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NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 24, 2025

CERTIFIED MAIL/RETURN RECEIPT

[redacted]
c/o Jamaica Hospital Nursing Home
89-40 135th Street
Jamaica, New York 11418

Noreen Bock, DSW
Jamaica Hospital Nursing Home
89-40 135th Street
Jamaica, New York 11418

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Michael Paulsen, Esq.
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136 State Street
Albany, New York 12207

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

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

Jamaica Hospital Nursing Home

Respondent,

to discharge him from a residential
health care facility.

DECISION AFTER HEARING

#DA25-6576

Hearing before: Shelby L. Foster
Administrative Law Judge

Hearing Dates: May 14, 2025
May 28, 2025
June 3, 2025

Held via: Webex Videoconference

Parties: Jamaica Hospital Nursing Home
89-40 135th Street
Jamaica, NY 11418

By: Samantha Katze, Esq.
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[redacted]
c/o Jamaica Hospital Nursing Home
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Jamaica, NY 11418

By: Jota Borgmann, Esq.
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JURISDICTION

By notice dated [redacted], 2025, Jamaica Hospital Nursing Home (Facility), a residential health care facility subject to Article 28 of the Public Health Law (PHL), determined to discharge [redacted] (Appellant) from care and treatment in its facility. The Appellant appealed the determination to the New York State Department of Health (Department) pursuant to 10 New York Codes, Rules, and Regulations (NYCRR) § 415.3(i).

The hearing was conducted pursuant to 10 NYCRR 415.3(i). Evidence was received and witnesses were examined.

HEARING RECORD

ALJ Exhibits:	I – Notice of Hearing and Notice of Discharge or Transfer
Respondent's Witnesses:	Kaushik Doshi, MD, Medical Director Ahmed Abdelhakim, MD, Rehabilitation Consultant Marie Constant, Nursing Care Coordinator, 2nd Floor Noreen Bock, Director of Social Work
Respondent's Exhibits:	1 – Physician Progress Notes 2 – [redacted] Consult 3 – Department of Health [redacted] Evaluation 4 – PT Progress Notes

5 – OT Progress Notes
6 – Nurse Progress Note
7 – [redacted] 2025 Letter from Noreen Bock
8 – Social Work Progress Notes
9 – [redacted], 2025 Minimum Data Set (MDS)
10 – Additional Nursing Notes
11 – Additional Medical Notes
12 – List of Unaccepting Facilities
13 – Additional Social Work Progress Notes
14 – Shelter Application
15 – [redacted] Referral Form
16 – [redacted], 2025 Discharge Plan Note Noreen Bock

Appellant's Witnesses: Alexis Jones, Social Worker
[redacted] Appellant

Appellant's Exhibits:
A – MD and Nurses Notes 1 of 2
B – MD and Nurses Notes 2 of 2
C – DSS-3122 Form
D – MDS Dated [redacted]/24
E – MDS Dated [redacted]024
F – Section 487.2 – Adult Home Definitions
G – Section 487.4 – Adult Home Admission Standards
H – Section 487.13 – Transitional Adult Homes
I – [redacted] Information
J – Health Record Request
K – CNA Accountability
L – [redacted] Doctor Notes Dated [redacted]/25
M – New York State Register Date [redacted]/19

Digital recordings of the hearings were made. (3:49:22 in duration on May 14, 2025, 4:31:17 in duration on May 28, 2025, and 54:16 in duration on June 3, 2025.)

ISSUES

Has the Facility established that its determination to discharge the Appellant is necessary and that its discharge plan is appropriate?

FINDINGS OF FACT

1. The Appellant is a [redacted]-year-old male who was first admitted to the Facility on [redacted], 2024, with a recurrent [redacted] on the [redacted] that required [redacted] care. (Exhibits [Exs.] 1, A; Testimony [T.] Doshi.)

2. While at the Facility, the Appellant's pain [redacted] and a scan showed his [redacted] had [redacted] The Appellant consulted with his surgeon in the community and was scheduled for surgery at [redacted] Hospital ([redacted] on [redacted] 2024. He was admitted to [redacted] post-surgery. (Ex. A.; T. Doshi.)

3. The Appellant returned to the Facility for rehabilitation on [redacted] 2024, with a primary diagnosis of an [redacted] and a secondary diagnosis of [redacted] on the [redacted]. He had [redacted] in his [redacted]. (Ex. 1, A; T. Doshi.)

