# Office of Medicaid
# BOARD OF HEARINGS

**Appellant Name and Address:**

[redacted]

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| **Appeal Decision:** | Approved | **Appeal Number:** | 2177337 |
| **Decision Date:** | 10/19/2021 | **Hearing Date:** | 10/12/2021 |
| **Hearing Officer:** | Paul Moore | | |

**Appellant Representative:**
Pro se, by telephone

**Nursing Facility Representatives:**
Michael Takesian, Administrator; Emily Getchell, R.N., Director of Nursing; Alma Kobacic, Licensed Social Worker, Fairhaven Healthcare Center (all by telephone)

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

# APPEAL DECISION

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| **Appeal Decision:** | Approved | **Issue:** | Expedited Nursing Facility Discharge |
| **Decision Date:** | 10/19/2021 | **Hearing Date:** | 10/12/2021 |
| **Nursing Facility Reps.:** | Administrator et al. | **Appellant Rep.:** | Pro se |
| **Hearing Location:** | Quincy Harbor South Tower | | |

## Authority

This hearing was conducted pursuant to Massachusetts General Laws ("M.G.L.") Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

## Jurisdiction

Through a Notice of Intent to Discharge or Transfer a Resident with Less than 30 Days' Notice dated September 23, 2021 ("discharge notice"), Fairhaven Healthcare Center ("the facility" or "Fairhaven") notified the appellant that it sought to discharge him effective September 23, 2021 to [redacted], [redacted] because "the safety of the individuals in the nursing facility is endangered due to the clinical or behavioral status of the [appellant]" (130 Code of Massachusetts Regulations (CMR) 610.028; Exhibit 1). The appellant filed a timely appeal with the Board of Hearings (BOH) on September 27, 2021 (130 CMR 610.015(B); 130 CMR 456.703; Exhibit 2). Challenging an expedited notice of transfer or discharge initiated by a nursing facility is a valid ground for appeal to BOH (130 CMR 610.032(C)).

## Action Taken by Nursing Facility

The nursing facility notified the appellant that it sought to discharge him on an expedited basis because the safety of the individuals in the nursing facility is endangered.

## Issues

The appeal issues are whether: (1) the facility had valid grounds to discharge the appellant to Lowell General Hospital; (2) the discharge notice and patient record meet the regulatory

requirements set forth in the Fair Hearing Rules at 130 CMR 610.028 and 610.029; and (3) the facility has provided sufficient preparation and orientation to the appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place.

# Summary of Evidence

A. Testimony and Documentary Evidence

Prior to hearing, the facility submitted a copy of some of the appellant's clinical records, including physician orders, nursing progress notes, and social service progress notes (Ex. 4). The facility's social worker, Ms. Kobacic, testified by telephone that in early August, 2021, the appellant was involved in an incident with his roommate, in which the appellant slapped his roommate and ran over the roommate's foot with the appellant's wheelchair. At that time, the facility issued an emergency notice of discharge to the appellant, as the facility representatives believed he presented a danger to the other residents at the facility. The appellant requested a fair hearing on the discharge notice, and a hearing was held before another hearing officer of the BOH in late August. Ms. Kobacic reported that the other hearing officer approved the appeal, and ordered the facility not to discharge the appellant until appropriate visiting nursing services could be set up for the appellant in the community (Testimony).[1]

Ms. Kobacic testified that the appellant, who is under age 65 and paraplegic, has voiced complaints about the quality of care he has received there, has refused his medications, has recorded other residents and staff with his cell phone, and in early September, 2021, voiced that he wanted to hit his new roommate (Testimony, Ex. 4, p. 322). As a result of the latter comment, the facility representatives moved the appellant's new roommate to a new room. Ms. Kobacic noted that the appellant worked with an agency called Thrive, and representatives of this organization came to the facility unannounced to review the appellant's care (Testimony).

According to the appellant's clinical record submitted into evidence, his medical diagnoses include paraplegia, major depressive disorder, post-traumatic stress disorder (PTSD), retention of urine, anxiety disorder, pressure ulcers of the sacral region and the right and left buttocks, chronic pain, muscle spasms, hypertension, and alcohol abuse (Ex. 4, pp. 1-2). According to Ms. Kobacic, he has resided at the facility since June, 2021, when he transferred there from another nursing facility that had closed (Testimony).

On the evening of September 22, 2021, the facility sent the appellant to [redacted] involuntarily under section 12(a) of M.G.L. c. 123.[2] The facility issued the instant expedited

[1] The undersigned hearing officer entered a copy of this decision in appeal number 2175997 into the record as Exhibit 5.

[2] M.G.L. c. 123, section 12(a) states: "Any physician who is licensed pursuant to section 2 of chapter 112 or qualified psychiatric nurse mental health clinical specialist authorized to practice as such under regulations promulgated pursuant to the provisions of section 80B of said chapter 112 or a qualified psychologist licensed pursuant to sections 118 to 129, inclusive, of said chapter 112, or a licensed independent clinical social worker licensed pursuant to sections 130 to 137, inclusive, of chapter 112 who, after examining a person, has reason to

discharge notice to the appellant on the following morning, informing him that they would not readmit him to the facility when discharged from the hospital. Ms. Kobacic stated that the notice was hand-delivered to the appellant at the hospital. According to the facility's director of nursing, Ms. Getchell, on the evening of September 22, 2021, the appellant was smoking outside in front of the facility, and spotted a staff member being dropped off for work by an individual against whom the appellant allegedly has a restraining order. Ms. Getchell reported that the appellant voiced that he believed the man dropping off the staff member had reached for a gun in his car, and that he believed that the man was going to shoot him. Ms. Getchell reported that the appellant then shared this version of events with other residents at the facility, who became anxious. On this occasion, the facility's assistant director of nursing contacted a physician, who ordered the appellant to be involuntarily admitted to the hospital under section 12(a) for a psychiatric evaluation, as he purportedly presented a danger to himself or others (Testimony, Ex. 4, p. 263).

Ms. Getchell testified that the appellant needs wound care for his pressure ulcers, and needs assistance with his activities of daily living (ADLs), including bathing, dressing and grooming. He has an indwelling Foley catheter and a colostomy bag, both of which require care (Testimony).

The appellant testified that he is still an inpatient at [redacted], not on the psychiatric unit. He continues to receive wound care at the hospital. He had resided at another facility prior to his admission to [redacted] Before that, he was a patient at the [redacted]. He testified that the man who appeared at the facility on the evening of September 22, 2021 was the father of a young man whom the appellant killed in self-defense in 2007. He stated that the young man had broken into his home. The appellant testified that he felt threatened by this man's father on the evening of September 22, 2021. Regarding the incident at the facility in August, 2021, he acknowledged slapping his roommate when the roommate took a swing at him. He stated that he regrets the incident, and that the facility never asked him what led to the assault. He stated that the facility had sent him out involuntarily for a psychiatric evaluation on that occasion as well (Testimony).

The appellant testified that his new roommate was stealing his belongings. The appellant stated that he never verbalized a threat directly to the new roommate. He stated that he is on good terms with this former roommate, who is no longer at the facility (Testimony).

The appellant denied telling other residents, on the evening of September 22, 2021, that there was a man with a gun in the facility parking lot or near the facility (Testimony).

The facility's administrator, Mr. Takesian, testified that the appellant has intimated other residents at the facility into making complaints about the quality of care provided by the facility, has recorded residents' conversations and care without their consent, repeatedly filed grievances, and alluded to his prior gang activity in the presence of residents. He asserted that the appellant has continued to negatively impact the health and well-being of other residents at the facility, as well as that of staff.

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believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person and apply for the hospitalization of such person for a 3-day period at a public facility or at a private facility authorized for such purposes by the department."

Mr. Takesian added that the facility is not a psychiatric facility, and does not have the capability to care for the appellant (Testimony).

The appellant stated that he recorded an incident outside the closed door of a quadriplegic resident at the facility, whom the appellant believed was being abused by his caregivers. He stated that he gave this recording to the resident's family (Testimony).

The appellant testified that he wants to go back to the facility because he feels the residents there cannot speak for themselves, and he wants to protect them. He considers himself to be a good Christian. He added that he is number one on the waitlist for handicapped-accessible housing in the city of Lowell (Testimony).

Ms. Kobacic stated that she called a visiting nursing association (VNA) with the appellant to try to arrange services for him in the community, and the VNA told him that they did not have staff available to take on his case. The appellant denied that Ms. Kobacic ever called a VNA with him present in the room. Ms. Kobacic also stated that other VNAs could not commit to working with the appellant.

The appellant testified that he can catheterize himself, and can change his own colostomy bag. He testified that he has difficulty recognizing his own medications. He asserted that a male nurse at the facility gave him an overdose of another resident's medication.

