Fillyow v Sprain Brook Manor Rehab LLC

2024 NY Slip Op 35205(U)

July 23, 2024

Supreme Court, Westchester County

Docket Number: Index No. 59621/2022

Judge: Gretchen Walsh

To commence the statutory time period for appeals as of right (CPLR 5513[a]), you are advised to serve a copy of this order, with notice of entry, upon all parties.

SUPREME COURT OF NEW YORK
COUNTY OF WESTCHESTER: COMMERCIAL DIVISION
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THERESA FILLYOW, Individually and as Administratrix of the Estate of LORRAINE ARCHER,

Plaintiff,

- against -

SPRAIN BROOK MANOR REHAB LLC, SPRAIN BROOK MANOR NURSING HOME, LLC and JOHN/JANE DOES #1-5 (fictitiously named as unknown employees and/or agents of SPRAIN BROOK MANOR REHAB, LLC, and/or SPRAIN BROOK MANOR NURSING HOME, LLC),

Defendants.
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Index No. 59621/2022
Motion Seq. Nos. 1
Motion Date: 5/10/24

DECISION & ORDER

WALSH, J.

The following e-filed documents, listed in NYSCEF by document numbers 17-33 were read on this motion by Defendants Sprain Brook Manor Rehab, LLC and Sprain Brook Manor Nursing Home, LLC (together "Sprain Brook" or "Defendants") pursuant to CPLR 3211(a)(1) and (7) and pursuant to the immunity defenses provided by the Emergency Disaster Treatment and Prevention Act ("EDTPA," codified as Public Health Law former §§ 3080-3082 or Article 30-D) and Public Readiness and Emergency Preparedness Act ("PREP Act," 42 USC § 247d-6d) for an Order dismissing the Verified Complaint dated April 21, 2022 (the "Complaint") of Plaintiff Theresa Fillyow, individually and as administratrix of the estate of Lorraine Archer ("Plaintiff"). Plaintiff opposes the motion.

Upon the foregoing documents, and for the reasons stated herein, Sprain Brook's motion shall be granted.

RELEVANT PROCEDURAL BACKGROUND

Plaintiff commenced this action on April 21, 2022 by filing a Summons and Complaint (NYSCEF Doc. No. 1). Sprain Brook filed its Answer on May 16, 2022 and its Corporate

Verification to its Answer on May 17, 2022 (NYSCEF Doc. Nos. 4, 6). The Court issued a Preliminary Conference Order on August 21, 2023 (NYSCEF Doc. No. 16) and, in response to Sprain Brook's demand, Plaintiff served a Verified Bill of Particulars dated December 13, 2023 (NYSCEF Doc. No. 29). Following multiple conferences with the Court, Sprain Brook filed this motion on March 26, 2024 (NYSCEF Doc. Nos. 17-30). Plaintiff opposes the motion (NYSCEF Doc. Nos. 31-33). On July 11, 2024, Plaintiff filed a consent to change attorney substituting Horn Wright, LLP for The Russell Friedman Law Group, LLP as attorneys for Plaintiff (NYSCEF Doc. No. 35).

ALLEGATIONS OF THE COMPLAINT

In her Complaint, Plaintiff seeks to recover "for the physical, mental, financial, and other damages Plaintiff sustained due to Defendants' negligence, gross negligence, and/or violation of the applicable statutes, laws, rules, and regulations including, but not limited to, 42 U.S.C. § 1395(i) et seq., 42 C.F.R. Part 483, New York Public Health Law § 2801-d, § 2803-c and, 10 N.Y.C.R.R. § 415.12" (Complaint at ¶ 1). Plaintiff asserts that, on April 18, 2022, the Surrogate's Court of the State of New York, County of Westchester granted Letters of Administration appointing Plaintiff the fiduciary of Archer's Estate (*id.* at ¶ 4). She states that at all relevant times, Sprain Brook "owned, operated, maintained, managed, supervised, and controlled a nursing home facility located at 77 Jackson Avenue, Scarsdale, New York" (the "Facility") (*id.* at ¶¶ 10-11). Plaintiff alleges that from on or about February 1, 2020 until her death on or about April 22, 2020, Archer resided at the Facility and was in the care and custody of Sprain Brook and the Individual Defendants[1] (*id.* at ¶¶ 12-15).

For her First Cause of Action for negligence, Plaintiff alleges that "Defendants had common law and statutory duties to provide care to Ms. Archer, including but not limited to, lodging and board, dietary supervision, hygiene services, physical observation and assistance, medical monitoring, care and treatment, and creating and maintaining medical records" as well as heightened duties to provide for her care and wellbeing including the "prevention, detection, and proper treatment of injury, illness, infection, and other medical conditions" (*id.* at ¶¶ 17-18). Plaintiff alleges that Defendants negligently breached these duties by failing to provide Archer the necessary attention, observation, care and treatment despite knowing that her condition required attention, care and treatment, resulting in "injuries, illness, fear of impending death, and other physical and psychological insults due to Defendants' negligence, from which she suffered until her death" (*id.* at ¶¶ 19-22). Plaintiff asserts that Plaintiff's damages were caused solely and wholly by Defendants' negligence without any negligence on the part of Archer or Plaintiff (*id.* at ¶ 23). Plaintiff alleges that, due to Defendants' negligence, Archer suffered medical conditions which caused her death on or about April 22, 2020 (*id.* at ¶ 24).

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[1] The term "Individual Defendants" refers to John/Jane Does #1-5 (fictitiously named as unknown employees and/or agents of Sprain Brook).

For her Second Cause of Action for gross negligence, Plaintiff alleges that Defendants and their agents, servants, and/or employees including Individual Defendants acted so carelessly and recklessly and/or failed to act in circumstance in which action was so clearly required as to evince a complete disregard of the consequences for others, including Archer (*id.* at ¶¶ 27-28). Plaintiff asserts that Defendants acted willfully and that due to Defendants' gross negligence, Archer sustained injuries, illness, infection, and other medical conditions which caused her death on or about April 22, 2020 entitling Plaintiff to punitive damages, attorneys' fees and costs in addition to all other damages (*id.* at ¶¶ 30-31).

For her Third Cause of Action for statutory violations, Plaintiff alleges that the Facility was a "nursing home" as defined in New York Public Health Law § 2801(2), that the Facility was a "residential health care facility" as defined in New York Public Health Law §§ 2801(3) and 2801-D, that the Facility was subject to the provisions of New York Public Health Law § 2803-C, and that the Facility was subject to the rules and regulations set forth in 42 U.S.C. § 1395(i) et seq. and 42 C.F.R. Part 483 (*id.* at ¶¶ 34-37). Plaintiff asserts that Archer's "injuries, illness, conscious pain, suffering, fear of impending death, and death were proximately caused by Defendants' violations of New York Public Health Law §§ 2801-C and 2803-C" (*id.* at ¶ 38). Plaintiff alleges that Defendants' duties to Archer pursuant to these statutes were nondelegable and that Defendants are directly and vicariously liable for all violations of Archer's rights "under the aforementioned statutes, laws, rules, and regulations by any person or entity of any type under their control, direct or indirect, including employees, agents, consultants, and independent contractors, whether in-house or outside, individuals, agencies, or pools, and/or caused by Defendant's policies, whether written or unwritten, or common practices" (*id.* at ¶¶ 39-40). Plaintiff asserts that Defendants, their employees, agents, consultants and independent contractors deprived Archer of her rights under these statutes causing her injury resulting in her death and that Plaintiff is entitled to attorneys' fees pursuant to Public Health Law § 2801-d(6), punitive damages pursuant to Public Health Law § 2801-d(2), and costs, in addition to all other damages (*id.* at ¶¶ 41-43).

