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Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

November 27, 2023

CERTIFIED MAIL/RETURN RECEIPT

Mendel R. Hagler
Deputy General Counsel
Centers Health Care
4770 White Plains Road
Bronx, New York 10470

RE: In the Matter of – 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,

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:
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

Carthage Center for Rehabilitation & Nursing,

Respondent,

to discharge him from a residential health care facility.

COPY

DECISION

DA23-6211

Hearing Before: Jeanne T. Arnold
Administrative Law Judge

Held via: WebEx Videoconference

Hearing Date: November 20, 2023

Parties: Carthage Center for Rehabilitation & Nursing
1045 West Street
Carthage, New York 13619
By: Mendel R. Hagler
Deputy General Counsel
Centers Health Care
4770 White Plains Road
Bronx, New York 10470

[redacted]

[redacted] Guardian
[redacted]

JURISDICTION

Carthage Center for Rehabilitation & Nursing (Facility), a residential health care facility subject to Article 28 of the New York Public Health Law (PHL), determined to discharge resident [redacted] (Appellant) from care and treatment in the Facility to the [redacted]). The Appellant's Guardian appealed the discharge determination to the New York State Department of Health (Department) pursuant to 10 NYCRR 415.3(i).

HEARING RECORD

Facility witnesses:	Barry Klinger, Facility Administrator Laura Bisone-Claeys, Facility Director of Nursing Patricia Tefel, [redacted] Director of Social Services [redacted] Appellant [redacted] Appellant's Guardian
Facility exhibits:	C (Accident/Incident Statement forms)
Appellant witnesses:	[redacted] Appellant [redacted] Appellant's Guardian
Appellant exhibits:	1 (Temporary Order of Guardianship)
ALJ exhibits:	I (Notice of Hearing and Discharge Notice) II (Admission Record)

Digital recording (R) of the hearing was made (R 1h:59m).

FINDINGS OF FACT

1. The Appellant is a [redacted]-year-old male who was admitted to the Facility on [redacted] 2021, with diagnoses of, among other things, [redacted] (Exhibit II.)

2. By Temporary Order dated ████████, the Appellant's ████ █████ ███ (Guardian) was appointed as Mental Hygiene Law § 81.02 Guardian of the person and property of the Appellant. (Exhibit 1.) The Order indicates that the appointment shall last until further order from the Supreme Court County of Onondaga. (Exhibit 1.) The Guardian has acted as guardian since this appointment. (R 1:26.)

3. The Appellant is ambulatory and performs activities of daily living (ADLs) well with only minimal supervision but "cycles psychologically" and requires medication management. (R 0:28-0:31.) He has a Brief Interview for Mental Status (BIMS) score of █/15. (0:33-0:34.)

4. Sometime after █████, 2023, when the Appellant had exhibited █████ behaviors on two consecutive days, the Facility began to consider discharge of the Appellant to a nursing home with a secure unit. (R 0:29-0:31.)

5. By notice dated █████████ 2023, the Facility determined to discharge the Appellant that same day to the █████████, because his "needs cannot be met after reasonable attempts at accommodation in the facility". (Exhibit I.)

6. Although the notice indicates that the Appellant's "designated representative" was verbally informed of the discharge on █████████, 2023 (Exhibit I), the Guardian learned of the discharge only after receipt of the notice on █████████, 2023. (R 1:31, 1:38.)

7. On █████████ 2023, the Appellant was discharged to the ██████████, a nursing home with a ██████████████. (Exhibit I.)

8. On ████████ 2023, the Guardian timely requested this hearing to contest the Facility's discharge determination. The Appellant also requests to return to the Facility. (R 1:03, 1:49.)

9. The Appellant remains at the █████████ pending outcome of this proceeding.

ISSUES

Was the Appellant appropriately discharged in accordance with his rights?

Has the Facility established that the Appellant's discharge was necessary and that the discharge plan was appropriate?

APPLICABLE LAW

A residential health care facility, or nursing home, is a facility which provides regular nursing, medical, rehabilitative, and professional services to residents who do not require hospitalization. PHL § 2801(2)(3); 10 NYCRR 415.2(k).

