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

[redacted]

APPEAL NO. 10N-00191

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

FILED
Feb 3, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 11, 2011 at 1:18 p.m.

APPEARANCES

For the Petitioner: [redacted] district manager Long Term Care Ombudsman

For the Respondent: [redacted] administrator

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge from the notice of November 4, 2010 is in accordance with the requirements of 42 CFR § 483.12(a)(2)(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…"

PRELIMINARY STATEMENT

By notice dated November 4, 2010, the facility informed the petitioner that she was to be discharged from the facility. On November 9, 2010, the petitioner timely requested a hearing to challenge the discharge.

The petitioner, the petitioner's representative and the respondent's representative appeared in person.

Witness for petitioner that appeared in person was [redacted], ombudsman.

Witnesses for respondent who appeared in person were [redacted] social services director, [redacted] minimum data set (MDS) coordinator.

FINDINGS OF FACT

1. The petitioner entered the facility on August 6, 2010. On August 12, 2010, the physician from the Department of Elder Affairs CARES Unit completed a Notification of Level of Care for the petitioner. The physician indicated that the petitioner's level of care was Intermediate I and the placement recommendation was temporary nursing facility.

2. The petitioner's treating physician is [redacted] M.D. [redacted] advanced registered nurse practitioner is [redacted], A.R.N.P. On August 26, 2010, the nurse practitioner provided to the facility an order that the petitioner may be discharged to an assisted living facility. On September 1, 2010, the nurse practitioner completed a follow-up for the petitioner. The nurse practitioner indicated that the petitioner's condition had been upgraded and the petitioner was receiving the lowest level of care.

3. The petitioner was seen by an occupational therapist on October 19, 2010. The occupational therapist indicated that the petitioner did not require any skilled occupation therapy services.

4. The petitioner was seen by the speech language therapist on October 20, 2010. The speech language therapist indicated that the petitioner did not require any speech therapy.

5. The petitioner was seen by the physical therapist on October 26, 2010. The physical therapist indicated that the petitioner was ambulatory for long distances, no functional decline noted, and no skilled physical therapy.

6. On November 4, 2010, the facility determined that the petitioner's health had improved sufficiently so that the petitioner no longer needed the services provided by the facility. The facility presented the petitioner with a Nursing Home Transfer and Discharge Notice. The discharge notice was signed by the petitioner's treating physician, [redacted] M.D.

7. On November 19, 2010 a PASRR/MI Level II determination was completed for the petitioner by a licensed mental health care provider. The Summary Report indicated as follows. The petitioner had medical diagnoses of hypothyroidism, chronic obstructive pulmonary disease, gastro-esophageal reflux disease and congestive heart failure. The petitioner had a mental health diagnosis of polysubstance abuse, depressive disorder, psychotic disorder, which considered stable as stated on a psychiatric assessment of October 18, 2010. The petitioner is mobile and able to walk. It was reported that the petitioner needs help with her activities of daily living. The licensed mental health care provider opined that nursing facility placement was determined to be appropriate due to

the petitioner's inability to perform activities of daily living independently and need for medical care as reported. Specialized Services were determined to not be needed and the petitioner is receiving psychiatric services.

8. On January 5, 2011, the petitioner was diagnosed with invasive ductal carcinoma of the right breast. The treatment that is intended is surgery and follow-up.

9. The social services director asserted that the petitioner was appropriate for discharge as she is able to perform her activities of daily living, she is able to leave the facility unsupervised using the bus and community resources, she has no cognitive impairments, her medications are the same as the petitioner was taking at home, and a less restrictive environment was ordered by the nurse practitioner.

10. The district ombudsman manager asserted that there was no doctor's order for discharge, the petitioner's new diagnosis of cancer will require care, and as the petitioner was admitted as Intermediate I, no skilled services are required for the petitioner to remain at the facility. The district ombudsman manager opined that the petitioner should remain in the facility.

11. The petitioner opined as follows. She needs help with her activities of daily living and supervision for taking her medication. The nights that she stays with her daughter, her daughter administers her medication and provides her care. She has taken the bus to her daughter's home twice. With her new diagnosis of cancer, she does not want to leave the facility.

CONCLUSIONS OF LAW

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

13. In accordance with Fla. Admin. Code § 65-2.060(1), the burden of proof was assigned to the respondent.

14. 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 he would be discharged from facility in accordance with Code of Federal Regulation at 42 C.F.R. § 483.12(a)(2)(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…”

15. The Code of Federal of Regulations sets forth documentation at 42 C.F.R. § 483.12, Admission, transfer and discharge rights:

> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section…

16. The Florida Statutes at 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states: “(8)…A copy of the notice must be placed in the resident’s clinical record…”

17. The petitioner’s treating physician signed the discharge notice. The notice becomes part of the resident’s clinical record. The petitioner’s treating physician’s signature on the discharge notice indicated that in his opinion the petitioner could be discharged as the petitioner health had improved. The petitioner’s level of care was temporary Intermediate I; however, the petitioner’s intermediate care services at the facility are no longer ordered by the petitioner’s treating physician. The petitioner did

not submit any order from a medical practitioner indicating that the petitioner's Intermediate I care needed to be provided by [redacted] Based upon the above cited authorities, the facility's action to discharge the petitioner was in accordance with Federal Regulations.

18. The hearing officer notes that the petitioner's new diagnosis of cancer is of concern. However, at the time of the hearing the petitioner had not had surgery. There was no current physician's order or current plan of treatment for the petitioner's care at [redacted] At any time as a result of this new diagnosis, the petitioner's treating physician could make a determination that the petitioner needs the care provided by a nursing facility; a plan of treatment could be established. That would then be a different admission to a facility.

DECISION

This appeal is denied as action to discharge the petitioner is correct and 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 _____, 2010,

in Tallahassee, Florida.

_____
Linda Jo Nicholson
Hearing Officer
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