For her Fourth Cause of Action for wrongful death, Plaintiff alleges that, due to the negligence, gross negligence and statutory violations of Defendants, their agents, servants and/or employees, Archer died on or about April 22, 2020, that she was aware that it was likely to due from the injuries, illnesses and conditions caused by Defendants and that she "sustained conscious pain and suffering, severe emotional distress and fear of impending death as manifested by apprehension, fear, defenselessness, vulnerability, insecurity, helplessness, distress, anxiety, panic, and trepidation" (*id.* at ¶¶ 46-48). Plaintiff states that she is Archer's sister and that she "contributed love, care, guidance, nurture, and other services to Plaintiff" and that due to Defendants' negligence, gross negligence and statutory violations, Plaintiff "has been deprived of Decedent's society, services, comfort, consortium, and companionship, has been physically, socially, and economically damaged as a result thereof and became liable for Ms. Archer's funeral expenses and other financial obligations" (*id.* at ¶¶ 49-51).

For her Fifth Cause of Action for failure to maintain adequate quality of care, Plaintiff alleges that Defendants participated in Medicare and Medicaid programs but failed to comply with the requirements for long term care under 42 C.F.R. Part 483, the Medicare and Medicaid

programs, and all other statutes, laws, rules, and regulations (*id.* at ¶ 55). Plaintiff alleges that Defendants "failed to prevent the development of bedsores and/or properly treat and promote the healing thereof, as required by 10 N.Y.C.R.R. §§ 415.12(c)(1) and (2) and 42 C.F.R. §§ 483.25(c)(1) and (2)" (*id.* at ¶ 56).[2] Plaintiff further alleges that Defendants failed to ensure that Archer's environment remained free of accident hazards as required by 42 C.F.R. § 483.25(h)(1), failed to ensure that she received adequate supervision to prevent accidents as required by 42 C.F.R. § 483.25(h)(2) and failed to exercise care reasonably necessary to prevent and limit the deprivation and injury for which liability is hereby asserted pursuant to 42 C.F.R. § 483.25(h)(1) and (2) (*id.* at ¶¶ 57-59). Plaintiff asserts that due to Defendants' failure to maintain the appropriate quality of care, Archer sustained injuries, illness, infection and other medical conditions which caused her death (*id.* at ¶ 60).

For her Sixth Cause of Action for negligent hiring, supervision and retention, Plaintiff alleges that Defendants owed Archer "the higher than ordinary duty of care applicable to nursing home residents within their custody, care, and control" and at least a duty to protect her from harm inflicted by its servants, agents and/or employees when receiving medical services (*id.* at ¶¶ 63-64). Plaintiff alleges that, prior to granting or renewing privileges or employment to its employees and/or agents who rendered care and treatment to Archer, Sprain Brook "negligently failed to properly investigate the qualifications, competence, capacity, abilities, and capabilities thereof," "negligently failed to properly train, oversee, and/or supervise its employees and/or agents who rendered care and treatment to Ms. Archer, including but not limited to Individual Defendants," and "knew or should have known that their employees and/or agents who rendered care and treatment to Ms. Archer, including but not limited to Individual Defendants, lacked the requisite skills, abilities, competence, and capacity to do so properly, and negligently allowed them to continue to do so" resulting in Archer being treated and cared for by physicians, nurse practitioners, nurses and/or other employees of Spain Brook who lacked the requisite skills, abilities, competence, and capacity to do so properly resulting in Archer suffering severe injuries and illnesses which led to her death (*id.* at ¶¶ 65-68).

In their Answer, Defendants deny the material allegations of the Amended Complaint and assert fourteen Affirmative Defenses.

THE PARTIES' CONTENTIONS

A. Sprain Brook's Contentions in Support of Their Motion

In support of their motion to dismiss, the Sprain Brook Defendants submit an affirmation of Sheilagh Lichtenfels, Esq. dated March 26, 2023 ("Lichtenfels Aff."), together with exhibits (NYSCEF Doc. Nos. 18-30).

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[2] Because Plaintiff's Bill of Particulars is bereft of any reference to a claim of negligence involving bedsores (see NYSCEF Doc. No. 29), and because Plaintiff fails to raise bedsores as a basis for Defendants' liability in opposition to Defendants' motion (see NYSCEF Doc. Nos., 31-32), Plaintiff has waived the right to present a negligence claim against Defendant based on bedsores.

The purpose of counsel's affirmation is to summarize Defendants' legal arguments and to provide copies of, inter alia, the pleadings in this action, certain statutes and cases cited in counsel's affirmation, and other documentary evidence (Lichtenfels Aff. at ¶¶ 1-72; Exs. A-L).

Also included among the exhibits to counsel's affirmation is an affidavit of Amy Mendizabal ("Mendizabal") sworn to on March 26, 2024 ("Mendizabal Aff."). Mendizabal avers that she has been the Director of Nursing at Sprain Brook since 2015, approves and oversees the implementation of all infection control policies and procedures for Sprain Brook and oversaw the implementation of all COVID-19 policies and procedures for Sprain Book from January of 2020 through April of 2020, as well as the "continuous Covid-19 education and trainings in place for all staff at Sprain Brook, from the start of the Covid-19 pandemic and as it continued" (Mendizabal Aff. at ¶¶ 1-2). She avers that Sprain Brook is a "rehabilitation and nursing facility located in Scarsdale, New York [which] consists of several units that are comprised of both long-term care and short-term rehabilitation for residents, for 121 residents" and that her affidavit references exhibits consisting of records and documents that she received and reviewed personally (*id.* at ¶¶ 4-5). Mendizabal avers that Sprain Brook had extensive infection control program and policies in place prior to the COVID-19 pandemic, including "policies related to Cleaning and Disinfecting Residents' rooms; communication during a pandemic; and pandemic preparedness plan, which includes a planning for surge capacity" and which addressed the use of PPE, surface disinfection and reusable equipment, safe inspection practices, resident placement, infection control and floor restrictions, as well as including topics related to airborne precautions in the transmission-based precaution policy (*id.* at ¶¶ 6-7). She avers that as early as March of 2020, and in response to the emerging COVID-19 pandemic, the Facility kept abreast of all federal (CDC and CMS), New York State Department of Health ("NYS DOH") and local regulations concerning COVID-19 and, in light of the directives issued by the WHO and CDC, created new policies, protocols and staff educations programs pursuant to the directives of these governmental agencies and that this comprehensive policy was in place as early as March of 2020 and was monitored, reviewed and revised based upon WHO, DOH, CMS and CDC guidance (*id.* at ¶¶ 8-9).

Mendizabal avers that the policies and procedures addressing COVID-19 in place as of March of 2020, included, inter alia, "screening visitors who enter the facility; policies and procedures pertaining to prevention and control of the spread/transmission of Covid-19; resident placement and distancing when Covid-19 positive or suspected Covid-19 positive; hand hygiene; personal protective equipment use, including gloves, gowns, respiratory protection, and eye protection; visitor access and movement within the facility; monitor and manage ill and exposed healthcare personnel; training and educating healthcare personnel; Covid-19 exposure for both residents and staff members; Covid-19 admission and re-admissions (including isolation precautions); implementing environmental infection control; and establishing reporting within healthcare facilities and to public health authorities," and included information on how the virus spread as well as its signs and symptoms (*id.* at ¶ 10).

