Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 1, 2019

CERTIFIED MAIL/RETURN RECEIPT

Doris Garcia, NHA
The Brightonian Nursing and Rehabilitation
1919 Elmwood Avenue
Rochester, New York 14620

c/o The Brightonian Nursing & Rehabilitation
1919 Elmwood Avenue
Rochester, New York 14620

Michael Scott-Kristansen, Esq.
Pullano & Farrow, PLLC
69 Cascade Drive, Suite 307
Rochester, New York 14614

Matthew M. Piston, Esq.
Evans Fox LLP
100 Meridian Centre Blvd., Suite 300
Rochester, New York 14618

RE: In the Matter of – Discharge Appeal

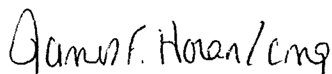
Dear Parties:

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,



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

The Brightonian Nursing and Rehabilitation,

Respondent,

to discharge him from a residential health care facility.

ORIGINAL

Decision After Hearing

Hearing before: John Harris Terepka
Administrative Law Judge

Held at: The Brightonian Nursing and Rehabilitation
1919 Elmwood Avenue
Rochester, New York 14620

Hearing dates: January 31, 2019; Record closed February 19, 2019

Parties: The Brightonian Nursing and Rehabilitation
1919 Elmwood Avenue
Rochester, New York 14620
By: Michael Scott-Kristansen, Esq.
Pullano & Farrow
69 Cascade Drive, Suite 307
Rochester, New York 14614

[redacted]
[redacted]man, *designated representative, guardian, power of attorney, health care proxy,*
[redacted]
By: Matthew M. Piston, Esq.
Evans Fox LLP
100 Meridian Centre Blvd., Suite 300
Rochester, New York 14618

JURISDICTION

The Brightonian Nursing and Rehabilitation (the Respondent), a residential health care facility subject to Article 28 of the Public Health Law, determined to discharge (the Appellant) from care and treatment in its nursing home. Pursuant to 10 NYCRR 415.3(h), the Appellant appealed the discharge determination to the New York State Department of Health.

SUMMARY OF FACTS

1. Respondent The Brightonian Nursing and Rehabilitation is a residential health care facility, or nursing home, located in Rochester, New York.

2. Appellant was admitted to The Brightonian on 2017. His , is his designated representative, legal guardian, power of attorney and health care proxy. (Exhibits 4, 5.)

3. The Appellant was admitted in 2017 without Medicare, Medicaid, or third-party insurance. As a "private pay" resident, he was directly responsible for the cost of his care. (Exhibit 4, pages 2, 12, 16, 20 of 34.) The Respondent's basic daily rate for his care on admission was $ to which was added a 6.8% New York State Tax Assessment Fee, for a total daily rate of $ (Exhibit 4 paragraph 3.1 and Attachments E & F, pages 2 & 20-23 of 34.) The basic daily rate increased to $ effective 2017. (Exhibit 8.)

4. The Appellant made irregular payments of $ or $ per month, although the statements sent to his designated representative showed his monthly charges exceeded $ By the end of 2017, his outstanding balance exceeded $ (Exhibits 3, 6.)

5. The Appellant applied for Medicaid on 2018, and was determined eligible in 2018 with coverage effective 2017. (Exhibit 10.)

6. As of 2018, the balance owed by the Appellant for the cost of his care was $ (Exhibit 3.) This amount is attributable to the charges for care that accrued during the period to 2017, during which time monthly statements of the charges were sent to the Appellant's designated representative, who failed to take issue with any of them. (Exhibit 6.) The Respondent has repeatedly notified the Appellant and his guardian/representative of the outstanding bill, but no payments have been made since 2018. (Exhibits 6, 7.)

7. By notice dated 2018, the Respondent advised the Appellant and his designated representative, who is also his that it had determined to discharge him on 2019, on the grounds that he has failed, after reasonable and appropriate notice, to pay for his stay at the facility. (Exhibit 2.)

8. The Appellant continues to require nursing home care. The Respondent's discharge plan is to transfer him to , a nursing home in offering a similar level of care to that provided at The Brightonian. (Exhibits 2, 9.) The Respondent's discharge plan includes arrangements for transportation and other logistical assistance to be provided as needed. (1h5m.)

