Department of Medical Assistance Services
Appeal Decision

Introduction

This is the Medicaid appeal decision of the Department of Medical Assistance Services ("Department" or "DMAS") on the appeal request dated December 28, 2021, filed on behalf of ("Appellant"). This decision may not be relied upon, used, or cited as precedent in other matters.

The information relied upon in adjudicating the appeal included the testimony of all parties at the appeal hearing, the Appellant's appeal request and accompanying documentation, and Harrisonburg Health and Rehabilitation Center's ("Nursing Facility") appeal summary.

Findings of Fact

1. The Appellant was a 70-year-old female who was admitted into the Nursing Facility on July 13, 2018.

2. On December 1, 2021, the Nursing Facility mailed a copy of a Notice of Discharge packet to the Appellant's Representative and the local ombudsman, indicating that the Appellant was being discharged from the Nursing Facility on or around January 1, 2021, due to endangerment of the staff and residents at the facility. (Exh. Band Testimony).

3. On December 9, 2021, the Nursing Facility mailed a revised copy of a Notice of Discharge packet to the Appellant's Representative and the local ombudsman, indicating the Appellant was being discharged from the Nursing Facility on or

around January 9, 2022, due to endangerment of the staff and residents at the facility. (Exh. C and Testimony).

4. On December 28, 2021, the Appellant's Representative requested an appeal of the Nursing Facility's proposed discharge actions with the DMAS Division of Appeals. (Exh. F and Testimony).

Issue

The issue before the Hearing Officer is whether the Nursing Facility had cause to discharge the Appellant and complied with the Federal and State regulations for an involuntary discharge action.

Discussion

Nursing Facility's Testimony

The Nursing Facility Representatives testified that a Notice of Discharge was mailed to the Appellant's Representative and the local ombudsman *on* December 1, 2020. They indicated that the Appellant was being involuntarily discharged from the Nursing Facility due to endangerment of the staff_ and residents at the Nursing Facility. The Nursing Facility Representatives stated that the Appellant was verbally abusive toward residents and staff. They testified that the Appellant would make racist statements to others, use foul language toward others and yell at the staff or residents. The Nursing Facility Representatives indicated that the Appellant had, on several occasions, threatened the staff, residents and to harm herself. However, they also indicated that the Nursing Facility did not believe the Appellant's verbally abusive behaviors and threats to harm herself or others were credible enough to warrant reports to Adult Protective Services and/or the police. The Nursing Facility Representatives stated that the Appellant's verbally abusive behavior endangered the emotional health and welfare of the residents and staff at the Nursing Facility and was just cause for her involuntary discharge from the Nursing Facility. (Exhs. A, D and Testimony).

The Nursing Facility Representatives testified that the initial Notice of Discharge was mailed to the Appellant's Representative and the local ombudsman on December 1, 2021, and indicated that the Appellant would be discharged to her daughter's residence on or around January 1, 2021. The Nursing Facility Representatives testified that, shortly after mailing the initial Notice of Discharge to the Appellant's Representatives, the Nursing Facility discovered an error in the Notice of Discharge. They stated that the Nursing Facility mailed a revised Notice of Discharge to the Appellant's Representatives and the local ombudsman on December 9, 2021, to the Appellant's daughter's residence with an effective date of discharge on January 9, 2022. The Nursing Facility Representatives indicated that the Appellant and her daughter were informed of the discharge plan in person and by telephone on December 9, 2022. They testified that the Appellant was oriented to her potential discharge action and reacted with additional verbal abuse and threats toward the staff.

The Nursing Facility Representatives indicated that the Appellant's nurse practitioner had evaluated the Appellant for her pending discharge and determined that she was medically fit to be discharged from the facility. The Nursing Representatives testified that the Appellant w0uld be discharged to her daughter's home with an order for personal care services, durable medical equipment and medications. They stated that a copy of the Appellant's medical records had been submitted to DMAS on the date of the appeal hearing. The Nursing Facility Representatives asked that, based upon the following discharge reasons, the Hearing Officer uphold their action to involuntarily discharge the Appellant to her daughter's home. (Exhs. A-D and Testimony).

