Saltanovich v Sea View Hosp. Rehabilitation Ctr.
2022 NY Slip Op 34509(U)
May 17, 2022
Supreme Court, Richmond County
Docket Number: Index No. 151312/2021
Judge: Thomas P. Aliotta
Cases posted with a "30000" identifier, i.e., 2013 NY Slip Op 30001(U), are republished from various New York State and local government sources, including the New York State Unified Court System's eCourts Service.
This opinion is uncorrected and not selected for official publication.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF RICHMOND: PART C2

---X

RAISA SALTANOVICH as Administrator of the Estate of MIKHAIL SALTANOVICH,

Plaintiff,

-against-

SEA VIEW HOSPITAL REHABILITATION CENTER and NEW YORK CITY HEALTH AND HOSPITALS CORPORATION,

Defendant.

---X

HON. THOMAS P. ALIOTTA

DECISION AND ORDER

Index No.: 151312/2021
Motion No.: 001

Recitation, as required by CPLR 2219(a) of the following papers numbered "1" through "4" were fully submitted on the 2nd day of February 2022:

	Papers Numbered
Defendants' Notice of Motion, Affirmation and Exhibits (NYSCEF 3-21)	1, 2
Plaintiff's Affirmation in Opposition with Exhibits (NYSCEF 29-32)	3
Defendants' Reply Affirmation with Exhibits (NYSCEF 33-37)	4

Upon the foregoing papers, defendants' motion for an order pursuant to CPLR § 3211 (a) (7) and New York Public Health Law §§ 3080 -3082, dismissing the complaint in its entirety, with prejudice, as defendant is immune from the liability claimed in this action is decided as follows:

This is an action to recover damages arising from the decedent's care and treatment at defendants' facility. The complaint alleges causes of action premised upon negligence, breach of

contract and wrongful death. Defendants have moved to dismiss this action pursuant to CPLR §§ 3211(a)(7) and Public Health Law §§ 3080-3082 as they are immune from liability.

I) Defendants' Motion

a) <u>Background Facts</u>

On January 17, 2020, the United States Centers for Disease Control ("CDC") issued a health alert with an update and interim guidance on a virus that later became known as "COVID-19". In response, the New York State Department of Health ("DOH") issued an Interim Guidance for Health Care Providers and Facilities in New York State. On February 6, 2020, the DOH started to provide healthcare facilities with information regarding the then-known clinical presentations and symptoms by persons suspected to have COVID-19. The DOH also disseminated the CDC guidelines for infection control and personal protective equipment in the face of the nationwide shortage of resources.

Due to the rapid and sharp increase of COVID-19 infections in New York State during March, April and May of 2020, facilities such as defendant were required to increase capacity, modify procedures, hire, and train new competent staff and monitor the rapidly changing regulatory and medical updates. As of March 2, 2020, New York State had the capacity to perform approximately 1000 tests per day, which increased on March 11, 2020 when additional testing facilities were added through public-private partnerships. Also on March 11, 2020, the DOH issued guidelines that, *inter alia,* directed employees, residents, and visitors to be screened for COVID-19. The DOH also directed that staff and residents who were symptomatic were to be quarantined. The next day, New York City declared a State of Emergency and then on March 13, 2020, the DOH issued guidelines that advised nursing homes and adult care facilities to suspend all visitation and implement screening procedures for personnel at the beginning of each

shift. Additionally, all staff were mandated to wear facemasks within six feet of residents and the facilities were required to monitor for signs and symptoms of COVID-19, as well as isolate residents suspected of having COVID-19.

In response to the guidelines, defendant, Sea View, implemented the following protocols: all staff and residents were issued personal protective equipment (PPE); educated staff and residents with respect to hand hygiene, contact precautions and isolation protocols; monitored compliance; and ended all communal meal service and restricted resident and staff movement within the facility to minimize contact and contain the spread of COVID-19. On March 21 2020, the DOH issued a health advisory that facilities were to presume that any febrile acute respiratory illness was COVID-19 since testing capacity remained limited and hospitalized healthcare workers were given priority.

Defendant also implemented its emergency operations center in response and created a Pandemic COVID-19 Planning Committee to monitor the evolving COVID-19 emergency and to develop guidelines, policies, and procedures related to preparedness and clinical issues.

The decedent was a long-term resident of Sea View, admitted in 2015 due to Alzheimer's disease. His state of health remained unchanged until March 25, 2020 when it was documented that he had a fever, decreased intake at breakfast, slight occasional productive cough with whitish secretions, was warm to touch, and was sleepy but arousable to verbal stimuli, with a temperature 100.9° and an O2 saturation of 90%. A care plan was developed in accordance with the DOH guidance to treat acute febrile illness as COVID-19, since testing was restricted to essential healthcare personnel, and recommended supportive care and antibiotics. The plan provided for blood work, a chest x-ray, Tylenol every four hours as needed for temperature greater than 100.5, IV fluids, and frequent monitoring of vital signs.