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

ISSUES

Has the Respondent established that the transfer is necessary and the discharge plan appropriate?

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 are set forth at 10 NYCRR 415.3(h). The Respondent relies on 10 NYCRR 415.3(h)(1)(i)(b), which provides:

> [T]ransfer and discharge shall also be permissible when the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third-party insurance) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility the facility may charge a resident only allowable charges under Medicaid. Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds.

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

This hearing was originally scheduled for January 10, 2019 (Exhibit 1), when counsel for both sides appeared. The hearing was then postponed twice at the Appellant's request and held on January 31, 2019. The Respondent presented documents (Exhibits 1-10) and testimony from Anne Clayton, accounts receivable manager, and Doris Garcia, administrator. The Appellant, who is diagnosed with (Appellant brief, page 1; 0h59m), and his designated representative, did not appear at the hearing. They were represented only by their attorney,

who presented documents (Exhibit A) but no witnesses. (1h11m.) Alana Russell, Long Term Care Ombudsman Program Director at , also appeared. A digital recording of the hearing was made. (1h19m.) On the Appellant's further request for additional time, the record remained open until February 19, 2019 for post-hearing written submissions.

When the Appellant was admitted to The Brightonian in 2017 he was initially responsible for the entire monthly cost of his care as a private pay resident. His monthly charge was in excess of $ (Exhibits 3, 4.) Monthly statements were sent to his designated representative, Ms. (Exhibit 6; 0h19m.) Sporadic payments in the total amount of $ were made through 2017, but the balance grew steadily from the date of admission, reaching over $ by the end of 2017. (Exhibits 3, 6.)

The Appellant finally applied for Medicaid on 2018. In 2018 he was determined eligible for Medicaid benefits effective 2017. (Exhibit 10; 0h18m.) His outstanding balance with the Respondent had exceeded $ by 2018, but the Respondent determined the amount that would retroactively be covered by Medicaid and recalculated the account to show a balance owed by the Appellant to be $ (Exhibits 3, 6.)

In 2018, after receiving the Medicaid eligibility determination and recalculating the unpaid balance due, the Respondent commenced a lawsuit for payment of the bill, which action is pending in the County Supreme Court. (Exhibit A.) The Appellant has paid approximately $ towards his charges since his admission in 2017, but he has made no payments since 2018 and a balance in

excess of $ remains unpaid. (Exhibit 3.) The Respondent made the determination to transfer him to another nursing home and issued the discharge/transfer notice at the end of 2018. (Exhibit 2.)

There is no dispute over the Medicaid determination. In the 2017 admission agreement the Appellant's designated representative agreed to notify the Respondent if resources declined to the point that a Medicaid application would be appropriate. (Exhibit 4, page 1 of 34.) She also agreed to promptly complete an application for Medicaid benefits when he became eligible. (Exhibit 4, page 16 of 34.) In 2017, the Respondent brought the growing overdue balance to Ms. s attention and reminded her of its offer to assist with a Medicaid application. (Exhibit 7; 0h21m.) There is no evidence that the Appellant took any action on a Medicaid application until 2018. Even if the Appellant might have been eligible for Medicaid, Medicare, or some other third-party insurance coverage before 2017, and there is no evidence that was the case, any delay in applying for or securing such coverage is not attributable to the Respondent.

The grounds for discharge

The Appellant argues that this discharge cannot proceed because a charge is in dispute. (0h5m; Appellant brief, page 3.) He has not explained what charge is disputed or why. His assertion "[t]he admission agreement, admitted as Exhibit 4, does not state which payment rate would be charged to Mr. upon his admittance to the facility" (Appellant brief, page 1) is not accurate: The rate is specified as $ per day. This is the facility's $ daily rate at the time plus the 6.8% state tax assessment. The Appellant agreed to this rate. (Exhibit 4, pages 2, 3, & 21 of 34.) Monthly

statements were thereafter sent to his designated representative with no evidence they were ever disputed. (Exhibit 6.) No appeal of the Medicaid eligibility determination is pending, nor has the Appellant suggested that Medicare or any other third-party insurance is available to cover the unpaid charges.

