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NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

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

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

June 15, 2020

CERTIFIED MAIL/RETURN RECEIPT

Meghan Smith, DSW
The Eleanor Nursing Care Center
419 North Quaker Lane
Hyde Park, New York 12538

[redacted]
c/o The Eleanor Nursing Care Center
419 North Quaker Lane
Hyde Park, New York 12538

[redacted]

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,

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 Eleanor Nursing Care Center

to discharge from a residential health care facility.

Before: Rayanne L. Babich
Administrative Law Judge (ALJ)

Held at: Webex Hearing
May 26, 2020

Parties: [redacted], Appellant
c/o [redacted]

The Eleanor Nursing Care Center
419 North Quaker Lane
Hyde Park, New York 12538

Through notice dated [redacted] 2020, The Eleanor Nursing Care Center (Facility), a residential health care facility subject to Article 28 of New York Public Health Law (PHL), sought to discharge [redacted] (Appellant) from the Facility. The Appellant requested an appeal with the New York State Department of Health (DOH) pursuant to Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York. (NYCRR Part 415.3(i).

The hearing was held on May 26, 2020 and in accordance with the PHL; Part 415 of 10 NYCRR; Title 42, Part 483 of the United States Code of Federal Regulation (CFR); the New York State Administrative Procedure Act (SAPA); and Part 51 of 10 NYCRR. The Appellant was

represented by his [redacted]. An audio recording was made of the hearing which appear in the record on one compact disc. [R@2:39:23]

RECORD

ALJ Exhibits:
I – Letter with Notice of Hearing
II – Notice of Discharge dated [redacted] 2020
III – [redacted] NIDCD Fact Sheet
U.S. Department of Health and Human Services; National Institute on [redacted] and other [redacted] Disorders; NIH Pub. No. 97-4257, December 2015
[redacted]

Facility Exhibits:
1 – Medical Progress Note dated [redacted], 2020
2 – Medical Progress Note dated [redacted], 2020

Appellant Exhibits: None

Facility Witnesses: Renee Maus, Administrator

Appellant Witnesses: [redacted], Appellant's [redacted]
[redacted], Appellant's [redacted]

FINDINGS OF FACT

The Findings of Fact were made after considering all testimony and documents admitted into evidence. The items that appear in parentheses following the findings indicate exhibits [Ex] or recording time [R] in evidence. In instances where any evidence contradicted other evidence, it was considered by the ALJ and rejected.

1. The Facility is a skilled nursing facility as defined under PHL §2801 (2)-(3).
2. Appellant was admitted to Facility on [redacted] 2018; his medical history and current diagnoses include: [redacted]

[redacted] [Ex 2; R@1:27:08]

3. On or about [redacted] 2020, Appellant first attempted to [redacted] the Facility [redacted] with a larger group of people but was noticed by Facility staff. [R@1:30:41]
4. On [redacted] 2020, Appellant attempted to leave the Facility by [redacted] and [redacted] of his first-floor room but was caught by Facility staff. The Facility notified Appellant's family of the incident. [R@1:21:05]
5. Following his attempt to leave on [redacted] 2020, Appellant was placed on frequent checks by Facility staff and was moved from his accommodations on the first floor to another location on the second floor of the Facility. [R@1:22:21]
6. On [redacted] 2020, a psychiatric consult was completed by [redacted] Nurse Practitioner (NP), who ordered medication changes and other interventions that included recreational programs, staff support, meals, showers/bath, support by nursing, music therapy, enjoying nature, culinary offerings, spa services, and follow up in two to three months or as needed. Documentation was entered on April 19, 2020. [Ex 1; R@1:32:41]
7. A "Wander Guard" was placed on Appellant's [redacted] to prevent him from exiting the building but Appellant was able to remove it on his own. [R@1:22:21]
8. On [redacted] 2020, [redacted] NP, recommended that Appellant was to be transferred to the [redacted] floor for tighter control and prevention of exit, and ordered that Appellant be monitored closely with regular rounds and to remove any items that would assist patient to cause harm or escape. Documentation was entered on [redacted] 2020. [Ex 2; R@1:32:41]

9. On [redacted] 2020, Appellant attempted to leave the Facility by [redacted] from his accommodations, [redacted] but was found by Faculty staff prior to execution. The Facility notified Appellant's family of the incident. [R@1:22:51]
10. On [redacted] 2020, Appellant attempted to leave the Facility by using a [redacted] but Facility staff intervened when alarms sounded. [R@1:25:10]
11. On [redacted] 2020, Ms. [redacted] NP, verbally recommended Appellant be sent to [redacted] for further [redacted] evaluation. [R@1:35:15]
12. Emergency services were called but they declined to transport Appellant due to the COVID-19 pandemic and Appellant presented calm after being given medication. [R@1:35:22]
13. On [redacted] 2020, the Facility contacted Appellant's [redacted], stating that the Appellant was not safe to remain in the Facility and family must collect Appellant as he will be discharged. [R@1:26:00]
14. On [redacted] 2020, Appellant's [redacted], collected Appellant from the Facility and was given his belongings and a bag of medications. [R@2:14:15]
15. On [redacted] 2020, the Facility issued a Notice of Discharge citing the discharge reason as Appellant's needs can not be met at the Facility because he is a danger to himself and showing a discharge location as the home of Appellant's [redacted] The Notice of Discharge also showed the reason for discharge as voluntary. [Ex II]

ISSUE

Whether the facility has met its burden to show that its determination to discharge Appellant was proper and whether the discharge plan is safe and appropriate?

