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

APPEAL NO. 08F-08554

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT:

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was first held before the undersigned hearing officer on January 23, 2009, at 2:09 p.m., in Plant City, Florida. The petitioner was not present for this first hearing, but was represented by his mother, also testified at the first hearing, but was not present for the second hearing. David Beaven, program analyst with the Agency For Health Care Administration (AHCA), represented the respondent and testified on both hearing dates. Phyllis Rothman, registered nurse with the Department of Health, appeared as a witness for the respondent at both hearing dates. Chris Russell, administrator with the Brain and Spinal Cord Injury Program (BSCIP), appeared as a witness for the respondent by telephone at both hearing dates.

The hearing was held again on February 12, 2009, at 1:32 p.m., at the same location. The petitioner appeared to represent himself and testify by

telephone at this second hearing. The petitioner's mother was not present for the second hearing. All other persons were present as in the first hearing.

ISSUE

At issue is the respondent's decision of December 10, 2008 to reduce personal care services provided under the BSCIP from four hours daily to 2.71 hours daily. Further at issue, the respondent reduced companion services from six hours daily to 4.5 hours daily. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner was injured in an accident about ten years ago. The petitioner is currently authorized to receive approved services in his home under the BSCIP. The petitioner was previously approved to receive four hours daily personal care services under the BSCIP. The respondent proposes to reduce these hours to 2.71 hours daily. The respondent previously approved companion services of six hours daily, but he respondent proposes to reduce these hours to 4.50 hours daily.
2. The petitioner is 31 years old. He lives with his 65 year old mother as the only other household member. The petitioner does not walk independently since he has paralysis from the chest down. The petitioner has some use of his arms. The petitioner is on no medical devices, but he does use a TENS unit for pain management. The petitioner wears special boots, and needs help with catherization.
3. The petitioner retains approval for two hours daily, three times weekly attendant care hours. A nurse arrives to assist with bowel care under

these attendant care hours. This attendant care nurse can assist with catherization needs during these hours. However, the petitioner's mother has assisted with catherization in the morning before she leaves for work in the morning, and when she returns in the late afternoon. The attendant care nurse works from 7:00 a.m. to 9:00 a.m. on Mondays, Wednesdays, and Fridays. The respondent did not reduce the prior approved consumable medical supplies of one hour monthly.

4. The combination of personal care and companion services had been provided ten hours daily, seven days weekly. On Mondays, Wednesdays, and Fridays, these services were provided after the exit of the attendant care nurse, from 9:00 a.m. to 7:00 p.m. On Tuesdays and Thursdays, these services were provided between 8:00 a.m. and 6:00 p.m. These services were provided on weekend days from 9:00 a.m. to 7:00 p.m. The respondent proposes to reduce these combined personal care and companion services from ten hours daily to 7.21 hours daily, seven days weekly. The times these services can be provided are flexible, per testimony. The prior amount of approved services have been continued pending the decision of this appeal.

5. The petitioner's mother is not a medical professional and is employed at a call center. She works full-time on weekdays. She leaves for work around 5:45 a.m., and returns around 4:00 to 4:15 a.m. The aides are permitted to perform needed shopping chores, per

testimony. However, the petitioner's mother does shopping for herself and her son. The petitioner's mother has not left her son in the home alone. There is no medical reason why the petitioner can not remain alone in the home. The petitioner has multi-media devices that he can use to contact persons by phone in the event of an emergency. The respondent program administrator offered to fund a home security system, due to expressed external home safety concerns.

6. In latter November 2008, the BSCIP state administrator looked at where individual BSCIP services could be reduced due to a statewide reduction in allocated funds for the program. The administrator then ordered the waiver specialists to examine where services could be reduced without jeopardizing the health and safety of the then 327 statewide recipients in the BSCIP.

7. Phyllis Rothman, a registered nurse and Medicaid Waiver specialist, visited with the petitioner in September 2008. After Ms. Rothman was advised of the need to reduce services under the BSCIP due to funding reductions, she conferred with the petitioner's community support coordinator. Ms. Rothman opined that personal care and companion care services could be safely reduced to the amounts at issue. There was no rebuttal evidence that these services could not be safely reduced to the amount at issue. On December 10, 2008, the respondent sent written notice to the petitioner of these reduced services under the BSCIP.

8. The petitioner testified that he can handle some reductions in the approved amount of hours. The petitioner's mother believes that she will need to reduce her work hours if services are reduced.

CONCLUSIONS OF LAW

The Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook (BSCIP Handbook) has been promulgated into rule under Florida Statutes 408.301, 408.302, and 409.919. Per this handbook, the Department of Health is authorized by the respondent agency to operate and oversee the BSCIP Medicaid Waiver Program. The general intent of the BSCIP program is to provide support and services to qualified individuals, which enable recipients to have the ability to live at home and in the community. Provided services are intended to delay or prevent institutionalization.

The BSCIP Handbook, page 2-15, show that services under the BSCIP must be defined as "medically necessary" to recipients per the definition set forth under the Florida Administrative Code (F.A.C.) Rule 59G-1.010. This F.A.C. rule addresses relevant definitions applicable to the BSCIP, which apply to the decision on the personal care and companion services at issue. Subsection (166) of the Florida Administrative Code Rule defines "medically necessary" care, goods or services, as follows:

> ...means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the reviewing nurse with the Department of Health recommends the reduction of the personal care and companion services based on her evaluation of the petitioner's needs. There was no rebuttal evidence to show that these services could not be safely reduced to the amounts at issue. The petitioner also testified that he could handle a certain amount of reduction in the amount of these hours.

In sum, it is concluded that the respondent decision to reduce attendant and companion services to the amounts at issue is correct, based on the available evidence applied to the medical necessity definition. Thus, the respondent has met its burden to justify the reduction of these services to the amounts at issue.

DECISION

This appeal is denied in that the respondent has met the burden to prove that the reduction of personal care and companion services can be safely reduced to the amounts at issue.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. 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 petitioner's responsibility.

DONE AND ORDERED this 10th day of April, 2009, in Tallahassee, Florida.

Jim Travis

Jim Travis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
Sue McPhee, Area 6 Medicaid Field Manager

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

PETITIONER,

Vs.

APPEAL NO. 09F-00274

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Clay
UNIT: 88369

CASE NO. 1239587074

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 17, 2009, at 2:15 p.m., in Orange Park, Florida. The petitioner was not present. The petitioner was represented by her niece, and husband, The Department was represented by Pamela Jackson, ACCESS economic self-sufficiency specialist.

ISSUE

The petitioner is appealing denial of Institutional Care Program benefits for the months of October 2008, November 2008 and December 2008 due to excess income.

FINDINGS OF FACT

1. On September 26, 2008, the petitioner's niece submitted an application for Institutional Care Program (ICP) Medicaid benefits for the petitioner. The petitioner was admitted into the Nursing Home as a Medicaid pending resident on

October 6, 2008. The petitioner was born on November 16, 1923. At the time of application, she was age 74. The petitioner suffers from severe arthritis; she is unable to perform the activities of daily living and requires skilled nursing care.

