



Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd Floor, Cranston, RI 02920
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August 31, 2015

Hearing Date 08-26-15
Docket # 15-1805



17 Castleton Street
Jamaica Plains, MA 02130

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) and Agency policy reference(s) were the matters before the hearing:

- RI Executive Office of Health and Human Services**
- MEDICAID CODE OF ADMINISTRATIVE RULES
- SECTION: 0376.40.10 NF Patient Appeal Rights
- SECTION: 0376.40.10.15 Pre-Transfer/Discharge Notice

The facts of your case, the Agency Rules and Regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: your daughter, your Alliance representative, Administrator [redacted] and Tom Conlon.

Present at the hearing were: your daughter, your son, your Alliance advocate, [redacted] attorneys, two CNAs, the social worker and the Administrator of [redacted] (Via telephone)

ISSUE: Were the proper steps taken to discharge the appellant from the Nursing Home?

EOHHS Rules and Regulations: Please see the attached APPENDIX for pertinent excerpts from the Executive Office of Health and Human Services Medicaid Code of Administrative Rules

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:**The Nursing Home's attorney presented:**

- The Appellant is being transferred / discharged from the facility for behavior that is a danger to self or others.
- The facility sent out letters to the Appellant's daughter, the Appellant and the ombudsman from the Alliance for Better Long Term Care on July 31, 2015.
- The Appellant's letter was hand delivered.
- The Appellant has had behaviors that are unacceptable to the facility involving both staff and other residents.

- [REDACTED]
- She has worked at [REDACTED] for four and a half years.
 - She has cared for the Appellant.
 - On May 19, 2015, she was assisting the Appellant from the bathroom to her chair. The Appellant had her walker and as the CNA was seeing her safely to her chair the Appellant reached back and slapped her wrist. The Appellant then began trying to kick the CNA. The CNA still stayed with the Appellant to make sure she did not fall. When they got to the Appellant's chair and the Appellant was turning around to sit she slammed her walker into the CNA.
 - As soon as she was sure the Appellant was safe she went and reported the incident to the nurse.
 - There was also another employee with the CNA at the time of the incident.
 - She believes that the Appellant's actions were intentional and the Appellant was trying to hurt her.
 - She is not aware of the Appellant's diagnoses.
 - No other residents have made her feel that she was in danger of personal harm.
 - She has not cared for the Appellant since the incident occurred.

CNA [REDACTED] testified:

- She has worked at [REDACTED] for over five years.
- She has provided care to the Appellant.
- On November 10, 2014 she was caring for the Appellant.
- When she went into the Appellant's room and told her it was time to do her care and the Appellant stated that she was not going to get up.
- The CNA reported this to a nurse.
- She gave the Appellant ten more minutes per her request.
- The Appellant still refused to get up at 11:30 A.M.
- The CNA washed the bottom of the Appellant in bed. She asked the Appellant to get up with her walker to do her top. The Appellant told the CNA to hold her hand but the CNA told the Appellant she had to use her walker to stand.
- The Appellant then grabbed the CNA's wrists and when the CNA lifted her hand the Appellant spit in her face.
- She asked the nurse to come into the Appellant's room.
- The Appellant left marks on her wrists.
- She no longer does the Appellant's care.
- The Appellant always said negative and hurtful things to her.
- She has no knowledge of the Appellant's diagnoses.
- The Appellant is capable of standing up on her own using her walker.

The Administrator of [REDACTED] testified via speakerphone:

- She has been the Administrator of [REDACTED] for twenty months.
- She is familiar with the Appellant.
- She is familiar with the care and treatment of the Appellant.
- In November 2014, there was an incident involving the Appellant and a staff member that she had to address.
- The incident was a physical assault on one of her staff members.
- At this time and going forward she became more involved in the Appellant's care and treatment.

