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NEW YORK STATE OF OPPORTUNITY. Department of Health

**ANDREW M. CUOMO**
Governor

**HOWARD A. ZUCKER, M.D., J.D.**
Commissioner

**LISA J. PINO, M.A., J.D.**
Executive Deputy Commissioner

November 17, 2020

**CERTIFIED MAIL/RETURN RECEIPT**

[redacted]
c/o Sea View Hospital Rehabilitation Center
460 Brielle Avenue
Staten Island, New York 10314

Sherry McShall, Dir. of Social Services
Sea View Hospital Rehabilitation Center
460 Brielle Avenue
Staten Island, New York 10314

**RE: In the Matter of [redacted] – Discharge Appeal**

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter. This Decision is final and binding.

The party who did not prevail in this hearing may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the party wishes to appeal this decision it may seek advice from the legal resources available (e.g. their attorney, the County Bar Association, Legal Aid, etc.). Such an appeal must be commenced within four (4) months from the date of this Decision.

Sincerely,

James F. Horan

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

In the Matter of an Appeal, pursuant to 10 NYCRR § 415.3, by

[redacted]

Appellant,

from a determination by

**Sea View Hospital Rehabilitation Center and Home**

Respondent,

to discharge her from a residential health care facility.

COPY

**DECISION**

Hearing Before: Natalie J. Bordeaux
Administrative Law Judge

Held via: Cisco WebEx Videoconference

Hearing Date: November 6, 2020

Parties: Sea View Hospital Rehabilitation Center and Home
460 Brielle Avenue
Staten Island, New York 10314
By: Sherry McShall, Director of Social Services

[redacted]
*Pro Se*

## JURISDICTION

By notice dated [redacted], 2020, Sea View Hospital Rehabilitation Center and Home (Facility), a residential health care facility subject to Article 28 of the New York Public Health Law, determined to discharge [redacted] (Appellant). The Appellant appealed the discharge determination to the New York State Department of Health (Department) pursuant to 10 NYCRR § 415.3(i).

## HEARING RECORD

Facility witnesses: [redacted] Social Worker
Debra Masucci, Resident Representative

Facility exhibits: 1-8

Appellant witnesses: [redacted] Appellant
[redacted] Appellant's [redacted]
[redacted] Appellant's [redacted]
[redacted] Appellant's [redacted]

The notice of hearing, discharge notice, and the accompanying cover letter were marked as ALJ Exhibit I. A transcript of the hearing was made.

## ISSUES

Has Sea View Hospital Rehabilitation Center and Home established that its determination to discharge the Appellant was correct and that its discharge plan was appropriate?

## FINDINGS OF FACT

1. The Appellant is a [redacted]-year-old female who was transferred from [redacted] Hospital to the Facility on [redacted], 2019 for short-term rehabilitation for [redacted]. (Exhibit 1.)

2. By notice dated [redacted] 2020, the Facility determined to discharge the Appellant, effective [redacted], 2020, because her health has improved sufficiently that she no longer requires the services provided by the facility, and because her needs cannot be met at the facility.

The notice advised the Appellant that she would be discharged to her home, a condominium unit currently occupied by her adult [redacted] (Exhibit 2.)

3. The Appellant does not require skilled nursing care and is independently able to perform activities of daily living without assistance. (Exhibit 4.)

4. The Appellant's clinical record contains documentation from the Appellant's physician that the Appellant's condition has improved such that she no longer requires the services of a skilled nursing facility, and that discharge to her home is appropriate. (Exhibits 4 and 5.)

5. On [redacted], 2020, the Appellant requested this hearing to contest the Facility's discharge determination.

## APPLICABLE LAW

A residential heath care facility (also referred to in the regulations as a nursing home) is a facility which provides regular nursing, medical, rehabilitative, and professional services to residents who do not require hospitalization. Public Health Law §§ 2801(2)-(3); 10 NYCRR § 415.2(k).

Department regulations at 10 NYCRR § 415.3(i) describe the transfer and discharge rights of residential health care facility residents. They state, in pertinent part:

> (1) With regard to the transfer or discharge of residents, the facility shall:
>
> > (i) permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility:
> >
> > > (a) the resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative, determines that:

> (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation in the facility;
>
> (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

When the facility transfers or discharges a resident for either of the reasons set forth in (1) and (2) above, the facility shall ensure that the resident's clinical record contains complete documentation made by the resident's physician and, as appropriate, the resident's interdisciplinary care team. 10 NYCRR § 415.3(i)(1)(ii)(a). The residential health care facility must prove by substantial evidence that the discharge was necessary and the discharge plan appropriate. 10 NYCRR § 415.3(i)(2)(iii)(b); State Administrative Procedure Act § 306(1).

