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

[redacted]

APPEAL NO. 21N-00023
21N-00039

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notices, the undersigned convened a telephonic nursing home discharge hearing in the above-referenced matter (21N-00023) on May 17, 2021 at 2:33 p.m. and (21N-00039) on September 9, 2021 at 2:00 p.m.

APPEARANCES: May 17, 2021

For Petitioner: [redacted]

For Respondent: [redacted] Nursing Home Administrator ("NHA")

APPEARANCES: September 9, 2021

For Petitioner: Lynn Hearn, Esq. Florida Long-Term Care Ombudsman Program, Department of Elder Affairs.

For Respondent: Jonathan Grout, Esq. with Goldsmith & Grout, P.A.

STATEMENT OF ISSUES

Petitioner appeals Respondent's action discharging Petitioner from [redacted] (the "Facility"). Respondent carries the burden of proof by clear and convincing evidence.

The only issue before the undersigned is whether the discharge was in accordance with federal regulations. Any issues concerning Petitioner's allegations of improper protocol of the facility staff, or treatment Petitioner received while residing at the facility are not within the jurisdiction of the hearing officer.

SUMMARY OF THE MAY 17, 2021 PROCEEDINGS (21N-00023)

On March 16, 2021, the Facility issued a Nursing Home Transfer and Discharge Notice informing Petitioner of its intent to discharge Petitioner from the Facility effective [redacted] 2021 due to "The safety of other individuals in the facility is endangered." On March 25, 2021, Petitioner timely filed an appeal challenging the discharge.

The following individuals from [redacted] appeared as witnesses for Respondent: [redacted] ("Resp't Wit. 1"), Housekeeping Supervisor; [redacted] ("Resp't Wit. 2"), Floor Technician; [redacted] ("Resp't Wit. 3"), Director of Nursing ("DON"); [redacted] ("Resp't Wit. 4"), Social Services Director ("SSD") and [redacted] ("Resp't Wit. 5"), Attending Physician.

[redacted] (Pet'r Wit. 1"), Ombudsman Manager, and [redacted] (Pet'r Wit. 2"), Ombudsman Volunteer appeared as witnesses for Petitioner.

Petitioner did not submit any exhibits. Respondent submitted one exhibit, which was marked and entered as Respondent's Exhibit one ("1"). The record was left open through May 18, 2021 for Respondent to supplement the record. The information was

timely received, it was marked and entered as Respondent's Exhibits two ("2") and three ("3"). The record closed for 21N-00023 on May 18, 2021.

No representative from the Agency for Health Care Administration ("AHCA") was present for this hearing. At the request of the undersigned, AHCA was notified to conduct an inspection of the facility and provide and written response to the undersigned.

On May 26, 2021, the undersigned received a letter from AHCA informing that an unannounced visit to the Facility was completed on May 10-11, 2021 and there were no violations. This letter was entered into evidence and marked as Hearing Officer's Exhibit one ("1").

SUMMARY OF THE SEPTEMBER 9, 2021 PROCEEDINGS (21N-00039)

This appeal was continued twice per the parties' requests.

On May 18, 2021, the Facility issued a Nursing Home Transfer and Discharge Notice discharging Petitioner from the Facility effective [redacted] 2021 due to "The health of other individuals in the facility is endangered." On May 24, 2021, Petitioner timely filed an appeal challenging the discharge.

On June 4, 2021, Lynn Hearn, Esq. with the Florida Long-Term Care Ombudsman Program ("Ombudsman') filed a Notice of Appearance and Ombudsman Verified Motion For Emergency Relief (the "Motion") with OAH requesting that Petitioner be allowed to return to the facility from the hospital pending the outcome of both appeals. The undersigned waited ten (10) days for Respondent to file a response to the Motion before making a ruling on it. Respondent did not respond to Petitioner's Motion.

On June 16, 2021, the undersigned issued an order Granting Petitioner's Motion.

On June 23, 2021, the Facility Administrator filed a statement with OAH objecting to the emergency order. Respondent has refused to allow Petitioner to return to the Facility pending a hearing decision.

The following individuals from [redacted] appeared as witnesses for Respondent: [redacted] ("Resp't Wit. 1"), [redacted] ("Resp't Wit. 2"), [redacted] ("Resp't Wit. 3") and [redacted] ("Resp't Wit. 4").

Petitioner (Pet'r Wit. 1") was present and appeared as a witness on his own behalf.

[redacted] (Pet'r Wit. 2") appeared as a witness for Petitioner.

No representative from AHCA was present for this hearing. At the request of the undersigned, AHCA was notified to conduct an inspection of the facility and provide and written response to the undersigned.

