Arnaud v Isabella Geriatric Ctr.
2026 NY Slip Op 30450(U)
February 5, 2026
Supreme Court, New York County
Docket Number: Index No. 450429/2018
Judge: John J. Kelley
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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: **HON. JOHN J. KELLEY** **PART** **56M**

Justice

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GEOVANNY ARNAUD, as Administrator of the Estate of MARIA ARNAUD, Deceased,

Plaintiff,

- v -

ISABELLA GERIATRIC CENTER,

Defendant.

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INDEX NO. 450429/2018

MOTION DATE 03/04/2025

MOTION SEQ. NO. 002

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 002) 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84

were read on this motion to/for JUDGMENT - SUMMARY.

In this action to recover damages pursuant to Public Health Law § 2801-d for purported violations of statutes and regulations governing nursing homes, for negligent hiring, training, supervision, and retention of healthcare personnel, and for wrongful death, the defendant Isabella Geriatric Center (hereinafter the defendant or Isabella) moves pursuant to CPLR 3212 for summary judgment dismissing the complaint. The plaintiff opposes the motion. The motion is granted, and the complaint is dismissed.

The crux of the plaintiff's claim is that the defendant nursing home violated numerous statutes and regulations governing nursing homes by failing to provide the appropriate oversight of his decedent, thus causing or contributing to her death. He further alleged that it failed properly to vet, train, and supervise its healthcare personnel, and that this failure also caused or contributed to his decedent's death. In his complaint, the plaintiff alleged that the defendant was liable to him pursuant to Public Health Law § 2801-d because it violated 42 USC § 1396r (requiring nursing homes, among other things, to promote maintenance or enhancement of the quality of life of each resident, maintain a quality assessment and assurance committee, and provide services and activities to attain or maintain the highest practicable physical, mental, and

psychosocial well-being of each resident), 42 USC § 1395i-3 (same obligations applicable to "skilled" nursing homes), 42 CFR 483.15 (requiring that nursing homes provide equal access to quality care for each patient), 483.20 (requiring proper resident assessments and articulating standards therefor), 483.20(b)(1) (requiring a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences, 483.25 (requiring that nursing homes maintain patient's quality of care), 483.25(a) (requiring appropriate monitoring and treatment of resident's vision needs), 483.25(c)(2) (requiring proper monitoring and enhancement of resident's range of motion), 483.25(h) (requiring that fluids be administered consistent with professional standards of practice), 483.25(i) (requiring provision of proper respiratory care), 483.30 (requiring provision of adequate physician's services), 483.35 (requiring provision of adequate nursing services), 483.40 (requiring provision of adequate behavioral health services), and 483.75 (requiring establishment, maintenance, and implementation of quality assurance and performance improvement program), Public Health Law § 2803-c (establishing nursing home residents' bill of rights), 10 NYCRR 405.18 (requiring hospitals to make rehabilitation services available to patients), 405.23 (requiring hospitals to provide proper food and nutritional services to patients), 415.3 (resident's bill of rights), more particularly, 415.3(a) (nursing homes must assure that residents enjoy rights to dignified existence, self-determination, respect, full recognition of their individuality), 415.5 (quality of life), 415.11 (requiring resident assessment and care planning), and 415.12 (assuring quality of care), more specifically, 415.12(a), (c), (h), and (i) (respectively addressing quality of resident's activities of daily living, assessment and treatment of bed sores, assuring a facility free from accident hazards, and maintenance of a resident's proper nutrition).[1]

[1] Although the plaintiff also alleged that the defendant violated 10 NYCRR 415.7(b), 415.9, and 415.10, those subsections do not currently exist, and it is unclear to which standards he is referring. It is possible that those subsections were repealed or recodified between 2016, when the plaintiff commenced this action in the Supreme Court, Bronx County, and 2025, when the defendant made the instant motion, but research has not revealed the status or content of those purported subsections.

In his bill of particulars, the plaintiff alleged that the defendant's wrongful conduct occurred from October 14, 2014 until November 27, 2014, and that his decedent died on December 12, 2014. Although he did not expressly assert a medical malpractice cause of action in his complaint, in his bill of particulars he articulated a medical malpractice cause of action by averring that the defendant was "careless, negligent and departed from good and accepted practice" in failing to obtain a full, proper, and informative medical history of his decedent, in failing to completely, accurately, and contemporaneously record information upon its receipt from the decedent, in failing to appreciate the significance of the history that it did obtain, in failing to perform an appropriate physical examination, in failing to appreciate the significance of the examinations that were conducted, in failing timely to order and/or perform radiological and other diagnostic tests and studies, and in failing to appreciate the significance of the studies that were conducted. He further alleged in his bill of particulars that the defendant negligently allowed his decedent to develop pneumonia, that it negligently failed to heed or take note of recognized risk factors for pneumonia formation that his decedent had manifested, and that it negligently failed to diagnose it in a timely fashion. He additionally asserted that the defendant failed adequately to treat that condition, thus causing water to build up in his decedent's left lung, and that it negligently caused an infection to develop in that lung, both of which caused his decedent's death. In this respect, he contended that the defendant failed properly to provide her with appropriate medical attention with respect to fluid retention. In addition, the plaintiff faulted the defendant for failing properly and adequately to evaluate and monitor his decedent' progress. He also alleged that the defendant failed timely to order necessary and indicated consultations with healthcare specialists, and to make timely and proper referrals. The plaintiff also alleged that the defendant failed to obtain his decedent's fully informed consent, but he did not identify the procedures for which such consent was required.[2]

[2] "A failure to diagnose cannot be the basis of a cause of action for lack of informed consent unless associated with a diagnostic procedure that 'involve[s] invasion or disruption of the integrity of the body'"

In his bill of particulars, the plaintiff also reiterated the various statutes and regulations that he had identified in his complaint as those that the defendant had violated. In addition, he contended that the defendant evinced a reckless disregard for the health, safety, and wellbeing of his decedent.

It is well settled that the movant on a summary judgment motion "must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see* CPLR 3212). The facts must be viewed in the light most favorable to the non-moving party (*see Flanders v Goodfellow,* 44 NY3d 57, 62-63 [2025]; *Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, "[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility" (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]; *see Haymon v Pettit*, 9 NY3d 324, 327 n [2007]). Once the movant meets that burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (*see Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*see id.; Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

"The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the

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(*Janeczko v Russell*, 46 AD3d 324, 325 [1st Dept 2007], quoting Public Health Law § 2805-d[2][b]; *see Lewis v Rutkovsky*, 153 AD3d 450, 456 [1st Dept 2017]), and that invasion or disruption is claimed to have caused the injury. Since the allegations here involve a failure to diagnose pneumonia and a failure properly to treat it, while the plaintiff made no claim that an invasion of his decedent's bodily integrity caused injury, this claim must be summarily dismissed.

issue is even 'arguable'" (*De Paris v Women's Natl. Republican Club, Inc.,* 148 AD3d 401, 403-404 [1st Dept 2017]; *see Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet the burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case, but must affirmatively demonstrate the merit of his or her defense (*see Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

"To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff's injury" (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; *see Foster-Sturrup v Long,* 95 AD3d 726, 727 [1st Dept 2012]; *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). Moreover, where a physician fails properly to diagnose a patient's condition, thus providing less than optimal treatment or delaying appropriate treatment, and the insufficiency of or delay in treatment proximately causes injury, he or she will be deemed to have departed from good and accepted medical practice (*see Perez v Fitzgerald,* 115 AD3d 177, 178 [1st Dept 2014]; *Perlin v King*, 36 AD3d 495, 495 [1st Dept 2007]; *see generally Zabary v North Shore Hosp. in Plainview,* 190 AD3d 790, 795 [2d Dept 2021]; *Lewis v Rutkovsky*, 153 AD3d 450, 451 [1st Dept 2017]; *Monzon v Chiaramonte*, 140 AD3d 1126, 1128 [2d Dept 2016] ["(c)ases . . . which allege medical malpractice for failure to diagnose a condition . . . pertain to the level or standard of care expected of a physician in the community"]; *O'Sullivan v Presbyterian Hosp. at Columbia Presbyterian Med. Ctr.*, 217 AD2d 98, 101 [1st Dept 1995]). Such a cause of action may be premised upon a claim that those departures allowed a patient's condition to worsen, and thus deprived him or her of an opportunity for a cure or a better outcome (*see Mortensen v Memorial*

Hosp., 105 AD2d 151, 156, 159 [1st Dept 1984]; *Kallenberg v Beth Israel Hosp.*, 45 AD2d 177, 178 [1st Dept 1974], *affd no op.* 37 NY2d 719 [1975]).

