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

APPEAL NO. 11N-00006

PETITIONER,

Vs.

ADMINISTRATOR

RESPONDENT.
________________________________/

FILED
April 11, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 11, 2011, at 8:57 a.m., at the , Florida.

APPEARANCES

For the Petitioner: , the petitioner's daughter

For the Respondent: administrator

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice dated January 14, 2011 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. § 483.12(a)(2): "(i)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility".

PRELIMINARY STATEMENT

By notice dated January 14, 2011, the facility informed the petitioner that she was to be discharged. On January 17, 2011, the petitioner timely requested a hearing to challenge the discharge.

The petitioner did not appear for the hearing. Witnesses for the petitioner, appearing in person, was [redacted] the petitioner's granddaughter, and [redacted] ombudsman.

Witnesses for respondent, appearing in person, were [redacted], social services worker, [redacted] executive director, [redacted], director of nursing, [redacted] director of community relations, and [redacted] M.D, facility medical director. [redacted] ombudsman, was observing.

The record was left open until March 21, 2011, for closing arguments. The hearing officer received closing arguments from the petitioner on March 17, 2011 and from the respondent on March 21, 2011. The record was closed on March 21, 2011.

FINDINGS OF FACT

1. The petitioner is an 83 year old female. The petitioner was previously living at home. After a stay at the hospital, the petitioner entered the facility. A Preadmission Screening and Resident Review Mental Health Evaluation Report was completed by [redacted] M.D., on September 12, 2009. Dr. [redacted] is the petitioner's treating psychiatrist.

2. The petitioner's diagnosis is Dementia with Lewy Bodies, complicated by depression. Urination frequency is one of the symptoms of Lewy Bodies. The petitioner has reverted to speaking in her first language which is Spanish. The petitioner is

continent of bowel and bladder. The petitioner requires assistance with activities of daily living, bathing, grooming and toileting.

3. The petitioner is being treated by [redacted], A.R.N.P., from [redacted] [redacted] Incorporated. [redacted] sees the petitioner at the facility. [redacted] saw the petitioner December 8, 2010 and noted that a more elevated level of care/placement may need to be considered. On December 10, 2010, she notified the family that the petitioner symptoms are difficult to manage with medication, some of the behaviors appear to be related to personality issues, and an alternative placement may be recommended. The nurse practitioner saw the petitioner on February 9, 2011. Her plan was to have the petitioner's medication reduced.

5. The petitioner's treating psychiatrist is prescribing the petitioner's medication. The petitioner's medications are kepakote, seroquel and klonopin.

6. [redacted] Ph.D., psychologist is seeing the petitioner. His notes were entered into the petitioner's medical record. On October 18, 2010, [redacted] suggested the primary care physician change the petitioner's medication. On October 25, 2010, [redacted] noted that the medication had not been changed. On November 15, 2010, [redacted] indicated that the petitioner's seroquel had been reduced. He noted that the petitioner was screaming repetitively and the staff was unable to calm or redirect the petitioner.

7. On October 26, 2010, the petitioner was seen by Dr. [redacted] for a neurology new office visit. His diagnoses were that the petitioner was not psychotic, was cognitively impaired, and was unable to appropriately express her needs, somewhat situational. He opined that very little could be done, and the chance of a

good response with a change to a new medication was low, based on empiric trial of other drugs.

8. From at least November 2, 2010, the facility documented the petitioner's medical record daily in the Progress Notes. The respondent had documented the attempts to console the petitioner, redirect the petitioner, and daily repeated toileting. The petitioner had periods of quiet, periods of listlessness from medication, and crying and screaming episodes. The screaming episodes are most days and sometimes several times a day. Sometimes the screaming episodes include yelling. The episodes occurred both during the day and night. The episodes were in the petitioner's room, common areas and dining room. The documentation indicated several instances of the petitioner's continued screaming after taking the petitioner to toilet several times. The documentation indicated an occasion that petitioner was not screaming, was taken to toilet and started screaming immediately after a successful toileting. This demonstrates that the petitioner has screaming episodes even when she does not need to toilet.

