Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2402128
Decision Date:	2/26/2024	**Hearing Date:**	02/22/2024
Hearing Officer:	Sara E. McGrath		

Appearances for Appellant:
[redacted]

Appearances for Nursing Facility:
Peter Lorigan, Administrator
Bob Baker, Director of Nursing
Pauline Anderson, Director of Social Services

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:	2/26/2024	**Hearing Date:**	02/22/2024
Nursing Facility's Reps:	Peter Lorigan Bob Baker Pauline Anderson	**Appellant's Rep:**	[redacted]
Hearing Location:	Board of Hearings, Quincy (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 February 12, 2024, the skilled nursing facility, [redacted] ("the facility"), informed the appellant of the facility's intent to discharge him to [redacted] on February 26, 2024 (Exhibit 1). The appellant filed a timely appeal with the Board of Hearings on February 12, 2024 (130 CMR 610.015(B); 130 CMR 456.703; and Exhibit 2). On February 14, 2024, the Board of Hearings administratively dismissed the appeal due to missing documentation (Exhibit 3). The appellant subsequently submitted the necessary documentation; the Board then vacated the dismissal and scheduled the hearing. Challenging a notice of transfer or discharge initiated by a nursing facility is a valid ground for appeal (130 CMR 610.032(C)).

Action Taken by Nursing Facility

The facility notified the appellant of its expedited intent to discharge him to a local shelter.

Issue

The appeal issue is whether the facility can appropriately discharge the appellant to the location on its notice.

Summary of Evidence

The nursing facility was represented by its Administrator, the Director of Nursing, and the Director of Social Services, all of whom appeared by telephone. The record and testimony reflect the following chronology: The appellant, a male in his [redacted], was admitted to the facility in [redacted] after a hospital admission related to chronic alcoholism (seizures and falls). He has diagnoses including chronic obstruction pulmonary disorder, hypertension, and a mood disorder. He received some skilled services for a short period, but then transitioned to custodial care. He currently has no skilled needs and is independent with his activities of daily living. Staff assists the appellant with medication management, but the appellant has the cognitive and functional abilities to take his medications independently. He takes oral medications to treat his hypertension and his mood disorder and takes Tylenol as needed for pain. He can leave the facility independently, and sometimes leaves on Sunday to attend church with a friend.

The facility representatives explained that the facility seeks to discharge the appellant for two reasons. First, the appellant's health has improved such that he no longer needs the services provided by the facility. The facility representatives stated that the appellant can walk and is completely independent with his activities of daily living. The facility's medical director recently documented in the appellant's medical record that "he wishes to stay at the nursing home despite not having any skilled needs. He is independent level of care and no longer requires SNF services" (Exhibit 5, p. 9). The appellant appeared at the hearing by phone and, on this issue, stated that his health is worse now than when he arrived at the facility.

The facility representatives explained that the facility also seeks to discharge the appellant because the safety of individuals in the facility is endangered by the appellant's behavior. Specifically, the appellant has been rude and aggressive toward ancillary staff and other residents on many occasions. The appellant yells and screams and is unable to be redirected. On more than one occasion, the police have been notified during or after an event involving the appellant. The nursing facility representatives referenced the following episodes in the record:

> Late entry for [redacted] This resident became irate in the am, as he was convinced that all the nurse's [sic] aides were in the unit manager's office. He opened the office door and began harassing the two aides who were on break, and yelling at this nurse in a disrespectful manner. He also began yelling at one of the aides after her break was done. The aide told him that she is legally entitled to a break. Resident became more agitated and called this aide a "[redacted] and said "[expletive] you" as he walked away. A few minutes later, he came back to the office and locked the door. The aides' personal belongings were locked in the office and

maintenance staff had to come in to unlock the door.

(Exhibit 5, p. 1).

On [redacted], at approximately 10:50 am, resident #1 reported to a nurse that on the prior evening at around 5:40 pm, while resident #1 was retrieving ice for her drink from the cooler on the unit when resident #2 approached her and they exchanged words. Resident #2 left the area and returned a short while later and intentionally bumped into resident #1 and pushed her aside. Resident #1 then in turn pushed resident #2 back and the two residents separated from each other. Resident #1 states that she did not report the incident because she was upset by the ordeal and just left the area and went to her room and went to bed. The incident was not witnessed by any staff.

As soon as this was reported to staff an assessment was completed, by the licensed nurse, on Resident #1 and there were no bruises, marks, or discoloration noted.

An assessment was completed by the licensed nursing staff on Resident #1 and there were no bruises or marks, or discoloration noted. MD and local police were notified. Both residents will be followed by Psych and IDT for psychosocial monitoring. . . . .

At the time of the incident the environment was clear and uncluttered. Resident #1's behavior can be abrasive and sarcastic at times. Resident #1's medication regime will be reviewed for possible adjustments by psych services. Resident #2 can be impulsive and intrusive in an attempt to manage his environment. He is often demanding and is care planned for the same. To reduce risk of this reoccurring resident #2 will be educated on asking the staff for assistance to alleviate issues arising. Both residents will be followed by social services weekly for psychosocial well-being times 4 weeks. The residents both will be followed by the interdisciplinary team and psych as needed. The residents' care plans have been updated.