B. Content of the discharge notice/patient record

The discharge notice at issue in this matter contains: a specific statement of the reasons for the intended discharge, the location to which the appellant is to be discharged, the effective date of the intended discharge, the right of the appellant to request a fair hearing on the intended discharge, the address and fax number of the Board of Hearings, the time frame for requesting a hearing, the effect of requesting a hearing as provided for under 130 CMR 610.030 (*to wit*, that the facility cannot discharge the appellant until 5 days after the hearing officer's decision is received), the name of the person at the facility who can answer any questions about the discharge notice and about the right to file an appeal, the name and address of the local legal-services office, the name and address of the local long-term care ombudsman office, and the mailing address of the agencies responsible for the protection and advocacy of mentally ill individuals, and the protection and advocacy for developmentally disabled individuals, respectively (Exs. 1 & 2).

The patient record for the appellant contains a copy of a telephone order from a physician, transcribed by a nurse, dated 9/22/2021 at 7:54 pm, which states as follows:

> SX 12. DC [appellant] to [redacted] with intent not to readmit. [Appellant] states he feels unsafe in building and untrusting of staff.

(Ex. 4, p. 263)

# Findings of Fact

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

1. The appellant is under age 65, and has resided at [redacted] since [redacted] (Testimony).

2. The appellant's medical diagnoses include paraplegia, major depressive disorder, PTSD, retention of urine, anxiety disorder, pressure ulcers of the sacral region and the right and left buttocks, chronic pain, muscle spasms, hypertension, and alcohol abuse (Ex. 4, pp. 1-2).

3. In early August, 2021, the appellant was involved in an incident with his roommate at the facility, in which the appellant slapped his roommate and ran over the roommate's foot with the appellant's wheelchair (Testimony).

4. Following this incident, the facility issued an expedited discharge notice to the facility (Testimony).

5. The appellant requested a fair hearing on this discharge notice, and a hearing was held before another BOH hearing officer in late August, 2021 (Testimony, Ex. 5).

6. The BOH hearing officer approved the appellant's appeal, because VNA services had not yet been arranged for the appellant to receive services in the community (*Id.*).

7. Through another expedited discharge notice dated September 23, 2021, [redacted] notified the appellant that it sought to discharge him effective [redacted] to [redacted] "the safety of the individuals in the nursing facility is endangered due to the clinical or behavioral status of the [appellant]" (Ex. 1).

8. The appellant filed a timely appeal of this expedited discharge notice with the BOH on September 27, 2021 (Ex. 2).

9. The appellant remains an inpatient at [redacted] (Testimony).

10. The appellant requires assistance in completing his ADLs, wound care, catheter care, and colostomy care (Testimony, Ex. 4).

11. On the evening of September 22, 2021, the appellant was smoking outside in front of the facility, and spotted a staff member being dropped off for work by an individual against whom the appellant allegedly has a restraining order (Testimony).

12. The appellant believed this man had a gun in his car and was going to shoot him, which he verbalized to individuals at the facility (Testimony).

13. The appellant had killed this man's son in 2007, in self-defense, when the man's son broke into his home (Testimony).

14. The facility's assistant director of nursing contacted a physician on the evening of [redacted], who ordered the appellant to be involuntarily admitted to the hospital under section 12(a) of M.G.L. c. 123 for a psychiatric evaluation, as he purportedly presented a danger to himself or others (Testimony, Ex. 4, p. 263).

15. The patient record for the appellant contains a copy of a telephone order from a physician, transcribed by a nurse, dated 9/22/2021 at 7:54 pm, which states as follows: "SX 12. DC [appellant] to [redacted] with intent not to readmit. [Appellant] states he feels unsafe in building and untrusting of staff" (*Id*.).

16. The facility alleges that the appellant has intimated other residents there into making complaints about the quality of care provided by the facility, has recorded residents' conversations and care without their consent, repeatedly filed grievances, and alluded to his prior gang activity in the presence of residents (Testimony).

17. The appellant verbalized wanting to strike his new roommate in early September, 2021 (Testimony, Ex. 4, p. 322).

18. The appellant recorded an incident outside the closed door of a quadriplegic resident at the facility, whom the appellant believed was being abused by his caregivers (Testimony).

19. The appellant wants to go back to the facility because he feels the residents there cannot speak for themselves and he wants to protect them, and he considers himself to be a good Christian (Testimony).

20. The appellant is on the waitlist for handicapped-accessible housing in the city of Lowell (Testimony).

21. The discharge notice at issue in this matter contains: a specific statement of the reasons for the intended discharge, the location to which the appellant is to be discharged, the effective date of the intended discharge, the right of the appellant to request a fair hearing on the intended discharge, the address and fax number of the Board of Hearings, the time frame for requesting a hearing, the effect of requesting a hearing as provided for under 130 CMR 610.030 (*to wit*, that the facility cannot discharge the appellant until 5 days after the hearing officer's decision is received), the name of the person at the facility who can answer any questions about the discharge notice and about the right to file an appeal, the name and address of the local legal-services office, the name and address of the local long-term care ombudsman office, and the mailing address of the agencies responsible for the protection and advocacy of mentally ill individuals, and the protection and advocacy for developmentally disabled individuals, respectively (Exs. 1 & 2).

