Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2311628
Decision Date:	12/6/2023	**Hearing Date:**	11/27/2023
Hearing Officer:	Casey Groff, Esq.	**Record Closed:**	11/29/2023

Appearance for Appellant:
Pro se
[redacted] Ombudsman Program Director, Central Mass Agency of Aging, Ombudsman Program

Appearance for Nursing Facility:
[redacted] Administrator;
Director of Social Services;
LSWA, Social Services;
After-care Coordinator;
R.N., Director of Nursing

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 Home Discharge - Expedited
Decision Date:	12/6/2023	**Hearing Date:**	11/27/2023
Nursing Facility Rep.:	[redacted] Administrator, Worcester Rehab & Health Care Center, *et. al.*	**Appellant's Rep.:**	*Pro se*; Ombudsman
Hearing Location:	Board of Hearings (Remote)		

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 October 26, 2023, the Worcester Rehab & Health Care Center ("the nursing facility") issued an expedited notice to discharge Appellant to the community on November 2, 2023. See Exhibit 1; 130 CMR 610.029(B). On November 1, 2023, Appellant signed a request for a fair hearing to challenge the discharge notice and, with the nursing facility's assistance, attempted to fax the request to Board of Hearings (BOH) the same day. See Exh. 2. See 130 CMR 610.015(B)(4); Exhibit 2. An attempt to discharge a resident from a nursing facility is valid grounds for appeal. See 130 CMR 610.032(C). On November 13, 2023, the facility learned, after contacting BOH, that the request for hearing had not been received. See Exh. 5, p. 26 and Exh. 2. The same day, the facility resent Appellant's request, which BOH received and processed for scheduling. See Exh. 5, p. 26 and Exh. 2. BOH scheduled the hearing a hearing to take place on 11/21/2023. See Exh. 3. At the time of the scheduled hearing, all parties appeared; however, the ombudsman, whom Appellant selected to represent her at hearing, had not arrived. At Appellant's

request, BOH rescheduled the hearing to 11/27/23 to accommodate her appeal representative.[1] At the conclusion of the hearing on 11/27/23, the record remained open until 11/29/2023 for the parties to submit additional evidence.

Action Taken by Nursing Facility

The nursing facility sought to discharge Appellant in fewer than 30 days based on a determination that Appellant's behavior or clinical status endangered the safety of the individuals in the facility.

Issue

The issue on appeal is whether the nursing facility complied with the regulatory and statutory requirements to discharge a resident to the community.

Summary of Evidence

At hearing, the nursing facility was represented by its administrator, the director of nursing (DON), a licensed social worker, the director of social services, and the after-care coordinator, (collectively "the facility representatives"). The facility representatives testified that Appellant is an adult female under the age of sixty. On [redacted]23, Appellant was admitted to the nursing facility following a hospitalization for both medical and psychiatric treatment. Her primary diagnosis on admission to the facility was chronic obstructive pulmonary disease (COPD) with secondary diagnoses of major depressive disorder (MDD), opioid dependence, anxiety, congestive heart failure (CHF), cirrhosis of liver, chronic pain syndrome, osteoarthritis, post-traumatic stress disorder (PTSD), hypothyroidism, hypokalemia, hepatitis B and C, obesity, and past myocardial infarction. See Exh. 5, p. 2. She ambulates independently with a wheelchair.

The facility representatives testified that on 10/26/23, the facility issued an expedited discharge notice to Appellant seeking to discharge her to [redacted] Transitional Living Center (LTLC) after Appellant had a second instance of smoking in the room of a bed-bound patient on oxygen. While this was the primary basis for seeking discharge, the facility also noted Appellant, on at least two occasions, was in possession of smoking contraband, and that her behavioral outbursts, which

