Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2306485
Decision Date:	09/06/2023	**Hearing Date:**	08/23/2023
Hearing Officer:	Alexandra Shube		

Appearance for Appellant:
Via telephone:
Pro se

Appearance for Nursing Facility:
Via telephone:
Lakiya Jackson, Director of Social Services
Peter Murfitt, Administrator

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:**	30-Day Nursing Facility Discharge
Decision Date:	09/06/2023	**Hearing Date:**	08/23/2023
Nursing Facility's Rep.:	Lakiya Jackson; Peter Murfitt	**Appellant's Rep.:**	Pro se
Hearing Location:	Springfield MassHealth Enrollment Center Remote	**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 30-Day Notice of Intent to Discharge Resident dated July 10, 2023, [redacted] Rehabilitation and Skilled Care Center (hereinafter, "the facility") informed the appellant of its intent to discharge him on [redacted] because his health has improved sufficiently so that he no longer needs the services provided by the facility (see 130 CMR 610.028 and Exhibit 1). The appellant filed this appeal in a timely manner on August 2, 2023 (see 130 CMR 610.015(B) and Exhibit 2). Notification of intent to discharge or transfer an individual from a nursing home facility is a valid basis for appeal (130 CMR 610.032).

Action Taken by Nursing Facility

The facility informed the appellant of its intention to discharge him because his health has improved sufficiently that he no longer needs the services provided by the facility.

Issue

The appeal issues are whether: (1) the facility has valid grounds to discharge the appellant; (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 pursuant to MGL Ch. 111, § 70E.

Summary of Evidence

The facility was represented at hearing via telephone by an administrator and the director of social services and testified as follows: the appellant was admitted in [redacted] 2022 after a below-the knee amputation of his right leg due to osteomyelitis and a non-healing foot wound. On [redacted] his attending physician at the facility, stated that the appellant "has completed physical therapy… is independent with wheelchair and has prostheses and is able to do his own ADLs so patient would be safe to be discharged home from a physical therapist therapy [sic] standpoint and medically he is stable and would need to follow-up as outpatient with primary care for further care and management."

Based on [redacted] assessment, the facility found a placement at a rest home which the appellant declined because he felt it was too far away. Social services at the facility has been counseling the appellant about finding employment, to which he has been receptive. The appellant is independent with his activities of daily living (ADLs), can walk 500 feet, and has a power wheelchair he can use in the community for longer distances. Social services along with the local elder services agency have been working on finding housing for the appellant. They sent applications to two rest homes, including the original one which the appellant now feels is not too far away. The transitional advisor and the director of social services spoke to one of the rest homes on [redacted] and it had three openings available. At a rest home, the appellant can have services, such as the Visiting Nurses Association (VNA), come to him. Because he declined the rest home and had no other home in the community, the nursing facility proposed a local homeless shelter as the discharge location. The facility testified that he could be safely discharged to the shelter and could access needed services while residing at the shelter.

The appellant testified that he cannot walk 500 feet. He takes twelve different pills in addition to insulin injections and he cannot handle them on his own. They are too much for him manage and he does not know what he would do at the shelter with the needles for his insulin injections. He got a newer prosthetic one to one-and-a-half months ago and he has had falls since then. He was supposed to do physical therapy but it stopped because he missed a few appointments.[1] He does

[1] Documentation submitted by the facility confirms that the appellant was discharged from physical therapy on [redacted] because of "limited participation with PT plan of care and goals not met due to non compliance."

not feel ready to be discharged without any help. He also disagreed with [redacted] assessment because he has not seen or spoken to him in months. He stated he turned down the rest home because it was too far away and he was not ready to leave the facility since he was still doing physical therapy. He is now ready to accept a rest home placement, but he feels he still needs physical therapy. He felt there was no way he could safely go to the homeless shelter because he cannot manage his medications, particularly those for his diabetes. In addition to his diabetes, he also has congestive heart failure.