During the hearing, Respondent filed a Motion for Decision And Motion for Continuance (the "Motion for Decision") of the scheduled hearing requesting a decision on appeal Number 21N-00023 as an appeal hearing for 21N-00039 may only be necessary based on the decision on 21N-00023. The undersigned denied the Motion for Decision and allowed the hearing to go forward.

Petitioner submitted evidence which was marked and entered as Petitioner's Exhibits one ("1") through six ("6"). Respondent submitted evidence which was marked and entered as Respondent's Exhibit one ("1") through thirty ("30") into the record.

The record was left open through September 23, 2021 to allow both parties time to submit closing statements and Proposed Final Orders ("PFO"). Both PFOs were received timely. The record for 21N-00039 closed on September 23, 2021.

Petitioner's Position

Petitioner took the position that Respondent's allegations regarding the incidents that occurred in the Facility are not totally accurate. Petitioner believes he is just being targeted for speaking out against mask wearing. Petitioner believes he no longer needs to wear a face mask based on the updated Centers for Disease Control and Prevention (CDC) guidance. Petitioner has not physically harmed anyone in the Facility. Additionally, Petitioner's position is that he is entitled to a thirty day notice on the May 18, 2021 involuntary discharge to the hospital under the Baker Act. Petitioner believes he should be allowed to return to the Facility pending a final decision.

Respondent's Position

Respondent took the position that Petitioner's behavior is alarming and concerning and has become a safety hazard for other residents and staff members due to his erratic and dangerous behavior using his wheelchair. Respondent also took the position that the health of other individuals in the Facility are endangered due to Petitioner's refusal to wear a face mask.

FINDINGS OF FACT[1]

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. On [redacted] 2020, the Facility admitted Petitioner for long term services. Petitioner was diagnosed with various medical ailments. (Hr'g R. May 17, 2021.)

[1] Citations within the Findings of Fact and Conclusions of Law in this order follow Florida Rule of Appellate Procedure 9.800 and *The Bluebook: A Uniform System of Citation* as the standard for citation.

2. Petitioner's progress notes are parts of Respondent's business record. The attached record(s) are duplicate copies; made at or near the time of the occurrence of the matters set forth by, or from information transmitted by, a person having knowledge of those matters; are kept in the course of the regularly conducted activity of our business and were made as a regular practice in the course of the regularly conducted activity of our business. (Hr'g R. May 17, 2021; Hr'g R. Sept. 9, 2021.)

3. Petitioner is not cognitively impaired. He scores very high on his "Cognitive Pattern" test. (Resp't Ex. 4.)

4. Petitioner was fully vaccinated against COVID-19 as of February 2021. (Hr'g R. Sept. 9, 2021.)

5. At the time of the notices at issue, less than half of the residents were fully vaccinated against COVID-19. Not all residents of the facility wore masks all the times. Respondent has not discharged any other resident for failing to wear a mask. (Resp't Wit. 2 Test. Sept. 9, 2021.)

6. On March 15, 2021, I was cleaning the floor when Petitioner used his motorized wheelchair in an aggressive manner knocking down the "wet floor" sign and bucket and almost knocked down my supervisor. I am afraid to do my job because of Petitioner's aggressive actions and careless usage of his wheelchair. (Resp't Wit. 2 Test. May 17, 2021.)

7. When I confronted Petitioner about his behavior, he responded with "bitch, fuck you" and told her "go back to your country." (Resp't Wit. 1 Test. May 17, 2021.)

8. On March 16, 2021, Petitioner attempted to hit the housekeeping supervisor with his wheelchair. When I confronted him with the allegation, Petitioner responded: "I hate her." (Resp't Ex. 19.)

9. On March 16, 2021, the Facility issued Nursing Home Transfer and Discharge Notice to Petitioner informing him of its intent to discharge Petitioner from the Facility effective [redacted] 2021, citing "The safety of other individuals in this facility is endangered." Brief explanation to support this action states: "Resident is using his motorized wheelchair in an aggressive threatening way towards a targeted staff member." Both the Administrator and Petitioner's physician at the Facility signed the notice. (Resp't Ex. 1 May 17, 2021.)

10. Petitioner's behavior got worse after he was issued the Discharge Notice. He has refused to wear a mask incompliance with CDC guidance and continued to be belligerent with staff members every time he got reminded to do so. (Hr'g R. May 17, 2021.)

11. On April 12, 2021, my assistant and I met with Petitioner about his desire to explore placement in an ALF facility. We discussed [redacted] as a possible facility for potential placement. (Resp't Ex. 23.)

12. On April 13, 2021, Petitioner made verbal threats of legal action against the Facility, staff, and other residents. (Resp't Ex. 18; Resp't Ex. 20.)

13. On April 14, 2021, [redacted] (ARNP) conducted a COVID-19 assessment on Petitioner and documented her observations in part: "Patient is manic and has an elevated mood, pressured speech, increased activity, racing thoughts, and is threatening [*sic*] hurt his roommate. Pt is refusing to respond to staff interventions to

keep him and others safe. Pt is agitated, restless, and is not redirectable. He is refusing all pharmacological attempts to stabilize him at this time, patient is requiring a higher level of care to ensure his safety and the safety of others." (Resp't Ex. 5 at 1.)

14. On April 20, 2021, Petitioner found his demented roommate in his bed and got upset and threated to hurt his roommate. The psychiatric ARNP ordered Petitioner to be Baker Acted. Petitioner has been verbally abusing staff and has attempted to hurt an employee using his motorized wheelchair as a weapon, while yelling racial slurs. Petitioner is intimidating and disrespectful towards some of the Latinos and African Americans and displays signs of antisocial personality disorder. (Resp't Ex. 16.)

15. On April 25, 2021 around 7:00 a.m., Petitioner forcefully pushed a locked automatic door, resulting it the door being inoperable. Law enforcement was called to the Facility and assigned case number [redacted] On April 26, 2021, the Facility called [redacted] Sheriff's Office [redacted] when Petitioner ignored staff request to turn his music down to an appropriate level. The music was loud laced with inappropriate language, obscenities. [redacted] added this incident to the case number assigned just one day earlier. (Resp't Ex. 14.)

16. On May 3, 2021, Governor DeSantis issued an executive order stating that government mask mandates could no longer be enforced. When Petitioner brought this to the attention of the Facility's staff, he was informed they followed CDC guidelines. (Pet'r Wit. 1 Test. Sept. 9, 2021.)

17. Between May 4, 2021 and May 14, 2021, the Social Service Director has been in communication with [redacted] relative to Petitioner's placement there. (Resp't Ex.23; Resp't Ex. 24; Resp't Ex. 25.)

18. On May 13, 2021, Petitioner learned that the CDC had revised its guidelines to state that fully vaccinated individuals could resume pre-pandemic activities without wearing a mask. Since then, Petitioner has refused to wear a mask and informed others they were no longer required to wear one. (Pet'r Wit. 1 Test. Sept. 9, 2021.)

19. On May 14, 2021, Petitioner was observed not wearing his mask. When reminded to do so, Petitioner responded that CDC says he did not have to. (Resp't Ex. 7.)

20. On May 14, 2021, Petitioner refused to wear his mask. "Staff provided Resident with education in reference to the current CDC guidelines as it pertains to masks current continuing to be required in this setting." Petitioner still refused to wear his mask. (Resp't Ex. 8.)

21. On May 16, 2021, the CDC updated its COVID-19 guideline for fully vaccinated individuals. The CDC guidance advised that fully vaccinated individuals can resume activities at pre-pandemic level without wearing mask. The guidance did not apply to healthcare settings, including nursing homes. (Resp't Ex. 28.)

22. Petitioner used verbally inappropriate and obscene language and profanity and sometimes maneuvers his motorized wheelchair erratically, with no disregards to others standing or walking in hallways. (Resp't Ex. 15.)

23. During the May 17, 2021 hearing, the Ombudsman Manager suggested that the safety issue could be resolved by taking away Petitioner's motorized wheelchair. [redacted] [redacted] did not recommend removing the motorized wheelchair from Petitioner as it will render him bed bound. Petitioner declined to give up his wheelchair in exchange for his stay at the Facility. (Hr'g R. May 17, 2021; Resp't Ex. 22.)

24. As of the May 17, 2021 hearing, Petitioner was still residing at [redacted] pending a hearing decision. (Hr'g R. May 17, 2021.)

25. On May 18, 2021, Petitioner "fired" [redacted] as his attending physician. [redacted] was assigned to assume his care. The Director of Nursing notified the ARNP of Petitioner's continued refusal to wear a face mask. "[redacted] psych, ordered Petitioner to be transferred to [redacted] via Baker Act." (Resp't Ex. 9; Resp't Ex. 10.)

26. Petitioner has been provided education and has refused numerous requests to wear his mask. Petitioner is increasingly defiant in following the Facility's rules regarding wearing a mask. (Resp't Ex. 11.)

