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

FILED
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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

APPEAL NO. 15N-00033

PETITIONER,

vs.

Administrator

RESPONDENT.

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FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter convened on May 6, 2015, at approximately 2:30 p.m. in Ocala, Florida.

APPEARANCES

For Petitioner: , Petitioner's wife

For Respondent: Administrator,

ISSUE

Respondent seeks to discharge Petitioner from its nursing home facility (NHF), alleging that "the safety of other individuals in this facility is endangered" by Petitioner's presence. Respondent bears the burden of proof to show, by clear and convincing evidence, that this discharge is appropriate per federal regulations (42 C.F.R. § 483.12).

PRELIMINARY STATEMENT

Via Nursing Home Transfer and Discharge Notice dated March 16, 2015, the Respondent notified the Petitioner that he was to be discharged from its NHF effective April 14, 2015, due to an asserted safety risk. On March 25, 2015, the Petitioner's wife requested a hearing to challenge the Respondent's action.

[redacted] Administrator of [redacted] represented the Respondent. Ms. [redacted] presented three additional witnesses: [redacted] RN, Director of Nursing; [redacted] LPN, floor nurse; and [redacted] Social Services Director, all employed at Respondent's facility. The Petitioner was represented by his wife, [redacted] however, shortly after hearing commenced, Ms. [redacted] excused herself, designating her daughters, [redacted] to represent Petitioner in her absence.

Dennis Phillips and Mark Croft, Ombudsmen, were also present on behalf of Petitioner. Gerald Stephens, Health Facility Evaluator II with the Agency for Health Care Administration (AHCA), observed the proceedings via teleconference. Respondent's Exhibits 1 through 8, inclusive, Petitioner's Exhibit 1, and a composite Hearing Officer Exhibit were entered into evidence.

FINDINGS OF FACT

1. The Petitioner has been a resident of Respondent's facility since June 16, 2014. He was admitted as a Medicaid patient, with diagnoses including dementia, hypertension, and generalized anxiety disorder. At the time of admission, Petitioner was prescribed 0.5 mg of Xanax, three times per day, 5 mg Zyprexa twice per day, and 3 mg melatonin at bedtime.

2. Petitioner is a 65-year old male, born [redacted] In addition to dementia and generalized anxiety, Petitioner has a diagnostic history of or is noted to experience insomnia, congenital syphilis, restlessness, muscle tension, psychosis, behavioral disturbances, psychomotor deficits, confusion, disorganized thinking, bipolar disorder, schizophrenia, depression, constipation, diarrhea, and urinary tract infections. Physical exams conducted while Petitioner has resided in the NHF reflect that he is thin, frail, and non-communicative, with diminished lung capacity and occasional rashes.

3. Petitioner currently resides in a secure/locked unit within Respondent's facility, which is specifically geared towards the needs of patients with dementia. The unit houses a maximum of 26 patients, who are at increased risk of wandering and elopement. Within the secure unit, the NHF maintains an approximate staff to patient ratio of 8:1 during the day and 12:1 at night. The secure unit residents live in semi-private rooms.

4. On June 19, 2014, shortly after admission to the facility, Petitioner underwent a Psychiatric Evaluation. This evaluation notes that Petitioner had a history of some aggression while living in the family home, but that said aggression improved with psychotropic medication. Per the evaluation, Petitioner's Axis I diagnosis is "dementia Alzheimer type with behavioral disturbance" and psychosis NOS. Recommendations include: "No need to give bid dosing of Zyprexa due to long half life will change to 10mg qhr for cost effectiveness."

5. Following a brief period of adjustment to residing in the facility, Petitioner exhibited some behavioral outbursts. Of primary concern to Respondent were incidents

which occurred on July 13th, July 18th, and July 26th of 2014. On these dates, Petitioner allegedly engaged in physical altercations with other residents.

6. Respondent's procedure for notating such altercations is that the person who is first alerted to the incident reports same to a floor nurse, who then documents the incident in the patient's file and/or files an incident report.

7. Respondent's case notes and incident reports reflect that on July 13, 2014, Petitioner was observed wandering into and out of other residents' rooms. Shortly thereafter, female resident was heard screaming. When staff responded, they found the female resident on the floor. The female resident told staff that Petitioner had pushed her down; however, there is no indication that anyone directly witnessed any contact between the two individuals. Following this incident, Petitioner was placed on 1:1 supervision, and met with the facility's psychiatric nurse practitioner.

8. On July 17, 2014, Petitioner was observed taking another resident's walker. Said resident pulled the walker back, without further incident. On July 18, 2014, Petitioner was walking around the unit, and was again observed trying to take a fellow resident's walker. Again, the resident pulled the walker back, and this time Petitioner slapped the resident on the side of her face. Based on this incident, Petitioner remained on 1:1 supervision until about July 21, 2014. On July 25, 2014, he met with the psychiatric nurse practitioner, who decreased his Zyprexa, gradually tittering him off of same and onto Seroquel (100 mg twice per day).

9. On July 26, 2014, Petitioner was observed "wandering without purpose," shortly before staff responded to a female resident's screams. The resident reported that

Petitioner had been trying to take away her chair, and had hit her in the stomach. There is no indication that anyone witnessed this altercation.

10. On July 29, 2014, the facility's psychologist met with Petitioner and his relatives for a family consult. The psychologist noted during this consultation, "Plan for addressing his behaviors reviewed and support provided." There is no further indication as to what the plans or support entailed.

11. It does not appear that Petitioner met with the psychologist again until September 2, 2014, at which point she noted "improved behavior overall," recommended that Petitioner continue with psychiatry for medication monitoring, and terminated psychotherapy.

12. Psychiatric (nurse practitioner) notes from August through September of 2014 reflect medication changes from Zyprexa to Seroquel, the latter of which was discontinued around September 8, 2014. On or about September 11, 2014, Petitioner began taking 25 mg of Trazadone, twice per day.

13. Around January of 2015, Petitioner was observed to be leaning to one side, and to have decreased stability. On January 19, 2015, at his family's request, he was seen by an outpatient neurologist. The neurologist noted that, due to the severity of his dementia, he would not recommend starting Aricept. He further noted, "use safety precautions to prevent wandering; I recommend Alzheimer's unit."

14. Although the 'Treatment Plan' portions of Petitioner's clinical notes do not reflect medicine updates (i.e., they show only Xanax PRN and Zyprexa from June 2014 through April 2015), it does not appear that Petitioner's medications or dosages have

changed from 0.5 mg Xanax, melatonin, and 25 mg Trazadone since September of 2014.

15. In late February of 2015, Petitioner developed "itchy bumps" on his upper chest, and was running a slight fever. Staff administered Tylenol and applied hydrocortisone cream to his chest.

16. On March 12, 2015, Petitioner was noted to be pacing throughout the "day room." Shortly thereafter, staff members observed Petitioner push a female resident to the floor. The Petitioner was placed on 1:1 supervision, which was subsequently discontinued on March 14, 2015. On March 16, 2015, he was seen by a dermatologist, who discontinued hydrocortisone and recommended that staff apply an ointment to his chest, daily.

17. Review of Petitioner's Plan of Care reflects the facility's approach to his behavioral issues as relatively unchanged since July of 2014. This approach includes medication management, redirection, and observation, with 1:1 supervision initiated when an incident occurs, and faded, thereafter. With regard to behavioral symptoms, the Plan notes:

> [Petitioner] triggers for behaviors due to his frequent wandering his inability to express...verbalized needs and follow simple direct commands. Family states he use[d] to be a logger and is usually constantly walking and touching wood or anything resembling. This wandering and touching puts resident at risk of harm if he touches another resident or wander[s] into their personal space. Resident can also become combative whenever care is being provided or if he feels threatened.

18. The facility held Care Plan meetings for Petitioner on December 3, 2014 and March 17, 2015. Petitioner's family was not in attendance. No changes were made to

his Plan of Care in December of 2014. Notes from the March 17, 2015 meeting note, in part:

> CNA from unit informed team that he [Petitioner] is unpredictable during care and when wondering [*sic*] in the hallways. He tends to reach out, hit or grab when someone [is] in the way.... SSD has given a 30 day notice to the family last night, no other items reviewed. No therapy in progress at this time.

19. Via the referenced 30-day notice, dated March 16, 2015, Respondent informed Petitioner and his family of its intent to pursue discharge, checking a box to indicate that "the safety of other individuals in this facility is endangered," and noting, by way of explanation: "[Petitioner] has unpredictable aggressive tendencies which endangers the safety of our secure unit residents." The discharge notice was signed by Dr. [redacted] [redacted], the facility's attending physician.

20. On March 25, 2015, Petitioner's family requested a hearing to challenge the discharge.

21. At hearing, Respondent indicated that the NHF seeks to discharge Petitioner after the incident on March 12, 2015 because of the severity of that event. Specifically, the facility maintains that Petitioner is very strong, and can cause harm to other residents. The woman he allegedly pushed on March 12, 2015 sustained a broken hip, and has since been moved to a different location within the facility. Respondent notes that said female is hard of hearing, and may indeed be perceived as confrontational when she attempts to communicate, as she gets very close to others' faces.

22. Although Respondent admits that a separate resident (other than Petitioner) previously engaged in a nearly identical altercation with this same woman – also

pushing her over, and also breaking her hip, said resident remains within Respondent's facility, and Respondent is not pursuing a discharge of that individual.

23. Respondent has not noticed any precipitating factors to Petitioner's behavior, and thus feels that he is unpredictable. The NHF states that they have attempted multiple measures to address Petitioner's behaviors, including medication adjustment, review for underlying physical precipitators (e.g., infection or pain), psychology consults, and discussion with his family members. Their most recent response has been to keep Petitioner on 1:1 supervision, except for when his family is visiting, at which point, the facility allows Petitioner's family to provide his care.