Mendizabal avers that "[w]ithin this policy, employees were instructed to follow CDC guidelines on handwashing, personal protective equipment use [including gloves, gowns,

respiratory protection, and eye protection], and to disinfect work areas" as well as being instructed concerning what to do if a resident was confirmed positive for COVID-19 (*id.* at ¶ 11). She states that protocols were put in place for both transfer to the hospital or treating in place and that "[e]xtensive guidance for the staff on the affected unit of a Covid-19 positive resident was also included with the policies and procedures they must follow to prevent transmission of the virus" (*id.*). Mendizabal represents that as it was not known in early 2020 if the virus was airborne or droplet-producing, the Facility had no ability to make independent decisions concerning the safety of its staff or residents and relied entirely on the directives provided by government agencies, which was transmitted locally to all skilled nursing facilities by New York's Department of Health ("DOH") after receiving its directives from the Center for Disease Control ("CDC") and the World Health Organization and, as information was learned from the CDC and WHO, the DOH would issue amended or revised guidance (*id.* at ¶¶ 12-14). Mendizabal states that as the pandemic continued, Sprain Brook held regular staff meetings, education and trainings to continue to inform and educate staff on all new information concerning COVID-19 with each update, as well as holding daily educational meetings and discussions over "proper PPE usage, appropriate chemicals, testing policies, visitor policies, treatment options, and best practices" (*id.* at ¶ 15).

According to Mendizabal, Sprain Brook began screening visitors for COVID-19 starting on March 2, 2020 (*id.* at ¶ 16). She states that on March 16, 2020, the DOH issued guidance on both asymptomatic and symptomatic employees returning to work following a COVID-19 infection including policies for mask wearing and the possibility of recurring symptoms (*id.* at ¶ 17). She further states that on March 21, 2020, the DOH issued guidance to nursing facilities stating that residents with febrile acute respiratory illness should be presumed to have COVID-19 unless testing indicated otherwise (*id.* at ¶ 18). Mendizabal avers that through March and April as the pandemic progressed, Sprain Brook implemented measures to ensure proper use of PPE pursuant to guidance issued by the DOH due to the shortage caused by the pandemic (*id.* at ¶ 19). She avers that on March 25, 2020, an Executive Order was issued by the then Governor of New York directing that facilities could not refuse to admit COVID-19 positive patients and that "all of our operations were therefore impacted by the response to the pandemic with respect to each and every resident, including Lorraine Archer" (*id.* at ¶ 20).

Specifically with respect to Archer, Mendizabal avers that Archer, who 86 years old at the time, was initially admitted to Sprain Brook from Northern Dutchess Hospital on February 6, 2020, for long-term care (*id.* at ¶ 27). She asserts that the Facility contacted Archer's family as early as March 10, 2020 to advise them of the ban on all visitation and instead offered family members opportunities to communicate via phone and video with Archer (*id.* at ¶ 28). Mendizabal avers that "[o]rders were in place to monitor Ms. Archer's oxygen levels upon admission due to her existing conditions including COPD, for which she received supplemental oxygen via nasal cannula" which were maintained throughout her admission to Sprain Brook and that, pursuant to Sprain Brook's policies and procedures implemented to identify, treat and prevent the transmission of COVID-19, Archer's vitals were monitored each shift starting as early as March 18, 2020 (*id.* at ¶ 29). Mendizabal avers that this monitoring of her oxygen and blood pressure continued daily until her discharge on April 14, 2020 and that, in addition to monitoring Archer's vitals, staff who were in

contact with Archer were screened for signs and symptoms of COVID-19 and were required to disinfect and wore appropriate PPE (*id.*).

Mendizabal states that, on or about this time, the Governor suspended the "minimum standards" of maintain records to the extent necessary to maintain the public health with respect to treatment or containment of individuals with or suspected to have COVID-19 and, due to this Executive Order, staff limited their interaction with one another including spending less time at communal locations such as the nursing station and computer kiosks where documentation would be entered (*id.* at ¶ 30). Mendizabal asserts that that because of this change, which was required to prevent the spread of COVID-19 at the Facility and minimize COVID-19 related complications to residents infected, as well as to minimize exposure and maximize social distancing, records on Archer may not have been entered daily (*id.*).

Mendizabal avers that from February of 2020 until April of 2020, Archer's oxygen saturation was measured to monitor for signs and symptoms of COVID-19 and that, as of March 5, 2020, due to the pandemic, like other residents, Archer was encouraged to socially isolate or distance from others, visitation was restricted and communal meals were cancelled (*id.* at ¶¶ 31-32). Mendizabal further avers that in response to a potential COVID-19 exposure, Archer was placed in an isolation unit on March 24, 2020 and that staff continuously wore PPE and were screened pursuant to Sprain Brook's policies for signs of COVID-19 (*id.* at ¶ 33). She states that Archer was reportedly found to have a clogged J-tube and was ordered to be transferred to the ER (*id.*). Mendizabal avers that her vitals were normal and her SpO2 was 95% (*id.*). Mendizabal further avers that Archer returned to Sprain Brook from the hospital on April 14, 2021 at 12:30 a.m., that her J-tube was not replaced in the hospital, that she was alert and verbally responsive and that her vitals were again normal and her SpO2 was 95% (*id.*). Mendizabal asserts that, on April 14, 2020, Archer went to Saint John's Riverdale Hospital ("SJRH") Radiology for an outpatient J-tube replacement (*id.* at ¶ 34). Mendizabal represents that, according to Dr. Sadloo, Archer became hypoxic while at SJRH and, at 10:20pm, she was transferred to and then admitted to SJRH with suspected COVID-19 (*id.* at ¶ 34). Mendizabal avers that Archer died at SJRH on or about April 22, 2020 (*id.* at ¶ 35).

Mendizabal avers that throughout her admission to Sprain Brook and during the COVID-19 pandemic, Archer was monitored, cared for and treated pursuant to directives from the DOH, CMS, CDC and the Facility's COVID-19 policies and procedures (*id.* at ¶ 36). She further avers that Archer's care and treatment at Sprain Brook was impacted by the Facility's response to the COVID-19 pandemic and, by mid-March 2020, her family was no longer able to visit and she was only seen by essential staff for essential reasons (*id.* at ¶ 36). Mendizabal states that Sprain Brook implemented preventative measures throughout Archer's stay at Sprain Brook "including taking and monitoring her vitals-such as her oxygen saturation and blood pressure, and screening her for the virus, as were staff members, who wore PPE in caring for these residents" (*id.* at ¶ 37). Mendizabal asserts that there is no way to determine when Archer contracted COVID-19, as she was out of the Facility when she was admitted to SJRH on April 13-14, 2020 and for the subsequent replacement of her J-tube (*id.* at ¶ 38). Mendizabal concludes by averring that, throughout Archer's stay, Sprain Brook provided health care in accordance with both applicable law and pursuant to

COVID-19 emergency rules and that all actions taken by Sprain Brook "to provide health care services to protect our residents between February and April of 2020 was done in utmost good faith to minimize possible Covid-19 spread and unnecessary death" (*id.* at ¶ 39).