To make a prima facie showing of entitlement to judgment as a matter of law, a defendant physician moving for summary judgment must establish the absence of a triable issue of fact as to his or her alleged departure from accepted standards of medical practice (*Alvarez v Prospect Hosp*., 68 NY2d 320, 324 [1986]; *Barry v Lee*, 180 AD3d 103, 107 [1st Dept 2019]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24) or establish that the plaintiff was not injured by such treatment (*see Pullman v Silverman,* 28 NY3d 1060, 1063 [2016]; *see generally Kristie M. v. Mercy Hosp. of Buffalo,* 240 AD3d 1228 [4th Dept 2025]; *Stukas v Streiter*, 83 AD3d 18 [2d Dept 2011]). To satisfy this burden, a defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific, and factual in nature (*see Roques v Noble*, 73 AD3d at 206; *Joyner-Pack v Sykes*, 54 AD3d 727, 729 [2d Dept 2008]; *Jones v Ricciardelli*, 40 AD3d 935, 935 [2d Dept 2007]). If the expert's opinion is not based on facts in the record, the facts must be personally known to the expert and, in any event, the opinion of a defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care" (*Ocasio-Gary v Lawrence Hospital,* 69 AD3d 403, 404 [1st Dept 2010]). Stated another way, the defendant's expert's opinion must "explain 'what defendant did and why'" (*id*., quoting *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Moreover, as noted, to satisfy the burden on a summary judgment motion, a defendant must address and rebut specific allegations of malpractice set forth in the plaintiff's bill of particulars (*see Wall v Flushing Hosp. Med. Ctr*., 78 AD3d 1043, 1045 [2d Dept 2010]; *Grant v Hudson Val. Hosp. Ctr.*, 55 AD3d 874, 874 [2d Dept 2008]; *Terranova v Finklea*, 45 AD3d 572, 572 [2d Dept 2007]).

Once satisfied by the defendant, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit or affirmation attesting to a departure from accepted medical practice and/or opining that the defendant's acts or omissions

were a competent producing cause of the plaintiff's injuries (*see Roques v Noble*, 73 AD3d at 207; *Luu v Paskowski*, 57 AD3d 856, 857 [2d Dept 2008]; *see also Kristal R. v Nichter,* 115 AD3d 409, 411-412 [1st Dept 2014]; *Bacani v Rosenberg*, 74 AD3d 500, 501-502 [1st Dept 2010]). Thus, to defeat a defendant's prima facie showing of entitlement to judgment as a matter of law, a plaintiff must produce expert testimony regarding specific acts of malpractice, and not just testimony that contains "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice" (*Alvarez v Prospect Hosp.,* 68 NY2d at 325; *see also Pancila v Romanzi,* 140 AD3d 516, 516 [1st Dept 2016]; *Callistro ex rel. Rivera v Bebbington*, 94 AD3d 408, 410 [1st Dept 2012], *affd sub nom. Callistro v Bebbington*, 20 NY3d 945 [2012]; *Frye v Montefiore Med. Ctr.*, 70 AD3d at 24). In most instances, a supported opinion of a qualified expert that the plaintiff's injuries resulted from a deviation from relevant industry or medical standards is sufficient to preclude an award of summary judgment in a defendant's favor (*see Murphy v Conner*, 84 NY2d 969, 972 [1994]; *Frye v Montefiore Med. Ctr*., 70 AD3d at 24).

Public Health Law § 2801-d(1) provides, in relevant part, that "[a]ny residential health care facility that deprives any patient of said facility of any right or benefit, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation." That subsection defines "right or benefit" as a

> "right or benefit created or established for the well-being of the patient by the terms of any contract, by any *state statute*, code, rule or regulation or by any applicable *federal* statute, *code, rule or regulation*, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority"

(*id*. [emphasis added]). Where a plaintiff alleges a deprivation of such right or benefit, the subsection further makes the nursing home's compliance with the relevant contract, statute, code, rule, or regulation an affirmative defense, so that the burden of proof is on the nursing home to prove compliance. The statute goes on to provide that

> "unless there is a finding that the facility exercised all care reasonably necessary

> to prevent and limit the deprivation and injury to the patient, compensatory damages shall be assessed in an amount sufficient to compensate such patient for such injury, but in no event less than twenty-five percent of the daily per-patient rate of payment established for the residential health care facility under section twenty-eight hundred seven of this article or, in the case of a residential health care facility not having such an established rate, the average daily total charges per patient for said facility, for each day that such injury exists."

(Public Health Law § 2801-d[2]). The statute also permits a patient's legal representative to prosecute such an action to recover damages (*see* Public Health Law § 2801-d[4-a]). Stated another way, to establish the right to recover pursuant to the cause of action created by Public Health Law § 2801-d, a patient must allege and prove that a nursing home deprived him or her of a right or benefit established for his or her well-being, as set forth in the terms of any contract or in any state or federal statute, code, rule or regulation (*see Cortez v Terrence Cardinal Cooke Health Ctr.,* 199 AD3d 450, 451 [1st Dept 2021]).

Social Security Act § 1919 (42 USC § 1396r) and § 1819 (42 USC § 1395i-3), which articulate federal statutory requirements governing the conduct and management of nursing homes receiving federal aid, are implemented in accordance with regulations codified at 42 CFR 488.402 and 42 CFR Part 483. Public Health Law § 2803-c is a state statute that defines numerous rights of nursing home patients, and articulates general duties and standards of care applicable to nursing home operators. As relevant here, it includes the "the right to receive adequate and appropriate medical care" (Public Health Law § 2803-c[3][e]). The New York State Department of Health has promulgated several regulations governing the provision of care in nursing homes, including 10 NYCRR part 415.

Social Security Act § 1919 (42 USC § 1396r) provides, among other things, that

> "[a] nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.
>
> "[a] nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate

> plans of action to correct identified quality deficiencies"

(42 USC § 1396r[b][1][A], [B]). It further requires a nursing facility to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care" (42 USC § 1396r[b][2]), and provides that a nursing facility

> "must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity; (ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A); (iii) uses an instrument which is specified by the State under subsection (e)(5); and (iv) includes the identification of medical problems"

(42 USC § 1396r[b][3][A]). The statute sets forth the administrative requirements for such an assessment and the necessary frequency of such an assessment (*see* 42 USC § 1396r[b][3][B], [C]), and further provides, as relevant here, that

> "a nursing facility must provide (or arrange for the provision of)—(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; (ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; (iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; (iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident; (v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident"

(42 USC § 1396r[b][4][A]), also requiring that "[t]he services provided or arranged by the facility must meet professional standards of quality" (*id.*), which must be provided by "qualified persons in accordance with each resident's written plan of care" (42 USC § 1396r[b][4][B]). Social Security Act § 1819 (42 USC § 1395i-3) sets forth virtually identical requirements applicable to "skilled nursing facilities," which are defined as institutions, or a distinct part of such institutions, that are primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured,

disabled, or sick persons, and are not primarily for the care and treatment of mental diseases (*see* 42 USC § 1395i-3[a][1][A], [B]).

42 CFR Part 483 is a set of federal regulations, promulgated pursuant to the Social Security Act, that governs nursing home operations. As relevant here, those regulations require a nursing home to "[c]are for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life" (42 CFR 483.15), and are more particularly articulated in 42 CFR 483.20 (requiring proper resident assessments and articulating standards therefor), 483.20(b)(1) (requiring a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences), 483.25 (requiring that nursing homes maintain patient's quality of care), 483.25(a) (requiring appropriate monitoring and treatment of resident's vision needs), 483.25(c)(2) (requiring proper monitoring and enhancement of resident's range of motion), 483.25(h) (requiring that fluids be administered consistent with professional standards of practice), 483.25(i) (requiring provision of proper respiratory care), 483.30 (requiring provision of adequate physician's services), 483.35 (requiring provision of adequate nursing services, including adequate staffing), 483.40 (requiring provision of adequate behavioral health services), and 483.75 (requiring establishment, maintenance, and implementation of quality assurance and performance improvement program).

Where a demand for relief is predicated on Public Health Law § 2803-c, and it is alleged that a nursing home violated a section within 10 NYCRR part 415, "it states a cognizable cause of action under" Public Health Law § 2801-d (*Zeides v Hebrew Home for the Aged at Riverdale, Inc*., 300 AD2d 178, 179 [1st Dept 2002]; *see Broderick v Amber Ct. Assisted Living,* 200 AD3d 840, 841 [2d Dept 2021] ["Public Health Law article 28 authorizes a private right of action by patients of 'residential health care facilities' for the deprivation of rights conferred by statute, regulation and contract, including those enumerated by Public Health Law § 2803-c"]; *Ward v Eastchester Health Care Ctr., LLC,* 34 AD3d 247, 248 [1st Dept 2006] [Public Health Law § 2801-d "authorizes a private right of action for the violation of rights enumerated in section

2803-c of the statute"]; *Goldberg v Plaza Nursing Home Co.,* 222 AD2d 1082, 1084 [4th Dept 1995], *overruled in part on other grounds*, *Kash v Jewish Home & Infirmary of Rochester, N.Y., Inc.*, 61 AD3d 146 [4th Dept 2009] [statute affords remedy to patients denied rights enumerated in Public Health Law § 2803-c(3)]; *see also Begandy v Richardson*, 134 Misc 2d 357, 361-362 [Sup Ct, Monroe County 1987]).