[1] Prior to the scheduled hearing, Appellant had not informed BOH that she designated a representative to assist her with the appeal. At the time of the hearing on 11/21/23, Appellant indicated that she met with an ombudsman who agreed to assist her with the appeal process. The facility stated that upon learning of the hearing date, it relayed this information to the ombudsman via voice message but had not yet received confirmation that she received the message. The hearing officer was able to reach the ombudsman by telephone. The ombudsman indicated that she had not received the message but stated she was able to participate in the hearing from her office by telephone. Appellant adamantly opposed going forward with the hearing without the ombudsman being physically present to assist her and noted that she felt outnumbered being in a room with multiple representatives from the facility. To assure due process, Appellant's request for a short reschedule was granted.

include verbal abuse of staff and residents, have posed further safety concerns for the individuals at the facility. Through testimony and documentary evidence, the facility provided the following background information regarding the hospital stay that preceded her admission to the facility:

On [redacted]23, Appellant was admitted to a hospital after she presented to the emergency department with shortness of breath and difficulty breathing. See Exh. 7 at 14. Prior to the hospital admission, Appellant was homeless and staying at a homeless shelter. Id. at 9. During her hospital stay, she was treated for acute hypoxic respiratory failure secondary to COPD exacerbation. Id. at 11. On 8/3/23, after being deemed medically stable, the hospital sought to discharge Appellant back to her shelter with instructions to follow-up with primary care. Id. at 14-20, 33.[2] See id. at 33

On [redacted]23, the date of her intended discharge, Appellant was instead transferred to the hospital's behavioral health unit for expressed suicidal ideation. See id. at 11. Appellant was voluntarily admitted for psychiatric treatment, stabilization of symptoms, medication evaluation, and assistance with discharge planning back to the community. Id. at 11, 34. On [redacted]23, a clinician entered a note regarding discharge planning with Appellant's treatment team. See Exh. 6, p. 21-23. The note described Appellant as being at her baseline functional mobility and that she was independent with wheelchair mobilization. See id. at 23. The clinician recommended that Appellant return home and that she may benefit from outpatient physical therapy (PT) "if appropriate for ambulation on discharge." See id. According to the clinician, Appellant "continued to decline all other after care options that [did] not offer skilled nursing." Id. She remained in the hospital's behavioral unit until her discharge and transfer to the nursing facility on [redacted]23.[3]

On [redacted]23, the hospital transferred Appellant to the nursing facility to receive short-term rehabilitation (STR). A social services admission note stated, in relevant part, the following:

> Resident … was admitted to Worcester Rehab on [redacted]23 for STR following hospitalization [redacted]…. with dx respiratory failure, copd exacerbation. [Past medical history]: cad, CHF, copd, gerd, obesity, chronic pain, anxiety, depression, SUDS- heroine/cocaine, PTSD, hep B. Prior to hospitalization she was homeless staying at […] Homeless shelter. She was w/c dependent. She reports that she has had frequent psych stays and has stayed at several STR facilities in [redacted] and [redacted] in the past 3 years. Her advanced directives were reviewed. She is a full code status. … She declines appointing an HCP at this

[2] The hospital records reflect that Appellant's prior shelter "refused to take her back" but did not indicate the basis for refusal. The social worker/case manager documented the hospital's continued efforts to locate a shelter that had availability with coordinated outpatient services. See Exh. 7 at 33.

[3] The hospital records indicate that at various points while Appellant was admitted for psychiatric care, she was temporarily transferred to other hospital units for arising health issues, including gastroenterology symptoms that were related to her cirrhosis. See Exh. 6 at 29.

time. She presents alert and oriented xs 3, able to recall st/lt memories. She received 15/15 on SIMS. She has dx depression, anxiety, SUDS abuse, PTSD. She is currently prescribed methadone, melatonin, clonazepam, trazadone, Neurontin. She has had multiple inpatient psych stays with multiple attempts of SI. There were no behaviors note/observed. She is participating in pt/ot services. Plan is to return to community once STR is complete. Social services will follow, monitor for changes/concerns, assist with d/c planning options available in community.

See Exh. 5, p. 35.