27. On May 18, 2021, Petitioner reused to put on his mask after request by management. Petitioner believes ("[redacted]") Florida Department of Health employee has told him he did not have to. The Facility's "NHA, DON and ADON called the Department of Health and they denied providing that advice." (Resp't Ex. 12.) Petitioner was observed telling other residents not to wear a mask without knowing about their health and vaccination status. (Resp't Ex. 13.) Petitioner has convinced at least one other resident to remove his mask. (Resp't Wit 2 Test. Sept. 9, 2021) Petitioner did not dispute his actions. (Hr'g R. Sept. 9, 2021.)

28. On May 18, 2021, the Facility's convened an interdisciplinary team (IDT) meeting comprising of the NHA, the DON, the SSD and [redacted] all agreed that Petitioner's conduct was endangering the health of the other residents and they decided to discharge him to the hospital. The Facility had no intention of readmitting Petitioner back from the hospital. (Resp't Wit 2 Test. Sept. 9, 2021; Hr'g R.)

29. A Certificate of Professional Initiating Involuntary Examination prepared by and signed by Psychiatric Nurse [redacted] states in relevant part:

> (Petitioner) has had several episodes of severe agitation, threatening staff, other residents, he will yell racial slurs and typically will target African American or Hispanic residents. He has difficulty following facility rules and will become violent when staff attempts to educate or redirect him. He is at risk of injuring self, staff, or another resident during these episodes of agitation. He has displayed 3 or more of the diagnostic criteria of antisocial personality disorder including impulsivity, irritability and aggressiveness and reckless disregard for the safety of self and others, lack of remorse, and deceitful…"

(Pet'r Ex. 2.)

30. On May 18, 2021, the Facility issued Nursing Home Transfer and Discharge Notice to Petitioner informing him of its intent to discharge Petitioner from the Facility effective [redacted] 2021, citing "[t]he health of other individuals in this facility is endangered." [redacted] was listed as the discharge location. Only the Facility's Social Service Director signed the notice. Petitioner did not sign the notice. (Pet'r Ex. 1.)

31. Respondent did not discuss any bed-hold with Petitioner because Respondent had no intention to re-admit Petitioner into the Facility after being discharged from the hospital. (Resp't Wit 2 Test. Sept. 9, 2021.)

32. Petitioner became aware that he would not be allowed to return to the Facility when he received his belongings while in the emergency room of [redacted] (Hr'g R. Sept. 9, 2021.)

33. On May 20, 2021, Petitioner was transferred to [redacted]. On May 22, 2021, Petitioner's Baker Act (BA) status was rescinded. (Pet'r Ex. 4.)

34. At the request of the undersigned, AHCA was notified to conduct an inspection of the facility and provide and written response to the undersigned. On July 22, 2021, a letter was mailed stating in relevant part: "AHCA completed an unannounced visit at [redacted] on July 8, 2021 and found that 'rules and laws were violated at the time of our visit. The facility received a statement of deficiencies and will be required to correct the deficiencies." (Pet'r Ex. 5; Pet'r Ex. 6.)

35. As of the day of this hearing, Petitioner is residing in another facility but would like to return to [redacted] pending a hearing decision on both appeals. Petitioner wears a mask while in the new facility. (Hr'g R. Sept. 9, 2021.)

CONTROLLING LAW

36. Section 400.0255(15), Florida Statutes ("F.S."), provides the Department of Children and Families, Office of Appeal Hearings, jurisdiction over the subject matter of this proceeding and the parties. This section further prescribes this order as the final administrative decision of the Department of Children and Families.

37. Section 400.0255(15)(b), F.S., sets forth the burden of proof and requires that it must be met at the clear and convincing evidence threshold.

38. Title 42 Code of Federal Regulations (C.F.R.) Section 483.15 sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

> …
> (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;

(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;
(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.

[Emphasis added].

39. Title 42 C.F.R. Section 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.
…

[Emphasis added].

40. Title 42 C.F.R. Section 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 wellbeing 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:

41. Title 42 C.F.R. Section 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…

42. Title 42 C.F.R. Section 483.15(c)(4)(ii) addresses Timing of the notice states in relevant part: **Notice must be made as soon as practicable before transfer or discharge when – (B)The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;**

[Emphasis added].

43. Section 400.0255 F.S., Resident transfer or discharge; requirements and procedures; hearings, states in part:

> …
> (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.
> …
> (7**) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:**
> …
> **(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the**

resident's medical records by the resident's physician or the medical director if the resident's physician is not available.
(8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department's Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. Further, the form must state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form must clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.
...
(10) (a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.
(b) **I**f 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.** Notice of an emergency discharge or transfer to the resident, the resident's legal guardian or representative, and the State Long-Term Care Ombudsman Program or the local ombudsman council if requested pursuant to subsection (9) must be by telephone or in person. This notice shall be given before the transfer, if possible, or as soon thereafter as practicable. The State Long-Term Care Ombudsman Program or a local ombudsman council conducting a review

> under this subsection shall do so within 24 hours after receipt of the request. The resident's file must be documented to show who was contacted, whether the contact was by telephone or in person, and the date and time of the contact. If the notice is not given in writing, written notice meeting the requirements of subsection (8) must be given the next working day.

[Emphasis added].

CONCLUSIONS OF LAW

44. The Facility issued its initial discharge notice on March 16, 2021 based on its belief that the safety of other individuals in the facility is endangered. This is one of the six reasons provided in the controlling federal regulations for which a nursing facility may involuntarily discharge a resident.

45. The Findings show that the initial discharge was addressed in a written notice signed by both the Administrator and Petitioner's physician. A 30-day advance notice was given, and discharge location of [redacted] ALF was given. The notice includes the reason and effective date of the discharge, the location to which Petitioner is to be discharged, and Petitioner's appeal rights along with other required assistance information. A copy was provided to Petitioner.

46. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The Facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the resident for a safe and orderly transfer or discharge from the Facility. The undersigned cannot and has not considered either of these issues. The undersigned has considered only whether the discharge is for a lawful reason and meets the requirements of the controlling authorities.

47. Any discharge by the Facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration ("AHCA") requirements. Should the resident have concerns about the discharge process, he may contact AHCA's health care facility complaint line at (888) 419-3456.

48. The findings show Petitioner has been verbally aggressive towards staff and other residents. The findings show Petitioner has used his motorized wheelchair to intimidate and others. The findings show Petitioner has used racial slurs against minorities and never show remorse for his abhorrent behavior.

49. Based on the evidence presented, the Facility has established that the safety other individuals in the facility is endangered. These is one of the six reasons provided in federal regulation for which a nursing facility may involuntarily discharge a resident.

50. On May 18, 2021, the Facility issued a secondary discharge notice transferring Petitioner to [redacted] on [redacted] 2021 based on its belief that "[t]he health of other individuals in this facility is endangered." Only the Facility's SSD signed the notice.

51. Petitioner's sole contention on the second notice was that Petitioner could not be discharged without a 30-day notice unless the condition presented an emergency. Neither party disputed that Petitioner's failure to wear a mask presents a safety issue to other residents in the Facility.

52. The above authorities governing admission, transfer, and discharge rights for residents of long-term care facilities provided authority to transfer or discharge a resident when safety or health of individuals in the facility would be endangered, with notice being made "as soon as practicable before transfer or discharge."

53. The findings show Petitioner has been defiant and has refused to wear his mask to comply with CDC guidance. The findings show Petitioner engaged in a continuous pattern of defiance of the Facility's rules as directed by the CDC. Petitioner was reminded on numerous occasions to wear his mask but has refused to follow staff direction and has advised other residents not to wear masks. The findings show the updated CDC guidance did not apply to long-term care facilities. Under these conditions, Petitioner could be discharged and transferred to another facility without providing resident and his family with a 30-day notice.

54. The Facility seeks to involuntarily discharge Petitioner on the contention that the safety and health of other individuals in the facility are endangered. The findings show Petitioner has behaved aggressively on several occasions. The findings show that Petitioner's clinical records were well documented with several scenarios of aggressive behaviors that put other people at risk. After several documented incidents, Respondent issued the initial discharge notice to Petitioner. Petitioner's behavior got worse after he was issued the Discharge Notice. The findings show Petitioner has refused to wear a mask in defiance of CDC guidance and continued to be belligerent with staff members every time he got reminded to do so, Respondent determined Petitioner's conduct was endangering the health of the other residents and they decided to issue a secondary notice discharging him to the hospital.

55. 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.

56. After careful review of the cited authorities, the cumulative evidence demonstrates, and the undersigned concludes the Facility has met the burden of proof in establishing that the safety and health of other individuals in the Facility are endangered by Petitioner.

DECISION

Based on the foregoing Findings of Fact, Controlling Law and Conclusions of Law, the appeals are DENIED. The Facility's action to discharge Petitioner is in accordance with Federal Regulations. The Facility may proceed with its proposed discharge action, as described in the Conclusions of Law and in accordance with all applicable Agency for Health Care Administration requirements.

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. 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 November, 2021,

in Tallahassee, Florida.

Roosevelt Reveil
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Copies Furnished To: [redacted] Petitioner
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[redacted]
Agency for Health Care Administration
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