Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2418526
Decision Date:	1/8/2025	**Hearing Date:**	12/19/2024
Hearing Officer:	Casey Groff	**Record Closed:**	01/03/2025

Appearance for Appellant:

[redacted]

Appearance for Respondent/Nursing Facility:
Tara Verge, Administrator
David Barrasso, M.D., Medical Director
Rebecca Cousins, 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:	Approved	**Issue:**	Nursing Facility Discharge; Expedited; Failure to Readmit
Decision Date:	1/8/2025	**Hearing Date:**	12/19/2024
Respondent Reps.:	Tara Verge; David Barrasso, M.D.; Rebecca Cousins	**Appellant's Reps.:**	[redacted]
Hearing Location:	Board of Hearings, 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 notice dated 11/28/24, the Respondent, [redacted] a nursing and rehabilitation center ("the nursing facility"), informed Appellant with less than 30 days' notice of its intent to not readmit him from the hospital. *See* Exhibit 1 and 130 CMR §§ 610.028(A)(2), 610.029(8)(2). Appellant, through his mother/health care proxy (HCP), filed a timely appeal on 12/4/24. See 130 CMR 610.015(B); Exhibit 2. An involuntary discharge of a nursing facility resident, including the failure to readmit the resident following a hospitalization, is valid grounds for appeal. *See* 130 CMR §§ 610.032(C), 610.012(5). A hearing was initially scheduled for 12/9/24. *See* Exh. 3. At Appellant's request, the hearing was rescheduled to 12/19/24. *See* Exh. 5. The hearing record remained open through 1/3/25 for the parties to submit additional evidence. *See* Exhs. 6-10.

Action Taken by Nursing Facility

The Respondent nursing facility notified Appellant that it would not readmit him to the facility following his hospital stay.

Issue

The issue on appeal is whether the facility met all requirements established under federal and state law when it discharged Appellant to a hospital with less than 30 days' notice by informing him that it would not readmit him following his hospital stay.

Summary of Evidence

Representatives for the Respondent nursing facility appeared at hearing by telephone and through documentation and testimony, presented the following evidence: Appellant is a MassHealth member under the age of 65 with a history of traumatic brain injury (TBI), cardiovascular accident (CVA) with left-sided hemiplegia, hypertension, hyperlipidemia, epilepsy vascular dementia, urinary incontinence, difficulty walking, muscle weakness, anxiety, and depression. *See* Exh. 11, p. 111.

The facility representatives testified that Appellant was admitted to the nursing facility for short-term rehabilitation after being hospitalized with rib fractures. *Id*. at 110-111. He has since completed all rehabilitation services and his short-term benefit has ended.[1] Prior to admission, Appellant lived by himself in an apartment via Section 8 housing. *Id*. At the time of admission, documentation indicates that his discharge plan was "unknown or uncertain" but he was considering long-term care (LTC) given his dementia and increased needs. *Id*.

The facility testified that since his admission, Appellant has engaged in continuous hypersexualized behavior comprised of inappropriate comments, unwanted touching of staff members, and threatening behavior, all of which have required frequent intervention and redirection from staff. The progress notes submitted by the facility during the record-open period indicate that nursing staff and social services routinely documented such instances. *Id*.

Approximately one month into his admission, Appellant was accused of inappropriately touching another resident and being physically and verbally abusive toward staff. *Id*. at 56. The incident was reported to DPH. A certified nurse practitioner (CNP) for the facility, on assessment, found that Appellant was "presenting as an imminent risk of harm to others" and recommended he be sent to the hospital for a "Section 12" evaluation. *See* Exh. 11, p. 54-66. The facility representatives testified that upon his return from the hospital, the facility started Appellant on a new psychotropic medication and increased its oversight of his behaviors, including 1:1 supervision and 15-minute safety checks. With the new interventions and medications, Appellant's behaviors improved but did not completely subside. *Id*. at 12-13. The ongoing

[1] Appellant's MassHealth benefit is managed through the Commonwealth Care Alliance's (CCA) ICO program. A document provided by Appellant's representatives shows that following his Medicare short-term benefit, CCA approved Appellant for under a custodial level of care. *See* Exh. 9.

behavioral issues continued to be documented in progress notes by nursing staff and social services. *Id.* at 8-16. For example, on [redacted]24, the director of nursing wrote that the Appellant continued with sexually inappropriate statements toward female staff but was "redirected easily" and that he was "not a threat to other resident's safety, although his behavior is inappropriate." *Id.* at 8. The facility testified that they did not have the staff capacity to continue the extent of supervision and care that was necessary to ensure Appellant would not harm other residents.