The nursing facility representatives detailed the incidents that occurred during Appellant's admission that prompted the need for her expedited discharge. While the facility focused primarily on the danger Appellant posed by smoking in an oxygenated room, it also noted Appellant's ongoing behavioral issues that compounded the current safety concerns. These instances were further detailed in Appellant's nursing facility records, which included, for example in chronological order, the following encounters:

- On [redacted]23, Appellant accused her roommate of breaking her television and became "very disruptive in unit." The nurse wrote that Appellant "threw ice water she was offered on the hallway" and prompted the need for security involvement. Id. at 22.

- A social service note dated [redacted]23, indicated that Appellant was transferred to another room/unit due to behaviors. Id. at 34. A separate nursing note that described the event indicated that during the room change, Appellant was "screaming, name-calling, yelling and cursing on everyone around." Id. at 21

- On [redacted]23, an LPN noted that she observed Appellant "yelling, cursing loudly in halls at CNAs and berating the nurse with a constant barrage of insults, complaints and curses." Id. at 20. According to another entry on this same date, Appellant met with the social worker and after care coordinator as she was requesting to return to community. When attempting to review her discharge options Appellant "kept yelling indicating she did not want to be at facility; however, refused to work with us regarding [discharge] planning and kept saying she was leaving on Monday. Id. at 33.

- On [redacted]23, a RN reported that Appellant was "screaming at the top of her lungs for hours calling the CNAs derogatory names and swearing profusely. At one point she pulled apart her bed linen after the CNA made her bed, throwing it on the floor and then trash, and demanding the CNA come back to change her bed. Id. at 19.

- On [redacted]23, a RN documented that during the [redacted] shift, Appellant was being verbally abusive toward other residents; that she "had to be stopped from attempting to

physically go after a patient in a "wheelchair;" and that she had been throwing towels with her feces into hallway. Id. at 18. The note further detailed Appellant's use of "constant profanity;" that she "constantly makes prejudicial statements towards Africans and African Americans;" that she "frequently threatens to throw things at people;" and that many patients complain of the constant screaming and swearing. Id. In the same note, the RN reported that Appellant placed her used tray after breakfast on the hallway floor which was a danger to other residents. Id.

- On [redacted]23, social services noted that Appellant "continue[d] to be behavioral with extreme verbal abuse towards staff and residents;" that she was "aggressive" towards another resident that evening; very difficult to redirect; and was refusing care. Id. at 33. Additionally, on the same date, the nursing supervisor made the following entry:

  [Appellant] is going into other resident[s] room and calling them names, verbally abusive towards staff and other residents, pacing around in [her wheelchair] and towards other residents. Unable to redirect. Behavior continues to escalate. Resident put herself on the floor, patient is harm to self and others. New order given by Dr. [redacted] *to section 12 patient out to Hospital for eval.* Id. at 17-18.

- On [redacted]23, the nursing supervisor observed Appellant "trying to hide a vape under her pants while sitting on the toilet." Id. at 12. When confronted, Appellant denied that she was the owner of the vape but verbalized her understanding of the facility policy to not keep a vape or cigarette in a non-smoking area or on the unit. Id.

- On [redacted]23, staff notified the nursing supervisor that Appellant was smoking in a room of another resident who has oxygen. The nurse noted that when she entered the room that "no cigarette [was] found, just the smell." Id. at 10-11. Additional progress notes state that Appellant "went to room 302 to smoke meanwhile there is oxygen in that room." Id. After the incident, Appellant was educated on risk involved with smoking in a nonsmoking area and areas where there is oxygen. Id.

- Progress notes from [redacted]23 indicated that Appellant was throwing used towels and dumping water on the floor, calling CNA's "slaves," and putting on the call light for no reason. Id. at 11.

- On [redacted]23, an LPN noted that when she tried to redirect resident from calling staff "pigs," Appellant threw a coffee cup at her while cursing at her and calling her names. Id. at 9.
- On [redacted]23, the nursing supervisor noted that while she was in Appellant's room to put her wheelchair away, she "noticed a vape under the cushion of the wheelchair." Id. at 7. Appellant admitted to owning vape but stated that she forgot to give it so staff to

be kept at the smoking area. Id. Appellant was educated on smoking policy and Appellant verbalized understanding. Id.; see also id. at 31.