2. At the time of the application, the petitioner's income was Social Security benefits and a retirement pension; combined total monthly income for 2008 was $2047. Both parties stipulated to the correctness of this figure. The petitioner's total monthly income exceeded the income standard for ICP benefits of $1,911 which was effective January 2008 through December 2008. Therefore, the petitioner was not eligible to receive ICP Medicaid unless a qualified income trust was established for her and funded each month.

3. On October 13, 2008, the Department sent the petitioner's niece a pending notice which reads in part: "A qtit (sic) needs to be set up and funded properly." The information due date contained on the notice was October 23, 3008. The petitioner's niece does not recall receiving that notice, but did not dispute the correctness of the address to which the Department asserted the notice was sent. The petitioner's niece argued that as the notice uses a lower case and abbreviated acronym "qtit" for the words income trust, she is not sure if she would have understood what was being requested of her had she actually received the notice.

4. An income trust was established for the petitioner in 2006 when she resided, for a brief time, in another nursing facility and received Medicaid. The account was not closed when the petitioner left the nursing facility to move into an assisted living facility; the family just stopped funding the trust as the petitioner's Medicaid benefits were terminated. The petitioner's niece asserted that a copy of this 2006 trust document was

faxed to the Department the first week in October 2008 to jump start the application process as there had been no response from the Department to the September 26, 2008 application. The petitioner's niece asserted that she was waiting for the Department to provide the specific amount required to properly fund the trust. The income trust information was faxed again to the Department on or about October 21, 2008 after speaking to the case processor who advised her that the original fax could not be located.

5. On January 14, 2009, the Department completed the ICP application. ICP Medicaid was approved for January 2009 forward; however, the petitioner was denied ICP Medicaid for the months of October 2008 through December 2008 because the income trust was not properly funded.

6. The petitioner's niece believes that the Department was negligent in not timely informing her of the amount needed to properly fund the trust, resulting in ineligibility for three months. The petitioner's niece argued that after not hearing anything from the Department after October 21, 2008 she began to call and e-mail the Department for a status update on the petitioner's case mid month November 2008; copies of the e-mails and the family's phone bills were submitted to prove the contact attempts. The petitioner's niece argued that after receiving no response from the Department, she e-mailed the circuit administrator of the local office processing the application the first week in January 2009, and received a call a few days later from a Department representative who advised her to use $7100 in the petitioner's banking account to pay some of the nursing home charges and fax the Department a confirmation receipt from the facility. The petitioner's niece asserted that she did this immediately and three days

later she received a call from the Department advising her that the ICP application was approved effective January 2009, but denied for the previous months (October 2008 – December 2008). The petitioner's niece argued that prior to the January 2009 phone call, the Department had never informed her verbally or in writing regarding how much to deposit monthly into the income trust. She believes the Department did not follow its own policy requiring staff to inform applicants of this requirement, when the income exceeds the ICP limit. The Department representative at the hearing repeatedly noted for the record that she was not one of the two or three representatives who actually worked on the case between September 2008 and January 2009 and had no first hand knowledge about the details of the case. She asserted that it is Department policy to notify ICP Medicaid applicants of the income limit and that all income above that limit must be deposited into an income trust; however she could not find any evidence that the Department followed that policy in this instant case beyond the October 13, 2008 notice detailed above.

7. Both parties stipulate that the income trust was not funded for the months of October 2008, November 2008 and December 2008. Both parties stipulate the income trust was funded for January 2009 forward. The petitioner's niece believes that had the Department not delayed in providing the information necessary to fund the income trust for the petitioner, the trust would have been funded October 2008 forward. The Department argued that because the family had experience with funding the income trust in 2006, they should know how to properly fund the trust. The Department maintains the position that, because the income trust was not funded for the months detailed above, the petitioner was ineligible for ICP benefits during those months

because the petitioner's income exceeded program limits. However, the Department representative again reiterated that she was unsure of the details surrounding this application as she was not one of the individuals who processed the case.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.701, "Definitions", states in part:

> (26) Qualified Income Trust: A trust established on or after October 1, 1993, for the benefit of an individual whose income exceeds the ICP income standard and who needs institutional care or HCBS. The trust must consist of only the individual's pension, Social Security and other income. The trust must be irrevocable and provide that upon the death of that individual the State shall receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of that individual pursuant to the state's Title XIX state plan.

Fla. Admin. Code 65A-1.702(15) "Trusts" in part states:

> (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).
> (b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.
> (c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to

someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

Fla. Admin. Code 65A-1.713 in part states:

SSI-Related Medicaid Income Eligibility Criteria.
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows: ...
(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(15), F.A.C.

Fla. Admin. Code 65A-1.205 Eligibility Determination Process, states:

(1)(b) Time standards for processing applications vary by public assistance program... time standards begin the date following the date the application was filed... For the Medicaid program, the time standard ends on the date the Department mails an eligibility notice. The Department must process and determine eligibility within the following time frames: ... For all other Medical Assistance and State Funded Programs **45 days**.

Fla. Integrated Pub. Policy Manual, 165-22 passage 1840.0110 in part states:

Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:
It is established on or after 10/01/93 for the benefit of the individual;
It is irrevocable;
It is composed only of the individual's income (social security, pensions, or other income sources); and
The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf...

> **The eligibility specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received.** (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)

The ICP Medicaid application was not completed until three months after the application was filed with the Department. The Findings of Fact show that the petitioner's income trust was not funded for months of October 2008, November 2008 and December 2008. Based on the above legal authorities, a requirement of eligibility is that the trust be funded for each month ICP eligibility is needed. It is also a requirement that the Department advise the individual that he or she cannot qualify for ICP Medicaid for any month in which the income is not placed in an executed income trust account in the same month in which the income is received.

The web application date was September 26, 2008. In January 2009, the Department advised the niece of the funding required for income trust; this was long after the 45 day processing time had elapsed. Once the Department advised of the need to fund the trust in January 2009, the niece funded the trust immediately. Therefore, the undersigned concludes the Department erred in not following its policy and the petitioner is to be considered to have met the ICP income standard for October 2008, November 2008 and December 2008. The Department must determine eligibility on all other factors.

DECISION

The appeal is granted. The ICP Medicaid denial for October, November and December 2008 is hereby reversed. The Department is to take corrective action within 10 days of the date of this order and issue a written notice of its decision.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner 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 petitioner 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 respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 10th day of April, 2009, in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
4 DPOFS Theola Henderson

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

APPEAL NO. 09F-00937
09F-00938

Vs.

CASE NO. 1063466121

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66296
AND
AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
RESPONDENT.
_____/

FINAL ORDER

An administrative hearing was convened before the undersigned on March 3, 2009 at 1:25 p.m. and on April 9, 2009 at 2:45 p.m. in Orlando, Florida. The petitioner represented herself. On the first occasion, Rogrigue Baly, ACCESS supervisor, represented the respondent. On the second date, ACCESS supervisor Sarah Tidwell was the representative for Appeal Number 09F-00937. On the second date, Lisa Sanchez, senior human service program specialist from AHCA, was the representative for Appeal Number 09F-00938.

ISSUE

The first issue was whether or not proration of food stamp benefits for December 2008 was correct. The second issue was whether or not AHCA can facilitate Social Security Administration (SSA) reimbursement to the petitioner following AHCA payment to SSA for the Medicare Part B monthly premiums.

FINDINGS OF FACT

FOOD STAMPS

1. The petitioner applied for food stamps for herself and her minor daughter on December 11, 2008 (Respondent's Exhibit 5). The respondent prorated benefits from that application date, with $60 authorized for December 2008 (Respondent's Exhibit 2). The petitioner challenged the level of benefit approval for that month.

2. The petitioner's adult daughter began receiving Supplemental Security Income (SSI) in September 2008. At that time, the petitioner was receiving food stamps for herself, that daughter and a younger daughter.

3. The respondent recalculated the food stamp budget using the new information. The daughter's SSI benefits were added to the petitioner's SSA income during fall 2008. Income exceeded standards of a three-person group. This is undisputed. The respondent cancelled food stamps of the petitioner and her daughters.

4. The adult daughter then began to receive food stamps on her own as a single person assistance group under the SUNCAP option.

QMB BUY IN

5. The petitioner is eligible for the Qualified Medicare Beneficiary (QMB) Program. AHCA pays the Medicare premium for the petitioner. That is undisputed and the petitioner is satisfied about that.

6. There appears to be an SSA problem as the petitioner has not received reimbursement for recent past payments that AHCA made to the SSA for the buy

> certain information verified. The State agency must act promptly on all applications and provide food stamp benefits retroactive to the month of application to those households that have completed the application process and have been determined eligible. ...

Federal guidelines also establish the proration system used for determining the benefit amount as follows:

> **§ 273.10 Determining household eligibility and benefit levels.**
>
> (a) *Month of application* —(1) *Determination of eligibility and benefit levels.* (i) A household's eligibility shall be determined for the month of application by considering the household's circumstances for the entire month of application. ... (ii) A household's benefit level for the initial months of certification shall be based on the day of the month it applies for benefits and the household shall receive benefits from the date of application to the end of the month ...

In view of the regulations cited and the facts, it is concluded that the application date and completion of the application process are critical. Benefits cannot be approved for a date before the date of application. With application of December 11, 2008, proration from that date was correct. Because the respondent authorized benefits effective December 11, 2008, and prorated benefits based on the day of the month the petitioner applied, that was the proper action. Federal regulations direct that procedure. Proration has been justified.

QMB BUY IN

This section will address the AHCA concern.

Federal regulation 42 C.F.R. **§ 431.241 Matters to be considered at the hearing** deals with state level administrative hearings and informs that:

> The hearing must cover—
> (a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility;

State rules appear at Florida Administrative Code 65-2.056 **Basis of Hearings** and deal with the hearing officer's ability to address actions as follows:

> The Hearing shall include consideration of:
> (1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

The Office of Appeal Hearings of the Department of Children and Families affords state level hearings related to state programs and does not have jurisdiction over federal SSA matters. The SSA notices issued to the petitioner may be addressed by SSA but are not within jurisdiction of AHCA. While the frustration and dissatisfaction are unfortunate, neither AHCA nor the Department of Children and Families has a remedy for the petitioner's reimbursement problem with SSA. The Department may not address the matter further.

DECISION

The food stamp appeal is denied. The SSA reimbursement issue is dismissed as nonjurisdictional.

NOTICE OF RIGHT TO APPEAL

FOOD STAMPS

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner 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 petitioner 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 petitioner's responsibility.

QMB BUY IN

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. 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 petitioner's responsibility.

DONE and ORDERED this 29th day of April, 2009,

in Tallahassee, Florida.

J W Alper
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
District 7 ACCESS Cassandra Johnson
AHCA, Judith Jacobs

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

APPEAL NO. 09F-00848

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 4, 2009, at 11:20 a.m., at the Lake Worth Service Center, in West Palm Beach, Florida. The petitioner was present, via the telephone and represented herself at the hearing. Also present as a witness for the petitioner, via the telephone, was the petitioner's friend. The Agency was represented by David King, management analyst from the Agency For Health Care (AHCA). The hearing was left open for the rest of the day in order for the respondent to submit additional information. Additional information was submitted within the time frame allotted.

ISSUE

The petitioner is appealing the Agency's action not to pay as a Medicaid service payment, for a dental procedure. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner receives disability benefits and is over twenty one years of age.

2. The petitioner, who is an SSI-Related Medically Needy enrollee, had met her share of cost on September 10, 2008. She was eligible for Medicaid coverage for the rest of the month of September 2008. The petitioner is also a Medicare recipient. Humana was her Medicare provider in September 2008.

3. The petitioner received dental treatment during the time she was Medicaid eligible in September 2008. The dental procedure involved the petitioner receiving five crowns. The petitioner's Medicare provider paid for one crown.

4. The petitioner alleged that a staff person from the Department of Children and Families had advised her to get the dental treatment as Medicaid would cover the bill. The petitioner had been in contact with various levels of (State) government employees from the Department of Children and Families (DCF), to someone at the Governor's Office and to AHCA, concerning Medicaid coverage.

5. The petitioner had sent her dental bills to DCF and these "bills" were used by the Department for the petitioner to meet her share of cost. In November 2008, a staff member from DCF had mailed to the petitioner a letter advising her that; "Your submission of medical bills to the Department does not mean Medicaid will pay that bill; it means we can determine eligibility for the Medicaid Program based on that bill."

6. Apparently the petitioner's Dental office provider had requested Medicaid pay for the other four crowns. Medicaid did not pay for this treatment. The petitioner did not get a Notice advising her from Medicaid or AHCA that the dental bill was not paid. The petitioner had contacted a staff member of AHCA in Tallahassee about the dental bill and

was verbally told that this medical/dental procedure (the crowns) was not and is not a covered service by Medicaid.

7. The respondent submitted into evidence, Respondent Exhibit1, which contains copies of fee schedules. There was information provided to this hearing officer prior to this hearing, by the petitioner and is accepted as Petitioner Exhibit 1.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-4.060 sets forth dental services of the Medicaid Program and states:

> (1) This rule applies to all dentists enrolled in the Medicaid program for dental services under Section 409.906, F.S.
>
> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Coverage and Limitations Handbook...
>
> Fla. Stat.ch 409.906 states in part:
>
> Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions pro409.906vided for in the General Appropriations Act or chapter 216. Optional services may include:
>
> (1) ADULT DENTURE SERVICES.—The agency may pay for dentures, the procedures required to seat dentures, and the repair and reline of dentures, provided by or under the direction of a licensed dentist, for a recipient who is age 21 or older.