9. On January 13, 2011, the medical record indicates that the petitioner experienced a decline in the last quarter.

10. On January 14, 2011, the facility issued a Nursing Home Transfer and Discharge Notice. The reason stated in the notice was that the petitioner needs cannot be met in the facility.

11. The petitioner had a psychiatric consult with , M.D on March 8, 2011. Dr. entered his notes into the petitioner's medical records. Dr. opined that the petitioner's behavioral issues were worsening and the petitioner needed to be transferred to a dementia unit with behavioral specialist for her safety as well as

the safety of other residents. [redacted] is the supervising physician for the nurse practitioner, [redacted]

12. [redacted] M.D. is the medical director for the facility. [redacted] oversees the care of the residents. [redacted] has observed the petitioner's screaming episodes. [redacted] opined as follows. Dementia patients do not respond to psychotic medication. The petitioner's medication is prescribed by the petitioner's treating psychiatrist. The preferred treatment is behavior modification and redirection. Every team member at the facility has gone over and beyond to assist the petitioner without success. Dr. [redacted] medical opinion is that the facility cannot meet the petitioner's unique needs for very personalized care.

CONCLUSIONS OF LAW

13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

14. In accordance with Florida Administrative Code § 65-2.060(1) the burden of proof was assigned to the respondent.

15. Federal Regulation limits the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case the petitioner was sent notice indicating that she would be discharged from the facility in accordance with of Code of Federal Regulation at 42 C.F.R. § 483.12(a)(2): "(i)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility".

16. The respondent's position is as follows. The petitioner's behavior negatively impacts the quality of life for the other residents. The petitioner's Lewy Body

Dementia's progression has exceeded the maximum medical and behavioral interventions attempted, rendering the respondent's ability to care for the petitioner's increased needs ineffective. The petitioner would be best served by transferring to a facility which specializes in the type of care and services that would meet the petitioner individual needs.

17. The petitioner's position is as follows. The facility can meet the petitioner's needs. The petitioner's screaming is the only behavior that she demonstrates in excess which is a dementia behavior. The respondent should be able to manage the petitioner's behavior and anticipate her needs. The family wants the facility to adjust the petitioner's medication. The facility has failed to have the petitioner's medications reevaluated and failed to understand the petitioner's disease.

18. The hearing officer concludes that the facility can meet the petitioner's activities of daily living needs of bathing, grooming and toileting. What remains to be determined by the hearing officer is whether or not the respondent can meet the petitioner's needs as they relate to her Dementia with Lewy Bodies.

19. The evidence demonstrates that the petitioner's treating psychiatrist is prescribing the petitioner's medication and is responsible for adjustments in the petitioner's medication. The nurse practitioner notified the family that the petitioner's symptoms are difficult to manage with medication, some of the behaviors appear to be related to personality issues, and an alternative placement may be recommended. The nurse practitioner's plan was to have the petitioner's medication reduced. The neurologist opined that very little could be done, and the chance of a good response with a change to a new medication was low based on empiric trial of other drugs. The

evidence demonstrated that Dr. [redacted] opined that the petitioner's behavioral issues were worsening and the petitioner needed to be transferred to a dementia unit with behavioral specialist for her safety as well as the safety of other residents.

20. The Code of Federal Regulations at 20 C.F.R. § 404.1527(d) addresses that medical opinions are given controlling weight. The hearing officer considered Dr. [redacted] expert testimony. Dr. [redacted] medical opinion was that the respondent cannot meet the petitioner's unique need for personalized care.

21. The evidence demonstrates that the petitioner is in need of additional psychiatric care and the petitioner's needs would be better met at another facility with either a dementia unit or on site psychiatric care. Therefore, the hearing officer concludes that the facility cannot meet the petitioner's needs and the discharge is necessary for the petitioner's welfare.

DECISION

This appeal is denied as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, as determined by the treating physician and in accordance with 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 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 ______ day of _________, 2011,

in Tallahassee, Florida.

____
Linda Jo Nicholson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: