LEGAL ISSUES

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A Resident's Right to Appeal a Facility-Initiated Discharge

On May 12, 2016, Mrs. D was admitted to an acute care facility after she was found collapsed in her home, unresponsive, covered with melenic stool, and with dried blood around her mouth. She could not provide a history, and her daughter (her caregiver) was unavailable. She was noted to have possible upper gastrointestinal bleeding, rhabdomyolysis (from a fall), and a urinary tract infection (UTI). She was hydrated aggressively, and her rhabdomyolysis and kidney injury resolved. Her upper endoscopy examination showed severe esophagitis and Barrett's esophagus. She had multiple abrasions and ulcerations of the skin. A wound consultation was requested.

Further inquiries by the acute care facility's case manager revealed that the patient's daughter had multiple medical problems and was often in the hospital herself. An Adult Protective Services (APS) report was filed by the police department for the unsanitary living conditions in the patient's home and suspicion of abuse/neglect. She had been nonambulatory for 15 years since having a stroke; she had a manual wheelchair, a power wheelchair, and a hospital bed. She was bedbound secondary to her lack of social support and her inability to transfer from bed to wheelchair alone. She reported having multiple falls at home. The case manager recommended long-term skilled nursing placement, and she agreed with that plan.

Two weeks later, Mrs. D was admitted to a skilled nursing facility. She had altered mental status, bilateral leg wounds, and pressure ulcers to her back and shoulder being treated with Medihoney and calcium alginate. Her past medical history included diabetes mellitus, congestive heart failure, stage 4 chronic kidney disease, hypothyroidism, and hypertension. She was placed on a regular diabetic diet. She was provided physical therapy, occupational therapy, and speech therapy.

One week after admission, the SNF discharge planner/social worker spoke with the daughter about her mother's discharge plans. She told the social worker that her mother would return home after treatment. At that time Mrs. D also told the social worker that her intention was to return to her home with her daughter, but later she changed her mind.

The social worker contacted APS about her discharge plans and confirmed that Medicare would pay for her stay up to her allotted 100 days. After that date she would become private pay. Mrs. D requested that the social worker contact her daughter and ask her to bring her debit card to the facility so she could manage her finances and pay her bills. The daughter refused to return the phone calls and refused to bring Mrs. D's debit card to the SNF. Mrs. D's daughter refused to pay her share of costs for the SNF out of her pension income. Eventually, Mrs. D owed the facility more than $10,000 in share-of-cost fees. Mrs. D continued to receive skilled nursing care at the facility, despite the fact that neither she nor her family paid her share of the cost.

The facility tried to set up a payment plan, but the resident and family refused to cooperate. The facility then notified the resident and family about their intention of issuing a 30-day notice. The facility issued a 30-day notice to vacate, which would be effective on November 7, 2016. The social worker arranged for home health care services to come and speak with Mrs. D about what they would provide. Mrs. D agreed to use home health care. The social worker also arranged for durable medical equipment to be delivered to her home. The ombudsman was notified about the proposed discharge and spoke with Mrs. D about her situation. On November 4, 2016, Mrs. D's physician met with her and went over the discharge plans. The physician wrote an order for Mrs. D to be discharged after evaluating her and the discharge plan.

On November 7, 2016, the facility drove Mrs. D to her home. Her daughter refused to allow her to enter the property. The administrator and assistant administrator were called out to the home. The police department was called out as well. The police and the administrator conferred about how to handle the situation and called an ambulance to transfer her to the nearest hospital. Upon admission to the hospital, she was diagnosed with dehydration and a UTI.

The Department of Public Health issued an A citation, which carried a significant civil money penalty. The facility elected to pay the penalty and is now defending itself in a civil lawsuit brought by Mrs. D for elder abuse, violation of her patient rights, and negligence. Mrs. D claimed the discharge was wrongful because the facility failed to prepare a safe and orderly discharge plan, specifically to her home where she had been found down, covered in feces, and neglected by her daughter.

Technical Perfection Required

According to the Code of Federal Regulations (CFR), before transferring or discharging a resident, the facility must provide written notice to the resident and the resident's representative in a language and manner they understand (42 CFR § 483.15(c)(3)(i)). The facility must send a copy of the notice to the Long-Term Care Ombudsman program. Except as specified, the notice must be provided at least 30 days before the resident is transferred or discharged, and the notice must include:

1. The reason for the transfer or discharge (42 CFR §483.15(c)(5)(i)).
2. The effective date of transfer or discharge (42 CFR §483.15(c)(5)(ii)).
3. The location to which the resident will be transferred or discharged (42 CFR §483.15(c)(5)(iii)).
4. A statement of the resident's appeal rights and information on how to obtain an appeal form and assistance in completing and submitting the appeal request (42 CFR §483.15(c)(5)(iv)).
5. The name, mailing address, email address, and phone number of the Transfer and Discharge Appeal Unit operated by the Office of Administrative Hearings and Appeals within the California Department of Health Care Services (42 CFR §483.15(c)(5)(iv) and California Department of Public Health All Facility Letter [AFL] 10-20).
6. The name, mailing address, email address, and telephone number of the Long-Term Care Ombudsman (42 CFR §483.15(c)(5)(v)).

Dodd and Pattee

from page 1

in strategic planning. In recent years, his work in co-chairing the Competencies Curriculum has supported the organization's mission and vision of including all practitioners who work in the post-acute space.

"I've worked with compassionate and visionary leaders, and I have no doubt that our Society has never been in a better position to take on the challenges of ensuring the very best care for our patients and residents," he said. "I look forward to many more years of long phone calls and weekend retreats," he joked.

Dr. Burl is a physician with the Reliant Medical Group (formerly the Fallon Clinic) in Worcester, MA, where he is known as a "go-to guy" who believes in innovation and education, and dives into every challenge and every opportunity with commitment, energy, and expertise. He also has held many positions in the Society over the years. He has worked on the Board of Directors as secretary and as state chapter board representative. He has been a faculty member for the Core Curriculum since 2004 and served as chair from 2011 to 2014. He's been on the finance, education, and program committees. He is a popular presenter at Society annual conferences, has published in *JAMDA*, and has presented webinars for the Society.

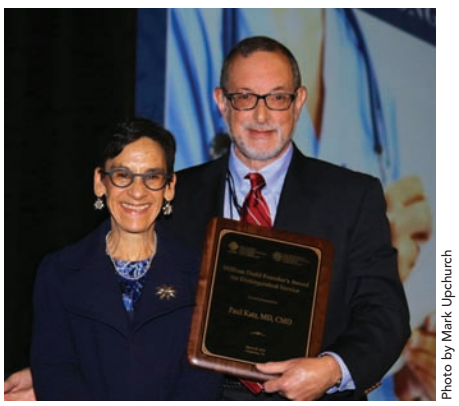

Photo by Mark Upchurch

Barbara Resnick presents the William Dodd Founder's Award to Paul Katz.

Alice Bonner, RN, PhD, accepted the award on Dr. Burl's behalf.

"It's special for me to have been asked to accept this award on his behalf because I was the first geriatric nurse practitioner — the first of many — to be welcomed into his practice, to be mentored and coached, by Jeff's kind and patient teaching," Dr. Bonner said. "And in 20 years of collaboration, he was the best teacher of geriatric principles and long-term care foundations that I ever had. I wish he were here today because I know how much this award means to him; it's only the third annual conference in 25 years that Dr. Burl hasn't been able to attend," she said.

Dr. Burl had prepared remarks, which Dr. Bonner shared with the audience: "I'm truly honored to be chosen as this year's recipient of the Pattee Award. When I was asked in which capacity I contributed the most, I unequivocally and wholeheartedly cite my 20 years as faculty in the Core Curriculum. This has given me the most professional satisfaction in my many years as clinician and mentor."

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7. For residents who have a developmental, intellectual, or mental disability, the phone number, mailing address, and email address of California's protection and advocacy agency, Disability Rights California (42 CFR §483.15(c)(5)(vi)&(vii).
8. A statement that the resident may represent him/herself or use legal counsel, a relative, a friend, or other spokesperson (42 CFR §431.206).
9. If the information in the notice changes, the facility must notify the resident and resident's representative of the changes as soon as practicable. 42 CFR §483.15(c)(6). For significant changes, such as a change in the destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification. (*CMS State Operations Manual, Appendix PP — Guidance to Surveyors for Long Term Care Facilities,* at F623).

In this instance, the plaintiff was presented with the eviction letter and now contests its validity because it omitted several of the CFR requirements. The letter failed to give the resident and the person who could represent her, if necessary, timely notice of her appeal rights. There was no mention of her appeal rights or directions to whom she should address her appeal. The facility simply stated they were sending a copy of the letter to the ombudsman and to the department of public health. Mrs. D did not appeal the eviction at the time she was presented with the eviction letter.

Furthermore, 1 week before the facility delivered the formal 30-day notice letter, the regulations changed. The change that was significant for Mrs. D was an addition stipulating that if she had submitted her paperwork for third-party payment (i.e., Medi-Cal, the California name for Medicaid) the facility could not initiate a nonpayment transfer/discharge action. This was a significant factor because she had told the facility that her sister had submitted the paperwork to Medi-Cal for coverage for her stay at the facility. Her medical record did not document whether Medi-Cal had denied coverage. If she was still under review for coverage at the time of discharge, the discharge was not appropriate.

Documentation Essential

The facility must show that discharge planning began early and involved the resident. Especially if the transfer/discharge is "facility-initiated," the documentation must conform exactly to the regulations. A facility-initiated discharge will most certainly undergo more rigorous scrutiny than a resident-initiated discharge. Furthermore, the location of the discharge will be under scrutiny if there were any problems associated with the location before the discharge.

In the case of Mrs. D, there should have been documentation of a home check before her discharge. The ombudsman probably also should have been more involved in the planning and implementation of this discharge as well. From a risk management standpoint, a case is much more defensible if the ombudsman is involved and is used as an ally as soon as a family member begins to show signs of either abandonment of the resident or possible financial or fiduciary abuse, and the chart should reflect that involvement.

Evictions for lack of payment are a very real problem, and they carry significant penalties and costs if they not carried out to the letter of the regulations. Many times the resident or family will appeal the eviction letter, necessitating a hearing with the department of public health. The resident cannot be evicted during the appeal process, thus increasing the costs incurred by the facility as it provides care and services, all the while knowing it will not be paid. The lesson learned here is that it is extremely important in a facility-initiated transfer to ensure that the regulations are followed and that the ombudsman is involved from the beginning. In that way, the facility may avoid being hit with a civil money penalty on top of the money it is owed.

This column is not to be substituted for legal advice. Mr. Wilson is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance.