STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED
Oct 02, 2019
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 19N-00085

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative nursing home discharge hearing in the above-referenced matter at 9:00 a.m. on August 27, 2019, at [redacted]

APPEARANCES

[redacted]

ISSUE

At issue is whether the respondent's (Facility) action to discharge the petitioner due to: (1) needs cannot be met, (2) the health of other individuals is endangered, and (3) the safety of other individuals is endangered, is proper. The Facility carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. Appearing as witnesses for the Facility wer [redacted] and the petitioner's [redacted] Appearing as a witness for the petitioner was [redacted]. Appearing as observers we [redacted]

The respondent submitted five exhibits, entered Respondent Exhibits "1" through "5". The petitioner submitted five exhibits, entered Petitioner Exhibits "1" through "5". At the request of the petitioner's representative, the record remained open for Proposed Orders. The record remained open until September 10, 2019, for the Proposed Orders. Neither party submitted Proposed Orders by the required date (September 10, 2019). The record was closed on September 11, 2019.

FINDINGS OF FACT

1. The petitione [redacted] was transferred from a hospital to the Facility in August 2017 for rehabilitation and remained as a long-term resident (Respondent Testimony).

2. HE [redacted] testified the petitioner i [redacted]

3. Prior to the action under appeal, the Facility had a secure unit (known as 300 secure unit), with a 16-bed capacity, since at least 2015. The secure unit had locked doors, which required door codes to enter; residents in the secure unit were restricted to the secure unit, unless authorized to leave the unit (Respondent Testimony).

4. Due to the petitioner's elopement issues, the petitioner was transferred to the secure unit shortly after being admitted to the Facility (Respondent Testimony).

5. In early 2019, the Facility considered making the secure unit a regular unit, because the majority of the residents had "aged in place" and a need for the secure unit was no longer necessary; 13 of the 16 beds were occupied (Respondent Testimony).

6. The Facility representative testified that he had numerous discussions with Facility Department Heads including the [redacted] and the petitioner' [redacted] prior to making the decision to no longer have a secure unit.

7. On April 17, 2019, the Facility representative mailed a letter to the residents' family members (Respondent Exhibit 3). The letter in part states:

> The facility has also decided that effective May 21st, we are going to operate the 300 secured unit as a regular non secured unit. There are several reasons why we have come to this decision, one of them being that many of our residents no longer require to be on a secured unit. Each resident will be evaluated by their doctor prior to May 21st to determine if they continue to require to reside on a secure unit. Our goal is to keep everyone residing at Ocean View. If your loved one is determined that they require to reside on a locked unit then the facility will assist in finding the closest most suitable facility to relocate to, but again our goal is not to relocate anyone. We will have these discussions with you on an individual basis.

8. The petitioner's representative argued that the Facility chose to close the secure unit and stated, "there was no necessity to close the secure unit".

9. Between April 17, 2019 and May 21, 2019, the Facility completed a trial to monitor the residents in the secure unit in an unsecure environment, dedicated CNA's monitored the residents; the secure unit doors were opened at different times of the day and night (Respondent Testimony).

10. Daily during the trial, Facility staff reported status of how the residents were adapting in the unsecure environment to the Director of Nursing and the Facility

representative. The petitioner was the only resident identified as "exit seeking", she would ambulate throughout the Facility; staff would redirect the petitioner from the exit doors (Respondent & three witnesses Testimony).

11. Once during the trial, Facility staff were instructed to conduct a test and not stop the petitioner from exiting the Facility (while monitoring the petitioner), to see if the Facility alarm sound would prevent the petitioner from exiting. The alarm did not deter the petitioner from exiting; staff had to redirect the petitioner back into the Facility and away from the exit doors (Respondent & three witnesses Testimony).

12. On May 22, 2019, due to the petitioner's exit seeking, notable anxiety, and aggressive behavior, HE ordered the petitioner be placed on one-on-one supervision, with a wonder guard on her leg. The petitioner remained on one-on-one supervision for 75 days, between May 22, 2019 and August 5, 2019 (Petitioner Exhibit 3, page 6).