In her affirmation, Lichtenfels states that the allegations in the case are that Defendants failed to prevent the transmission of COVID-19 and death of Archer during the time that she was a resident of the Facility during the height of the COVID-19 pandemic and, as Sprain Brook is a licensed long-term care facility, it is immune from liability and suit and, therefore, the Complaint must be dismissed (Lichtenfels Aff. at ¶ 2). Lichtenfels lists the exhibits she submits and summarizes the history of the PREP Act and EDTPA's enactment (*id.* at ¶¶ 4-9). Lichtenfels asserts that, in terms of Sprain Brook's response to the COVID-19 pandemic, prior to the pandemic Sprain Brook had an extensive infection control program and policies in place including related to "cleaning and disinfecting residents' rooms; communication during a pandemic; and pandemic preparedness plan, which includes a planning for surge capacity" (*id.* at ¶ 10). She states that these policies and procedures also addressed topics such as "the use of personal protective equipment (PPE), surface disinfection and reusable equipment, safe infection practices; resident placement; infection control; and floor restrictions," including topics relating to airborne precautions (*id.* at ¶ 11). Lichtenfels asserts that "[a]s early as March of 2020 and in response to the emerging COVID-19 pandemic, the facility kept abreast of all federal (Center for Disease Control ('CDC') and Centers for Medicare and Medicaid Services ('CMS'), New York State Department of Health ('NYS DOH') and local regulations concerning COVID-19" and in light of these directives, Sprain Brook created new policies, protocols and staff education programs pursuant to the directives of these government agencies (*id.* at ¶ 12). Specifically, Lichtenfels states that to comply with these directives, Sprain Brook developed and implemented a program to plan for the prevention, mitigation and treatment of COVID-19 involving the promulgation of the practices directed by the government agencies and the "development of protocols and policies, in-service education and drafting of written policies to memorialize the practices and protocols that were implemented pursuant to the directives of the CDC and CMS and relayed to Sprain Brook by the NYS DOH and to be adopted by all staff members in caring for residents," which was in place as early as March of 2020 (*id.* at ¶ 13).

According to Lichtenfels, from January through at least May of 2020, Sprain Brook was closely monitoring the development of COVID-19 and, as of March of 2020, had a comprehensive policy based off of the WHO to minimize exposure to respiratory pathogens, including COVID-19, including minimizing change for exposure upon both admission and with residents who began exhibiting symptoms of COVID-19 which was reviewed and revised based upon WHO, DOH, CMS and CDC guidance (*id.* at ¶ 14). Lichtenfels states that these policies and procedures specifically addressing COVID-19 in place as of March of 2020 included: "screening visitors who enter the facility; policies and procedures pertaining to prevention and control of the spread/transmission of COVID-19; resident placement and distancing when COVID-19 positive or suspected COVID-19 positive; hand hygiene; personal protective equipment use, including gloves, gowns, respiratory protection, and eye protection; visitor access and movement within the facility; monitor and manage ill and exposed healthcare personnel; training and educating healthcare personnel; COVID-19 exposure for both residents and staff members; COVID-19

admission and re-admissions (including isolation precautions); implementing environmental infection control; and establishing reporting within healthcare facilities and to public health authorities" and also included information on how the virus spread as well as its signs and symptoms (*id.* at ¶¶ 15-16). Lichtenfels asserts that, within this policy, employees were instructed to follow CDC guidelines on "handwashing, personal protective equipment use [including gloves, gowns, respiratory protection, and eye protection], and to disinfect work areas" and given instructions as what to do if a resident was confirmed positive for COVID-19, including protocols for both transfer to the hospital or treating in place as well as guidance for the staff of the affected unit to prevent transmission of the virus (*id.* at ¶ 17).

Lichtenfels states that as it was not yet known in early 2020 if the virus was airborne or droplet-producing as a contagion, the Facility administration and nursing staff had no ability to make independent decisions about how to manage the safety of the residents or the staff beyond their ordinary infection control policies and procedures in place prior to any specific COVID-19 directive or regulation was issued and relied entirely on the directives provided by governmental agencies (*id.* at ¶ 18). She states that communications about the directives were transmitted locally to all skilled nursing facilities by the DOH after it received direction from the CDC and WHO and that these notifications "were received nearly daily in the first month of the pandemic, and in some cases more than once a day" (*id.* at ¶ 19). Lichtenfels asserts that as the pandemic continued, "regular staff meetings, education, and trainings were held in which Sprain Brook would continue to inform and educate the staff on all new information" and were performed with each update of the pandemic (*id.* at ¶ 20). She also states that daily educational meetings took place discussing these items and proper PPE usage, appropriate chemicals, testing policies, visitor policies, treatment options, and best practices (*id.*).

According to Lichtenfels, beginning on March 2, 2020, Sprain Brook began screening visitors for COVID-19 (*id.* at ¶ 21). Lichtenfels states that, on March 16, 2020, the DOH issued guidance on employees returning to work following a COVID-19 infection and, on March 21, 2020, the DOH issued guidance advising nursing facilities that residents with febrile acute respiratory illness should be presumed to have COVID-19 unless testing indicated otherwise (*id.* at ¶¶ 22-23). Lichtenfels asserts that, as the pandemic progressed through March and April, Sprain Brook "implemented measures to ensure proper use of PPE pursuant to guidance issued by the . . . DOH, because there was a shortage, all in response to the pandemic" (*id.* at ¶ 24). She represents that, on March 25, 2020, the NYS DOH issued an advisory pursuant to an Executive Order issued by the then-Governor directing that nursing facilities could not refuse to admit COVID-19-positive patients, which impacted Sprain Brook's operations with respect to all residents, including Archer (*id.* at ¶ 26).

With respect to this action, Lichtenfels affirms that Archer, who was 86 years old at the time, was initially admitted to Sprain Brook from Northern Dutchess Hospital on February 6, 2020 for long-term care and refers to the Affirmation of the Director of Nursing, Amy Mendizabal, RN, DON regarding the facts of Archer's stay, as well as her chart, both included as exhibits (*id.* at ¶¶ 27-28, Exs. B, H at ¶¶ 27-39). Plaintiff further affirms that on December 13, 2023, in response to

Sprain Brook's demand, Plaintiff served a Verified Bill of Particulars claiming that Sprain Brook's alleged negligence caused Archer to contract COVID-19 leading to her death (*id.* at ¶¶ 30-31).

As Defendants' legal argument, Lichtenfels contends that, based upon the Bill of Particulars, Sprain Brook is immune from suit and liability. Lichtenfels first argues that Plaintiff's Complaint should be dismissed pursuant to EDTPA immunity. She asserts that "Public Health Article 30-D, the EDTPA, enacted on April 6, 2020, and made retroactive to March 7, 2020, limited liability to health care facilities for all civil matters for negligent injuries or death resulting directly due to the COVID-19 pandemic" and, therefore, a facility, including nursing homes, only needed to demonstrate that the treatment of the individual was impacted the facility's decisions or activities in response to or as a result of the COVID-19 outbreak (*id.* at ¶¶ 32-34). Lichtenfels further asserts that the statute does not qualify how treatment must be impacted and that, therefore, this impact may be positive, negative or otherwise (*id.* at ¶ 34). Lichtenfels argues that, although the EDTPA was limited in August of 2020 and repealed on April 6, 2021, the First, Third and Fourth Departments have ruled that the repeal was not meant to be retroactive and the Second Department must follow this precedent (*id.* at ¶ 35). Lichtenfels contends that "New York courts have found the factual predicate for invoking EDTPA immunity to be minimal" and cites to cases in which she asserts immunity was found under the same allegations as in this case (*id.* at ¶ 36). She further contends that other Westchester County judges have already determined that dismissal is warranted based on the EDTPA, as well as citing decisions from the Supreme Courts in Queens County, Bronx County and Nassau County, which she argues have rejected the notion of retroactivity of the repeal and dismissed "identical" complaints (*id.* at ¶ 37).

