

JOHN J. FOLEY SKILLED NURSING FACILITY

OVERSIGHT COMMITTEE

A regular meeting of the John J. Foley Skilled Nursing Facility Oversight Committee was held in the Downstairs Conference Room of the William H. Rogers Legislative Building, 725 Veterans Memorial Highway, Smithtown, New York, on Tuesday, November 30th, 2010 at 10:00 a.m.

Members Present:

Len Marchese - Chairman/Director of Management-Dept of Health Services
Presiding Officer William Lindsay - Legislative District #8
Dot Kerrigan - John J. Foley Skilled Nursing Facility Representative/ 4th Vice-President
Kim Brandeau - County Executive's Budget Office

Also In Attendance:

Legislator John Kennedy - Legislative District #12
Terrence Pearsall - Chief-of-Staff/Presiding Officer Lindsay's Office
Dr. James Tomarken - Commissioner/Department of Health Services
Dr. Eli Avila - Chief Deputy Commissioner/Department of Health Services
Kevin Carey - Administrator/John J. Foley Skilled Nursing Facility
Dan Farrell - 2nd Vice-President/AME
Kenneth Crannell - County Executive's Office
Beth Reynolds - County Executive's Budget Office

Verbatim Minutes Taken By:

Lucia Braaten - Court Reporter

[THE MEETING WAS CALLED TO ORDER AT 10:14 A.M.]

MR. MARCHESE:

Thank you, everybody, for coming. I just wanted to introduce everybody. I've already set up -- Kevin Carey is our new Administrator. He took over a couple of weeks ago?

MR. CAREY:

A week and --

MR. MARCHESE:

A few days?

*(*Laughter*)*

He's got a background in health care prior to that. He served as a -- he's a Retired Police Captain from the New York City Police Department, so he brings a little bit of governmental experience behind him as well, and I think that experience is going to serve him well with helping us out with Foley.

With that, I'll -- you know, I don't think -- I don't have much on the agenda, so, you know, I'll kind of leave it open to whatever we want to discuss, but we can go through some of the basics and we'll go from there. So I'll give this to Kevin.

MR. CAREY:

All right. Number one is the census, which currently is 234, which is basically what we've been averaging lately. Out of that, we have 11 in the hospital, 19 total vacancies for the building. The issue with the census is we -- stability in the building, in the public, I guess, is a key issue for families in the hospitals. I mean, they're speaking to the discharge planner what mixed facility they want to go to. And we need a marketer out in the field; two key issues for the low census, based on my opinion, for this week. Adult day care issues.

LEG. KENNEDY:

Can we -- before you go on, with the marketer, in the past, I know that we have had two people in the acceptance area -- not the acceptance, I'm mangling the term.

MR. CAREY:

The Admissions Office.

LEG. KENNEDY:

Right. I heard recently that one of those nurses was reassigned out to the floor and that currently now we don't have anybody that's actually going out to the hospitals, it's being done all by the electronic discharge --

MR. CAREY:

Yes.

LEG. KENNEDY:

-- screening?

MR. CAREY:

Right. There's one woman working in the Admissions Office, an LPN.

LEG. KENNEDY:

Right.

MR. CAREY:

And her -- she actually had a part-time assistant two days a week. She actually resigned this week and -- yes, the one that was out doing the marketing was reassigned a short time ago back to the floor. So there is just one person working in the Admissions Office.

LEG. KENNEDY:

Okay.

MR. MARCHESE:

Some of the -- we have SCINs that we're looking to hire now. That person that you call a marketer really is an RN or an LPN, because they have to evaluate the case.

LEG. KENNEDY:

Right.

MR. MARCHESE:

So we have some RN SCINs in hand and LPN SCINs in hand, so we're interviewing, hopefully to focus our hiring on one of those individuals.

MS. KERRIGAN:

Excuse me, but isn't it required to have an RN to do the admissions screening?

MS. BRAATEN:

I'm sorry, I can't -- Dot, I can't hear you.

MS. KERRIGAN:

I'm sorry. I believe it was an RN's position to do the admissions screening, you know, required to be an RN, New York State requirement.

MR. MARCHESE:

Well, there's no -- we changed the policy recently. As a result of us reviewing the census and determining that there was a lot of inappropriate placements in the facility, we basically changed the way we do admissions in Foley in that in addition to them being pre-screened by either an RN or an LPN, all admissions are signed off by Dr. Crowley, who is our Medical Director, and Kevin, who's our Administrator. So that's who's going to approve any admission that comes into the facility. It's not going to be approved by an RN or an LPN.

MS. KERRIGAN:

Oh, the Medical Director.

MR. MARCHESE:

The Medical Director herself is signing off on it.

LEG. KENNEDY:

Can I just ask? Obviously, I think that it's very important that, you know, we have appropriate admissions in there. Everybody around the table I think has been of that mind all the time that we've been talking about this, notwithstanding what may have been there or not. However, the little bit that I've seen from this as a layman is that there's not a whole lot of time when a health care facility decides that, yes, now we have Mary Smith who's appropriate to move from the acute

care setting over to whatever it is, short-term rehab or long-term whatever, and they actually go up and are made available for a nursing home to go ahead and screen and accept. If we build in a four-part evaluation, isn't that almost going to mean we're never going to get somebody, because they'll be picked up by anybody else?

MR. MARCHESE:

No, no.

LEG. KENNEDY:

No?

MR. MARCHESE:

No, because they're -- they're on site every day. They're both full-time employees. When they're notified of an admission, they can review a chart in ten minutes.

LEG. KENNEDY:

So we're not going to have any kind of lag from the time that --

MR. MARCHESE:

Not on their -- not on their end.

LEG. KENNEDY:

Linda gets a call from --

MR. MARCHESE:

There might be a lag by the time we get a call and we get a nurse or somebody out there to evaluate the patient, but physically, you know, actually looking at the patient. But in terms of once you -- looking at the chart and the PRI, they'll -- that will be part of their workload during the day.

LEG. KENNEDY:

Well, here, again, I've had the opportunity to interact with a couple of the Hospital Directors. Dennis Verzi is up at Saint Catherine's, I talk to him quite often. I've talked to Rich Margolis over at Brookhaven, and even Dr. Strongwater. So what's a reasonable thing that I could say if I'm in a conversation with them. If they have somebody that's going to be -- this morning we have, you know, somebody over on 18 North up in Stony Brook who's now available to go out. What could I say to them would be a reasonable time that somebody from Foley might be able to say, "Okay, looks like they fit our profile," and we can have somebody there to eyeball it, 24 hours, 48 hours?

MR. MARCHESE:

Less than 24 hours. If it's during the week, during the work week?

LEG. KENNEDY:

Yes.

MR. MARCHESE:

Yeah. I mean, over the weekend it would be more difficult, although we do take admissions over the weekend, but it's not -- you know, it's not as easy.

LEG. KENNEDY:

Okay.

MR. MARCHESE:

During the workday, you know, we got a call at 9 o'clock or 10 o'clock or 11 o'clock in the morning,

we can have that patient evaluated that day.

P.O. LINDSAY:

So the one nurse we have there is available to go right away?

MR. MARCHESE:

That nurse, we wouldn't use that nurse right -- again, we're trying to hire somebody right now.

P.O. LINDSAY:

But we don't as of right now?

MR. MARCHESE:

As of this morning --

P.O. LINDSAY:

We don't have it.

MR. MARCHESE:

No, because we reassigned the RN that was in there onto a floor. She's now a -- she was an RN supervisor, we actually demoted her, she's back down to an RN floor nurse, so we're looking to fill that position.

P.O. LINDSAY:

So what happens this morning, Stony Brook calls up, "I have a patient," we don't have anybody to send out to evaluate?

MR. MARCHESE:

How would we evaluate?

MR. CAREY:

I'd use either one of my nurses off the floor to send out then, or my extra admissions person could go out there and somebody else can man the phone while she goes out.

MR. MARCHESE:

We've used Savie, who's our day adult -- a day supervisor. He's our -- he goes out. We have -- during the day shift, we have extra experienced RNs around, so we can share one of them. I mean, it's just that if it's after five, then that becomes an issue for us. But we usually -- you wouldn't -- 95% of the admissions don't happen after five, they're either there or they're not there.

LEG. KENNEDY:

But so, in other words, if I happen to be talking to Dennis or to Strongwater, or something like that, even going forward this week, notwithstanding the fact that you're looking to fill another skin, tomorrow somebody can go there and they can be evaluated, and if appropriate, admitted to John J. Foley.

MR. CAREY:

Yes.

LEG. KENNEDY:

Okay. So -- all right, fine. Thank you.

MR. CAREY:

Adult day care, currently, we have 50 registrants. We're averaging about 25 a day coming in.

Once again, that's another department that needs a director. That would help with the marketing and increasing the census.

MR. MARCHESE:

Our last adult day care director resigned about four weeks ago, three weeks ago.

MS. KERRIGAN:

Right after our last -- sometime after our last meeting.

MR. MARCHESE:

Yeah, right after the last meeting that we had here. And, you know, it's a difficult position to recruit for. We've interviewed a couple of individuals, but when I get into some of the details of the external things, the qualified ones basically decline, so we're running it on a temporary basis now with an acting director.

LEG. KENNEDY:

What are the quals for a director there? I mean, is it a social worker or is it an OT, a PT, what --

MR. MARCHESE:

Yes, it's pretty broad. There's -- different models have different -- different facilities use different -- some of them have an RN, some of them have a social worker, some of them have an occupational or physical therapist that run it. It is actually a pretty broad area in different facilities.

LEG. KENNEDY:

So what kind of a person would you be looking for for this one?

MR. MARCHESE:

There is a job spec. We actually have a job spec on our Civil Service -- they have to meet the Civil Service job spec, it's on our website.

LEG. KENNEDY:

Okay. And is it something -- I know we've looked at this before. The last time I looked at the reimbursement on this, I think we get about a hundred and fifty to a hundred and sixty dollars a day for a person who's there in day care. What's the break-even to make this not profitable, but not a loss, to go ahead and continue to operate it? How many people do you need?

MR. MARCHESE:

Well, it's kind of a complicated question, because we're currently in a -- in a situation with the State where we're not arguing, I guess discussing how our rate was determined, because we're on a cost-based rate, and what that means is when we went in, they took the total cost of the program, divided it by, you know, the amount of average daily census and they came up with a rate. But what the State has now come back with us and said was, "Hold on a second, that should not be your rate, your rate should be your total cost divided by what your licensed capacity is." So the math goes from our average daily census divider of 25 divided by, say, a million in cost up to 60, which we've never been close to, divided into a million dollars. And now you do that math, my rate becomes crazily different, and it's a big problem for us right now as we speak. I mean, this just came up like the last week or two. So your question, although it seems simple, is not so simple right now because the rate is in flux.

P.O. LINDSAY:

So the State Health Department is doing a job on us again.

MR. MARCHESE:

Again. You know, it's a double-edge sword. We went to expand the capacity --

P.O. LINDSAY:

But we didn't have a license for the amount of people we had there.

MR. MARCHESE:

Right. But now, had that license stayed at 30, our rate would have been much higher, as opposed to when we asked the 60 and now they're dividing it by 60. This is like the crazy conversation I'm having with them and this -- they have an incentive to cut our rate. So the fact is that it does cost us about 150 -- on a per-patient basis now, if we run around 30 and we're getting 150 a day, we're about break-even, but that's on a \$150 rate.

LEG. KENNEDY:

You know, the 900 pound gorilla in the room is, is that we have, you know, a closure issue that's out there, but notwithstanding, we're talking about day-to-day operations. Have we looked at an alternative -- not an alternative use, but just -- that's why I go back to the cost issue. Maybe you can't give me a simple answer, but I guess I need to have a follow-up conversation with you to understand, looking at that from a cost perspective and whether or not there's adequate alternatives, whether those people's needs can be met, you know, in other places.

MR. MARCHESE:

Yeah, it's just not a simple answer.

LEG. KENNEDY:

Okay.

MR. MARCHESE:

It's a little bit more complicated than that. Again, that's why I don't like to say one thing and then, "Well, you said this," and then, "Well, that's not really the case."

LEG. KENNEDY:

No, no, I --

MR. MARCHESE:

There's a lot of different things we're going through.

LEG. KENNEDY:

Okay, agreed.

P.O. LINDSAY:

What was our census in adult day care in August?

MR. MARCHESE:

We have charts. It's been dropping. I mean, 30, low 30s, 31, 32. We probably had some charts that were out there, I don't have them. Do you have a chart?

MS. BRANDEAU:

This was -- this was the October meeting. We passed that out. Is it in there?

MR. MARCHESE:

Yeah. Well no, that's the house.

MS. KERRIGAN:

We reported 48 last -- on October 14th.

MR. MARCHESE:

27.23 was the average daily visits in August, so it was up from the prior month of 25, and September dropped to 26.8, and then I kind of just told you October's.

P.O. LINDSAY:

There was a real concern when we found out we weren't -- our license was only for 30.

MR. MARCHESE:

Right.

P.O. LINDSAY:

We were over the -- we were over that 30, that the State --

MR. MARCHESE:

That began --

P.O. LINDSAY:

-- was going to ask for money back.

MR. MARCHESE:

Right, because that was back in March and April where we had an average daily census of 33.22. So that's when we discharged like five or six patients, and that brought us down below the 30. Well, they were arguing that we had a license for 28, but then, after we did an appeal, then they gave us the 60. Okay.

MR. CAREY:

Next is the EMR, the electronic medical records. I believe we had like two false starts in the past. I'm hoping to have a definite start in about two weeks or three weeks. Currently, the CNAs are documenting using the EMR, but they are the only ones in the building doing that. The nurses, the physicians, the social work, pharmacy, is not using the EMR. We actually have the Chief Operating Officer for the ADL, the company that we're contracted with, he's actually coming next week on the 7th. And we hope to have one more training session. Basically, our goal is to -- everybody -- most of the people have been trained already, so we're going to train some basically super-users or key people to be on the floors, set a start date and just get it up and running, hopefully two to three weeks tops. That's my goal with the EMR.

LEG. KENNEDY:

Still, with the fifth floor, is that the start floor?

MR. MARCHESE:

We're going to roll out the whole house, I think, in one shot.

MR. CAREY:

Right, one shot, yeah. I want to bring a like a super-user or somebody well trained on each floor.

MR. MARCHESE:

Part of the problem with that is the grant expires 12/31. So, if we don't spend whatever money we had allocated by December 31st, we're not going to be able to have outside reimbursement, so we're going to have to just implement it now, that's it.

LEG. KENNEDY:

There you go.

MR. CAREY:

Patient issues. We've had some difficult patients in the building. I'm actually trying to tighten it up, as far as we have some alcohol abusers coming and going as they please. We actually just had an incident last week. A TBI patient passing another patient in the hallway, minor argument went off, and assaulted the other resident. Actually, we had called that into the State. We're waiting for the State to come in, but I don't foresee that being in immediate jeopardy. Like one of the systems which I really have to tighten up is like our accident and incident system, which we're tightening up right now as we speak. We have a brand new system in place. But when the minor incidences occur, we have to be very proactive with a plan to prevent it from happening again, and this is one of those instances where it could have been prevented had we done prior action. We had an incident the other night. Discharged a patient Tuesday morning of last week. Wednesday night, the patient came back drunk. He's an alcoholic, actually attempted suicide in the lobby. So we have our challenging -- our patients that are a little more difficult than the basic geriatric patient in the traditional nursing home.

MR. MARCHESE:

We've been dealing with a lot of these issues that come up after 5 o'clock on a pretty regular basis. The Commissioner is involved, I'm involved, we've got the County Attorney involved, because a lot of them involve getting an order of protection issued for the facility, and having a person locked up, you know. So, in the past three to four weeks, I think we've had fewer -- three arrests, and that's not staff arrests, that's just patient arrests. These are all -- these are inappropriate patients that we're really making an effort to discharge, but it's not -- if they -- if they are not accepting a discharge, it's not so easy to just get a person that's not appropriate in our facility into another private setting or whatever.

DR. TOMARKEN:

This has all been precipitated by unacceptable behavior.

LEG. KENNEDY:

You got a resident who's drinking who's going out and hitting a bar and taking a --

DR. TOMARKEN:

They go to work --

LEG. KENNEDY:

It's not a hotel.

DR. TOMARKEN:

They go to work during the day, they go out at night afterwards, or get drunk and then come back.

MR. MARCHESE:

And then they act up in the facility.

MR. CAREY:

That's my goal right now, is to tighten up all of the rules. Like, if they're going out, they're going to be stricter out on a pass. If they want to go out, they're going to sign out against medical advice and be discharged.

P.O. LINDSAY:

How many people do we have working, patients?

DR. TOMARKEN:

I don't know exactly, but I know we have a couple. The last incident was a guy who's -- that was his thing, he was working during the day. He discharged himself, as I understand it, on a Monday, he came back this Tuesday night drunk asking to be readmitted. He was told that wasn't appropriate. And he did -- I don't think he -- well, my impression was he didn't attempt suicide, he made a gesture, cut himself with a piece of glass.

DR. AVILA:

I had someone earlier, when I first started, also was working and admitted. This was when Mr. Fine was there. And I had to call the Office of Medicaid Inspector General because of the implications of receiving Medicaid and also working. We couldn't be held complicit with that, and they did perform an investigation.

P.O. LINDSAY:

So somewhere between when we admitted the patient, which he must have or she must have qualified for admission, they got a job after the fact?

DR. TOMARKEN:

Probably. And probably either they had the job or got it, but they never advised the Social Work Department that they had this extra income. But it was sort of common knowledge, from my impression, throughout the facility, Joe Smith would be going out in the morning and where he was going was going to a job.

MR. MARCHESE:

Yeah, the bus pulls up right in front. It makes it very easy for a patient to just get on a bus and go to work and come back. You know, we did that for convenience of visitors and such, but the staff out at Foley have been asking me, can we redirect the bus line so they don't stop right at least right there, they can stop on the corner. So that at least, if the patients going out there, we kind of know that it's a patient in a wheelchair going down the road a little bit, and a visitor can walk the 100 yards to the facility. You know, that -- actually, what they told me was -- when we tried to do that, we got some resistance from the ADA or some -- they were saying that you have to give them access at the point of the facility, so there were some other issues with handicapped services.

P.O. LINDSAY:

Isn't there a system with patients to sign in and out?

MR. MARCHESE:

Yeah, that's what Kevin was talking about.

MR. CAREY:

Yes.

P.O. LINDSAY:

We don't have that now?

MR. CAREY:

We do. It needs to be tightened up, but, yeah, we do.

DR. TOMARKEN:

It's difficult, because, remember, this is their home, so you can't lock them up.

P.O. LINDSAY:

You know, my father-in-law was in the VA Hospital in Stony Brook for three years. You know, he couldn't leave there without signing out.

DR. TOMARKEN:

Yeah, signing out, but that doesn't do much, it just tells us that he's out of the building. Doesn't say where he's going, what he's doing, when he'll be back, that sort of stuff. So sometimes --

P.O. LINDSAY:

Ask those questions over there, because I used to sign him in and out.

DR. TOMARKEN:

But, if he signs out himself and says, you know, "Going to the mall," and he ends up going to a job, we may not know that. And if he goes out and comes back drunk -- you know, we can't control what he or she does out there, unless we say, can't go unless you go with some supervision, relative, friend.

MR. MARCHESI:

There's a problem on a lot of levels, too, because, you know, we have a controlled diet for the patient, there's a whole regimen that we're controlling them. Once they leave, we don't know where they're eating, what they're eating, you know, they come -- obviously, you know, there's the alcohol issues, the drug issues. It's a big problem for us all around and something -- it all starts -- the root cause of that is accepting the inappropriate patient to begin with. And once you stop it from that end and you clean up what you have, then the typical nursing home patient is what you are left with, and not an adult that really doesn't need a nursing home placement, and that's what we have. We have a significant amount of people like that. All right.

MR. CAREY:

Staff issue. A little, I guess, negative attitudes about everything that's going on in the newspaper and everything. We're short a couple of key positions. We're short -- well, we just promoted a new Director of Nursing. We are short the Adult Day Care Director, four Nurses Aides, two Registered Nurses, one Senior Clerk Typist. We have to replace the Material Control Clerk and one Occupational Therapist we could really use, but that's a really tough position to fill. I guess really overall the staff issue, I'm working on things like going out on pass, accident and incidents, tightening the ship. The ship is very loose, it really needs to be tightened up, and I'm hoping for some stability. They've had three new Directors of Nurses and three new administrators in three months, which is really difficult to maintain control of all the systems that went on in the building, which is somewhat inconsistent supervision at the top.

MS. KERRIGAN:

Excuse me. Who is the new Director of Nursing?

MR. CAREY:

Winsum Thompson.

MS. KERRIGAN:

Thank you.

MR. CAREY:

And we're moving ahead with the front lobby. The carpet's pretty shot. We have an order in right now. We're waiting for the installer to get the tiles in to tile the front. The carpet looks terrible when you walk in the door.

LEG. KENNEDY:

No doubt, has for quite sometime.

MR. CAREY:

We're also awaiting the front door and the employee side door, hopefully before winter.

MR. MARCHESE:

Yeah, well that was part -- that's the last phase of this grant, so all of that money -- all the whole front was ripped up and all new concrete was put in, so that was done. The entranceway is the final piece, and the employee entrance, and then that will finish up whatever we could spend on that grant. I think we're going to come up short, but it's a significant amount of maximizing the expenditure on the grant because of the time constraints.

LEG. KENNEDY:

Can we go back to the positions that you had just spoken about?

MR. CAREY:

Yes.

LEG. KENNEDY:

There are signed SCINs on all those positions and we're actively interviewing, or we're --

MR. CAREY:

Yes.

MR. MARCHESE:

Those are the ones with the signed SCINs?

MR. CAREY:

Yeah, approved for hire.

LEG. KENNEDY:

Okay. Four CNAs and two RNs?

MR. CAREY:

Yes.

LEG. KENNEDY:

Okay. Thank you.

MR. CAREY:

One of those RNs we would be using in admissions.

LEG. KENNEDY:

And we -- I know that we've been shipping resumes to -- who were we supposed to be feeding to, is it going to you, Doctor?

DR. TOMARKEN:

No, I haven't gotten them.

LEG. KENNEDY:

Who are the --

DR. TOMARKEN:

Well, I've gotten a few from your office.

MR. MARCHESE:

Well, if you have resumes for staff, they can go right out to the HR Unit out at Foley, Colleen Trucchio.

LEG. KENNEDY:

Okay. I know Leslie had a couple that she had sent to you.

DR. TOMARKEN:

Yeah, I got a couple from her, but not more than that.

LEG. KENNEDY:

Okay. Thank you.

MS. KERRIGAN:

And can I just ask about staffing on the holiday? Was that difficult, was that a problem?

MR. CAREY:

No.

MS. KERRIGAN:

Full coverage?

MR. CAREY:

Full coverage, not a problem.

MR. MARCHESE:

Anything else?

MR. CAREY:

No.

MR. MARCHESE:

All right. So, just getting onto, I guess, the current issues with regard to closure, sale, etcetera. A letter went out to the employees last week, I think everybody here was copied on it, with regard to what the actions were with the County -- with the budget that was adopted by the Legislature, and I guess the County Executive, that whole process. We've been in touch with the State with regard to that. Prior to that letter going out, we had that approved by the State. The State kind of gets involved with the whole process of closure, sale, whatever. So we've been in regular contact with Richard {Helion}, who is the Regional Director of Long-Term Care, and we showed him that letter. There was another letter, similar letter, that we're waiting approval for to go to the residents. We're waiting for that approval; should be any day now. And we're kind of in a -- what we do and what I've instructed Kevin to do is, at this point, we're operating until we're told not to operate. So we're kind of doing two things at once here. Because I have a budget, a looming budget in '11 that defunds the facility and abolishes positions. We have to plan for that as a department. On the other hand, we have to operate it to make sure that everybody is taken care of until the last possible moment, or whatever, so we're doing both. It's going to result in us probably -- if the decision is for closure and there's not a sale alternative next year, we're probably going to wind up overstaffing the facility while we discharge patients, because we want to err on the side of patient safety, and so we're going to overstaff while we're downsizing.

If the decision is for -- are for sale, then that's another avenue, and, you know, we have obligations under the sale to continue operations and to deliver the facility in as best possible condition as possible, including full census as best we can and full maintenance of the facility.

So those are two scenarios that we're kind of running simultaneously, and, hopefully, the actions of the Legislature and the Executive over the next month will put this issue -- give us closure one way or the other, not that we're in closure, but a decision one way or the other on what we're doing with the facility. I think everybody, you know, one way or the other, would feel a little bit easier if they kind of know what's going to happen one way or the other.

DR. TOMARKEN:

The danger, obviously, is that if there's a decision made, for instance, to close, that staff will be obviously looking for jobs. And to keep the place rung is going to be a difficult job, because we'll have to bring in some contract people, temporary staff, if people start leaving in droves. Because usually what happens when you close a facility and you say it's three, six months down the road, people start looking for jobs. As soon as they get a job, they're gone. Okay? And then hiring is completely out of the question, obviously, so then you grab a contract nurse or any health care professional to fill the role, but they don't know the facility, and so you end up -- it can be a very dangerous and difficult place to run. That's why I want to keep it as short as possible, so we don't have this prolonged period of time where we have this influx and efflux of staff.

P.O. LINDSAY:

That's within our control if the determination is to close. I mean, doesn't that go back to that State Health Department?

DR. TOMARKEN:

Yeah, it does, yeah.

MR. MARCHESE:

Yeah, they kind of direct the process once we ban. Once we stop and we ban admissions, then we inform the State and then we -- they accept our closure plan, which details how we're going to do things, and pretty much they get involved on a regular basis.

DR. TOMARKEN:

But the problem is that nobody has control over elements like how quickly staff leave, how easy or difficult it is to get staff from agencies and how good they are and stuff, so it's just an issue to be aware of.