For his claim that the charges are in dispute, the Appellant relies entirely upon having interposed an answer in the lawsuit initiated by the Respondent in █████ 2018 for payment of the charges incurred from █████ through █████ 2017. His answer consists of general denials upon information and belief and fails to make any factual allegations to controvert the Respondent's evidence establishing a balance due in the amount of $█████ (Exhibit A.)

The Appellant's argument that merely by interposing an answer and denial in a separate lawsuit brought against him for payment, he establishes that the amount owing is "in dispute" for the purposes of this discharge proceeding, is rejected. Whether a charge is in dispute for the purposes of establishing grounds for discharge under 10 NYCRR 415.3(h)(1)(i)(b) is an issue of fact for this hearing. The Appellant has offered nothing to place in dispute the accuracy of the Respondent's account of unpaid charges.

The Appellant also suggests that because he does not have the ability to pay the $█████ he owes, he cannot be discharged because funds for payment are not "actually available." (0h6m; Appellant brief, page 3.) The regulation he relies on reads:

> Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds. 10 NYCRR 415.3(h)(1)(i)(b).

Nowhere does this regulation support the view that a nursing home resident cannot be discharged if he is unable to pay for, or have paid under Medicare, Medicaid or third-

party insurance, a stay at the facility. This discharge is permissible because a charge is not in dispute and no appeal of a denial of benefits is pending. The Respondent has no obligation to also prove either that funds for payment are actually available or that the Appellant refuses to cooperate with the facility in obtaining them.

The Appellant further argues that the Respondent is somehow "estopped" from discharging him because he entered nursing home care without Medicaid or other third-party coverage, and later qualified for Medicaid. According to his brief:

> **The Brightonian is Legally and Equitably Estopped from Discharging the Resident**
> The testimony and the exhibits presented by the facility suggest that Mr. █ was admitted to the facility as a "private pay" resident, subsequently qualified for Medicaid, and was then switched to a "Medicaid pay" rate. This ability to alter rates is not reflected in the facilities [sic] Admission Agreement...
>
> [T]here is no indication, however, within the Admission Agreement, that clearly states which rate of pay would be charged to Mr. █ and the ability to change that rate of pay without the necessity of a new agreement/contract between the parties...
>
> Thus, the "private pay" agreement between the facility and Mr. █ terminated when Mr. █ qualified for Medicaid... In other words, the facility and Mr. █ are now operating under a new agreement...
>
> The "private pay" agreement between the facility and Mr. █ is a past agreement, and Mr. █ through Medicaid, is current and nondelinquent in any charges by the facility for care provided to Mr. █ under the current agreement as a "Medicaid pay" resident. Thus, the facility is legally and equitably estopped from discharging Mr. █ (Appellant brief, pages 3-4.)

As an initial matter, the Appellant's assertions that the agreement does not state what the charges would be and does not permit any alteration in them are plainly wrong. The admission agreement clearly specifies the charges on admission, and is replete with references to the possibility that these charges could change depending on Medicare, Medicaid, third party insurance, or private pay status:

> 3.1 Resident agrees to pay the daily Basic Charge as set forth below and in Attachment E for the Basic Services... You agree to remain personally liable for any cost of care determined not covered by any third-party payor including Medicare, Medicaid or any third-party insurance carrier. Facility reserves the right to adjust the Basic Charge and charges for additional services upon giving thirty (30) days' prior notice to Resident.
>
> ...
>
> Attachment E: FOR MEDICARE PART A COVERED RESIDENTS AND ALL NON-MEDICAID RESIDENTS: Resident, who is not covered by Medicare Part A, agrees to pay the Facility the sum of $ (private) $ (semi-private) per day, plus any assessment levied by New York State from time to time...
>
> FOR RESIDENTS WITH MEDICAID APPLICATIONS PENDING AND WHO HAVE MEDICARE PART D COVERAGE: ... Once the Resident becomes a Medicaid recipient, the Basic Charge for the basic services listed in the Admission Agreement shall be the Medicaid rate for Facility.... This rate may be changed from time to time by the State Government without notice to the Resident. (Exhibit 4, pages 2 & 20-21 of 34.)

These provisions are consistent with Department regulations that provide: "For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid." 10 NYCRR 415.3(h)(1)(i)(b).

