Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2175997
Decision Date:	9/08/2021	**Hearing Date:**	08/30/2021
Hearing Officer:	Samantha Kurkjy	**Record Open:**	08/30/2021

Appellant Representative:
Pro se
[redacted]

Nursing Facility Representatives:
Michael Takesian, Administrator
Alma Kobacic, Social Worker
Emily Getchell, Director of Nursing

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street
Quincy, MA 02171

APPEAL DECISION

Appeal Decision:	Approved	**Issue:**	Nursing Facility Discharge/Transfer
Decision Date:	9/08/2021	**Hearing Date:**	08/30/2021
Nursing Facility Reps.:	Michael Takesian; Alma Kobacic; Emily Getchell	**Appellant Rep.:**	[redacted]
Hearing Location:	Quincy HarborSouth Tower		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a Notice of Intent to Discharge Resident With Less than 30 Days' Notice (Expedited Appeal) ("Notice of Intent") dated August 9, 2021, [redacted] ("the facility") notified the appellant that it was planning to discharge him to home/[redacted], [redacted] on [redacted] for the following reason: "The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident." (Exhibit 1; Exhibit 5.) The appellant filed this appeal in a timely manner on August 9, 2021. (130 CMR 610.015(B); Exhibit 2; Exhibit 5.) Discharge of a nursing facility patient is a valid ground for appeal. (130 CMR 610.032(C).) On August 11, 2021, the Board of Hearings dismissed the appeal because the appellant did not submit an entire copy of the notice which prompted the appeal. (Exhibit 4.) The appellant provided a full copy of the notice on August 13, 2021. (Exhibit 1.) A hearing was scheduled for August 30, 2021. (Exhibit 3.) The hearing officer was on a period of medical leave due to a serious illness, which extends the deadline for rendering a hearing decision pursuant to 130 CMR 610.015(D)(4)(b).

Action Taken by the Nursing Facility

The facility notified the appellant that it seeks to discharge him to the community on August 24, 2021.

Issue

Whether the nursing facility may discharge the appellant under its Notice of Intent dated August 9, 2021.

Summary of Evidence

The facility was represented at hearing by its Administrator, the Director of Nursing, and the Social Worker. A Notice of Intent dated August 9, 2021 informed the appellant that the facility was planning to discharge him to [redacted] on [redacted] for the following reason: "The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident."[1] (Exhibit 1; Exhibit 5.) The appellant filed an appeal on August 9, 2021.

The facility representatives testified as follows: On August 4, 2021, the appellant became physically aggressive with his roommate. The appellant slapped his roommate in the face and wheeled his wheelchair over the roommate's foot. The Social Worker and Director of Nursing called the [redacted] and two officers responded to the facility. The Ombudsman was also called. The appellant admitted to the police, Director of Nursing, and Social Worker that he slapped his roommate due to the roommate making certain comments to him. The appellant was very upset, yelled at the Director of Nursing and used profanity, and stated he "dog slapped" his roommate because the roommate disrespected his name. The appellant refused to go to [redacted] for an evaluation so the facility sent him to the hospital on a Section 12. The appellant returned to the facility on August 5, 2021.

The facility representatives submitted a packet into evidence, which was marked Exhibit 5. The Social Worker referenced page 242 of the packet, which is a telephone order from a physician at the facility, signed by another staff member at the facility. The order dated August 25, 2021, states that the appellant should be discharged home with services and medication pending the hearing. A note in the appellant's records made by the facility physician states that one August 4, 2021, the appellant

> became physically aggressive toward another resident slapin him on the face and runing with his wheelchair on the foot….He said he used to be good friends with the resident he slaped and feels bad

[1] The notice was hand-delivered to the appellant on August 9, 2021 and was also hand-delivered and mailed to his mother, who is his designated family member. (Exhibit 5, p. 52.)

> and sad and missed him, he said a female resident is the one instigating the situation.

(Exhibit 5, pp. 28 & 31) (as written).

The appellant appeared at hearing with his mother. The appellant testified as follows: The dispute with his roommate began in their room. The roommate, whose wife was dying, was ignoring the appellant. The appellant lined up to go outside to smoke and was informed by other residents that his roommate was talking about him. The appellant maneuvered his wheelchair toward his roommate and stopped 12 feet away from him. He asked his roommate what the issue was, and the roommate "exploded," ran at him, and swung his hand at the appellant. The appellant blocked his roommate's hand with his left hand, which had been holding a metal water bottle, and smacked his roommate with his right hand. The appellant then turned his wheelchair around in place and accidentally rolled over his roommate's foot. The appellant went outside to smoke and the Director of Nursing came outside and screamed at him and told him she was going to get him evaluated. She told the appellant that her husband is a police officer, which the appellant interpreted as a threat. The appellant wanted to take time to calm down and he used profanity towards the Director of Nursing. The appellant has PTSD and welcomed the arrival of the police officers, as he did not feel comfortable with the way the Director of Nursing was acting.

The appellant presented a witness, who is another resident at the facility. The witness testified that he was sitting near the dining room approximately 30 feet away from the appellant and his roommate and he heard them arguing. He heard the appellant ask his roommate to "back off" three times. He saw the roommate swing his arm at the appellant and observed the appellant dropping his water bottle and striking his roommate.

The appellant testified that the facility representatives said they had three witnesses for hearing but none of them are here. He testified that his roommate apologized to him after the incident and has no fear towards him. The appellant's roommate was called into the room to testify at hearing. He testified that the appellant hit him in the face and declined to offer additional testimony.[2]

The Social Worker responded that she listened to the appellant's explanation on the day of the incident and he did not state that his roommate swung at him first. She testified that she learned of that aspect of the story a few days before the hearing. The Director of Nursing testified that the facility is still seeking to discharge the appellant because the staff needs to keep everyone safe. She noted that the appellant assaulted an elderly person, and the roommate told her and the Social Worker that he was in fear for his life. She testified that she did not tell the appellant her husband is a police officer; the appellant brought up that fact, told her that he had been imprisoned, and that her husband should look up his rap sheet to see what he is capable of.

[2] The appellant testified that the roommate did not wish to admit he tried to hit the appellant because he was afraid the appellant's attorney would be present at the hearing and he would be charged with a crime.

The Social Worker testified that the appellant's application for the Acquired Brain Injury waiver was denied two weeks ago. In terms of discharge planning, the appellant had been trying to find housing while at a previous nursing facility but encountered difficulty getting proof of income from the Social Security Administration. The Social Worker testified that the current facility's Business Office assisted the appellant with obtaining that proof, and the requested paperwork was received. The facility chose home as the appellant's discharge location. The appellant stated he could not go home, so the facility called a shelter that takes medically-compromised patients. The shelter informed the facility that they could not accept the appellant because he requires a lot of assistance throughout the day and the shelter does not provide that help. The facility also reached out to the VNA company the appellant used before being admitted to the facility, and they said they most likely would not take the appellant back, but also stated they could be called at the time of discharge. The facility called another VNA company that said "they may not be the best fit" for the appellant's needs and told the facility they need a location and date of discharge before determining anything further. (Exhibit 5, p. 51.) The Social Worker also called a third VNA company regarding services for the appellant and was told the appellant needs a discharge date and location. In addition, the Social Worker contacted an organization regarding mental health services for the appellant and the appellant was added to the organization's wait list. The Social Worker testified that the appellant needs skilled nursing, home health aide services, physical therapy, and occupational therapy.

The appellant responded that he did not initially mention that his roommate swung at him first because he is not "a rat." He testified that no one has asked him why he hit his roommate. The appellant and his mother testified that the mother is having trouble with her hips and the appellant's step-father has spinal issues. They live in a one-bedroom apartment and the appellant does not want to be a burden to them. The apartment has a living room, which the appellant's mother testified was the size of a closet.

The appellant testified he has a petition signed by most of the residents on his floor at the facility. The residents wrote nice things about the appellant. He testified that he was told by the facility that he could not bring the petition to the hearing. The hearing record was left open for the appellant until the end of the day so that he could submit the petition to the hearing officer.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. A Notice of Intent dated August 9, 2021 informed the appellant that the facility was planning to discharge him to [redacted] on [redacted] for the following reason: "The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident." (Exhibit 1; Exhibit 5.)

2. The appellant filed a timely appeal on August 9, 2021.

3. The appellant had a dispute with his roommate on August 4, 2021.

4. The appellant lined up to go outside the smoke and was informed by other residents that his roommate was talking about him. The appellant maneuvered his wheelchair toward his roommate in the dining hall and stopped 12 feet away from him. He asked his roommate what the issue was, and the roommate approached and swung his hand at the appellant. The appellant blocked his roommate's hand with his left hand, which had been holding a metal water bottle, and hit his roommate in the face with his right hand. The appellant then turned his wheelchair around and rolled over his roommate's foot.

5. After the incident, the appellant was very upset, yelled at the Director of Nursing and used profanity, and stated he "dog slapped" his roommate because the roommate disrespected his name.

6. The appellant did not state that his roommate attempted to hit him when he reported the incident.

7. The Social Worker and Director of Nursing called the [redacted] and two officers responded to the facility. The Ombudsman was also called.

8. The appellant admitted to the police, Director of Nursing, and Social Worker that he slapped his roommate due to the roommate making certain comments to him.

9. The appellant refused to go to [redacted] for an evaluation so the facility sent him to the hospital on a Section 12.

10. The appellant returned to the facility on August 5, 2021.

11. A witness for the appellant testified that he was sitting near the dining room approximately 30 feet away from the appellant and his roommate and he heard them arguing. He testified he heard the appellant ask his roommate to "back off" three times. He testified he saw the roommate swing his arm at the appellant and observed the appellant dropping his water bottle and striking his roommate.

12. The appellant's roommate testified that the appellant hit him in the face. He declined to offer additional testimony.

13. The roommate is elderly and the roommate told the Director of Nursing and the Social Worker that he was in fear for his life.

14. The appellant testified that the roommate apologized to him.

15. A telephone order dated August 25, 2021 from the facility physician states that the appellant should be discharged home with services and medication pending the hearing.

16. A note in the appellant's records made by the facility physician states that one August 4, 2021, the appellant

> became physically aggressive toward another resident slapin him on the face and runing with his wheelchair on the foot….He said he used to be good friends with the resident he slaped and feels bad and sad and missed him, he said a female resident is the one instigating the situation.

(Exhibit 5, pp. 28 & 31) (as written).

17. The appellant's application for the Acquired Brain Injury waiver was denied two weeks before the hearing.

18. The appellant had been trying to find housing while at a previous nursing facility but encountered difficulty getting proof of income from the Social Security Administration. The current facility's Business Office assisted the appellant with obtaining that proof, and the requested paperwork was received.

19. The facility chose home as the appellant's discharge location. The appellant stated he could not go home. The appellant's mother is having trouble with her hips and the appellant's step-father has spinal issues. They live in a one-bedroom apartment and the appellant does not want to be a burden to them. The apartment has a living room, which the appellant's mother testified was the size of a closet.

20. The facility called a shelter that takes medically-compromised patients. The shelter informed the facility that they could not accept the appellant because he requires a lot of assistance throughout the day and the shelter does not provide that help.

21. The facility also reached out to the VNA company the appellant used before being admitted to the facility, and they said they most likely would not take the appellant back, but also stated they could be called at the time of discharge.

22. The facility called another VNA company that said "they may not be the best fit" for the appellant's needs and told the facility they need a location and date of discharge before determining anything further. (Exhibit 5, p. 51.)

23. The Social Worker also called a third VNA company regarding services for the appellant and was told the appellant needs a discharge date and location.

24. The Social Worker contacted an organization regarding mental health services for the appellant and the appellant was added to the organization's wait list.

25. The appellant needs skilled nursing, home health aide services, physical therapy, and

occupational therapy.

26. The hearing record was left open until the end of the day for the appellant to submit a petition signed by most of the residents on his floor at the facility, including his roommate, with positive comments on his character.

Analysis and Conclusions of Law

Pursuant to 130 CMR 456.701(A)-(C), Notice Requirements for Transfers and Discharges Initiated by a Nursing Facility,

> (A) A resident may be transferred or discharged from a nursing facility only when:
>
> (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;
>
> (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;
>
> (3) **the safety of individuals in the nursing facility is endangered**;
>
> (4) the health of individuals in the nursing facility would otherwise be endangered;
>
> (5) the resident has failed, after reasonable and appropriate notice, to pay for (or failed to have the Division or Medicare pay for) a stay at the nursing facility; or
>
> (6) the nursing facility ceases to operate.
>
> (B) **When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 456.701(A)(1) through (5), the resident's clinical record must contain documentation to explain the transfer or discharge. The documentation must be made by:**
>
> (1) the resident's physician when a transfer or discharge is necessary under 130 CMR 456.701(A)(1) or (2); and
>
> (2) **a physician when the transfer or discharge is necessary under 130 CMR 456.701(A)(3) or (4).**
>
> (C) Before a nursing facility discharges or transfers any resident, the nursing facility must hand deliver to the resident and mail to a designated family member or legal representative a notice written in 12-point or larger type that contains, in a language the member understands, the following:
>
> (1) the action to be taken by the nursing facility;
>
> (2) the specific reason or reasons for the discharge or transfer;

(3) the effective date of the discharge or transfer;
(4) the location to which the resident is to be discharged or transferred;
(5) a statement informing the resident of his or her right to request a hearing before the Division's Board of Hearings including:
(a) the address to send a request for a hearing;
(b) the time frame for requesting a hearing as provided for under 130 CMR 456.702; and
(c) the effect of requesting a hearing as provided for under 130 CMR 456.704;
(6) the name, address, and telephone number of the local long-term-care ombudsman office;
(7) for nursing-facility residents with developmental disabilities, the address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. s. 6041 et seq.);
(8) for nursing-facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act (42 U.S.C. s. 10801 et seq.);
(9) a statement that all residents may seek legal assistance and that free legal assistance may be available through their local legal-services office. The notice should contain the address of the nearest legal-services office; and
(10) the name of a person at the nursing facility who can answer any questions the resident has about the notice and who will be available to assist the resident in filing an appeal.

(Emphasis added.)

As a threshold matter, every discharge or transfer notice must comply with 130 CMR 456.701(C). The notice issued to the appellant complies with the regulation, and the appellant did not note any deviation from the regulation.

Although the appellant claims that his roommate was the first aggressor, he conceded at hearing, as well as to staff at the facility and responding police officers, that he did strike his roommate. The facility representatives credibly testified that the roommate, an elderly patient, fears the appellant and that they are required to keep other residents safe. While the appellant provided a petition attesting to his personality signed by residents on his floor, including his roommate, this document cannot be relied upon to show that the appellant is not a danger. It is reasonable that a person who

has been assaulted by someone and expressed fear of that person would not be honest about his feelings when asked by the person who assaulted him to sign a petition. Regardless of whether the statements on the petition are credible, physical violence in a nursing facility cannot be tolerated.[3] The appellant could have removed himself from the situation with his roommate or blocked his roommate's arm without then striking his roommate with his other arm. The weight of the evidence shows that the facility was correct to issue a discharge notice to the appellant under the regulations.

In addition to the MassHealth regulations above, however, the nursing facility has an obligation to comply with all other applicable state laws, including M.G.L. c.111, §70E. The key paragraph of that statute provides as follows:

> A resident, who requests a hearing pursuant to section 48 of chapter 118E, shall not be discharged or transferred from a nursing facility licensed under section 71 of this chapter, unless a referee determines that the nursing facility has provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility to another safe and appropriate place.

(M.G.L. c.111, §70E.)

The appellant's physician at the facility indicated that the appellant may be discharged to the community with medication and services. Because the appellant objected to being discharged home to live with his mother and step-father, the facility attempted to arrange a shelter discharge location. This attempt was unsuccessful. However, no evidence was presented to indicate that the appellant's home is an unsafe discharge location. At hearing, the appellant testified he did not want to burden his parents, who have medical conditions. The appellant's mother testified that she lives in a one-bedroom apartment with a small living room. The information provided by the appellant and his mother does not indicate that a discharge to home is inappropriate. While the appellant's mother has hip issues and his step-father has spinal issues, the facility will arrange for the appellant to have the appropriate services to care for his needs and his mother and step-father should not have to provide additional care, which may be beyond their physical abilities. Despite the indication that the home is small, there was no statement made by the appellant or his mother that the appellant would not be able to maneuver in his wheelchair in the home, nor was there a specific statement that there was no space in which the appellant could reside. Additionally, the nursing facility representatives testified that the appellant's income verification was procured, so the appellant may pursue other housing options before discharge if he wishes. The evidence indicates that the discharge location chosen by the facility is appropriate.

However, the facility is required to "ensure safe and orderly transfer or discharge from the facility[.]" (M.G.L. c.111, §70E.) One of the VNAs indicated it was hesitant to provide services to the appellant (but would still consider providing the services). Two other VNAs were called.

[3] Now that the facility is aware of the allegation that the roommate tried to strike the appellant, they may decide a further investigation into the roommate's actions is warranted.

One of the VNAs was unsure whether they could provide for the appellant's needs but was open to discussing the possibility more once a discharge date and location were determined. The third VNA asked to be contacted again once the discharge date and location were determined. It is unclear at this point in time whether any of the VNAs will be able to provide for the appellant's needs. In addition, the Social Worker testified that she reached out to a mental health services organization, which added the appellant to its waitlist. It is unknown how long the appellant will have to wait before he may begin receiving these services.

While the facility did not err in issuing a discharge notice to the appellant and also chose an appropriate location for discharge, the appellant's support services in the community are not yet secured. These services must be in place in order to ensure that the discharge is both "safe and orderly[.]" (M.G.L. c.111, §70E.)

Accordingly, the appeal is approved.

Order for Nursing Facility

Do not discharge the appellant under this Notice of Intent.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Implementation

If this nursing facility fails to comply with the above order, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Samantha Kurkjy
Hearing Officer
Board of Hearings

cc: [redacted]