Lichtenfels asserts that the "only claims that do not fall under the EDTPA are claims that conduct was intentional criminal misconduct or infliction of harm, gross negligence, or reckless misconduct, or those which arose before March 7, 2020. Public Health Law former § 3082(2)" and argues that the Complaint fails to state a cause of action for gross negligence or intentional misconduct (*id.* at ¶ 38). She first contends that "it is clear from the attached affirmation and exhibits referenced therefrom that Sprain Brook treated and cared for Ms. Archer pursuant to a COVID-19 emergency rule" as defined by the EDTPA (*id.* at ¶ 39). She further contends that Mendizabal "outlined at length the CDC, . . . DOH, and WHO directives that Sprain Brook based its COVID-19 plan upon" (*id.*).

Second, Lichtenfels argues that "there has been a more than a clear showing that Ms. Archer's treatment was impacted by the facility's response to the pandemic" because "by mid-March 2020 her family was no longer able to visit, communal activities were stopped, and she was seen only by essential staff who wore PPE when caring for these residents, had her blood pressure and oxygen saturation monitored daily, and was screened for signs and symptoms of COVID-19" (*id.* at ¶ 40). She relies on the affidavit of Mendizabal in asserting that the Facility responded to the pandemic and enacted a plan and policies in response to the pandemic to prevent residents and staff from contracting COVID-19 (*id.* at ¶¶ 40-41).

Third, Lichtenfels asserts that Sprain Brook applied its policies and procedures in good faith in its care and treatment for Archer to prevent illness and death and that social distancing was

practiced for her as well as monitoring her vital signs and symptoms for COVID-19 (*id.* at ¶ 42). Lichtenfels states that, following a potential exposure on March 24, 2020, Archer was transferred to an isolation unit and monitored, and that staff continuously wore PPE and were screened for signs of COVID-19 (*id.*). Lichtenfels asserts that, on April 13, 2020, Archer was found to have a clogged J-tube and was ordered to be transported to the ER (*id.*). Lichtenfels asserts that Archer's vitals were normal, her oxygen saturation was 95% and she returned from the hospital at 12:30 am on April 14, 2021 (*id.*). Lichtenfels argues that Archer's J-tube was not replaced at the hospital and that Archer was alert and verbally responsive with normal vitals and an oxygen saturation at 95% (*id.*). Lichtenfels asserts that, on April 14, 2020, Archer went to SJRH for an outpatient J-tube replacement, became hypoxic while there and at 10:20 p.m., she was transferred to and then admitted to SJRH with suspected COVID-19 (*id.* at ¶ 43). Lichtenfels states that Archer died on or about April 22, 2020, at SJRH (*id.* at ¶ 43).

According to Lichtenfels, throughout Archer's stay, Sprain Brook followed CMS and DOH guidance in response to the pandemic through limiting visitation to only essential workers, providing PPE for its staff, and wearing PPE in front of patients, as well as updating protocols as more information was learned and disseminated regarding the virus (*id.* at ¶¶ 44-45). Lichtenfels states that Archer "was isolated for COVID-19 protection on March 24, 2020, and as early as March 2020, Sprain Brook was regularly practicing social distancing, pursuant to guidance from the DOH, NYDOH, CMS, and the CDC," [h]er vitals were monitored for signs and symptoms of COVID-19" and "she did not begin to display symptoms of COVID-19 until after she was transferred out of the facility for outpatient treatment at SJRH, making it impossible to determine where she contracted the virus" (*id.* at ¶ 46). Lichtenfels argues that Archer was monitored, cared for and treated during her admission at the Facility but that her treatment was impacted by the Facility's response to the COVID-19 pandemic and that Sprain Brook acted in good faith as pursuant to the language provided by the EDTPA and therefore is entitled to immunity from suit and liability as a matter of law (*id.* at ¶ 47).

Next, Lichtenfels argues that the gross negligence cause of action cannot be sustained as a matter of law because Plaintiff's allegations of gross negligence and recklessness are too vague and boilerplate (*id.* at ¶ 48). She asserts that such claims are speculative, duplicate and conclusory with no specificity as to each individual action and, therefore, fails to state a claim upon which relief can be granted (*id.*). Relying on various New York cases, she argues that Plaintiff is "making an attempt to plead outside of the statute and under the exception to immunity" and that "[s]uch conduct clearly demonstrates how there is no basis in law for the general boilerplate allegations in this case" (*id.* at ¶ 49). Lichtenfels argues that "Plaintiff's bill of particulars merely lists blanket assertions that the facilities actions amounted to gross negligence without specifying how or what specific actions were grossly negligent" (*id.* at ¶¶ 50-52). She contends that there is no distinction between the conduct alleged to constitute ordinary negligence and that alleged to constitute gross negligence and that the same facts are used to support the negligence and violation of the Public Health Law claims as the gross negligence claim, demonstrating that this action is not "tailored" to any specific acts at the Facility (*id.* at ¶ 52). Therefore, Lichtenfels argues, Plaintiff's allegations concerning gross negligence, recklessness and willful misconduct relating to nursing home case should be dismissed (*id.* at ¶ 53). Lichtenfels also argues that "pursuant to the . . . DOH Advisory

dated March 25, 2020, nursing home facilities were prohibited from refusing admission to a resident based solely on a confirmed or suspected COVID-19 diagnosis" and, therefore, "to the extent that any of plaintiff's allegations refer to the fact that Sprain Brook knowingly accepted COVID-19-positive residents . . . Sprain Brook did so in compliance with a . . . DOH directive, and thus, did not act with gross negligence" (*id.* at ¶ 54). Lichtenfels contends that Sprain Brook is similarly immunized from liability for Plaintiff's allegations that Sprain Brook improperly failed to train staff at its Facility and failed to maintain an accurate medical chart based on the EDTPA (*id.* at ¶ 55). She argues that Sprain Brook staff acted in good faith and relied on continuous governmental guidance with respect to handling the unprecedented health emergency and that these claims should be dismissed (*id.* at ¶ 56). Lichtenfels also argues that Sprain Brook has complete immunity pursuant to New York State Executive Order 210.10 (*id.* at ¶ 57).

Third, Lichtenfels argues that dismissal is warranted based on the PREP Act given the "totality of the allegations made therein, and the logical impact of their most central allegations, the PREP Act is implicated by plaintiff's claims against Sprain Brook as 'covered persons' engaged in 'recommended activities' under the Act" (*id.* at ¶ 59). She asserts that Sprain Brook is a covered person under the PREP Act "because it is a nursing home licensed by the State of New York and because it was following the guidance of authorities having jurisdiction (such as the state or federal government) when administering and using covered countermeasures and making decisions to such use and administration in managing and operating a COVID-19 countermeasure program plan and location/facility" and that it was acting as a "program planner" that supervised its COVID-19 infection control program (*id.* at ¶¶ 60-61). Lichtenfels argues that Sprain Brook's employees were acting as employees of a "program planner" and were also acting as "qualified persons" under 42 U.S.C. § 247d-6d "because the employees were authorized to administer, deliver, and use FDA-approved covered countermeasures, such as PPE and FDA-approved COVID-19 devices and diagnostic tests, to diagnose and prevent COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom" (*id.* at ¶ 64). Lichtenfels contends that "[b]ecause Sprain Brook acted in its statutory role as a program planner to make reasonable choices and 'reasonably' follow state and federal guidance in using and allocating covered countermeasures, managing the infection control program, prioritizing the administration or use of covered countermeasures, and following applicable guidance, all of their actions, as well as any omissions, fall under the PREP Act" (*id.* at ¶ 65). Lichtenfels asserts that Plaintiff's claims fall within the scope of the PREP Act because they "arise out of Sprain Brook's administration, allocation, use, and supervision of use, of COVID-19 countermeasures in response to the COVID-19 pandemic" and, in support, she relies upon Plaintiff's Verified Bill of Particulars (*id.* at ¶ 66). Lichtenfels further contends that, additionally, "because the PREP Act provides broad immunity 'from suit' and sets forth detailed procedural and pleading requirements that must be met when a 'willful misconduct' claim is asserted (none of which are met here), dismissal is warranted for both lack of subject matter jurisdiction and failure to state a claim" (*id.* at ¶ 69). Lichtenfels concludes that Sprain Brook should be afforded immunity under the PREP Act as a "covered person" that used and administered covered countermeasures in responding to the COVID-19 public health emergency (*id.* at ¶ 70).

Lichtenfels also argues that because Plaintiff's Complaint alleges that Defendants acted willfully, the PREP Act vests sole jurisdiction over claims of willfulness in the U.S. District Court for the District of Columbia (*id.* at ¶ 71). She states that "[e]very decision that Sprain Brook made with respect to Archer's care and was at the direction of and in compliance with the directives being promulgated by the federal, state, and local governments" and Sprain Brook was acting in good faith in caring for Archer (*id.* at ¶ 72).

B. Plaintiff's Contentions in Opposition

In opposition to Sprain Brook's motion, Plaintiff submits: (1) an affirmation of Neil Flynn, Esq. dated April 23, 2024 ("Flynn Opp. Aff.") together with an exhibit; and (2) a memorandum of law dated April 23, 2024 ("Plf's Mem.").

In his affirmation, following a summary of the procedural background and facts, Flynn affirms that Archer was admitted to the Facility on February 6, 2020, that she was in the exclusive care and custody of Defendants while at the Facility and that because her J-tube became clogged while at the Facility, she was transported to SJRH to have it replaced on April 14, 2020 and that she died on or about April 22, 2020 at SJRH (Flynn Opp. Aff. at ¶¶ 11-13). Flynn affirms that "[i]t was determined that Ms. Archer died of a Cardiorespiratory Arrest due to or as a consequence of COVID-19, adrenal insufficiency, and achalasia cardia" (*id.* at ¶ 15).

In her memorandum of law, Plaintiff first argues that Defendants have not conclusively established EDTPA immunity (Plf's Mem. at 4). Plaintiff argues that the EDTPA "provides any nursing home or health care professional immunity from any civil or criminal liability 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 so long as (1) services were provided pursuant to a COVID-19 emergency rule, (2) the act or omission was impacted by decisions or activities that were in response to or a result of COVID-19 outbreak, and (3) the services were arranged for or provided in good faith" but that immunity does 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 professional (*id.*). Following a recitation of the elements of gross negligence, Plaintiff then argues that the question of gross negligence is generally a question to be determined by the trier of fact (*id.*). Plaintiff argues that Defendants relied in part upon the Mendizabal Affidavit which "touches upon the supposed treatment" of Archer under Defendants' care and the "need to replace Ms. Archer's J-tube as it became clogged while she was at the facility" (*id.* at 5). She then summarizes the allegations of her Complaint concerning gross negligence in which she contends that Defendants owed Archer heightened common law and statutory duties to care for her "including the prevention, detection, and proper treatment of injury, illness, infection, and other medical conditions" and that they negligently breached these duties causing her death by acting in complete disregard for her rights and safety (*id.*).

Plaintiff asserts that the Court must consider the evidentiary material submitted by Defendants which shifts the criterion for granting this motion to whether Plaintiff has pleaded a

cause of action, not whether one is stated (*id.*). She contends that in her Affidavit, Mendizabal states that she managed Archer's care at the Facility and that Archer's J-tube got clogged during her stay at the Facility (*id.*). Plaintiff argues that this fact "raises concern" as to whether Defendants' conduct that led to the J-tube being clogged "evinced a reckless disregard for Mrs. Archer's rights" (*id.* at 5). Plaintiff contends that Archer's death certificate attached as an exhibit states that Archer "died of a Cardiorespiratory Arrest due to or as a consequence of COVID-19, adrenal insufficiency, and achalasia cardia, thus, it is possible that Ms. Archer's clogged J-tube contributed to her death" (*id.* at 5-6). Plaintiff concludes by stating that she has established that Defendants' conduct constitutes gross negligence as the Complaint meets each element required to make a prima facie showing of gross negligence and that Defendants did not provide documentary evidence that conclusively establishes their immunity from suit and liability under the EDTPA (*id.* at 6).

Second, Plaintiff argues that Defendants have not conclusively established PREP Act Immunity (*id.*). Plaintiff asserts that the PREP Act "provides immunity to a 'covered person' from suit and liability under Federal and State law with respect to claims for loss caused by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure," but excepts instances of death or serious injury caused by the willful misconduct of the covered person or entity (*id.*). Regarding Defendants' reference to Advisory Opinion 20-04, which states in part that suits alleging an exception to the immunity for covered persons can only be brought in the United States District Court for the District of Columbia and Plaintiff's argument that her claims fall within the scope of the PREP Act as Plaintiff's claims touch upon the "covered countermeasure" portion of the PREP Act, Plaintiff argues that the PREP Act does not provide the exclusive cause of action to the United States District Court for the District of Columbia (*id.* at 7). Plaintiff contends that, under the PREP Act, a plaintiff must first exhaust administrative remedies or elect to accept compensation from the Process Fund instead of filing suit in federal court (*id.*). Plaintiff states that her Complaint alleges that Defendants' acts were willful during Archer's stay at the Facility and that she died while under Defendants' care and, therefore, the exception to the PREP Act applies (*id.*). She asserts that "Defendants' willful conduct likely resulted in Ms. Archer's J-tube being clogged, which contributed to Ms. Archer's death" (*id.*). Relying upon *Estate of Pierro by Stazzone v Carmel Richmond Healthcare & Rehabilitation Ctr.* (81 Misc 3d 1085 [Sup Ct, Richmond County 2023]), Plaintiff reiterates that she is not required to file suit in the United States District Court for the District of Columbia (*id.*). Plaintiff concludes by arguing that Defendants' motion to dismiss pursuant to CPLR 3211(a)(1) and (7) on the grounds that Defendants are immune from suit and liability under the PREP Act must be denied as Plaintiff alleges Defendants' willful conduct as a cause of Archer's death and because Defendants did not conclusively establish an immunity defense under the PREP Act in their submitted documentary evidence (*id.* at 8).