13. The one-on-one supervision caused the petitioner to become highly agitated, she stated that, "someone was following her" and was cursing, yelling at staff and peers and attempting to elope (Respondent & three witnesses Testimony).

14. The petitioner's representative argued that the Facility must accommodate the petitioner's needs of one-on-one supervision in accordance with 42 C.F.R. § 483.70, "Facility Assessment".

15. Discussions between the Facility and the petitioner's daughter about transferring the petitioner to a secure Facility started in May 2019; due to the petitioner's high risk of elopement and the fact that the one-on-one supervision could not continue "forever" (Respondent Exhibit 4).

16. Also in May 201 [redacted] informed the petitioner's daughter that she had located several secure Facilities to transfer the petitioner. The petitioner's daughter requested the process wait until she returned from her vacation (Respondent Exhibit 4).

17. HE testified that he assessed the petitioner on July 2, 2019; the petitioner was confused and was wondering the Facility. HE recommended the petitioner be transferred to a secure Facility, because the Facility could not handle her needs (Petitioner Exhibit 3).

18. Also on July 2, 2019, the Facility issued a Nursing Home Transfer and Discharge Notice, reason for transfer "Your needs cannot be met in this facility." (Respondent Exhibit 1). The notice was signed by the Facility representative and [redacted] The notice states, "Patient needs a secure unit due to advance dementia and wandering".

19. The petitioner's Care Plan identifies "current status" of the petitioner's behavior and was updated prior to the Nursing Home Transfer and Discharge Notice(s). The Care Plan notates the petitioner behavior with elopement, risk/wandering, high agitation, and cursing due to dementia and psychosis (Respondent Exhibit 4).

20. Medical & Behavioral Health documentation completed by [redacted], dated between [redacted] state the petitioner h [redacted] (Petitioner Exhibit 2).

21. The petitioner's representative argued that in accordance with Medical & Behavioral Health (dated August 2, 2019), the Facility staff needed to review the petitioner's

Behavior Support Plan (dated July 5, 2018) to know how to deal with the petitioner's behavior (Petitioner Exhibit 2).

22. Behavior Support Plan, dated July 5, 2018, (Petitioner Exhibit 2, page 9 of 32) in part states:

[redacted]

[redacted]

24. The petitioner's representative argued that the petitioner has had a history of walking, which was part of her normal routine.

2 [redacted], said the Facility was aware the petitioner had a history of walking and it was a non-issue when the secure unit existed because of the locked doors.

26. Progress Notes between May 22, 2019 through August 5, 2019, indicate the petitioner's daughter was kept informed of the petitioner's status, including her [redacted]ng (Petitioner Exhibit 3 and Respondent Exhibit 4).

27. HE testified that on August 5, 2019, the petitioner had a [redacted] consequently, the petitioner had to be isolated, so the [redacted]

28. HE said the petitioner would not stay in her room which made her a risk to herself by attempting to elope and a risk to others by spreading the [redacted]; therefore, HE had the petitioner [redacted]

29. Certificate of Professional Initiating Involuntary Examination, dated August 5, 2019, completed by [redacted]Respondent Exhibit 5), states in part:

[redacted]

30. On August 5, 2019, the Facility issued a Nursing Home Transfer and Discharge Notice, reasons for discharge "(1) Your needs cannot be met in this facility, (2) The health of other individuals in this facility is endangered and (3) The safety of other individuals in this facility is endangered." (Respondent Exhibit 2). The notice was signed by the Facility representative and HE. The notice states, "Patient risk to herself,

trying to get out of the Facility, patient risk to others due to ESBL in urine, unable to keep on isolation."

31. On August 16, 2019, the petitioner was discharged from [redacted] to [redacted] (Respondent Exhibit 3). The petitioner remains [redacted] (Petitioner's witness Testimony).