LEG. KENNEDY:

We've used a substantial amount of agency folks throughout this year, though, haven't we?

DR. TOMARKEN:

Yeah.

MR. MARCHESE:

Yeah, we have agency nurses. Yeah.

LEG. KENNEDY:

Okay.

MR. FARRELL:

In regards to a sale, what's the transition like, is it a flip of the switch, or is it a prolonged process,

or --

MR. MARCHESE:

If the sale was to take place, it's -- you, again, need State Health Department approval to approve the vendor who's purchasing the facility. It's a CON process and that process can take up to a year, and that's one avenue that you can go.

MS. BRANDEAU:

In this case, when we went through the A9-6 process, the State already screened the proposed hire and had given them preliminary approval, so it won't be the same.

MR. MARCHESE:

Well -- but the bottom --

MS. BRANDEAU:

It shouldn't be the same drawn out process.

MR. MARCHESE:

The bottom line is, under the two scenarios, closure, the employees would lose their jobs in the first quarter of the year, absolutely. If it was a sale, it could go on to the fourth quarter of the year.

P.O. LINDSAY:

How can you say absolutely? What happens if the Health Department doesn't give you approval? I mean, you still have to move all the patients out.

MR. MARCHESE:

Well, we have to move the patients out, but that process will start immediately. That would start immediately upon them approving our plan. They haven't indicated that our plan is not acceptable. We've submitted a preliminary plan and they've said our plan is acceptable.

DR. TOMARKEN:

Well, they haven't said that, yet, they're reviewing it.

MR. MARCHESE:

Yeah, okay. So once they approve that plan, then you move forward as quick as you can, because once you start losing census and your fixed costs are fixed, you lose money a lot quicker. I mean, the less -- the quicker you close it, the less you lose, that's kind of what happens.

P.O. LINDSAY:

Like we have the last two months. Our census have went down dramatically.

MR. MARCHESE:

Right, it has gone down.

MR. PEARSALL:

Len, in 2008 you proposed a 20 million dollar plan to close it. You applied for a grant. Where are you coming up with that 20 million dollars to close it?

MR. MARCHESE:

That's not me. It's not me.

MR. PEARSALL:

You told us that it would cost 20 million dollars.

MR. MARCHESE:

There was a grant application to the State of New York and there was a closure plan.

MR. PEARSALL:

Yes.

MR. MARCHESE:

Well, I think this budget includes revenues and expenditures consistent with that plan. I don't think that they were just made up. I think the first quarter of the year calls for -- if this was to close by April 30th, has a ramping down of expenses based on, say, day one, 250 employees, then day 30, 125 employees, and dropping down between the first of the year and the end of March, so it consistently drops down. And those costs are scheduled out, and that's what was, I think, included in the budget.

MS. BRANDEAU:

Yeah, the money for the debt service payoff.

MR. MARCHESE:

Correct.

MS. BRANDEAU:

That was a big chunk of the 20 million dollars to pay off the debt service and that was included.

MR. MARCHESE:

Right. I think that's all -- that's all the budget.

LEG. KENNEDY:

Have you looked at the employee succession process in the event that it does go to closure?

MR. CRANNELL:

The bump and retreat analysis is completed.

LEG. KENNEDY:

It is.

MR. CRANNELL:

Yes, it is.

LEG. KENNEDY:

Okay. And do you have any idea yet how many employees would migrate back into other departments?

MR. MARCHESE:

Yeah. I think we originally gave some estimates. I think there was on order of about 50 that had spot fallback back into the Health Department.

MS. REYNOLDS:

But they're bumping 50 people out to the Health Department --

MR. MARCHESE:

Yeah. No, right. Well, ultimately, 250 people --

MS. REYNOLDS:

So, you're just flipping employees --

MR. MARCHESE:

Two hundred and fifty people, I think, are being dropped off the payroll, but not necessarily people at Foley, because, you know, again, if there were new hires in Hauppauge, they would go first. If somebody had a common title at Foley, they would drop back in.

LEG. KENNEDY:

And, I mean, it's been a while since I went through this. It was back in Halpin's time when I got my layoff notice. What is the -- what's the actual time frame in the schedule, was it 30 days or 45 days?

MR. MARCHESE:

You get 60 days notice by -- I guess by Civil Service regulations, or is it union?

MS. BRANDEAU:

I think that's contractual.

MR. MARCHESE:

It's a contractual thing?

MR. CRANNELL:

That's right.

MR. MARCHESE:

It's either contractual or Civil Service. We've agreed to 60 days.

MR. CRANNELL:

That's right. It's my understanding it's 60 days under the contract.

LEG. KENNEDY:

So the budget funds through April. Rolling back the clock, that means you would be anticipating you'd be sending notices, what, at the end of January?

MR. MARCHESE:

No, probably before that.

MR. CRANNELL:

Well before that.

MR. MARCHESE:

As soon as this decision -- as soon as the decision is made with the resolution one way or the other, I would think the next day, if it was to close.

MR. CRANNELL:

Yes, that's correct.

LEG. KENNEDY:

You would send notices, but they would be notices for termination effective what?