- In November 2014 it was reported to her by one of her staff that they had been assaulted by the Appellant. The staff member reported that her wrists were grabbed by the appellant and that marks were left from her nails. It was also reported that the Appellant had spit in the staff member's face.
- She spoke with the Appellant and informed her that behavior involving physical assault and spitting at staff would not be tolerated at Bethany Home. She told the Appellant that if this kind of behavior continued she would have to leave Bethany Home.
- The Appellant stated she would like another chance and she would not behave that way again.
- On April 2, 2015 she was advised of an incident regarding the Appellant throwing a urine soaked brief across her room to her roommate's side of the room.
- The roommate's family members were offended and outraged by this.
- The Appellant's daughter was called to advise her of the incident and discuss care.
- The Alliance for Better Long Term Care was also called and Med Options regarding psych care.
- She called the alliance shortly after this incident to seek information as to what she could do to assist this resident.
- LTC (Long Term Care) Ombudsman came to the home and met with the Administrator and the Appellant.
- The Appellant was advised that if she did not change her behavior she would not be allowed to stay at [REDACTED].
- The Ombudsman, the Administrator and the Appellant came up with a plan regarding the Appellant's behavior that included; covering up her private areas, not screaming to or at the staff, using her call button and not swearing,
- The Appellant's bad behavior had been escalating and people were becoming fearful.
- The Appellant had been continuously educated by the staff as to using the call light instead of screaming.
- Skirts were purchased for the Appellant to wear as she usually did not wear anything below the waist and this was not proper because visitors and male staff had to go in the room and she was exposed.
- Although the Appellant would put the skirt on she would roll it up above her waist.
- Throughout the Appellant's residency at [REDACTED] she always refused to wear clothing below the waist. She would sit on a liner on her chair and walk uncovered to the bathroom.

She was continuously encouraged to cover herself for her "own dignity and for roommate relations as well".

- On May 19, 2015, CNA [REDACTED] reported to me that she was physical assaulted by the appellant. The CNA was encouraged to call the police.
- The CNA had been punched, kicked and slammed with a walker by the appellant.
- The CNA was fearful for her safety after this incident.
- She feels the police should have been called.
- She discussed the thirty day notice after this incident.
- She had a meeting with the Appellant's daughter after this incident. They discussed the incident and she told the Appellant's daughter that she was at her wits end as to what to do for the Appellant; she had brought in many professionals at this point. The nursing facility had been continuously working with the Appellant to try and modify her behavior. She did not want to give the Appellant a thirty day notice; however, felt she had no alternative, especially because of the physical assaults.
- The daughter stated she would appeal because she did not want her mother to leave the facility.
- Even after this meeting the Appellant's behavior continued. A new roommate came into the Appellant's room, she was very elderly and her family complained that she was being bullied by the Appellant. A complaint was made to the Department of Health and written statements from family were obtained; however, due to confidentiality they cannot be introduced here.
- The facility is required by law to report this type of incident to the Department of Health.
- The roommate's family feared for her physical and emotional safety due to the Appellant's actions. The roommate was moved to another room.
- She now decided that the Appellant should receive a thirty day notice.
- The patients' Bill of Rights is posted in several areas in the facility.
- The Appellant was given behavioral health evaluations at the facility.
- Dr. [REDACTED] completed these evaluations.
- The last evaluation was completed in April 2015. All prior evaluations did not find the Appellant to be a danger to self or others, but the April 6, 2015 evaluation did.
- On July 31, 2015 the Appellant was given a pre transfer/ discharge notice.

- The notice set out reasons for the transfer/discharge.
- The behaviors were documented in the Appellant's clinical record, including; aggressive and assaultive behavior towards residents and staff, screaming and yelling, swearing, indecent exposure and bullying.
- Due to the Appellant's incontinence and refusal to wear a brief and refusal of care, her room often has an offensive odor. This infringes on the quality of life of other residents.
- The Appellant refuses to use the call light and screams for staff to come into the room to do things for her.
- The Appellant's daughter was also notified that the facility intended to transfer/discharge her mother.
- There have never been any resident complaints against the two CNAs involved in incidents with the Appellant.
- The Appellant was followed by Med Options for psychiatric care.
- It is the facilities practice to invite each resident to their care meetings as well as a family member.
- The facility's medical director has a strong medical opinion about serving alcohol to residents as he believes it does not interact well with other medications.
- It has been her experience that when you send a resident to an ER for a psych evaluation they return without any positive impact on their care.
- The Appellant was not moved to a private room because it would not change her behaviors but reward her for bad behaviors.