The Agency's Dental Services Coverage and Limitations Handbook sets forth the dental covered services through the Medicaid Program and states in part on page 2-3:

> The adult denture program provides for the reimbursement of services necessary to seat dentures...
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for adult Medicaid recipients. Emergency dental care shall be limited to emergency-problem-focused evaluations, necessary radiographs, extractions, and incisions and drainage of abscess, for recipients 21 years of age or over.

As shown in the Findings of Fact, the Agency did not pay through Medicaid for the dental procedure occurring in September 2008 for the petitioner as requested. The dental procedure was for four crowns, as this was and is not a Medicaid covered service for adults.

The petitioner argued that she was told by a DCF staff person that she could go ahead with her dental procedure and Medicaid would cover the cost. She argued that the dental procedure was medically necessary as she was in pain and unable to eat. She argued that the Agency should make an exception to the rule for her situation.

The respondent argued that a DCF staff person would not be aware of what Medicaid pays as a service, as the DCF person makes eligibility decisions only for the Medicaid benefits. He argued that no one from AHCA told her that the dental procedure would be covered under Medicaid. He argued that the dental provider, is the one, beside AHCA that would know the procedure is not covered by Medicaid. He also argued that Medicaid pays for very limited procedures for adult dental, as noted in the Agency's dental

handbook. He argued that the request for the payment of the crowns as a dental procedure is not a covered service through Medicaid.

An argument concerning the Department (DCF) providing incorrect information, pertains to equitable estoppel. In order for equitable estoppel to be applied, there would have to be a representation as to a material fact that is contrary to a later asserted position, a reliance on that representation, and a change in position detrimental to the party claiming estoppel caused by the representation and reliance therein. After careful consideration, it is determined that equitable estoppel does not exist in this case.

For the case at hand, the Agency's above noted handbook does not specifically mention dental procedures that are not covered by Medicaid; it does address what is covered by Medicaid. The hearing officer thus agrees with the respondent's last argument.

After considering the evidence, the Florida Administrative Code Rule and all of the authorities as set forth in the findings above, the hearing officer finds the Agency's action not to pay for the petitioner's dental procedure; the four crowns, as this procedure is not a covered by Medicaid procedure, is correct.

DECISION

This appeal is denied and the Agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 8th day of April, 2009,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
Mark Pickering, Area 9 Medicaid Adm.
Bill Porter
David King

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

APPEAL NO. 09N-00023

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on March 25, 2009, at 3:10 p.m., at the respondent/facility location. The respondent/facility was represented by the executive director of the facility, , who also testified. The petitioner was present to testify, but was represented by , attorney with The petitioner's friend appeared as a potential witness for the petitioner. , an employee of observed. the facility business office manager, appeared as a witness for the respondent. facility admissions office, appeared later in the hearing as a witness for the respondent.

ISSUE

At issue is whether or not the facility's discharge action of January 30, 2009 is a correct action. The discharge action is based on non-payment by the petitioner. The respondent facility has the burden of proof to justify the discharge action by a standard of clear and convincing evidence.

FINDINGS OF FACT

1. The petitioner was admitted to the respondent facility on November 20, 2008 after a stay at a hospital. The petitioner was in the hospital due to a broken leg after a large dog jumped on her. The petitioner will be 65 years old in May 2009 as her birth date is May 2, 1944.
2. The hospital referred the petitioner, and was later admitted to the respondent facility based on pending Medicaid eligibility. The petitioner receives Social Security early retirement income of approximately $507 monthly as her only income source. The petitioner applied for Institutional Care Program and Medicaid eligibility (ICP) on December 10, 2008. The Department of Children and Families (DCF) denied ICP benefits on January 7, 2009 based on not meeting disability criteria. There is no evidence that the petitioner has any insurance or other payor source for her stay at the facility.
3. On January 21, 2009, the petitioner was given a nursing home transfer and discharge notice based on non-payment. The petitioner owed $32,949.27 to the facility as of the hearing date,

per testimony. The respondent seeks to discharge the petitioner because of non-payment. On January 31, 2009, the petitioner received a billing notice that she owed $16,816 to the respondent facility. The petitioner did not understand the amount of accumulated charges prior to this notice, per testimony. The petitioner made an $800 payment to the facility after receiving this billing notice. The petitioner did not receive a billing notice any earlier than January 31, 2009.

4. The petitioner does not have a home in the community. The discharge notice listed the discharge location as the in Sarasota, Florida. The petitioner mostly uses a wheelchair for mobility. The petitioner needs assistance walking and walks only a very short distance. The petitioner understands that she can not be discharged to the because she can not walk independently. The petitioner's representative argues that the is not a reasonable discharge location.

CONCLUSIONS OF LAW

Appropriateness of Discharge Planning

42 C.F.R.§ 483.12 Admission, transfer and discharge rights.

(a) Transfer and discharge...(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.

This law provides that an individual may be discharged from a facility for one of the above listed reasons.

The fair hearing process is set forth in the Code of Federal Regulations:

42 CFR § 431.220 When a hearing is required.
(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged...

42 CFR § 431.241 Matters to be considered at the hearing.
The hearing must cover—

c) A decision by a skilled nursing facility or nursing facility to transfer or discharge a resident...

Federal regulations require states to have a fair hearing process to determine whether a person can be transferred or discharged from a nursing facility. The state took this action in Florida Statute § 400.0255 (Resident transfer or discharge; requirements and procedures; hearings,) and assigned the responsibility for conducting the hearings to the Department of Children and Families, Office of Appeal Hearings.

The regulations further define what is to be considered at the hearing. With discharge or transfers, the only matter that can be determined is whether the *decision* to transfer or discharge is in accordance with one of the above listed reasons in the federal regulation.

A hearing for determining whether a nursing home can discharge a resident is guided by Goldberg v. Kelly 397 U.S. 254 (1970). The issue in Goldberg was

> ... whether a State that terminates public assistance payments to a particular recipient without affording him the opportunity for an evidentiary hearing prior to termination denies the recipient procedural due process in violation of the Due Process Clause of the Fourteenth Amendment. (at 255)

Therefore, a resident of a nursing home that participates in Title 18 and Title 19 federal funding must be provided an opportunity to challenge a discharge action in a fair hearing. (*see* 42 CFR §§ 483.12 and 483.200) The hearing officer is determining whether due process guarantees were followed. "Procedural due process serves as a vehicle to ensure fair treatment through the proper administration of justice where substantive rights are at issue." (Dept. of Law Enforcement v. Real Property, 588 So.2d 957, 960.) Questions have been raised as to what the fair hearing process can review in a procedural due process hearing.