APPLICABLE LAW

A residential health care facility, or nursing home, is a facility which provides regular nursing, medical, rehabilitative, and professional services to residents who do not require hospitalization. (PHL §2801 (2)-(3); 10 NYCRR 415.2(k). Under 10 NYCRR 415.3(i)(1)(i)(a)(1), "the resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative, determines that: (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation in the facility…" In addition, pursuant to 415.3(i)(1)(ii), the facility shall:

> (ii) ensure complete documentation in the resident's clinical record when the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (i) of this paragraph. The documentation shall be made by:
>
> > (a) the resident's physician and, as appropriate, interdisciplinary care team when transfer or discharge is necessary under subclause (*1*) or (*2*) of clause (*a*) of subparagraph (i) of this paragraph;

Beyond developing the grounds for discharge, under 10 NYCRR 415.3(i)(1)(vii)-(viii), the Facility must:

> (vi) provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility, in the form of a discharge plan which addresses the medical needs of the resident and how these will be met after discharge, and provide a discharge summary pursuant to section 415.11(d) of this Title; and

(vii) permit the resident, their legal representative or health care agent the opportunity to participate in deciding where the resident will reside after discharge from the facility.

According to 10 NYCRR 415.11(d)(3), the "plan of care that shall be developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive service have been arranged and are available to meet the identified needs of the resident." Furthermore, the Facility has the burden to prove that the discharge plan and location is safe and appropriate. 10 NYCRR 415.3(i)(2)(iii)(b). The standard of proof is substantial evidence. (SAPA § 306(1).

DISCUSSION

Grounds for Transfer

The Facility has not met its burden to show its determination to transfer Appellant was proper under 10 NYCRR 415.3(i). Through its Notice of Discharge, the Facility alleges the transfer is proper under 10 NYCRR 415.3(i)(1)(i)(a)(1) because the Appellant's needs can no longer be met at the Facility and cites that the Appellant is a danger to himself due to recent efforts to leave the Facility. [Ex II] In support of its argument, the Facility points to the Appellant's four attempts to leave the Facility unattended over the course of four to five days. Before the Facility can claim it can no longer meet the needs of its resident, it must also show that reasonable attempts at accommodation in the Facility have been made. (10 NYCRR 415.3(i)(1)(i)(a)(1). Although the Facility made some alterations to Appellant's care, they failed to reasonably address the Appellant's care needs and chose instead to discharge Appellant to the community.

The first consideration is Appellant's mental status and ability to understand. Ms. [redacted] NP, documented that "[p]atient suffers from [redacted] impairment s/p [redacted] [Ex 1] The

medical records showed Appellant suffered a [redacted] and was diagnosed with a [redacted] According to the U.S. Department of Health and Human Services, [redacted] is a disorder which "[redacted]" [Ex III] The Facility reports that it can be difficult for Appellant to make his needs known and that although Appellant appears alert and oriented, he has no safety awareness and is not able to leave the Facility independently. [R@1:27:08; 1:49:05] Appellant can perform most of his activities of daily living either independently or with set up and instruction, but he requires supervision 24 hours per day. [R@2:04:00]

Appellant was admitted to the Facility on [redacted] 2018, and the Facility reported his first attempt to leave the Facility unattended was over 16 months later on [redacted] 2020 when he attempted to [redacted] with a large group of people. [R@1:30:41] Two days later, Appellant again attempted to [redacted] the Facility through the [redacted] and the Facility's response was to relocate Appellant to a [redacted] floor because there were fewer exits. [Ex 2; R@1:22:29] The Facility added frequent checks by staff and reinforced the window of the second-floor room by [redacted] yet, the Appellant was still able to make [redacted] [R@1:23:24] Appellant was seen by nurse practitioners, Ms. [redacted] and Ms. [redacted] on [redacted] 2020 and [redacted] 2020, respectively, who both advised medication and environmental changes. [Ex 1,2] Appellant's final attempt to [redacted] the Facility was [redacted] and staff response prevented Appellant from succeeding. [R@1:25:10] Each time the Appellant attempted to leave the Facility, it reasonably appeared he was attempting to return to his family as they had not been able to visit due to the