The LTC Ombudsman testified:

- When someone is admitted to a facility with a diagnosis of dementia there is an expectation that some accommodations will be made for that resident due to diagnosis.
- The Appellant was never sent out to a hospital for a psychiatric evaluation.
- The Appellant stayed in a double room even after it was stated that she was verbally assaultive.
- It was suggested that the Appellant be moved to a private room.
- In the spring of 2015 the alliance and the Appellant had a meeting with the Administrator.
- She was not aiming at the roommate when she threw urine soaked brief.
- She does not dispute the Appellant's behavior or that she was warned she could be discharged because of her behaviors.

The facility social worker testified:

- Her name is [REDACTED] and she has worked for [REDACTED] for about five months.
- She is aware of the Appellant.
- She was informed of the Appellant's behaviors during her first week of work for the facility.
- She was informed that the Appellant had thrown a urine soaked brief at her roommate's visitors during her first week working at the facility.
- The next month the Appellant assaulted a staff member and the social worker contacted the Alliance for Better LTC and discussed the fact that she was going to speak to the Appellant about finding another residence.
- She spoke with the Appellant on May 27, 2015 and asked her to find another residence because her recent behaviors were unacceptable. The Appellant was told that the Alliance had been notified and was in agreement that the Appellant could no longer reside at the [REDACTED]
- The Appellant asked if she would be given a second chance and was told that she had been given many chances. The Appellant said okay.
- The facility waited for the Alliance to get in touch with the Appellant's daughter to help her find a new facility.
- The Appellant was always invited to her care meetings but did not want to attend.

The appellant's daughter testified:

- They have been aware that their mother's behaviors leave a lot to be desired; however, they do not feel that she is a danger to self or others.
- The facility did keep them updated about significant events.
- They feel more is expected of their mother than should be expected of someone with her diagnoses.
- She had conversations in the spring that there was a possibility of transfer/discharge; however did not realize that it had moved to intent to transfer/discharge.
- There was no mention of behavior or the discharge in the care meeting on August 3, 2015.
- The phone call she received prior to the notice talked about the chance of discharge only.
- She never had a face to face meeting before the notice was issued.

- At the care meeting on August 3, 2015, the Administrator said it's not like the Appellant had Dementia. The nurse did indicate that the Appellant has a diagnosis of mild Dementia with behavioral disturbances.
- The diagnosis always included mild Dementia with behavioral disturbances.
- When her mom first arrived at the nursing facility she had a CT scan and it was reported to her daughter that it indicated that her mother had a history of micro-vascular strokes and early Dementia.
- Don't facilities expect certain behaviors that go along with a diagnosis of Dementia?
- Was their mom invited to care meetings; she never attended one. Her behavior did not improve due to expecting a meeting.
- She has not been seen through the lens of her diagnoses.
- She had been told that the facility may want to discharge but it was not aware it was their absolute intent.
- The Appellant's sister in-law died before she moved in and she does not remember it now even though it was a significant occurrence in her life.
- Also they had another aunt who [REDACTED] thirty years ago and this was a very significant family event. Their mother does not remember that.
- They do not expect her to act like a well person because she is not a well person.
- She does not believe her mother is capable of intending to act the way she does.
- Before her mother was admitted to the facility she used to drink about 16 to 20 oz. of alcohol a day.
- When her mother was first admitted to the facility she had a prescription for 4oz. of alcohol a day. Her doctor felt that if she stopped drinking all together she would go into severe withdrawal.
- On March 6, 2015 the prescription was no longer active at the facility. She would not receive alcohol in the facility any longer. She called her son very agitated about this.
- They are actually happy she is not drinking anymore but were not advised of this before it was stopped.
- The note in the record said that her son was notified, but he was not. The inaccuracy of the note concerns her.
- Their mother did sit undressed below the waist at home before she was admitted to the nursing facility.

- None of the people who are perfectly comfortable taking care of her mom were heard from.

FINDINGS OF FACT:

- The Appellant was given a letter dated July 31, 2015 informing her that she would be transferred/discharged from the nursing facility.
- The Appellant's POA was also sent a pre- discharge Notice dated July 31, 2015.
- The Appellant filed a request for hearing received by the Agency on August 7, 2015.
- The Appellant still resides at the facility that issued the discharge notice.
- The hearing took place on August 26, 2015.