The facility responded that there is nothing about his medications that would prevent the appellant from administering them at the shelter. The facility can teach him how to manage his medications before discharge. If he is at a shelter, the facility can refer him to an agency to receive physical therapy and other services. Such a referral would be made before discharge, but these services have not been discussed yet. The facility also stated that at the shelter, the appellant would likely have a case manager and access to a lock box for his medications.

According to documentation provided by the facility, in addition to the right, lower leg amputation that occurred on [redacted] 2022, the appellant has the following diagnoses: type 2 diabetes mellitus, congestive heart failure, hypertension, major depressive disorder, anxiety disorder, hypercholesterolemia, and dyslipidemia.

Findings of Fact

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

1. The appellant has resided at the nursing facility since [redacted] 2022 after he had his right leg amputated below the knee (Testimony and Exhibit 4).

2. On July 10, 2023, the facility issued a 30-Day Notice of Intent to Discharge because the appellant’s health has improved sufficiently so that he no longer needs the services provided by the facility (Testimony and Exhibit 1).

3. The proposed discharge location is a homeless shelter in the community (Testimony and Exhibit 1).

4. In addition to the right, lower leg amputation that occurred on September 20, 2022, the appellant has the following diagnoses: type 2 diabetes mellitus, congestive heart failure, hypertension, major depressive disorder, anxiety disorder, hypercholesterolemia, and dyslipidemia (Exhibit 4).

5. The appellant requires insulin injections in addition to twelve oral medications (Testimony).

6. The appellant does not know how to manage his medications without assistance (Testimony).

7. The facility found a placement for the appellant at a rest home, but he initially refused it (Testimony and Exhibit 4).

8. The appellant's attending physician at the facility stated that he is medically stable; has completed physical therapy; is independent with wheelchair; has a prosthesis; and can perform his activities of daily living (ADLs) independently (Testimony and Exhibit 4).

9. The appellant was discharged from physical therapy for non-compliance and limited participation (Testimony and Exhibit 4).

10. The facility is actively working with the appellant and senior services to find a placement at a rest home where he could receive more support than at a homeless shelter (Testimony and Exhibit 4).

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 both at 130 CMR 456.000 and 130 CMR 610.000.

A "discharge" is "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." (130 CMR 456.002; see also 130 CMR 610.004.)
The requirements for a nursing facility discharge or transfer are:

> (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 MassHealth agency 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;

(130 CMR 610.028(A)-(C) (emphasis added); see also 130 CMR 456.701(A).)

Typically, a nursing-facility must provide 30-days-notice of its intent to discharge. 130 CMR 610.029(A).

Furthermore, in addition to the MassHealth-related regulations discussed above the nursing facility also has an obligation to comply with all other applicable state laws, including M.G.L. c.111, §70E, which went into effect in November of 2008. 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.[2]

This appeal is APPROVED. While there is documentation supporting that the appellant's health has improved sufficiently that he no longer needs the services provided by the facility, there are concerns regarding the safety and appropriateness of the nursing facility's discharge planning and location. The current discharge location is a homeless shelter where VNA services are not available. The appellant is adamant that he cannot safely handle his twelve medications plus insulin injections and is concerned about his ability to keep the needles for those injections at the shelter. The nursing facility stated that it would work on teaching the appellant how to administer his medication prior to discharge and would refer him to an agency where he can go for physical therapy and other services in the community; however, that preparation has not yet taken place. While medication assistance is not a need necessitating skilled nursing care, the facility has not shown that the appellant can safely manage his medications upon discharge to the homeless shelter. It is unclear how well the nursing facility would be able to "provide[] sufficient preparation and orientation to the resident to ensure safe and orderly … discharge" to a homeless shelter during the discharge timeline.

For these reasons, the appeal is approved.

Order for Nursing Facility

Rescind the July 10, 2023 discharge notice. Do not discharge the appellant under this discharge notice.

[2] The term "referee" in the statute refers to a Board of Hearings hearing officer.

Implementation of this Decision

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.

Alexandra Shube
Hearing Officer
Board of Hearings

cc:
[redacted]