The doctor notated that the decedent had a "MOLST" order (a Medical Order for Life Sustaining Treatment), to wit: Do Not Resuscitate, Do Not Intubate, Do Not Hospitalize, and administer palliative care. A chest x-ray, later that day, displayed no acute disease, but on March 27, 2020, decedent's temperature increased to 102.7 degrees. It was documented that decedent had a productive cough and O2 saturation of 88% on room air. The plan was to continue IV for hydration support, continue Tylenol as needed, supplemental oxygen as needed, start IV antibiotics, and start a nebulizer. On March 29, 2020, decedent's temperature dropped to 102.1° and his O2 saturation level rose to 94% on room air. The doctor recommended to continue with the prior course of treatment and to continue with COVID-19 protocols with respect to PPE and sanitizing the facility. His condition continued to improve but starting on April 3, 2020, his oral intake was decreasing. Therefore, the care plan was to continue IV hydration without artificial feeding. The decedent was assessed with a grave prognosis and remained in palliative care. On April 9, 2020, he was in respiratory distress, with a fever of 100.6°, respiratory congestion and labored breathing. Plaintiff was advised that the decedent was actively dying. It was agreed that Morphine was to be administered so that he could peacefully pass away.

b) <u>Procedural History and the Pleadings</u>

Plaintiff, the decedent's daughter, served a Notice of Claim on September 22, 2020 alleging that from March 25, 2020 through April 12, 2020, defendants, and "its agents were negligent and failed to provide adequate and appropriate medical services that ultimately lead to the death of Mikhail Saltanovich" (NYSCEF 6, ¶3). It was further alleged that defendants failed to provide adequate supervision and training of their staff, failed to transfer the decedent to a hospital despite exhibiting signs of illness, all of which deprived the decedent of vital medical

care and treatment (Id.). A hearing pursuant to General Municipal Law §50-h was held March 10, 2021 via the Zoom video conferencing platform (NYSCEF 7, p.8:18-23).

Plaintiff testified that prior to March 2020, she would visit her father every Sunday (NYSCEF 7, 73:10-13). The last time she visited her father prior to his death was Sunday, March 8, 2020 due to the quarantine in effect (74:23-25, pp.75-76). However, she was able to see and communicate with him one final time via FaceTime on March 16, 2020 (86:4-18; 110:21-25). He was not wearing a face covering during this FaceTime visit (87:18-21). Plaintiff believed that the social worker was holding the iPad for her father, but this person did not appear on screen (88:3-19). During this virtual visit, the decedent did not exhibit breathing issues (92:23-25, 93:2-3). It was not until March 25, 2020 that plaintiff received a phone call that her father was sick (93:21-25, 94:2-3).

Plaintiff asked whether her father was tested for COVID and was advised that defendants "do not test for COVID because they don't have kits to test for COVID and they were instructed to treat symptoms, and that's what they're doing" (94:8-20; 101:16-23). She was also advised that a chest x-ray confirmed that in addition to possibly being infected with COVID, the decedent had pneumonia (103:17-23) and despite IV fluids and antibiotics, he was not responding to treatment and his condition was worsening (104:4-13; p.105). Plaintiff described her father's condition between April 3 and April 9, 2020, as being "a big yo-yo up and down". When plaintiff would inquire about his appetite, she would constantly get different answers (108:11-24). On April 9, 2020, she was advised that treatment would be stopped, and morphine would be administered to make him more comfortable (p.105). Plaintiff was advised that decedent was dying from the COVID virus and, unfortunately, there was nothing defendants could do (106:3-9). She asked the defendants to make him comfortable (134:5-15). Plaintiff

testified that a signed "do-not resuscitate order" was in effect (pp.79-83). This order was never rescinded (84:6-8). She summarized the timeline as follows:

> Q: Can you tell me what's written in your notes?
>
> A: It's March 12th closed doors, March 16th FaceTime, March 25th got sick, Eunu called me. April 3rd Eunu called me is -- that my father is not doing well and he's dying from the virus and then I have no date, but it says that he's doing better and they stopped antibiotic and IV fluids. April 9th that he's dying again and morphine was ordered. April 12th doctor called that my father passed away. (134:5-16).

During this phone call on April 12, 2020, the doctor did not inform plaintiff of the cause of death (117:15-25). It was not until the funeral home advised her that since the death certificate noted "suspected COVID" as the cause of death, her father's body needed to be placed in a special disaster bag for burial (118:7-16).[1]

Plaintiff commenced this action on July 12, 2021 electronically filing the summons and complaint. However, the complaint expanded the dates of the alleged negligent care as February 1, 2020 to April 12, 2020. The complaint alleges, *inter alia,* that defendants through their agents servants and/or employees,

> ...were negligent, reckless, willful and wanton in their ownership, management, maintenance, care and control of the facility: in failing to establish infection prevention and control policies and procedures; in failing to follow infection prevention and control policies and procedures; in failing to train their staff on the infection prevention and control policies and procedures; in failing to enforce the infection prevention and control policies and procedures; in failing to heed the warnings of the seriousness of Covid-19; in failing to appreciate the risks Covid-19 posed to the residents of nursing home facilities; in failing to enforce standard infection prevention and control policies and procedures; in failing to timely segregate ill residents from healthy residents; in failing to timely and accurately screen employees for signs and symptoms of Covid-19; in failing to timely and accurately screen visitors for signs and symptoms of Covid-19; in failing to timely establish Covid-19 policies and procedures; in failing to timely enforce recommended Covid-19 policies and procedures; in failing to have sufficient personal protective equipment and supplies for the safety and protection of residents and staff; in failing to timely transfer MIKHAIL SALTANOVICH to the hospital when he exhibited signs

