Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2205384
Decision Date:	8/18/2022	**Hearing Date:**	08/11/2022
Hearing Officer:	Thomas Doyle	**Record Open to:**	

Appearance for Appellant:
Pro se

Appearance for Fairhaven Healthcare Center: Emily Getchell, Director of Nurses; Patricia McCarron, Staff Development Coordinator

Interpreter: Ruth Nelson, Director of Activities for Fairhaven

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

Appeal Decision:	Denied	**Issue:**	Nursing Facility Discharge
Decision Date:	8/18/2022	**Hearing Date:**	08/11/2022
Fairhaven Healthcare Rep.: Emily Getchell, Dir. Of Nurses; Patricia McCarron, Staff Development Coordinator		**Appellant's Rep.:**	Pro se
Hearing Location:	Remote (phone)	**Aid Pending:**	No

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 dated June 22, 2022, the nursing facility informed the appellant that she would be discharged to the Lowell Transitional Living Center, 193 Middlesex St., Lowell, MA on July 22, 2022 because the safety of individuals in the facility is endangered. (130 CMR 610.028(A)(3); Ex. 1). The appellant filed this appeal in a timely manner on July 18, 2022. (130 CMR 610.015(B); Ex. 2). Notice of discharge from a nursing facility is valid grounds for appeal (see 130 CMR 610.032).

Action Taken by the Nursing Facility

The nursing facility issued a notice of discharge to the appellant.

Issue

The appeal issue is whether the facility satisfied its statutory and regulatory requirements pursuant to 130 CMR 610.028 when it issued the appellant the notice of intent to discharge.

Summary of Evidence

Appellant and facility representatives all appeared telephonically from the same location. The nursing facility was represented by its Director of Nurses and its Staff Development Coordinator. The facility's Director of Activities acted as a Spanish interpreter for appellant.[1] The Director of Nurses testified that appellant was admitted to the facility on [redacted] from Lowell General Hospital. The Director of Nurses testified appellant was not receiving any skilled services. Appellant was made aware of the facilities smoking policy upon admission via a Spanish interpreter and documents. (Testimony; Ex. 5, No. 9 and Ex. 6). The Director of Nurses testified the facility has 104 residents and was moving to discharge appellant for safety reasons because appellant was not following the facility's smoking guidelines. The safety reasons include oxygen is present in the facility and, if not supervised by staff while smoking, appellant could possibly drop a cigarette and it could ignite. There are designated smoking periods and areas and a staff member is present to light the resident's cigarettes. Residents cannot keep cigarettes or lighters, which are held at the nursing station. She further testified appellant was suspected of smoking in her room instead of the designated smoking areas. Cigarette butts were found in appellant's room, in her sink and on a table in the room. Appellant's roommate complained of cigarette smoke in their room. Facility staff found a cigarette lighter on the appellant and saw appellant smoking outside while not in the designated smoking area or at the designated times. Appellant was redirected on several occasions regarding her disregard of the smoking guidelines. The Director of Nurses testified that she had spoken to appellant and her daughter, with a Spanish interpreter, about the seriousness of smoking in the facility and that a staff member needs to be with appellant when she is smoking. Another meeting involved the Director of Nurses and the Director of Social Services meeting with appellant and her daughter to explain that appellant cannot smoke in her room. Appellant continued to smoke. (Testimony).

Appellant testified through a Spanish interpreter. She testified it was all lies and she never smoked in her room and no cigarettes were found on her table in her room. Appellant testified that she never received "paper" on smoking and the only thing she knew about any smoking policy was relayed to her from other residents. Appellant testified that facility staff never told her about smoking policy but only where to smoke. She reiterated that what the Director of Nurses said in her testimony was not the truth and she was never caught with cigarettes. (Testimony).

Findings of Fact

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

1. Appellant is [redacted] and was admitted to the facility on [redacted]. (Testimony; Ex. 4, p. 2).

2. Appellant is receiving no skilled services. (Testimony).

[1] Appellant was asked if she wanted an interpreter provided by the Commonwealth and she declined.

3. Appellant was informed of the nursing facility's smoking policy on the day of her admission. (Ex. 5 and 6).

4. Appellant signed a document on the day of admission to the facility that she would abide by established smoking privileges. (Ex. 5). Appellant signed a Resident/Patient Smoking Policy Signature Addendum on the day of her admission to the facility that placed her on notice that any violation of any or all smoking policy statements may result in discharge from the facility. (Ex. 6).

5. Appellant is a current smoker. (Testimony). Appellant smokes 6-10 cigarettes a day. (Ex. 4, p. 214).

6. Appellant does not have any cognitive impairment that may affect her understanding of the facility smoking agreement. She is aware that smoking occurs only during scheduled smoking times. (Ex. 4, p. 167).

7. The Director of Nurses spoke to appellant and her daughter, through a Spanish interpreter, about smoking in the facility. (Testimony).

8. Appellant is her own representative (Ex. 4, p. 214) and remains responsible for herself. (Ex. 4, p. 300).

9. Discarded cigarette butts were found in appellant's room. (Testimony; Ex. 4, p. 48).

10. The aroma of smoke was noticed in appellant's room. (Testimony; Ex. 4, pp. 55, 49, 42, 39, 36, 20, 14 and 7).

11. The facility Nurse Practitioner found appellants continued disregard of the facilities smoking policy is a safety issue. (Ex. 4, p. 227).

Analysis and Conclusions of Law

Per 130 CMR 456.701(A) and 130 CMR 610.028(A), a nursing facility resident may be transferred or discharged 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 MassHealth Agency or Medicare) a stay at the nursing facility; or

(6) the nursing facility ceases to operate.