Moreover, a cause of action alleging inadequate staffing may be maintained in the context of a statutory cause of action asserted against a nursing home pursuant to Public Health Law § 2801-d (*see Jenack v Goshen Operations, LLC*, 222 AD3d 36, 37-38, 47 [2d Dept 2023]; 42 CFR 483.35; 10 NYCRR 415.26[c]).

As noted above, 10 NYCRR 405.18 requires hospitals to make rehabilitation services available to patients, 10 NYCRR 405.23 requires hospitals to provide proper food and nutritional services to patients, 10 NYCRR 415.3 sets forth a nursing home resident's bill of rights, and, more particularly, 10 NYCRR 415.3(a) provides that nursing homes must assure that residents enjoy rights to dignified existence, self-determination, respect, full recognition of their individuality. In addition, 10 NYCRR 415.5 requires nursing homes to provide for optimal quality of life for residents, 10 NYCRR 415.11 requires resident assessment and care planning, and 10 NYCRR 415.12 requires nursing home to assure a certain level of quality of care. As the plaintiff asserted, the defendant more specifically violated 10 NYCRR 415.12(a), (c), (h), and (i), which respectively address standards for assuring that a nursing home assure the quality of a resident's activities of daily living, the assessment and treatment of bed sores, the maintenance of a facility free from accident hazards, and the maintenance of proper nutrition standards.

To establish a cause of action to recover for negligent hiring, supervision, training, and retention of health-care personnel, a plaintiff must demonstrate that the defendants either "knew, or should have known," of their employees' "propensity for the sort of conduct which caused the [patient's] injury" (*Sheila C. v Povich*, 11 AD3d 120, 129-130 [1st Dept 2004]; *see Kuhfeldt v New York Presbyt./Weill Cornell Med. Ctr.*, 205 AD3d 480, 481-482 [1st Dept 2022]).

The plaintiff's claim alleging negligent hiring, training, supervision, and retention of healthcare employees, as set forth in his complaint and bill of particulars, sounds in common-law negligence (*see Calamari v Panos*, 131 AD3d 1088, 1090 [2d Dept 2015] [negligent hiring cause of action against private medical practice sounds in general common-law negligence, and is subject to three-year limitations period]). In other words, allegations of negligent hiring, training, supervision, and retention constitute a cause of action independent of a medical malpractice cause of action (*see Burgos v Lau*, 2025 NY Slip Op 33250[U], *2 n 2, 2025 NY Misc LEXIS 7290, *2 n 2 [Sup Ct, N.Y. County, Aug. 28, 2025] [Kelley, J.]; *Estate of Gebert v Huntington Hills Ctr. for Health*, 2024 NY Misc LEXIS 51911, *16 [Sup Ct, Suffolk County, Sep. 5, 2024]; *see also Taylor v Methodist Hosp*., 6 Misc 3d 1008[A], 2004 NY Slip Op 51750[U], *4, 2004 NY Misc LEXIS 2898, *9 [Sup Ct, Kings County, Nov. 1, 2004] [deeming allegation of "negligent credentialing" to constitute an independent cause of action]).

In support of its motion, the defendant submitted the pleadings, the plaintiff's bill of particulars, relevant medical, hospital, and nursing home records, transcripts of the parties' deposition testimony, a prior court order, the note of issue, correspondence, an attorney's affirmation, and the expert affirmation of board-certified pulmonologist, internist, and critical care and sleep medicine specialist Steve H. Salzman, M.D., who opined that the defendant did not depart from good and accepted practice, did not violate any applicable statute or regulation, did not negligently hire, train, supervise healthcare personnel, and did not inadequately staff its facility. He also concluded that nothing that the defendant did or did not do caused or contributed to the onset of pneumonia in the decedent, or cause her death.

Dr. Salzman first explained that, contrary to some of the allegations set forth in the complaint, the decedent's dates of admission to the defendant's facility were from October 14, 2014 until November 27, 2014. He asserted that, at the time of her admission to the defendant's facility, the decedent was an "end-stage patient" whose body was no longer able to maintain a fluid balance due to a combination of heart failure, atrial fibrillation, cirrhosis, kidney

problems, asthma, and morbid obesity, all of which he explained tend to cause fluid retention. Dr. Salzman stated that, based on his review of the decedent's records, she had a history of hypercapnia, sometimes referred to as hypercapnic respiratory failure, which he explained is characterized by elevated levels of carbon dioxide in her blood and body. According to Dr. Salzman, she also had a history of pulmonary edema, that is, accumulation of fluid in the lung tissues, pleural effusion, that is, accumulation of fluid between the two layers of the pleural membranes that surround the lung, and exacerbation of heart failure, resulting in respiratory failure, which he concluded both predated and postdated her admission to Isabella. He explained that the medical management of these fluid overload conditions required the administration of diuretic medications to remove the excess fluid, but that, when the failure of key organs is present, as it was in the decedent's case in connection with her heart, liver, and kidney, the optimization of the fluid balance becomes increasingly difficult, and is not always possible. In this respect, he opined that the administration of otherwise appropriate diuretic medications, which may remove fluid and, thus, improve the function of certain organs, can compromise other organs. With respect to the decedent's history, Dr. Salzman opined that her history of taking diuretic medications caused cardiac compromise that resulted in hypotension, which he concluded can occur even when appropriate care is provided.

In describing the decedent's medical history prior to her admission to Isabella, Dr. Salzman explained that, from January 17, 2013 to February 8, 2013, the decedent was assessed at Montefiore Medical Center (MMC) for wheezing and low oxygen saturation, which was measured at 83%. He noted that preliminary diagnostic studies included a chest x-ray, which he characterized as significant for congestive heart failure, with moderate bilateral pleural effusions. During this admission to MMC, the decedent was placed on a ventilator to treat hypercapnic respiratory failure, and that she developed "onset atrial fibrillation" in response to which she was administered the intravenous blood thinner heparin and the diuretic Lasix. In addition, Dr Salzman noted that, at that time, the decedent was treated at MMC for suspected

hepatic encephalopathy, which he explained was suggestive of an underlying diagnosis of cirrhosis, due to hepatitis C with liver failure. He further noted that an MMC pulmonologist wrote in her chart that her hypoxia likely was caused by several factors. According to Dr. Salzman, the decedent then underwent aggressive diuresis that improved her pleural effusions.

The decedent's relevant chart reflected that, on February 8, 2013, she was discharged from MMC to The New Jewish Home (NJH), with a principal diagnosis of respiratory failure, and additional diagnoses of atrial fibrillation, hypertension, chronic renal failure, type-2 diabetes, pleural effusion, hepatitis C cirrhosis, chronic kidney disease, and schizophrenia, and that, during her entire February 8, 2013 to February 26, 2013 admission, she remained on diuresis to treat pleural effusion. In addition, NJH staff administered the synthetic sugar lactulose to control her hepatitis C cirrhosis, as well as supplemental oxygen, as needed, to aid in respiration. The decedent was discharged from NJH to her home on February 26, 2013, with a referral for in-home nursing and physical therapy. In April 2014, she was hospitalized at MMC for decompensated congestive heart failure, while, from September 28, 2014 to October 14, 2014, she was again hospitalized at MMC, following an unwitnessed fall at home, and presented to MMC personnel with altered behavior and bloody stool, with the source of the bleed purportedly undetermined. According to Dr. Salzman's interpretation of the MMC chart, the decedent's mental status improved after being placed on a hepatic encephalopathy regimen that employed the administration of lactulose. Nonetheless, Dr. Salzman concluded that her admission to MMC was complicated by bilateral pleural effusions due to fluid overload, atrial fibrillation with rapid ventricle response, and episodes of hypotension that required clinicians to "hold" diuretics. He explained that this latter problem demonstrated the difficulty of balancing enough diuretics to remove fluid from the decedent's pleura and lung to mitigate the effects of her shortness of breath, hypoxemia, and respiratory failure, while still avoiding a compromise of heart function that could lead to hypotension. As he described it, when the administration of diuretics was held back, the decedent's pleural effusion worsened, which he claimed was a reflection of the "see-

saw balance of trying to optimize her physiology with medications when her bodies homeostatic processes have failed." Ultimately, Dr. Salzman noted that her respiratory status improved after diuresis, which had resumed once the decedent was no longer hypotensive. He explicitly explained that this process occurred at MMC in the absence of infection.