Public Health Law § 2803-z and Department regulations at 10 NYCRR 415.3(i) describe the transfer and discharge rights of residential health care facility residents.

The regulations at 10 NYCRR 415.3(i) 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.

When the facility transfers or discharges a resident for this reason, 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 Facility must ensure that the discharge is documented in the resident's medical record and must include documentation from the resident's physician. 42 CFR 483.15(c)(2)(ii)(A); 10 NYCRR 415.3(i)(1)(iii)(b).

The Facility must notify the resident and designated representative, if any, and if known, family member of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner the resident and/or family member understand (10 NYCRR 415.3[i][1][iii][a]) at least 30 days before the resident is transferred or discharged. PHL § 2803-z(1)(c); 10 NYCRR 415.3(i)(1)(iv).

The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility, in the form of a discharge plan which addresses the medical needs of the resident and how these will be met after discharge and provide a discharge summary pursuant to section 415.11(d) of this Title. 10 NYCRR 415.3(i)(1)(vi). The discharge summary shall include, in addition to a recapitulation of the resident's stay and a final summary of the resident's status, a post-discharge plan of care "developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive service have been arranged and are available to meet the identified needs of the resident." 10 NYCRR 415.11(d). The facility must also permit residents and their representatives the opportunity to participate in deciding where the resident will reside after discharge. 10 NYCRR 415.3(i)(1)(vii).

The facility has the burden of proving 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 Facility's Transfer/Discharge Notice dated [redacted] 2023 states that the Appellant was discharged from the Facility to the [redacted] because his needs could not be met after reasonable attempts at accommodation in the Facility (Exhibit I), pursuant to 10 NYCRR 415.3(i)(1)(i)(a)(1). Before a facility transfers or discharges a resident for this reason, it must notify the resident *and* the designated representative of the transfer or discharge and the reasons for the move in writing at least 30 days before the resident is transferred or discharged. Public Health Law § 2803-z(c); 10 NYCRR 415.3(i)(1)(iv).

The Facility counsel contends that 30-day notice was not required here because the Appellant "voluntarily agreed" to the discharge, citing 10 NYCRR 415.3(i), which states that "[t]ransfer and discharge shall not refer to movement of a resident to a bed within the same certified facility, and does not include transfer or discharge made in compliance with a request by the resident, the resident's legal representative or health care agent, *as evidenced by a signed and dated written statement*" (emphasis supplied). The Facility presented no such signed written statement. In fact, notably absent on the Transfer/Discharge notice are **both** the Appellant's and Guardian's signatures. (Exhibit I.) While Facility Administrator Barry Klinger (Administrator) testified that the Appellant "seemed okay" and did not disagree with the discharge to the [redacted], engaging in conversation on the ride over (R 0:11-0:12), the Appellant testified that, although he is content at the [redacted] (R 1:02), he would rather be returned to the Facility. (R 1:03, 1:49.) In fact, the Appellant testified that when the Facility staff asked him if he wanted to go to [redacted] he said "no." (R 1:49.)

Further, the Appellant was deemed an incapacitated person by Order of the Supreme Court County of Onondaga on [redacted] 2014, and the Guardian was appointed over both his person and

property. (Exhibit 1.) The Guardian was not asked about or informed of the discharge to the [redacted] until after the discharge occurred when he received the notice dated [redacted], 2023 in the mail on [redacted], 2023. (R 1:31, 1:38.) The Facility counsel argued that because the Guardian produced only a temporary order of guardianship (Exhibit 1), there is no proof that the Guardian remains guardian. However, the guardianship papers themselves detail that the appointment shall last until further order of the Court, the Guardian both completed appropriate Article 81 training (Exhibit 1) and testified in no uncertain terms that he is the Appellant's guardian and sends an annual report as guardian. (R 1:26.)

In any event, even if there was a superseding guardianship order, the regulations still require the Facility to notify the Appellant's "designated representative" of the discharge and the reasons for it at least 30 days prior to it. 10 NYCRR 415.3(i)(1)(iv). Here, as the guardian and/or designated representative, the Guardian received the written notice of the discharge on [redacted] 2023, and still was not informed about the rationale for the move because the notice did not describe why the Appellant's needs could no longer be met at the Facility. (R 1:32; Exhibit I.) That same day, the Guardian called the Facility and was told he must speak with the Administrator. (R 1:31.) The Guardian then attempted to reach the Administrator again on [redacted] and [redacted], until he finally conversed with the Administrator on [redacted] 2023. (R 1:32-1:33.)

While the Administrator testified that he spoke with the Guardian twice, once before discharge and once afterwards, he remembered details of only the conversation that occurred after the discharge (R 0:12, 0:17) and the Guardian testified adamantly that he spoke with the Administrator only once on [redacted], 2023. (R 1:34, 1:37.) The Administrator acknowledged that when he spoke with the Guardian in [redacted] the Guardian expressed concern about why the

Appellant was moved so far away. (R 0:14.) Although the Administrator said he explained it was because the Appellant required a [redacted] (R 0:15), the Guardian testified that he was unaware of the secure unit setting until he explored the [redacted] website. (R1:33.) The Guardian testified that the Appellant does not require a [redacted] and that he was never consulted about a potential discharge from the Facility to a nursing home with a [redacted]. (R 1:36-1:37.) The Appellant, thus, was inappropriately discharged from the Facility to the [redacted] in contravention of his notice rights. 10 NYCRR 415.3(i).

The Facility also failed to prove that the discharge from the Facility to the [redacted] was necessary. At the hearing the Facility raised issues concerning an escalation in the Appellant's behaviors contending that a nursing home with a secure unit was required in the Appellant's best interest. (R 0:15, 0:29-0:35.)

Facility Director of Nursing Laura Bisone-Claeys (Director of Nursing), testified that although the Appellant functionally manages well and has a BIMS score of [redacted] 15 (R 0:28, 0:33-0:34), psychologically, the Appellant cycles. (R 0:29-0:29.) On [redacted], 2023, at 1:00 AM, the Appellant attempted to call 911 but when he could not get a dial tone, he became [redacted] and [redacted]

[redacted] (Exhibit C; R 0:41:00-0:43:00.) Similarly, on [redacted] 2023, at 9:40 PM, the Appellant requested to fax something and, when informed by the Facility staff to wait until the morning, he became [redacted] a nursing assistant, [redacted] a nurse in the [redacted] and [redacted]. (Exhibit C; R 0:43-0:45.)

The Director of Nursing did not witness either of the [redacted] incidents. (R 41:00, 43:00.) She admitted that she never found the Appellant to be [redacted] but instead polite and well-mannered, and she did not rule out the Guardian's contention that the Appellant's medication regimen may

have contributed to his behaviors. (R 0:50.) The Appellant's daily prescription for an [redacted] [redacted] drug, [redacted] was halved in [redacted] 2023 from 10 milligrams to 5 milligrams, and the Appellant began to exhibit escalating, although non-violent, behaviors in [redacted] requiring return to the original dosage of 10 milligrams. (R 0:47-0:49.) After the [redacted] incidents, the Appellant's [redacted] dosage was increased again to 15 milligrams, and his [redacted] ceased. (R 0:50.) From [redacted] until his discharge on [redacted], 2023, the Appellant did not have any more incidents at the Facility (R 0:50) nor has he had any incidents since transfer to the [redacted] [redacted] (0:59-1:00.)

When the Guardian visited the Appellant on [redacted] 2023, at the Facility, he expressed concerns to the Facility staff about the Appellant's medication because the Appellant did not recognize him, but no one addressed those concerns. (R 1:28-1:29.) The Guardian testified that the Facility contacted him on [redacted], 2023, to inform him of the [redacted] episode and the Guardian again inquired about the Appellant's medication to no avail. (R 1:30.) When the Guardian visited the Appellant at the Facility on [redacted] 2023, the Appellant appeared more alert. (R 1:31.) Although during that visit to the Facility, a staff nurse informed the Guardian that she would inquire about the Appellant's medications, no one contacted the Guardian with such information prior to the discharge. (R 1:31.)

The Director of Nursing testified that both a Physician and Psychiatrist at the Facility examined the Appellant multiple times, and records of same were in the Appellant's case file (R 0:54-0:55), yet the Facility did not produce any such records. The Facility thus failed to meet its regulatory burden to prove that a discharge of the Appellant from the Facility to a nursing home with a secure unit was necessary. 10 NYCRR 415.3(i)(1)(ii)(a); 10 NYCRR 415.3(i)(1)(iii)(b); 42 CFR 483.15(c)(2)(ii)(A).

Additionally, the Facility failed to meet its burden that its discharge plan was appropriate. The Facility did not submit any documentation concerning a discharge plan. The Administrator testified that he believed he discussed searching for a nursing home with a secure unit with the Guardian sometime after the ███ incidents but had no notes of same. (R 0:17, 0:22-0:26.) Likewise, although the Administrator believed that the ████████████████ was mentioned as an option then and "most likely" someone from the Facility called to see if a bed was available, he had no proof of same. (R 0:19-0:20, 0:22-0:26.) The Guardian refutes that any discussion took place in ███ or ████ concerning a potential discharge, and testified both that he keeps a record of all calls, and the only conversation he had with anyone from the Facility during that time was on ████ 2023, during one of the Appellant's two behavioral incidents. (R 1:39.) Only on █████ 2023 -- after the Appellant's discharge – did the Guardian mention that ████████ would be a better alternative than the ███████ because of its proximity. (R 1:36.) The ███████ is unacceptable for the Appellant because, in part, it is in ███ and is more than two hours away from the Guardian. (R 1:42.) The Guardian testified that he has a close relationship with the Appellant as they grew up living across the street from one another, and he wants to be able to visit the Appellant. (R 1:27-1:28.) The Guardian lives less than one hour away from the Facility, and he testified that he visited with the Appellant as frequently as possible before the transfer to ███ and has always fulfilled his obligations as guardian. (R 1:42.)

The Administrator testified that he always talks to the residents when a discharge or transfer to another facility is proposed for them. (R 0:09-0:10.) He described how difficult it is to get anyone into ████████ and that the Facility staff constantly are calling there to inquire of bed availability. (R 0:10.) The Administrator testified that in addition to ████████, the Facility checked into availability at both the ████████████████, but ultimately only

the [redacted] had an opening for the Appellant. (R 0:10-0:11.) Although the Administrator testified that he had emails from the [redacted], the Facility did not offer any documentation from the Appellant's case file concerning discharge planning.

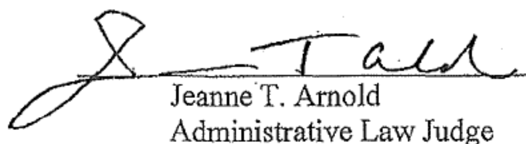
In determining an appropriate discharge location, to the extent possible, the Facility should make reasonable efforts to find a place within the resident's geographic area. The resident – and the Guardian – must be included in the discharge location planning. Here, not only was the Guardian not consulted but the Appellant himself said "no" to the [redacted] location at discharge. (R 1:49.) Although the Appellant agreed that he was happy with the care he has thus far received at the [redacted] (R 1:02), the Facility did not produce a discharge summary and plan of care developed with the participation of the resident and his family to, among other things, assure that needed medical and supportive service have been arranged and are available to meet the identified needs of the resident. 10 NYCRR 415.11(d). The Facility never invited the Guardian's input as to where the resident should reside after discharge until after discharge. 10 NYCRR 415.3(i)(1)(vii).

DECISION

The appeal is granted. Carthage Center for Rehabilitation & Nursing denied the Appellant of his legal rights as delineated in 10 NYCRR 415.3(i) and failed to establish that its determination dated [redacted], 2023 to discharge the Appellant from its Facility to the [redacted] was necessary and that the discharge plan was appropriate.

Carthage Center for Rehabilitation & Nursing must readmit the Appellant to the next available bed at the Facility.

Dated: November 24, 2023
Rochester, New York



Jeanne T. Arnold
Administrative Law Judge