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

[redacted]

APPEAL NO. 11N-00069

PETITIONER,

Vs.

Administrator

[redacted]

RESPONDENT.
_____/

FILED
June 3, 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 May 9, 2011, at 9:00 a.m., in [redacted], Florida.

APPEARANCES

The petitioner was present and was represented by [redacted], her son.

The respondent was represented by [redacted] executive director.

STATEMENT OF ISSUE

The petitioner is appealing the [redacted] March 17, 2011 action of transferring her from the facility, because her health has improved sufficiently so that she no longer needs the services provided by the facility.

PRELIMINARY STATEMENT

The facility gave the petitioner a Nursing Home Transfer and Discharge Notice dated March 9, 2011, informing her that she was being transferred from the facility because her health has improved sufficiently so that she no longer needs the services provided by the facility.

Present from the facility was [redacted] health care administrator; [redacted] care plan coordinator; and [redacted], physical therapist.

FINDINGS OF FACT

1. The petitioner resides, as of the time of the hearing, at the [redacted] in [redacted] Florida. On March 17, 2011, she received a Nursing Home Transfer and Discharge Notice that was signed by [redacted], and [redacted].

2. The March 17, 2011 Nursing Home Transfer and Discharge Notice states that the petitioner requires only minimal assistance with all of her activities of daily living, and mobility. It also states that she is able to make her own choices independently, and that she dictates her own medical regimen.

3. Dr. [redacted] completed a Physician Notes form dated February 15, 2011, stating that the petitioner's chief complaint is lower extremity edema. Listed in these notes is an assessment plan stating that the petitioner's lower extremity edema is resolved, her anemia is resolved, and her hypertension is stable.

4. The February 15, 2011 Physician Notes states that the petitioner is ambulating without difficulty. She denies complaints, she is doing very well, she has an excellent prognosis, and she requires minimal assistance for most activities of daily living.

5. Dr. [redacted] completed a Physician Notes form dated March 15, 2011, stating that the petitioner denies any complaints, and she is doing very well. Listed in these notes is an assessment plan stating that the petitioner's coronary artery disease is stable, a right ankle ulcer is completely resolved, and her hypertension is stable.

6. The March 15, 2011 Physician Notes states that the petitioner continues to be independent for most activities of daily living, and that she is a good candidate for an assisted living facility setting.

7. The petitioner's psychiatrist, Dr. [redacted] completed a Psychiatric Progress Notes form dated April 22, 2011, stating that the petitioner has psychosis and anxiety. The doctor states that the petitioner can have her needs met at an assisted living facility.

8. There is a copy of a statement dated April 19, 2011 from [redacted] a medical records consultant. She explains that she has a bachelor of science degree from [redacted] and 30 years experience as a medical records consultant for skilled nursing facilities.

9. After reviewing the petitioner's medical records from October 15, 2007 to July 13, 2010, it is Ms. [redacted] opinion that the petitioner is performing her activities of daily living independently, with some staff supervision, and with limited staff assistance. These activities of daily living include eating, dressing, walking, transferring, bed mobility, personal hygiene, and toilet use.

10. There is a copy of a Care Plan form stating that as of March 14, 2011, the petitioner requires no assistance with her activities of daily living and mobility. Listed is her doctor, [redacted] M.D. with a history of cellulitis/abscess leg, hypertension, backache, urinary tract infection, anemia, depressive disorder, vaginal wall prips,

athrscir. coronary, personal fall, difficulty in walking, depression, dementia, esophageal reflux, constipation, gastrointestinal hemorrhage, iron deficiency, psychosis, senile NOS, and muscle weakness.

11. There is a Physical Therapy Plan of Treatment for Rehabilitation form completed by Ms. [redacted] covering the dates of February 28, 2011 to March 16, 2011. It states that the petitioner has made very good progress with skilled therapy. She is able to consistently ambulate 212 to 300 feet with her rolling walker. Even on days that she feels more fatigued, she is able to ambulate these distances with periodic stops.

12. The petitioner's physical therapy goals were that she would be able to ambulate with her rolling walker in her room, be able to transfer from her bed to a chair, and be able to ambulate safely with her rolling walker 150 feet in order to go from her room to the nurse's station and back. The petitioner's physical therapy plan of treatment shows that she was discharged to restorative care three times per week because her physical therapy goals were met.

13. The petitioner's representative disagrees to the transfer of the petitioner from the facility, and listed the following reasons about the petitioner: she has a limited capacity/ability to walk, she gets out of breath after attempting to walk very short distances, and she has a problem with balance when attempting to walk. Other reasons are her personal hygiene, she needs to use a bedpan on a consistent basis, she refuses/unable to bathe/shower/clean herself properly, she is unable/unwilling to eat in the dining area, she needs to eat in bed, she refuses certain medications, x-rays, and therapy prescribed by doctors.

14. The petitioner's representative asserts that she has a social/personality disorder, which manifests itself in a disagreeable and argumentative nature. This causes conflict and distress amongst the staff and possibly other residents in the facility. Due to verbal threats made by the petitioner, many staff members are fearful to interact with her.

15. The petitioner's representative asserts that the staff has developed a vague/weak documentation trail of the petitioner's capabilities as a resolution to remove a problematic and high maintenance resident from their facility. They have been unable to effectively care for her due to her argumentative nature, and her unwillingness to cooperate with their requests and directives in their attempts to provide care for her.

16. The petitioner's representative asserts that the petitioner has problems dealing with roommates, she has a hoarding disorder, she has caustic behavior, and she will not accept direction on all recommended medications. He asserts that she was Baker Acted last summer when she fell, and she was unwilling to accept treatment from the staff. He asserts that as a result of past circumstances and her unstable psychological condition, she needs a high level of medical attendance and support.

CONCLUSIONS OF LAW

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

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

19. In accordance with the Federal Regulations at 42 C.F.R. § 483.12 (a):

> (2) *Transfer and discharge requirements*. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs 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 for (or to have paid under Medicare or Medicaid) a stay at the facility. 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
> (vi) The facility ceases to operate.

20. The petitioner, a resident of the [redacted] was being discharged from the facility because her health has improved sufficiently so that she no longer needs the services provided by the facility.

21. The March 17, 2011 Nursing Home Transfer and Discharge Notice states that the petitioner requires only minimal assistance with all of her activities of daily living, and mobility. It also states that she is able to make her own choices independently, and that she dictates her own medical regimen.

22. The testimony and evidence presented from the parties is taken into consideration in making a final decision. This includes the petitioner's testimony, her representative's arguments, and his written statement disagreeing with the transfer.

23. Physician Notes from [redacted] dated March 15, 2011 states that the petitioner continues to be independent for most activities of daily living, and that she is a good

candidate for an assisted living facility setting. The petitioner's psychiatrist, [redacted] completed a Psychiatric Progress Notes form dated April 22, 2011, stating that the petitioner can have her needs met at an assisted living facility.

24. In addition to the petitioner's two doctors attesting that she can have her needs met at an assisted living facility, the staff that attended the hearing testified that they agree with the transfer. They include the executive director, the administrator, her physical therapist, and a care plan coordinator. A medical records consultant's opinion is that the petitioner is performing her activities of daily living independently, with some staff supervision, and with limited staff assistance.

25. After careful consideration, it is determined that the petitioner would be best served by transferring to a place that would better treat her needs. It is determined that the action to transfer the petitioner from the facility is upheld.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied, and the [redacted] action to transfer the petitioner from the facility is affirmed.

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.

_____
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