- On [redacted]23, the facility substance abuse counselor (SAC) presented Appellant with a "no harm agreement" in response to the vape that was found in her room. Appellant signed the agreement; however, insisted that she forgot to return it to staff. Id. at 30. Appellant was again re-educated on the facility smoking policy. Id.

- On [redacted]23, Appellant was found, for the second time, smoking in an oxygenated resident's room. The nursing entry indicated that the room "smelt of smoke and perfume." Id. at 30. When confronted, Appellant alleged that the occupant of the room had been smoking, not her.[4] Appellant was subsequently moved to a different unit for safety issues.

- On [redacted]23, the SAC noted that during the room transfer, security found a nicotine vape and a single cigarette in Appellant's room. Id. at 29.

The nursing facility representatives testified that the events on [redacted] and [redacted] were the final instances that prompted the need for discharge. Accordingly, on [redacted] the facility social worker hand delivered a letter to Appellant entitled "Notice of Intent to Discharge Resident With Less than 30 Days' Notice (Expedited Appeal)." See Exh. 1. The notice informed Appellant that the facility sought to discharge Appellant to the [redacted] Transitional Living Center on November 2, 2023, because "*the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident. Two incidents of smoking in a patient's oxygenated room and other substance-related incidents.*" Id. at 1. Appellant appealed the discharge notice.[5] Id. at 5.

Appellant's physician, [redacted] M.D.,[6] wrote a letter in support of the facility's intended discharge. In the letter, Dr. [redacted] reviewed Appellant's medical history and explained that the discharge was appropriately issued after Appellant was "found smoking in the room of another patient who is bed-bound and dependent on oxygen." See Exh. 5, p. 3 and Exh. 6, p. 3. Dr. [redacted] further stated, in relevant part, the following:

> [Appellant] had several discussions with Nursing staff, substance abuse counselor (SCA), and social workers who warned her that continued behavior surrounding smoking contraband is a safety concern and could result in a discharge. The fact that [Appellant] was found to be smoking in an oxygenated room with an especially vulnerable patient twice is a great cause for concern, not only for [Appellant's]

[4] According to facility notes, the other resident denied smoking, stating Appellant was smoking in the room. Id.
[5] Social service notes indicate that that social worker explained the basis for the discharge to Appellant and aided her with pursuing an appeal of the notice. Id. at 26-29.
[6] The nursing facility noted that this is the physician for the facility and is the primary physician responsible for the care of all facility residents.

safety but everyone else in the building.

Id.

At hearing, the social worker testified that the [redacted] Transitional Living Center (LTLC) is a medical shelter for homeless individuals. The facility is familiar with this location, which caters towards individuals, like Appellant, who have medical issues but who do not require a skilled level of care. The facility representatives testified that LTLC offers onsite health care services and assigns case managers to each resident. This location will provide Appellant with a greater level of care than is provided by traditional homeless shelters, like where Appellant previously resided, and is a safe and appropriate discharge location. The DON testified that Appellant's functional status is "modified independent," meaning that she is independent with the use of her wheelchair and that she is listed as "supervision only" for all ADLs. A review of PT and OT notes show that Appellant was discharged from both therapies on [redacted]23 after reaching maximum potential or highest practical level. See Exh. 7, pp. 3-1. The facility representatives testified that Appellant has no skilled need to remain at the facility. She was admitted for short-term rehab services, which have been provided and that she is not coded for long-term care.[7]

The facility representatives from social services noted that Appellant is enrolled in a one-care plan with CCA and has an assigned has community care worker to help coordinate her Medicare and MassHealth benefits. The social worker explained that she made efforts to assist with discharge planning, including placements for VNA; however, Appellant has not cooperated with efforts assist her in discharge planning and has offered no alternative discharge location. Id. at 34-35. Appellant insists on remaining in a skilled nursing facility, but there is no medical need to justify her continued stay. The smoking violations expedited the discharge, but the plan on admission has always been to discharge her back into the community. Because Appellant receives methadone, social services discussed options to switch her clinic to one that is local to the LTLC. Id. at 29. Appellant will still receive community services available through CCA and MassHealth, including covered outpatient treatments and medical transportation.