MR. MARCHESE:

Well, the problem is we don't know exactly when, because of the -- the unknown is when patients

would be discharged. We don't know what our staffing patterns necessary to run it would be. So there is -- there's a little bit of an unknown. It would be as soon as a date, but it could be longer based upon our needs after that date. So, if we were planning on having 150 patients at that point and there were 200, because we couldn't discharge 50, we would need the staff hired. On the other side, if we went down to 100, we would have the other -- it becomes a very tricky staffing operational problem.

LEG. KENNEDY:

So, then you have to give a unilateral date across the board subject to the need to extend.

MR. MARCHESE:

Exactly.

MR. CRANNELL:

That's correct.

MR. MARCHESE:

That's probably what we would --

LEG. KENNEDY:

So you'd look for what, like February 15, February 28?

MR. MARCHESE:

January, February -- yeah, February 15th.

LEG. KENNEDY:

So everybody's going to be told that they should be prepared to be terminated effective February 28th, subject to the needs of the facility to be continued on on whatever it is, a two-week increment or one-week increment.

MR. MARCHESE:

I guess, yeah.

MR. CRANNELL:

Yeah, that's pretty consistent --

LEG. KENNEDY:

Is that -- that's what the thinking is?

MR. CRANNELL:

I don't know about the date, but that's the thrust of the date.

LEG. KENNEDY:

Okay. Is that what you guys -- your understanding was with this process with AME?

MR. FARRELL:

Yeah. I mean, it is what it is, and, you know, we're looking -- you know, what I'm more concerned is is jobs, you know. So what's going to happen with the jobs, that's our concern and we'll see what we can do with the jobs and --

LEG. KENNEDY:

Well, they're telling you right now 250 folks are getting free-fall.

MR. FARRELL:

I understand that. I'm not happy about hearing this, but all I can say at this point is we're working on other things and we'll see what happens. You know, I'm not at liberty to, you know, speak anymore than that, and --

LEG. KENNEDY:

Okay.

MR. FARRELL:

-- it is what it is.

LEG. KENNEDY:

Okay. All right.

MS. KERRIGAN:

Is there a possibility that the State will approve -- I mean, no matter what the Legislature decides, the State will -- has to approve the closing.

MR. MARCHESE:

Yeah. They're worried about the patients and being discharged to appropriate placements, and a safe discharge plan, and we've prepared a plan that identifies how we're going to do that. And our plan wasn't just made up, it was modeled after other facilities in the state who have successfully went through the discharge and closure process that they've already approved, the State has approved. So it's not just that we just came up with it.

Any other comments, questions? So I guess that -- those issues will be decided over the next 30 days. Bear in mind, also, the sale contract expires December 31st as well, so if no action is taken on that, that also is terminated, so that goes away.

LEG. KENNEDY:

Len, I have one request, maybe it's just an oversight or whatever. I have been getting a daily census information each day and I haven't seen it in the last four or five days.

MR. MARCHESE:

Okay. Chester handles that. She should -- I don't know why.

LEG. KENNEDY:

And she does --

MS. BRANDEAU:

It hasn't gone out, because I didn't get it either. I usually get it.

LEG. KENNEDY:

Yeah. Maybe she --

MR. MARCHESE:

Maybe she's on vacation or something.

LEG. KENNEDY:

Could be, could be. In the past, I think the other woman who has been reassigned might have -- {Loesh}, is that her name Trish {Loesh}? Or I don't know, somebody.

MS. KERRIGAN:

Yeah.

MR. MARCHESE:

Trish.

LEG. KENNEDY:

Sent when Linda wasn't around. But if I could just get that. It's like one of those things that I look at first thing in the morning.

MR. MARCHESE:

Okay.

LEG. KENNEDY:

Thank you.

MR. MARCHESE:

All right. The 2011 budget is kind of what we've just talked about. That's what's basically giving us the directive to do what we have to do at this point in time, because, as a department, we have no other action to take. The positions have been abolished. The facility is not in the budget, and we need to do our actions based on that document, because that's the only document we have to go by.

MS. KERRIGAN:

Did you say the positions are abolished?

MR. MARCHESE:

In '11, yes. All right. Other issues. You guys have anything else you want to discuss?

LEG. KENNEDY:

One other question I guess I'd ask you, going back to what we started about before, about the appropriateness of admissions versus I guess what we're looking for there at Foley. What are we looking for? I mean, what kind of like -- what person is fitting the model of what we're looking to take in, versus what is not appropriate?

MR. CAREY:

The traditional geriatric, even mild psychiatric patients.

LEG. KENNEDY:

Mary Kelly over at Pilgrim, as a matter of fact, I know has referred a number of folks, and that's a dialogue we started up probably within the last year.

MR. MARCHESE:

All the acute rehab patients are perfect patients for us. You know, those are -- you know, those would be great patients. Anybody that's on Medicare would be a great patient for us.

LEG. KENNEDY:

Okay.

MR. MARCHESE:

I mean, those are like -- those are pre-screening things. If you see Medicare and acute illness, those are like prime patients.

LEG. KENNEDY:
Acute rehab, right?

MR. MARCHESE:
Yeah.

LEG. KENNEDY:
Okay.

MR. MARCHESE:
You know, when you see behavior issues and see a lot of psychotropic drugs, and whatever, on the PRI, it leads you to think that there's some difficulties there with that patient.

LEG. KENNEDY:
Again, I agree with you, that, you know -- but then, when you talk about the whole premise for the facility for the first instance, in a way, we were talking about people that didn't necessarily get snapped up as preferred geriatrics by, you know, some of the other -- the Gurwins and the Nesconsets of the worlds.