Appellant's Representative's Testimony

The Appellant's Representative testified that they were contesting the Appellant's involuntary discharge/transfer action because the Nursing Facility did not have a *valid* reason for the involuntary discharge action and they did not comply with the requirements for an involuntary discharge action stated within the €ode of Federal Regulations. The Appellant's Representatives confirmed that the Appellant was a 70-year-old female

They stated that the Appellant had complex medical conditions that complicated her involuntary discharge back into the community. (Exhs. E-P and Testimony).

The Appellant's Representatives stated that the Nursing Facility was aware that the Appellant had a mental health condition (bipolar disorder) that may cause her to have emotional and behavioral outbursts at times. They stated that the Appellant's incidents with verbal and emotional outbursts coincided with the times that the Appellant's medications were being changed or adjusted. The Appellant's Representatives testified that, while the Appellant may have verbal and emotional outbursts, her actions were not physical in nature and did 11ot endanger the health and safety of the staff and residents in the Nursing Facility. They stated that the Nursing Facility's failure to report these verbal and emotional outbursts to Adult Protective Services or the police is sufficient evidence to show that these verbal and emotional outbursts were *not* considered to be endangering the health and safety of the Nursing Facility staff and residents. The Appellant's Representatives stated that the Appellant's actions did not justify her involuntary discharge from the Nursing Facility and asked that the Hearing Officer reverse the action of the Nursing Facility on these grounds. (Exhs. E-F and Testimony).

The Appellant's Representatives testified that the Appellant, her daughter and the local ombudsman received the Notices of Discharge dated December 1, 2021, and

December 9, 2021. They stated that the Appellant and her family did not take part in a formal discharge plan meeting. The Appellant's Representatives stated that the Appellant was oriented to her potential discharge action, but they were never provided with a list of medical services, orders or durable medical equipment. The Appellant's Representatives stated that the Appellant was not evaluated by her attending physician or the medical director of the Nursing Facility to determine if she was medically fit for an involuntary discharge action. They stated that the Nursing Facility did not provide them with any medical records approving of the involuntary discharge action. The Appellant's Representatives testified that the Appellant's discharge location was inadequate. because the Appellant's daughter rented the mobile home and her landlord would not allow for any overnight guests. They stated that the mobile home was also not ADA compliant and the Appellant could not use her wheelchair to move around inside and outside of the home. The Appellant's Representatives also indicated that the mobile home was two bedrooms and inhabited by the Appellant's daughter, her spouse and their son. They stated that there was no bedroom for the Appellant to have a hospital bed in. The Appellant's Representatives stated that the Nursing Facility was aware that the discharge location was inadequate because it had been discussed during the two prior involuntary discharge actions. The Appellant's Representatives requested that the Hearing Officer reverse the involuntary discharge action of the Nursing Facility because the Nursing Facility did not comply with the Code of Federal Regulations. (Exhs. E-F and Testimony).

Conclusions of Law and Policy

A. TRANSFER AND DISCHARGE: RIGHTS - (A) IN GENERAL.-a nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless-

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
(ii) 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;
(iii) the safety of individuals in the facility is endangered;
(iv) the health of individuals in the facility would otherwise be endangered;
(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XVIII on the resident's behalf) for a stay at the facility; or
(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. for purposes of clause (v), in the case of a resident who becomes eligible for assistance under this title after admission to the facility, only charges which may be imposed under this title shall be considered to be allowable.

PRE-TRANSFER AND PRE-DISCHARGE NOTICE - Before effecting a transfer or discharge of a resident, a nursing facility must-

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons for the discharge.

(II) record the reasons in the resident's clinical record (inch.1ding any documentation required under subparagraph (A)), and

(III) include in the notice the items descri0ed in clause (iii).

(ii) TIMING OF NOTICE. -The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except-

(!) in a case described In clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii)' of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case Where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

ITEMS INCLUDED IN NOTICE.-Each notice under clause (i) must include-

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

(II) the name, mailing address, email address, and telephone number of the State long term care ombudsman (established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act);

(III) in the case of residents with developmental disabilities, the mailing address, email address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 ; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address, email address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

ORIENTATION.-A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Social Security Act Section 1919 [42 U.S.C. 1396r]; Code of Federal Regulations, 42 CFR 483.15.