specific circumstances of the community health crisis.[1] [R@1:25:50; 1:31:31] After each of his attempts to leave, the Appellant's demeanor appeared [redacted] and [redacted] but he verbally agreed with Facility staff that he would not try to leave again. [R@1:21:45] On or about the final attempt to leave the Facility, Ms. [redacted] NP, verbally recommended to the Facility that Appellant receive further [redacted] evaluation at the [redacted] however; when emergency services declined to transport Appellant, the Facility abandoned this option and proceeded to discharge Appellant immediately. [R@1:35:15] Reasonableness provides that the Facility should have followed through with the recommendation of its own provider and sought further clinical intervention to better understand and address Appellant's needs especially considering that these behaviors began just days prior to discharge. Although managing elopement behaviors of its residents may be challenging, the Facility has the ability to begin to manage these risks as shown by its use of "Wander Guard" system. If, after further evaluation with providers and other services as necessary, a determination was made that even with reasonable accommodations, the Facility can not meet all of the needs of the Appellant, a discharge under 10 NYCRR 415.3(i) would be proper. For this Appellant, these steps were not taken.

The regulations under 10 NYCRR 415.3(i)(1)(ii) require that the Facility "shall ensure complete documentation in the resident's clinical record when the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (i) of this paragraph." For discharge specifically under Part 415.3(i)(1)(i)(a)(1), such documentation should be entered by "the resident's physician and, as appropriate, interdisciplinary care team…" The documentation offered by the Facility are progress notes authored by nurse practitioners, not physicians. More importantly, they do not address Appellant's discharge in any manner and in contrast, make

[1] Due to the community health crisis known as COVID-19, visitors inside the Facility have been prohibited and residents have not been able to leave except for medical appointments.

recommendations for his further care and treatment in the Facility. [Ex 1,2] Testimony from the Facility showed that neither a physician nor nurse practitioner wrote a progress note regarding Appellant's discharge. [R@1:35:15] This lack of documentation addressing the discharge combined with the Facility's failure to make reasonable accommodations to meet Appellant's needs led to an improper ground for discharge under 10 NYCRR 415.3(i).

Discharge Plan

The Facility has failed to secure a safe and appropriate discharge as required under 10 NYCRR 415.3(i)(2)(iii)(b). The Facility is required to provide a plan of care that is "developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive services have been arranged and are available to meet the identified needs of the resident." 10 NYCRR 415.11(d)(3). Appellant's [redacted], testified that he was not provided with any information about placement options and believed that he had no choice other than accept the Appellant's discharge. [R@2:03:31] Although the Facility testified there was one potential placement which contained a locked unit, it was not considered further because it was known to have positive COVID-19 cases. [R@2:27:15] The failure here is that the Facility did not follow through with any additional discussion or investigation of any alternative placements and advised the Family that the only safe option was for Appellant to return to their home. [R@1:24:33; 1:53:11] In fact, the Facility testified that had there not been a COVID situation, they would have had a more extensive in-person meeting and that their "normal procedure" would have been to pursue other Facilities with PRI screenings as they determined Appellant required a locked facility where "he'd truly be safe." [R@1:53:45; 2:22:44; 2:27:15] Although the Facility's position is

that the family was in agreement with a discharge to their home, Appellant's [redacted] and [redacted] both testified that they believed they had no other choice as they were pressured into taking Appellant home and did not believe the discharge was voluntary. [R@2:03:31; 2:05:31; 2:26:05] Appellant's [redacted] and [redacted] also stated there had been some consideration in the past about accepting Appellant into their homes but it was not pursued because of financial obligations. [R@2:00:12; 2:12:40] Once in their home, Appellant's [redacted] and [redacted] immediately began the process of seeking another Facility, an act which should have been completed by the Facility. [R@2:10:21] The Facility could have contacted the family through videoconference or other digital means for the purposes of discharge planning, especially as they were aware the family was not able to care for Appellant in their home.

Appellant's discharge to the home of his family also lacked appropriate care and services as required under 10 NYCRR 415.3(i)(1)(vii)-(viii) because it did not address the medical needs and how they will be met after discharge. Appellant clearly required, at minimum, continuous supervision and no provisions were made to assist the family with this goal. The Facility testified that "the family did not discuss with us that they needed any services," however; it is the responsibility of the Facility to ensure the safe and appropriate discharge. [R@1:55:10] If the Facility was unable to provide the necessary care and services for Appellant, the expectation that one or two family members can do so without services is misguided. The Facility's efforts consisted of providing medications and advised that Appellant should follow up with his primary care provider, whom he had last seen prior to his admission over 18 months ago. [R@2:29:05] The Facility did assist with providing necessary documents after discharge as the family sought alternative placement, but this does not meet the requirements for a safe and appropriate discharge.

ORDER

For the reasons stated above, The Eleanor Nursing Care Center has not established that its determination for discharge is proper and that its discharge plan is appropriate under 10 NYCRR 415.3(i), and the Appellant's appeal is GRANTED.

1. The Facility is required to admit Appellant to the next available bed.
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.

Rayanne L. Babich
Administrative Law Judge

Dated: June 12, 2020
Albany, New York