHC, page 062). The patient's physical therapy at CHC ended in the early afternoon of Thursday, April 7th.

In the evening of April 7th, the patient was noted to have a "blue discoloration under [her] left eye" (CHC, page 175) (Nursing Progress Note, dated April 7th and timed at 7:31 p.m.). The following morning on April 8th, the "discoloration under [the patient's] left eye still persist[ed]" (CHC, page 173) (Nursing Progress Note, dated April 8th and timed at 6:11 a.m.). Later the same day, the patient was examined at bedside by Dr. Fahimmudin who diagnosed her with the "left periorbital ecchymosis" (CHC, page 174). In his pretrial testimony (at page 48, line 16), Dr. Fahimmudin characterized the patient's left periorbital ecchymosis as a "bruise" (the "bruised-eye incident"). Referencing in his pretrial testimony

(at page 56, line 9-17) the absence of any entries in CHC's records on the cause of the bruised-eye incident, Dr. Fahimmudin attributed its cause to a spontaneous "ecchymosis due to thin capillary walls as a result of [the patient's] old age, and [her status] on Lovenox for DVT prophylaxis" (CHC, page 174).

The patient's residence at CHC continued for three days following the bruised-eye incident, although her mental status and food intake progressively declined. The patient's food intake fell to 25% in the afternoon of April 8th, and two days later on April 10th, she ate only 25% of her breakfast and ate nothing at all for the remainder of that day. On April 10th, the patient's family requested that she be immediately transferred to Kingsbrook because she was not herself, she was not talking to them, and she had a very poor appetite. Dr. Fahimmudin, without re-examining the patient, authorized her "acute" (or urgent) transfer to Kingsbrook on account of her "altered mental status" – "decreased consciousness (sleepy, lethargic)" – which "stayed the same" after it started (CHC, pages 192, 198, and 199; Dr. Fahimmudin's EBT transcript, page 59, lines 5-8).

In the evening of April 10th, the patient was re-hospitalized at Kingsbrook in "serious condition" (Kingsbrook, page 0775). At re-hospitalization, the patient's Glasgow Coma Score was 8 on the scale of 3 to 15, indicating a decreased level of consciousness. A CT scan of the patient's head, performed at 10:38 p.m. on April 10th, was concerning for: (1) "a large left-sided subdural hematoma[, with the] acute and subacute components, . . . measur[ing] approximately 15 mm in its widest dimension"; (2) a "significant mass effect and . . . [an] approximately 13 mm midline shift from left to right";

and (3) a suspected "uncal herniation" (Kingsbrook, pages 0773-0774). With uncal herniation, the rising intracranial pressure forces portions of the brain to move from one intracranial compartment to another.

On April 12th, the patient underwent a left craniotomy with the evacuation of the subdural hematoma. Her post-operative course was complicated by dysphagia, and on April 29th, a PEG tube was placed. On May 3rd, the patient was discharged to nonparty Rutland Nursing Home. Approximately four years later on February 12, 2020, the patient passed away from unrelated causes at the age of 100 years and three months at Rutland Nursing Home.

Standard of Review

A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing either that there was no departure from the applicable standard of care, or that any alleged departure was not a proximate cause of the plaintiff's injuries. *See Cooper v Branca*, ___ AD3d ___, 2025 NY Slip Op 00423, *1 (2d Dept 2025). Specifically, "[a] defendant moving for summary judgment in a medical malpractice case must demonstrate the absence of any material issues of fact with respect to at least one of these elements." *Ciceron v Gulmatico*, 220 AD3d 732, 734 (2d Dept 2023) (internal quotation marks omitted). "[B]are conclusory assertions by defendants that they did not deviate from good and accepted medical practices, with no factual relationship to the alleged injury, do not establish that the cause of action has no merit so as to entitle defendants to summary judgment." *DiLorenzo v Zaso*, 148 AD3d 1111, 1112 (2d Dept

2017) (internal quotation marks omitted). In opposing a motion for summary judgment in a medical malpractice case, a plaintiff needs "only to rebut the moving defendant's prima facie showing." *Stukas v Streiter*, 83 AD3d 18, 23 (2d Dept 2011).

