BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
U N	)	OAH No. 15-0455-PTD
	)	

DECISION

I. Introduction

U N resides in the No Name Hospital Long Term Care Unit ("the Hospital"). On April 17, 2015, the Hospital notified Mr. N that it was discharging him because his health had improved to the point that he no longer required the facility's services. Mr. N requested a hearing to challenge his discharge.

Mr. N's hearing was held on May 20 and June 3, 2015. Mr. N represented himself. Michael Gatti represented the Hospital.

Mr. N's treating physician determined that he could be medically discharged from the Hospital. Based upon her determination, as documented in Mr. N's clinical record, the Hospital is allowed to discharge Mr. N.

II. Facts

The following facts were established by a preponderance of the evidence.

Mr. N is a No Name resident. He was admitted to the Hospital on December 1, 2014. His admission was as a swing bed patient for rehabilitation following surgery and treatment for a cervical cyst at facilities in Seattle. He is currently in the Hospital's long-term care unit. Mr. N has quadriparesis and a loss of feeling below his C4 disc. He has a neurogenic bowel and bladder, and requires care for both of those. His other conditions include sleep apnea, atrial fibrillation, neuropathic pain, a depressed mood, and anxiety. He is at risk for autonomic dysreflexia, having had one incident since his admission to the Hospital, which was relieved by him sitting up. He also has a preexisting hernia, which can be repaired at his convenience.[1]

While at the Hospital, Mr. N participated in both occupational therapy and physical therapy. His occupational therapist and physical therapist both agree that he is physically capable of functioning independently.[2] Dr. C has been Mr. N's treating physician since his

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1 Dr. E C's testimony; Ms. L U's testimony.

2 T D's and M E's testimony.

admission to the Hospital. Her medical opinion is that Mr. C is ready for discharge from the Hospital, and has been for some time. The only medical impediment to his discharge was the need for him to receive assistance with his bowel regimen, but that concern was addressed by the Veteran's Administration agreeing to provide for it.[3]

Dr. C's chart notes show that Mr. N was ready to "go home and live independently" as of March 11, 2015.[4] She held a discharge planning conference on March 24, 2015, with Mr. N's participation, and her notes from that conference confirm that Mr. N is medically ready for discharge.[5]

On April 17, 2015, the Hospital notified Mr. N that he would be discharged.[6] Four days later, Dr. C and Mr. N participated in another discharge planning conference.[7] Dr. C completed a discharge summary on April 22, 2015, reiterating that Mr. N is medically stable and capable of performing his activities of daily living, with the exception of the bowel care that has been arranged for through the Veteran's Administration.[8]

Mr. N believes he is depressed and that he has post-traumatic stress disorder. He is afraid of leaving the Hospital.[9] Dr. C is aware that Mr. N may be depressed, but she does not believe that his psychological state makes him inappropriate for discharge.[10] Mr. N is seeing a counselor through No Name Services.[11]

The only impediment to Mr. N's discharge is social. He apparently does not have a place to be discharged to. When not hospitalized, he has resided in a trailer with his wife. However, they have filed for dissolution of their marriage, and returning to the marital home is not feasible. His son, who lives in No Name, is not willing to house him.[12] D V, the social work coordinator for the Hospital, has tried to assist Mr. V with finding housing. However, Mr. N has not been cooperative.[13]

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3 Dr. C's testimony.
4 Ex. 2, pp. 3 – 4 (Documents submitted on May 13, 2015).
5 Ex. 2, pp. 1 – 2 (Documents submitted on May 13, 2015).
6 Ex. 2 (Documents submitted on May 1, 2015).
7 Ex. 4 (Documents submitted on May 1, 2015).
8 Ex. 1 (Documents submitted on May 13, 2015).
9 U N's testimony.
10 Dr. C's testimony.
11 Ex. 2, p. 2 (Documents submitted on May 13, 2015). No Name Services is a tribal entity.
12 U N's testimony.
13 D V's testimony; Ex. 2, pp. 12, 15, 17, 20 (Documents filed on May 13, 2015).

III. Discussion

A resident of a nursing facility has a number of rights. One of those rights is that he or she cannot be discharged involuntarily from that facility, unless certain conditions are satisfied.[14] The relevant condition for this case is whether the "resident's health has improved sufficiently so the resident no longer needs the services provided by the facility."[15] In order to discharge a resident based on improvement, that improvement must be documented in the resident's clinical record by his or her physician.[16]

The Hospital has the burden of proof in this case.[17] It must establish, by a preponderance of the evidence, that Mr. N's health has improved to the point that he no longer requires the Hospital's services. The evidence shows that Mr. N is physically stable and has not required nursing home care since March 11, 2015. While Mr. N has concerns about his mental state, he is being separately treated for that through No Name Services, and Dr. C, who has provided Mr. N's medical care since December 2014, does not believe his concerns justify continued residency. Dr. C's testimony demonstrates that Mr. N's mental state does not justify continued residency.

By federal regulation, a nursing facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly . . . discharge from the facility."[18] The Hospital has tried to provide that preparation and orientation for Mr. N, but Mr. N has not cooperated. the Hospital has met its obligations under this regulation.

IV. Conclusion

The Hospital has satisfied its burden of proof: Mr. N's condition has improved, as documented by Dr. C in the clinical record, to the point where he does not require residency at the Hospital, and the Hospital has complied with the requirement that it provide the requisite preparation and orientation. The Hospital's decision to discharge Mr. N is upheld.

DATED this 29th day of June, 2015.

Signed
Lawrence A. Pederson
Administrative Law Judge

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14 42 U.S.C. § 1396r(c)(2)(A); 42 C.F.R. § 483.12(a)(2).
15 42 U.S.C. § 1396r(c)(2)(A)(ii); 42 C.F.R. § 483.12(a)(2)(ii).
16 42 C.F.R. § 483.12(a)(3)(i).
17 7 AAC 49.135.
18 42 U.S.C. § 1396r(c)(2)(C); 42 C.F.R. § 483.12(a)(7).

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 16th day of July, 2015.

By: *Signed*
Name: Jared C. Kosin
Title/Agency: Executive Director, ORR, DHSS

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ORDER DENYING MOTION FOR RECONSIDERATION

U N's August 4, 2015 Request for Reconsideration of the Final Decision in this case, which was entered on July 16, 2015, is DENIED.

Appeal Rights:

Judicial review of the Final Decision in this case may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this Order.

DATED this 6th day of August, 2015.

By: *Signed*
Jared C. Kosin
Executive Director, Office of Rate Review
Department of Health and Social Services

[This document has been modified to conform to the technical standards for publication.]