4. When the Appellant returned to the Facility on [redacted], 2024, he was receiving [redacted] care, physical therapy (PT), occupational therapy (OT), and pain management. (T. Doshi.)

5. On [redacted] 2025, the [redacted], and on [redacted] 2025, [redacted] orders were discontinued. (Ex. B.)

6. The Appellant was discharged from PT and OT on [redacted] and [redacted], 2025, respectively, as he had achieved the highest practical level of functionality. (Exs. 4, 5; T. Abdelhakim.)

7. The Appellant is currently on active pain management. (T. Doshi.)

8. The Appellant is independent in his activities of daily living (ADLs). (Exs. 1, 6, 10, 11, A, B; T. Doshi, Abdelhakim, Constant, Bock.)

9. The Appellant can ambulate more than [redacted] feet with a rollator, can negotiate more than [redacted] steps independently, and transfers independently. (Exs. 4, 7, 8, 16; T. Abdelhakim, Bock.)

10. The Appellant's clinical record includes documentation made by a physician confirming that he is no longer in need of the services of a nursing home. (Exs. 1, 11, A.)

11. By notice dated [redacted], 2025, the Facility advised the Appellant of its determination to discharge him on [redacted] 2025, on the grounds that the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as evidenced by: completion of rehabilitation and skilled nursing needs. (ALJ Exhibit I.)

12. The discharge notice advised the Appellant that he would be discharged to [redacted], New York (the address for the [redacted] Shelter). (ALJ Exhibit I.)

13. The Appellant timely appealed the Facility's discharge determination and proposed discharge location.

14. The Appellant remains at the Facility pending the outcome of this hearing.

APPLICABLE LAW

A residential health care facility, 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(2), (3); 10 NYCRR 415.2(k).

Transfer and discharge rights of nursing home residents are set forth at 10 NYCRR 415.3(i), which provides, 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:
> > >
> > > ...
> > >
> > > (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 because the resident's health has improved sufficiently that the resident no longer needs the services provided by the facility, 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 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. 10 NYCRR 415.3(i)(1)(vi). 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). Further, the facility shall use its best efforts to secure appropriate placement or a residential arrangement for the resident, other than temporary housing. PHL § 2803-z(1)(b).

The Facility has the burden of proving that the discharge or transfer is necessary and that the discharge plan is appropriate. 18 NYCRR 415.3(i)(2)(iii)(b).

DISCUSSION

Grounds for Discharge

Although some contradictory information can be found among the several exhibits admitted into the record and the testimony provided, substantial evidence exists to support that the Appellant's health has improved sufficiently so that he no longer requires the services of a nursing home. The Appellant is independent in all activities of daily living and is not receiving physical or occupational therapy at the Facility.

Kaushik Doshi, MD, the Facility's Medical Director and Attending Physician, testified that he has been overseeing the Appellant's medical care at the Facility since [redacted] 2025. Dr. Doshi testified that the Appellant's [redacted] in [redacted] and there was no indication that it needed to be [redacted]. On [redacted], 2025, he noted an improved [redacted]

[redacted], with no [redacted] since [redacted] 2025. (Exs. 1, 11, A.) Dr. Doshi further testified, and noted in the Appellant's clinical record on [redacted] 2025, that Mr. [redacted] is independent in his ADLs and does not require skilled nursing care. (Exs. 1, 11, A.) As the Appellant's condition has improved and he is able to ambulate using a rollator without issue, Dr. Doshi testified that it is appropriate to discharge Mr. [redacted]

Ahmed Abdelhakim, MD, the Facility's Rehabilitation Consultant, oversees the Appellant's treatment at the Facility and, based on his review of the records for PT and OT, the Appellant no longer requires a skilled nursing level of care. Dr. Abdelhakim testified, and it is supported by the PT and OT discharge summaries, that Mr. [redacted] was discharged from PT and OT on [redacted] and [redacted] 2025, respectively, as he had achieved the highest practical level of functionality. (Exs. 4, 5.) When questioned about Mr. [redacted] still requiring standby assistance to navigate [redacted] stairs, Dr. Abdelhakim testified that [redacted] stairs was the highest level of performance the Appellant could achieve, and that Mr. [redacted] had advised the therapist that he was going to a place without stairs and didn't need to do stair training. Dr. Abdelhakim further testified that the Appellant has been independent in his ADLs as of [redacted], 2025 (Ex. 5.), and from a rehabilitation perspective, it is appropriate to discharge Mr. [redacted]

