Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2304733
Decision Date:	7/17/2023	**Hearing Date:**	06/27/2023
Hearing Officer:	Mariah Burns		

Appearance for Appellant:
[redacted]

Appearance for Nursing Facility:
Amy Oriakhi, et. al.

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:	Approved	**Issue:**	NH Discharge
Decision Date:	7/17/2023	**Hearing Date:**	06/27/2023
MassHealth's Rep.:	Amy Oriakhi, et. al.	**Appellant's Rep.:**	[redacted]
Hearing Location:	Remote		

Authority

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

Jurisdiction

On June 7, 2023, the nursing facility issued a 30-day notice that the appellant would be discharged to a homeless shelter because the safety of individuals in the facility would be endangered due to the appellant's clinical and behavioral status. *See* 130 CMR 610.028 and Exhibit 1. The appellant filed this appeal in a timely manner on June 9, 2023. *See* 130 CMR 610.015(B) and Exhibit 1. Notice of transfer or discharge from a nursing facility is valid grounds for appeal 130 CMR 610.032.

Action Taken by Nursing Facility

The nursing facility issued a 30 day notice of discharge to the appellant.

Issue

Whether the nursing facility sufficiently proved, pursuant to 130 CMR 610.028, that the appellant's clinical and behavioral status endangers the safety of individuals in the facility.

Summary of Evidence

At hearing, the nursing facility was represented telephonically by its administrator and two social

workers. The appellant was present on the call and was assisted by her son and a friend. Based on testimony and documentary evidence submitted into the record, the following information was provided:

The appellant was admitted to the nursing facility on [redacted] 2022. Prior to April 27, 2023, the appellant exhibited no documented or reported behavioral problems. On that day, the facility conducted a room search for the appellant and recovered the following items:

1. 1 full bottle of ZZZ Quil
2. 1 empty bottle of ZZZ Quil
3. Melatonin 10 mg gummies
4. 2 vape pens
5. 3 lighters
6. 1 pack newport cigarettes
7. 1 loose cigarette
8. A 15 surgical blade
9. Over 30 unidentified pills in sandwich bags

See Exhibit 3 at 31. As a result of the room search, facility staff met with the appellant, reminded her of the facility's safety guidelines, and issued a no-harm agreement, which detailed safety measures the facility would be implementing for the following two weeks. *Id.* at 4. The agreement allowed the facility to search the appellant's room as-needed and to search her upon her entry to the facility and expired on May 12, 2023. *Id.*

On May 8, 2023, the appellant was found to be in possession of a lighter, which resulted in her room being searched. Exhibit 3 at 31. The following items were recovered:

1. Small can of hairspray
2. 4 lighters
3. 1 steak knife
4. Unidentified nasal inhaler
5. 15 blade
6. Small smoking pipe with marijuana residue
7. Hempvana pain cream
8. Clorox cleaning wipes

See Id. A second no harm agreement was executed as a result of this search, and the appellant's leave of absence privileges were revoked until May 23, 2023. *Id.* at 8. The appellant also signed the facility's smoking policy, which states, in relevant part, that residents may not be in possession of any tobacco or marijuana smoking paraphernalia, that their smoking materials would be kept in a designated location, and they may only smoke at a particular time and place. *Id.* at 10-11.

On [redacted] 2023, the appellant was searched upon returning from the doctor's office, and two surgical blades were found in her purse. *See* Exhibit 3 at 21. A third no-harm agreement was thereby issued on [redacted] and the appellant refused to sign. *Id.* at 37.

On [redacted] 2023, the appellant approached the nurses station, "threw" a note at her physician and stated "that's the number from my pain doctor, he needs to speak to you today." Exhibit 3 at 17. She was documented as having called the doctor a jerk, and later apologized.[1] *Id.*

On [redacted] 2023, the appellant exhibited some lethargy, which led the facility to administer a urine screen[2], which came back positive for "UOPI2." Exhibit 3 at 16. When asked what this meant, at hearing, the facility representative indicated that it was an opioid, but was unable to testify as to which type. The facility explained that the presence of an opioid is indicative that the appellant was a danger. The hearing officer pointed out that the appellant has been prescribed Percocet, as depicted in her progress note on Page 32 of Exhibit 3, which is an opioid. The facility representatives agreed that there could have been a legitimate reason for the appellant to have tested positive for Percocet.

On [redacted] 2023, the facility issued the notice at issue for this hearing. When asked what prompted the notice, the facility representatives referred to the three previous no-harm agreements. When asked why there was a three-week delay between the most recent no-harm agreement on [redacted] and the discharge notice on [redacted] the facility representatives explained that it took that long for a physician to document the danger that she poses to the facility. Finally, when asked if there were any incidents between [redacted] and [redacted] in which the appellant exhibited dangerous behavior, the facility representatives referred to the urine screen from June 3. They did not indicate that any dangerous behavior or incidents had occurred since the notice issued.

Findings of Fact

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

1. The appellant was admitted to the nursing facility on [redacted] 2022.

2. Between the admission date and April 24, 2023, the appellant exhibited no notable

[1] It is notable that a different note depicting this interaction is detailed on page 17 and is seemingly stricken from the appellant's clinical record. In this notation, the physician stated he would discharge the appellant that afternoon and demanded a written apology. The listed "Strike Out Reason" was listed as "Incorrect Documentation." There is no additional evidence in the record as to why that note is incorrect.