Appellant appeared at the hearing and was accompanied by the Ombudsman, who is the Program Director for the Central Mass Agency of Aging. Throughout her testimony, Appellant adamantly denied the allegations that she had been smoking in the other resident's room. She stated she agreed to bring the other resident food because the resident was unable to get out of bed and asked her for food. The entire time, she was standing at the door as she is not allowed inside the resident's room. Appellant stated that the occupant of the room was smoking on both

[7] A review of nursing notes did not reflect Appellant receiving skilled care services. Nursing notes indicate that Appellant is monitored for respiratory symptoms and is repeatedly negative for shortness of breath or signs of respiratory distress. See Exh. 5, pp. 9 -25. Appellant's clinical record also reflects that she frequently refused care, including refusal of certain prescribed medications. Id. A nurses entry dated [redacted]23 reflected that Appellant was supervised by the nurse when transferred from her bed to her wheelchair safely. Id. at 10

occasions because her condition prevents her from going outside to smoke. Appellant characterized the facility's allegations as being "all lies" and stated that everyone from the facility was "against me and they do not want me here." Appellant also refuted the allegations that she was knowingly in possession of vape or cigarettes. She stated that the first time she signed the papers, but that in the subsequent instance, she had never used the vape, Appellant asserted that the smoking attendant gave her the empty vape cartridge. She explained security will buy vapes and cigarettes for other residents and felt she was being targeted. Additionally, she does not smoke cigarettes so the one that was found was obviously not hers.

Appellant testified that she cannot go to the medical center because they cannot care for her there. She is in a wheelchair and cannot walk. She needs assistance being put into bed. She receives methadone treatment in Springfield, and MassHealth will not provide transportation that would take her that distance. She requires skilled level of care and needs to be in a nursing facility. Appellant stated that she requires a higher level of care than can be provided at the medical shelter and that she was kicked out of her previous shelter because they told her she required a higher level of care. Appellant also challenged the accuracy of the nursing facility records that were submitted into evidence. Appellant stated that Dr. [redacted] letter was inaccurate and that it forgot about her cirrhosis, and that she requires three lactulose a day, and other medicines to clean out her liver.

The Ombudsman added that Appellant has not had any further smoking violations since she received the discharge notice.

In response, the nursing facility agreed that Appellant did not have further smoking violations since she received the discharge notice. When asked if this could serve as a basis for potential resolution, the facility unanimously indicated they wished to proceed with the discharge given the gravity of the past conduct. The nursing staff added that Appellant has been moved to multiple units and rooms, tried numerous interventions, and given multiple warnings. None of these efforts led to improvement in her behavior. The facility indicated a concern that if it were to rescind the notice, Appellant would resume her behavior.

Following the hearing, the parties were permitted to submit additional documentation in support of their respective positions. In her post-hearing submission, Appellant submitted medical documentation (Exhibits 8 and 9), including a [redacted]23 letter from her gastroenterologist stating that Appellant "*has a known diagnosis of cirrhosis and there is a concern for possible hepatic encephalopathy. This leads to a concern for altered mental status and falls. Given this concern we would not recommend discharge at this time.*" See Exh. 8, p. 1. She also provided encounter notes from a [redacted]23 orthopedic consultation for surgery. Id. at 2. The encounter notes reflect Appellant has "right knee end-stage osteoarthritis, previous left hip girdle stone, and limited ambulation." See Exh. 9 During the visit, Appellant informed the orthopedist that she cannot have further physical therapy, but "if she undergoes a total knee arthroplasty then she would be able to stay in her skilled facility." Id. While Appellant was

reportedly "adamant that she needed to undergo total knee arthroplasty," the doctor concluded that he could not recommend a surgical procedure due to concerns about her ability to recover successfully. Id. The encounter note concluded with orders for outpatient PT and outpatient injection angenicular nerve block. MD. Appellant's submission also included a confirmed follow-up visit and a prescription for an electric wheelchair. Id.