---

[1] The death certificate lists the immediate cause of death as "Suspected Covid-19" with other significant conditions contributing thereto as "End Stage Alzheimer's Disease, Coronary Artery Disease, Hypertension" (*See,* NYSCEF 15, p.109)

and symptoms of illness, depriving him of vital medical care; in failing to establish policies and procedures to insure they have the ability to care for the needs of all the residents who are admitted to their facility; in failing to provide the quantity of qualified staff necessary to deliver all care needed to meet the needs of all their residents in general, and MIKHAIL SALTANOVICH in particular; in failing to hire, train and supervise sufficient numbers of care giving staff to insure that residents at SEA VIEW HOSPITAL REHABILITATION CENTER, including MIKHAIL SALTANOVICH, were protected from health and safety hazards and were provided with adequate custodial care; and in failing to take any action to prevent resident neglect (NYSCEF 10, pp.6-7).

c) **Decedent's Medical Records**

On 3/25/2020, decedent was alert and verbally responsive, but confused and disoriented (Id. at p.104-105). The medical records document diagnoses of viral pneumonia, fever of 100.5° and contact with and suspected exposure to other viral communicable diseases (Id.). This fever was treated with a rectal suppository every 4 hours as needed. The fever varied between 100.5° and 100.9° (Id. at p.104). The records indicate that starting on 3/25/2020, there was an ongoing fluctuation in temperature as follows:

3/25/2020	101.2°, 100.9°, and 98.5°
3/26/2020	103°, 101.9°, 101.8°, 98.8° and 98.6°
3/27/2020	102° and 102.2°
3/28/2020	100° and 99.9°

On 3/27/2020, antibiotic therapy was ordered for decedent due to a Respiratory Infection/Acute Bronchitis which was presumed to be COVID. A care plan was developed with two goals that, "The resident will be free from s/sx of infection by review date" and "The resident will be free of symptoms of respiratory distress through the review date" (Id. at p. 106). Further, the plan stated that the facility was to "ensure wearing of mask if tolerated when within 6 feet from caregivers or other residents." On 3/30/2020, "Raya Saltanovich" was informed that the antibiotic therapy would be extended through 4/3/2020. He was alert and responsive without signs of distress or discomfort on 3/31/2020, 4/1/2020 and 4/2/2020 with a temperature between

98.9° and 100°. On 4/3/2020, the decedent's temperature returned to 98.2°; on 4/6/2020, his temperature was between 98.7° and 99.1° with an O2 saturation level of 97%.; and on 4/6/2020, he was being treated with antibiotics for acute bronchitis which is also noted the day before on 4/5/2020 with a temperature of 98.76°.

As of 4/7/2020, the decedent's appetite was good, he was alert and responsive, but he required oxygen for shortness of breath. His temperature varied from 97.6° to 99°. However, he became lethargic on 4/9/2020, with a temperature of 100.6° and an O2 saturation level of 84%. Later that day, his temperature registered 99.5° with an O2 saturation level of 90% and later, 99.7° and 92%. It was noted that the entire facility was on "contact/droplet" precautions for COVID (NYSCEF 15, at p.36). It was also noted that "communicated Plan with Family/POA, "Raya Saltanovich"... Aware resident is actively dying and having SOB. Agrees with morphine...she wants him to die in peace" (Id.). On 4/10/2020, the decedent was reported to be lethargic, tolerated suctioning well and was sleeping comfortably. His temperature was 97.5° with an O2 saturation level of 90%. On 4/11/2020, decedent was noted to have increased secretions requiring suctioning; Tylenol and cooling measures were provided for the fever which reduced the fever from 100.3° to 98.9° with an O2 saturation level of 97%. He was to receive oxygen as needed for shortness of breath.

On the date of his demise, it was reported that the decedent had increased oral mucus secretion with a temperature of 100.3° at 6:04 A.M. He received cooling measures which reduced the temperature to 98.9°; had an O2 saturation level of 97%; and was receiving oxygen via a face mask. Then, at 07:05 A.M., his temperature was reported as 99.8° with an O2 saturation level of 94% and he was being monitored for any changes. The congestion persisted and oropharyngeal suctioning was needed for mucus. His temperature then rose again to 100.8°;

he was lethargic and congested; and his O2 saturation level was 87% at 11:00 A.M. At 2:48 P.M., the decedent was moved from the bed to a wheelchair. At 6:00 P.M., he ceased breathing and no vital signs were detected, and he passed away at 6:10 P.M.

d) Legal Argument

Defendants argue that this action must be dismissed since it is barred by New York State Public Health Law §§ 3080-3082 that was in effect during the dates of treatment as alleged in the Notice of Claim which granted immunity to defendants arising out of the decedent's care and treatment related to COVID-19. Any claims of negligent treatment, breach of contract or wrongful death relating to care and treatment rendered prior to the effective date of Public Health Law §§ 3080-3082 are conclusory without factual or legal grounds. Decedent's medical records and plaintiff's testimony conclusively establish that up until March 25, 2020, decedent was in his usual state of health. Defendants were following all protocols enacted by the New York State Department of Health and any staffing or resource shortages in combating the pandemic were not due to any willful or intentional criminal misconduct, gross negligence, reckless misconduct or intentional acts of defendants. Therefore, none of the exceptions to Public Health Law §§ 3080-3082 are applicable to plaintiff's causes of action as defendants were arranging for or providing health care services in good faith under the extraordinary uncertainties in the early days of the COVID-19 pandemic.

II) Plaintiff's Opposition

Plaintiff argues that at the time Public Health Law §§ 3080-3082 was repealed, the Legislature retroactively withdrew the immunity previously granted to nursing homes. In support of this position, plaintiff relies upon the investigative report of the New York State Attorney General as revised on January 30, 2021. The report determined that a large number of

nursing home residents died from COVID-19. Further, it was the lack of compliance with infection control protocols that put residents at an increased risk of harm during the COVID-19 pandemic. This lack of compliance consisted of insufficient PPE for nursing home staff which, in turn, increased this risk of harm. More importantly, the funds for PPE were diverted elsewhere to increase profits. It was the opinion of the Attorney General that some nursing homes exploited the immunity granted by Public Health Law §§ 3080-3082 and made "financially-motivated" decisions in lieu of rendering care and treatment to the residents in good faith.