On October 14, 2014, the decedent was transferred from MMC to Isabella for subacute rehabilitation, with a discharge instruction directing Isabella, as the post-discharge provider, to assess her breathing volume and respiratory status, and to adjust the dosage of diuretics as needed. As Dr. Salzman explained it, the decedent was 77 years old when she was admitted to Isabella on October 14, 2014, she had not ambulated in over a year, and her medical history and diagnoses included hepatitis C cirrhosis, acute hepatic encephalopathy, gastrointestinal bleed, atrial fibrillation, hypertension, congestive heart failure, diabetes, obesity, asthma, chronic kidney disease, iron deficiency anemia, and schizophrenia. Her chart reflected that she nonetheless was alert and oriented, her vital signs were normal, she was afebrile, no healthcare personnel reported the presence of any acute discomfort, and the decedent was able to make her needs known in Spanish. In connection with the initial care rendered to decedent by the defendant, Dr. Salzman asserted that its healthcare personnel took a chest x-ray of the decedent, and that the resultant radiology report indicated the possible presence of a bilateral *basal* pneumonia with air bronchogram on the right, and a possible left-sided pleural effusion. He concluded, however, that the cause of the decedent's pleural effusion was her congestive heart failure, atrial fibrillation, and cirrhosis, not pneumonia or infection. In this regard, he opined that heart and liver failure causes retention of fluid in the body, which engorges blood vessels and increases the pressure within capillaries, exceeding their capacity to hold the fluid, which, in turn, causes leakage of fluid into tissues, such as pulmonary edema and pleural effusion. In any event, Dr. Salzman explained that, after the x-ray films were interpreted, Isabella's staff notified Licensed Practical Nurse Phadia Jean, and he asserted that portable chest x-ray films, such as those taken of the decedent upon her admission to Isabella, are

difficult to interpret, thus rendering nonspecific certain findings that are seemingly abnormal, especially in the lung base, which he asserted could also be attributed to poor respiration at the moment the image was obtained. He nonetheless concluded that the decedent did not then have an infection or pneumonia. Rather, he asserted that the x-ray film depicted a buildup of noninfectious fluid that was present because of the decedent's congestive heart failure, atrial fibrillation, and cirrhosis.

The decedent's chart at Isabella reported that, on October 15, 2015, internist Michael E. Rosen, M.D., examined her, and "appreciated" her medical history, including the recent congestive heart failure exacerbation that had been treated with diuresis. Dr. Rosen reported that her lungs were clear to auscultation, but that she had poor air entry bilaterally, although she manifested no chest pain, shortness of breath, or edema, and was afebrile. Dr. Rosen ordered physical and occupational therapy to address her weakness, continued the administration of the diuretic Lasix and the beta blocker metoprolol, and ordered the bronchodilator albuterol, as well as laboratory blood and urine testing. The results of that testing indicated that the decedent's ammonia level, white blood cell (WBC) count, and lymphocyte levels were within normal range. Dr. Salzman adverted to Dr. Rosen's deposition testimony, in which the latter averred that, given the decedent's overall clinical situation, including lack of fever and normal WBC count, the decedent was not suffering from pneumonia on admission, but instead required continued therapy to treat her heart failure, asthma, and cirrhosis.

According to Dr. Salzman's interpretation of the decedent's chart, Dr. Rosen conducted a follow-up examination on October 16, 2014, and that, upon examination, Dr. Rosen concluded that the decedent's lungs remained clear to auscultation, but that she was wheezing bilaterally. Dr. Rosen reported that there was no sign of edema, that the decedent was euvolemic and afebrile, and that her pulse, respiratory rate, and blood pressure were normal. The chart further reflected that Isabella staff administered albuterol via a nebulizer and supplemental oxygen via nasal cannula, as needed. Dr. Salzman asserted that the decedent was monitored, and

remained stable, alert, oriented, and able to make her needs known at that juncture. The October 20, 2014 chart entries indicated that, as of that date, the decedent's ammonia level and WBC count were within normal range, and that the decedent remained stable, alert, oriented, and able to make her needs known. According to Dr. Salzman, her oxygen level was consistently above 92% on room air, while she requested supplemental oxygen as needed. After Dr. Rosen's October 23, 2014 follow-up visit with the decedent, Dr. Rosen reported that the decedent denied experiencing chest pain, shortness of breath, nausea, vomiting, diarrhea, fever, or urinary changes, that her lungs were clear, that no wheezing was heard, that she evinced no edema, and that her vital signs were normal.

On October 24, 2014, gastroenterologist William Winkler, M.D., consulted with Isabella's healthcare team, and recommended restarting the administration of lactulose on a daily basis, but to discontinue the medication if the decedent developed diarrhea. As Dr. Salzman explained it, lactulose is used in cirrhotic patients to prevent bouts of confusion due to hepatic encephalopathy, but that it frequently causes diarrhea, at which point the dose needs to be reduced. According to the decedent's chart, blood and urine samples were collected on October 27, 2014, which, according to Dr. Salzman, reflected that, although the decedent's ammonia level was high at 82 micromoles per deciliter (µmol/dL) of blood, with the reference range being 11 to 51 µmol/dL, her white blood cell count was normal at 4,050 cells per microliter (µL) of blood, and that this result suggested the absence of infection. Dr. Rosen examined the decedent on October 28, 2014 to assess the cause of her hyperammonemia, but found no observable evidence of hepatic encephalopathy. At that point, the administration of lactulose was restarted, the recommendations of the consultants were "appreciated," and Dr. Rosen planned to continue monitoring the decedent's ammonia level. According to the Isabella chart, at Dr. Rosen's October 30, 2014 follow-up visit, the decedent manifested no change in mental status, and denied chest pain, shortness of breath, nausea, vomiting, diarrhea, fever, and

urinary changes, while her vital signs were normal, her lungs were clear to auscultation with no rales, rhonchi, or wheezes, and there was no edema present in her lower extremities.

As Dr. Salzman explained it, a urine and fluid elimination diary was used throughout the month of November 2014 to assist Isabella's staff in monitoring of the decedent's "fluid status." Staff collected blood samples on November 4, 2014, and testing indicated that the decedent's ammonia level was decreasing, from 82 µmol/L to 57 µmol/L, while her WBC count remained normal, she made no complaints of pain, and she remained "alert, verbal, and oriented in all spheres." Dr. Salzman asserted, however, that, on November 5, 2014, the decedent developed wheezing and shortness of breath, and reported loose bowel movements, upon which nurse practitioner Sylvia Simmons examined the decedent that day, reporting that the decedent was then alert, oriented, and cooperative, was afebrile, manifested normal heart rate and blood pressure, and had a measured oxygen saturation level of 88% to 91% on room air. The decedent denied dizziness, chest pain, nausea, or vomiting. Simmons's assessment was that the decedent had slight abdominal breathing, bilateral wheezing, and cough, and thus ordered that albuterol be administered to the decedent every six hours for three days, along with two liters of oxygen via nasal cannula to maintain oxygen saturation levels over 90%. Simmons also ordered a chest x-ray to rule out pleural effusion and congestive heart failure, which, according to Dr. Salzman, can cause wheezing, and directed that Lasix be continued. The chart indicated that Isabella's staff had been instructed to elevate the decedent's lower extremities while she was out of bed. Dr. Salzman stated that, since the decedent was afebrile and her sputum was white, Simmons determined that no antibiotics were warranted, "as pneumonia or respiratory infection were unlikely and loose bowel movements were most likely due to lactulose."

Simmons also directed that the decedent's ammonia level be retested on the morning of November 6, 2014, and, if it continued to trend downward, healthcare personnel, including Dr. Rosen, should consider reducing the dosage or frequency of administration of lactulose. According to Dr. Salzman, by that time, the decedent's oxygen saturation level improved to

94%, she was sleeping comfortably, and there was no sign of distress. He also noted that the laboratory test results from November 6, 2014 reflected that the decedent's ammonia level was normal, that Dr. Rosen reportedly agreed with Simmons that the decedent's loose bowel movements were caused by lactulose, that he "confirmed" that her shortness of breath and wheezing had resolved, while her lungs were clear to auscultation with no rales, rhonchi, or wheezes, and that the decedent remained afebrile, with no edema to her lower extremities. The chart reflected that the administration of Lasix was continued to prevent exacerbation of the decedent's congestive heart failure, while albuterol nebulizer treatments were continued to treat the decedent's asthma. According to Dr. Salzman, when the decedent made attempts to remove the nasal cannula, staff encouraged her to keep it in place but, that, in any event, the decedent was stable, her lungs remained clear, her ammonia levels decreased, and there was no sign of edema. Moreover, after going for an outpatient gastrointestinal appointment on November 7, 2014, the decedent returned to Isabella in stable condition.