The Notices of Discharge dated December 1, 2021, and December 9, 2021, indicated that the Appellant was being involuntarily discharged from the Nursing Facility because her verbally abusive behaviors were endangering the safety and welfare of the residents and staff. While there is sufficient evidence in the record to show that the Appellant had verbal and emotional outbursts at the Nursing Facility toward staff and residents, these verbal and emotional outbursts appear to be caused by her mental health condition and the changing/adjusting of her medications. There was insufficient evidence in the record to show that these verbal and emotional outbursts endangered the health, safety or welfare of the Nursing Facility staff and residents. The fact that the Nursing Facility testified that the Appellant's verbal and emotional outbursts were not severe enough to be reported to Adult Protective Services or the local police for investigation supports the finding that the Appellant's verbal and emotional outbursts were not endangering the health, safety and welfare of the Nursing Facility, its staff or its residents. Since there was no additional evidence provided to show how the Appellant's verbal and emotional outbursts were endangering the Nursing Facility residents or staff, the Hearing Officer finds that the Nursing Facility did not meet the requirements of having a valid reason for an involuntary discharge action from the Nursing Facility. (Exhs. A, B, C and Testimony).

Before a facility discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the discharge in writing. The notice of discharge must be made by the facility at least 30 days prior to the date of the resident's discharge unless it meets an exception as stated in the law. Code of Federal Regulations, 42 CFR §483.15{c){3)(i); §483.15(c)(4)(i); Social Security Act Section 1919 [42 U.S.C. 1396r]: Nursing Facility Manual, Chapter VII (p. 7). The written notice is required to state the effective date of transfer or discharge. Code of Federal Regulations, 42 CFR §48B.15(c){5)(ii). The Nursing Facility provided the Appellant's Representative with two Notices of Transfer/Discharge on December 1, 2021, and December 9, 2021. Although, the initial notice did not provide the required 30 days of notice prior to an involuntary discharge action., the revised Notice of Discharge dated December 9, 2021, had a discharge date of January 9, 2022, which thereby complied with the Code of Federal Regulations. (Exhs. A, B and Testimony). Therefore, the Nursing Facility did provide the Appellant with the required 30 days of notice.

The written Notice of Discharge must include the following information: the reason for the discharge, the effective date of djscharge, the location to which the resident is to be discharged, a statement that the resident has the right to appeal, the name, address (mailing and email) and telephone number of the entity which receives appeal requests, and the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care (LTC) Ombudsman. For nursing home residents with developmental disabilities or mental illness, the notice must include the mailing and email address and telephone number of the Department for Rights bf Virginians with Disabilities. Code of Federal Regulations, 42 CPR §483.15(c)(5); Nursing Facility Manual, Chapter VII (p. 7).

While the Notice of Discharge stated the discharge reason as being the endangerment of the Nursing Facility staff and residents, there was insufficient evidence and testimony provided to justify this reason for involuntary discharge action. The Notice of Discharge informed the Appellant of her right to appeal and provided the name, mailing address, and telephone number of the entity that receives appeal requests (DMAS), The Notice of Discharge provided the name, mailing address, and telephone number for the State LTC Ombudsman. The Appellant had a mental health diagnosis and the Notice of Discharge included the contact information for the agency responsible for the protection and advocacy (P&A) of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. However, the Notice of Discharge failed to incl de an adequate discharge location as required under the law. While the Notice of Discharge location was indicated as the Appellant Daughter's residence the evidence and testimony from both parties indicated that this address was not a suitable residence for the Appellant's discharge. The Appellant's medical conditions limited her ability to ambulate without a wheelchair and the discharge location was not ADA compliant to accommodate a wheelchair. The discharge location did not have any additional space or rooms for the Appellant to live in and the owner of the residence would not allow any additional tenants to reside in the mobile home. The testimony shows that the Nursing Facility was aware that the discharge location was inadequate prior to mailing the two Notices of Discharge. Furthermore, the Appellant required a nursing facility level of care due to her complex medical conditions and discharging her back into the community would not provide for the Appellant's level of care needs. The Hearing Officer finds that the Nursing Facility's Notice of Discharge was not in compliance with the requirements of the Code of Federal Regulations, 42 SF §48B.15(o)(5); (Exhs. A, B, C and Testimony).