# Analysis and Conclusions of Law

The federal Nursing Home Reform Act (NHRA) of 1987 guarantees all residents the right to advance notice of, and the right to appeal, any transfer or discharge initiated by a nursing facility. MassHealth has enacted regulations that follow and implement the federal requirements concerning a resident's right to appeal a transfer or discharge, and the relevant MassHealth regulations may be found in both (1) the Nursing Facility Manual regulations at 130 CMR 456.000 et seq., and (2) the Fair Hearing Rules at 130 CMR 610.000 et seq.

The regulations at 130 CMR 456.002 define a "discharge" as "the removal from a nursing facility to a noninstitutional setting of an individual who is a resident where the discharging nursing facility ceases to be legally responsible for the care of that individual; this **includes a nursing facility's failure to readmit following hospitalization or other medical leave of absence**" (emphasis added). Similarly, 130 CMR 610.004 defines a discharge as "the removal from a nursing facility of an individual who is a resident where the discharging nursing facility ceases to be legally responsible for the care of that individual."

The Nursing Facility Manual regulations at 130 CMR 456.701 provide in relevant part:

> 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. § 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. § 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)

Further, the Nursing Facility Manual regulations at 130 CMR 456.702 set forth the requirements that must be met by a nursing facility when it issues an expedited notice of discharge, as follows:

(B) Instead of the 30-day-notice requirement set forth in 130 CMR 456.702(A), the notice of discharge or transfer required under 130 CMR 456.701 must be made as soon as practicable before the discharge or transfer in any of the following circumstances, which are emergency discharges or emergency transfers.
**(1) The health or safety of individuals in the nursing facility would be endangered and this is documented in the resident's record by a physician.**
(2) The resident's health improves sufficiently to allow a more immediate transfer or discharge and the resident's attending physician documents this in the

resident's record.
(3) An immediate transfer or discharge is required by the resident's urgent medical needs and this is documented in the medical record by the resident's attending physician.
(4) The resident has not resided in the nursing facility for 30 days immediately prior to receipt of the notice.
(C) When the transfer or discharge is the result of a nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence, the notice of transfer or discharge, including that which is required under 130 CMR 456.429, must comply with the requirements set forth in 130 CMR 456.701 and must be provided to the resident and an immediate family member or legal representative at the time the nursing facility determines that it will not readmit the resident.

(Emphasis added)

Based on the evidence in the record, I agree that the facility has sufficient grounds to discharge the appellant, as his behavior presents a danger to the safety of other residents. His actions and words reflect a propensity for violence, and his behavior toward other residents and staff is intrusive and unsettling. The appellant exhibited a desire to try to advocate on behalf of other residents, but this is clearly not his role, especially when other residents and staff are made uncomfortable by such efforts.

I also find that the discharge notice issued by the facility to the appellant meets the regulatory requirements set forth at 130 CMR 456.701(C) and 130 CMR 456.702(B).

However, the appellant's clinical record in evidence does *not* contain documentation by a physician explaining the reasons for his intended discharge. In fact, the only physician documentation referring to the appellant's discharge is a telephone order for an involuntary psychiatric hospitalization on the evening of September 22, 2021; this order refers to the appellant's own complaints of feeling unsafe in the facility and his mistrust of staff. There is no narrative in the record by a physician explaining how the appellant is a danger to the safety of others. Such documentation is r*equired* by 130 CMR 456.701(B)(2) and 130 CMR 456.702(B)(1), above.

Also relevant to this appeal, an amendment to M.G.L. c. 111, §70E, which went into effect in November of 2008, states 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.**

(Emphasis added)

Because I have found that the facility did not meet the requirements in the Nursing Facility Manual regulations regarding physician documentation, I need not decide at this time whether the facility has provided sufficient preparation and orientation to the appellant to ensure his safe and orderly transfer or discharge from the facility to another safe and appropriate place.

Based on the record and the above analysis, this appeal is APPROVED.

## Order for Nursing Facility

Rescind discharge notice of September 23, 2021, and readmit the appellant to the first available bed at the facility, if the appellant seeks re-admission.

## Implementation of this Decision

If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

## 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.

Paul Moore
Hearing Officer
Board of Hearings

cc: [redacted]