According to Dr. Salzman, the decedent manifested no changes in her status until November 11, 2014, when nursing staff alerted Dr. Rosen of signs of shortness of breath and wheezing, and that the decedent's oxygen saturation levels were between 88% and 91%. Dr. Rosen evaluated her that day, confirmed the presence bilateral wheezing, but no rales, and determined that the decedent was edematous (+2), while her pulse and blood pressure were normal, she was afebrile, and her WBC count from samples collected on November 10, 2014 was normal. As Dr. Salzman explained it, Dr. Rosen's differential diagnosis for shortness of breath was congestive heart failure versus asthma exacerbation, and he thus ordered an immediate x-ray, albuterol treatment, fluid restriction, a prednisone taper, monitoring of vital signs, and the administration of an intramuscular 40-milligram dose of Lasix. He further explained that these therapies addressed both asthma and congestive heart failure. Dr. Salzman additionally asserted that the November 11, 2014 chest x-ray depicted moderate-size left pleural effusion, which he characterized as an increase in size from a May 14, 2014 study.

He nonetheless concluded that, since there was no indication of focal infiltrate, and pulmonary vasculature was normal, the x-ray did not suggest the presence of any infection, including pneumonia. After the test results were reported to Dr. Rosen, he directed the administration of albuterol and ipratropium nebulizer treatments, which thereafter reportedly afforded some relief to the decedent. Later that morning, however, the decedent resumed wheezing, and her body temperature was measured at 99.2 degrees Fahrenheit. After Dr. Rosen was informed thereof, he ordered the administration of 1 gram per day of the broad-spectrum antibiotic ceftriaxone for one week, while nursing staff thereafter administered Lasix and ceftriaxone, for pleural effusion, and reported that albuterol nebulizer treatments "continued with good effect." In this respect, Dr. Salzman noted that, by the afternoon of November 11, 2014, the decedent's oxygen saturation level improved to 95%, and she presented with no signs of acute respiratory decompensation. Dr. Salzman explained that ceftriaxone is not only prescribed to treat bacterial infection, but is also employed to prevent the exacerbation of obstructive lung diseases such as asthma. He further asserted that, as Isabella staff did in the decedent's case, the drug is used along with inhaled bronchodilators and prednisone or other steroid medication.

According to Dr. Salzman, Isabella's nursing staff and Simmons continued to monitor the decedent's vital signs, urine elimination, mental status, and respiratory status, and continued to follow Dr. Rosen's orders with regard to respiratory treatments and the administration of medications, including Lasix and ceftriaxone. He asserted that, by this time, the administration of the cortical steroid prednisone was tapered, and that the decedent evinced no sign of distress, with her blood pressure, temperature, and heart rate measured as normal. Dr. Salzman stated that, on November 13, 2014, Dr. Rosen reevaluated the decedent to assess her response to the various medications and treatments, reporting that her loose bowel movements had resolved and that her breathing had improved, and, that although she reported an occasional cough and desire to return home, she denied the presence of chest pain, shortness of breath, nausea, vomiting, fever, or urinary changes. According to Dr. Salzman, the decedent

was afebrile, while her pulse, blood pressure and respiratory rate were normal, she had no edema, and her lungs were clear to auscultation, with no rales, rhonchi, or wheezes. Dr. Rosen's differential diagnosis for shortness of breath remained congestive heart failure and asthma, and he thus continued the administration of Lasix, ceftriaxone, and albuterol treatments, as well as the directives for fluid restriction and prednisone taper. His plan of treatment was to repeat the chest x-ray and monitor the decedent's vital signs. The repeat chest x-ray, which was taken on November 13, 2014, and compared to the November 11, 2014 x-ray, revealed that the decedent's left-sided effusion was slightly larger. Dr. Salzman opined that, since the decedent was still taking ceftriaxone, and the effusion had grown, the condition was not caused by an infection. Dr. Rosen reported his impression as bilateral pleural effusions, moderate to large on the left and small on the right, with adjacent atelectasis. Dr. Salzman asserted that no signs of pneumonia were suggested by the radiologist and that the decedent's clinical status also did not suggest pneumonia.

On November 14, 2014, Dr. Rosen reevaluated the decedent, and reported that she denied shortness of breath, with only a minor cough. Dr. Rosen reported that she was afebrile at the time, her heart rate was normal, her lungs were clear to auscultation with no rales, rhonchi, or wheezes, and she had edema (+2) to her bilateral lower extremities, with chronic skin changes. Dr. Rosen's diagnosis remained congestive heart failure exacerbation, and he increased the frequency of Lasix to intramuscular administration for two days, although he continued the administration of ceftriaxone, oxygen, and albuterol, and continued to taper the decedent off of prednisone, to restrict her fluid intake to 1 liter per day, and to monitor her vital signs. On November 15, 2014, however, the decedent developed low blood pressure, upon which internist Mitra Rezvani, M.D., examined her. According to the chart, the decedent reported feeling that her blood pressure was low and that she was experiencing shortness of breath. The decedent reportedly ate breakfast, was not dizzy, and denied fever, nausea, or vomiting, although edema was still present in her lower extremities. The chart reported that the

decedent's lungs were clear with no wheezing heard on examination. Dr. Rezvani diagnosed the decedent with fluid overload and hypotension, and ordered a temporary discontinuation of Lasix and metoprolol to address the decedent's hypotension, as well as a temporary discontinuation of anti-hypertensive drugs Norvasc and benazepril that the decedent also had been taking. Isabella's staff was instructed to monitor the decedent's blood pressure, and to transfer her to a hospital emergency department it dropped further, while Dr. Rezvani scheduled an echocardiogram for November 17, 2014. According to Dr. Salzman, the decedent's blood pressure improved over the course of November 15, 2014, while test results from samples collected November 17, 2014 reflected normal ammonia level and WBC count, which he concluded reflected "good compensation of her cirrhosis and no infection likely." After examining the decedent on November 17, 2014, Dr. Rosen determined that the decedent's hypotension was caused by a combination of her medication and the administration of intramuscular Lasix. He thus discontinued the administration of the antihypertensive amlodipine/benazepril, after which he reported that the exacerbation of the decedent's congestive heart failure had slowed, although restrictions on the decedent's fluid intake remained in place and oral administration of Lasix by mouth was continued.

According to Dr. Salzman's interpretation of the decedent's chart, on November 20, 2014, Dr. Rosen performed a follow-up examination, and reported that the decedent was "much improved from recent congestive heart failure exacerbation and possible coexistent COPD exacerbation." During that examination, the decedent reported a minimal cough and reportedly denied the presence of chest pain, shortness of breath, nausea, vomiting, fever, or urinary changes, while she was afebrile, her blood pressure and pulse were normal, her lungs were clear to auscultation with no rales, rhonchi, or wheezes, and her edema had improved. Dr. Rosen thus continued her on Lasix, beta blockers, and fluid restrictions

Results from the testing of blood samples that had been collected on November 24, 2014 reportedly reflected that the decedent's ammonia level and WBC count were normal. On

November 25, 2014, Dr. Rosen reevaluated the decedent after she had experienced a decrease in oxygen saturation while she was participating in therapy, although the decedent allegedly reported to Dr. Rosen that her breathing had improved, and denied chest pain and cough. According to the chart, the decedent was afebrile, and her pulse rate and respirations were normal, although that examination was "significant" for edema to her lower extremities (+2) and her lungs had decreased breath sounds at the bases. On that date, Dr. Rosen diagnosed the decedent with hypoxia, likely secondary to congestive heart failure, and ordered a repeat chest x-ray, along with the continuation of oxygen, fluid restrictions, and Lasix. The x-ray that was performed on November 25, 2014 purportedly showed no change in the left pleural effusion from the November 13, 2014 study, and reflected the decedent's right lung was clear. As the chart reported it, the decedent was alert and afebrile, with no acute respiratory distress, her blood pressure was normal, and her oxygen saturation was 95% using a nasal cannula. Isabella scheduled the decedent to undergo an echocardiogram on November 28, 2014.

Dr. Salzman asserted that, on November 26, 2014, Isabella's nursing staff continued to monitor the decedent and carry out physicians' orders. On that date, the chart indicated that she was afebrile, alert, and voiced no complaints during the morning and afternoon. During the evening of November 26, 2014, however, the decedent experienced occasional exertional dyspnea, albeit with no acute respiratory distress. Her oxygen saturation at that time was 96% using the nasal cannula, she was afebrile, and her blood pressure was normal. On November 27, 2014, at 1:00 a.m., the decedent experienced an episode of tachycardia, although the chart reported that she was not experiencing any respiratory distress, and that she denied chest pain. The chart further reported that the decedent's vital signs at 6:00 a.m. on that date, including heart rate, blood pressure, and temperature, were normal. She also was examined that morning by Dr. Rosen for preexisting left breast inflammation. Dr. Rosen continued the decedent on Lasix, and planned a breast clinic referral if the swelling persisted. At approximately about 9:00 a.m. on that date, after physical therapy, Isabella staff noted that the

decedent was experiencing shortness of breath, although she remained afebrile, alert, and communicative. Healthcare personnel administered oxygen via nasal cannula and albuterol via a nebulizer, which allegedly provided the decedent with some relief. At 10:45 a.m., the decedent again was noted with shortness of breath, although her oxygen saturation level was 95% using nasal cannula. According to the Isabella chart, the decedent's son requested that she be transferred to a hospital emergency room, an ambulance was called, the ambulance arrived at 10:57 a.m., and the decedent was transferred to New York Presbyterian Hospital (NYPH) at 11:19 a.m.

