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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

October 4, 2024

CERTIFIED MAIL/RETURN RECEIPT

c/o Regeis Care Center
3200 Baychester Avenue
Bronx, New York 10475

Steven D. Weiner, Esq.
Kaufman Borgeest & Ryan, LLP
200 Summit Lake Drive
Valhalla, New York 10595

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: nm
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

Regeis Care Center

Respondent,

to discharge her from a residential
health care facility.

COPY

DECISION
#DA24-6415

Hearing before: Kendra Vergason
Administrative Law Judge

Hearing date: August 12, 2023
By videoconference

Parties: Regeis Care Center
By: Steven D. Weiner, Esq.
Kaufman Borgeest & Ryan, LLP
200 Summit Lake Drive
Valhalla, New York 10595
sweiner@kbrlaw.com

[redacted] pro se
[redacted]

JURISDICTION

By notice dated [redacted] 2024, Regeis Care Center (Respondent), a residential health care facility (RHCF) subject to Article 28 of the Public Health Law, determined to discharge [redacted] (Appellant) to the [redacted] Women's Shelter, [redacted], [redacted]. The Appellant appealed the discharge determination to the New York State Department of Health pursuant to 10 NYCRR 415.3(i).

HEARING RECORD

Respondent witnesses: Karee Gordon, RN, assistant director of nursing
Julia Cruz, director of social work
Mahtab Motieian, MD, attending physician
Rose Brown, RN, nurse manager
Ricardo St. Hill, director of rehab

Respondent exhibits: A – MDS Section C, Mental Status Assessment (BIMS) [redacted]/2024
B – resident face sheet
D – psychological services case notes excerpts
E – discharge instructions
F – internet information page for [redacted] Women's Shelter
G – written summaries by staff
I – Care Plan Activity Report
J – nursing note [redacted]/2024
K – resident progress notes
L – psychiatry consultation [redacted]/2024
M – facility video [redacted]/2024, part 1
N – facility video [redacted]/2024, part 2 (2 files due to size)
O – facility video [redacted]/2024, part 3
P – audio recording [redacted]/2024
Q – facility video [redacted]/2024
R – physician monthly assessment [redacted]/2024

Appellant witnesses: [redacted]

Appellant exhibits: none

ALJ exhibits: I (notice of hearing with notice of discharge)

A digital recording of the hearing was made. (R. 6h5m.)

SUMMARY OF FACTS

1. The Appellant is a [redacted]-year-old female who was admitted to the Respondent's facility on [redacted] 2023, for rehabilitation after hospitalization, with multiple medical diagnoses including [redacted] the most recent being in [redacted] 2023, and a [redacted] (Exhibits B, E, L, R; Testimony [T:] Motieian.)

2. The Appellant was discharged from occupational and physical therapies on [redacted] 2024, after achieving all her established goals. She is independent in ambulation with the use of a rollator walker but is unable to [redacted]. She is independent with most activities of daily living (ADL) but requires assistance with [redacted] body dressing and toileting, hygiene and bathing. Her plan of care requires two staff members to assist her with showering. (Exhibits E, I; T: St. Hill, [redacted]

3. The Appellant has no skilled nursing needs, and her [redacted] medical conditions can be managed on an outpatient basis. (Exhibits E, R; T: Motieian.)

4. On at least three occasions, the Appellant was transferred to a hospital emergency department for [redacted] evaluation and acute care after she was [redacted] [redacted] aggressive towards staff on her unit. (Exhibits D, G, I, J, K, I, M, N, O; T: Gordon, Cruz, Brown, [redacted]

5. The Appellant's behavioral care plans, which identify appropriate staff interventions required to address her [redacted] [redacted] [redacted] abusive behaviors, have not been updated or revised since they were initiated in [redacted] [redacted] [redacted] 2023. (Exhibit I.)

6. On [redacted] 2024, the Respondent issued a discharge notice advising the Appellant of its determination to discharge her because "[t]he safety or health of residents in the facility would

be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to address the problem as evidenced by:" The notice provided no further information or evidence of the failed alternatives to discharge. (Exhibit ALJ I.)

7. The proposed discharge location is the [redacted] Women's Shelter located at [redacted] [redacted]. (Exhibit ALJ I.) The shelter does not have services available to provide assistance with ADLs. (Exhibit F.)

8. The Respondent presented no evidence that the Appellant has been accepted for shelter placement. The Respondent presented no evidence of its efforts to secure an alternative discharge location for the Appellant other than the shelter.

ISSUES

Has the Respondent established that its determination to discharge the Appellant is authorized and the discharge plan is appropriate?

APPLICABLE LAW

A residential health care facility (RHCF), or nursing home, is a facility that provides regular nursing services, professional services, and physical care to sick, invalid, infirm disabled or convalescent persons who do not need the services of a general hospital. PHL § 2801(2)&(3); 10 NYCRR 415.2(k). The Respondent, located in Bronx, New York, is a nursing home within the meaning of PHL § 2801(2) and is subject to federal and state laws and regulations relating to the discharge and transfer of its residents. 10 NYCRR 400.2.

Transfer and discharge rights of nursing home residents are set forth in Public Health Law § 2803-z, Department regulations at 10 NYCRR § 415.3(i) and federal regulations at 42 CFR § 483.15(c). A nursing facility may discharge a resident when the interdisciplinary care

team, in consultation with the resident, determines that "the safety of individuals in the facility is endangered." 42 CFR 483.15(c)(1)(i)(B); 10 NYCRR 415.3(i)(1)(i)(a)(2). When discharge is for this reason, the facility must ensure complete documentation in the medical record, made by a physician, that includes the basis for the discharge. 42 CFR 483.15(c)(2); 10 NYCRR 415.3(i)(1)(ii).

The facility must provide and document sufficient preparation and orientation to the resident to ensure safe and orderly 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. 42 CFR 483.15(c)(7); 10 NYCRR 415.3(i)(1)(vi). The discharge summary shall include a post-discharge plan of care, developed with the participation of the resident, which assures that needed medical and supportive services have been arranged and are available to meet the identified needs of the resident. 10 NYCRR 415.11(d).

Prior to initiating a discharge of a resident, the facility shall use its best efforts to secure appropriate placement or a residential arrangement for the resident, other than temporary housing assistance, i.e., a shelter for adults. PHL § 2803-z(1)(b). The facility must permit residents and their representatives the opportunity to participate in deciding where the resident will reside after discharge. 10 NYCRR § 415.3(i)(l)(vii).

The Respondent has the burden of proving that the discharge is necessary and that the discharge plan is appropriate. 10 NYCRR 415.3(i)(2)(iii)(b).

DISCUSSION

Grounds for Discharge

The Respondent presented four videos and an audio recording as evidence that the safety of individuals in the facility is endangered by the Appellant. Three of the videos are of one

event that took place on [redacted], 2024 (Exhibits M, N), the audio recording is from [redacted], 2024 (Exhibit P), and the fourth video is from [redacted] 2024 (Exhibit O). In each of the videos and the audio recording, the Appellant does exhibit [redacted] and [redacted] aggression towards a staff member. However, it is not evident when considering all of the medical record documentation and testimony that the Appellant's clinical or behavioral status endangers the safety of other individuals in the facility. On the contrary, the evidence shows that the Respondent's failure to appropriately provide the necessary treatments and services to meet the Appellant's mental and psychosocial needs played a significant role in the [redacted] of her aggressive behaviors and that such behaviors are avoidable.

On [redacted], 2024, the Appellant overheard a certified nurse aide (CNA) and the medication nurse talking about her and became upset. (Exhibit G.) Although the Appellant was exhibiting [redacted] behavior, as evident in the video recording, the nurse and the CNA failed to implement any behavioral interventions per the Appellant's care plan. Instead, the nurse deliberately and continually ignored the Appellant while she became [redacted] aggressive until she had to be transferred to the emergency room for [redacted] evaluation and care after she [redacted] the nurse, [redacted] her on the [redacted] and [redacted] (Exhibits K, G, M, N.)

On [redacted] 2024, four management staff and a social worker entered the Appellant's room unannounced, with an audio recorder, to serve her with a 30-day notice of discharge. This encounter was purposely set-up for the Appellant to fail: The five staff members entered the room knowing it would result in the Appellant becoming aggressive, they refused to comply with her repeated requests and pleas that they leave her room and they continued to provoke her. Instead of deescalating the Appellant's behaviors the staff's conduct exacerbated them.

After describing and characterizing the Appellant's behavior as aggressive, director of social work Julia Cruz, is recorded as saying "we got it" before she then turned off the recorder. (Exhibit P.)

On [redacted] 2024, the Appellant was [redacted] [redacted] aggressive towards nurse manager Rose Brown at the nurse's station. (Exhibits D, I, J; T: Brown, Motieian, Gordon.) The video recording shows the Appellant, [redacted] at Ms. Brown, then [redacted] and a [redacted] from the station desk [redacted] Ms. Brown, [redacted] Ms. Brown in the [redacted] with the [redacted]. Another staff member appropriately intervened by redirecting the Appellant and they continued down the hall towards their destination. Ms. Brown informed the Appellant's physician of the incident, and the Appellant was later transferred to the emergency room for a [redacted] evaluation. (Exhibit I; T: Brown, Motieian, Gordon.)

The Appellant has several Behavioral Symptoms Care Plans to address [redacted] [redacted] [redacted] abusive behavior. (Exhibit I.) The behavioral care plan for [redacted] abusive behavior was initiated in [redacted] 2023 with the goal that Appellant "[w]ill not sustain injury when engaged in [redacted] abusive behavior in the next 90 days." A quarterly review of the plan on [redacted], 2024, states "[no] further behavioral symptoms noted. Will continue with POC."

The Respondent is required to ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. 10 NYCRR 415.12(f)(1). There is no evidence of the Respondent's efforts to ensure the Appellant received appropriate treatment and services to address her behaviors. Other than the quarterly review in [redacted] 2024, there are no other care plan reviews or revisions

documented. Two notes regarding the ███ incident describe inconsistent details of the event, and the ███ and ███ incidents are not even addressed or mentioned in the behavioral care plans.

Lastly, the documentation in the medical record by the Appellant's physician does not support the basis for discharge identified in the notice. The only evidence of documentation by a physician in the medical record that describes the basis for the discharge is a physician monthly assessment dated ███, 2024, and a discharge evaluation dated ███, 2024, by Dr. Motieian, the attending physician at the Respondent facility. (Exhibit R.) Dr. Motieian's testimony at the hearing about her note recommending discharge is as follows:

Q: Well, you wrote, "would recommend safe discharge planning due to the possible risk of danger to staff and other residents at this level of care based on previous events during her stay." You wrote that, correct?
A: Yeah.
Q: Okay, so you believe that she is a danger to staff and other residents?
A: The thing is you see those things going on and you wait til something happens, it can be too late, you know, and it would be, you know, it could end not in a good way. So, you should be proactive, you should see what possibilities are coming. So yeah, that's why I put that in the notes.

A ███ 2024, physician evaluation, also by Dr. Motieian, describes the Appellant as "no acute issues/ ███ risk of ███." This is not documentation that the safety of other individuals is endangered.

The evidence does not show that the safety of others in the facility is endangered due to the clinical or behavioral status of the Appellant. The evidence shows that the Respondent failed to adequately address and treat the Appellant's mental and psychosocial needs by not ensuring staff are employing appropriate interventions in response to her behavioral symptoms. It is not permissible to proactively discharge a resident because of a "possible risk of danger"

to others or "risk of aggression." (Exhibits E, R.) A theoretical threat, especially one that could be diminished with appropriate care planning, supervision and staff conduct is not sufficient to show that discharge of the Appellant is necessary on these grounds.

Discharge Location

The Respondent proposes to discharge the Appellant to the New York City Department of Homeless Services (NYC DHS) - [redacted] Women's Intake Shelter. According to *New York City Department of Homeless Services Referral From Healthcare Facilities Policy*, issued June 28, 2018 (DHS- Institutional_referral_procedure_7182018.pdf (nyc.gov)) the shelter is not an appropriate discharge location for individuals that require assistance with ADLs such as dressing and bathing. Although the Appellant's physician has determined the Appellant "medically cleared for discharge to shelter" (Exhibit E), the Appellant is not independent in her ADLs and has continuing needs for assistance. She requires assistance with [redacted] body dressing and [redacted] toileting, and bathing. (Exhibit E; T: St. Hill, [redacted] Her plan of care requires she have two-person assistance with showering. (Exhibit I.) The evidence presented by the Respondent does not indicate the shelter is an appropriate discharge location for the Appellant. The shelter also requires a review and acceptance of all individuals referred from healthcare settings. The Respondent did not provide any evidence that the Appellant was accepted for placement to the shelter.

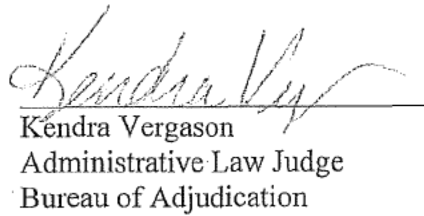
Further, New York Law requires the Respondent, prior to initiating discharge, to use its best efforts to secure appropriate placement or a residential arrangement other than to temporary housing or a shelter. The Respondent did not produce evidence that it made any efforts to find an alternative discharge location. On the other hand, there is evidence of the Appellant's efforts to secure permanent housing in the community by obtaining SSI/SSD benefits. (Exhibit K.)

The Respondent has failed to establish that discharge of the Appellant is necessary for the safety or health of other individuals in the facility and has failed to establish the discharge plan is appropriate.

DECISION AND ORDER

The appeal is granted. Regeis Care Center is not authorized to discharge the Appellant in accordance with the [redacted] 2024, discharge notice.

Dated: Rochester, New York
October 3, 2024



Kendra Vergason
Administrative Law Judge
Bureau of Adjudication