Except in an emergency involving the patient's health or well-being, no patient shall be transferred or discharged without prior consultation with the patient, the patient's family or responsible party and the patient's attending physician. If the patient's attending physician is unavailable, the facility's medical director In conjunction with the nursing director, social worker or another health professional shall be consulted. In case of an involuntary transfer or discharge, the attending physician of the patient or the medical director of the facility shall make a written notation in the patient's record approving the transfer or discharge after consideration of the effects of the transfer or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge. Code of Virginia, §32.1-138.1.B. The Appellant's attending physician or the medical director of the Nursing Facility must make the required written notation in the Appellant's record. Code of Virginia, §32.1-138.1.

When a nursing facility transfers or discharges a resident for the reasons stated above, the transfer or discharge must be documented in the resident's medical record by a physician and must include the basis for the transfer or discharge. Code of Federal Regulations, 42 CFR §483.15(c)(2}.

There was no evidence to show that the Appellant's attending physician or the Nursing Facility's medical director had recently evaluated the Appellant. While the Nursing Facility' testified that a medical letter/record was submitted to DMAS *for* the appeal on the date of the appeal hearing, this documentation was not received by the DMAS Appeals Division and is thereby not part of the record. Even with this documentation, the testimony in the record shows that Appellant was evaluated by a nurse practitioner and not an attending physician or medical director as required by the law. There were no signed medical records to show that medical orders, medical services and durable medical equipment had been provided to the Appellant for her potential involuntary discharge action. Accordingly, the Hearing Officer finds that the Nursing Facility's proposed discharge of the Appellant was not in compliance with the applicable law and policy requiring a physician's approval. (Exhs. A-F and Testimony).

A nursing home must provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the nursing home. In addition, the nursing home must assist the resident and his or her family in locating and coordinating the services needed for a smooth transition. Residents and their families and legal representatives have the right to choose their own service providers. Code of Federal Regulations, 42 CFR §483.15(c)(7); Nursing Facility Manual, Chapter VII (p. 7). The Nursing Facility Representatives indicated that a discharge planning meeting was conducted in person with the Appellant and over the phone with her daughter when the Notice of Discharge was delivered on December 9, 2021. While the Nursing Facility may have discussed the Appellant's discharge with her and her daughter when they delivered the Notice of Discharge, this does not constitute a discharge planning meeting. This meeting was not about planning the discharge, but informing the Appellant that she was being discharged. Based on the evidence and testimony in the record, it appears that there was no discharge plan meeting conducted with the Appellant and her representatives prior to the delivery of the Notice of Discharge action. Therefore, the Hearing Officer finds that the Nursing Facility failed to comply with the applicable law and policy for a discharge plan meeting of the Appellant. (Exhs. A-F and Testimony).

Conclusion

After reviewing the testimony of the Appellant's Representatives, testimony of the Nursing Facility Representatives, and exhibits A through F, the Hearing Officer finds that the Nursing Facility did not have valid cause to discharge/transfer the Appellant; did not issue a Notice of Discharge that was in compliance with the Code of Federal Regulations; did not have the Appellant evaluated by her attending physician prior to the Notice of Discharge action; and did not conduct a discharge plan meeting with the Appellant's Representatives prior to the issuance of the Notices of Discharge on December 1, 2021 and December 9, 2021.

Decision

Therefore, the Hearing Officer must reverse the involuntary discharge action of the Nursing Facility and the Appellant is entitled to remain in the Nursing Facility.

List of Exhibits

Exhibit	Description	Page
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B	Notice of Discharge dated December 1, 2021	2
C	Notice of Discharge dated December 9, 2021	3
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