Dr. Salzman also provided a detailed summary of the treatment and care that NYPH healthcare personnel rendered to the decedent during her admission there. As relevant to the plaintiff's claims against Isabella, he noted that a chest x-ray taken at the NYPH emergency room upon the decedent's admission showed opacification of the left hemithorax with contralateral midline shift, while an electrocardiogram (EKG) reflected the presence of atrial fibrillation with no ischemic changes. He noted that, at that time, the decedent did not require intubation, but that she was admitted to the hospital for diuresis, thoracentesis, and monitoring, with a differential diagnosis that included left pleural effusion or left lobar collapse, secondarily worsened by congestive heart failure and atrial fibrillation, albeit with what he described as a "low suspicion for sepsis." Despite this low level of suspicion, Dr. Salzman noted that NYPH personnel nonetheless ordered the administration of antibiotics for "broad coverage for possible pneumonia," although the NYPH plan was to discontinue them if cultures were negative. In any event, he explained that the NYPH chart reported that the decedent underwent a left thoracentesis that removed 1.1 liters of fluid, but noted that the chemical and cellular analysis of that pleural fluid "confirmed" that the pleural effusion was due to fluid overload characteristic of congestive heart failure and cirrhosis, but was not due to pneumonia or other infection. Dr. Salzman asserted that the decedent's respiratory function improved after the fluid was removed, and that she did not then require a chest tube. He further asserted that, on November 29, 2014,

the decedent was "downgraded to the medicine floor," although her heart rate was irregular and an EKG showed atrial fibrillation. Dr. Salzman opined that,

> "[i]mportantly, her blood culture was negative, the thoracentesis culture was negative, her respiratory panel culture (PCR) was negative and there was no growth from the urine culture. It was determined that hypoxemia was likely due primarily to pleural effusion in the setting of heart failure exacerbation."

He concluded that, although the decedent was "treated for pneumonia empirically," the evidence established that she was free from infection, since she had no fever, no leukocytosis, and no positive cultures, while her chronic obstructive airway disease was noted. Dr. Salzman further opined that "the antibiotics used empirically were helpful for treating COPD exacerbation" even in the absence of infection.

Dr. Salzman explained that, on November 30, 2014, at about 12:30 a.m., the decedent developed worsening atrial fibrillation with associated hypotension, which, according to him, limited the ability of NYPH staff to continue diuresis. He noted that, at that point, the decedent was intubated and transferred to the intensive care unit to treat her for worsening hypercapnia and hypoxemia, which was "determined to be likely in the setting of atrial fibrillation with rapid ventricular response and flash pulmonary edema with some reaccumulated pleural fluid." Dr. Salzman asserted that opacities were reflected on a chest x-ray taken that day and that, as such, the administration of antibiotics were continued "empirically." He explained that the decedent completed her course of antibiotics by December 4, 2014, and that "[p]neumonia remained low on the differential based on negative cultures, no leukocytosis, and lack of fever." On the morning of December 4, 2014, the decedent experienced another episode of atrial fibrillation, with rapid ventricular response, and was determined to be more hypoxemic, at which point NYPH personnel increased her dosage of the beta blocker metoprolol to slow her heartrate and administered the diuretic Lasix intravenously to diurese fluid, reduce pulmonary edema, and improve oxygen saturation. According to Dr. Salzman, as a consequence of taking these drugs, the decedent developed intermittent hypotension, which he characterized as

"another demonstration of the difficulty in fine-tuning her physiologic balance when her systems could no longer maintain homeostasis on their own." He opined that, in other words, "[t]he cost of removing fluid from the lung to improve oxygenation was accompanied by too low a fluid level to maintain adequate cardiovascular function, resulting in hypotension."

Dr. Salzman further asserted that the decedent was transiently responsive to an initial normal saline bolus, but less responsive to the second normal saline bolus, which was administered in an attempt to increase her low blood pressure, upon which NYPH personnel reduced the dosage of metoprolol, and administered the vasopressor norepinephrine. He averred that NYPH staff determined that pulmonary edema was contributing to the worsening hypoxemia and to hypercarbia, that is, elevated carbon dioxide levels in the blood and body. Although NYPH healthcare personnel determined to extubate the decedent and remove her from her ventilator, Dr. Salzman asserted that these tasks were delayed due to recurrent atrial fibrillation, with rapid ventricular response, and that she nonetheless was extubated to a BiPAP mask-based oxygen delivery system on December 8, 2014, but that, because her tolerance was poor, she was reintubated on December 10, 2014 to treat hypercarbic respiratory failure. He asserted that the decedent subsequently required further diuresis due to fluid overload, with edema, and explained that, on December 15, 2014, the decedent again became hypotensive, thus requiring the administration of vasopressors and the discontinuance of diuresis.

Dr. Salzman conceded that, on December 15, 2014, NYPH physicians first diagnosed the decedent with ventilator-associated pneumonia due to increasing oxygen requirements, the results of a chest x-ray that depicted worsening left-sided retrocardiac opacity with developing air bronchograms and bilateral pleural effusions, the presence of multidrug resistant E. coli. bacteria in her respiratory and urine cultures, and an elevated white blood cell count of 16,300 cells/μL of blood, which he concluded "collectively" indicated that pneumonia then was likely. An NYPH nephrologist was called for consultation in connection with proper fluid volume management in the setting of worsening volume overload and acute respiratory distress

syndrome. The nephrologist recommended, and the decedent's healthcare team implemented, the resumption of diuretics, along with the administration of vasopressors to maintain blood pressure. On December 19, 2014, the administration diuretics again was discontinued due to rising creatinine levels, which Dr. Salzman explained was indicative of volume overload and acute kidney injury. At a "goals-of-care" family meeting that NYPH providers conducted on December 22, 2014, they explained to the decedent's family that her respiratory status was "tenuous," inasmuch as she required full ventilator support, while her renal function was declining, she had experienced a recent episode of hypothermia, and she required increasing vasopressor support. According to Dr. Salzman, the decedent's family requested a do-not-resuscitate order, no further escalation of care, and no dialysis, although the antibiotic and antimicrobial drugs vancomycin and Flagyl were added to her medication regimen to treat diarrhea caused by infection with C. dificile bacteria. As Dr. Salzman interpreted the relevant chart, the decedent's clinical status continued to worsen, at which time her family requested palliative care. On December 24, 2014, at 12:30 a.m., the decedent died, with her cause of death reported as acute respiratory distress syndrome due to ventilator-associated pneumonia, and with other significant conditions contributing to her death identified as diastolic heart failure, atrial fibrillation, chronic obstructive pulmonary disease (COPD), and hepatitis C virus cirrhosis.

Dr. Salzman averred that patients such as the decedent, whom he described as being in "such a tenuous state for months on end," are sometimes referred to as chronically critically ill. He explained that such patients are sufficiently stable to be managed, with close medical supervision, in a non-hospital setting, such as the defendant's nursing home, even though they can become unstable any given day.

As Dr. Salzman described it, pneumonia is an infection in the lung that causes inflammation of lung tissue, and sometimes causes fluid to leak into the chest cavity, which he characterized as an inflammatory-infectious pleural effusion with many proteins and cells, and which he distinguished from the "watery bland fluid found in heart failure and fluid overload

states." He asserted that symptoms of pneumonia typically include fever, headache, muscle pain, and a cough that produces sputum or mucus. Dr. Salzman asserted that, based on the decedent's diagnostic results, including laboratory blood analysis and radiological studies, her symptoms, the measurements of her vital signs, and complaints that she did not articulate, she did not develop any infection or pneumonia at any point in time during her admission to the defendant's facility. He concluded that the decedent's pleural effusion was appropriately managed with diuretics and fluid restrictions, inasmuch as that condition was due to her congestive heart failure and cirrhosis, and not caused by pneumonia. Dr. Salzman further opined that the decedent was appropriately examined, monitored, and treated while at the defendant's facility, and, in fact, was not diagnosed with pneumonia until more than two weeks after her discharge. He explicitly concluded that the pneumonia that the decedent did develop was "ventilator-associated, not community acquired," and that her death approximately one month after her discharge by the defendant "was a consequence of congestive heart failure, cirrhosis, and atrial fibrillation and not caused by an act or omission by Isabella."