(Exhibit 5, p. 2).

Effective Date: [redacted] Type: Behavior

Behavior: Intrusive, Verbally aggressive, Disruptive
Intervention: Redirect no effect. Police involvement necessary
Outcome: Police spoke to resident regarding behavior

(Exhibit 5, p. 3).

Effective Date: [redacted] Type: Behavior
Behavior: this writer was at the third floor nursing station when [appellant] came off the elevator and began to yell loudly at the UM. He began to point his finger in her face and tell her that she does nothing, and she is violating everyone's rights. He was yelling regarding another resident, which was already being handled.
Intervention: this writer stepped between UM and resident, and asked [appellant] to please walk away. He continued to yell going down the elevator, and once on ground floor, began yelling loudly again to staff on the ground floor. UM came to check on other residents, and [appellant] began to point in her face again yelling "call the police, call the state." UM obtained an order to send to ED if resident escalates. [redacted] arrived, they spoke with [appellant] outside, and were unable to get him to listen. [redacted] stated they were on call and would come back quickly if he escalated again.
Outcome: continued to talk about staff and state how he does not want to be here.

(Exhibit 5, p. 4).

The facility representatives also referenced several grievance records wherein other residents have reported that the appellant makes mean comments, teases, antagonizes, and yells (Exhibit 5, pp. 5-6).

The appellant responded and stated that he does have a temper and tends to yell when he gets angry. Further, he did not have his psychiatric medication for several days, which makes things worse.[1] He feels he needs to be an advocate for other residents who cannot speak for themselves. Regarding the incident at the ice machine, he stated that he has never pushed or touched another resident. He got angry because the other resident was putting her hands in the ice machine and contaminating the ice, rather than waiting for staff assistance.[2] He took the ice away from her.

The facility's Director of Social Services explained that the discharge location, a local shelter, requires residents to leave during the day. In the evening, beds are available on a first come, first served basis. Residents can call in the morning and request to reserve a bed or come in person in the late afternoon. She stated that she feels that the appellant will be able to manage at the shelter. The appellant responded and stated that he wants to stay at the facility; he likes 90% of the people there. He has had a knee replacement in one knee and arthritis in the other; he heard that the area around the shelter is hilly, and he is worried about getting around. He explained that prior to his admission, he lived in a tent near the train tracks in [redacted] He lived there, on and off, for years, and was able to manage well.

[1] The facility's Director of Nursing noted that medication is always ordered in advance and if a shipment is delayed, the facility has on-site access to a supply of many medications, including the medication taken by the appellant for his mood disorder.
[2] The facility Administrator stated that the incident is on video, and his review of the video confirms that the appellant bumped the other resident as described in the written report above.

Findings of Fact

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

1. The appellant, a male in his 60s, was admitted to the facility in [redacted] after a hospital admission related to a chronic alcoholism.

2. The appellant currently has no skilled needs; nursing staff currently only assists the appellant with medication administration.

3. The appellant can independently manage his medications, which include medication to treat hypertension and a mood disorder, as well as Tylenol as needed for pain.

4. In recent months, the appellant has been verbally abusive toward staff and other residents; he cannot be redirected during these episodes.

5. The appellant was recently involved in an argument with another resident that involved physical contact; neither party was physically injured as a result of this incident.

6. On February 12, 2024, the facility issued an expedited discharge notice, seeking to discharge the appellant to a local shelter because his health had improved and because his behavior has endangered others in the facility.

7. On February 12, 2024, the appellant timely appealed this discharge notice.

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*.

130 CMR 610.028 sets forth the notice requirements for transfers and discharges initiated by a nursing facility, 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.

(B) 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).

In this case, the facility initiated discharge proceedings because it determined that the appellant's health has improved and because his behavior has endangered the safety of individuals at the facility.

As noted, the facility seeks to discharge the appellant because his health has improved such that he no longer needs nursing facility services. The parties agree that at the time of his facility admission two years ago, he needed skilled services for a period. The parties also agree that the appellant no longer requires any skilled services. The facility medical director has recently documented that the appellant is independent and no longer requires skilled nursing facility services (Exhibit 5, p. 9). On this record, the facility has demonstrated that discharge based on improved health is justified.[3]

Further, the facility has satisfied its obligation under the applicable laws and regulations. The nursing facility has an obligation to comply with all other applicable state laws, including M.G.L. c.111, §70E. 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.

[3] The facility also determined that the appellant's behavior has endangered the safety of individuals at the facility. In light of my conclusion regarding the appellant's improved health, an analysis of whether discharge is appropriate on this alternative basis is unnecessary.

In this case, the discharge location is a local shelter. While it is understandable that the appellant would prefer an alternative housing arrangement, he has not demonstrated that the shelter poses a safety risk. The appellant lived in a tent in the woods for years and, in his own words, did just fine. A shelter, while perhaps not an ideal destination, can offer the appellant protection from the elements, as well as a bed, a meal, and staff support. The facility has met its burden and has satisfied the requirements of M.G.L. c.111, §70E.

The appeal is denied.

Order for the Nursing Facility

Proceed with planned transfer, to be implemented no less than five days after 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 Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Implementation

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.

Sara E. McGrath
Hearing Officer
Board of Hearings

cc: [redacted]