On April 6, 2021, approximately 66 days after the final report was released, the New York State Legislature repealed Article 30-D of the Public Health Law, §§ 3080-3082 (*See,* Senate Bill S5177). The purpose or general idea of Senate Bill S5177 set forth that, *"This bill repeals Article 30-D of the Public Health Law...with the intent of holding health care facilities, administrators, and executives accountable for harm and damages incurred."* Therefore, plaintiff argues that the remedial aspect of the repeal is readily apparent from the bill's memorandum and the Attorney General's January 30, 2021 report specifically referenced therein.

Alternatively, plaintiff argues that even if the Court holds that the repeal was not intended to be retroactive, the ordinary law of negligence as applied to a nursing home's response to COVID-19 is rapidly changing. Once again, plaintiff relies upon the Attorney General's report wherein she opines that it is unclear to what extent facilities can be held accountable if found to have failed to appropriately protect the residents in their care. Here, defendants were not providing services to the decedent pursuant to the COVID-19 emergency laws that were put in place. Rather, decedent was a long-term resident in the facility pursuant to a contractual

agreement. Therefore, defendants had a duty to protect decedent from infectious diseases. The protections should have been in place prior to the COVID-19 outbreak. If such protections were in place, the outbreak of COVID-19 in defendants' facility would have been minimal. Plaintiff relies upon a citation issued to defendants in 2018 for deficiencies regarding infection prevention and control.

Finally, plaintiff argues that her allegations are broad enough to establish a cause of action based upon gross negligence and discovery is necessary to explore defendants' acts. Ultimately, the question of whether defendants' conduct rose to such a level is a question of fact to be determined by the jury.

III) Defendants' Reply

In reply, defendants argue that plaintiff has failed to establish that the Legislature retroactively repealed the immunity previously granted under Public Health Law §§ 3080-3082. Plaintiff fails to acknowledge that there is a strong presumption against retroactivity of statutes. In support, defendants point to the New York State Assembly Transcript (NYSCEF 35, 45-46, 48, 53-54, 58-60, 64-68, 70, 73, 82, 84, 86, 90-92),[2] and the Senate Transcript (NYSCEF 36, p.1835-1838).[3] Defendants also rely on General Construction Law § 93 and § 110.

In an attempt to bypass this legal principle, plaintiff has alternatively argued that defendants breached a duty of care by failing to predict and protect against a newly-evolved pathogen that killed millions of people world-wide. At the time of the statute's enactment and decedent's demise, health care workers and patients were "dying in droves" and the immunity was broad. At the time of its repeal, the first wave had abated.

[2] The Members stated on the record that the repeal was not intended to be retroactive.

[3] Senator Mayer states that, "And I want to clarify that my understanding is that this bill is prospective, it will apply going forward."

Based upon the plain wording of the statute and defendants actions in rendering COVID-19 care and treatment to decedent despite the lack of a definitive diagnosis, no further discovery can defeat immunity. Moreover, plaintiff's failure to specifically allege gross negligence by "shoehorning" ordinary allegations of negligence is insufficient to overcome this pleading deficiency. The facts as alleged do not constitute gross negligence.

It is further argued that plaintiff imputes words into the statute that do not exist. The plain wording of statute, as enacted, provides that immunity is granted where "the treatment of the individual is impacted by the health care facility's...decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives" (NYSCEF 33, ¶7). The question is whether the decedent's care and treatment were impacted by defendants' response to COVID-19, not whether defendants' decisions substantially or negatively impacted the care and treatment.

Based upon all of the above, defendants argue that the motion must be granted.

IV) Discussion

a) Legislative History – Article 30-D

On March 7, 2020, then Governor Cuomo signed Executive Order 202 ("EO 202"), declaring a Disaster Emergency in the State of New York (9 NYCRR 8.202).[4] The preamble to EO 202 stated that it was issued in response to the World Health Organization designating the novel coronavirus, COVID-19 outbreak as a Public Health Emergency of International Concern. Additionally, on January 31, 2020, the United States Health and Human Services Secretary declared a public health emergency for the entire United States to aid the healthcare community's ability to respond to the outbreak (Id.). The preamble also emphasized that the

[4] The Executive Orders have been removed from www.governor.ny.gov. Therefore, this Court sites to Title 9, Subtitle A, Chapter I, Part 8 of the New York Administrative Code.

State of New York needed to address the threat posed by COVID-19 to the health and welfare of its residents and visitors (Id.). EO 202, in an attempt to address emerging staffing shortages, permitted "unlicensed individuals, upon completion of training deemed adequate by the Commissioner of Health, to collect throat or nasopharyngeal swab specimens from individuals suspected of being infected by COVID-19, for purposes of testing; and to the extent necessary to permit non-nursing staff, upon completion of training deemed adequate by the Commissioner of Health, to perform tasks, under the supervision of a nurse, otherwise limited to the scope of practice of a licensed or registered nurse" (Id. – Sections 6521 and 6902 of the Education Law).