The facility representatives testified that on [redacted]24 – [redacted]– Appellant entered the room of [redacted] female resident who has Parkinsons and is non-ambulatory. The director of nursing noted the incident, in which the resident reported that Appellant was "socially inappropriate with her and approached her while she was sitting in her wheelchair, which upset her." *Id.* at 1. At hearing, the facility representatives explained that his approach caused the resident to "scream" in fear, to which the Appellant responded something to the effect of, "don't scream, you're mine." The documentation indicates that "staff immediately intervened preventing any assault or physical contact between the 2 residents, which was confirmed by the resident and [her] family." *Id.* Through a different entry on [redacted]24, a facility RN noted that the incident amounted to a "change in condition" prompting him to be sent to the hospital. *Id.* at 2-3. In a late entry on [redacted]24 (applicable to [redacted]24) social services noted that Appellant was transferred to the hospital on [redacted]24 due to threatening and attempting to psychically assault a female resident and that "Transfer notice (do not re-admit) was provided by nursing, family informed [and that the social worker] will continue to be available to provide psychosocial support as needed." *Id.*

A partial copy of the discharge notice was submitted by Appellant at the time he filed his fair hearing request, however, only the first page was included. *See* Exh. 1. None of the facility submissions contained a full copy of the notice. The available documentation shows that the facility, through a notice dated [redacted]24, informed Appellant that it "does not intend to readmit you to [the facility address] following your release from [the hospital of transfer] [based on the reason that] the safety of the individuals in the nursing facility would otherwise be endangered." *Id.* Though the facility documented in a progress note that it had informed Appellant's family of the transfer, the notice does not list any "representative" that would receive a copy of the notice. *Id.* Additionally, the address listed for Appellant was for his apartment in the community. According to the fair hearing request, Appellant confirmed that he received the discharge notice on 11/28/24. *See* Exh. 2. Additionally, Appellant's mother signed the fair hearing request on 12/4/24, at which time, the appeal was faxed to BOH. *Id.*

Among the representatives that appeared at hearing on behalf of the facility, was the facility medical director, [redacted] testified that Appellant's chronic hypersexualized behavior dates back many years and stems from a TBI which he sustained approximately 40 years prior, following a stroke. Appellant is prone to urinary tract infections (UTIs) due to having a neurogenic bladder, which can exacerbate his behavioral issues. The medical director clairified that even when he is at his baseline, Appellant's behaviors pose a risk

to the safety of other individuals in the facility. [redacted] testified that, as the medical director for the facility, he oversees the well-being of *all* facility residents – a large portion of whom are medically frail and vulnerable to Appellant's behaviors. The medical director testified that he supported the decision to not readmit Appellant to ensure the safety of the other residents. He also indicated that prior to hearing, he read recent psychology assessent notes, which has been "eye-opening" and raised further safety conerns. The medical director and facility representatives could not say for certain whether the medical director or other physician documented the basis for the discharge in the Appellant's record, but that it could provide something in writing.

During the record open period, the resident's record was updated via a progress entry by the medical director dated [redacted] 24, which stated that "after an incident of inappropriate behavior toward a female resident with Parkinson's dementia and inability to ambulate, [Appellant] was discharged to [the hospital] with a plan to not readmit him to the center due to safety concerns." *See* Exh. 11, p. 1.

The facility representatives testified they made efforts, unsuccessfully, to discharge Appellant to another facility. According to Appellant's record, earlier in his admission, there had been discussion of discharging Appellant back into the community. *Id.* at 106. In a 9/18/24 discharge planning meeting, social workers from the facility, Appellant's community advocates and his mother addressed their concern that Appellant required more structured care than could be offered in the community, due to his dementia. *Id.* at 84. The facility representatives testified that they had been actively sending referrals to various rehabiliation and nursing centers, but none had accepted Appellant. *Id*. at 10-16. Additionally, the facility sought placement for Appellant at another one of its locations [redacted] that has a behavioral unit, but ultimately this location was unable to accommodate Appellant.