The Appellant's argument that qualifying for Medicaid in 2018, effective 2017, has somehow "estopped" the Respondent from discharging him for nonpayment of charges he accumulated from through 2017, is not supported by applicable law or by the facts. There is no "new agreement" to be distinguished from a "past agreement" between the Appellant and the Respondent. There is one agreement, entered into on 2017, in which the Appellant agreed to pay, or to have paid, the charges for his care. (Exhibit 4.) That agreement clearly stated that the Appellant accepted responsibility and remained liable for the cost of his care to the extent that no other source of payment was established.

These are reasonable provisions to protect a nursing home from a situation in which a resident with resources that render him ineligible for Medicaid is admitted as

private pay and then proceeds to disperse assets instead of paying the nursing home charges, thereby "spending down" to the point that he becomes eligible to have his care thereafter paid by Medicaid. This hearing record does not disclose precisely what the Appellant's financial situation was between 2014, when he designated Ms. as his agent – a designation that included authority to make gifts to herself from his assets - (Exhibit 5), and 2017 when he became eligible for Medicaid. But his failure even to apply for Medicaid in 2017 when he entered The Brightonian, and his continued failure to do so as his unpaid bill climbed to over $ by 2017, fits this scenario.

The Respondent never waived the charges accumulated between and 2017, and it sent regularly monthly bills for them to which the Appellant never objected. The Respondent has continued to give "reasonable and appropriate notice" of his failure to pay these charges ever since. It hardly follows that if the Appellant's current charges are being paid (only because he is now covered by Medicaid), the unpaid past charges he accumulated have somehow evaporated, or that the Respondent is "estopped" from discharging him for failing to pay those charges.

The Appellant also raised at the hearing, but did not address in his brief, an argument that this hearing cannot proceed without leave of the County Supreme Court, which has jurisdiction over the lawsuit brought by the Respondent in an attempt to recover the $ it is owed. (0h7-8m.) The Appellant's only evidence about this lawsuit is a copy of the complaint and the Appellant's answer. (Exhibit A.) The documents show that an action for payment of a debt, not transfer to another nursing

home, has been brought against the Appellant and his individually and as his attorney-in-fact and guardian.

For the purposes of this administrative proceeding, Ms. is the Appellant's representative, and she was designated by the Appellant pursuant to 10 NYCRR 415.2(f)(1)(ii), not by a court of law pursuant to 415.2(f)(1)(i). (Exhibit 5.) The Appellant offered no evidence that any person other than Ms. acts as his representative or guardian, or that any court has been advised of, has expressed or has any interest in connection with this administrative proceeding to discharge him from The Brightonian and transfer him to another nursing home.* No reason why this administrative hearing to discharge the Appellant from The Brightonian cannot proceed is evident.

Department regulations require notice of discharge to be provided to the resident and designated representative, if any and, if known, family member. 10 NYCRR 415.3(h)(1)(iii)(a). This requirement is understandable because it is not uncommon for a nursing home resident to be incapable of representing himself. If he has a designated representative, that person can appropriately be expected to protect his interests. The Appellant's designated representative and family member was provided with notice of

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* Interestingly, paragraph 5 of the Respondent's complaint in the lawsuit alleges:

> 5. Upon further information and belief, Ms. has been maintaining the finances for the Resident as his Article 81 Guardian due to the Resident's lack of capacity. The Guardianship Proceeding is County Index Number (Exhibit A, Complaint paragraph 5.)

Yet the Appellant's answer, submitted on behalf of the Appellant and Ms. , is:

> 5. The Defendant denies knowledge or information sufficient to form a belief as to the allegations set forth in Plaintiff's Complaint and styled as Paragraph 5, and therefore denies the same. (Exhibit A, Answer paragraph 5.)