The petitioner argues that the discharge action should not be upheld because the respondent has failed to conduct appropriate discharge planning pursuant to federal regulations irrespectively of whether the grounds for discharge are valid under the authorities. Prior to determining whether that is

true, it must first be determined if discharge planning and the ultimate discharge location is an issue to be reviewed in this procedural due process hearing. The scope of these hearings is defined in Goldberg:

> In the present context these principles require that a recipient have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally. These rights are important in cases such as those before us, where recipients have challenged proposed terminations as resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases. (at 267, 268)

The fair hearing process includes due process procedures to assure that the resident received adequate notice to be able to mount a meaningful challenge the action (the discharge) under appeal. Federal law requires a resident to have notice of the discharge action that will be taking place. The requirements of the notice are established in 42 CFR 483.12. Specifically,

> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
> (i) The reason for transfer or discharge;
> (ii) The effective date of transfer or discharge;
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;

The reason for the discharge will be discussed in the subsequent preceding paragraphs. The only other issue to be determined is whether the notice meets the requirements that are established in federal regulations. The hearing officer is limited to the four corners of the notice to determine whether proper procedures were followed and whether the discharge can commence. In

the instant case, all of the requirements have been met in the notice supplied to the petitioner. Regarding location, the regulations simply require that one be listed.

The respondent has stated on the notice that the petitioner is being discharged for failure to pay for his stay at the facility. This is a valid reason for discharge under the law and the respondent has the burden to show that such has occurred in accordance with the standards set in the authorities. Further, the notice informed the petitioner of her right to have a hearing where she will have an effective opportunity to defend by confronting any adverse witnesses and by presenting her own arguments and evidence orally. In this hearing the petitioner will be able to challenge the proposed discharge or transfer for a variety of reasons including incorrect or misleading factual premises or on misapplication of rules or policies to the facts of her case. The hearing officer concludes the notice sufficiently meets the requirements of adequate notice under Goldberg.

The petitioner asserts that discharging the petitioner to the
is not appropriate discharge planning and that the intended discharge action should be reversed because the discharge planning was not completed correctly. The authorities require a skilled nursing facility to permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

> 42 CFR § 1395i-3. Requirements for, and assuring quality of care in, skilled nursing facilities
> (2) Transfer and discharge rights
> (A) In general

> A skilled 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 subchapter or subchapter XIX of this chapter on the resident's behalf) for a stay at the facility; or
> (vi) the facility ceases to operate.

Failure to complete discharge planning is not listed as one of the six reasons to permit the resident to stay in the facility. The authorities further limit the matters to be considered at the hearing to the decision by a skilled nursing facility or nursing facility to transfer or discharge a resident. The correctness of the discharge planning or the discharging location listed on the notice is not listed in the regulation as a matter to be considered in the hearing. The hearing officer's authorities are limited to that specifically conveyed by legal authority.

That is not to say that the facility is not required to conduct discharge planning. Federal regulation 42 C.F.R. 483 discusses discharge planning both in § 483.12 Admission, transfer and discharge rights and § 483.20 Resident assessment. These regulations require a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Florida Statute § 20.42 Agency for Health Care Administration provides that the Agency for Health Care Administration is responsible for health facility licensure, inspection, and regulatory enforcement;

investigation of consumer complaints related to health care facilities. Additionally Chapter 400 provides for claims for resident's rights violation or negligence by a facility. Any of these may be options under which the petitioner may pursue her concerns about the correctness of the discharge planning.

Discharge as a Result of Non-payment

The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by extension of the federal regulations appearing at 42C.F.R.§431.200. As earlier stated, federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment. Federal regulations do permit a discharge for this reason, as set forth at 42 C.F.R. §483.12(a)(2)(v), as follows:

> 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;

The petitioner had an unpaid balance of $32,949.27 due the facility as of the hearing date. The petitioner was denied ICP benefits and has no payor source besides $507 monthly Social Security income. However, the petitioner did not receive any billing statement(s) on charges during her stay at the facility until the day after the discharge notice on January 30, 2009. In view of the lack of these billing notices prior to the discharge notice, it can not be concluded that the petitioner received "reasonable and appropriate" notice to pay for her stay at the facility, as required in the language of the above federal regulation.

Therefore, the nursing facility does not meet its burden of proof in this specific discharge action for non-payment.

Attorney Fees

The court addressed attorney fees in fair hearings in French v. Dep't of Children and Family Services, 920 So.2d 671 (Fla. 5th DCA 2006). The decision addresses attorney fees under s.120.569 F.S. Section 120.569 addresses decisions affecting substantial interests, states in part: "(1) The provisions of this section apply in all proceedings in which the substantial interests of a party are determined by an agency ...". Although in accordance with federal requirements a resident of a nursing facility being discharged is entitled to a fair hearing, that hearing is not conducted under F.S.120.569, as the substantial interests of the petitioner have not be been determined by a state agency but rather by the private party, the nursing facility. The hearings are rather conducted under s. F.S. 400.0255, which does not include language providing for attorney fees.

DECISION

The appeal is granted. The facility is prohibited from discharging the petitioner based on this specific discharge action under appeal. This decision is not binding on any possible future discharge action(s), if later initiated by the respondent facility.

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 First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party 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 29th day of April, 2009,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 09N-00019

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 5, 2009, at 3:45 p.m., at the facility. The petitioner was present. Present representing the petitioner was his daughter, . Present as witnesses for the petitioner were , certified ombudsman, Florida Long-Term Care Ombudsman Program and , ombudsman manager, Florida Long-Term Care Ombudsman Program. The respondent was represented by administrator. Present as witnesses for the respondent were , social services supervisor, director of nursing and regional nurse consultant.

ISSUE

At issue is whether or not the action by the facility to discharge the petitioner, on the basis that his health has improved sufficiently so that he no longer needs the

services provided by the facility and the safety of other individuals in the facility was endangered, is correct.

The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. §483.12.

FINDINGS OF FACT

1. The petitioner has been residing at the facility since July 9, 2008. The petitioner's date of birth is July 20, 1925; the petitioner is age 83.

2. The petitioner has been diagnosed with dementia, hypertension and osteoarthritis.

3. On January 21, 2009, the petitioner was given written notice that he was being discharged effective February 28, 2009 because his health had improved so that he no longer needed services provided by the facility and also that the safety of other individuals in the facility is endangered.

4. In a letter dated January 16, 2009, the petitioner's attending physician at the facility, Dr. , stated that he felt that the petitioner is appropriate for assisted living. However, it would be important for medications to continue to be supervised.

5. On March 4, 2009, Dr. signed a discharge order stating that the petitioner was to be discharged to an Assisted Living Facility (ALF). Progress note dated March 4, 2009, which was signed by Dr. :, states that he believed that the petitioner would do well in an ALF.

6. Resident Health Assessment for Assisted Living Facilities (ALF) form dated February 19, 2009, states that the petitioner could ambulate, eat and transfer

independently, could bathe, groom and dress himself with supervision and that he needed supervision with toileting. The petitioner needs assistance with preparing meals, shopping and making phone calls. The petitioner would need daily oversight to remind him of important tasks and to take his medication.

7. The petitioner has had a number of episodes of pneumonia during the past five months and two have required hospitalization. However, he was treated with oral antibiotics and his condition improved. The facility believes that the petitioner no longer requires 24 hour a day skilled nursing care and he has not been receiving services at the facility that are considered skilled nursing services.