The outbreak continued to spread rapidly and on March 20, 2020, Governor Cuomo signed EO 202.10 (9 NYCRR 8.202.10) to take effect on March 23, 2020. It is this EO that fostered the creation of Article 30-D of the Public Health Law, §§ 3080-3082 (*See* NYSCEF 35, p.55 [The page number refers to the page number of the transcript, not the digital page on NYSCEF]). This subsequent EO expanded the breadth of EO 202.

Specifically, EO 202.10 granted immunity, except as to acts of gross negligence, to medical professionals, as well as shielding healthcare workers and clinical students from civil and criminal liability in effort to mitigate staffing shortages in the face of the rapidly escalating pandemic. EO 202.10 suspended the restrictions otherwise required by law for such employment and contractual services. This immunity and the related provisions were not initially included in EO 202. EO 202.10 stated in relevant part as follows:

> • Sections 405.13 and 755.4 of Title 10 of the NYCRR to the extent necessary to permit an advanced practice registered nurse with a doctorate or master's degree specializing in the administration of anesthesia administering anesthesia in a general hospital or free-standing ambulatory surgery center *without the supervision of a qualified physician* in these health care settings;
>
> • Paragraph 1 of Section 6542 of the Education Law and Subdivisions (a) and (b) of Section 94.2 of Title 10 of the NYCRR to the extent necessary to permit a physician assistant to provide medical services appropriate to their education, training and

experience *without oversight from a supervising physician* without civil or criminal penalty related to a lack of oversight by a supervising physician;

• Paragraph 1 of Section 6549 of the Education Law and Subdivisions (a) and (b) of Section 94.2 of Title 10 of the NYCRR to the extent necessary to permit a specialist assistant to provide medical services appropriate to their education, training and experience *without oversight from a supervising physician* without civil or criminal penalty related to a lack of oversight by a supervising physician;

• Subdivision (3) of Section 6902 of Education Law, and any associated regulations, including, but not limited to, Section 64.5 of Title 10 of the NYCRR, to the extent necessary to permit a nurse practitioner to provide medical services appropriate to their education, training and experience, *without a written practice agreement, or collaborative relationship with a physician*, without civil or criminal penalty related to a lack of written practice agreement, or collaborative relationship, with a physician

• Subdivision (15) of section 3001, and Sections 800.3, 800.15 and 800.16 of Title 10 of the NYCRR with approval of the department, to the extent necessary to define "medical control" to include emergency and non-emergency direction to all emergency medical services personnel by a regional or state medical control center and to permit emergency medical services personnel to operate under the advice and direction of a nurse practitioner, physician assistant, or paramedic, provided that such medical professional is providing care under the supervision of a physician and pursuant to a plan approved by the Department of Health;

• Subdivision (2) of section 6527, Section 6545, and Subdivision (1) of Section 6909 of the Education Law, *to the extent necessary to provide that all physicians, physician assistants, specialist assistants nurse practitioners, licensed registered professional nurses mid licensed practical nurses shall be immune from civil liability for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional in the course of providing medical services in support of the State's response to the COVID-19 outbreak, unless it is established that such injury or death was caused by the gross negligence of such medical professional;*

• Any healthcare facility is authorized to allow students. in programs to become licensed in New York State to practice as a healthcare professional, to volunteer at the healthcare facility for educational credit as if the student had secured a placement under a clinical affiliation agreement, *without entering into any such clinical affiliation agreement*; (emphasis in *italics* added)

This EO exposed managerial staff and administers to liability resulting from unsupervised and unaffiliated workers. Thereafter, the Legislature created Article 30-D, the Emergency or Disaster Treatment Protection Act. The Act was created due to the emerging public health emergency that was occurring statewide requiring an enormous response from state and federal and local governments working in concert with private and public health care

providers in the community (*See* Public Health Law § 3080). Therefore, the furnishing of treatment to patients was a matter of vital state concern affecting the public health, safety, and welfare of *all citizens*, not just those who were stricken by the virus. The purpose of Article 30-D was to "promote the public health, safety and welfare of *all citizens* by broadly protecting the health care facilities and health care professionals in this state from liability that may result from treatment of individuals with COVID-19 under conditions resulting from circumstances associated with the public health emergency" (Id., *italics added*). The term "health care services" for the purposes of Article 30-D was defined as,

> ...services provided by a health care facility or a health care professional, regardless of the location where those services are provided, that relate to:
>
> (a) the diagnosis, prevention, or treatment of COVID-19;
>
> (b) the assessment or care of an individual with a confirmed or suspected case of COVID-19; or
>
> (c) the care of any other individual who presents at a health care facility or to a health care professional during the period of the COVID-19 emergency declaration. (*See* Public Health Law § 3081 [5]).

The immunity provisions were codified in Public Health Law § 3082, which set forth as follows:

> Limitation of liability. **1.** Notwithstanding any law to the contrary, except as provided in subdivision two of this section, any *health care facility or health care professional shall have immunity from any liability, civil or criminal, for* ***any harm or damages*** alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services, if:
>
> (a) the health care facility or health care professional is arranging for or providing health care services pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law;
>
> (b) the act or omission occurs in the course of arranging for or providing health care services and the treatment of the individual is impacted by the health care facility's or health care professional's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives; and

> (c) the health care facility or health care professional is arranging for or providing health care services in good faith.
>
> **2.** The immunity provided by subdivision one of this section shall not apply if the harm or damages were caused by an act or omission constituting willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm by the health care facility or health care professional providing health care services, provided, *however, that acts, omissions or decisions resulting from a resource or staffing shortage shall not be considered to be willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm* (emphasis added).