The Appellant's answer to the complaint also raises "As and for a Ninth Affirmative Defense," that the County Supreme Court "lacks jurisdiction over the person of the Defendant." (Exhibit A, Answer paragraph 84.)

the discharge (as was the State long term care ombudsman), and requested this hearing on the Appellant's behalf. (Exhibits 1, 2, 9.) The regulations governing this administrative proceeding, and the State Administrative Procedure Act (SAPA) Article 3, mention no requirement that any additional notice be given to anyone else, or that leave be obtained from any court simply because a nursing home resident, who has a designated representative, is diagnosed with

Since 2018 the Appellant has failed to make any payments to reduce the substantial balance owed to the Respondent for his care. (Exhibit 3; 0h12m.) At no point in this proceeding has the Appellant offered any explanation for making only sporadic payments totaling $ between and 2017 while his charges climbed to over $ only $ more since then, and nothing at all since 2018, leaving an unpaid balance of over $ The Appellant having failed after reasonable and appropriate notice to pay for his stay at The Brightonian, the Respondent has met its burden of establishing valid grounds for discharge pursuant to 10 NYCRR 415.3(h)(1)(i)(b).

The discharge plan

With regard to the appropriateness of the discharge plan, there is no dispute that the Appellant continues to require the level of care provided by a nursing home. The Respondent proposes to transfer him to , another nursing home under the same ownership that provides a similar level of care to The Brightonian. The Appellant offered no evidence to challenge the Respondent's evidence that is an appropriate nursing home offering an appropriate level of care. (0h49-50m; Exhibit 9.)

A nursing home must permit residents and their representatives the opportunity to participate in deciding where the resident will reside after discharge. 10 NYCRR 415.3(h)(1)(vii). The Respondent met this responsibility by involving the Appellant's designated representative in discharge planning. The Respondent offered to and did contact and assist her with referrals to any nursing homes in which she expressed an interest. On 2018, she provided the Respondent with a list of six area nursing homes. In some instances, the facilities she identified did not have available beds, but in other instances she failed to follow through on the referrals by submitting the required applications. (Exhibit 9; 0h43-47m.) There is no evidence that the Appellant's designated representative has made any further effort since 2018 to work with the Respondent to develop an alternative discharge plan. (Exhibit 9.)

Appellant's counsel also raised the issue that Ms. might be inconvenienced in visiting the Appellant if she had to fly from to and then drive an additional and a to reach him in (1h3m.) According to his brief:

> The only individual known to visit Mr. is his who flies in from to visit him. The Brightonian is less than 15 minutes from the , and the facility is approximately an and a from the airport. (Appellant brief, page 4.)

There is no evidence in this hearing record to establish that Ms. is "known" to visit him. The Appellant failed to offer any evidence of any visits. Although the Appellant has been a resident at The Brightonian for two years, the Respondent's administrator testified she was unaware of any visits having been made by Ms. , who did not appear at this hearing. The Respondent's social worker dealt with her entirely by telephone or email. (Exhibit 9; 1h03m.) The Appellant

now complains, however, that she might have to travel from to rather than to an additional distance of miles, should she decide to visit him.

The Appellant offered no other evidence of family or local contacts that would necessitate transfer to a nursing home closer to Rochester. His attorney did express concern, however, that the Appellant might no longer be able to receive medical care from Dr. , "the physician of his choosing," if he leaves The Brightonian. (Appellant brief, pages 4-5.)

There is little reason to attribute significance to Dr. as the "personal physician" of the Appellant's choosing. Dr. did not appear at this hearing, nor were any medical records prepared by him or anyone else offered into evidence, nor was any representation made by Dr. in writing or through the testimony of any witness that he has any medical or any other concerns about the proposed transfer of the Appellant to another nursing home. Discharge planning notes document:

> Dr. is aware of the facilities [sic] decision to discharge the resident d/t non-payment and that is listed at the receiving facility at this point. is a safe d/c location that can meet Mr. needs. (Exhibit 9.)

The Brightonian, understandably, requires a resident to appoint a physician upon admission. (Exhibit 4, pages 1 & 12 of 34.) The resident has the right to appoint the physician of his choice, but The Brightonian also, understandably, requires that the physician be credentialed to practice at the facility. 10 NYCRR 415.3(e)(1)(iii). (Exhibit 4, page 9 of 34.) Dr. is a physician who is familiar with and known at the Brightonian and is credentialed to practice there. Ms. accordingly designated Dr. in the admission agreement she signed in 2017. (0h51-

2m; Exhibit 4, page 1.) The Appellant offered no evidence that he or his family even knew Dr. before 2017, when he became a resident at The Brightonian.*

The Appellant will not be "forced to find another physician." (Appellant brief, page 5.) The discharge plan includes arrangements for transfer to , another nursing home where he will receive appropriate referral to a treating physician if he does not wish to choose his own. (1h5m.)