[2] It does not appear that the appellant was seen by a physician on this day.

behavioral issues within the facility. Testimony, Exhibit 3.

3. On [redacted], 2023 and [redacted] 2023, the facility conducted searches of the appellant's room that yielded, among other items, sharp surgical blades and smoking materials. In both instances, the appellant signed a no-harm agreement where she was reminded of the facility's safety guidelines, and her freedom was restricted for a certain period of time. Exhibit 3.

4. On [redacted] 2023, staff at the facility recovered two surgical blades from the appellant's purse when she returned from the doctor's office. Exhibit 3 at 21. A third no-harm agreement was executed, and the appellant refused to sign it. Exhibit 3 at 37.

5. On [redacted] 2023, the appellant exhibited some lethargy, which led to the execution of a urine screening. Her urine tested positive for some unknown opioid. Testimony, Exhibit 3 at 16.

6. The appellant has a prescription for Percocet, which is an opioid. *Id.* at 32.

7. There is no evidence that the appellant has ever threatened anyone at the facility or exhibited any dangerous behavior beyond possession of the blades and smoking materials.

8. On [redacted] 2023, the facility issued a 30 day discharge notice, stating that the appellant's clinical and behavioral status endangered individuals in the facility. Exhibit 1.

9. There have been no credible behavioral incidents involving the appellant since May 18, 2023.

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 mirror the federal requirements concerning a resident's right to appeal a transfer or discharge, and the relevant MassHealth regulations may be found in the Nursing Facility Manual regulations at 130 CMR 456.000 *et seq*. and in the Fair Hearing Rules at 130 CMR 610.000 *et seq*. Thus, when issuing a notice of discharge for a resident, the nursing facility must comply with the requirements set forth within those regulations regardless of whether the resident is a MassHealth member.

Under 130 CMR 610.028, a resident may only be discharged from a nursing facility under the following circumstances:

> (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 Medicaid or Medicare pay for) a stay at the nursing facility; or
> (6) the nursing facility ceases to operate.

When, as it is here, the transfer or discharge is sought due to the circumstances specified in either (3) or (4) above, the resident's clinical record must contain documentation by a physician to explain the transfer or discharge. *See* 130 CMR 610.028(B); 130 CMR 456.701(B). The facility must also typically provide 30-days' notice, but it may give less than 30-days' notice where 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." 130 CMR 610.029(B)(1).

Furthermore, the nursing facility must demonstrate that it has complied with the requirements under M.G.L. c.111, §70E, which states the following:

> 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.

In the present case, the facility indicated on the notice that the discharge was appropriate because the safety of individuals in the nursing facility were endangered. While this is an acceptable reason for discharge, the facility did not meet the regulatory requirements related to discharging a resident.

Though the nursing facility contends that the appellant must be discharged because she is a danger to the other residents and staff, their actions indicate a lack of urgency. It is undoubtably concerning that the appellant has, on multiple occasions, been in possession of surgical blades, but the nursing facility has taken several steps that suggest that they do not feel that the appellant poses any immediate danger.

First, rather than issuing a notice of discharge after the first search of the appellant's room on April 23 yielded a surgical blade, the nursing facility met with the appellant, came to a "no harm agreement," and allowed her to remain as a resident, albeit subject to stricter supervision. When

another blade was found in her room on May 8, the nursing home repeated those same steps, and when two blades were recovered from her person on May 18, they again attempted to issue a no harm agreement rather than move toward discharge.

Second, it apparently took a physician three weeks to document the apparent danger the appellant poses to the facility and its residents. The nursing facility contends that the May 18 incident is what led to the issuance of the notice on June 7, but reports that the reason for the delay is that they were waiting for the physician to sign off on the proper paperwork. This lack of haste implies that there was not any immediate concern that the appellant presented a danger within the facility.

Third, and perhaps the most damning piece of evidence is that, despite the regulatory option to request an expedited hearing pursuant to 130 CMR 610.029(B)(1), the nursing facility chose to pursue a standard 30-day hearing. This indicates, again, that the facility did not believe that the there was any impending danger with allowing the appellant to remain in the facility. Additionally, there was no evidence that the appellant ever threatened anyone ("throwing" a piece of paper can hardly be considered menacing), she had, prior to April of 2023, been a resident without any issues for nearly a year, and there have been no documented incidents involving the appellant since May 18. It therefore strains credulity to suggest that the facility feels that the appellant is actively dangerous.

It goes without saying that the appellant's possession of these blades raises safety concerns for herself and others. However, it would appear that the appellant is, at present, abiding by her end of the no harm agreement. Should she deviate from that behavior, the facility would be within its rights to file an emergency discharge notice, provided it complies with G.L. ch. 111 §70E, 130 CMR 610.028, and any other applicable law.

As such, I find that the nursing facility has not met its burden of proof that the appellant endangers the safety of individuals within the nursing facility pursuant to 130 CMR 610.028(A)(3), and the appeal is thereby approved.

Order for MassHealth

Rescind the [redacted] 2023 discharge notice.

Compliance with this Decision

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

Mariah Burns
Hearing Officer
Board of Hearings

cc:
Appellant Representative: Shane Darcy, 11 John Alden Circle, Bellingham, MA 02019

[redacted]