Following the hearing, the facility submitted documentation including the hospital's [redacted] 24 psychiatric report. *See* Exh. 12. The report documented that Appellant "does not meet Section 12 critieria." *Id.* In addition, the evaluating provider noted that Appellant had been seen by multiple psychiatric providers in the ED and, per the record and assessments, agreed that Appellant "has significant cognitive impairment due to stroke making his brain substrate vulnerable at baseline lowering threshold for potential deliruum." *Id*. The entry continued to state the following:

> On admission [Appellant was] found to have UTI, which may explain recent changes/escalation in behavior and with treatment has improved. Pt continues to be calm, cooperative and pleasant. He does not endorse any symptoms consistent with depression, mania or anxiety. He denies any safety concerns, feels safe in the hospital. Despite making inappropriate comments, he has remained in good behavioral control and responsive to redirection. While the patient awaits placement, it is reasonable to set up and engage in a behavioral

plan focused on modifying the current behavior…

Appellant was represented by two case managers from an entity funded by the statewide head injury program. The representatives explained that they have been involved in Appellant's case for several years. It was their position that Appellant's hypersexualized behavior only became apparent earlier this year, after a UTI compounded his existing brain injury, and that he had not returned to baseline since.

Prior to admission, Appellant remained financially stable through his Section 8 housing voucher. He was able to rely on community supports, but over time it became evident that due to his physical decline in mobility and progressing dementia, he was not safe living independently. According to Appellant's representatives, the facility agreed that once Appellant's short-term benefit ended, they would pursue a conversion to long-term care. Appellant's representatives testified that both the facility and CCA representatives assured them that Appellant could remain at the facility until a bed became available at the other facility location. When Appellant's short-term benefit ended, CCA authorized a conversion to allow Appellant to remain at the facility under custodial care. *See* Exh. 9. Appellant's representatives obtained a letter from the facility business office manager, dated 11/4/24, confirming that Appellant would remain at the facility for long-term care "as he can no longer care for himself." *See* Exh. 8. The effect of the conversion from short term to custodial care caused the housing authority to release Appellant's Section 8 voucher. The Appellant's representatives testified that they were never informed that the other facility revoked its decision to accept Appellant.

Appellant's representatives testified that Appellant did not meet the requisite criteria to be admitted to the hospital's psychiatric unit. He is currently held on a medical floor while the representatives, and hospital staff, look for alternative discharge locations. Combined, they have issued over 60 referrals to various locations, including [redacted] Hospital; however, all requests have been denied. Appellant cannot be discharged to the community without housing and would not survive a homeless shelter. The representatives asserted that until an appropriate discharge location is secured, Appellant should be readmitted to the facility.

Findings of Fact

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

1. Appellant is a MassHealth member under the age of 65 with a history of TBI, CVA, left-sided hemiplegia, hypertension, hyperlipidemia, epilepsy vascular dementia, urinary incontinence, difficulty walking, muscle weakness, anxiety, and depression. (Testimony; Exh. 11).

2. Appellant was admitted to the nursing facility for short-term rehabilitation after being hospitalized with rib fractures and he has since completed all rehabilitation services.

(Testimony; Exh. 11).

3. Prior to admission, Appellant lived by himself in Section 8 housing; however, since his admission his Section 8 voucher ended. (Testimony).

4. During his admission, Appellant has continuously engaged in hypersexualized and socially inappropriate behavior with residents and staff.

5. The facility implemented numerous interventions to address Appellant's behaviors, including initiating a new psychotropic medication, increased 1:1 supervision, and 15-minute safety checks, which did not entirely resolve his behaviors.

6. On [redacted]24, Appellant entered the room of [redacted] female resident with Parkinsons and approached her while she was sitting in her wheelchair, causing her to scream in fear, and prompting the Appellant to make threatening remarks to the resident. (Testimony; Exh. 11).

7. On [redacted]24, following the incident, the facility transferred Appellant to the hospital at which time, Appellant was informed, via a facility notice, that it would not readmit him following his hospitalization because "the safety of the individuals in the nursing facility would otherwise be endangered." (Testimony; Exh. 1; Exh. 2; Exh. 11).

8. The notice included Appellant's address from his apartment in the community and did not identify a representative that would receive a copy of the notice. (Exh. 1).

9. On 11/28/24 Appellant signed the fair hearing request, disputing the discharge, and on 12/4/24, his mother, as his representative, signed the fair hearing request. (Exh. 2).

10. A hearing was conducted on 12/19/24. (Exhs. 4-5).

11. A physician progress note dated [redacted]/24 entered by the facility medical director, indicated that "after an incident of inappropriate behavior toward a female resident with Parkinson's dementia and inability to ambulate, [Appellant] was discharged to [the hospital] with a plan to not readmit him to the center due to safety concerns." (Exhibit 11, p. 1).

12. No other physician entries were identified in the documentation to support the discharge aside from the [redacted]24 entry. (Exh. 11).

13. During his admission, the facility made efforts to secure an appropriate discharge location for Appellant, however, as of the date of discharge, none of the locations indicated it could accept him. (Testimony; Exh. 11).

14. Following his admission to the hospital Appellant underwent various psychiatric assessments and was not deemed to have met Section 12 protocal to warrant admission to the hospital's psychiatric unit. (Testimony; Exh. 12).

15. According to a hospital psychiatric report dated [redacted]24, Appellant was found, on admission to the hosptial, to have a UTI, which the psychiatric provider noted "may explain recent changes/escalation in behavior and with treatment has improved." (Exh. 12).

16. As of the hearing date, Appellant remained in the hospital on a medical floor; and despite placing numerous referrals to various locations, all such admission requests have been denied. (Testimony).

Analysis and Conclusions of Law

The federal Nursing Home Reform Act (NHRA) of 1987, now codified at 42 USC 1396r(c), guarantees all nursing facility residents the right to advance notice of, and the right to appeal, any transfer or discharge initiated by such a facility. In compliance with the NHRA, Massachusetts has enacted statutory and regulatory requirements that mirror the federal resident rights protections, which are found in M.G.L. c. 111 § 70E and MassHealth regulations at 130 CMR 456.000 *et seq*., and 130 CMR 610.00 *et. seq*.

In addition, MassHealth has adopted federal protections that require nursing facilities to implement bed-hold policies for resident's placed on a medical leave of absence (MLOA). [2,3] Specifically, when a nursing facility transfers a resident/member to a hospital for acute medical care, the facility is required to hold the member's bed during their MLOA *and* is required to readmit the resident following hospitalization either immediately (when the period of hospitalization was 20 days or less) or to the next available bed (if the hospitalization was longer than 20 days), provided that the member continues to require nursing facility services.[4] *See* 130 CMR §§ 456.426(C), 456.428.

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[2] Pursuant to 130 CMR 456.402, the term "Medical Leave of Absence (MLOA)" is defined as "[a]n inpatient (or observation) hospital stay for an individual who is a resident of a nursing facility."

[3] Federal law at 42 U.S.C.A. § 1396r(iii) requires that a nursing facility establish and follow a written policy under which a resident (I) who is eligible for medical assistance for nursing facility services under a State plan, (II) who is transferred from the facility for hospitalization or therapeutic leave, and (III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident.

[4] If a facility fails to adhere to its bed-hold policy, MassHealth may impose administrative sanctions. *Id.*

A facility's failure or refusal to readmit a resident following a MLOA, is considered both a "discharge" and "transfer" under the relevant regulatory definitions. *See* 130 CMR §§ 456.402, 610.004. As such, the facility must adhere to the same requirements applied to traditional discharge/transfers, to ensure that the discharge/transfer of the resident whom they are refusing to readmit, is lawful and appropriate. *See* 130 CMR §§ 456.701(D), 610.029(C). Specifically, the facility cannot discharge a resident, unless the following requirements are met:

First, a resident may be transferred or discharged *only* in 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); 130 CMR 456.701(A); 42 USC § 1396r(c)(2)(A).

Second, when a transfer or discharge is necessary under subsections (3) or (4) above, as is the case here, the resident's clinical record must be documented by "a physician." *See* 130 CMR §§ 610.028(B)(1), 456.701(B)(1).

