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Department of Health

KATHY HOCHUL
Governor

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

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

June 7, 2024

CERTIFIED MAIL/RETURN RECEIPT

[REDACTED]
c/o St. John's Episcopal Hospital
327 Beach 19th Street
Far Rockaway, New York 11691

Jacquline Lutchmidat, DSW
St. John's Episcopal Hospital
327 Beach 19th Street
Far Rockaway, New York 11691

Nechama Reichmann, NHA
Ocean Gardens Care Center
64-11 Beach Channel Drive
Arverne New York 11692

Barbara Phair, Esq.
Abrams Fensterman, LLP
3 Dakota Drive
Lake Success, New York 11042

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,

Natalie J. Bordeaux/cm

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

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

[REDACTED]

Appellant,

from a determination by

Horizon Care Center,

Respondent,

to discharge her from a residential health care facility.

DECISION AFTER HEARING

#DA24-6380

Hearing before: John Harris Terepka
Administrative Law Judge
June 6, 2024
By videoconference

Parties: Horizon Care Center
64-11 Beach Channel Drive
Arverne, New York 11692
Nechama Reichmann, Administrator
nreichmann@oceangardenscare.com
By: Barbara Stegun Phair, Esq.
Abrams Fensterman, LLP
3 Dakota Drive
Lake Success, New York 11042
BPhair@Abramslaw.com

[REDACTED]
By: Jacquline Lutchmidat, Director of Social Work
jlutchmi@ehs.org
St. John's Episcopal Hospital
327 Beach 19th Street
Far Rockaway, New York 11691

JURISDICTION

Horizon Care Center (the Respondent), a residential health care facility (RHCF) subject to Article 28 of the Public Health Law, discharged (the Appellant) from care and treatment in its nursing home. The Appellant appealed the discharge to the New York State Department of Health pursuant to 10 NYCRR 415.3(i). The Respondent has the burden of proving that the discharge was necessary and that the discharge plan is appropriate. 18 NYCRR 415.3(i)(2)(iii)(b).

SUMMARY OF FACTS

1. Respondent Horizon Care Center is a residential health care facility, specifically a nursing home within the meaning of PHL 2801(2) and 10 NYCRR 415.2(k), located in Arverne, New York.

2. Appellant age was admitted as a resident in 2024 from . (Exhibit A, page 103; Exhibit 3.) Her medical history includes . (Exhibit A, page 11; Exhibit 1.)

3. On 2024, the Respondent transferred the Appellant to St. John's Episcopal Hospital, in Far Rockaway, for evaluation because she and actions. St. John's determined that she was a and admitted her on , 2024. (Exhibit A, pages 1-2, 50, 57, 59.)

4. St. John's Episcopal Hospital is a general hospital within the meaning of PHL 2801(10). By the hospital had determined that the Appellant no longer required continued inpatient medical care at a general hospital and was ready to return to the Respondent's care. She is alert and oriented with normal motor activity and memory,

logical thought processes, and remains stable and ready for return to the Respondent's nursing home. (Exhibit A, pages 16, 22, 28, 33, 38, 43, 61, 67, 73, 78, 99-105.) She wants to be discharged from the hospital back to Horizon Care Center. (Exhibit A, pages 13-15.)

5. The Respondent refuses to readmit the Appellant. (Exhibit A, pages 101-105.)

6. At no time did the Respondent provide to the Appellant or her designated representative or other family member a written notice of discharge including the grounds for discharge, discharge location, the Appellant's appeal rights, and the other information required by 10 NYCRR 415.3(i)(1)(iii),(iv)&(v).

7. The Respondent has not developed an appropriate post-discharge plan of care for the Appellant that addresses her long-term care and medical needs and how they will be met after discharge, as required by 10 NYCRR 415.3(i)(1)(vi).

ISSUES

Has the Respondent established that the Appellant's discharge from Horizon Care Center is necessary and that the discharge plan is appropriate?

HEARING RECORD

Respondent witnesses:	Syed Abidi, MD, consulting Annemarie Coombs, Director of Nursing Chennia Findlay, Director of Admissions Nechama Reichman, Administrator
Respondent exhibits:	1-3
Appellant witnesses:	Kamalendra Sen, MD, attending psychiatrist, St. John's Appellant Jennel Bagnall, Social Work, St. John's Bamidele Agada, Nurse Practitioner, St. John's
Appellant exhibits:	A (St. John's Episcopal Hospital records)
ALJ exhibit:	ALJ I (hearing notice)

The hearing was held and recorded by Webex videoconference. (2h26m.) The Appellant was present at the hearing and was assisted by Jacquline Lutchmidat, Director of Social Work at St. John's Episcopal.

DISCUSSION

A residential health care facility (RHCF), or nursing home, is a residential facility providing nursing care to sick, invalid, infirm, disabled or convalescent persons who need regular nursing services or other professional services but who do not need the services of a general hospital. PHL 2801; 10 NYCRR 415.2(k).

Transfer and discharge rights of nursing home residents have been codified in Public Health Law 2803-z and set forth in Department regulations at 10 NYCRR 415.3(i) and federal regulations at 42 CFR 483.15(c). They include the requirement that before it transfers or discharges a resident, the nursing home must notify the resident and designated representative, if any, of the transfer or discharge and the reasons for the move in writing. The required written notice must be given no later than the date on which a determination was made to transfer or discharge the resident and must include, among other things:

- the reason for the transfer or discharge
- the specific regulations that support the action
- the effective date of the transfer or discharge
- the location to which the resident will be transferred or discharged
- a statement that the resident has the right to a hearing to appeal the discharge
- the name, address and telephone number of the State long term care ombudsman

10 NYCRR 415.3(i)(1)(iii),(iv)&(v); 42 CFR 483.15(c)(3)&(5).

The Respondent has failed to comply with these notice requirements of New York State law and both state and federal regulations. Department policy disseminated to nursing home administrators by "Dear Administrator Letter" (DAL) explicitly confirms that these requirements are applicable if a nursing home does not want to readmit a resident who has been hospitalized:

> Q: If a resident is sent to the hospital due to the resident's clinical or behavioral status that endangers the health and/or safety of other individuals in the facility, do I need to issue a Discharge/Transfer Notice?

> A: A hospital is not an appropriate discharge location. Admission assessments are key to ensuring the facility can care for the residents admitted. If there is evidence a facility cannot meet the resident's needs, or the resident poses a danger to the health and safety of his/herself or others, the facility must follow all the requirements as they apply to discharge including the basis for discharge, provide notice to the resident, his/her representative and the LTCOP, reason for discharge, discharge location and appeal rights information. A facility's determination not to permit a resident to return must not be based on the resident's condition when originally sent to the hospital. DAL-NH 19-07, August 20, 2019; *reissued* October 11, 2022.

The Respondent claims that the safety of the Appellant or other individuals in the facility is endangered by the Appellant, that it cannot safely monitor her behavior and meet her care needs, and that it is unable to provide the care and supervision she requires. When discharge is alleged to be necessary due to the endangerment of the health or safety of other individuals in the facility, the resident's clinical record must include complete documentation made by a physician. 10 NYCRR 415.3(i)(1)(ii)(b); 42 CFR 483.15(c)(2)(ii)(B). The facility is also required to document in the resident's clinical record the risks to the resident or others if the resident were to remain in the facility. PHL 2803-z(e). When discharge is alleged to be necessary because the resident's needs cannot be met after reasonable accommodation in the facility, the resident's clinical record must include complete documentation made by the resident's physician of the specific needs that cannot be met and the facility's attempt to meet those needs. PHL 2803-z(d); 10 NYCRR 415.3(i)(1)(ii)(a); 42 CFR 483.15(c)(2)(i)&(ii). The Respondent has failed to produce documentation to show compliance with these requirements.

A facility's determination not to permit a resident to return from a hospital transfer must not be based on the resident's condition when originally sent to the hospital. DAL-NH 19-07, *supra*. The St. John's Hospital record reflects that the Appellant was in need

of treatment on 2024 when the Respondent initially transferred her for acting out behavior. (Exhibit A, pages 1-2, 50, 57, 59.) Since however it has been the opinion of the hospital physicians and care team that she no longer requires hospitalization for either medical or reasons and that a nursing home is an appropriate placement that can and should be expected to meet her care needs. The hospital record documents that by she did not require hospitalization at or elsewhere, and that she was ready to return to the Respondent. (Exhibit A, pages 16, 22, 28, 33, 38, 43, 61, 67, 73, 78, 99-105.) The Respondent has failed to meet its burden of documenting and proving otherwise.

The Respondent has offered no evidence about the Appellant's current condition to call the St. John's assessment into question. The only facility clinical record by a physician that the Respondent has produced is a physician note dated 2024, this hearing. (Exhibit 1.) The note discusses the Appellant's condition and history of emergency room transport up to , 2024 when she was originally sent to St. John's. It contains no mention, however, of her current condition, nor does it record that the physician has seen or in any way assessed her, or even reviewed the St. John's hospital record, since when she was sent to the hospital. This note, furthermore, does not state that the Respondent was or is unable to meet the Appellant's care needs.

In addition to ignoring the notice requirements and failing to document grounds for discharge as required, the Respondent failed to conduct and document appropriate discharge planning. When a resident is hospitalized, the nursing home is required to establish and follow a written policy that includes readmission to the facility if the resident requires nursing home care. 10 NYCRR 415.3(i)(3); 42 CFR 483.15(e). If the resident is

not appropriate for return to the nursing home, the nursing home is required to provide sufficient preparation and orientation to ensure safe and orderly transfer or discharge in the form of a discharge plan which addresses the medical needs of the resident and how these will be met after discharge, and to provide a discharge summary pursuant to 10 NYCRR 415.11(d). 10 NYCRR 415.3(i)(1)(vi).

Discharge to a general hospital does not meet the nursing home's responsibility to provide an appropriate discharge plan. Department policy is explicit on this point:

> State and Federal regulations require that nursing home residents who are temporarily hospitalized be allowed to return to the facility following hospitalization… Hospitals are not acceptable discharge locations. When sending residents with episodes of acting out behavior to hospitals for treatment, the nursing home is responsible to readmit the resident and/or develop an appropriate discharge plan. In these cases, the hospital is not considered to be the final discharge location. DAL-NH 15-06, September 23, 2015.

The Respondent maintains that the Appellant needs placement in some other residential care setting, but it has failed to develop a plan to address this claimed need. It admitted the Appellant from █ in █ 2024. In █ 2024, when refusing to readmit the Appellant, the Respondent referred the St. John's social work department to █ and requested that she be transferred there. The Respondent told St. John's that it had a "90 day turn around agreement" with █. Upon inquiry by St. John's social work department, however, █ denied the existence of any such agreement, and advised that it does not agree to take the Appellant back because she is █ stable and does not require █. (Exhibit A, page 103.)

If, as the Respondent claimed, █ agrees to readmit the Appellant, that might have been an appropriate plan provided the Respondent also documented proper

grounds for discharge and gave the required notice. But the Respondent has not established the existence of any such agreement. Respondent witnesses Coombs, Findlay and Reichman all continued to insist at this hearing that has agreed to readmit the Appellant and that all St. John's needs to do is send some paperwork, yet the Respondent has failed to present any direct confirmation or even evidence of that claim from Instead, it produced an email dated 2024, this hearing, from Dexter Del Rosario at to the Respondent, that stated:

> During her stay in your facility, if she is needing setting, she should be evaluated and admitted to your local hospital, and a referral should be sent to our facility (PPC) for her continued care and treatment. (Exhibit 3.)

This communication from clearly is not an offer to simply admit the Appellant to It is instead entirely consistent with the information St. John's received from on , when it did attempt a referral which rejected. (Exhibit A, page 103.)

The Respondent's efforts to meet the Appellant's needs since 2024 have been to simply send her to various local hospital emergency departments each time she has acted out. (Exhibit 2.) It has repeatedly failed to establish and document a need and referral for discharge to inpatient care, or to develop any other discharge plan. Leaving the Appellant at a series of general hospital emergency rooms, St. John's being just the latest, is not a permissible plan.

Shifting a difficult resident off to a general hospital without any discharge plan, and then refusing to take her back, is known as a "hospital dump." In this case the Respondent's actions have been compounded by a complete failure to comply with notice and discharge planning requirements. The Respondent is proposing that the Appellant remain at St.

John's Episcopal Hospital until the long term care plan that the Respondent claims is required but has failed to develop, is accomplished. This is an inappropriate, costly, and medically unnecessary solution that places the care management and planning burden on the hospital. Department and Federal regulations clearly intend that the discharge planning burden remain on the nursing home that undertook the Appellant's residential care.

> Facilities are required to determine their capacity and capability to care for the residents they admit, so in the absence of atypical changes in residents' conditions, it should be rare that facilities that properly assess their capacity and capability to care for a resident then discharge that resident based on the inability to meet the resident's needs. Therefore, facilities should not admit residents whose needs they cannot meet based on the facility assessment. DAL-NH 19-07, *supra.*

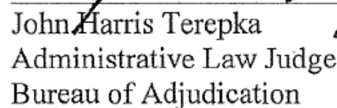
The management and care planning issues presented by this resident cannot be solved in this hearing decision, but responsibility for them can be and accordingly is reaffirmed. If the Respondent believes some other placement is appropriate, it has the responsibility to find that placement, develop an appropriate discharge plan, and issue the required written notice of discharge.

DECISION: Respondent Horizon Care Center has failed to establish that the discharge of Appellant █ █ was necessary and that its discharge plan is appropriate.

The Respondent is directed, pursuant to 10 NYCRR 415.3(i)(2)(i)(d), to readmit the Appellant prior to admitting any other person.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

Dated: Rochester, New York
June 6, 2024



John Harris Terepka
Administrative Law Judge
Bureau of Adjudication