Findings of Fact

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

1. On [redacted]23, Appellant was admitted to the nursing facility following a hospitalization for both medical and psychiatric treatment. Her primary diagnosis on admission to the facility was COPD with secondary diagnoses of MDD, opioid dependence, anxiety, CHF, cirrhosis of liver, chronic pain syndrome, osteoarthritis, PTSD, hypothyroidism, hypokalemia, hepatitis B and C, obesity, and past myocardial infarction.

2. She ambulates independently with a wheelchair.

3. on 10/26/23, the facility issued an expedited discharge notice to Appellant seeking to discharge her to medical shelter.

4. Between [redacted]23 and [redacted]23, Appellant was hospitalized for acute hypoxic respiratory failure secondary to COPD exacerbation.

5. Prior to her hospitalization, Appellant was homeless and residing in a shelter.

6. Between [redacted]23 and [redacted]23 Appellant received psychiatric care in the hospital's behavioral unit.

7. On [redacted]23, the hospital transferred Appellant to the nursing facility to receive short-term rehabilitation including PT and OT.

8. Appellant was discharged from both therapies on [redacted]23 after reaching maximum potential or highest practical level.

9. Appellant's functional status is "modified independent," meaning that she is independent with the use of her wheelchair and that she is listed as "supervision only" for all ADLs.

10. Appellant has no skilled need to remain at the facility.

11. The facility documented repeated episodes of Appellant behavioral issues, including frequent outbursts, verbally abusing staff and residents, throwing items at or near staff and residents, resisting care, and being unable to be redirected during her outbursts.

12. On [redacted]23, the nursing supervisor observed Appellant trying to hide a vape under her pants while sitting on the toilet. When confronted, Appellant denied that she was the owner of the vape but verbalized her understanding of the facility policy to not keep a vape or cigarette in a non-smoking area or on the unit.

13. On [redacted]23, Appellant was found smoking in a room of another resident, who is bed-bound and on oxygen.

14. On [redacted]23, the nursing supervisor found a vape under the cushion of Appellant's wheelchair.

15. On [redacted]23, the facility substance abuse counselor (SAC) presented Appellant with a "no harm agreement" in response to the vape that was found in her room.

16. After each smoking violation, the facility_re- educated on smoking policy and risk involved with smoking in a nonsmoking area and areas where there is oxygen.

17. On [redacted]23, Appellant was found, for the second time, smoking in an oxygenated resident's room.

18. Appellant was subsequently moved to a different unit for safety issues.

19. On [redacted]23, during the room transfer, security found a nicotine vape and a single cigarette in Appellant's room.

20. On 10/26/23, the facility social worker hand delivered a letter to Appellant entitled "Notice of Intent to Discharge Resident With Less than 30 Days' Notice (Expedited Appeal)." The notice informed Appellant that the facility sought to discharge Appellant to the [redacted] Transitional Living Center on November 2, 2023, because "*the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident. Two incidents of smoking in a patient's oxygenated room and other substance-related incidents.*"

21. Appellant's physician, [redacted] M.D., wrote a letter in support of the facility's intended discharge noting that Appellant had several discussions with facility staff who warned her that continued behavior surrounding smoking contraband is a safety concern and could result in a discharge and stating that "The fact that [Appellant] was found to be

smoking in an oxygenated room with an especially vulnerable patient twice is a great cause for concern, not only for [Appellant's] safety but everyone else in the building."

22. The designated discharge location is a medical shelter for homeless individuals and providers case management and certain on-site health care services.

23. The DON testified that Appellant's functional status is "modified independent," meaning that she is independent with the use of her wheelchair and that she is listed as "supervision only" for all ADLs.

24. Appellant has not cooperated with the facility's attempts to assist her in discharge planning and has offered no alternative location where she can be discharged to.