The Respondent's responsibility is to provide a safe and appropriate plan of care upon discharge. Under the discharge plan arranged by the Respondent and with Medicaid Program coverage, Mr. will continue to receive the residential health care he clearly needs. The proposed transfer to , a nursing home providing a similar level of care to The Brightonian, meets the Respondent's obligation to establish an appropriate discharge plan. The Appellant's representative is, of course, entitled to pursue any other discharge plan that she might find more convenient. The Respondent, however, is not obligated to continue to maintain the Appellant as a resident while she does so.

Conclusion

Mr. ability to pay the charges for his care from to 2017 is now, for unexplained reasons, apparently gone.* As the Respondent points out in its brief, The Centers for Medicare and Medicaid Services (CMS) State Operations Manual reflects awareness and concern about precisely this kind of situation, stating:

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* The Appellant's own attorney and designated representative do not appear willing or able to even say just how or when this personal patient/physician relationship alleged to be of such significance began. The Appellant's brief coyly asserts "Dr. has been Mr. personal physician since, at least, Mr. was admitted into the facility." (Appellant brief, page 4.)

> In situations where a resident representative has failed to pay, the facility may discharge the resident for nonpayment; however, if there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility should take steps to notify the appropriate authorities on the resident's behalf before discharging the resident. (CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, pages 170-71. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html)

This hearing record is devoid of evidence to explain why, if he was not eligible for Medicaid when he was first admitted to The Brightonian and for ten months thereafter, the Appellant's resources were not applied to ensure that the cost of his necessary residential health care was paid. No guardian, representative, power of attorney, health care proxy, family member or relative or any other witness appeared at this hearing or offered any written statement, evidence or information to explain this.

The Appellant instead levels the accusation:

> [A]ny discharge of Mr. █ from the Brightonian appears to be purely out of spite for what it alleges is a balance due from when Mr. █ was being charged the "private pay" rate. (Appellant brief, page 5.)

The Respondent's forbearance while the Appellant ran up a six-figure bill for his care, followed by its efforts to involve his designated representative and family in the development of a discharge plan of their choosing, stands in sharp contrast to the actions of the Appellant's family and representatives.

The Appellant also complains:

> This discharge means that Mr. █ will leave his current favorite pastime behind, will need to chose [sic] a different personal physician, and will be forced, as a man suffering for [sic] █ to learn and become comfortable in a completely new environment. (Appellant brief, page 5.)

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* That is, ironically, one of his arguments in this hearing: The Appellant calls attention to a bounced check to the Respondent in █ 2018 in support of his position that the Respondent has not established grounds for this discharge. (Appellant brief, page 3.)

This is a fairly accurate statement of an unfortunate turn of events for this resident at this time in his life. There is little reason to believe that any of this is the fault of Mr. [REDACTED] His affairs have been managed by Ms. [REDACTED] since 2014. (Exhibit 5.) This is not, however, a situation of the Respondent's creation. Responsibility for it lies squarely with the family and representatives who assumed the management of his assets and other affairs yet failed to apply his resources in a manner that would enable him to avoid this transfer, continue in his "current favorite pastime," keep his "personal physician," and remain in the comfort of a familiar environment.

The Appellant "requests that the facility be held to their burden of proof in this instance." (Appellant brief, page 3; 0h7m.) The Respondent has met that burden by producing substantial, credible evidence and witnesses in support of both the grounds for its discharge determination and the appropriateness of its discharge plan. The Appellant in return, has offered nothing: no witnesses, no evidence, not even a written statement from his designated representative.

DECISION: Respondent The Brightonian has established valid grounds for the discharge of Appellant [REDACTED] [REDACTED] and has established that the discharge plan is appropriate.

The Respondent is authorized to discharge the Appellant in accordance with the [REDACTED], 2018 discharge notice.

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

Dated: Rochester, New York
February 28, 2019

John Harris Terepka
Administrative Law Judge