This legislation closed the gap between management and administrators and the front-line workers. Then, as the uncertainty swirling around the pandemic abated, the New York State Legislature amended Public Health Law §§ 3080-3082 effective August 3, 2020 (NYSCEF 35, pp.43-44). The broad immunity related to COVID-19 prevention and care for non-COVID patients was stricken from the statute. The term "health care services" was amended and defined as,

> ...services provided by a health care facility or a health care professional, regardless of the location where those services are provided, that relate to:
>
> (a) the diagnosis, ~~prevention,~~ or treatment of COVID-19;
>
> (b) the assessment or care of an individual ~~with~~ **as it relates to COVID-19, when such individual has** a confirmed or suspected case of COVID-19; or
>
> (c) ~~the care of any other individual who presents at a health care facility or to a health care professional during the period of the COVID-19 emergency declaration.~~ (*See* Public Health Law § 3081 [5], L.2020, Ch.134, S8835).

Further, Section 3082 was amended to remove the broad language of "arranging for" health care services thereby limiting the immunity to instances where a health care facility or professional was "providing health care services and treatment" (Public Health Law § 3082 [1][a]-[c], L.2020, c.134, S8835). The Legislature added Public Health Law § 3082 [3], which stated "This act shall take effect immediately and shall apply to claims for harm or damages if

the act or omission that causes such harm or damaged occurred on or after such effective date; provided however this act shall not apply to any act or omission occurring after the expiration of the COVID-19 emergency declaration." The plain statutory language set forth that the statute was to be applied prospectively.

The statute was revisited in early 2021 after the release of the Attorney General's "Nursing Home Response to COVID-19 Pandemic" report. This report concluded that the foregoing immunity provisions may have allowed facilities to make financially-motivated, profit driven decisions since they could not be held liable for acts, omissions or decisions resulting from a resource or staffing shortage (NYSCEF 31, pp. 38-39). The Attorney General concluded that facilities may have interpreted this blanket immunity as a way to be insulated from liability even if the shortage of resources or staff was intentional to increase the facilities' profit margins (Id. at p. 39-40). This report was revised and finalized on January 31, 2021.

On January 26, 2021 prior to the release of the Attorney General's final report, Assemblyman Ronald T. Kim, introduced Bill No. 3397, entitled "Repeal the emergency or disaster treatment protection act." The repeal of Public Health Law §§ 3080-3082 was approved by Senate Bill S5177 and effective April 6, 2021 (L.2021, c.96, §1). The Sponsor Memo stated that,

> PURPOSE OR GENERAL IDEA OF BILL:
>
> This bill repeals Article 30-D of the Public Health Law (colloquially known as the Emergency or Disaster Treatment Protection Act) with the intent of holding health care facilities, administrators, and executives accountable for harm and damages incurred…
>
> JUSTIFICATION:
>
> As the COVID-19 pandemic has progressed in New York State, it is now apparent that negligence by administrators and executives of nursing homes has occurred to an extraordinary degree…Article 30-D egregiously uses severe liability

> standards as a means to insulate health care facilities and specifically, administrators and executives of such facilities, from any civil or criminal liability for negligence. *Repealing this article is a much-needed step to holding health care administrators accountable and doing everything possible* ***to stop more preventable deaths from happening*** (emphasis added).

b) Legislative History – Assembly and Senate Transcripts - March 2021.

Article 30-D was repealed effective April 6, 2021, without any further substantive statutory language. As a result, the Court must now turn to the transcript of the Legislative history.

Assemblyman Kim was emphatic that this bill should be applied retroactively. However, his colleagues did not agree. The excerpts from the Assembly transcript reveal that the following assembly members voted for the bill and provided their reasoning why it should not be applied retroactively: Goodell, Tauge, Woerner, McDonald, Lavine, Byrne, Fahy, Eichenstein, Burdick and Griffin (NYSCEF 35). In arguing against retroactivity, Assembly Member McDonald emphasized that, *"[W]e as collectively as a society, but the medical community in particular, was dealing with a crisis of unknown proportions that quickly changed not day by day, but minute by minute in many aspects. I do believe many individuals made the right decisions at the right time when it came to providing patient healthcare. And arguably, unfortunately, in some circumstances the result was not what was hoped for"* (Id. at p. 70). Assembly Member Byrnes voted no for this same reason, i.e., she did not "like the possibility it could be retroactive and hurt good people who did their best in terrible times (Id. at p. 84). Assembly Member Lawler stated that the law should not be retroactive due to the fact that many of the nursing homes were under Executive Order to accept COVID-positive patients into their nursing homes. The Executive Orders created problems for the facilities (Id. at p. 89-90). Assembly Member Eichenstein stated that if the legislation was to be retroactive, there should be clear language in the statute (Id. at

p.91). Assembly Member Burdick concurred that if the law was to be retroactive, the Legislature must have explicitly stated so in the statute (Id. at p.91).

When the bill was introduced on the Senate floor, Senator Mayer stated that, "*And I want to clarify that my understanding is that this bill is prospective, it will apply going forward. We think it's time for a change. There are lessons learned.* ***Let us use the standard of liability that is the standard adopted by the courts to apply to these cases going forward,*** *and let us learn from the past year and ensure that we protect the families of those who have passed away or have been injured, going forward in our quest to have justice be done for all of them*" (NYSCEF 36, pp. 1835-1836).

c) Case Law

"Amendments [to statutes] are presumed to have prospective application unless the Legislature's preference for retroactivity is explicitly stated or clearly indicated" (*Ion re Gleason,* 96 NY2d 117, 122 [2001]). If a statute is remedial in nature, it should be given retroactive effect to implement its beneficial purpose (Id.). However, other factors need to be considered, such as "(1) whether the Legislature has made a specific pronouncement about retroactive effect or conveyed a sense of urgency; (2) whether the statute was designed to rewrite an unintended judicial interpretation; (3) and whether the enactment itself reaffirms a legislative judgment about what the law in question should be" (Id.).

Then, the Court must also consider the impact on the parties' rights when determining whether to apply a statute either retroactively or prospectively. The Court must determine if the statute has a retroactive effect such that, "would it impair rights a party possessed when he [she] acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed, thus impacting substantive rights (*Regina Metropolitan Co., LLC*

v. New York State Division of Housing and Community Renewal, 35 NY3d 332, 366 [2020], *citing Landgraf v. USI Film Products,* 511 U.S. 244, 365 [1994] [internal quotations omitted]). "[T]he Court must ask whether the new provision attaches new legal consequences to events completed before its enactment" (*Landgraf v. USI Film Products,* 511 U.S. 269-270). Therefore, "[E]ven absent specific legislative authorization, application of new statutes passed after the events in suit is unquestionably proper in many situations. When the intervening statute authorizes or affects the propriety of prospective relief, application of the new provision is not retroactive" (*Landgraf v. USI Film Products,* 511 U.S. 244, 273).

The Supreme Court in *Landgraf,* was faced with the task of determining whether the significant amendments to Title VII were to be applied retroactively. When Title VII was initially enacted, a plaintiff who was claiming to be discriminatorily discharged was only entitled to monetary relief in "an amount equal to the wages the employee would have earned from the date of discharge to the date of reinstatement, along with lost fringe benefits such as a vacation pay and pension benefits" (*Landgraf v. USI Film Products,* 511 U.S. 244, 253). However, the amendment to Title VII created a new cause of action and right to recovery where none previously existed. As amended, a plaintiff who won backpay was now permitted to seek compensatory damages for "future pecuniary losses, emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other nonpecuniary losses" (Id.).

The Supreme Court, relying on the legislative history, held that there was no clear evidence of congressional intent that § 102 of the Civil Rights Act of 1991 was to be applied retroactively. Specifically, the Legislative history revealed "no evidence that Members believed that an agreement had been tacitly struck on the controversial retroactivity issue, and little to suggest that Congress understood or intended the interplay" between the different provisions of

Title VII (*Landgraf v. USI Film Products,* 511 U.S. 262-263). More importantly, the legislative history conveyed "the impression that legislators agreed to disagree about whether and to what extent the Act would apply to pre-enactment conduct" (*Landgraf v. USI Film Products,* 511 U.S. 263).

The Supreme Court was meticulous to point out that applying legislation retroactively is strongly disfavored in our jurisprudence. One only need to look to the United States Constitution, i.e., the *Ex Post Facto Clause,* the prohibition on Bills of Attainder, and the prohibition of impairing contractual obligations (*see Landgraf v. USI Film Products,* 511 U.S. 266). Therefore, it is the judiciary's constitutional duty to check the Legislature's unmatched powers and abilities to "sweep away settled expectations suddenly and without individualized consideration" arising from its "responsivity to political pressures" (Id.). In responding to such pressures, the Legislature "may be tempted to use retroactive legislation as a means of retribution against unpopular groups or individuals (Id.). Essentially, the Court has a duty to restrict "governmental power by restraining arbitrary and potentially vindictive legislation (*Landgraf v. USI Film Products,* 511 U.S. 267).

V. Analysis

After a review of the Legislative history, there can be no doubt that the Legislature neither reached an agreement that the repeal of Article 30-D should be retroactive, nor understood the interplay between the EO 202, 202.10, Article 30-d as enacted in April 2020, amended in August 2020, and then repealed in 2021 and ordinary principles of negligence and contract law (*Landgraf v. USI Film Products, supra*). What is clear from the Legislative history is that the Legislature reacted to the political pressures following the release of the Attorney General's report and repealed the statute at least in part to punish unpopular individuals in the

healthcare industry (Id.). In doing so, the Legislature admittedly deferred the determination of retroactivity to the Courts. For these reasons, the Court holds that the repeal of Article 30-D is not retroactive, and defendants are immune from liability.

To hold otherwise, the substantive rights and liability of those individuals covered by EO 202, EO 202.10 and Article 30-D during the early days of the pandemic may be negatively impacted and create liability where none existed at the time (*Regina Metropolitan Co., LLC v. New York State Division of Housing and Community Renewal,* and *Landgraf v. USI Film Products, supra*). As stated by Assembly Members McDonald, Byrnes and Lawlor and Senator Mayer, many individuals made the right decisions at the right time when it came to providing patient healthcare and, at times, with unfortunate results. The foregoing members recognized that a retroactive repeal did not take into consideration the individuals who acted in good faith and would have their rights swept away by politically motivated legislation, for which there was no consensus or agreement by the Legislature (*see Landgraf v. USI Film Products, supra*). Therefore, if this statute were to be applied retroactively, it "could hurt good people who did their best in terrible times" when the nursing homes were "under Executive Order to accept COVID-positive patients into their nursing homes" (NYSCEF 35). It is noted that since the Legislature cannot repeal EO 202 and 202.10, any retroactive effect would restore the potential liability gap between management and administrators and the frontline workers when former Governor Cuomo suspended ordinary negligence and contract law as it related to the healthcare industry. The healthcare industry as a whole (and not only the defendants) was dealing with turmoil and uncertainty in unprecedented times and should not be held to a pre-pandemic standard in hindsight because of others who did not act in the best interest of the patients and public at large.

Having determined that the statute is not retroactive, the Court must now consider whether defendants are entitled to assert immunity as a defense. The determination of whether the statute is retroactive turns on the Legislative intent and not the facts of any one case such as the one before the Court. For the reasons set forth below, this action is dismissed in its entirety.

Plaintiff's argument that from February 1, 2020 through the effective date of the statute defendants were not relying on the statutory protections and should be held liable under ordinary negligence and breach of contract principles is without merit. Plaintiff's allegations in the complaint that defendants' negligent acts commenced on or about February 1, 2020 is in direct contradiction to the Notice of Claim.

A claim against a municipality has the added hurdle of serving a notice of claim prior to the commencement of a lawsuit. The intended purpose of a notice of claim is to provide information to a municipal defendant so that it "can conduct a proper investigation and assess the merits of the claim while the information is still readily available" (*Se Dae Yang v. New York City Health and Hospitals Corporation,* 140 AD3d 1051, 1052 [2d Dept. 2016] [*internal citations omitted*]). Plaintiff may not use the pleadings to assert additional theories of liability not raised in the Notice of Claim (*see Clare-Hollo v. Finger Lakes Ambulance EMS, Inc.*, 99 AD 3d 1199, 1201 [4th Dept. 2012], *citing, Semprini v. Village of Southampton,* 48 AD3d 543, 544 [2d Dept. 2012]). Plaintiff is bound by the dates in the Notice of Claim and any claims premised upon ordinary negligence and contract law on dates outside of the Notice of Claim cannot be considered by the Court.

Plaintiff is also bound by the allegations and theories set forth in the Notice of Claim. Therefore, the facts of decedent's unfortunate demise also do not defeat the immunity afforded to defendants. The plain statutory language of Public Health Law § 3082 (2) clearly stated that,

"*however, that acts, omissions or decisions resulting from a resource or staffing shortage shall not be considered to be willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm.*" The allegations of staffing shortages as set forth in the Notice of Claim and the complaint do not, as a matter of law, fall within the definition based upon the explicit statutory language. Further, the inadequate supervision and training allegations are in direct contradiction of EO 202.10 which permitted physician assistants and specialist assistants to provide services without oversight from a supervising physician. It also permitted nurse practitioners to provide medical services without a practice agreement or collaborative relationship with a physician. Of note is that the medical records demonstrate that decedent's progress was monitored daily and frequently; he was treated as a suspected COVID-19 case; and a "do not hospitalize" order was on file. Plaintiff's statutory hearing testimony corroborates the medical records and the "do not hospitalize" order. The medical records and plaintiff's testimony conclusively establish that all decisions with respect to the care and treatment rendered from March 25, 2020 through April 12, 2020 were directly impacted by the nursing home's response to the COVID-19 pandemic and in accordance with decedent's health care directives for palliative care. Thus, defendants are entitled to immunity protections of Public Health Law §§ 3808-3802.

Moreover, a finding of gross negligence requires an almost complete lack of any diligence or care (*Skywest, Inc. v. Ground Handling, Inc.*, 150 AD 3d 922 [2d Dept. 2017]). "When a party moves to dismiss a complaint pursuant to CPLR § 3211(a)(7), the standard is whether the pleading states a cause of action, not whether the proponent of the pleading has a cause of action…the court must accept the facts as alleged as true…[and] accord plaintiffs the benefit of every possible favorable inference" (*Skywest, Inc. v. Ground Handling, Inc.*, 150 AD

3d 923 [internal citations omitted]). Ultimately, the Court must decide if the facts fit within any cognizable legal theory and if it considers evidentiary material, the criterion for the determination shifts to whether plaintiff has a cause of action (Id.)

Here, the facts as alleged do not fall within the exception to immunity as set forth in Public Health Law § 3802 (2). Plaintiff is essentially arguing that the Attorney General's report provides the basis for a potential finding of gross negligence against defendants by alleging that they prioritized occupancy and revenue while ignoring staffing and care. However, the Court takes judicial notice that the New York State Department of Health Advisory was issued on March 25, 2020, the same day that decedent started to exhibit symptoms of COVID-19.[5] This directive prevented nursing homes from denying residents admission or re-admission to a nursing home solely on the basis of a confirmed or suspected diagnosis of COVID-19 and prohibited the nursing home from testing residents for COVID-19 prior to admission. The nursing homes were directed to rely upon the discharging hospital's determination that the resident was medically stable for discharge. Therefore, as it is undisputed that decedent was exhibiting symptoms of COVID-19 on the same day this directive took effect, any nexus between the directive and the alleged prioritization of occupancy and staffing based upon the cloak of immunity granted on April 7, 2020 by Public Health Law §§ 3808-3802 is without merit. It is without question that the plaintiff does not have a cause of action for grossly negligent, willful, or intentional conduct (*see Skywest, Inc. v. Ground Handling, Inc., supra*).

Accordingly, it is hereby

ORDERED, that defendants' motion to dismiss this action with prejudice is granted in its entirety; and it is further

---

[5] DOH_COVID19__NHAdmissionsReadmissions__032520_1585166684475_0.pdf (monroecounty.gov); *see also* the Attorney General's Report, NYSCEF 31, p.36.

ORDERED, that the Clerk shall enter judgment accordingly.

This constitutes the decision and order of the Court.

Dated: May 17 , 2022

ENTER:

HON. THOMAS P. ALIOTTA, J.S.C.