8. Resident assessment and care screening completed from July 2008 through March 2009, showed that the petitioner was alert, oriented, had clear speech, was usually understood, was usually able to understand others and that his cognitive functions vary in relation to his overall physical/medical health from normal to mild cognitive deficit. Respondent's Exhibit 2 is a March 3, 2009 statement from

MSW ACSW LCSW LMFT indicating that the petitioner has not been adjudicated incompetent and that he can make his own decisions in reference to his physical, medical needs and living arrangements.

9. On July 30, 2008, the petitioner started exhibiting inappropriate sexual behaviors. Medical records from July 30, 2008 through March 4, 2009 documenting the incidents of inappropriate behaviors exhibited by the petitioner were submitted as part of the Respondent's Composite Exhibit 1.

10. The petitioner's daughter believes that the petitioner requires skilled nursing care because of his physical and mental conditions. However, there was no medical

evidence presented that rebutted Dr. orders and the facility's medical record that the petitioner could be discharged to an ALF and that he did not require skilled nursing services.

11. The petitioner signed a statement on March 4, 2009 that he no longer wishes to reside at the above named facility and that he wishes to either go to another named facility or home with his family (Respondent's Composite Exhibit 1).

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by federal regulations appearing in 42 C.F.R. §431.200. Additionally, federal regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

Federal regulations at 42 C.F.R. §483.12 states in part:

> (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.
> (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; and
(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

The facility wishes to discharge the petitioner. The legal authority cited above makes it clear the facility holds the burden of proof at the level of clear and convincing. The evidence showed that the petitioner no longer requires 24 hour a day skilled nursing care, which is one of the discharge reasons in the above controlling regulation. The petitioner's attending physician signed a discharge order for the petitioner to be discharged to an ALF. No rebuttal expert medical opinion was submitted by the petitioner. The petitioner is competent and indicated he wanted to leave the facility.

The undersigned concludes that the petitioner's episodes with pneumonia do not prevent him from completing the activities of daily living and do not require skilled nursing care.

After carefully reviewing all the evidence, the undersigned hearing officer concluded that the facility met its burden by presenting evidence which proves that the petitioner no longer requires skilled nursing care.

The discharge reason based on the safety of other individuals in the facility being endangered will not be addressed in the conclusions because the discharge is being affirmed based on the petitioner not requiring services provided by the facility due to the improvement in his health.

DECISION

The appeal is denied. The facility may proceed with the discharge 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 24th day of April, 2009, in Tallahassee, Florida.

Morris Zamboca
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

PETITIONER,

APPEAL NO. 09N-00020

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 1:00 p.m. on March 19, 2009 at , Orlando, Florida. The petitioner represented himself and the respondent was represented by , administrator, with testimony available from the following: therapy program manager; , social service director; , activities director; , dietary director; , social service assistance; and , RN unit manager.

ISSUE

At issue was whether or not intent to discharge was correct based upon health improvement. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner entered the nursing facility on July 11, 2008, after a hospital stay. At admission, he expected to stay only a short time.

2. He received nursing care at the nursing facility and his health improved. He continues to have health problems and needs medical attention including medical appointments and tests. He does not need skilled nursing inpatient care.

3. He is not elderly, but he is disabled. He receives Social Security Disability benefits including Medicare.

4. Since fall of 2008, facility staff members have been working with the petitioner in relocation efforts. Assisted living facility or other nonmedical residence (Respondent's Exhibit 2) were options.

5. On January 14, 2009, the petitioner's attending doctor signed a Nursing Home Transfer and Discharge Notice (Respondent's Exhibit 1). It said the petitioner's "health has improved sufficiently so that you no longer need the services provided by this facility." Effective date for discharge was February 13, 2009. The doctor has not reversed that directive.

6. Discharge location was identified on the notice as an assisted living facility in a neighboring county. The petitioner believed the Osceola County location would be too far from his family. He said he would like to leave the nursing facility but he wants an alternative that is acceptable to him.

7. The petitioner appealed the discharge notice (Petitioner's Exhibit 1).

CONCLUSIONS OF LAW

Jurisdiction to conduct this hearing is assigned to the Department under federal regulations at 42 C.F.R. § 431.200. Also relevant from 42 C.F.R. is the following excerpt:

§ 483.12 **Admission, transfer and discharge rights.**

(a) Transfer and discharge-- ...
(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-- ...
(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...
(3) Documentation. ... 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; ...
(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. ...
(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged
...

The petitioner's health has improved enough that his doctor has recommended and directed alternate placement to an assisted living facility. The notice fully informs of such and is signed by the petitioner's personal physician. The notice meets all regulatory standards for proper discharge as reflected in the regulations above. Despite the petitioner's preferences, the discharge notice as it was issued was sufficient. Therefore, it is concluded that the discharge intent has been adequately justified.

DECISION

The appeal is denied and the respondent's action 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 First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party 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 16th day of April, 2009, in Tallahassee, Florida.

J W Alper
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 09N-00024

PETITIONER,

Vs.

R

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 31, 2009, at 1:10 p.m., at the facility. The petitioner was not present. Present representing the petitioner was her sister, Present as witnesses for the petitioner was sister and , district ombudsman manager, Florida Long-Term Care Ombudsman Program. The respondent was represented by administrator. Present as a witness for the respondent was office manager.

ISSUE

At issue is whether or not the facility's action of January 24, 2009 to discharge the petitioner was correct on the basis of nonpayment for care and services provided.

The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. §483.12.

FINDINGS OF FACT

1. The petitioner is a resident of the respondent's skilled nursing facility. The petitioner has been admitted into the facility on two occasions. Her last admission was on September 15, 2008 as a private pay resident.

2. As of March 31, 2009, the petitioner's outstanding bill was $29,278.73 for services provided as a private pay resident. The last payment received by the facility from the petitioner for her care was during December 2008.

3. The nursing facility sent monthly statements for payment of the petitioner's cost of care to the petitioner and/or the petitioner's representative. The petitioner's representative was aware of the amount due to the facility.

4. The petitioner's representative argued that the petitioner has private long-term care insurance which will help pay for the cost of her care at the facility. However, there has been a delay in the completion of the paper work needed to submit a claim for payment. The petitioner has chosen not to apply for Institutional Care Program Medicaid benefits through the Department of Children and Families.

5. On January 24, 2009, the facility, by Nursing Home Transfer and Discharge Notice, notified the petitioner of its intent to discharge her because the bill for services at the facility had not been paid, after reasonable and appropriate notice to pay.

6. The location to which the petitioner was to be discharged was listed on the above notice as another skilled nursing facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for

which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment.

Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant part:

> (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...(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;...

The petitioner has an outstanding balance, owed to the facility, for the cost of her care and the facility has notified the petitioner and/or the representative of the balance due for the cost of her care. The represented is aware of the balance owed.