MR. MARCHESE:
But part of some of those problems, when we admitted those patients, is they required one-to-one aides. They've been so detrimental and dangerous to either the residents or the staff, that we've had to put an aide on them one-to-one. So, you know, at some point, yeah, maybe they need another appropriate placement, but in our facility, they're a danger to the rest of our patients and the staff.

LEG. KENNEDY:
No doubt. And, I mean, look, this is pragmatically about the operation of John J, it's not like the board of philosophical discussion about what resource is or isn't out there. But then I turn to you, and you know, as a matter of fact, that's one of the chronic problems in our county, we don't have enough acute care psych beds anywhere.

DR. TOMARKEN:
Right. And that was -- what you're addressing is, really, if you're going to do that at Foley, then you better make a psychiatric unit.

LEG. KENNEDY:
Sure.

DR. TOMARKEN:
And then staff it appropriately.

LEG. KENNEDY:
No doubt.

DR. TOMARKEN:
Don't staff it with medical people, staff it with people that -- that's -- I mean, if that's the kind of patient you want, fine, just make sure you've got the facility to handle it.

LEG. KENNEDY:
Again, not so much the kind of patient that you want, and that's --

DR. TOMARKEN:

Well --

LEG. KENNEDY:

If we acknowledge the need --

DR. TOMARKEN:

Yeah.

LEG. KENNEDY:

-- and we say that, yes, we'll staff to help alleviate or meet that unmet need.

DR. TOMARKEN:

Right.

LEG. KENNEDY:

Then we'll staff to what's necessary to take that patient.

DR. TOMARKEN:

Right.

LEG. KENNEDY:

Okay.

MR. CAREY:

Pretty doable. It's just setting the criteria and hiring the staff to deal with it, yes.

LEG. KENNEDY:

What about from the money end of the equation, like a true psych -- a primary psych diagnosis, where do they shape up compared to --

MR. MARCHESI:

I don't think that they're high on the reimbursement scale, but I would have to look into it. Again, it's -- that's more of a maintenance type of a person, so it's -- but when you talk about maintenance --

LEG. KENNEDY:

Right.

MR. MARCHESI:

The key in this business is rehab, rehab, rehab. That's where the monies at, so a maintenance patient is similar to a dementia, Alzheimer's patient.

LEG. KENNEDY:

A PC.

MR. MARCHESI:

Where's it's a basic low level --

LEG. KENNEDY:

Two-eighty, two-ninety, or whatever, a bargain basement.

MR. MARCHESE:

There you go.

LEG. KENNEDY:

Okay. And on the other end of it, depending upon how a person fits in there, if it's short-term private pay, somewhat reimbursable, we can be going upwards of what, 600, 700 bucks a day?

MR. MARCHESE:

Our managed care rates on a short-term basis, depending on the acuity of what they're coming in with, is 600-plus a day, yeah.

LEG. KENNEDY:

Okay.

MR. MARCHESE:

All right. Good. Schedule the next meeting or --

MS. KERRIGAN:

Can I -- I just have one other question about the HIV patients.

P.O. LINDSAY:

Can't hear you, Dot.

MS. KERRIGAN:

The HIV patients. If the facility was to close, are there plans? I mean, do you have anything in mind with them?

MR. MARCHESE:

Well, we would go through a discharge plan similar to any other patient in the facility, yeah. There's appropriate placements for every person in that facility.

P.O. LINDSAY:

Could be out of the county.

MS. KERRIGAN:

Out of county. There aren't any HIV beds. That's why I was asking, are there HIV beds that you're aware of.

MR. MARCHESE:

I don't know.

MR. CAREY:

Well, traditional nursing homes can admit an HIV patient. Just because we've developed our own special wing for them, but a traditional nursing home -- so I'm sure many of them will be placed in a regular nursing home.

DR. TOMARKEN:

And there are -- a couple of months ago, I was told by Mr. {Helion} there was 400 vacant beds in Suffolk County, nursing home beds.

MR. MARCHESE:

Do we schedule another meeting, or what dates -- what do you want to do? What's everybody's pleasure?

P.O. LINDSAY:

Well, I think you should schedule something early in the year, see where we are.

MR. MARCHESE:

So January --

P.O. LINDSAY:

We should know where we are by the end of this month.

MR. MARCHESE:

So January, first two weeks or so?

P.O. LINDSAY:

Yeah, probably the first week of January would be okay.

LEG. KENNEDY:

When do we have the Organizational Meeting?

MR. PEARSALL:

Monday, the 3rd.

MR. MARCHESE:

Okay. So how about late in that week, like Thursday, Friday, or -- is that okay? Thursday? Oh, we have a committee.

MS. BRAATEN:

Do you want to be on the record for this, or do you just want to discuss it off the record?

MR. MARCHESE:

Yeah, this is just setting up -- yeah, we're done with talking.

MS. BRAATEN:

So go off? Okay.

MR. MARCHESE:

This is just scheduling the meeting.

*(*Discussion Was Held Off the Record*)*

MR. MARCHESE:

Friday, the 7th, at 10 o'clock. That's January 7th at 10 o'clock.
Thank you, everybody.

*(*The Meeting Was Adjourned at 11:00 a.m. *)*

{ } Indicates spelled phonetically.