Dr. Salzman expressly opined that the decedent did not contract pneumonia or an infection in the course of her residency at Isabella. He concluded that the medical and nursing attention, care, and treatment that she received at Isabella in connection with fluid accumulation and retention was appropriate, and conformed with the standard of care, and that Isabella provided all of the care and treatment reasonably necessary to prevent the development of pneumonia. Moreover, he asserted that the decedent's pleural effusion was not caused by Isabella's malpractice, but instead was a product of her congestive heart failure, atrial fibrillation, and cirrhosis, with additional contributions from her other comorbidities, which included obstructive lung disease (COPD/asthma), obesity, and kidney problems. As he explained it,

> "[u]pon admission to Isabella, Ms. Arnaud's vital signs were normal, she was afebrile, and voiced no complaints of discomfort. The radiology report in connection with the chest x-ray suggested possible presence of a bilateral basal pneumonia, but based on clinical context and given the inherent limitations of portable frontal radiographs in bed-bound patients this was an unwarranted

> inference. It is my opinion that x-ray instead showed a buildup of non-infectious fluid due to Ms. Arnaud's congestive heart failure, atrial fibrillation, and cirrhosis. Ms. Arnaud did not have an infection."

Dr. Salzman concluded that Isabella's personnel timely and appropriately examined the decedent during the entire course of her residency there, administered appropriate medications and treatments, and assured that appropriate monitoring was in place. He reiterated that she manifested no signs of infection, acute illness, or distress, and her respiratory status was satisfactory given her baseline. He further concluded that, when elevated ammonia levels were recognized, that result was properly reported to a physician, who appropriately ordered that she restart the administration of lactulose, and that, at no point during her admission did the decedent develop hepatic encephalopathy, while her hyperammonemia resolved.

Dr. Salzman further opined that Isabella personnel appropriately treated her on November 5, 2014 for loose bowel movements, that, as of that date, despite some bilateral wheezing and a cough, she manifested no indicia of an infection, that her bowel movements were a side-effect of taking lactulose, and that Isabella physicians properly determined that no antibiotics were warranted. He reiterated that the November 6, 2014 examination confirmed the absence of any signs of infection, pneumonia, or acute illness that warranted additional testing, consultations, or treatments, and that there were no medically significant changes to her medical or respiratory status until November 11, 2014, when she developed wheezing and signs of shortness of breath. Nonetheless, he concluded that Dr. Rosen appropriately examined the decedent on that date, and that, "based on her medical history, edema, lack of fever, and normal vitals, he appropriately judged Ms. Arnaud's shortness of breath to be a consequence of congestive heart failure with a differential diagnosis of asthma exacerbation." Dr. Salzman opined that Dr. Rosen's orders for immediate diagnostic testing and the amendment of the regimen of medications were appropriate, and noted that the chest x-ray taken that day confirmed that the decedent's symptoms were a consequence of pleural effusion, which was due to congestive heart failure exacerbation that was being appropriately managed with

diuretics. He repeated that the x-ray study did not reveal the presence of pneumonia and that the decedent did not manifest any symptoms of infection to warrant any different or additional treatment than that which already was in place, since she was receiving appropriate treatment for congestive heart failure exacerbation.

Dr. Salzman further concluded that, although the decedent resumed wheezing and had a body temperature of 99.2 degrees Fahrenheit later in the day on November 11, 2014, Dr. Rosen appropriately added ceftriaxone empirically, since, even though she did not have pneumonia, it was appropriate for him to prescribe that antibiotic to treat COPD and asthma, and to prescribe an inhaled bronchodilator and prednisone that would also have treated pneumonia had it been present. He asserted that all of the diagnostic studies, examinations, observations, and information obtained from the decedent all reflected that the wheezing was a consequence of pulmonary edema due to congestive heart failure, atrial fibrillation, and cirrhosis or asthma/COPD exacerbation, or both. Dr. Salzman further supported this opinion by noting that, by that afternoon, the decedent's oxygen saturation level improved to 95%, and her body temperature remained normal. He further concluded that the decedent's responses to medications, a fluid intake restriction regimen, and respiratory treatments were appropriately monitored and positive, and that Isabella staff continued appropriately to treat and monitor her for congestive heart failure and plural effusion, which he concluded were consequences of her heart and liver failure. Dr. Salzman opined that Dr. Rosen appropriately changed the administration of Lasix to an intramuscular administration for two days in order to treat the decedent's edema in her lower extremities, that the diagnosis and treatment of congestive heart failure exacerbation was appropriate, and that, based on the clinical assessment and diagnostic studies, the decedent did not have pneumonia or an infection.

Dr. Salzman opined that the decedent's subsequent development of hypotension and shortness of breath on November 15, 2014 was appropriately attributed to over-diuresis of the fluid overload, and that, given this change in her status, it was appropriate temporarily to

discontinue the administration of Lasix, Norvasc, benazepril, and metoprolol, all of which would worsen hypotension. He further approved of Dr. Rosen's determination to continue the restrictions on fluid intake and to order the decedent to engage in proper bedrest. Dr. Salzman also approved of Dr. Rosen's November 20, 2014 determination that the decedent was "much improved" from her recent congestive heart failure and coexistent COPD exacerbation, and that she then evinced no signs, clinically or diagnostically, of pneumonia. He also opined that the decedent's retention of fluids was appropriately monitored and treated, and that there were no other indicated medications, treatments, tests, or assessments that were not already being provided. Dr. Salzman further concluded that, when Dr. Rosen was apprised of the decedent's decrease in oxygen saturation after her November 25, 2014 physical therapy exercise, the latter appropriately examined and observed edema and decreased breath sounds at the bases, appropriately ordered a chest x-ray, as well as a continuation of the administration of Lasix, oxygen support, and fluid restrictions, and properly diagnosed her with hypoxia, "likely secondary to congestive heart failure." He was also of the opinion that, since the November 25, 2014 chest x-ray showed no change in the left pleural effusion despite the administration of the antibiotic ceftriaxone, and the right lung was clear, the decedent's pleural effusion was a consequence of her congestive heart failure, and not caused by an infection or pneumonia, which she did not have in any event. Dr. Salzman further concluded that it was proper for Dr. Rosento continue her on the existing medications and treatments, and continue to monitor her inasmuch as she was afebrile, her blood pressure was normal, she had no acute respiratory deterioration, and laboratory test results did not suggest an infection, as well as the fact that she made no complaints of discomfort or shortness of breath.

Dr. Salzman opined that, when the decedent did develop shortness of breath on November 27, 2014, but she was afebrile and had no sign of infection, it was appropriate for Isabella staff to transfer her to NYPH at the request of her family. He also concluded that, upon

her admission to NYPH, hospital medical staff correctly attributed her pleural effusion to congestive heart failure and atrial fibrillation, not pneumonia. Dr. Salzman further stated that the pleural effusion was not caused by, or worsened due to, any act or omission by Isabella staff, but instead was a consequence of her underlying and preexisting heart failure and cirrhosis. Dr. Salzman additionally asserted that, while NYPH staff administered antibiotics "empirically," the decedent did not have an infection or pneumonia since her cultures were negative, she did not manifest leukocytosis, and she was afebrile, and that the fact that her respiratory status improved after the left thoracentesis performed at NYPH constituted further proof that she was suffering from pleural effusion from congestive heart failure, cirrhosis, and atrial fibrillation, but not due to pneumonia.

Dr. Salzman asserted that there was nothing that the defendant's staff did, or failed to do, that resulted in the decedent's need for ventilator support at NYPH, and that, in any event, at the time she was placed on ventilator support, she still did not have pneumonia or any other infection. As he explained it, it was not until December 15, 2014, or more than two weeks after her discharge from Isabella, that the decedent developed an infection, inasmuch as that was the first time that she had an elevated WBC count, and the first time that she tested positive for multidrug resistant E. coli in both her respiratory and urine cultures. Furthermore, he agreed with NYPH's diagnosis of ventilator-associated pneumonia, and asserted that the decedent was never diagnosed with chronic or community acquired pneumonia. Dr. Salzman concluded that the decedent's decline continued due to multiorgan failure and her chronic comorbidities.

Dr. Salzman additionally opined that there was no basis for the plaintiff's negligent hiring claim and no basis upon which to claim that Isabella violated the Public Health Law or the other statutes and regulations identified in plaintiff's bill of particulars.

In opposition to the defendant's motion, the plaintiff relied on many of the same documents that the defendant had submitted, and he also submitted an attorney's affirmation and an affirmation from board-certified geriatrician, and forensic, family, and emergency

medicine specialist Terrance L. Baker, M.D., who asserted that the defendant departed from good and accepted medical and nursing practice, and that its departures caused or contributed to the decedent's pneumonia. Dr. Baker conceded that Isabella thoroughly assessed the decedent's medical, nursing, social, nutritional, and psychological needs and conditions upon its initial assessment, and properly determined that it would be appropriate to admit her. He asserted that at no time did Isabella's staff document that they were unable to care for the decedent as her condition required. Upon reviewing the decedent's October 14, 2014 x-ray, Dr. Baker explicitly opined, contrary to Dr. Salzman's opinion and Dr. Rosen's conclusion, that the image in fact depicted bilateral basal pneumonia, and that the decedent's November 27, 2014 chest x-ray demonstrated progression of her pneumonia and pleural effusion. He asserted that the "progression of the pleural effusion and associated pneumonia represented a progression of the patient's underlying medical condition which had gone untreated throughout the admission to the Isabella Geriatric Center."