Third, the facility must ensure that the physical notice of discharge/transfer is formatted and delivered in accordance with the requirements set forth under 130 CMR 610.028(C). In summary, this provision requires the facility to: hand-deliver the notice to the resident; mail a copy of the notice to any designated family member or legal representative known to the resident; ensure the notice is legible and written in a language the resident understands; and ensure that the notice contain: (1) the action to be taken by the nursing facility; (2) the specific reason for discharge/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/her right to appeal the notice and right to seek free legal assistance through their local legal services office, (6) contact information for the local long-term-care ombudsman office and, if applicable, the contact information of the agency(s) responsible for the protection and advocacy of developmentally disabled individuals and/or mentally ill individuals; and (7) the name of someone at the nursing facility who is available to assist the resident with any of the

foregoing. *See* 130 CMR 610.028(C).

Fourth, the nursing facility must provide the resident with timely notice of the discharge/transfer. Generally, the facility must provide the resident with at least 30 days' notice before the date of the intended transfer or discharge. See 130 CMR 610.029(A). In lieu of the 30-day notice requirement, subsection (B) of § 610.029 allows the facility to give notice "as soon as practicable *before* the discharge or transfer in any of the following circumstances, which are considered to be emergency discharges or emergency transfers:"

(1) 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.
(2) The resident's health improves sufficiently to allow a more immediate transfer or discharge and the resident's attending physician documents this in the resident's record.
(3) An immediate transfer or discharge is required by the resident's urgent medical needs and this is documented in the medical record by the resident's attending physician.
(4) The resident has not lived in the nursing facility for 30 days immediately before receipt of the notice.

See 130 CMR 610.029(B)(emphasis added); *see also* 130 CMR 456.701(B).

Subsection (C) of § 610.029 provides that when the transfer or discharge is the result of a nursing facility's failure to readmit a resident following hospitalization or other MLOA, the notice must be provided to the resident and an immediate family member or legal representative, if such a person is known to the nursing facility, at the time the nursing facility determines that it will not readmit the resident. *See* 130 CMR 610.029(C).

Finally, before a nursing facility may discharge a resident, it must comply with the requirements set forth 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****.*

See also 42 USC 1396r(c)(2)(C) (a nursing facility must provide sufficient preparation and orientation to resident to ensure safe and orderly transfer or discharge from the facility).

Appellant, through his representatives, sufficiently demonstrated that Respondent failed to comply with the aforementioned requirements by discharging Appellant to the hospital on [redacted]24. It is noted that, with respect to the first requirement, the facility did demonstrate proper grounds for discharge under 130 CMR 610.028(A); i.e., that it considers Appellant's

behavior to endanger the safety of other individuals in the nursing facility. The documentation submitted during the record open period corroborated the facility's testimony that Appellant engaged in ongoing sexually inappropriate behaviors, involving unwanted physical and verbal contact, including threats, of facility residents and staff. *See* Exh. 11. Given the facility's high population of medically frail residents who are particularly vulnerable to such behavior, the Respondent has an understandable and legitimate basis in seeking Appellant's discharge.

However, even when the facility demonstrates an appropriate basis for the discharge, it still must ensure all remaining criteria are met. As explained above, when discharging a resident pursuant to § 610.028(A)(3), the resident's clinical record must be documented by a physician. *See* 130 CMR 610.028(B). For expedited discharges, this requirement is again imposed, essentially as a precondition of the expedited discharge itself. Specifically, the facility *cannot* discharge a resident with less than 30-days' notice, *unless* "[t]he 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) (emphasis added). Notwithstanding the credible and persuasive testimony presented by the facility's medical director at hearing, it was not evident, upon reviewing the Appellant's clinical record, that a physician had documented the discharge until [redacted]24 - the day following the hearing. Although the regulations do not set an explicit timeframe for when the physician entry must be made, the regulatory language implies a timeliness component, which should at least coincide with the time of discharge. Given the urgent nature of Appellant's discharge, it is understandable that the facility may have been unable to obtain the requisite documentation before or immediately after the discharge occurred. However, the absence of any documentation by a physician in Appellant's record until nearly a month following the discharge fails to meet the standard imposed under 130 CMR §§ 610.028(B) and 610.029(B)(1).[5]