Marie Constant, the Facility's Nursing Care Coordinator for the Facility's second floor, has been overseeing the Appellant's nursing treatment at the Facility since [redacted], 2025. She testified that Mr. [redacted] does not have any skilled nursing needs. Nursing staff only ensure that the Appellant's "out on pass" forms are signed and provide medication. A [redacted] 2025, progress note from Ms. Constant indicates that the Appellant performs all ADLs

independently but does require supervision/set-up for bathing and dressing. (Ex. 6, 10, B.) Ms. Constant described the assistance provided to Mr. [redacted] for bathing as ensuring the path is clear, and that he has a towel, wash cloth, and soap available to him. They are not providing any hands-on care. In terms of dressing, Ms. Constant testified that staff ensure that the Appellant's clothes are within reach, but do not provide hands-on assistance with this task. She also testified that setting up needed items is standard procedure for all residents in a nursing facility. Ms. Constant asserted that Mr. [redacted] discharge is appropriate because he no longer requires dressing changes or wound care; he does everything independently; and he does not require any assistance.

Noreen Bock, the Facility's Director of Social Work, has overseen the Appellant's care at the Facility since his first admission in [redacted] 2024. Ms. Bock testified that the Appellant does not require any skilled nursing services or nursing home level of care; his [redacted], his [redacted] has been resolved, and he does not require any wound care. The Appellant does not require any physical assistance from staff, and staff do not provide him with any skilled care. Ms. Bock testified that Mr. [redacted] is capable of administering his own medications, however Facility staff currently administer them as that is standard procedure for all residents in a nursing facility.

The Appellant testified that he is still receiving assistance from staff at the Facility. They make his bed, they bathe him, and they help him get dressed. He testified that they bring him his food, although there are several notes in the admitted exhibits indicating Mr. [redacted] retrieves his own food. He testified that they also bring him his medicine and place his [redacted] [redacted] on every day, although there are also several notes in the admitted

exhibits indicating Mr. [redacted] has refused medication and [redacted]. According to the Appellant, the assistance he receives with dressing includes helping with both putting on and taking off items of clothing. He testified that he can dress himself when he sits and uses the "gadgets" (adaptive equipment) the Facility has provided him. The Appellant described the assistance he receives with bathing as washing areas he has trouble reaching: his [redacted]. He uses a shower chair to prevent falls. Ms. Constant credibly testified that Facility staff is not providing hands-on care.

The Appellant testified that, since receiving the discharge notice, he has seen an [redacted] specialist in the community, who detected another medical concern and referred him back to his surgeon, Dr. [redacted], for evaluation. According to Mr. [redacted] the [redacted] specialist requested samples from the [redacted] and an [redacted] with [redacted] and would like to review the [redacted] results before he continues treatment for his [redacted] and [redacted]

The Appellant had an appointment with [redacted], MD, on [redacted], 2025. He returned with recommendations that included continued physical therapy and a referral back to his surgeon, [redacted], MD, for evaluation of his [redacted]. (Ex. B.) While Dr. Doshi disagrees with Dr. [redacted] recommendation that the Appellant continue physical therapy, it should be noted that if the Appellant wishes to do so, PT can be provided in the community. Physical therapy does not warrant a continued stay in a nursing home, nor does awaiting the scheduling or results of medical imaging.

Appellant's counsel argued that his [redacted] diagnosis and [redacted] issues should have been considered in his discharge planning. The Appellant's [redacted] diagnosis was made seven years ago; he is not currently exhibiting any symptoms of [redacted] nor has he since coming to the Facility. Mr. [redacted] is not taking any medication to treat [redacted] and he is not under [redacted] or [redacted] care. A [redacted] assessment was conducted on [redacted], 2025, by Dr. [redacted]. The Appellant was upset that he was being evaluated and indicated to Dr. [redacted] "I don't have [a] [redacted] problem. I didn't see a [redacted] in 7 years." Dr. [redacted] noted that Mr. [redacted] was not currently presenting with any [redacted] symptoms. (Ex. 2.)