As Dr. Baker explained it, progressive pleural effusion associated with pneumonia of unknown origin is a serious, potentially life threatening and/or life ending process. He opined that emergent evaluation of the progression of the effusion and *apparent* associated pneumonia "requires emergent evaluation of the differential diagnosis of possible causes." Dr. Baker stated that, only by thorough and complete evaluation of the differential diagnosis can appropriate treatment be provided. He opined that emergency transfer to a hospital emergency room, and admission to a hospital, was required to provide the decedent with the necessary radiographic imaging, laboratory testing, infectious disease consultation, and probable thoracentesis, although he did not opine when that transfer should have occurred. He opined that the administration of ceftriaxone alone "would reasonably be expected to be ineffective and an incomplete treatment of the facility acquired pneumonia and associated pleural effusion." Rather, he concluded that an additional antibiotic, such as azithromycin, would have been necessary in conjunction with ceftriaxone to effectively combat the pneumonia, and that the

administration solely of ceftriaxone constituted incomplete treatment that failed to satisfy the applicable standard of care.

Dr. Baker asserted that, throughout her admission to Isabella, the decedent experienced an "undiagnosed pulmonary infiltrate associated with an undiagnosed pleural effusion." He stated that, based upon the available x-ray imaging, "this unknown, undiagnosed process appears to have worsened progressively throughout her admission."

According to Dr. Baker, Isabella departed from the applicable standards of care by failing to obtain a full and proper physical history of the decedent, failing to appreciate the significance of the medical history that it did obtain, and failing to develop, implement, and update an adequate and appropriate patient care plan to meet the needs of the decedent, which included plans for skin care, nutrition, hydration, and treatment of asthma, pleural effusion, and pneumonia. He further asserted that Isabella committed malpractice by failing to formulate a proper discharge plan. Dr. Baker further faulted Isabella for its alleged failure adequately to monitor, document, and appreciate the decedent's signs and symptoms and the change in her condition, including a request for supplemental oxygen. In addition, he concluded that Isabella committed malpractice by virtue of its failure properly to perform appropriate, necessary serial physical examinations, its failure to appreciate the significance of the examinations conducted, its failure properly and/or adequately to evaluate the decedent's risk of developing progressive pneumonia, its failure timely to diagnosis, recognize, and treat her pneumonia/pleural effusion, its failure properly and adequately to evaluate and monitor her progress, its failure to order, perform, or refer the decedent for necessary diagnosis tests and procedures, including serial x-rays, and its failure to initiate treatment or refer the decedent to a hospital for treatment on a timely basis. Dr. Baker concluded that, notwithstanding Isabella's knowledge of the decedent's needs for specialized care and services, its staff repeatedly "failed to take appropriate actions and failed to ensure proper nursing/medical along with basic care and services were provided, resulting in Ms. Amaud's progressive deterioration and death."

In reply, the defendant submitted an attorney's affirmation, in which counsel argued, among other things, that Dr. Baker's affirmation was conclusory, speculative, and completely unsupported by the facts contained in the medical records.

The court concludes that Isabella established its prima facie entitlement to judgment as a matter of law in connection with all of the causes of action asserted in the complaint, including the medical malpractice claims that were subsumed in the cause of action seeking to recover pursuant to Public Health Law § 2801-d. Moreover, the court agrees with Isabella's contention that Dr. Baker's affirmation was indeed conclusory, and not supported by the facts in the medical records. A physician's opinion is deemed to be conclusory where there is no reference to any objective evidence supporting that opinion, such as dispositive imaging, diagnostic testing, or clinical proof (*see Fernandez v Sukhdeep*, _____AD3d_____, 2026 NY Slip Op 00422, *17-18 [1st Dept, Jan. 29, 2026] [Mendez, J., dissenting], citing *Glynn v Hopkins*, 55 AD3d 498, 498 [1st Dept 2008]; *Cota v Adirondack Med. Ctr.*, _____AD3d_____, 2025 NY Slip Op 07256, *4 [3d Dept, Dec. 24, 2025] [opinion is conclusory where it failed to address specific physical therapy modalities employed by defendant physician and their appropriateness for a fracture, ignored important medical records, and mischaracterized plaintiff's testimony about post-surgical improvement]; *Valette v Correa*, 216 AD3d 500, 501 [1st Dept 2023] [opinion is conclusory because it did not address intervening treatment by a nonparty physician]).

Critically, Dr. Baker did not address the crucial evidence that was set forth in both Isabella's and NYPH's charts, and did not address the conclusions of Dr. Salzman, that every laboratory blood, urine, and bacterial culture study performed by Isabella over the course of the decedent's residency there from October 14, 2014 until November 27, 2014, and every laboratory study performed by NYPH between November 27, 2014 and December 15, 2014, including WBC counts, was negative for pneumonia or any other infectious vector. Dr. Baker failed to support his opinion that the decedent did in fact have pneumonia as early as October 2014 with any conclusion that all of these tests yielded false negative results, and, if he indeed

believed that was the case, why he came to such a conclusion. Dr. Baker also did not explain how a patient could have infectious pneumonia for a period of eight weeks, and only once have a mildly elevated body temperature that was barely above normal, while manifesting only an occasional cough and wheeze, and clear sputum. He did not describe a process by which a patient could have contracted facility-based pneumonia and not manifest worsening symptoms over an eight-week period, particularly because he concluded that the administration of ceftriaxone alone would have been insufficient to suppress or treat infectious pneumonia. He also did not explicitly conclude that, merely by reviewing x-ray imaging, he could determine that the decedent's ongoing pleural effusion was caused by an infectious process, rather than as a combined consequence of congestive heart failure, COPD, and cirrhosis, as asserted by Dr. Salzman. Nor did he address Dr. Salzman's interpretation of the results of the thoracentesis procedure that NYPH medical personnel performed on the decedent in late November 2014 as having revealed no infection in the fluid that had been removed from the decedent's lung.

Moreover, although Dr. Baker recited with approval a litany of allegations that the plaintiff made in the bill of particulars concerning Isabella's alleged departures from the applicable standard of care, he did not specify either in what way Isabella's conduct fell within the ambit of each of these alleged departures, nor how any of these departures caused or contributed to the onset of the decedent's pneumonia, and her deteriorating condition. He did not specify that any of the diuretic, vasopressor, beta blocker, or bronchodilator drugs administered to the decedent during her residency at Isabella were contraindicated or nonindicated, or that the dosages that were administered were improper. Although he opined that Isabella did not properly and timely take x-rays, he did not assert how many x-rays it should have taken, and when they should have been taken. Virtually all of his other opinions were contradicted by the medical records. In short, Dr. Baker's affirmation constituted a perfect example of a "conclusory" affirmation that is insufficient to raise a triable issue of fact.

Since most of the alleged violations of the statutes and regulations governing nursing homes that were within the ambit of the plaintiff's Public Health Law § 2801-d cause of action involved alleged departures from good and accepted medical and nursing practice, and the plaintiff failed to raise a triable issue of fact in opposition to Isabella's prima facie showing of entitlement to judgment as matter of law in connection therewith, summary judgment must be awarded to Isabella dismissing claims based thereon. The other alleged violations were either inapplicable (e.g., those referable to hospitals and one referable to vision care), referred to general requirements to provide adequate supervision and care, or referred to purported violations which, even if committed, did not proximately cause any injuries. Moreover, since Isabella established, prima facie, that it was not negligent in the hiring of healthcare personnel and the maintenance of staffing levels, and Dr. Baker did not address those issues in his affirmation, summary judgment must be awarded to Isabella dismissing that cause of action as well. Since a wrongful death cause of action may be premised upon medical malpractice (*see Roques v Noble*, 73 AD3d at 207), and the court is summarily dismissing the Public Health Law § 2801-d cause of action in which the claims of medical malpractice are subsumed, summary judgment must be awarded to Isabella dismissing the wrongful death cause of action as well.

Accordingly, it is,

ORDERED that the motion of the defendant Isabella Geriatric Center for summary judgment dismissing the complaint is granted, and the complaint is dismissed; and it is further,

ORDERED that the Clerk of the court shall enter judgment dismissing the complaint.

This constitutes the Decision and Order of the court.

2/5/2026
DATE

JOHN J. KELLEY, J.S.C.

CHECK ONE:	[X]	**CASE DISPOSED**		[ ]	**NON-FINAL DISPOSITION**		
	[X]	**GRANTED**	[ ] **DENIED**	[ ]	**GRANTED IN PART**	[ ]	**OTHER**
APPLICATION:	[ ]	**SETTLE ORDER**		[ ]	**SUBMIT ORDER**		
CHECK IF APPROPRIATE:	[ ]	**INCLUDES TRANSFER/REASSIGN**		[ ]	**FIDUCIARY APPOINTMENT**	[ ]	**REFERENCE**