According to the above authorities, the facility may not discharge except for certain reasons, of which one is when the resident has failed, after reasonable and appropriate notice to pay for the stay at the facility. Therefore, the Hearing Officer concludes that the nursing facility has met its burden to prove that the petitioner has not appropriately paid for her stay at the facility, and that reasonable and appropriate notice to pay for such stay has been made. Therefore, the hearing officer concludes that the discharge action is in accordance with the federal regulations.

DECISION

The appeal is denied. The facility met the burden of proof to show the discharge reason meets the reasons stated in the Federal Regulation. The facility may proceed

with the discharge in accordance with applicable Agency for Health Care Administration requirements, when appropriate placement is found.

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 29th day of April, 2009,

in Tallahassee, Florida.

Morris Zamboca

Morris Zamboca
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 09N-00011

PETITIONER,

Vs.

Administrator

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on March 18, 2009, at 3:05 p.m., in Rockledge, Florida. The petitioner was present and represented herself. friend, was present, as was . Ombudsman. nursing home administrator, represented the respondent. social services director, was also present.

A continuance was granted to the petitioner for a prior scheduled hearing.

ISSUE

At issue is whether or not the respondent's January 7, 2009 proposed action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer and discharge the petitioner because her "bill for services at the facility has not been paid

after reasonable and appropriate notice to pay". The nursing home has the burden of proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. The petitioner is a resident of the respondent's skilled nursing facility. She became a resident on June 11, 2008. She is residing in the nursing facility pending the outcome of this appeal.

2. On January 7, 2009, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of February 6, 2009. The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The discharge location in the notice is the petitioner's residence (Respondent's Exhibit 1).

3. The petitioner's income is from Social Security and a retirement pension. The petitioner receives Medicaid benefits to help her pay for her care. She has a patient responsibility to the nursing facility for her care, which is currently $1285.52 per month. Currently, the nursing facility is the payee for only the petitioner's monthly Social Security income of $1053 (effective January 2009).

4. Prior to January 1, 2009, the petitioner received $442 from a retirement pension. In January, it increased to $493.17. The petitioner has not assigned that income to the nursing facility so that she could continue to pay her mortgage, insurance, and utility bills in the community. Her friends paid her property taxes. She explains that she is not wasting the money each month and needs to stay in the facility until her home is finished. A site visit of the petitioner's home was completed by the ombudsman prior to

the hearing. She saw the materials at the site, but asserts the house is not ready for occupancy and may not be for at least 60 more days. The petitioner had expected to leave in December 2008 but the refitting and repairs on her house were not completed. As of the date of the hearing, the house was not ready due to various reasons, mostly health issues of the individuals doing the repairs.

5. Because the petitioner had not been paying her full patient responsibility each month, she accrued an outstanding balance for her care. At the end of March 2009, the outstanding balance was $3,813.33 (Respondent's Exhibit 2). Collection efforts were made by the business office and nursing home administrator. The petitioner acknowledges she owes the money and received statements, but explains she can not give them her pension check because she will lose her house in the community if she has no way to pay for its upkeep.

6. The discharge plan was to send the petitioner home after the completion of the construction on her home. The petitioner explains that she recently started physical therapy for her legs and that she needs help with her Foley bag. No actual assessment has been completed to determine whether the petitioner should go home.

7. The respondent was willing to establish a timeline and get a payment plan in effect if the petitioner was to stay in the facility. The petitioner would agree to sign a promissory note. However she has a concern about how she will make payments.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment.

Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant part:

> (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...(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; ...

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner on January 7, 2009. The nursing home administrator signed the notice.

The Notice, as required, indicated the reason for transfer or discharge, as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The effective date of the transfer or discharge was given as February 6, 2009.

The Findings of Fact show that the petitioner has an undisputed balance owed to the facility for the cost of her care. Prior to the issuance of the discharge notice or the date of the hearing, no formal payment arrangements had been made and the petitioner's retirement check had not been redirected to the respondent.

According to the above authorities, the facility may not discharge except for certain reasons, of which one is when the resident has failed after reasonable and

appropriate notice to pay for the stay at the facility. The hearing officer concludes that the nursing facility has met its burden to prove that the resident has failed after reasonable and appropriate notice to pay for her stay at the facility. Therefore, the hearing officer concludes that the discharge action is in accordance with the federal regulations.

Once discharge planning has been completed to include a safe and appropriate location, the respondent may proceed with its discharge in accordance with the guidelines established by the Agency for Health Care Administration.

DECISION

The appeal is denied. The respondent met its burden of proof to show the discharge reasons meets the reasons stated in the federal regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements when appropriate placement is found.

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 10th day of April, 2009,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 09N-00033

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 24, 2009, at 1:25 p.m., at Rehabilitation and Nursing Center, in St. Petersburg, Florida. The petitioner was present. , ombudsman, assisted the petitioner. The respondent was represented by , administrator, , director of nursing and social services director. unit manager was observing.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice dated February 23, 2009 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

(2)(iii) The safety of individuals in the facility is endangered;

and threatening staff and residents in a loud voice. The administrator, director of nursing and social services director observed the petitioner swinging his cane at residents. The petitioner's inebriation, loud threats and swinging of his cane were documented by two other employees in the petitioner's medical record on February 22, 2009. The social services director observed the petitioner shoving an elderly resident's wheelchair. The administrator, director of nursing and the social services director are concerned for the safety of the facility's older, frail residents.

5. The director of nursing attested that the petitioner's treating physician recommended the petitioner for discharge after observing the petitioner inebriated and speaking is a loud and threaten voice. The facility issued a Nursing Home Transfer and Discharge Notice on February 23, 2009. The discharge notice was signed by the petitioner's treating physician. The location of discharge was an assisted living facility. The administrator personally handed the petitioner the discharge notice with a copy to his friend. The director of nursing and the social services director witnesses the administrator given the petitioner and his friend copies of the discharge notice.

6. The petitioner is helped by his friend who could not be at the hearing. The petitioner attested that neither he nor his friend ever received any discharge notice from the facility. The petitioner admitted that he did smoke in his room. He smoked the one time in his room as no one came to assist him to go to the smoking area when he was new to the facility. The petitioner rebutted the testimony of the administrator, director of nursing and social services director as

follows. He has never returned to the facility drunk. He has never waved his cane at any one. He has never pushed any one's wheelchair. He raises his voice as he is blind and cannot tell if any one is near him and listening to him. He pushes carts aside as he is blind. The petitioner does not wish to remain in the facility. The petitioner only wants to stay in the facility until he can find a place to live. He does not want to go to an assisted living facility.

CONCLUSIONS OF LAW

Federal Regulation limit 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 the facility in accordance with of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

> (2)(iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered...