Ms. Bock testified that the Appellant's [redacted] diagnosis has not impacted his day-to-day functioning at the Facility. The [redacted] consultation was requested because of a [redacted] issue. Ms. Bock testified that the Appellant demonstrates [redacted] behavior of [redacted] towards staff. The Appellant's medical record is riddled with entries regarding his [redacted] refusal to accept treatment, and refusal of medication, even though he is on active pain management. (Exs. 10, A, B.) For example, there is a Social Work note dated [redacted] 2025, that indicates the Appellant thought he still had an [redacted] so nursing staff offered to do lab work to ensure the [redacted] had cleared, but Mr. Hughes refused to do blood work. (Ex. 8, 16.) Ms. Bock attributes these [redacted] issues to frustration with the rules and regulations of a nursing home and, recently, being asked to leave the Facility. She does not attribute this behavior to a [redacted] issue or the Appellant's [redacted] diagnosis.

Ms. Bock also testified that as a person staying at a nursing home for more than 30 days with a [redacted] diagnosis, the Appellant had to undergo a preadmission screening and resident review (PASSR) by a third-party [redacted] It was determined Mr. [redacted] did not meet the PASSR inclusion criteria because they could not find evidence of a serious [redacted] history; he had not been hospitalized [redacted] for the last two years and was not on any [redacted] medication. There were no recommendations for his care plan related to his [redacted] diagnosis. Further, Dr. Doshi testified that, in his medical opinion, Mr. [redacted] status does not indicate a substantial functional disability, nor does it mean that he can't be discharged.

The services the Appellant is currently receiving, and any possible future physical therapy he may choose to do, can be provided in the community. They are not skilled nursing needs, and they do not require the Appellant to remain in a nursing home.

The Facility has established that the Appellant's health has improved sufficiently so that he no longer requires the services provided by the Facility.

Discharge Plan

The Facility has determined to discharge the Appellant to the [redacted] Shelter. (Ex. ALJ I.)

According to Social Work Progress Notes (Ex. 8.), Facility social workers began discharge planning on [redacted], 2024, shortly after the Appellant's initial admission to the Facility. At that time, Mr. [redacted] indicated he planned to return to [redacted] home. On [redacted] 2024, the Appellant requested a referral to [redacted] Nursing Home. A

referral was made, but Mr. [redacted] was not accepted for admission (T. Bock). On [redacted] 2024, the Facility made referrals to [redacted] and [redacted] ([redacted]), and [redacted] The Appellant was not accepted at [redacted] but was accepted at [redacted] On account of his [redacted] history, Mr. [redacted] needed to undergo a Department Adult Care Facility [redacted] before being admitted to [redacted] was unable to admit the Appellant because the Department [redacted] evaluation confirmed that he meets the criteria for [redacted] (Ex. 3), and admission standards require [redacted] to limit the percentage of residents with a [redacted]. (T. Jones.)

According to Social Worker Alexis Jones, [redacted]), and [redacted]) have the same representative, and they advised that [redacted] and [redacted] were not interested in admitting the Appellant, either. A referral to [redacted] was made in [redacted] 2024, and an acceptance decision was pending during the Appellant's [redacted] 2024 hospitalization. When the Appellant was readmitted in [redacted] 2024, the discharge plan was to an assisted living facility or shelter. Social work did not follow up with [redacted] at that time, as the Appellant indicated he did not want to go to [redacted]. (T. Jones.) Social Work provided a list of facilities that they tried to refer the Appellant to, but he was not accepted at any of those facilities. (Ex. 12.) Reasons for not accepting the Appellant, if given, varied from not being able to meet his needs to his [redacted] diagnosis. (T. Bock.)

Ms. Jones testified that she and the Appellant discussed [redacted] when he was first admitted. She advised him that the process is expected to take quite some time, and if he didn't need to remain in the Facility, he wouldn't be able to stay through the completion of that process. This earlier discussion about [redacted] is not reflected in the social work progress notes, but Ms. Jones advised that when they went over the admission packet, in [redacted] 2024, they provided information about [redacted], and the Appellant signed a form acknowledging receipt of that information. Ms. Jones testified that she also discussed [redacted] with the Appellant, a program which describes itself as "your portal to find and apply for affordable housing opportunities in New York City," but Mr. [redacted] didn't believe it to be a real program. Ms. Jones testified that Social Work reached out to [redacted] consisting of 13 facilities, but their central admissions department advised that Mr. [redacted] had already been referred to them from a facility where he had previously stayed, [redacted], and they were not interested or willing to revisit the referral.