24. Petitioner's daughters indicated that they were taken aback by the facility's attempt to discharge their father. They visit the NHF on a daily basis – and Respondent confirms that the family is very helpful in caring for the Petitioner, as well as in assisting other residents in need. Petitioner's family testified that they have intervened to break up altercations between other residents (not including their father). The family has observed many similar incidents with other residents, and understood that this was a common aspect of dealing with patients who suffer from dementia. Though the daughters could not recall whether they were contacted regarding all three incidents in 2014, they testified that whenever Respondent alerted them to Petitioner's behavioral issues, Respondent assured them that it was nothing to worry about.

25. With regard to the most recent, March 2015 incident, the family was not involved in developing a responsive approach, nor were they aware of the NHF's plan to provide 1:1 supervision, except when a family member was with Petitioner; instead, the daughters reported many occasions when they visited and found their father

unsupervised. They report that Petitioner does get defensive if others get too close to him, step on his toes, or otherwise invades his personal space. However, they feel it is unfair for Respondent to discharge the Petitioner for incidents that also occur between other residents, particularly given that the altercation on March 12, 2015 is so similar to one that occurred previously, for which the offending individual was not discharged.

26. Respondent agrees that Petitioner is not definitively an "aggressive" person, noting that his behaviors may very well be reactive or defensive in nature. It is Respondent's position that the facility cannot know what causes Petitioner's behaviors, and that this is precisely what makes him a risk to other residents.

27. There is no evidence that Respondent has provided behavioral evaluations/therapy, implemented diversionary tactics/enrichment programs, or sought other methods of determining the source of Petitioner's behavioral issues. It is their position that the Petitioner is unable to participate in such measures due to the severity of his dementia, and that it is difficult to implement a behavior plan if one does not know what is causing the problematic behaviors.

PRINCIPLES OF LAW AND ANALYSIS

28. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 400.0255(15). In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

29. The burden of proof (clear and convincing evidence) is assigned to the Respondent.

30. Federal Regulations appearing at 42 C.F.R. § 483.12, set forth the reasons a facility may involuntary discharge a resident as follows:

> Admission, transfer and discharge rights.
>
> (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.

31. Per documentation and testimony, Petitioner was admitted to Respondent's facility as a dementia patient with anxiety, behavioral issues, and a history of psychosis. Almost immediately upon admission, it was noted that Petitioner had a tendency to wander the halls, and to place his hands on objects which he passes. Prior to every incident involving an altercation with another resident, the NHF observed Petitioner wandering, entering other patients' rooms, and/or pacing the floors. Respondent's records reflect that Petitioner has difficulty communicating, and that he is defensive with regard to personal space.

32. Each of Petitioner's three prior, physical altercations occurred in July of 2014. Following medication changes, there were no further altercations for nearly eight months, until March 12, 2015. Of note, a few weeks prior to the

March incident, Petitioner was ill, with a fever. He was also observed to have a chest rash/bumps, for which he was still being treated on March 16, 2015.

33. While Respondent contends that Petitioner displays no warning signs or predictors prior to engaging in physical altercations, the facility's case notes not only reflect a pattern of precipitating behavior (wandering, pacing), but with regard to the March incident, also reflect the presence of a potential, underlying illness or discomfort (itchy rash). More importantly, it is unclear how Respondent could conclude that no predicating factors exist, without first obtaining a comprehensive behavior evaluation.

34. The facility contends that Petitioner's dementia is too severe to enable participation in a plan geared toward targeted behaviors (i.e., decreasing physical aggression). However, there is no evidence that such measures were attempted, failed, and ruled out. There is also no indication that alternative/multidisciplinary approaches – such as increased diversion or speech or physical therapy – have been considered.

35. Respondent believes that discharge is appropriate because Petitioner is perceived as a strong individual, who may harm other residents. In contrast, Petitioner's physical exams consistently reflect frailty and compromised lungs, a lean towards one side, and lack of stability. On January 19, 2015, the neurologist who saw Petitioner specifically recommended that he reside in a secure dementia unit, where his wandering could be monitored. Moreover, even after the March 12, 2015 incident, Petitioner's behaviors had sufficiently

improved to permit discontinuation of 1:1 supervision two days later, on March 14, 2015.

36. It is understandable that the facility may not be able to provide 24-hour, 1:1 care for Petitioner. However, Respondent's secure unit is specifically geared toward housing patients with dementia. Respondent has a duty to attempt provision of appropriate services, and to exhaust all reasonable attempts at addressing Petitioner's occasional behavioral issues. This is particularly true in that Petitioner was admitted based, in part, on anxiety and related behaviors, and that Respondent seeks to discharge him for an incident nearly identical to one committed by a separate patient who is *not* being discharged. Per testimony from both sides, Petitioner's behaviors do not appear markedly different than those of other residents within the secure unit.

37. After considering the entire record, the undersigned concludes that Respondent has not met its burden to prove, by clear and convincing evidence, that the Petitioner presents a continued risk to the safety of his fellow residents.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Petitioner's appeal is GRANTED. The facility has not established that discharge is permissible under federal regulations.

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 18th day of June, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci

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