CONCLUSIONS OF LAW

32. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

33. Title 42 of the Code of Federal Regulations § 483.15, Admission, transfer and discharge rights, in relevant part states:

> ...
> (c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility **unless—**
> **(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;** (emphasis added)
> (B) 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;
> **(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;**
> **(D) The health of individuals in the facility would otherwise be endangered;** (emphasis added)
> (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after

> admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (F) The facility ceases to operate…

34. In accordance with the above authority, the Facility Discharge Notice(s) lists three of the six reasons a Facility may involuntarily discharge a resident: (1) needs cannot be met, (2) the health of other individuals is endangered, and (3) the safety of other individuals is endangered.

35. Florida Statutes, Title 29, Section 400.0255, Resident transfer or discharge; requirements and procedures; hearings, in relevant part states:

> …
> (3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant…

36. In accordance with the above authority, the Discharge Notice(s) were signed by the Facility Administrator and the petitioner's physician.

37. Title 42 of the Code of Federal Regulations § 483.15, Admission, transfer and discharge rights, in relevant part states:

> …
> (2) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
> (i) Documentation in the resident's medical record *must* include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

38. The evidence submitted establishes that the petitioner's clinical records were documented, pursuant to the above authority; prior to the discharge notices.

39. Title 42 of the Code of Federal Regulations § 483.40, Behavioral health services, states in relevant part:

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
(2) Implementing non-pharmacological interventions.
(b) Based on the comprehensive assessment of a resident, the facility must ensure that—
(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma

> **and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;** (emphasis added)

40. In accordance with the above authority, the Facility implemented a one-on-one supervision safety plan for the petitioner.

41. The evidence submitted establishes the petitioner's one-on-one supervision continued for 75 days.

42. The petitioner's representative argued that the Facility must accommodate the petitioner's needs of one-on-one supervision in accordance with 42 C.F.R. § 483.70, Facility assessment.

43. Title 42 of the Code of Federal Regulations § 483.70, Administration, in part states:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident…
> **(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:**
> **(1) The facility's resident population, including, but not limited to,**
> **(i) Both the number of residents and the facility's resident capacity;**
> **(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;**
> **(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;** (emphasis added)
> (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and

> (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services…
> **(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law**… (emphasis added)

44. The above authority does not mention that the Facility must provide indefinite one-on-one supervision to one resident; in this case the petitioner. On the contrary, it must assess "the facility's resident population."

45. The evidence submitted establishes that the petitioner became more agitated when placed on one-on-one supervision.

46. In accordance with the above authority, the Facility completed a trial to determine if a secure unit was required for the 13 residents.

47. The evidence submitted, and testimonies made, establish that 12 of the 13 residents in the secure unit "aged in place"; the petitioner was the only resident identified with elopement issues, requiring a secure unit.

48. The evidence submitted establishes that the petitioner would not stay in her room when she was isolated, due to th [redacted] hich made her a risk to herself by attempting to elope and a risk to others by spreading the bacteria.

49. Also, in accordance with the above authority, the petitioner's physician had the petitioner Baker Acted to the hospital because she would not stay isolated; due to her [redacted]

50. Florida Statutes, Title 29, Section 400.0255, Resident transfer or discharge; requirements and procedures; hearings, in relevant part states:

> ...
> (10)(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.
> (11) **Notwithstanding paragraph (10)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the time after the notice is given and before the time a hearing decision is rendered**...

51. In accordance with the above authority, the Facility Baker Acted, "emergency discharge", the petitioner t [redacted] prior to a hearing decision was rendered.

52. The evidence submitted establishes that the petitioner's clinical records were well documented that the petitioner: (1) needs cannot be met, (2) the health of other individuals is endangered, and (3) the safety of other individuals is endangered.

53. The controlling authorities require a higher standard of proof in nursing home discharge hearings; there must be substantial and credible evidence at the level of clear and convincing.

54. In careful review of the cited authorities, evidence and testimonies, the undersigned concludes the Facility's evidence rises to the level of clear and convincing.

55. The Hearing Officer concludes the Facility's action to discharge the petitioner due to: (1) needs cannot be met, (2) the health of other individuals is endangered, and (3) the safety of other individuals is endangered, is proper.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. The Facility has established that the discharge is permissible under federal regulations and state statutes.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700.The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 02 day of October, 2019,

in Tallahassee, Florida.

[redacted]

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