CONCLUSION:

The issue to be decided is whether the Appellant was given proper advance notice of transfer/discharge from a Nursing Home.

A review of the Agency's rules and regulations regarding involuntary transfers/discharges finds that the Nursing Facility (NF) must provide the patient with a DHS-200NF (Notice of Your Transfer and Discharge Rights) and a copy of a DHS-121NF (Request For a Hearing) form at the time that they issue the 30-day pre-discharge or pre-transfer notice.

The Nursing facility (NF) Administrator testified that the appellant was properly notified of her appeals rights and a copy of the form; therefore, she was given proper notice of the facility's intent to discharge her. According to testimony, the nursing facility sent all proper paper work. The NF provided evidence that the appellant had been notified of rules governing the facility when she was admitted.

The NF provided proof that the Appellant had ongoing behavior problems that she was counseled about many times. The Appellant's POA testified that they did not dispute behaviors but rather the intent of the behaviors considering the Appellant's diagnoses.

Further review of Agency Rules and Regulations reveals that Section 1919 (e) (3) of the Social Security Act requires States to provide appeal hearings for all nursing facility residents who wish to challenge their transfers or discharges. By statute, the appeals process cannot be limited to only Medical Assistance eligible nursing facility residents. Therefore, DHS will conduct administrative hearings for any NF resident who wishes to appeal a transfer or discharge from the facility, whether

Medical Assistance or Medicare eligible, or private pay. The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if; the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility, the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the health of individuals in the facility would otherwise be endangered. The basis of the transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

Before effecting a transfer or discharge of a resident, a nursing facility must: notify the resident (and, if known, an immediate family member or legal representative of the resident) of the transfer or discharge and of the reasons for the move and record the reasons in the resident's clinical record. The nursing facility must notify the resident by use of a Pre- Transfer or Pre-Discharge Notice (DHS-100NF) at least thirty (30) days in advance of the resident's transfer or discharge. At the time the resident receives the Pre-Transfer or Pre-Discharge Notice, s/he receives a Notice of Your Transfer and Discharge Rights (DHS-200NF) and a copy of Request for a Hearing (DHS-121NF).

In this case the Appellant received all required notices. The Alliance for better Long Term care ombudsman was also sent this notification as was the Appellant's daughter. Although the Appellant's daughter testified that she did not receive it, the facility social worker testified that she sent it and that the mail was not returned. It should be noted that at the time of the notice the Appellant's daughter was her financial power of attorney; therefore the nursing facility did notify in writing everyone they should have. The Appellant's daughter was contacted by the nursing facility and the Alliance by phone and made aware of the intent to discharge or transfer.

In this case the Appellant's daughter argues that she should not be held accountable for her behaviors in light of her diagnosis of mild Dementia. The facility argues that they have consistently worked with the Appellant to try to help her receive the care she needs in their facility (this is verified in the clinical record); however as her behavior has continued to escalate to physical and verbal abuse to staff and other residents she has become a danger to the health and welfare of other residents and herself. It is documented in the Appellant's clinical record that she has become a danger to self and others as required by the rules and regulations.

Although the Appellant's daughter argued that her prescription for alcohol had been changed without prior notice, the Appellant's behaviors are well documented in the clinical record before and after the change in the prescription. There is voluminous evidence as well as sworn testimony that the Appellant's behaviors were unacceptable and that she and her family were warned many times that this was a reason that would lead to transfer or discharge. The ombudsman from the Alliance was also notified on more than one occasion and was aware of the situation. The ombudsman met with the Appellant to no avail.

The Appellant's daughter testified that the facility did not look at the Appellant through the lens of an unwell individual; however the members of the facility care team all testified to their continued efforts to re-direct the Appellant's behaviors.

After a careful review of the Rules and Regulations, as well as the evidence and testimony given, this Appeals Officer finds that the appellant was issued a proper pre-transfer/discharge notice; therefore, her request for relief is denied.



Geralyn B. Stanford

Appeals Officer

APPENDIX

0376.40.10 *NF Patient Appeal Rights*

REV:06/1994

Section 1919 (e) (3) of the Social Security Act requires States to provide appeal hearings for all nursing facility residents who wish to challenge their transfers or discharges. By statute, the appeals process cannot be limited to only Medical Assistance eligible nursing facility residents. Therefore, DHS will conduct administrative hearings for any NF resident who wishes to appeal a transfer or discharge from the facility, whether Medical Assistance or Medicare eligible, or private pay.