The petitioner told the hospital he only drank a little. The hospital considered his blood alcohol level to be at such an unsafe level which warranted hospitalization. He attested that neither he nor his friend ever received a discharge notice from the facility. The administrator attested she personally handed the petitioner and his friend copies of the notice of discharge which was witnessed by the director of nursing and the social services director. The petitioner attested that he never inebriated nor did he swing his cane at residents. The administrator, director of nursing and social services director attested that they had seen the petitioner inebriated and swinging his cane at residents. The petitioner's inebriation and swinging of his cane were

documented by two other employees in the petitioner's medical record. In weighing the testimony, the petitioner's rebuttals are not persuasive in view of first hand testimony by several employees of the facility and documentation in the medical record. The administrator, director of nursing and the social services director are all concerned for the safety of the facility's older, frail resident based on the petitioner's documented aggressive behavior in the facility and the petitioner's history. The hearing officer weighed the evidence and determined that the facility had met their burden that the safety of other resident's in the facility is endangered.

No evidence was brought forth that contradicted the fact that the petitioner's treating physician signed the discharge notice. The physician recommended and initiated the discharge and the discharge location. The hearing officer concludes that the discharge is consistent with the recommendation of the treating physician.

Additionally, but not listed as a reason of discharge is that the petitioner no longer meets a skilled nursing level of care, as of January 1, 2009. The petitioner is able to leave on his own for the weekends to go out with his friends. This further supports that the petitioner's placement with frail, elderly residents who require skilled nursing is not appropriate. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations.

DECISION

This appeal is denied as the facility's 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 2nd day of April, 2009,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 09N-0030

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on April 21, 2009, at 8:48 a.m., in Miami, Florida. The petitioner was present and represented himself at the hearing along with the assistance of , ombudsman. Representing the facility was Dr. , facility physician and witnesses for the respondent were: , registered nurse; and social worker. served as translator. The hearing was previously scheduled for March 25, 2009, but was continued at the request of the petitioner.

ISSUE

At issue is whether or not the facility's action of February 17, 2009 to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The discharge Notice issued to the petitioner was due to "Your health has improved sufficiently so that you no longer need the services provided by this facility."

The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner (age 55) is a resident of , r in Miami-Dade County.
2. The petitioner was admitted to the facility in November 2008 due to a stroke that resulted in weakness of the left side. The petitioner primarily uses a wheelchair and therefore, requires wheelchair accessibility.
3. The petitioner's primary physician states that the petitioner is independent in transfers and in his activities of daily living (ADL) and does not require the skilled care provided in the facility. The petitioner is independent in bathing; with medications; eating; transfer; and he goes out into the community daily. He states that from a medical standpoint he is ready to live in the community, possibly in an adult living facility (ALF) in order to receive assistance.
4. The petitioner would continue to receive therapy and follow-up medical care in the community.
5. The physician states that the petitioner himself and his son requested the discharge since December 2008, but additional time was allowed in order for the petitioner and the family to make the arrangements. The petitioner and the petitioner's son originally agreed to have the petitioner return to California in order to live with them and in the alternative, live with a relative in Miami.

6. On February 17, 2009, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found to have improved sufficiently where he no longer requires the skilled level of care provided at the facility. A Notice of Discharge was issued to the petitioner the same day. The petitioner filed for an appeal of that action indicating, "I need more therapy."
7. The facility's social worker and an agency that provides assistance in locating living facilities have been closely working with the petitioner in an attempt to find a suitable placement.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer and discharge rights states in part:

> (a) *Transfer and discharge-* (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plants or not. (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- (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; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner's states that although he likes the ALF that he visited, it does not provide in house therapy.

The ombudsman argued that discharge to the son's address is not a for sure thing right now and discharging the petitioner would be "unsafe." He feels that once the discharge location is resolved, then discharging the petitioner would not be a concern.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The reason for the discharge was because the petitioner's health had improved sufficiently so that he no longer requires services from a skilled nursing facility.

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician. The notice issued by the facility also provided a location (son's home) to which the petitioner could be transferred to and provided an agency to assist with locating an assisted living facility. At least one living facility was visited and the petitioner liked, except for not having in-house therapy available to him. The nursing facility has met its burden of proof and is in compliance with the appropriate federal regulations. The hearing officer cannot resolve the indecisiveness concerning the discharge location however, the respondent did meet its burden of proof in providing a location to transfer the petitioner.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

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 29th day of April, 2009,

in Tallahassee, Florida.

A. G. Littman
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:

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

APPEAL NO. 09N-0029

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 25, 2009, at 9:00 a.m., in Miami, Florida. The petitioner was present and represented himself at the hearing along with the assistance of , ombudsman. Present as witnesses for the petitioner were , proxy and sister, and , cousin. Representing the facility was Dr. , facility physician and witnesses for the respondent were: , physical therapist; social worker; and , social worker. served as translator.

ISSUE

At issue is whether or not the facility's action of February 5, 2009 to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The facility explained that the discharge Notice issued to the petitioner in Spanish had the incorrect reason marked. However, the petitioner understood the reason

for the discharge as explained by the facility and the Notice was because "Your health has improved sufficiently so that you no longer need the services provided by this facility."

The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner (age 81) is a resident of , in Miami-Dade County. The petitioner was admitted to the facility in 2005 with multiple medical problems. The petitioner primarily uses a wheelchair and can ambulate a very short distance with a walker and supervision and requires wheelchair accessibility.
2. The petitioner's primary physician states that the petitioner is independent in transfers and in her activities of daily living (ADL) and does not require the skilled care provided in the facility. He states that from a medical standpoint she is ready to live in the community, possibly in an adult living facility (ALF) as she requires supervision.
3. The physician states that the petitioner has been a candidate for discharge since late 2007, but the family could not find a place for the petitioner.
4. The physical therapist states that the petitioner is able to transfer from wheelchair to bed and she abides by all safety rules. She does require assistance with walking short distances as she does have some weakness and balance problem.

5. The petitioner has Supplemental Security Income (SSI) and Medicaid to cover expenses in the community and Special Transportation System for follow up doctor appointments.
6. On February 5, 2009, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found that she has improved sufficiently where she no longer requires the services of the facility. A Notice of Discharge was issued to the petitioner the same day. The petitioner filed for an appeal of that action.
7. The ombudsman confirmed that the petitioner's family was given a list of ALFs to choose from in different areas of the county.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer and discharge rights states in part:

(a) *Transfer and discharge-* (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plants or not. (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- (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; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner's states that she does not want to leave the facility because she knows the staff and has been treated very well there.

The family stated that the last time the discharge was attempted, they went to ALFs that they were not satisfied with. The facility offered to assist in locating a suitable ALF and the ombudsman stated that there are approximately 500 ALFs in South Florida and should be able to find one that the petitioner would accept.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The reason for the discharge was because the petitioner's health had improved sufficiently so that she no longer requires services from a skilled nursing facility.

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician. The notice issued by the facility provided a list of different locations of ALFs, to which the petitioner had the option of choosing in order to be discharged and therefore, all requirements were found to have been met by the nursing facility.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

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 21 day of April, 2009,

in Tallahassee, Florida.

A. G. Littman
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: