No. 71P24 THREE-A DISTRICT

SUPREME COURT OF NORTH CAROLINA

****

DORIS GRIFFIN LAND and ELLIOTT LAND, Plaintiffs-Respondents, v. KORI B. WHITLEY, M.D., PHYSICIANS EAST, P.A. d/b/a GREENVILLE OB/GYN, PITT COUNTY MEMORIAL HOSPITAL, INC. d/b/a VIDANT MEDICAL CENTER, and PITT COUNTY MEMORIAL HOSPITAL, INC. d/b/a VIDANT SURGICENTER, Defendants-Petitioners.	From Pitt County No. COA 23-250 No. 22 CVS 395

****

BRIEF OF AMICI CURIAE NORTH CAROLINA HEALTH CARE FACILITIES ASSOCIATION, NORTH CAROLINA SENIOR LIVING ASSOCIATION, AND NORTH CAROLINA ASSISTED LIVING ASSOCIATION IN SUPPORT OF DEFENDANTS' PETITION FOR DISCRETIONARY REVIEW

****

INDEX

TABLE OF AUTHORITIES

Cases

Statutes

Executive Orders

Other Authorities

No. 71P24 THREE-A DISTRICT

SUPREME COURT OF NORTH CAROLINA

****

DORIS GRIFFIN LAND and ELLIOTT LAND, Plaintiffs, v. KORI B. WHITLEY, M.D., PHYSICIANS EAST, P.A. d/b/a GREENVILLE OB/GYN, PITT COUNTY MEMORIAL HOSPITAL, INC. d/b/a VIDANT MEDICAL CENTER, and PITT COUNTY MEMORIAL HOSPITAL, INC. d/b/a VIDANT SURGICENTER, Defendants.	From Pitt County No. COA 23-250 No. 22 CVS 395

****

BRIEF OF AMICI CURIAE NORTH CAROLINA HEALTH CARE FACILITIES ASSOCIATION, NORTH CAROLINA SENIOR LIVING ASSOCIATION, AND NORTH CAROLINA ASSISTED LIVING ASSOCIATION IN SUPPORT OF DEFENDANTS' PETITION FOR DISCRETIONARY REVIEW[1]

****

[1] There is no person or entity other than the amici curiae, their members, and/or their counsel, who helped write this brief or who contributed money for its preparation.

STATEMENT OF INTEREST OF AMICI CURIAE

Amici's members house and care for many of our State's seniors and others needing skilled nursing and long term care. There are 422 licensed nursing homes[2] and 581 adult care homes[3] that house and care for approximately 70,940 residents in North Carolina.[4] Amici are the statewide associations of nursing homes, assisted living facilities, post-acute care facilities, and other skilled nursing facilities. The North Carolina Health Care Facilities Association represents and advocates for skilled nursing and post-acute care facilities and the residents and families they serve. The North Carolina Senior Living Association is the oldest assisted living association in the State whose members are licensed adult and family care homes. The North Carolina Assisted Living Association represents 350 assisted living facilities caring for 15,000 residents in adult and family care homes across the State.

---

[2] *Nursing Home Facilities Licensed by the State of North Carolina Department of Health and Human Services – Division of Health Service Regulation As of 2/2024*, NH_WebReportAlphabeticalPdf (ncdhhs.gov) (last visited Mar. 14, 2024).

[3] *Adult Care Homes / Homes for the Aged Licensed by the State of North Carolina Department of Health and Human Services – Division of Health Service Regulation As of 2/2024*, NH_WebReportAlphabeticalPdf (ncdhhs.gov) (last visited Mar. 14, 2024).

[4] Number of residents in certified nursing facilities by state U.S 2023 | Statista (last visited Mar. 15, 2024); North_Carolina-AL.pdf (ahcancal.org) (last visited Mar. 15, 2024).

Amici write from an industry perspective to emphasize the severe repercussions of the Court of Appeals' decision imposes on long term care facilities[5] and, by extension, some of the State's most vulnerable citizens who depend on their shelter and care.

The Court of Appeals' narrow construction of the Emergency or Disaster Treatment Protection Act, which the General Assembly passed unanimously to provide amici's member facilities[6] and other health care providers broad immunity from civil liability while caring for citizens of this State during Covid, coupled with the Court of Appeals' lowering of the pleading standard for gross negligence, will deprive amici's member facilities of the immunity granted in most cases and will multiply and perpetuate the harmful effects of Covid on long term care facilities and all health care providers for years to come. Therefore, amici respectfully urge the Court to certify the decision by the Court of Appeals for discretionary review.

---

[5] While amici's members include post-acute care facilities and other skilled nursing facilities, they will collectively be referred to in this brief as "long term care facilities."

[6] The Emergency or Disaster Treatment Protection Act grants immunity to health care facilities, which are defined to include entities licensed under Chapters 131D and 131E of the General Statutes. N.C.G.S. §§ 90-21.133 and 90-21.132. Adult care homes are licensed under Chapter 131D. Nursing homes and other skilled nursing facilities are licensed under Chapter 131E. Therefore, amici's members are entitled to the immunity provided by this statute.

ISSUES ADDRESSED IN THE BRIEF

I. Is there significant public interest in whether the Court of Appeals' decision will deprive our State's health care providers, who remained steadfast on the front lines of Covid in service to our State, of the protection our legislature decided they should have?

II. Does the Court of Appeals' narrow construction of the Act, which disregards the Act's plain language, violates its purpose to grant broad immunity from liability during Covid, and defies its mandate of liberal construction as needed to effectuate its purpose, involve a legal principle of major significance to the jurisprudence of the State?

III. Does the Court of Appeals' decision that allows a plaintiff to state a claim for gross negligence by merely adding that phrase to a complaint, without alleging sufficient facts to support a conclusion that the defendant was grossly negligent, involve a legal principle of major significance to the jurisprudence of the State?

INTRODUCTION

Covid was an unprecedented worldwide public health crisis that wreaked havoc on every aspect of our society and threatened the health, safety, and welfare of every North Carolinian. It became clear at the onset of Covid that we would depend almost entirely on health care providers to defend us against the scourge of Covid. Sustaining our public health system was, and still is, a matter of significant public interest. While we all implored and expected health care providers to

remain steadfast on the front lines of Covid in service to our State, our elected representatives took deliberate measures to ensure the stability of our public health system.

Normally, health care providers may be held liable for negligence that causes injury to their patients. However, our elected representatives understood that these were extraordinary times of uncertainty. It was inconceivable that we would expect our health care providers to be our heroes and, at the same time, hold them accountable for mistakes. With full bipartisan support, our legislature took measures to sustain our public health system. The Senate and House unanimously passed the Emergency or Disaster Treatment Protection Act to promote the health, safety, and welfare of our citizens by broadly protecting health care providers and facilities from liability during Covid. They understood that it was not possible for health care facilities to conduct operations as usual during the public health emergency, or to deliver the same continuity and quality of care as before. Covid severely impacted long term care facilities as they cared for seniors.

While long term care facilities navigated the treacherous waters of the pandemic, they relied on this insulation of immunity from liability

for mistakes they would undoubtedly make during that chaotic time. They were bound to comply with ever-changing government directives amidst severe staffing shortages, all while trying to meet the needs of their residents. Even now, facilities must comply with ongoing Covid restrictions and still struggle to overcome staffing shortages, financial deficits, and other Covid-induced challenges. In addition to the increased administrative, operational, and regulatory burdens imposed by Covid, these facilities have dealt with the added threat of agency enforcement, such as monetary penalties or facility closures, if they fail to meet Covid infection control standards.

If health care providers had been forced to face these hefty burdens while also facing the specter of increased liability that would certainly follow for inevitable mistakes, they might have found themselves with only one viable alternative: to not even try to stay on the front lines of Covid. Our legislators knew that exposure to increased liability was simply an untenable, destabilizing force, so they took action in the best interests of our State to remove it.

Our State should not bait and switch our health care heroes now that memories of Covid are starting to fade. Instead, our courts should

uphold the policy choice our legislature made. The Court of Appeals' narrow construction of the Act and lowering of the pleading standard for gross negligence will deprive health care providers of the immunity granted. This is a matter of significant public interest to long term care facilities still trying to recover from the disruption of the pandemic. If the decision below stands, it will perpetuate Covid's harmful effects on these facilities for years to come. Implementing the Act is critically important to the long term care sector of the health care industry.

Therefore, amici respectfully urge the Court to certify the decision by the Court of Appeals for discretionary review.

BACKGROUND

I. Covid was an unprecedented worldwide public health crisis.

COVID-19 ("Covid") was an unprecedented worldwide public health crisis that threatened the stability of health care systems around the world.[7] On 31 January 2020, the World Health Organization and the Secretary of the United States Department of Health and Human

[7] Nkengasong, J.N., *COVID-19: unprecedented but expected*, Nat Med 27, 364 (2021), https://doi.org/10.1038/s41591-021-01269-x.

Services (DHHS) declared public health emergencies due to Covid.[8] On 10 March 2020, Governor Cooper declared a state of emergency in North Carolina, invoking the Emergency Management Act. Exec. Order No. 116, Cooper (Mar. 10, 2020); N.C.G.S. § 166A-19.10 *et seq*.

One week later, the North Carolina Department of Health and Human Services (NCDHHS) confirmed that the number of Covid cases continued to rise. Exec. Order No. 118, Cooper (Mar. 17, 2020). That news was accompanied by a spate of executive orders in the following weeks that sought to manage and stop the spread of the disease. *See*, *e.g.*, Exec. Order No. 120, Cooper (Mar. 23, 2020); Exec. Order No. 121, Cooper (Mar. 27, 2020). By 27 March 2020, NCDHHS had documented 763 cases of Covid across sixty counties and identified widespread transmission. Exec. Order No. 121, Cooper (Mar. 27, 2020).

II. Executive orders recognized the critical role long term care facilities and other health care providers would serve in sustaining public health during the pandemic.

From the onset of the pandemic, executive orders responsive to the pandemic recognized that health care professionals were "integral to ensuring the state [was] best situated to respond to and mitigate the

[8] *CDC Museum COVID-19 Timeline*, CDC Museum COVID-19 Timeline | David J. Sencer CDC Museum | CDC (last visited March 17, 2024).

threat posed by" Covid, Exec. Order No. 117, Cooper (Mar. 14, 2020), and prioritized North Carolina's "critical need to support healthcare providers, nursing and adult group home staff, . . . and others working to keep communities safe and healthy during the [Covid] pandemic," Exec. Order No. 119, Cooper (Mar. 20, 2020). To address this need, the Governor issued several executive orders in March and April 2020. First, the Governor ordered that persons licensed in other states, territories, or the District of Columbia could provide health care services in our State. Exec. Order No. 116, Cooper (Mar. 10, 2020).

Based on recommendations by NCDHHS urging limitations on visitors at long term care facilities and other measures to control the spread of Covid in long term care settings,[9] the Governor ordered long term care facilities to restrict visitation of all visitors and non-essential health care personnel in skilled nursing facilities and adult care homes. Exec. Order No. 120, Cooper (Mar. 23, 2020).

To address the needs of health care providers for childcare for their school-aged children, certain childcare regulations were suspended and

---

[9] *North Carolina Department of Health and Human Services' Recommendations on Visitation in Long Term Care Facilities to Reduce Risk of Transmission of COVID-19* (Mar. 13, 2020), Microsoft Word - NCDHHS COVID-19 Visitation Guidance for LTC Facilities 2020-03-13; *see also* Exec. Order No. 120, Cooper (Mar. 23, 2020).

certain health department regulations were waived. Exec. Order No. 119, Cooper (Mar. 20, 2020).

The Governor designated health care facilities as essential businesses and ordered them to (1) maintain at least six feet distance from other individuals, (2) wash hands using soap and water for at least twenty seconds as frequently as possible or use hand sanitizer, (3) regularly clean high-touch surfaces, and (4) facilitate online or remote access by customers if possible. Exec. Order No. 121, Cooper (Mar. 27, 2020).

North Carolina health care providers expressed concern that existing health care facilities would not be sufficient to care for those who got sick. Exec. Order No. 130, Cooper (Apr. 8, 2020). A composite modeling forecast by experts from North Carolina universities and research organizations estimated that by the end of May 2020, approximately 250,000 North Carolinians would be infected with Covid, even with social distancing measures in place. *Id.* Governor Cooper issued Executive Order No. 130, entitled "Meeting North Carolina's Health Care and Human Services Needs," urging North Carolina to take all reasonable actions to expand capacity of its health care system. *Id.*

The order granted NCDHHS and occupational licensing boards authority to waive or suspend legal and regulatory constraints and delegated authority to health care licensure boards to waive licensure requirements for health care personnel. *Id.* This allowed persons with inactive or no North Carolina licenses, skilled but unlicensed volunteers, and certain students to provide health care services. *Id.*

The order also permitted waivers of limitations on nursing home facility licensed bed capacity, waived requirements for certain in-person applications or assessments for DHHS programs, and relaxed regulations on adult care homes when conducting criminal history records checks and controlled-substance screens. *Id.*

Executive Order No. 130 further acknowledged that "many potential health care workers ha[d] raised concerns about a lack of malpractice insurance or potential liability if they were to serve North Carolinians during this pandemic." *Id.* It extended the immunity from civil liability already provided to emergency management workers by the Emergency Management Act to persons providing health care services to treat Covid. *Id.* The Emergency Management Act provides immunity to emergency management workers from civil liability for death or injury to

persons while performing governmental functions requested by the State. N.C.G.S. § 166A-19.60.

The Governor extended this immunity to health care providers during Covid by ordering that (1) all persons licensed or otherwise authorized under the order to perform professional skills in the field of health care were being requested to provide emergency services to respond to the Covid pandemic, and (2) they would be considered emergency management workers entitled to insulation from civil liability pursuant to N.C. Gen. Stat. § 166A-19.60. Exec. Order No. 130, Cooper (Apr. 8, 2020). The executive order "intend[ed] to provide insulation from liability to the maximum extent authorized by N.C. Gen. Stat. § 166A-19.60, except in cases of willful misconduct, gross negligence, or bad faith." *Id.*

III. Our legislature decided to ensure the stability of our health care system by granting broad immunity from liability to health care providers during Covid.

Our General Assembly was also hard at work in the early weeks of the pandemic, taking measures to ensure stability of our public health system. On 2 May 2020, both houses of our General Assembly unanimously passed the Emergency or Disaster Treatment Protection

Act "to promote the public health, safety, and welfare of all citizens by broadly protecting the health care facilities and health care providers in this State from liability that may result from treatment of individuals during the COVID-19 public health emergency under conditions resulting from circumstances associated with the COVID 19 public health emergency." N.C.G.S. § 90 21.131.

North Carolina's deliberate policy choice to extend immunity from liability to its health care providers during the pandemic aligned with similar measures taking place across the nation.[10] Indeed, "in an effort to extend the capacity of our nation's health care workforce to provide care on the frontlines of the [Covid] crisis," the Secretary of the United Department of Health and Human Services issued a letter and associated guidance urging all state governors to take a number of immediate actions, including shielding health care professionals from medical liability."[11] At least twenty-eight other states passed Covid immunity

---

[10] American Medical Association, *Liability protections for health care professionals during COVID-19* (Apr. 8, 2020), Liability protections for health care professionals during COVID-19 | American Medical Association (ama-assn.org).

[11] Azar, Alex M., Secretary, U.S. Department of Health and Human Services (Mar. 24, 2020), Governor-Letter-from-Azar-March-24.pdf (nga.org).

statutes.[12] For example, Georgia enacted the Georgia COVID-19 Pandemic Business Safety Act, which granted immunity to health care facilities and providers, including nursing homes and assisted living facilities, from liability for damages during Covid. *See Arbor Mgmt. Servs., LLC v. Hendrix*, 364 Ga. App. 758, 766, 875 S.E.2d 392, 399 (2022). Other states relied on executive orders and/or good Samaritan statutes.[13]

IV. Covid severely impacted long term care facilities that cared for seniors during the public health emergency.

Covid disrupted long-term care facilities in myriad ways, compromising their ability to maintain continuity and quality of care for their residents during this period.

A. Facilities were bombarded with frequently changing federal, state, and local government directives and guidelines that significantly disrupted operations.

The Covid pandemic created a public health emergency that "rapidly alter[ed] the provision of health care services across the country based on guidance and recommendations from the Centers for Disease Control and Prevention and other federal, state and local government

[12] National Conference of State Legislators, Report, COVID-19: State Health Actions (Sept. 27, 2021), COVID-19: State Health Actions (ncsl.org).
[13] AMA, *supra* note 10.

directives."[14] Long term care facilities were forced to respond to the challenges presented by the Covid virus within their facilities, while simultaneously working to comply with all of these shifting directives and guidelines.

In addition to CDC guidelines imposed on long term care facilities, CMS[15] and the Occupational Safety and Health Administration (OSHA)[16] issued federal directives and guidelines that applied to these facilities. State agency directives were issued by NCDHHS[17] and the North Carolina Department of Labor.[18]

By executive order, Governor Cooper established long term care risk mitigation measures. Exec. Order No. 131, Cooper (April 9, 2020). He ordered skilled nursing facilities and urged adult care homes to do the

---

[14] AMA, *supra* note 10.
[15] CMS, COVID-19 Data & Updates, COVID-19 Data & Updates | CMS (last visited Mar. 19, 2024).
[16] OSHA ALERT, *COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers*, COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers (osha.gov) (last visited Mar. 19, 2024).
[17] North Carolina Department of Health and Humans Services, *Guidance for Long-Term Care Providers and Facilities*, Long-Term Care Facilities | NC COVID-19 (ncdhhs.gov))(last visited Mar. 19, 2024).
[18] North Carolina Department of Labor, *Emergency Temporary Standard on Occupations Exposure to COVID-19*, COVID-19 | NC DOL (last visited Mar. 19, 2024).

following, "to the extent possible given the constraints on the availability of personal protective equipment":

- "Remind staff to stay at home when they are ill and prevent any staff who are ill from coming to work and/or staying at work";
- "Screen all staff at the beginning of their shift for fever and respiratory symptoms," which includes "[a]ctively taking that staff member's temperature" and "[d]ocumenting an absence of any shortness of breath, any new cough or changes in cough, and any sore throat"; and, "[i]f the staff member is ill, the facility must have the staff member put on a facemask and leave the workplace";
- "Cancel communal dining and all group activities, including internal and external activities";
- "Implement universal use of facemasks for all staff while in the facility, assuming supplies are available";
- "Actively monitor all residents upon admission, and at least daily, for fever and respiratory symptoms (shortness of breath, new cough or change in cough, and sore throat), and shall continue to monitor residents";
- "Notify the local health department immediately about either of the following: (a) Any resident with new, confirmed, or suspected [Covid]. (b) A cluster of residents or staff with symptoms of respiratory illness. A 'cluster' of residents or staff means three (3) or more people (residents or staff) with new-onset respiratory symptoms in a period of 72 hours."

Id.

Amici's member facilities report that the impacts of Covid on their facilities' operations were numerous and far-reaching. In addition to arranging for and providing care to residents, management and staff were forced to expend considerable time and financial and human resources tracking and learning about Covid and the related directives and guidelines imposed by numerous authorities.

Management and staff devoted time and resources to keep up with Covid and compliance in the following ways:

- Facility management and staff devoted time to tracking and understanding federal, state, and local directives and guidelines and developing and implementing new policies and procedures to ensure compliance;
- Facility management and staff devoted time to staying informed of the changing science of Covid, even when our national and State leaders lacked understanding;
- Facility management formed committees for continuing monitoring of Covid science, directives, and guidelines.

Covid required new patient procedures and protocols. For example:

- Facilities devoted time to altering patient protocols and establishing alternate treatment procedures due to Covid;
- Facilities modified infection control policies and procedures, which required staff to perform new

tasks such as disinfecting, cleaning, filtration, housekeeping, ordering and donning personal protective equipment (PPE), and frequent hand washing;

- Facilities attempted to obtain supplies of masks for residents and staff and implement and manage policies requiring face masks;

- Facility management developed and implemented new policies and procedures for staff absenteeism for Covid-related reasons;

- Facilities planned and conducted new in-service training programs to teach staff new policies and procedures related to infection control, resident care, no-visitation or limited visitation, contractor admission, staffing, and vaccination; and

- Facilities implemented and executed mandatory vaccination programs for employed health care workers.

Covid also required modification to facilities themselves, and changes in how those spaces were utilized:

- Facilities restructured buildings to create areas of isolation for Covid-positive residents and space for social distancing of residents and staff; and

- Facilities regrouped residents to provide for social distancing, which required physically moving residents and their belongings.

Implementing these new procedures and modifications was complicated by industry-wide staffing and PPE shortages during Covid. Specifically:

- Facilities suffered from staffing shortages due to mandatory fourteen-day quarantining when staff tested positive for Covid or were exposed to Covid;

- Facilities suffered from staffing shortages due to staff being unable to report to work when they lacked childcare due to school closures or when their child caregivers tested positive for Covid;

- Out of necessity, facilities employed less experienced workers who treated patients, as permitted by government orders and guidelines;

- Out of necessity, many facilities had to use agencies they had never used before to provide staffing for health care and other services for residents; and

- Facilities faced scarcity of needed resources such as PPE, respirators, Covid therapeutics, and vaccines due to limited supply of these products and significant supply chain issues.

Against the backdrop of these staffing challenges, facilities had to rewrite the book on how they dealt with non-resident visitors. For example:

- Facility staff devoted time to communicating with residents' family members who could not visit, including facilitating FaceTime calls;

- Facility staff devoted time to notifying family members of status of residents more frequently due to no-visitation policies;

- At the same time, facilities lacked the valuable eyes and ears of family members who were not permitted to visit residents, as mandated by government orders and guidelines;

- Facility management and staff created and posted required notices, directives, and signage for contractors, other visitors, and staff;
- Facility staff devoted time to admitting contractors into facilities according to newly developed protocols, such as taking their temperatures and recording contact tracing information; and
- Facility staff performed certain tasks that had previously been done by third parties who no longer entered the facilities, such as taking blood to the lab to be tested.

Due to increased costs and decreased occupancy resulting from these impacts and necessary policy changes, facilities suffered significant financial setbacks.

While expending much time and financial and human resources to comply with the directives and guidelines that were frequently changing, long term care facilities were also working hard every day to keep their residents from contracting Covid and to maintain their general health. Amidst all of these constraints, facilities feared the threat of monetary or injunctive enforcement against them by State health regulators if they fell short of full compliance with Covid infection-control directives.

B. The effects of Covid pervaded facilities' arrangement and provision of health care services for residents, preventing facilities from providing the same quality of care during Covid as they provided before Covid.

Covid's pervasive impact affected *all* arrangement and provision of care for residents during the pandemic.

A critical aspect of long term care is staffing.[19] Pre-existing structural challenges that had limited long term care facilities' ability to hire and retain staff before Covid became "worse for [nursing homes] during the coronavirus pandemic."[20] Long term care staff could not socially distance because their jobs require close contact with residents.[21] Early in the pandemic, long term care facilities lacked PPE to prevent transmission of Covid within facilities.[22] PPE shortages "put staff at increased risk of contracting the virus, with staff suspected of having contracted [Covid] required to quarantine for at least 14 days," resulting in existing staff often being sidelined.[23]

---

[19] Huwien Xu, Orna Intrator & John Bowblis, *Shortages of Staff in Nursing Homes During the COVID-19 Pandemic: What are the Driving Factors?*, J. Post-Acute and Long-Term Care Med. (2020), Shortages of Staff in Nursing Homes During the COVID-19 Pandemic: What are the Driving Factors? - Journal of the American Medical Directors Association (jamda.com).
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*

Long term care facilities needed to implement infection control protocols, including isolating residents who were suspected of having Covid, while the ban on visitors "reduced the availability of some informal care provided to residents by visiting relatives."[24] "This created a situation in which time and effort needed from [nursing home] staff increased, yet structural factors made it more difficult to address, creating the potential for a staff shortage."[25] Centers for Medicare & Medicaid Services (CMS) "acknowledged this shortage by temporarily suspending the competency requirement for providing direct care to residents, but the additional $600 per week federal unemployment benefit hurt the ability of [nursing homes] to recruit needed staff."[26]

Long term care facility staff also suffered from mental health issues during Covid, including burnout.[27] Covid "exacerbated existing vulnerabilities of workers through increasingly unsafe working conditions, increased workloads, and emotional exhaustion."[28] Long term

---

[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] Jennifer C. Morgan, Waqar Ahmad, Yun-Zih Chen & Elizabeth O. Burgess, *The Impact of COVID-19 on the Person-Centered Care Practices in Nursing Homes*, National Library of Medicine (2023) (nih.gov).
[28] *Id.*

care staff experienced "multiple layers of trauma" during the pandemic, including "increased workloads, unclear and often contradictory instruction, emotional overload, stress, fear and exposure to contagion and death, and the dearth of staff and protective equipment."[29] "Uncertainty and fear about the unfolding situation resulted in emotional exhaustion, sleep disturbances, and loss of appetite" for staff and residents.[30] "Nursing home administrators and owners faced problems in organizing and managing physical and human resources to adequately respond to the pandemic and often failed to address the emotional exhaustion among employees and residents."[31]

Even measures intended by the government to improve infection control or to alleviate the strains on long term care facilities caused by the pandemic inevitably reduced continuity and quality of patient care. For example, the United States Secretary of the Department of Health and Human Services authorized blanket waivers of many Centers for Medicare & Medicaid Services' (CMS) requirements for nursing homes,

---

[29] *Id.*
[30] *Id.*
[31] *Id.*

retroactive to 1 March 2020.[32] To separate symptomatic residents from asymptomatic or Covid-negative residents, CMS waived requirements that facilities provide notice and rationale for changing a resident's room and regulations ensuring residents could choose roommates and refuse to transfer rooms.[33] CMS also waived requirements that physicians and practitioners make in-person visits to nursing homes.[34] To assist in staffing shortages due to Covid, CMS waived certain requirements for training and certifying nurse aides.[35]

C. Covid caused serious financial harm to long term care facilities.

Covid heaped pressure on long term care facilities and put them in financial dire straits by increasing their costs and decreasing their revenues.[36] Long term care facilities expended extensive resources trying to protect residents and staff from Covid.[37] Costs of PPE, routine testing,

---

[32] Centers for Medicare & Medicaid Services, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers,* COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (cms.gov).
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] Orewa G, Weech-Maldonado R, Feldman S, Becker D, Davlyatov G, Lord J., *Financial Outcomes Associated with COVID-19 in Nursing Homes*, Innov Aging (Dec. 21, 2023), FINANCIAL OUTCOMES ASSOCIATED WITH COVID-19 IN NURSING HOMES - PMC (nih.gov).
[37] American Health Care Association and National Center for Assisted Living, *COVID-19 Exacerbates Financial Challenges Of Long Term Care Facilities* (Feb. 17,

and staff support "have severely strained" their budgets.[38] In 2020, nursing homes spent roughly $30 billion on PPE and additional staffing alone."[39]

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) estimated that the long term care industry would lose $94 billion between 2020 and 2021.[40] Declining occupancy due to fewer new residents contributed to the financial crisis for long term care facilities.[41] Long term care industry insiders have referred to the pandemic as a "business nightmare."[42] One study found that Covid increased operating cost per patient day and decreased operating margin.[43] The ratio between the increase in operating cost per patient day to the operating revenue per patient doubled.[44] The study predicted facility closures and reduced access to long term care caused by

---

2021), COVID-19 Exacerbates Financial Challenges Of Long Term Care Facilities (ahcancal.org).

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] Orewa G, Weech-Maldonado R, Feldman S, Becker D, Davlyatov G, Lord J., *Financial Outcomes Associated with COVID-19 in Nursing Homes*, Innov Aging (Dec. 21, 2023), FINANCIAL OUTCOMES ASSOCIATED WITH COVID-19 IN NURSING HOMES - PMC (nih.gov).

[44] *Id.*

the "deterioration in financial performance" of long term care facilities during the pandemic.[45]

Even with government interventions, financial burdens became "too difficult to overcome for many providers": many facilities shuttered, "leaving thousands of vulnerable seniors in search of new care."[46] Because "most residents have multiple underlying health conditions and require a high-level of around-the-clock, specialized care," facility closures "leave residents displaced from their long-standing communities and loved ones, and reduce their options for quality care, especially in rural areas."[47]

ARGUMENT

I. There is significant public interest in whether the Court of Appeals' decision will deprive our State's health care providers, who remained on the front lines of Covid in service to our State, of the protection our legislature decided they should have.

It is hard to imagine any other event or issue of our generation, or even in the past, which has fully captivated the public interest like the worldwide Covid pandemic has. Undoubtedly, we all remember where

---

[45] *Id.*
[46] *Id.*
[47] *Id.*

we were when we learned that our businesses and schools were closing and, later, when we were ordered to stay at home. Covid affected every person, family, business, and community in profound ways that we will not soon forget. Covid caused devastating physical and emotional pain to many people in the world. Most of us had never before experienced the degree of isolation Covid forced us to endure. Perhaps the biggest tragedy was the prolonged isolation of our seniors from their family members, friends, and even from the people living near them in their own facilities.

North Carolina's Act that provided broad immunity from liability assured long term care facilities that they would be insulated from liability while navigating the pandemic and the severe pressures and constraints it imposed. Long term care facilities relied on the Act to protect them from the reality that "[v]irtually any patient [might] feel aggrieved by failing to receive state-of-the-art medical care during an emergency that would have been provided in routine health care environments. Against this backdrop, the potential arises for legal action resulting from perceived or actual denial or limitation of health care services during a crisis."[48]

---

[48] CMS, *supra*, note 32.

During public health emergencies, "[l]egal conflicts inherent in balancing individual and communal interests invariably arise, including the oft-debated liability risks of [health care workers] and entities."[49] "[G]overnments have established policy norms, passing an array of statutory and regulatory liability protections . . . that collectively immunize practitioners, volunteers, and some entities from negligence claims resulting from actions during declared emergencies."[50] When health care providers "perceive a significant threat of liability, they may fail to respond in kind with allocation plans that refocus resource decision-making away from individual patient outcomes toward protecting the public's health."[51]

> Relying on shifts in medical standards of care during emergencies to fully insulate providers from negligence claims ignores the distinctions between medical and legal standards of care. Just because the medical standard of care may change in emergencies does not always mean the legal standard follows suit. During the implementation of [crisis standards of care], [health care providers] must make tough decisions about who receives and who is denied specific services or medicines. Some patients may be negatively impacted in the

[49] James G. Hodge, Jr., Dan Hanfling & Tia P. Powell, Practical, Ethical, and Legal Challenges Underlying Crisis Standards of Care, J. Law, Med. & Ethics, 52 (2013), Crisis-Standards-of-Care-Hodge-JLME-2013.pdf (networkforphl.org)
[50] *Id.* at 54.
[51] *Id.* at 54.

> interests of protecting the public's health. Exposing [health care providers] to liability for ordinary negligence compromises these decisions.[52]

For all of these reasons, "federal, state, and local governments, public health agencies, and public health and health care organizations have consistently supported limited liability or indemnification protections for health care and public health actors, especially volunteers, during emergencies."[53]

> Lacking sufficient legal precedents, the provision of reasonable care through medical triage in a crisis may be viewed by many as insufficient or negligent because it may deviate extensively from normal standards as a result of the scarcity of resources. The development of national guidance on [crisis standards of care] may obviate some claims by clarifying the roles and responsibilities of practitioners during an emergency, against which the reasonableness of their actions or omissions may be adjudicated. Such results, however, are not assured. Facing potential uncertainty as to how courts or other arbitrators will assess claims arising from crisis care, qualified health care practitioners, volunteers, and entities naturally are concerned about their actual or perceived risks of liability. Nonetheless, all levels of government provide limited legal liability protections for many practitioners and entities responding during emergencies to offer

---

[52] *Id.* at 54.

[53] Valerie G. Koch, *Crisis Standards of Care and State Liability Shields*, 57 San Diego L. Rev. 973, 973-77 (2020).

> assurances and incentives for their participation in emergency response efforts.[54]

"An additional concern of many healthcare practitioners is the extent to which medical malpractice and other forms of insurance will cover medical mistakes or care given outside a provider's scope of practice under crisis standards of care situations. Medical malpractice insurance coverage in declared emergencies differs across states and is dependent on specific insurance policy language."[55]

During Covid, our elected State leaders and leaders of other states worked to address perhaps the most pressing matter of public interest of our time. One of the efforts they uniformly embraced was ensuring that health care providers would be immune from liability for alleged mistakes during the public health emergency.

Like many leaders throughout the world, North Carolina's elected policymakers accepted their responsibility to address the needs of our public health system in an unprecedented crisis that uniformly garnered overwhelming public interest. They were unified in their mission to

---

[54] Hodge, *supra,* note 49, at 57.

[55] Bruce M. Altevogt et al., *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report* (2009), Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations - NCBI Bookshelf (nih.gov).

protect the health, safety, and welfare of the citizens of our State. One deliberate measure our elected leaders took to sustain our public health system was granting broad immunity from civil liability to health care providers and facilities during Covid.

II. The Court of Appeals' narrow construction of the Act, which disregards the Act's plain language, violates its purpose to grant broad immunity from liability during Covid, and defies its mandate of liberal construction as needed to effectuate its purpose, involves legal principles of major significance to the jurisprudence of the State.

Our elected State leaders understood even in the early weeks of the pandemic that the circumstances of the unprecedented, worldwide public health crisis caused by a contagious, deadly virus could permeate and affect *all* arrangement and provision of health care services. Indeed, history has borne out that Covid's impacts on long term care facilities, especially, were so pervasive that they overlaid everything.

The broad language of the Act reflects the legislature's deliberate effort to broadly define the protected conduct so as to include all acts and omissions in good faith while providing health care services during the state of emergency. Under the Act, a health care facility is immune from "any civil liability from *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 the facility was "*arranging for or providing health care services during the period of* the [Covid] emergency declaration, including, but not limited to, the arrangement or provision of those services pursuant to a [Covid] emergency rule," the defendant's "arrangement or provision health care services was *impacted, directly or indirectly*" by the facility's "decision or activities in response to or as a result of the [Covid] pandemic," and the facility was "arranging for or providing health care services in good faith." N.C.G.S. § 90-21.133(a) (emphasis added)..

Further, the Act broadly defines "health care services" to include "[t]reatment, direction, supervision, management, or administrative or corporate service" "provided by a health care facility or health care provider during the period of the [Covid] emergency declaration." N.C.G.S. § 90-21.132(8).

The plain language of the statute affords immunity from liability to health care defendants who show that their acts or omissions that allegedly caused injury occurred during the Covid state of emergency and while the defendants were acting as health care providers, as long as

their actions were not in bad faith, grossly negligent, or intentionally harmful.

Given the plain language of the statute, it is *not* plausible that our legislators intended that a court, when applying the statute in a particular case, would parse out the defendant's interactions with the plaintiff granularly, moment by moment, looking discretely at each interaction to determine whether there was a justification or excuse for each act or omission that was attributable to Covid. This construction and treatment of the Act would simply leave no room for the honest mistakes the legislature intended to insulate from liability.

Our legislators intended to provide such broad immunity from liability during Covid because they were able to understand and foresee that it would not be *possible* for health care facilities to deliver the same continuity and quality of care as they did before Covid, and it might be likely they would make more honest mistakes under such unusual and uncontrollable circumstances.

The Court of Appeals' construction of the Act rewrites the statute in a major way, by adding a causation requirement that is not in the statute, which the the legislature did not intend defendants to have to

establish in order to qualify for immunity. The decision below turns the burden of proof on its head and nullifies the intended immunity for ordinary negligence, by requiring defendant health care providers and facilities to prove that plaintiffs' alleged injuries were *caused* by Covid.

Examining the New York court's construction and treatment of that state's similarly broad Covid immunity statute in *Crampton v. Garnet* is instructive here. *Crampton v. Garnet* illustrates what amici contend is the correct way to apply North Carolina's immunity statute. In response to the pandemic, New York enacted an immunity statute almost identical to North Carolina's Act. *Compare* Public Health Law § 3082 (NY) (repealed 2021) *with* N.C.G.S. § 90-21.133 *et seq*. New York's statute grants health care facilities immunity from any 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," as long as the facility "is arranging for or providing health care services pursuant to a [Covid] 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 . . . 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 facility or health care professional "is arranging for or providing health care services in good faith." Public Health Law § 3082.

In *Crampton v. Garnet Health*, the Supreme Court of Orange County evaluated and applied the immunity statute. 73 Misc. 3d 543, 155 N.Y.S.3d 699 (N.Y. Sup. Ct. 2021). A resident of a long term care facility in New York filed a complaint against the facility alleging injuries occurring during Covid. *Id.* at 545, 155 N.Y.S.3d at 701. The facility moved for dismissal based on the immunity provided by New York's Covid immunity statute. *Id.* at 547, 155 N.Y.S.3d at 702. After examining the statute's broad purpose and its broad definitions of "health care facilities" and "health care services," the court determined that "a facility, to avail itself of [] immunity from liability, need demonstrate only that the treatment of the individual is impacted by the health care facility's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives." *Id.* at 557–58, 155 N.Y.S.3d at 709–10 (internal marks omitted). The court concluded that "the statute does not qualify how treatment must be affected — whether

positively, negatively, or otherwise — it merely requires that treatment be 'impacted.'" *Id.* (citation omitted).

The court examined the defendant-facility's affidavit, which averred that the plaintiff's medical treatment was impacted because "she was required to undergo [Covid] testing, monitoring and temperature checks"; "staff time with residents was reduced by the staff's need to comply with [Covid] PPE requirements"; and Covid "prevention measures resulted inter alia in her communal activities and meals being stopped, her visitation being curtailed, and her being kept in her room with the door closed." *Id.* 559-60, 155 N.Y.S.3d at 710–711.

In holding that the immunity attached, the New York court explained that the facility "need not have demonstrated that [the plaintiff's] treatment was impacted in some particular manner different from that of other residents. Nor must [the facility] have demonstrated any particular manner in which her medical treatment was adversely affected. [The facility's] evidence unequivocally demonstrates the basic linkage — between the facility's [Covid] measures and the treatment of [the plaintiff]" required by the statute for immunity to attach. *Id.* at 560, 155 N.Y.S.3d at 711.

Although not binding on this Court, *Crampton* is instructive because it conflicts with our Court of Appeals' interpretation of almost identical statutory language.

Our courts should not, now, when Covid might be getting smaller in the rearview mirror for most, undo this deliberate effort our legislature made to sustain our public health system.

Whether the broad immunity the legislature granted will be afforded by our courts is of significant public interest to long term care facilities and other health care providers in our State, and is legally significant. Amici submit that our courts should not nullify the public policy set by the legislature. Indeed, while still serving on the Court of Appeals, then-Judge Riggs' suggested recently that courts should follow the text of statutes that the General Assembly has passed unanimously. *See McKinney v. Goins*, 290 N.C. App. 403, 431, 892 S.E.2d 460, 479 (2023) ("[T]he General Assembly's unanimous enactment of the SAFE Child Act and its Revival Window was a united response to developing science. . ."). Likewise, during the early months of the Covid pandemic, our General Assembly's unanimous enactment of the Emergency or Disaster Treatment Protection Act was a united response to the

developing science of Covid. Our courts should not rewrite the Act that our General Assembly unanimously enacted. Whether our courts uphold statutes as written is legally significant and is a matter of significant public interest.

III. By lowering the pleading standard for gross negligence, the decision below nullifies the immunity granted by the Act, involves a legal principle of major significance to the jurisprudence of the State, and conflicts with a decision of this Court and other Court of Appeals' decisions.

By allowing mere conclusory allegations of gross negligence, the Court of Appeals' decision nullifies the immunity granted by the Act. Further, the decision below conflicts with one decision by this Court and decisions by other panels of the Court of Appeals.

The Act expressly provides that the "immunity shall not apply if the harm or damages were caused by an act or omission constituting gross negligence, reckless misconduct, or intentional infliction of harm." N.C.G.S. § 90-21.133(b). This Court has defined gross negligence as "wanton conduct done with conscious or reckless disregard for the rights and safety of others. Further, an act is wanton when it is done of wicked purpose, or when done needlessly, manifesting a reckless indifference to the rights of others." *Parish v. Hill*, 350 N.C. 231, 239, 513 S.E.2d 547,

551–52 (1999) (citations, internal quotation marks, and brackets omitted). The Court has further clarified that "[a]n act or conduct rises to the level of gross negligence when the act is done purposely and with knowledge that such act is a breach of duty to others, i.e., a *conscious* disregard of the safety of others; an act or conduct moves beyond the realm of negligence when the *injury* or *damage* itself is intentional." *Yancey v. Lea*, 354 N.C. 48, 53, 550 S.E.2d 158, 158 (2001) (citation omitted).

Further, the Court of Appeals' decision conflicts with one decision by this Court and decisions by other panels of the Court of Appeals. *See Meyer v. Walls*, 347 N.C. 97, 114, 489 S.E.2d 880, 890 (1997) (noting conclusory allegations of willful and wanton conduct insufficient to withstand motion to dismiss) ("The facts alleged in the complaint must support such a conclusion."); *Green v. Howell*, 274 N.C. App. 158, 167, 851 S.E.2d 673, 679-80 (2020) (citations omitted) ("A conclusory allegation that a public official acted maliciously or corruptly is not sufficient, by itself, to withstand a motion to dismiss. The facts alleged in the complaint must support such a conclusion." (citations and internal quotation marks omitted)); *Doe v. Wake County*, 264 N.C. App. 692, 696,

826 S.E.2d 815, 819 (2019) (citation omitted) (holding that complaint failed to allege "facts which would support a legal conclusion that defendant[s] acted with malice" because plaintiff did not "offer any facts or forecast any evidence that [defendant] took actions that went beyond—at worst—simple negligence").

Additionally, the Act expressly states that "acts, omissions, or decisions resulting from a resource or staffing shortage shall not be considered gross negligence." N.C.G.S. § 90-21.133(b). Here, the legislature made understaffing and scarcity of resources *per se* exceptions to the gross-negligence exception to the immunity granted. By requiring plaintiffs to plead at least some facts to support the conclusion that the defendant was grossly negligent, courts ensure that they can meaningfully evaluate whether the allegations of gross negligence are grounded in allegations of understaffing or scarcity of resources. Without demanding any facts supporting the magic words, the judiciary ignores the express language in the statute and nullifies this provision in the Act.

Indeed, the vast majority of injurious acts and omissions that occurred during Covid were in some way related to understaffing or scarcity of resources. For example, if out of necessity a facility employed

a person less qualified than usual to perform certain tasks, then a mistake that does not appear on its face to have been caused by Covid was certainly impacted by understaffing or scarcity of resources, even if only indirectly. The statute expressly contemplates indirect impact.

IV. If it stands, the Court of Appeals' decision will multiply and perpetuate the harmful effects of Covid on long term care facilities for years to come.

The decision below deprives the very people and public health system that our elected leaders undertook to support of the protection those leaders provided. During the pandemic, long term care facilities and other health care providers relied on being insulated from the consequences of unintentional mistakes as they navigated the treacherous waters of this unprecedented public health crisis.

Because long term care facilities had assurance that they would not be exposed to liability during Covid, they were able to respond to the crisis and care for our seniors, unencumbered by the specter of exposure to liability based on typical standards of care. Facilities' day-to-day and longer-term decisions were affected in many ways by the chaotic scourge of Covid. Relying on the immunity provided by the Act, long term care facilities were able to strive in earnest to manage the crisis and comply

with the guidelines imposed by federal, state, and local authorities, despite the reality that continuity and quality of patient care could be adversely affected.

The Act was meant to *decrease* the risk of liability. But the decision below will *increase* risk of liability. If it stands, it will open the floodgates to protracted litigation against long term care facilities for mistakes made during a state of public health emergency in circumstances almost entirely out of the facilities' control. Depriving health care providers of the immunity granted by the Act will force health care defendants to litigate how Covid's impact lowered the standard of care. By enacting the Act, the legislature put trial courts in a position very early in the litigation to acknowledge the impact of Covid and to provide the immunity that was intended.

If the Court of Appeals' narrow construction of the Act stands, then the judiciary will unravel the deliberate public policy the legislature declared when passing the Act. It is axiomatic that when a statute is clear, courts should not nullify public policy set by the legislature.

Absent review, the decision below will not only permit, but force, juries to decide what the legislature already definitively decided and

articulated in the Act: that as a matter of public policy, we will not subject the health care providers who remained steadfast on the front lines of Covid to liability for accidents and mistakes they made during an unprecedented time, when it was not possible for them to provide the same level of care they could deliver in normal times.

Heaping tort liability on the plates of long term care facilities that have already suffered financial harm will likely push many of them over the edge financially, potentially resulting in closures of homes for our State's seniors.

CONCLUSION

The General Assembly unanimously passed the Emergency or Disaster Treatment Protection Act to provide amici's member facilities and other health care providers broad immunity from civil liability while caring for citizens of this State during Covid. The Court of Appeals' narrow construction of the Act and lowering of the pleading standard for gross negligence will deprive amici's members of immunity in most cases and will multiply and perpetuate the harmful effects of Covid on long term care facilities. Amici respectfully urge the Court to certify the decision by the Court of Appeals for discretionary review.

Respectfully submitted on this the 19th day of March, 2024.

YOUNG MOORE AND HENDERSON, P.A.

By: Electronically Submitted
Christy C. Dunn
N.C. State Bar No. 54816
Christy.Dunn@youngmoorelaw.com
P.O. Box 31627
Raleigh, North Carolina 27622
Telephone: (919)782-6860

Rule 33(b) Certification:
I certify that all of the attorneys listed below have authorized me to list their names on this document as if they had personally signed it.

Angela Farag Craddock
N.C. State Bar No. 32667
Angela.Craddock@youngmoorelaw.com
P.O. Box 31627
Raleigh, North Carolina 27622
Telephone: (919)782-6860

Counsel for Amici Curiae North Carolina Health Care Facilities Association, North Carolina Senior Living Association, and North Carolina Assisted Living Association

CERTIFICATE OF SERVICE

The undersigned certifies that a copy of the foregoing document has been served on the following counsel of record by e-mail:

ROBINSON, BRADSHAW & HINSON, P.A.
Matthew W. Sawchak
msawchak@robinsonbradshaw.com
Erik R. Zimmerman
ezimmerman@robinsonbradshaw.com
Ethan R. White
ewhite@robinsonbradshaw.com

WALKER, ALLEN, GRICE, AMMONS, FOY, KLICK & MCCULLOUGH, L.L.P.
Elizabeth P. McCullough
elizabeth@walkerallenlaw.com
Kelsey Heino
kelseyh@walkerallenlaw.com

HARRIS, CREECH, WARD & BLACKERBY, P.A.
W. Gregory Merritt
wgm@hcwb.net

MILLER LAW GROUP, PLLC
Bruce W. Berger
Bruce@millerlawgroupnc.com
MaryAnne Hamilton
maryanne@millerlawgroupnc.com

This the 19th day of March, 2024.

Electronically Submitted
Christy C. Dunn
Young Moore and Henderson, P.A.
Counsel for Amici Curiae
North Carolina Health Care Facilities Association, North Carolina Senior Living Association, and North Carolina Assisted Living Association