130 CMR 610.028(A); 456.701(A).

When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 610.028(A)(1) through (5), the resident's clinical record must be documented. The documentation must be made by

(1) the resident's physician when a transfer or discharge is necessary under 130 CMR 610.028(A)(1) or (2); and

(2) a physician when the transfer or discharge is necessary under 130 CMR 610.028(A)(4).

130 CMR 610.028(B).

The issue on appeal is whether the safety of individuals in the facility is endangered but for the discharge of the appellant, pursuant to 130 CMR 610.028(A)(3).

Despite her denials and accusations of representatives of the facility lying in testimony, there is sufficient evidence that the appellant was in violation of the smoking policy of the nursing facility. Appellant signed an acknowledgement, on the day of her admission to the facility, that she was given the opportunity to review the facility's smoking policy. Her signature on the acknowledgement was witnessed. (Ex. 5 and 6). On numerous occasions over a period of months, staff smelled smoke in appellant's room. (Ex. 4, pp. 55, 54, 49, 42, 41, 39, 36, 28-29, 20, 14 and 7). Appellant's roommate told the facility that appellant was smoking in the bathroom of their room. (Ex. 4, p. 47). At various times, facility staff found in appellant's room two half smoked cigarettes. (Ex. 4, p. 48, 13). Staff saw ashes and tobacco in the sink in appellant's room (Ex. 4, p. 41). Staff saw two lighters on appellant's bed. (Ex. 4, p. 6). Staff took a cigarette lighter from appellant and noted she was not happy about it. (Ex. 4, p. 44). Twice on June 12, 2022, appellant was caught smoking behind bushes with cigarettes and a lighter in her shorts. She said she was bored. (Ex. 4, p. 23). On June 25, 2022, appellant was seen smoking outside by herself at nonsmoking times. (Ex. 4, p. 17). On July 7, 2022, appellant left the building to smoke at nonscheduled times and refused to come back into the facility or give up her lighter and cigarettes. (Ex. 4, p. 12). Appellant was also seen on July 9 and 10, 2022 smoking outside at nonsmoking hours. (Ex. 4, p. 11). Appellant was given verbal redirection about smoking policy and safety issues numerous times over a period of months. (Ex. 4, pp. 54, 50, 41, 39, 28-29, 23, 13 and 11). The Director of Social Services for the facility and the Director of Nurses met with appellant on July 5, 2022, with an interpreter, to discuss smoking issues. Appellant was offered support and education not to have lighting materials on her person or in her room due to safety concerns. Appellant turned over cigarettes for the lock box at the nurse's desk. (Testimony; Ex. 4, p. 13). The facility representative said violations of the smoking policy affect safety because there is oxygen in the facility, and it is a hazard to smoke indoors due chances of a dropped cigarette igniting a fire. (Testimony). The appellant's actions in disregarding the facility's smoking policy put nursing facility residents at risk. The nursing facility has provided support for its claim that the safety of the individuals in its facility is endangered.

The second issue is whether the nursing facility has met the requirements of 42 CFR 483.15(c)

and MGL Chapter 111, Section 70E in providing sufficient preparation and orientation to the appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place. "The Federal Centers for Medicare and Medicaid, during the times relevant here known as the Health Care Finance Administration, is the Federal agency charged with administering the Medicaid program and promulgating regulations. Sufficient preparation means, according to HCFA,[2] that the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation; the facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence." Centennial Healthcare Investment Corp. v. Commissioner of the Division of Medical Assistance, 61 Mass. App. Ct. 1124, n. 5, 2004 (Appeals Court Rule 1:28).

The nursing facility has met its burden of providing sufficient preparation and orientation to the appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place. The nursing facility intends to discharge appellant to a homeless shelter in Lowell Massachusetts or to an apartment that appellant and her daughter have been seeking for months. (Testimony; Ex. 1, p.1). I determine that the place to which the nursing facility intends to discharge the appellant is safe and appropriate based on the appellant's nursing facility record. The appellant is receiving no skilled services at this time. The facility's nurse practitioner noted appellant is a safety issue for the facility due to her noncompliance with the smoking guidelines. (Ex. 4, p. 227). On July 13, 2022, appellant met with a facility Licensed Independent Clinical Social Worker. The worker noted appellant was feeling well physically and emotionally and appellant told worker she was on a list for a new residence and has been having meetings because she wants a new living environment. (Ex. 4, p. 140). The facility representative said appellant and her daughter had sought an apartment for months. (Testimony). The nursing facility involved the appellant, to the extent possible, in discharge planning. The appellant was informed she was being discharged to a homeless shelter in Lowell or she could get her own apartment. The facility representative said they would arrange transportation to the shelter for appellant or her daughter could pick her up. The facility's social services unit involved appellant and her daughter in seeking a new residence (testimony) and the fact that appellant has not found an alternative place to live does not negate this fact and is out of the control of the nursing facility. The nursing facility's notice of discharge dated June 22, 2022 meets the requirements of 130 CMR 610.028 and MGL Chapter 111, section 70E. The appeal is denied.

Order for the Nursing Facility

Proceed with the discharge as set forth in the notice dated June 22, 2022 after the 30 days stay (from the date 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

[2] The Health Care Finance Administration is now known as the Centers for Medicare and Medicaid Services.

Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Thomas Doyle
Hearing Officer
Board of Hearings

cc:
Emily Getchell, Director of Nurses, Fairhaven Healthcare Center, 476 Varnum Ave., Lowell MA 01854

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