The more pronounced issues raised in this appeal, however, concern the timeframe in which the facility "notified" Appellant of the discharge, as well as the discharge location. A discharge based on a refusal to readmit a resident implies that a hospitalization or MLOA has already taken place (or is underway). But that is not what occurred in this case. The notice informing Appellant that the facility would not readmit him was issued contemporaneously with the [redacted]24 transfer itself. While there is little authority on this issue, the Centers for Medicare and Medicaid Services' (CMS) *State Operational Manual (SOM)*, *Appendix PP*, offers some guidance.[6] It states that in examining whether a discharge that has been made due to the resident's behavior, is appropriate, the reviewer must ensure that "the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility." *See SOM, App.*

[5] It is also noted that the first page of the notice did not appear to have a correct address for Appellant, nor did it identify a "representative" for the resident. It is also noted that despite these deficiencies, Appellant was appropriately served with (and received) the notice, and the facility documented that it informed Appellant's family when the transfer/refusal to readmit occurred. *See* Exhs. 2 and 11.

[6] CMS, through the *State Operations Manual*, provides guidance to states on the certification and oversight of Medicaid Programs. A copy of *Appendix PP* – which was last issued on 8/8/24 - can be found online at: https://www.cms.gov/medicare/provider-enrollment-and certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

PP, § F622. This is further described in § F626, of *Appendix PP*, which offers the following guidance on implementing federal regulation at 42 CFR §483.15(e)(1), *Permitting Residents to Return to Facility*:

> A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on his or condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to [communicate with the hospital regarding the resident's status upon receiving treatment in the hospital setting and to assess whether the facility can appropriately resume care for the resident].[7]

By providing notice of its refusal to readmit Appellant contemporaneously with Appellant's hospital transfer, the facility did not have an opportunity to evaluate Appellant in the hospital following the [redacted]24 incident. Notably, a psychiatric report dated [redacted]24 indicated that on admission, Appellant was found to have a UTI, "*which may explain recent changes/escalation in behavior and with treatment [he] has improved. [Appellant] continues to be calm, cooperative and pleasant*." *See* Exh. 12. Regardless of whether this finding would have changed the facility's position that it could resume care for Appellant, it serves to demonstrate why it is not appropriate for a facility to "base the discharge on the resident's status at the time of transfer to the acute care facility." *See SOM, App. PP*, § F622.

Lastly, the selected discharge location did not meet the statutory requirements imposed on the nursing facility under MGL c. 111, §70E. According to the evidence, Appellant was admitted to the facility to receive short-term rehabilitation. During the course of his stay, the discharge plan focused on finding a more structured living situation than Appellant had in the community.[8] The representatives of the facility stated that despite efforts and referrals to

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[7] The specific steps identified in *Appendix PP*, state that the facility should: (1) Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services. (2) Ascertain an accurate status of the resident's condition—this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital. (3) Find out from the hospital the treatments, medications, and services the facility would need to provide to meet the resident's needs upon returning to the facility. If the facility is unable to provide the treatments, medications, and services needed, the facility may not be able to meet the resident's needs. For example, a resident now requires ventilator care or dialysis, and the nursing home is unable to provide this same level of care. (4) Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to: Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return; Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.

[8] In addition, the evidence indicates that because Appellant remained at the facility following his short-term benefit, Appellant lost his Section 8 voucher and could no longer return to his apartment.

secure placement at other nursing and rehabilitation facilities, they could not find a location that would accept him. The hospital is undisputedly a *safe* location for Appellant, but it is not an *appropriate* discharge location. It is not within the purview of the hospital to provide non-acute skilled care on a long-term basis. While the hospital transfer for an evaluation was justified, there is no evidence that Appellant, as of the hearing date, had any medical need to remain in the hospital. Specifically, the evidence indicates that Appellant, pursuant to the hospital's assessment on arrival, did not meet the criteria to be involuntarily committed to the hospital's psychiatric unit under M.G.L. c. 123 § 12(b). As of the hearing date, Appellant remained on a medical floor until the hospital, or an advocate on his behalf, could find a suitable discharge location. While the nursing facility has a legitimate and understandable interest in ensuring that its staff and residents remain safe from Appellant's behaviors, it may not displace its legal obligations upon the hospital, by prematurely relinquishing legal responsibility over Appellant's care.

Accordingly, the appeal is APPROVED.

Order for Nursing Facility

Upon receipt of this decision, the nursing facility must promptly readmit the resident to the next available bed. *See* 130 CMR 610.030(D).

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, at the address on the first page 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.

Casey Groff
Hearing Officer
Board of Hearings

cc:

[redacted]