25. Appellant refuted the facility's allegation that she was smoking in the oxygenated resident's room.

26. Appellant has not had additional instances of smoking violations since she was given the discharge notice on 10/26/23.

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.

MassHealth regulations at 130 CMR 610.028 set forth the requirements that a nursing facility must meet to initiate a transfer or discharge, and provides in part as follows:

> (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.

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

When the transfer or discharge is sought due to the circumstances specified in (3) 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).

In addition, the nursing facility must also demonstrate that it has complied with the requirements under M.G.L. c.111, §70E, which states, with emphasis added, 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.

Based on the applicable laws and regulations, Appellant has not demonstrated that the facility issued the 10/26/23 discharge notice in error. The facility cited proper grounds for discharge under 130 CMR 610.028(A)(3); specifically, that it considers Appellant's behavior to endanger the safety of other individuals in the nursing facility. The evidence indicates that on two occasions, Appellant was found smoking in the room of an oxygenated and bed-bound resident. She was also found in possession of smoking paraphernalia in violation of the facility smoking policy. As the facility explained at hearing, the risks posed by smoking indoors is significantly heightened in the presence of oxygen. Despite being given warnings and opportunities to correct her behavior, Appellant continued the harmful behavior violating the smoking policy repeatedly. See Exh. 5, p. 2. Additionally, the facility documented Appellant's frequent emotional and physical outbursts, including her verbal abuse of residents and staff. The facility demonstrated that the behaviors further compound the already present danger Appellant poses to the individuals in the facility. These instances, which were documented in Appellant's clinical record, by her physician, were cited as an appropriate basis for the facility's plan to expedite Appellant's discharge to the community. See Exh. 5, p. 2. The grounds for the intended discharge have been documented in Appellant's clinical record as required under 130 CMR §§ 610.028(B); 610.029(B)(1), above.

In addition, the facility demonstrated that it has met the requirements of G.L. c.111, § 70E, above, by discharging Appellant to her a medical shelter. While Appellant asserted that she needs to remain at a skilled facility due to her medical condition, there is no evidence to suggest that the

medical services she can obtain at the medical shelter and elsewhere in the community would be insufficient to address her needs.[8] The evidence shows that Appellant has completed all short-term OT and PT rehabilitation services; she does not require any skilled level of care; and she is able to manage most ADLs independently or modified independent with use of her wheelchair. Records reflect that Appellant receives primarily supervision assistance by nursing facility staff and monitoring of symptoms.[9] To the extent she does require assistance in the community, Appellant will continue to have access to case management and medical services offered through the center and her care coordinator through her One-Care program. There is no evidence that the facility failed to ensure a safe and orderly discharge of Appellant to a safe and appropriate location. See G.L. c.111, § 70E.

Based on the foregoing, the appeal is DENIED.

Order for Nursing Facility

Proceed with the discharge plan as set forth in the 10/26/23 notice. Discharge Appellant no sooner than five days from the date of this decision pursuant to 130 CMR 610.030(B).

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.

Casey Groff, Esq.
Hearing Officer
Board of Hearings

cc:

[8] In support of her position, Appellant offered into evidence a letter from her gastroenterologist dated [redacted]23, which advised against discharge given the "possible" concern she could develop cirrhosis-related hepatic encephalopathy which can lead to altered mental status and falls. See Exh. 8, p. 1. While the doctor's opinion may certainly be valid, it is not persuasive in this context. Specifically, the letter does not speak to Appellant's medial status, nor does it identify a current skilled need. Rather, the recommendation Appellant remain in the facility is based solely on the potential that Appellant *could* develop more serious symptoms. The letter also fails to address the repeated behaviors that the facility cited as endangering the safety of its residents and staff.

[9] Appellant's functional status is further corroborated by hospital notes that discussed the hospital's efforts to discharge Appellant back to a shelter in the community. There was no mention in the hospital records to indicate that Appellant required admission for skilled nursing care.

[redacted]

[redacted]