Liability under Public Health Law ("PHL") § 2801-d "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." *Zeides v Hebrew Home for Aged at Riverdale, Inc.*, 300 AD2d 178, 179 (1st Dept 2002) (internal quotation marks omitted), *rearg denied* 306 AD2d 959 (1st Dept 2003), *appeal withdrawn* 1 NY3d 623 (2004). A cause of action for violation of PHL § 2801-d is separate and distinct from – and involves considerations different from – a medical malpractice or a negligence cause of action. *See Sullivan v Our Lady of Consolation Geriatric Care Ctr.*, 60 AD3d 663, 665 (2d Dept 2009).

Discussion

Plaintiff's Primary Causes of Action Against BHH

BHH has failed to establish, prima facie, that it abided by accepted community standards of practice or that its care for the patient was not a proximate cause of her injuries resulting from the fall incident. BHH submitted the expert affirmation of Dr. Roy Goldberg, a board certified doctor in Internal Medicine and Geriatric Medicine. Dr. Goldberg merely recounted the care and treatment rendered, and opined in a conclusory manner that such care and treatment did not represent a departure from good and accepted

medical practice, or a breach of duty to plaintiff, or a violation of PHL § 2801-d. *See Martinez v Orange Regional Med. Ctr.*, 203 AD3d 910, 912 (2d Dept 2022); *Wodzenski v East Long Is. Hosp.*, 170 AD3d 925, 927 (2d Dept 2019); *Barlev v Bethpage Physical Therapy Assoc., P.C.*, 122 AD3d 784 (2d Dept 2014). Dr. Goldberg's bare, conclusory denials of plaintiff's allegations are insufficient to establish that BHH is entitled to summary judgment dismissing her primary causes of action sounding in medical malpractice, negligence, and violation of PHL § 2801-d. *See Cortez v Terrence Cardinal Cooke Health Ctr.*, 199 AD3d 450, 451 (1st Dept 2021).

Dr. Goldberg's opinion (in ¶ 20 of his affirmation) that the fall incident "did not exacerbate any of [her] pre-existing injuries or other maladies, including the subdural hematoma that she [had] suffered from upon admission," flies in the face of common sense and the evidence in the record. Whereas the patient's hematoma immediately before her transfer to BHH from Kingsbrook on March 22nd was stable at only 6 mm long/thick and without a midline shift and without any herniation, her hematoma (as was shown on her second CT scan at Interfaith in the afternoon of March 26th, following her fall earlier that morning) was 13 mm long/thick, with a 6 mm midline shift, and with a subfalcine herniation. *Compare* Kingsbrook, page 0548, *with* Interfaith, pages 016-017.

Because BHH failed to eliminate all triable issues of fact regarding plaintiff's primary causes of action sounding in medical malpractice, negligence, and violation of PHL § 2801-d, the branch of its motion for summary judgment dismissing such causes of

action is denied, without regard to the sufficiency of plaintiff's opposition papers. *See Weber v Sharma*, 232 AD3d 930, 933 (2d Dept 2024).

Plaintiff's Primary Causes of Action Against CHC

In support of its motion, CHC relies on the expert affirmation of a board-certified internist and geriatrician, Dr. Lawrence Diamond, who opines (in ¶ 57 of his affirmation at NYSCEF Doc No. 192) that "there is no merit to plaintiff's claim that the [patient] fell or suffered any type of trauma at [CHC]." In that regard, Dr. Diamond maintains (in ¶ 58 of his affirmation) that the bruised-eye incident happened – in effect, spontaneously – "due to the [patient's] thin capillary walls secondary to her advanced age of 96 and because she was on subcutaneous Lovenox (an anticoagulant) for DVT prophylaxis." In so opining, Dr. Diamond overlooks the fact that, following the bruised-eye incident on April 7th, the patient was continued on Lovenox at CHC through April 10th, instead of being immediately switched to the Venodyne boots, which is a non-pharmacologic modality for DVT prophylaxis. Further, Dr. Diamond downplays the progressive alteration in the patient's mental status over her remaining three-day stay at CHC following the bruised-eye incident.

Dr. Diamond's follow-up opinion (in ¶ 61 of his affirmation) that "the left subdural hematoma found on the repeat CT scan of the [patient's] head at [the inception of her re-hospitalization at] Kingsbrook . . . was not due to a fall or head trauma at [CHC] and was not proximately caused by the care and treatment rendered to the [patient] at [CHC]" is controverted by the radiographic findings of the enlargement of the patient's hematoma following the bruised-eye incident, both in terms of its thickness/length and its midline

shift, coupled with the radiographic suspicion of the uncal herniation (Kingsbrook, pages 0773-0774).

Contrary to Dr. Diamond's contention (in ¶ 62 of his affirmation), it is irrelevant that "the CT scan [films] of the [patient's] head performed at Kingsbrook . . . on 4/10/16 [were] compared with [the] CT scan [films] of the head performed at that facility on 3/13/16[,] and not with the CT scan[] [films] of the head performed at Interfaith . . . and [NYP-]Columbia on 3/26/16 following the [patient's] fall at [BHH]." At the issue-identification stage of litigation, a significant exacerbation of the patient's hematoma, as shown on the April 10th CT scan reports and as compared to the March 26th CT scan reports, is sufficient to raise a triable issue of fact on the subject of causation.

In any event, plaintiff's experts have raised triable issues of fact as to: (1) whether CHC complied with 10 NYCRR § 415.12 (h) ("Quality of Care – Accidents"), which requires that nursing homes ensure that "the resident environment remains as free of accident hazards as is possible; and [that] each resident receives adequate supervision and assistive devices to prevent accidents"; and (2) whether CHC was negligent in failing to hospitalize the patient immediately following her bruised-eye accident, instead of continuing her on Lovenox at its nursing home for three additional days while her mental status was deteriorating corresponding to the increase in the intracranial pressure from the swelling subdural hematoma. *See Napolitano v Wighton*, ___ AD3d ___, 2025 NY Slip Op 00663, *2 (2d Dept 2025); *Donohue v Grossman*, 233 AD3d 1003, ___, 2024 NY Slip Op 06595, *2 (2d Dept 2024).

Plaintiff's Ancillary Causes of Action Against BHH and CHC

Plaintiff's experts do not address her sixth through eighth causes of action sounding in lack of informed consent, negligent hiring/retention, and (as against BHH) wrongful death. *See Clarke v New York City Health & Hosps.*, 210 AD3d 631, 633 (2d Dept 2022); *Carcia v Greif*, 182 AD3d 464, 466 (1st Dept 2020). Therefore, those cause of action are dismissed as abandoned.

Further, plaintiff's request for an award of punitive damages is without merit. "The standard for an award of punitive damages is that a defendant manifest evil or malicious conduct beyond any breach of professional duty." *Dupree v Giugliano*, 20 NY3d 921, 924 (2012), *rearg denied* 20 NY3d 1045 (2013). Defendants' alleged acts and omissions – viewed in a light most favorable to plaintiff – were, at most, negligent, and do not support punitive damages under either PHL § 2801-d or the common-law theories. *See Valensi v Park Ave. Operating Co., LLC*, 169 AD3d 960, 961-962 (2d Dept 2019); *Vissichelli v Glen-Haven Residential Health Care Facility, Inc.*, 136 AD3d 1021, 1023 (2d Dept 2016).

The Court has considered the parties' remaining contentions and found them either academic or without merit in light of its determinations. All relief not expressly granted is denied.

Conclusion

Based on the foregoing, it is

ORDERED that in Seq. No. 7, BHH's motion for summary judgment dismissing all claims as against it is granted to the extent that plaintiff's sixth through eighth causes

of action sounding in lack of informed consent, negligent hiring/retention, and wrongful death, respectively, are dismissed as against BHH, and her demand for punitive damages as against BHH is stricken; and the remainder of BHH's motion is denied; and it is further

ORDERED that in Seq. No. 8, CHC's motion for summary judgment dismissing all claims as against it is granted to the extent that plaintiff's sixth and seventh causes of action sounding in lack of informed consent and negligent hiring/retention, respectively, are dismissed as against CHC, and her demand for punitive damages as against CHC is stricken; and the remainder of CHC's motion is denied; and it is further

ORDERED that plaintiff's counsel is directed to electronically serve a copy of this Decision and Order with notice of entry on defendants' respective counsel and to electronically file an affidavit of service thereof with the Kings County Clerk.

This constitutes the Decision and Order of the Court.

ENTER,

J. S. C.
HON. ELLEN M. SPODEK

KINGS COUNTY CLERK
FILED
2025 APR 14 A 8:45