0376.40.10.05 Transfer Discharge Criteria

REV: 06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- o The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- o The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- o The health of individuals in the facility would otherwise be endangered.

The basis of the transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.10 Documentation Requirements

REV:06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- o The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- o The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- o The health of individuals in the facility would otherwise be endangered;

The basis or transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.15 Pre-Transfer/Discharge Notice
REV:06/1994

Before effecting a transfer or discharge of a resident, a nursing facility must:

- o Notify the resident (and, if known, an immediate family member or legal representative of the resident) of the transfer or discharge and of the reasons for the move; and,
- o Record the reasons in the resident's clinical record (including any required documentation).

The nursing facility must notify the resident by use of a PRE- TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF) at least thirty (30) days in advance of the resident's transfer or discharge. At the time the patient receives the Pre-Transfer or Pre-Discharge Notice, s/he receives at the same time a NOTICE OF YOUR TRANSFER AND DISCHARGE RIGHTS (DHS-200NF) and a copy of REQUEST FOR A HEARING (DHS-121NF).

Thirty (30) day advance notice is not required under the following circumstances:

- o In the event of danger to the safety or health of the individuals in the facility;
- o When the resident's health improves sufficiently to allow a more immediate transfer or discharge;
- o Where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs;
- o When the resident has not resided in the facility for a period of at least 30 days.

In the case of such exceptions, notice must be given as many days before the date of the move as is practicable, and include:

- o The right to appeal the transfer or discharge through the administrative appeals process;
- o The name, mailing address, and telephone number of the State long-term care ombudsman.

In the case of residents with developmental disabilities, the pre-transfer or pre-discharge notice must include:

- o The mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

The resident must request an appeal within thirty (30) days of the date of the pre-transfer/discharge notice.

0376.40.05.05 Involuntary Relocation Restrictions

REV:06/2000

The Nursing Home Resident Protection Amendments of 1999 prohibit the transfer or discharge of residents from a nursing facility as a result of the facility's voluntary withdrawal from participation in the Medicaid Program.

Individuals residing in a nursing facility on the day before the effective date of the facility's withdrawal from MA participation may not be transferred or discharged as a result of the facility's withdrawal. This includes residents receiving MA benefits at the time, as well as individuals who are residents but not yet eligible for MA.

To continue receiving MA payments, the nursing facility must comply with all Title XIX nursing facility requirements related to treating patients residing in the facility in effect at the time of its withdrawal from the program.

Involuntary relocation of a resident patient is permitted when the basis for discharge or transfer is:

- * to meet the resident's welfare and that welfare cannot be met in the facility;
- * the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- * the safety of individuals in the facility is endangered;
- * the health of individuals in the facility would otherwise be endangered;
- * the resident has failed, after reasonable and appropriate notice, to pay (or have paid by Medicare or Medical Assistance) for a stay at the facility; or
- * the facility ceases to operate.

0376.40.10.20 Administ Appeals Process
REV:06/1994

The Department of Human Services will conduct administrative hearings for any nursing facility resident who wishes to appeal a transfer or discharge from the facility. The patient or patient's representative may request a hearing by completing Sections I and II of DHS form, REQUEST FOR A HEARING (DHS-121NF). The hearing request form should then be routed promptly to the Department of Human Services, Hearing Office, 600 New London Avenue, Cranston, RI 02920. Upon receipt, the Hearing Office will date stamp the form and send a copy with a letter to the nursing facility instructing the facility to complete Section III and return the form to the Hearing Office within seven (7) days.

The request for a hearing must be submitted within 30 days of the date of the PRE-TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF). If the request is submitted within 10 days of the date of the PRE-TRANSFER OR PRE-DISCHARGE NOTICE (DHS-100NF), the patient will remain in the facility pending the decision of the Hearing Officer.

The administrative hearing generally will be conducted at the resident's nursing facility unless otherwise requested by the patient or the patient's representative. Official notice of the hearing is sent to all parties involved at least five (5) days prior to the scheduled hearing date.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Executive Office of Health and Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