DISCUSSION

A. Standard of Review for Dismissal Based on CPLR 3211(a)(1) and (7)

To succeed on a motion to dismiss pursuant to CPLR 3211(a)(1) on the ground that a defense is founded on documentary evidence, the documentary evidence that forms the basis of the defense must be such that it resolves all factual issues as a matter of law, and conclusively disposes of the plaintiff's claim (*AG Capital Funding Partners, L.P. v State St. Bank & Trust Co.*, 5 NY3d 582 [2005]; *511 W. 232nd Owners Corp. v Jennifer Realty Co.*, 98 NY2d 144 [2002]; *Held v Kaufman*, 91 NY2d 425 [1998]; *Leon v Martinez*, 84 NY2d 83 [1994]; *Fontanetta v Doe*, 73 AD3d 78 [2d Dept 2010]). To qualify as "documentary," the evidence relied upon must be unambiguous and undeniable, such as judicial records and documents reflecting out-of-court transactions such as mortgages, deeds, and contracts. Letters, affidavits, notes, and deposition transcripts are generally not documentary (*Fontanetta*, 73 AD3d at 83-85).

If the documentary evidence disproves an essential allegation of the complaint, dismissal is warranted even if the allegations, standing alone, could withstand a motion to dismiss for failure to state a cause of action (*Snyder v Voris, Martini & Moore, LLC*, 52 AD3d 811 [2d Dept 2008]; *Peter F. Gaito Architecture, LLC v Simone Dev. Corp.*, 46 AD3d 530 [2d Dept 2007]).

The legal standards to be applied in evaluating a motion to dismiss pursuant to CPLR 3211(a)(7) are well-settled. In determining whether a complaint is sufficient to withstand a motion to dismiss pursuant to CPLR 3211(a)(7), the sole criterion is whether the pleading states a cause of action (*Cooper v 620 Props. Assoc.*, 242 AD2d 359 [2d Dept 1997]). If from the four corners of the complaint factual allegations are discerned which, taken together, manifest any cause of action cognizable at law, a motion to dismiss will fail (*511 W. 232nd Owners Corp.*, 98 NY2d 144; *Cooper*, 242 AD2d 359). The court's function is to "'accept . . . each and every allegation forwarded by the plaintiff without expressing any opinion as to the plaintiff's ability ultimately to establish the truth of these averments before the trier of the facts'" (*Cooper*, 242 AD2d at 360, *quoting 219 Broadway Corp. v Alexander's, Inc.*, 46 NY2d 506, 509 [1979]). The pleading is to be liberally construed and the pleader afforded the benefit of every possible favorable inference (*511 W. 232nd Owners Corp.*, 98 NY2d 144).

Where the plaintiff submits evidentiary material, the Court is required to determine whether the proponent of the pleading has a cause of action, not whether he or she has stated one (*Leon v Martinez*, 84 NY2d 83 [1994]; *Simmons v Edelstein*, 32 AD3d 464 [2d Dept 2006]; *Hartman v Morganstern*, 28 AD3d 423 [2d Dept 2006]; *Meyer v Guinta*, 262 AD2d 463 [2d Dept 1999]). On the other hand, a plaintiff may rest upon the matter asserted within the four corners of the complaint and need not make an evidentiary showing by submitting affidavits in support of the complaint (*Kempf v Magida*, 37 AD3d 763 [2d Dept 2007]). A plaintiff is at liberty to stand on the pleading alone and, if the allegations are sufficient to state all of the necessary elements of a cognizable cause of action, will not be penalized for not making an evidentiary showing in support of the complaint (*Kempf*, 37 AD3d 763; *see also Rovello v Orofino Realty Co.*, 40 NY2d 633 [1976]).

Affidavits may be used to preserve inartfully pleaded, but potentially meritorious claims; however, absent conversion of the motion to a motion for summary judgment, affidavits are not to be examined in order to determine whether there is evidentiary support for the pleading (*Rovello*, 40 NY2d 633; *Pace v Perk*, 81 AD2d 444 [2d Dept 1981]; *see Kempf*, 37 AD3d 763; *Tsimerman v Janoff*, 40 AD3d 242 [1st Dept 2007]). Affidavits may be properly considered where they conclusively establish that the plaintiff has no cause of action (*Taylor v Pulvers, Pulvers, Thompson & Kuttner, P.C.*, 1 AD3d 128 [1st Dept 2003]; *M & L Provisions, Inc. v Dominick's Italian Delights, Inc.*, 141 AD2d 616 [2d Dept 1988]; *Fields v Leeponis*, 95 AD2d 822 [2d Dept 1983]).

B. Defendants are Immune from Liability Under the EDTPA

The EDTPA was enacted on April 3, 2020 in response to the COVID-19 pandemic, and it was retroactively applied to March 7, 2020 (*see* Public Health Law Article 30-D, §§ 3080-3082). The stated purpose of the statute was to "broadly protect[] 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" (Public Health Law § 3080). The EDTPA confers broad immunity upon providers who rendered "health care services" during the COVID-19 pandemic. Specifically, EDTPA provides:

> [A]ny 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 (Public Health Law § 3082[1]).

Additionally, Section 3081(5) defines "health care services" as the following:

> [S]ervices 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 (Public Health Law § 3081[5]).

Accordingly, the EDTPA applies where: (1) the defendant is a "health care professional" or "facility"; (2) the defendant was arranging for or providing "health care services"; (3) the services were provided in accordance with law or a COVID-19 emergency rule; (4) the services were impacted by the defendant's response to COVID-19; and (5) the services were rendered in good faith and did not amount to gross negligence or recklessness.

The Court agrees with Defendants that because all five elements have been met, Plaintiff's Complaint should be dismissed. First, the EDTPA defines "health care facility" to include "a hospital, nursing home or other facility licensed or authorized to provide health care services" (Public Health Law § 3081[3]), such that Sprain Brook, which owned and operated the Facility, is a "health care facility" as contemplated by the EDTPA. Second, because the EDTPA broadly applies to "arranging for" or providing services that "relate to," inter alia, "the diagnosis, prevention, or treatment of COVID-19" (Public Health Law § 3081[5]), Sprain Brook, in its operation of the Nursing Home and its conduct in seeking to prevent and treat COVID-19 was arranging for or providing "health care services" in connection with the EDTPA. With respect to the related third and fourth factors, both Plaintiff's allegations in her Complaint and Sprain Brook's submissions on this motion demonstrate that Defendants were providing services to patients, including Archer, in accordance with law as a licensed nursing home, and that such services were impacted by Defendants' response to the COVID-19 pandemic. Fifth and finally, the Complaint does not include any allegation that Defendants failed to render their services in good faith, and Sprain Brook has furnished the Mendizabal Affidavit in which Mendizabal avers that Defendants rendered their services at the Facility in good faith and details the extensive and continuously updated policies and procedures put in place at Sprain Brook to respond to the COVID-19 pandemic, as well as how it applied those policies and procedures in good faith in its treatment of Archer for the duration of her stay there to prevent illness and death (Complaint at ¶¶ 1-69; Mendizabal Aff. at ¶¶ 30-39).

With respect to the EDTPA's exception for injuries caused by "willful or intentional misconduct, gross negligence, reckless misconduct, or intentional infliction of harm" (Public Health Law § 3082[2]), the Court does not credit Plaintiff's assertion that she has sufficiently alleged gross negligence supported by specific factual allegations (Plf's Opp. at 4-6). It is well settled that a claim of gross negligence must be supported by factually allegations evincing "a

reckless indifference to the rights of others" or smacking of "intentional wrongdoing" (*John v Varughese*, 194 AD3d 799, 802 [2d Dept 2021], *quoting Ryan v IM Kapco, Inc.*, 88 AD3d 682, 683 [2d Dept 2011]; *Mancusso v Rubin*, 52 AD3d 580 [2d Dept 2008]). Here, Plaintiff's allegations of gross negligence are too vague, speculative and conclusory to state a claim upon which relief can be granted.

In her Complaint, Plaintiff includes a Second Cause of Action for gross negligence and a Fourth Cause of Action for wrongful death and, in addition, sprinkles conclusory references to gross negligence in her Compaint (Complaint at ¶¶ 1, 26-32, 45-52). In her Verified Bill of Particulars,[3] Plaintiff purports to bolster these boilerplate allegations through the following response to Defendants' request for a "statement of each and every act of negligence, commission, or omission which you will claim as the basis of the alleged action against the answering defendant herein:"

> Defendants, were negligent, reckless, and grossly negligent with regard to the treatment and care of Plaintiff's-Decedent in, inter alia: failing to institute and follow proper infectious disease precautions, protections and preventive procedures; failing to properly staff their facilities; failing to prevent her from contracting COVID-19; allowing staff members to interact with her after interacting with residents suffering from COVID-19, before taking necessary and adequate procedures to prevent transmission of the disease; violating their own policies and procedures with regard to her care and treatment; failing to timely transfer her to a hospital when her condition warranted it; failing to properly supervise, monitor, assess, manage and/or control her care; failing to provide her with necessary care and treatment; failing to properly train, supervise and/or oversee their personnel in proper procedures regarding, inter alia, patient care, personal protective equipment ("PPE"), Contact and Droplet Precautions, nutrition, hygiene measures; failing to assess her condition and act accordingly; treating her with contraindicated medication(s); violating Sections 2801-d and 2803-c of New York's Public Health Law and 10 NYCRR Section 45, failing to respond to her dehydration, emaciation, and declining physical and mental state; failing to develop and implement a proper care plan; hiring and continuing to employ inept, incompetent, untrained staff; failing to create, maintain and adhere to an accurate medical chart reflecting Plaintiff's Decedent's medical condition, needs, requirements and prohibitions related to her care; allowing staff, employees and/or agents to abuse and mistreat Plaintiff's Decedent; failure to provide, monitor and manage Plaintiff's-Decedent's nutritional needs including, inter alia, enteral and parenteral nutrition and, failing to clean her feeding tube; and were otherwise grossly negligent and reckless in caring for Plaintiff's Decedent (NYSCEF Doc. Nos. 5 at ¶ 5, 29 at ¶ 5).

[3] Although a bill of particulars may not cure or alter a pleading to the advantage of the pleader, it may be read with a pleading to bolster it on a motion to dismiss for failure to state a cause of action or on a motion for summary judgment (*see generally* 84 NY Jur. 2d Pleading § 312).

Here, Plaintiff's terse and cursory allegations of "gross negligence" are insufficient to support that Defendants are exempt from the immunities afforded by the EDTPA. Indeed, these types of wholly conclusory allegations that are devoid of any factual detail and are comprised solely of a legal conclusion are insufficient to support the denial of a motion to dismiss (*see, e.g., Martinez v New York City Health & Hosps. Corp.*, 2024 NY Slip Op 00186 [2d Dept 2024]; *Mera v New York City Health & Hosps. Corp.*, 220 AD3d 668 [2d Dept 2023]; *Whitehead v Pine Haven Operating LLC*, 222 AD3d 104 [3d Dept 2023]; *see also Godfrey v Spano*, 13 NY3d 358, 373 [2009] [noting that "claims consisting of bare legal conclusions with no factual specificity [ ] are insufficient to survive a motion to dismiss"]; *SNS Bank, N.V. v Citibank, N.A.*, 7 AD3d 352, 355 [1st Dept 2004] [stating that "[e]ven on a motion to dismiss, a court need not accept as true conclusory allegations that a defendant was grossly negligent or acted willfully, in bad faith or with reckless disregard of its duties"]).

Notably, even in her Verified Bill of Particulars Plaintiff fails to distinguish between which conduct she alleges constitutes negligence and which she alleges constitutes gross negligence (NYSCEF Doc. No. 29 at ¶ 5; *see, e.g. Kalogiannis v New York Ctr. for Rehabilitation and Nursing*, 80 Misc 3d 1219[A] at *2 [Sup Ct, NY County 2023] ["As plaintiff's Complaint failed to plead specific allegations that rise to the level of gross negligence, which differ in kind, not only degree, from claims of ordinary negligence, the exception to EDTPA for gross negligence actions has not been met"]).[4] Indeed, a review of the various unpublished decisions attached to Defendants' moving papers involving similar conclusory allegations of gross negligence in which the courts dismissed the complaints under the EDTPA further supports the dismissal of this action (*see* Lichtenfels Aff., Ex. J at NYSCEF Doc. No. 28; *see, e.g., McCaffrey v Jewish Home Life Care*, Index No. 62102/2022 [Sup Ct, Westchester County 2023] [dismissing complaint based on immunity under the EDTPA when plaintiff alleged she developed bed sores during her stay at

[4] The sole basis for Plaintiff's contention that Defendants are not entitled to EDTPA immunity based on the gross negligence exception is Plaintiff's reliance on "an issue with Ms. Archer's 'j-Tube,' notably that it got clogged during her stay at Defendants' facility" (Plf's Opp. Mem. at 5) Plaintiff contends that this "fact itself raises concern as to whether Defendants' conduct that led to Ms. Archer's j-tube being closed evinced a reckless disregard for Ms. Archer's rights" and that, as Archer's death certificate states she "died of a Cardiorespiratory Arrest due to or as a consequence of COVID-19, adrenal insufficiency, and achalasia cardia it "is possible that Ms. Archer's clogged j-tube contributed to her death" (*id.* at 5-6 [emphasis added]). However, Plaintiff's conjecture (without any evidentiary foundation) that the clogged j-tube evidences reckless disregard to Plaintiff's rights is insufficient to support Plaintiff's claim of gross negligence so as to support the denial of Defendants' motion. It is undisputed that Plaintiff did not die from a clogged j-tube and furthermore, Plaintiff's Complaint is bereft of allegations supporting a claim of gross negligence based on a clogged j-tube.

defendant health care facility]).[5] Accordingly, because Plaintiff's Complaint does not state a claim for gross negligence, the EDTPA's exception for gross negligence does not apply to this action.

Given the Court's determination that this action must be dismissed pursuant to the EDTPA, the Court need not address Defendants' contention that it should also be dismissed pursuant to the PREP Act.

Accordingly, for all of the reasons set forth above, Defendants' motion to dismiss shall be granted.

CONCLUSION

Based on the foregoing and for the reasons stated above, it is hereby

ORDERED that the motion by Defendants Sprain Brook Manor Rehab, LLC and Sprain Brook Manor Nursing Home, LLC to dismiss the Complaint is granted and the Complaint is hereby dismissed.

The foregoing constitutes the Decision and Order of this Court.

Dated: White Plains, New York
July 23, 2024

ENTER:

HON. GRETCHEN WALSH, J.S.C.

[5] Notably Plaintiff does not cite a single case regarding this issue beyond the black letter law concerning the elements required for EDTPA immunity and the standard for a claim of gross negligence.

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