Appellant's counsel argued that the Facility's discharge plan is not appropriate because the Facility failed to offer the Appellant access to community-based services to facilitate his participation in discharge planning as required by 10 NYCRR 415.3(c). This argument is flawed in that, as it relates to discharge, the regulatory reference provided requires the Facility to ensure that all discharge activities align with subdivision (i) of the same section, as detailed in the Jurisdiction and Applicable Law clauses above.

The Appellant testified he was not invited to a meeting to discuss his discharge plan; however, the Facility submitted a social work progress note describing an [redacted] 2025 care

plan meeting to which the Appellant and his [redacted] were invited, and memorializing Mr. [redacted] statement that he didn't want to attend. (Ex. 8.)

On [redacted] 2025, Social Work met with the Appellant, at his request, to discuss submitting an [redacted] referral. Ms. Jones submitted a referral that same day (Ex. 15.) but again advised the Appellant that the process can be lengthy. At that time, Mr. [redacted] was also made aware that a shelter could provide assistance with housing resources as well, which, according to Ms. Bock, would likely be quicker than going through [redacted]. Ms. Jones followed up with [redacted] on [redacted], 2025, and was advised that a transitional specialist would be scheduling an intake appointment with Mr. [redacted] Ms. Jones attempted to contact the specialist but had to leave a request for a call back. (Exs. 8, 13.) No further information was provided by either party relative to the status of the [redacted] referral.

On [redacted] 2025, Ms. Bock spoke with [redacted], where the Appellant had previously resided prior to his [redacted] 2024 hospitalization, about the possibility of Mr. [redacted] returning. They indicated they would not offer readmission to the Appellant. (Ex. 13, T. Bock.)

The Appellant testified that he doesn't think he can meet his needs in a homeless shelter, or any setting, without assistance from other people. He testified that he is [redacted], in [redacted] pain most of the day, has side effects from his medications, and doesn't think he can tend to his bathing needs at a homeless shelter. Mr. [redacted] further testified that he did not tell anyone that he wanted to go to a homeless shelter; however, on [redacted], 2025, there is a social work progress note made by Ms. Jones that reads: "Resident is in agreement for continued placement until medically appropriate to be referred to shelter." (Ex. 8.) Despite

the lack of context in the note, Ms. Jones and Ms. Bock both credibly testified that the Appellant's agreement to go to the shelter was because he wanted to go through the shelter system to get a voucher for housing.

Ms. Bock completed a shelter application dated [redacted] 2025 (Ex. 14.), and the Appellant's ADL assessment makes him appropriate for a shelter placement. (T. Bock.) It specifically notes that residents may use shower chairs and mobility devices. Mr. [redacted] use of a shower chair and a rollator do not prevent him from being discharged, including to a shelter. Ms. Bock further testified that the Appellant would be suitable for a shelter placement because, if appropriate, they have mental health shelters that can provide social services, case management, crisis intervention, and any follow-up Mr. [redacted] would need.

Appellant's counsel argued that the Department [redacted] (Ex. 3) confirms Mr. [redacted] has a [redacted], which would qualify him for the [redacted] (Ex. I.), and the Facility failed to help him with that program. Ms. Bock testified that she peripherally knew about the program as it was new, and she had only reviewed a PowerPoint presentation released in [redacted] Ms. Bock did call to inquire about the program for the Appellant and was told Mr. [redacted] had already called himself and had been screened on [redacted] 2025. No further information was provided by either party relative to the outcome of this screening.

The record establishes that the Facility has used its best efforts to secure appropriate placement, including a residential arrangement for the Appellant, as required by PHL § 2803-z(1)(b). The Facility has established that the shelter is an appropriate discharge location for the Appellant.

DECISION

The Jamaica Hospital Nursing Home has established that the discharge of the Appellant is necessary and that the discharge plan is appropriate.

1. The Jamaica Hospital Nursing Home is authorized to discharge the Appellant pursuant to the Notice of Discharge dated [redacted] 2025.
2. This decision may be appealed to a court of competent jurisdiction pursuant to Article 78 of the New York Civil Practice Law and Rules.

Dated: Menands, New York

June 24, 2025

Shelby L. Foster
Administrative Law Judge

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