Adler v Dewitt Rehabilitation & Nursing Ctr.
2026 NY Slip Op 31898(U)
May 1, 2026
Supreme Court, New York County
Docket Number: Index No. 159720/2024
Judge: John J. Kelley

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

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

Justice

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MARC ADLER, as the Executory of the Estate of SONJA MARGULES, Deceased,

Plaintiff,

- v -

DEWITT REHABILITATION AND NURSING CENTER, doing business as UPPER EAST SIDE REHABILITATION AND NURSING CENTER,

Defendant.

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INDEX NO. 159720/2024

MOTION DATE 05/21/2025

MOTION SEQ. NO. 001

DECISION + ORDER ON MOTION

The following e-filed documents, listed by NYSCEF document number (Motion 001) 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99

were read on this motion to/for DISMISSAL.

In this action to recover damages pursuant to Public Health Law § 2801-d for purported violations of statutes and regulations governing nursing homes, for common-law negligence, negligent hiring, training, supervision, and retention of healthcare personnel, wrongful death, and, in effect, for medical malpractice, the defendant moves pursuant to CPLR 3211(a) to dismiss the complaint on the grounds that documentary evidence establishes a complete defense to the action (CPLR 3211[a][1]), the court lacks subject matter jurisdiction over the action (CPLR 3211[a][2]), the action is time-barred (CPLR 3211[a][5]), and the claims asserted by the plaintiff fail to state a cause of action (CPLR 3211[a][7]) because the defendant is immune from civil liability for any acts or omissions occurring during the plaintiff's admission to its facility by virtue the Emergency or Disaster Treatment Protection Act (Public Health Law former §§ 3080-3082; hereinafter EDTPA) and the federal Public Readiness and Emergency Preparedness Act (Pub L 109-48, 42 USC §§ 247d-6d, *et seq*, eff. Dec. 30, 2005; hereinafter

the PREP Act). The plaintiff opposes the motion. The motion is granted, and the complaint is dismissed, on the ground that EDPTA conferred immunity upon the defendant for any acts or omissions occurring during and after the residency of the plaintiff's decedent, Sonja Margules, at its facility, and because the action is time-barred.

In his complaint, the plaintiff alleged that, between February 1, 2020 and April 29, 2020, his decedent was a resident at the defendant's facility[1], and that, during her admission, she became infected with SARS-CoV-2 and COVID-19, developed respiratory distress and hypoxia, and ultimately died on April 29, 2020 as a consequence thereof. The plaintiff commenced this action on October 18, 2024, asserting that the defendant's violation of statutes and regulations and its negligence in staffing and training its personnel, and the manner in which it failed to retard the spread of the virus, caused his decedent to contract and die from COVID-19.

Initially, the court has subject matter jurisdiction over the claims asserted in this action. Subject matter jurisdiction

> "refers to the power of the court to hear the kind of case that is presently before it for adjudication (*Matter of Newham v Chile Exploration Co*., 232 NY 37; *Matter of Rougeron*, 17 NY2d 264; *Thrasher v United States Liab. Ins. Co*., 19 NY2d 159; *Hunt v Hunt*, 72 NY 217). Whether a court has subject matter jurisdiction is determined by the Constitution, statutes and (occasionally) the rules which confer jurisdiction. (Siegel, *Practice Commentaries*, McKinney's Cons Laws of NY, Book 7B, CPLR 3211, C3211:11, at 17), and not by the particular facts of any case. (*Hunt v Hunt*, *supra*.) The question to be resolved is whether the court has jurisdiction over the 'type' of case, not whether it has jurisdiction over 'this particular' case. (*1890 Realty Co. v Ford*, 121 Misc 2d 834; Treiman, *Subject Matter Jurisdiction in Summary Proceedings*, NYLJ, Mar. 2, 1990, at 1, col 1; *Hunt v Hunt*, *supra*.)"

(*New York County Dist. Attorney's Office v Oquendo*, 147 Misc 2d 125, 127-128 [Civ Ct, N.Y. County 1990]). Thus, subject matter jurisdiction

> "'refers to objections that are 'fundamental to the power of adjudication of a court.' 'Lack of jurisdiction' should not be used to mean merely 'that elements of

[1] The decedent's chart, however, established that she actually was first admitted to the defendant's facility on March 9, 2020 and was discharged therefrom on April 9, 2020.

> a cause of action are absent,' but that the matter before the court was not the kind of matter on which the court had power to rule"

(*Manhattan Telecom. Corp. v H & A Locksmith, Inc*., 21 NY3d 200, 203 [2013], quoting *Lacks v Lacks*, 41 NY2d 71, 74 [1976]; *see Garcia v Government Emps. Ins. Co.*, 130 AD3d 870, 871 [2d Dept 2015]). "Subject matter jurisdiction is a 'power to adjudge concerning the general question involved' in litigation, and 'is not dependent upon the state of facts which may appear in a particular case'" (*Henry v New Jersey Tr. Corp*., 39 NY3d 361, 371 [2023], quoting *Hunt v Hunt*, 72 NY 217, 229 [1878]). Pursuant to NY Constitution, art VI, § 7(a), "[t]he supreme court shall have general original jurisdiction in law and equity." Crucially, immunity from suit is a waivable defense and, hence, cannot be the basis for the invocation of lack of subject matter jurisdiction (*see Henry v New Jersey Tr. Corp*., 39 NY3d at 369-372, citing *Franchise Tax Bd. of Cal. v Hyatt,* 587 US 230, 235 n 1 [2019] [sovereign immunity is waivable and, hence, does not implicate a court's subject matter jurisdiction]; *Grimaldi v Mary Manning Walsh Nursing Home Co., Inc.,* 2025 NY Slip Op 32908[U], *3-4, 2025 NY Misc LEXIS 6815, *5-6 [Sup Ct, N.Y. County, Aug. 18, 2025] [Kelley, J.]; *Gillis v Carmel Richmond Nursing Home, Inc.*, 83 Misc 3d 1256[A], 2024 NY Slip Op 50984[U], *5, 2024 NY Misc LEXIS 3283, *13 [Sup Ct, Richmond County, Jul. 29, 2024]). This court thus has subject matter jurisdiction over the instant action.

Under CPLR 3211(a)(1), a dismissal is warranted "if the documentary evidence submitted conclusively establishes a defense to the asserted claims as a matter of law" (*Leon v Martinez*, 84 NY2d 83, 88 [1994]; *see Ellington v EMI Music, Inc*., 24 NY3d 239 [2014]). In order for evidence to qualify as "documentary," it must be unambiguous, authentic, and "essentially undeniable" (*Dixon v 105 W. 75th St., LLC*, 148 AD3d 623, 629 [1st Dept 2017], citing *Fontanetta v John Doe 1*, 73 AD3d 78 [2d Dept 2010]). Documents such as deeds, which reflect out-of-court transactions and are essentially unassailable, qualify as "documentary evidence" (*see Granada Condominium III Assn. v Palomino*, 78 AD3d 996, 997 [2d Dept 2010]; *Suchmacher v Manana Grocery*, 73 AD3d 1017, 1017 [2d Dept 2010]; *Fontanetta v John Doe 1,*

73 AD3d at 86). A release also qualifies as documentary evidence (*see Sotomayor v Princeton Ski Outlet Corp*., 199 AD2d 197, 197 [1st Dept 1993]), as does a contract (*see Fontanetta v John Doe 1*, 73 AD3d at 84-85), including an assignment agreement (*see Vasiliu v Miller*, 2018 NY Slip Op 32487[U] [Sup Ct, N.Y. County, Oct. 2, 2018]). Affidavits or affirmations do not qualify as documentary evidence (*see Granada Condominium III Assn. v Palomino*, 78 AD3d 996 [2d Dept 2010]; *Suchmacher v Manana Grocery*, 73 AD3d 1017 [2d Dept 2010]; *Fontanetta v John Doe 1*, 73 AD3d at 85; *Tsimerman v Janoff,* 40 AD3d 242 [1st Dept 2007]), and, other than the text of EDTPA or the PREP Act themselves, the defendant adverted to no documents that would conclusively establish a defense to the complaint.

When assessing the adequacy of a pleading in the context of a motion to dismiss under CPLR 3211(a)(7), the court's role is "to determine whether [the] pleadings state a cause of action" (*511 W. 232nd Owners Corp. v Jennifer Realty Co.*, 98 NY2d 144, 151-152 [2002]). To determine whether a claim adequately states a cause of action, the court must "liberally construe" it, accept the facts alleged in it as true, accord it "the benefit of every possible favorable inference" (*id*. at 152; *see Romanello v Intesa Sanpaolo, S.p.A.*, 22 NY3d 881, 884 [2013]; *Simkin v Blank*, 19 NY3d 46, 52 [2012]), and determine only whether the facts, as alleged, fit within any cognizable legal theory (*see Taxi Tours, Inc. v Go New York Tours, Inc.,* 41 NY3d 991, 993 [2024]; *Hurrell-Harring v State of New York*, 15 NY3d 8, 20 [2010]; *Leon v Martinez*, 84 NY2d 83, 87-88 [1994]; *Weil, Gotshal & Manges, LLP v Fashion Boutique of Short Hills, Inc*., 10 AD3d 267, 270-271 [1st Dept 2004]; CPLR 3026). "The motion must be denied if from the pleading's four corners factual allegations are discerned which taken together manifest any cause of action cognizable at law" (*511 W. 232nd Owners Corp. v Jennifer Realty Co*., 98 NY2d at 152 [internal quotation marks omitted]; *see Leon v Martinez*, 84 NY2d at 87-88; *Guggenheimer v Ginzburg*, 43 NY2d 268, 275 [1977]). Where, however, the court considers evidentiary material beyond the complaint, as it does here, the criterion becomes "whether the

proponent of the pleading has a cause of action, not whether he [or she] has stated one" (*Guggenheimer v Ginzburg*, 43 NY2d at 275), but dismissal will not eventuate unless it is "shown that a material fact as claimed by the pleader to be one is not a fact at all" and that "no significant dispute exists regarding it" (*id.*). Nonetheless, "conclusory allegations—claims consisting of bare legal conclusions with no factual specificity—are insufficient to survive a motion to dismiss" (*Godfrey v Spano*, 13 NY3d 358, 373 [2009]). As relevant here, dismissal is warranted where a defendant has established its statutory immunity from liability, since such immunity forms an appropriate basis for a CPLR 3211(a)(7) motion to dismiss the complaint (*see Mera v NY City Health & Hosps. Corp.*, 220 AD3d 668, 670 [2d Dept 2023]; *see also Martinez v NYC Health & Hosps. Corp.*, 223 AD3d 731, 732-733 [2d Dept 2024]).

In March 2020, then-Governor Andrew Cuomo signed Executive Order No. 202 (9 NYCRR 8.202), declaring a disaster emergency in New York state, and Executive Order No. 202.10 (9 NYCRR 8.202.10), conferring, upon certain healthcare workers and facilities, immunity from civil liability for any injury or death alleged to have been sustained directly as a result of the provision of medical services in support of New York's response to the COVID-19 pandemic, except where such injury or death was caused by gross negligence or recklessness. On April 3, 2020, the Legislature passed EDTPA, granting certain healthcare facilities and healthcare professionals immunity from civil or criminal liability related to the care of patients during the COVID-19 pandemic crisis, provided that:

> "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; 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 the health care facility or health care professional is arranging for or providing health care services in good faith"

(Public Health Law former § 3082[2]). This immunity did not apply where an act or omission constituted willful or intentional criminal misconduct, gross negligence, reckless misconduct, or

intentional infliction of harm (*id.*). EDTPA was effective retroactive to March 7, 2020, making it applicable to acts or omissions that occurred on or after that date. On April 6, 2021, the legislature repealed EDTPA, with the repeal to take effect immediately.

Separately, on March 17, 2020, and in response to the pandemic, the Secretary of the United States Department of Health and Human Services issued a declaration invoking and implementing the PREP Act (*see* Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, 85 FR 15198-01, Mar. 17, 2020), pursuant to which Congress had provided immunity from liability to covered persons for loss caused by or relating to the administration or use of a "covered countermeasure" in times of a public health emergency (*see* 42 USC § 247d-6d[a][1]). "Covered countermeasures" include the administration of any "antiviral, drug, [or] biologic" used to treat, diagnose, cure, prevent, or mitigate COVID-19, or the employment of any device employed to treat, diagnose, or mitigate the spread of COVID-19, as well as the use of protective personal equipment (PPE) and the performance of COVID-19 tests that had been approved by United States Food and Drug Administration (FDA), along with common medical devices such as thermometers and ventilators (*see Escobar v Mercy Med. Ctr.*, 83 Misc 3d 1213[A], 2024 NY Slip Op 50704[U], *2-3, 2024 NY Misc LEXIS 2457, *7-8 [Sup Ct, Nassau County, Jun. 11, 2024]). The only exception to PREP Act immunity from liability for engaging in "covered countermeasures" was "for death or serious physical injury proximately caused by willful misconduct" by a covered person, and allowed an action to be instituted by the person who suffered such an injury, or by any representative of such a person (*see* 42 USC §§ 247d-6d[d][1], [2]).

With respect to the issue of whether the repeal of EDTPA was retroactive, thereby negating statutory immunity for acts or omissions that occurred between March 7, 2020, and April 6, 2021, the Appellate Divisions have consistently determined that it is not. As the Appellate Division, First Department, held in *Hasan v Terrace Acquisitions II, LLC* (224 AD3d

475, 477 [1st Dept 2024]), the statutory text does not contain retroactivity language, and multiple factors relevant to retroactivity analysis were deemed inapplicable. The Second Department adopted that analysis as well (*see Byington v North Sea Assoc., LLC,* 244 AD3d 1177, 1179 [2d Dept 2025]; *Hyman v Richmond Univ. Med. Ctr.*, 239 AD3d 617, 618 [2d Dept 2025]; *Damon v Clove Lakes Healthcare & Rehabilitation Ctr., Inc.*, 228 AD3d 618, 619 [2d Dept 2024]). Likewise, in *Whitehead v Pine Haven Operating LLC* (222 AD3d 104, 107 [3d Dept 2023]), the Third Department found that both the text and legislative history of the repeal supported prospective-only application. Similarly, in *Ruth v Elderwood at Amherst* (209 AD3d 1281, 1287 [4th Dept 2022]), the Fourth Department concluded that the Legislature's expressions of intent were insufficient to support retroactive repeal. Accordingly, EDTPA remains applicable to the claims in this case that arose from alleged acts and omissions that occurred during the statute's effective period, which included the entirety of the duration of the decedent's admission to the defendant's facility.

The court concludes that, pursuant to EDTPA, the defendant is entitled to immunity from the claims asserted by the plaintiff that arose from the care that his decedent received at the defendant's facility between March 9, 2020 and April 9, 2020. With respect to the criteria required to be considered by EDTPA, the defendant established, prima facie, that it was arranging for or providing health care to the decedent within the meaning of that statute, and was doing so in good faith. The court further concludes that the defendant made a prima facie showing that the care that it provided to the decedent indeed was affected or impacted by those its medical and nursing determinations or activities that had been made in response to, or as result of, the COVID-19 outbreak, and that those determinations and activities had been made in response to, as result of, or in support of the State's COVID-19 directives. The court notes that EDTPA does not specify that the "treatment of the individual" must be impacted one way or another, that is, it does not specify that the treatment must be affected positively, negatively, or

otherwise, it does not require the patient to have been uniquely impacted as compared to other patients, and it does not identify any particular aspect of, or assign weight to, any aspect of the treatment that must be impacted by such determinations and activities (*see Holder v Jacob*, 231 AD3d 73, 85 [1st Dept 2024]). Moreover, EDTPA immunity applies not only to causes of action sounding in malpractice, but also to causes of action prosecuted pursuant to Public Health Law § 2801-d (*see Byington v North Sea Assoc., LLC,* 244 AD3d at 1178-1179).

In demonstrating that its care and treatment of the decedent was impacted by COVID-19 and by its determinations and activities addressed thereto, the defendant submitted, among other things, the affirmation of its administrator, Scott Mair, its pre-pandemic infection policies, its own COVID-19 policies and procedures, those relevant regulations, advisories, and guidance letters issued by the New York State Department of Health (NYS DOH) and the federal Center for Medicare and Medicaid Services (CMS), and affirmations submitted by healthcare professionals in similar cases, as well as the decedent's medical chart.

Mair asserted that he was directly involved in the facility's response to the COVID-19 pandemic and the implementation of applicable policies and procedures, which were first drafted in February 2020, and that he was familiar with how the defendant's policies, procedures, and practices with respect to COVID-19 prevention and treatment were implemented in connection with the decedent's care. As he explained it, in early 2020, those procedures included in-service training of staff on the use of PPE, thermometers, and pulse oximeters, as well as COVID-19 infection prevention, such as the use of disinfectants and sanitizing agents. Mair averred that the defendant had an extensive infection control program and policies in place before the COVID-19 pandemic began, which included, among other things, surveillance of infections, criteria for classifying infections by symptoms, such as fever or respiratory symptoms, a respiratory protection program, the employment of disposable particulate respirators, the use of PPE, the isolation of residents to prevent transmission of

infections, the "cohorting" of residents, point-of-care testing, a protocol for respiratory hygiene and cough etiquette, hand hygiene, the control of transmission of infections, terminal cleaning of residents' rooms, and the regulation of medical waste, including needles and sharps. As he explained it, on February 1, 2020, the NYS DOH issued a notice that COVID-19 had been designated as a communicable disease and a significant threat to public health, and that, on February 6, 2020, the NYS DOH sent a notice to the defendant regarding the preservation of PPE in light of the pandemic, thereafter issuing numerous additional directives concerning the pandemic. Mair attested that, in response to these directives, as well as other information emanating from the federal Centers for Disease Control (CDC) and the World Health Organization (WHO), the defendant revised its policies, procedures, and protocols with respect to PPE, handwashing, and disinfection practices. He averred that the defendant implemented new policies and procedures that "provided extensive guidance to staff on a preventing the transmission of the virus. . . . Additional instructions were provided for sanitizing rooms and equipment used to treat COVID-19 residents. . . . The facility also created a contingency plan for managing an increased need for postmortem care and disposition of deceased residents."

Mair asserted that,

> "[a]s this was a novel virus, in early 2020 it was not yet known if the virus was airborne or a droplet-producing contagion. Accordingly, the facility administration and nursing staff had no ability to make independent decisions with respect to managing the safety of residents or staff beyond the ordinary infection control policies and procedures in place prior to any specific COVID-19 directive or regulation was issued. We relied entirely on the directives provided by governmental agencies as they researched and learned about the virus. Communications about directives were transmitted locally to all skilled nursing facilities by the NYSDOH after it received their directions from the CDC and WHO. These notifications were received nearly daily in the first month of the pandemic, and in some cases more than once a day. As information was learned from the CDC and WHO, the NYSDOH would issue amended or revised guidance."

He stated that, beginning on March 4, 2020, the New York State Health Facilities Association issued guidance directing that residents with a suspected COVID-19 infection should

be isolated and given a surgical or procedure mask to wear, while staff members treating these residents were directed to follow CDC guidelines with regard to selection, use, and disposal of PPE, including gloves, isolation gowns, and N95-or-higher filtering face-piece respirators, and to maintain a social distance of six feet from the resident wherever possible. Moreover, he explained that a CDC guidance issued that same day advised facilities to monitor and screen visitors at the facility for symptoms of COVID-19 and for any international travel in the preceding 14 days from restricted countries, in response to which the defendant developed and implemented a program to plan for the prevention, mitigation, and treatment of COVID-19. Mair went on to describe the numerous additional advisories and directives that the defendant received from the NYS DOH, CDC, and WHO during March 2020, asserting that the defendant implemented directives concerning the screening of residents and employees for respiratory illness, regulation of visitors, restriction of group dining and congregation at the facility, the use of PPE, the husbanding of supplies, and protocols or cleaning and disinfection.

Mair explained that, as the COVID-19 pandemic continued, regular staff meetings, education, and training sessions were held at the defendant's facility to continue educating the staff with respect to new information concerning the COVID-19 pandemic, including guidance and education regarding best practices, that these meeting and sessions were conducted daily, and included each update of the pandemic, addressing proper PPE usage, appropriate chemicals, testing policies, visitor policies, treatment options, and best practices. He attested that "[t]he facility relied heavily on covered countermeasures, such as PPE, thermometers, pulse oximeters, supplemental oxygen, and COVID-19 testing when it became available" and that, consequently, all of the defendant's operations were therefore impacted by its response to the pandemic with respect to each and every resident, including the decedent.

The decedent's chart reflected that the decedent was 93 years old when she was admitted to the defendant's facility on March 9, 2020, having been transferred from Mount Sinai

Hospital for short-term rehabilitation due to pelvic fracture, gait instability, a history of falling, severe debility, a fracture of the vertebrae at the C7-T1 level of her spine, and a bilateral superior and inferior displaced rami fracture. Upon admission, her body temperature was 99 degrees Fahrenheit, her pulse rate was 90 beats per minute (BPM), her respiratory rate was 16 breaths per minute (bPM), her blood pressure was 107/57, and her oxygen saturation was 91% on room air. The chart reflected that the defendant created a comprehensive care plan on that date. On March 10, 2020, the decedent's temperature was 98.3 degrees, her pulse rate was 95 BPM, her respiratory rate was 17 bPM, her blood pressure was 104/54, and her oxygen saturation was 93% on room air, while she was alert and oriented and could communicate her needs, although her Brief Interview for Mental Status (BIMS) score was a 9, indicating cognitive impairment. On March 11, 2020, the decedent's temperature was 98.5 degrees, her pulse rate was 86 BPM, her respiratory rate was 16 bPM, her blood pressure was 114/63, and her oxygen saturation was 93% on room air, while on March 15, 2020, her temperature was 98.5 degrees, her pulse rate was 92 BPM, her respiratory rate was 16 bPM, her blood pressure was 110/62, and her oxygen saturation was 94% on room air. On that date, the defendant's facility called the decedent's daughter to inform her that all visitation privileges had been suspended.

In the early portion of March 16, 2020, the decedent's temperature was 98.5 degrees, her pulse rate was 96 BPM, her respiratory rate was 16 bPM, her blood pressure was 144/76, and her oxygen saturation was 93% on room air, while, later that day, her temperature was 98.0 degrees, her pulse rate was 75 BPM, her respiratory rate was 16 bPM, her blood pressure was 130/71, and her oxygen saturation was 93% on room air. According to Mair, on March 20, 2020, an order was implemented instructing staff to measure the decedent's temperature once per shift for the next 14 days. On March 21, 2020, the decedent's temperature was 97.8 degrees, her pulse rate was 99 BPM, her respiratory rate was 16 bPM, her blood pressure was 139/70, and her oxygen saturation was 96% on room air. On March 22, 2020, her temperature

was 97.7 degrees, her pulse rate was 85 BPM, her respiratory rate was 16b PM, her blood pressure was 130/70, and her oxygen saturation was 96% on room air, while she was oriented as to her identity, and her lungs were bilaterally clear to auscultation. She had no difficulty breathing and no cough was noted. On March 23, 2020, although a physician assessed the decedent due to possible exposure to COVID-19, she did not manifest any shortness of breath, sore throat, nausea, vomiting, cough, or chest pain. On March 25, 2020, her temperature was 97.9 degrees in the morning, 99.1 degrees in the afternoon, and 98.6 degrees in the evening and, upon assessment for possible signs of acute respiratory infection, she evinced no signs of dyspnea, chills, fever, shortness of breath, or chest pain. On March 26, 2020, the decedent's temperature was 97.6 degrees in the morning, 98.4 degrees in the afternoon, and 98.1 degrees in the evening. On March 27, 2020, her temperature was 98.1 degrees and she again was assessed for a viral illness, assumed to be COVID-19, that had been observed in other patients. At that juncture, the decedent denied any complaints of fever, chills, cough, sore throat, shortness of breath, chest pain, nausea, or vomiting. On March 28, 2020, the decedent's temperature was 98.2 degrees, her pulse rate was 78 BPM, her respiratory rate was 16 bPM, her blood pressure was 129/78, and her oxygen saturation was 96% on room air. On March 29, 2020, a physician examined the decedent, and noted that she was being monitored for suspicion of COVID-19 infection, upon which the decedent was administered Zithromax and hydroxychloroquine, although her temperature was only 97.7 degrees and she evinced no wheezing or use of accessory muscles when breathing. On March 30, 2020, the decedent's temperature was 98.8 degrees, and she continued to receive the medications that had been administered to her on the previous day. Later that same day, however, the decedent’s temperature had increased to 100 degrees, and although she manifested no other symptoms, her scheduled March 31, 2020 discharge date was cancelled for her own safety. The plan that the defendant’s physician had formulated was to continue with her daily Zithromax regimen for

three days, and her hydroxychloroquine regimen for five days. On March 31, 2020, the decedent's temperature was 98.1 degrees in the morning, 98.8 degrees in the afternoon, and 98.1 degrees in the evening. The plan for the administration of that medication was adhered to.

On April 1, 2020, the decedent's temperature was 98.2 degrees in the morning, 100.4 degrees in the afternoon, and 99.7 degrees in the evening, she was alert and oriented as “to person,” her lungs were bilaterally clear to auscultation, she had no difficulty breathing, and no cough was noted. On April 2, 2020, her temperature was 99.5 degrees in the morning, 99.4 degrees in the afternoon, and 98.8 degrees in the evening, and her other conditions remained the same. On April 3, 2020, the decedent was assessed by a physician in connection with her recent episodes of a low-grade fever, but she displayed no signs of acute distress, fever, shortness of breath, chest pain, or vomiting, while she was “taking nutrition and hydration orally and showed no signs or symptoms of a swallowing disorder.” On April 4, 2020, upon the completion of the decedent's medication regime, she was afebrile with no indication of pain and, although both of her lungs were clear on auscultation, she manifested shortness of breath while lying flat, and thus was monitored for signs of respiratory changes. On April 6, 2020, a physician assessed the decedent in connection with her recent fevers and the spread of COVID-19 infections on her floor. The decedent's temperature at that time was 98.8 degrees, and her oxygen saturation was 92% on room air, while she evinced no signs of acute distress. On April 7, 2020, the defendant contacted the decedent's daughter, and informed the latter that it had scheduled the decedent’s discharge for April 9, 2020. On April 8, 2020, the decedent's temperature was 98.8 degrees, her pulse rate was 75 BPM, her respiratory rate was 16 bPM, her blood pressure was 133/75, and her oxygen saturation was 96% on room air, while she evinced no indications of pain, and she was alert and oriented to person, place, and time. Her lungs were bilaterally clear to auscultation, and no cough or signs of difficulty breathing were noted, but the monitoring protocol was continued with respect to respiratory issues. The

defendant ordered a hospital bed for the decedent's use after her discharge to home. One of the defendant's healthcare employees wrote in the decedent's chart that she was doing better overall since completing treatment pursuant to the COVID-19 protocol, since she did not show signs of acute distress or shortness of breath, and all respiratory symptoms had resolved.

As Mair explained it, the

> "consistent documentation of the decedent's vital signs demonstrates monitoring continued throughout the admission, despite the numerous obstacles and hurdles in place due to state and federal guidance and the policies and procedures in compliance with those mandates. Despite additional measures implemented pursuant to COVID-19, including: preservation of PPE, staff shortages due to staff who had symptoms or confirmed COVID-19, increased sanitization requirements and focus on monitoring residents for COVID-19 symptoms, I ensured that the staff still appropriately and consistently monitored the decedent throughout the admission consistent with our facility's policies."

The decedent's chart reported that, on April 9, 2020, her temperature was 98.8 degrees, her pulse rate was 99 BPM, her respiratory rate was 16 bPM, her blood pressure was 145/89, and her oxygen saturation was 95% on room air, that she was taking nutrition and hydration orally, and that she had no complaints of thirst, while her lungs were clear to auscultation, she did not have a cough or difficulty breathing and was breathing room air. The plaintiff was discharged to her home on April 9, 2020 in stable condition. According to Mair, the defendant did not treat the decedent at any time after her discharge. Mair asserted that, on April 10, 2020, the decedent's daughter called the defendant's facility and reported that the decedent was refusing to drink fluids. The decedent's primary care physician, internist Inna Janas, M.D., suggested to the decedent's daughter that the decedent be sent to a hospital for further evaluation, but the decedent's daughter allegedly refused. The decedent died at home on April 29, 2020.

Mair expressly asserted that the decedent's care and treatment was impacted by the COVID-19 pandemic and the facility's good faith response to the pandemic. In this respect, he noted that she was only seen by essential staff who wore PPE when caring for residents, her vital signs were monitored regularly, and she was being screened for signs and symptoms of

the COVID-19 virus, as were staff members, while in-person visitation and group activities were suspended due to the COVID-19 pandemic, and social distancing was enforced. He explained that, inasmuch as the decedent was a resident at the defendant's facility during the earliest days of the pandemic, there were no in-house COVID-19 tests, COVID-19 vaccines, or even approved treatments for COVID-19 available at that time, but that the defendants' healthcare personnel regularly monitored and screened the decedent for any signs or symptoms of COVID-19, and that the decedent was provided care and treatment in accordance with both applicable state and federal COVID-19 advisories and guidance related to prevention, diagnosis, and treatment of COVID-19. Specifically, he asserted that, in connection with the prevention of COVID-19, the decedent had her vital signs measured frequently, in-person visitation and group dining and recreation activities were cancelled, and there was an increase in sanitizing the facility, including bathrooms and residents' rooms. Mair further attested that the defendant adopted and implemented policies concerning the utilization of PPE to prevent the spread of COVID-19 and to protect the residents, while the decedent was carefully monitored for signs and symptoms of COVID-19, and was administered Zithromax and hydroxychloroquine out of an abundance of caution when COVID-19 was suspected. Mair additionally averred that,

> "[a]s part of decedent's care and treatment, [the defendant] utilized and administered covered countermeasures, such as PPE, thermometers, pulse oximeters, respiratory monitoring, and prescribed treatments."

He attested that the defendant's personnel "worked around the clock at the facility to protect and care for our residents, and we exhausted every available resource to do so."

The defendant also relied upon the affirmations of nurses and physicians that had been submitted in actions litigated against other nursing homes, each of whom averred that medical, nursing, and personal care staff in all nursing homes in the New York City metropolitan area were stretched to the breaking point in responding to the contingencies created during the early days of the pandemic.

The court concludes that the defendant dispositively established that the decedent's treatment and care at its facility was affected by the nature and severity of the pandemic, that the care also was affected by the facility's compliance with state and federal rules, guidelines, and directives, and that the facility responded in good faith thereto in its overall management of residents, as well as in its care and treatment of the plaintiff. The plaintiff, who has not even demonstrated that his decedent contracted COVID-19 at the defendant's facility, as opposed to contracting it from ambulance workers or visitors to her home, has not presented any material factual dispute undermining the applicability of EDTPA immunity in this case. The affirmation of the plaintiff's expert physician, Terrance Baker, M.D., to the effect that the defendant was understaffed both before, during, and after the period of EDPTA immunity, involves the very type of alleged wrongdoing for which EDTPA was intended to confer immunity. Consequently, the court finds that the plaintiff's opposition failed to raise a factual dispute as to the defendant's entitlement to immunity under the EDTPA for care rendered during the statutory immunity period. Although the plaintiff suggested that the defendant had preexisting, pre-pandemic compliance issues and staffing concerns, these allegations do not meet the high bar required to overcome EDTPA immunity. In fact, the first case of COVID-19 in New York was first reported on March 1, 2020. Accordingly, the court finds that the plaintiff's implications that the defendant should have or could have been prepared for the pandemic, before anyone knew of its severity and virulence, lacked sufficient factual support, and failed to defeat the statutory immunity provided under the EDTPA, particularly because the decedent's admission to the defendant's facility post-dated the date on which EDTPA immunity went into effect, and her discharge pre-dated the date of EDTPA's repeal.

In light of the court's determination with respect to EDTPA immunity, it need not address the defendant's contention that it also was conferred immunity from suit by virtue of the federal PREP Act. Were the court to address that issue, it would be constrained to conclude that it is

not entitled to PREP Act immunity. In a state court action, when addressing an immunity defense pursuant to the PREP Act, the court first must determine whether the plaintiff's claims fall within the act's immunity provision (*see* 42 USCS § 247d-6d[a][1]; *Thomas v Highland Care Ctr.*, 2024 NYLJ LEXIS 3209 [Sup Ct, Queens County, Sep. 27, 2024]). The PREP Act is triggered only where there are allegations that the defendant administered countermeasures improperly, thus causing injury (*see Whitehead v Pine Haven Operating LLC*, 2022 NY Slip Op 34685[U], *5, 2022 NY Misc LEXIS 35761, *5 [Sup Ct, NY County, Nov. 29, 2022], citing *Parker v St. Lawrence County Pub. Health Dept.*, 102 AD3d 140, 141-142 [3d Dept 2012]). In this instance, the plaintiff's claims pertain only to the defendant's *failures* to act, and such allegations do not amount to the administration of countermeasures (*see id.*; *see also Estate of Ortiz v Archcare at Terence Cardinal Cooke Health Care Ctr.,* 2025 NY Slip Op 32270[U], *9-10, 2025 NY Misc LEXIS 5809 *14-15 [Sup Ct, N.Y. County, Jun. 26, 2025] [Kelley, J.]; *Adler v Troy*, 2023 NY Slip Op 33804[U], *8, 2023 NY Misc LEXIS 11547, *11-12 [Sup Ct, N.Y. County, Oct. 18, 2023], citing *Dupervil v Alliance Health Operations, LLC*, 516 F Supp 3d 238, 255 [ED NY 2021]). In other words, "[t]he acts and omissions listed in the complaint are unrelated to the administration, prioritizing, or purposeful allocation of a drug, biological product, or device to an individual within the meaning of the PREP Act" (*Murray v Staten Is. Care Ctr.,* 82 Misc 3d 1220[A], 2024 NY Slip Op 50347[U], *5, 2024 NY Misc LEXIS 1605, *24-25 [Sup Ct, Richmond County, Mar. 22, 2024]).

To the extent that the plaintiff implicitly argues that EDTPA immunity is inapplicable because the defendant committed gross negligence or engaged in reckless conduct, the court rejects such an implication. The decedent's medical records and Mair's affirmation negated any such claims of gross negligence (*see Hasan v Terrace Acquisitions II, LLC*, 224 AD3d at 479) and, hence, those submissions dispositively established that the plaintiff does not have a cause of action to recover for such tortious conduct. Allegations purporting to support a gross

negligence claim that are, as here, devoid of factual specificity and replete with legal conclusions cannot survive dismissal (*see Byington v North Sea Assoc., LLC,* 244 AD3d at 1179-1180; *Lociero v Park Avenue Operating, LLC* [Sup Ct, Nassau County, Index No. 615904/2022, Sep. 26, 2023], citing *Godfrey v Spano*, 13 NY3d at 373).

In any event, the court concludes that the action was time-barred by the limitations period applicable to causes of action to recover for wrongful death, medical malpractice, and common-law negligence. On a motion to dismiss a complaint as time-barred, "a defendant must establish, prima facie, that the time within which to sue has expired. Once that showing has been made," the burden shifts to the plaintiff to raise an issue of fact as to "whether the statute of limitations has been tolled, an exception to the limitations period is applicable, or the plaintiff actually commenced the action within the applicable limitations period" (*Flintlock Constr. Servs., LLC v Rubin, Fiorella & Friedman, LLP*, 188 AD3d 530, 531 [1st Dept 2020], quoting *Quinn v McCabe, Collins, McGeough & Fowler, LLP,* 138 AD3d 1085, 1085-1086 [2d Dept 2016]; *see Murray v Charap*, 150 AD3d 752 [2d Dept 2017]; *Williams v New York City Health & Hosps. Corp*., 84 AD3d 1358 [2d Dept 2011]; *Rakusin v Miano*, 84 AD3d 1051 [2d Dept 2011]).

The court notes that, in accordance with L 2020, ch 23, § 2 (eff Mar. 3, 2020), the Legislature amended Executive Law § 29-a to authorize the Governor to issue, by executive order, any directive necessary to respond to the state disaster emergency arising from the COVID-19 pandemic, including a declaration that all statutory periods for the service and filing of papers in legal actions were tolled. On March 20, 2020, the Governor, pursuant to that authority, issued Executive Order (EO) 202.8, which provided, in relevant part:

> "In accordance with the directive of the Chief Judge of the State to limit court operations to essential matters during the pendency of the COVID-19 health crisis, *any specific time limit for the commencement, filing, or service of any legal action, notice, motion, or other process or proceeding, as prescribed by the procedural laws of the state, including but not limited to . . . the civil practice law and rules* . . . , or by any other statute, local law, ordinance, order, rule, or regulation, or part thereof, *is hereby tolled from the date of this executive order until April 19, 2020."*

(emphasis added). The terms of that EO, including the tolling deadlines set forth therein, were extended 13 times between March 20, 2020 and October 4, 2020. On October 4, 2020, the Governor issued EO 202.67, providing for a final extension of the tolling deadline until November 3, 2020, with the toll no longer in effect as of November 4, 2020 (*see Brash v Richards*, 195 AD3d 582 [2d Dept 2021] [explicitly concluding that the executive orders effectuated a toll and not a mere suspension of filing deadlines]). "A toll suspends the running of the applicable period of limitation for a finite time period, and '[t]he period of the toll is excluded from the calculation of the [relevant time period]'" (*id.* at 582, quoting *Chavez v Occidental Chem. Corp.*, 35 NY3d 492, 505, n 8 [2020]; *see Landwehrle v Bianchi,* 2022 NY Slip Op 50649[U], *2, 2022 NY Misc LEXIS 3094, *5 [Sup Ct, N.Y. County, Jun. 24. 2022] [Kelley, J.]; *Pollock v Rengasamy*, 2022 NY Slip Op 22160, *5, 2022 NY Misc LEXIS 2154, *10 [Sup Ct, Washington County, May 18, 2022]). The toll thus was in effect for 228 days.

The limitations period applicable to a cause of action to recover for common-law negligence causing personal injury is three years from the date of injury (*see* CPLR 214[5]; *Haynes v Williams*, 162 AD3d 1377, 1377-1378 [3d Dept 2018]). A negligent hiring, training, supervision, and retention cause of action against a private medical provider constitutes a cause of action independent of a medical malpractice cause of action (*see Burgos v Lau*, 2025 NY Slip Op 33250[U], *2 n 2, 2025 NY Misc LEXIS 7290, *2 n 2 [Sup Ct, N.Y. County, Aug. 28, 2025] [Kelley, J.]; *Estate of Gebert v Huntington Hills Ctr. for Health*, 2024 NY Misc LEXIS 51911, *16 [Sup Ct, Suffolk County, Sep. 5, 2024]; *see also Taylor v Methodist Hosp.*, 6 Misc 3d 1008[A], 2004 NY Slip Op 51750[U], *4, 2004 NY Misc LEXIS 2898, *9 [Sup Ct, Kings County, Nov. 1, 2004] [deeming allegation of "negligent credentialing" to constitute an independent cause of action]). Such a cause of action sounds in general common-law negligence, and it is subject to the three-year limitations period of CPLR 214(5) (*see Calamari v Panos*, 131 AD3d 1088, 1090 [2d Dept 2015]). Similarly, a cause of action prosecuted pursuant to Public Health Law § 2801-

d is subject to a three-year limitations period (*see Gold v Park Ave. Extended Care Ctr. Corp.*, 90 AD3d 833, 834 [2d Dept 2011]). The statute of limitations applicable to actions to recover for medical malpractice against a private health-care provider is two years and six months, measured from "the act, omission or failure complained of or last treatment where there is a continuous treatment for the same illness, injury or condition which gave rise to the said act omission or failure" (CPLR 214-a). The "continuous treatment" provision of CPLR 214-a posits that the limitations period applicable to a medical malpractice cause of action "does not begin to run until the end of the course of treatment when the course of treatment which includes the wrongful acts or omissions has run continuously and is *related to the same original condition or complaint*" (*Nykorchuck v Henriques*, 78 NY2d 255, 258 [1991] [internal quotation marks omitted] [emphasis added]; *see Massie v Crawford*, 78 NY2d 516, 519 [1991]; *McDermott v Torre*, 56 NY2d 399, 405 [1982]; *Borgia v City of New York*, 12 NY2d 151, 155 [1962]; *Jajoute v New York City Health & Hosps. Corp.*, 242 AD2d 674, 676 [1st Dept 1997]). The limitations period applicable to a wrongful death cause of action is two years from the date of the decedent's death (EPTL 5-4.1).

The wrongful death cause of action accrued on April 29, 2020, the date of the decedent's death. The court will assume that the other causes of action accrued when the decedent first sustained injury by evincing symptoms of COVID-19, which presumably was on April 10, 2020, when Dr. Janas told her daughter to transport her to a hospital emergency room. Accounting for the toll on limitations periods in effect from March 20, 2020 through November 3, 2020, the plaintiff was required to interpose the wrongful death cause of action on or before November 3, 2022, any cause of action sounding in medical malpractice on or before May 3, 2023, and any cause of action to recover for common-law negligence, including negligent hiring and insufficient staffing, as well as any cause of action pursuant to Public Health Law § 2801-d, on or before November 3, 2023. The failure to commence an action within the applicable

limitations period bars the plaintiff from seeking a remedy (*see Tanges v Heidelberg N. Am., Inc.*, 93 NY2d 48, 54-55 [1999]; *Paver & Wildfoerster v Catholic High Sch. Assn*, 38 NY2d 669, 676 [1976]). It is well settled that a court may not extend a statute of limitations (*see* CPLR 201; *McCoy v Feinman*, 99 NY2d 295, 300-301 [2002]; CPLR 201 [“"no court shall extend the time limited by law for the commencement of an action”]), even by a single day (*see Bacalokonstantis v Nichols,* 141 AD2d 482, 483-484 [2d Dept 1988]). The plaintiff commenced this action on October 18, 2024 by filing a summons and complaint (*see* CPLR 304[a]). Since that date was long after the limitations periods applicable to all of his causes of action had expired, the defendant’s motion, to the extent that it was premised upon CPLR 3211(a)(5), must be granted on that ground as well.

Accordingly, it is,

ORDERED that the defendant’s motion to dismiss the complaint pursuant to CPLR 3211(a) is granted on the grounds that the complaint failed to state a cause of action and because the action is time-barred, the complaint is dismissed, and the Clerk of the court shall enter judgment dismissing the complaint.

This constitutes the Decision and Order of the court.

5/1/2026
DATE

JOHN J. KELLEY, J.S.C.

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