## DISCUSSION

The Appellant was admitted to the Facility on [redacted], 2019 for short-term rehabilitation to restore her functional mobility after [redacted]. Although she was not transferred to the Facility for treatment of her mental health conditions, the Appellant was and remains diagnosed with [redacted] and [redacted]. (Exhibit 1.)

By notice dated [redacted], 2020, the Facility determined to discharge the Appellant, effective [redacted], 2020 because her health has improved sufficiently that she no longer requires the services provided by the Facility, and because her needs, specifically her mental health needs, cannot be met in the Facility. (Exhibit 2.) While the Facility has not established that it is unable to meet the Appellant's medical needs, including her mental health needs, the hearing record does establish that the Appellant's conditions have improved to the extent that she no longer requires the services provided by a nursing home.

The Appellant received physical and occupational therapy at the Facility until she met her rehabilitation goals and reached her maximum rehabilitation potential. She no longer requires assistance with activities of daily living and can perform all tasks independently without the use of an assistive device and with minimal supervision. (Exhibits 4 and 5.)

The Appellant neither receives nor requires skilled nursing care. Facility staff dispenses her medications, and she receives periodic consultations from the staff [redacted] assigned to all of the Facility's 304 residents on request. However, the Appellant does not receive any care at the Facility that she would be unable to obtain in the community.

Neither the Appellant nor her family members articulated a medical need for her continued stay at the Facility. Although the Appellant contended that the [redacted] have not yet healed and that her [redacted]," she confirmed that she requires a consultation with the community-based [redacted] surgeon who operated on her before she was admitted to the Facility. Similarly, while she requests consultations with the Facility-based [redacted] the care she receives is no different from that which she would be able to obtain as an outpatient.

At the same time, she acknowledged that she will require outpatient medical care, the Appellant insisted that she has no need to leave the Facility because her needs are all being tended to on the premises. The needs she described are not medical in nature and are also available in the community. For example, the Appellant's expressed need for assistance with meal preparation may be addressed with personal care services or home care hours in the community. Similarly, the Appellant's receipt of daily "activity therapy," at the Facility (which she explained was a way of keeping residents busy) can be replaced by hobbies in the community and an adult day care program when such programs are permitted to resume.

The Appellant's [redacted] and [redacted] also contended that the Appellant's physical abilities have not yet been fully restored. They both claimed that the Appellant is [redacted] and has [redacted]. However, they were unable to explain why these conditions require nursing home care or how the Appellant's continued occupancy at the Facility would improve her physical independence. The Facility has established that the Appellant's conditions have improved to the extent that she no longer requires the services provided by the Facility.

The Facility has determined to discharge the Appellant to her home, a condominium unit which she conveyed to her [redacted] and [redacted] at some date before qualifying for Medicaid. Although the Appellant contended that she cannot return to the two-story condominium unit because she no longer owns it, neither her [redacted] nor her [redacted] asserted that the Appellant is legally precluded from physically returning to her home.

The Facility had previously explored other discharge options to address the Appellant's expressed reluctance to return to her home. In [redacted] and [redacted] 2020, Facility Social Worker [redacted] had several discussions with the Appellant regarding the prospect of placement in an assisted living facility. Ms. [redacted] believed that the Appellant might prefer to be discharged to an environment with similarly situated residents and some supportive programs. The Appellant testified at this hearing that being around other patients has been comforting to her.

Only a small fraction of assisted living facilities within [redacted] are affordable for the Appellant due to her limited income and receipt of Medicaid. Out of those assisted living facilities meeting that criteria, Ms. [redacted] sent referrals to six facilities. The Appellant's application was denied by four of those facilities because the administrators were uncertain that they would be able to meet the Appellant's mental health needs. Although the

Appellant initially agreed to consider placement at a [redacted] assisted living facility that specialized in residents with mental health needs, she subsequently refused to proceed with the interview because the facility was not located closer to her family. Yet, paradoxically, the Appellant also changed her mind about considering an assisted living program on the same premises as the Facility, which would have enabled her to remain in [redacted], in an area within minutes of her former home where her [redacted] continues to reside. (Exhibits 6 and 7.)

During the summer months and the weeks preceding the issuance of the discharge notice, Ms. [redacted] asked the Appellant's [redacted] to identify other assisted living facilities. However, the Appellant's [redacted] made no such effort. At the hearing, the Appellant's [redacted] claimed that she did not know how to find other assisted living facilities and was discouraged by Ms. [redacted] explanation that many assisted living facilities do not accept Medicaid. Yet, she also admitted that she was awaiting the outcome of this hearing before taking any other action. The Facility made reasonable attempts to secure the Appellant's discharge to an assisted living program. Thwarting of those efforts by both the Appellant and her [redacted] do not render the Facility culpable for the failure of its efforts.

Once the prospect of the Appellant's discharge to an assisted living program was eliminated, Ms. [redacted] proceeded to effectuate the Appellant's safe discharge to her home. She coordinated the Appellant's Medicaid Managed Long-Term Care evaluation for home care services, which resulted in a provisional authorization to receive services in the amount of two days per week. However, the Appellant's [redacted] did not return the evaluator's phone calls to schedule an assessment of the Appellant's needs in the home, specifically, assistive devices, supportive equipment, and aspects of the home which may necessitate additional home care services hours to ensure that the Appellant is safe in the home. (Exhibit 6.)

The Appellant's family members asserted that her return to the community is not safe. Although the Appellant's [redacted] claimed that the Appellant will not be able to navigate the staircase in the condominium and insisted that the Appellant would need to climb the stairs in order to access a bed, she acknowledged that the first floor could accommodate a small bed. It is also noted that the Appellant's [redacted] was unwilling to allow an evaluator to review those issues.

The Appellant's [redacted] who is employed on a full-time basis outside of the home, also expressed concern that the presence of home health aides in her condominium would heighten her own risk of contracting the novel coronavirus. The issues for this hearing are limited to reviewing the Appellant's medical conditions and needs, not those of her family.

The Appellant resided in her [redacted] home for approximately one year, which ended shortly before the accident that led to the Appellant's hospital admission and transfer to the Facility. The Appellant's [redacted] testified that the Appellant cannot be left unattended and requires round-the-clock monitoring, which the Facility provides. She explained that the Appellant is '[redacted] by [redacted] and [redacted] when she goes outside. The Appellant's [redacted] also fears that the Appellant's discharge to her home would be a heavy burden for her [redacted] Avoidance of a home care evaluation by the Appellant's [redacted] will only increase her personal responsibility toward her [redacted]

The Appellant reiterated her need to feel safe and secure. She stated that she feels best at the Facility. Even so, she has had [redacted] during her stay. [redacted], a Resident Representative, testified that staff at the Facility had to call for emergency on two occasions that necessitated hospital evaluations over the past several months. (Exhibits 6 and 8.)

On the first occasion, emergency room physicians concluded that the Appellant was stable for return to the Facility. The Appellant acknowledged her tendency to become [redacted] and [redacted] but felt her behavior justified because she had been kept waiting too long to speak to the Facility's CEO. On the second occasion, the Appellant was transferred to the emergency room after [redacted]. During that evaluation, emergency room staff determined to place the Appellant in an [redacted] unit, which the Appellant refused because she was afraid of being harmed by [redacted] staff. Had these incidents occurred in the community, the Appellant would likely have been brought to a hospital emergency room anyway. Sporadic and unpredictable calls for hospital or emergency intervention do not justify a continued stay at a skilled nursing facility for someone who lacks a need for skilled nursing care.

The arguments by the Appellant's family showed no reduction in risk to the Appellant's safety if she remains at the Facility instead of returning to the community. The Appellant's family's reluctance to deal with the Appellant's mental health problems and related [redacted] is not a legitimate basis to refute the discharge determination. No one in the Appellant's family attempted to work with Facility staff to identify alternative discharge locations or to proceed with home care evaluations for the Appellant.

The Facility fulfilled its responsibilities toward the Appellant, a short-term rehabilitation patient. As a skilled nursing facility, it successfully assisted the Appellant with regaining her physical independence to effectuate a safe return to the community. The Facility was required to devise a discharge plan which addressed the Appellant's medical needs and how those needs will be met after discharge. 10 NYCRR § 415.3(i)(1)(vi). It has met this regulatory obligation. The Appellant's [redacted] is encouraged to work with Ms. [redacted] and other social workers at the Facility to effectuate a smooth discharge for the Appellant. In particular, cooperation in the

arranging of home care services is important because the Appellant's [redacted] participation and input would likely lighten her personal responsibility for her [redacted] care.

## DECISION

Sea View Hospital Rehabilitation Center and Home has established that its determination to discharge the Appellant was correct, and that its discharge plan was appropriate.

Dated: November 16, 2020
Menands, New York

Natalie J. Bordeaux
Administrative Law Judge