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

In the Matter of	)	
	)	
L.W.	)	OAH No. 18-1026-PTD
	)	

DECISION[1]

I. Introduction

L.W. resides in the Denali Center (Denali), a nursing facility located in Fairbanks. On September 25, 2018, Denali notified Ms. W. that she was going to be discharged from Denali because "[t]he safety of other individuals in this facility is endangered." Ms. W. requested a hearing to challenge her discharge.

Ms. W's hearing was held on January 14th and 15th, 2019. Ms. VonRonCeilier was represented by James J. Davis, Jr. Denali was represented by LouAnn Cutler and Shane Kanady.

The evidence in this case shows that Ms. W is endangering other residents, despite Denali's protective efforts, and that Denali has made extensive efforts to find an appropriate placement for her. Ms. W disagrees with that placement. However, the placement Denali located is an appropriate one given the factors that impact her placement. As a result, Denali has met its burden of proof by a preponderance of the evidence and may discharge Ms. W.

II. Facts

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

A. Background Facts

Ms. W has been a resident of Fairbanks, Alaska for approximately 50 years.[2] She experiences severe physical and mental health issues. These include dilated cardiomyopathy, Parkinson's disease, history of cirrhosis, bipolar disorder type 1, and histrionic and narcisstic personality. She demonstrates explosive behavior and an inability to control her

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[1] The proposed decision issued on January 29, 2019 contained several minor clerical errors; it referred to Dr. Bartling by the wrong name several times. That proposed decision has been changed to correct those errors. *See* 2 AAC 64.350(a). The proposed decision otherwise remains unchanged.

[2] Ms. W's testimony.

impulses, which is most likely due to her psychiatric conditions.[3] Her health was very poor when she was living on her own in the community. "Emily C.", her long-time friend, found her twice at home in such poor condition that she called 911.[4]

Dr. Victor Bartling, D. O., is a Fairbanks physician, and has been the medical director for Denali, a skilled nursing facility located in Fairbanks, for 20 years. He became familiar with Ms. W through her admissions at Fairbanks Memorial Hospital. After seeing that Ms. W had over 31 emergency room admissions in the first nine months of 2017, and had at least 8 psychiatric ward admissions, he arranged to have Ms. W admitted to Denali, where he is her attending physician.[5]

Ms. W was admitted to Denali in September 2017. Denali has several wings, Aspen, Birch, Tamarack, and Willow. She was originally admitted to the Aspen wing of Denali. The Aspen wing is for post-acute care patients, who require a fair amount of nursing care and therapies, such as someone recovering from an acute injury. The Birch and Tamarack wings have long term care patients. The Willow wing is reserved for dementia patients.[6]

Ms. W's condition improved to such an extent that she was subsequently transferred from the Aspen wing to the Birch wing. The facility does not have private rooms and Ms. W had to have a roommate. Ms. W is fully ambulatory and is capable of what are referred to as "activities of daily living" or "ADLs." These encompass physical functional acts such as walking, dressing, bathing, etc. Ms. W is the exception in the Birch wing, where most of the residents are not fully physically functional.[7]

B. Behavioral Incidents

Ms. W displays volatile behavior. As observed during the hearing, she can speak loudly and colorfully. She has engaged in what can only be described as assaultive behavior towards staff, and sexual harassment of both staff and her roommate's husband. Denali presented the following evidence on these points:

- Angelia Webb, a R.N. formerly employed with Denali, testified that Ms. W cursed at her, yelled at her, and pushed her on April 13, 2018. In addition, Ms. Webb was informed, on June 14, 2018, by a fellow staff member that Ms. W had

3 Dr. Bartling's prefiled testimony, sections 13 and 14, and hearing testimony.
4 Hearing testimony of "Emily C."
5 Dr. Bartling's hearing testimony.
6 Dr. Bartling's hearing testimony.
7 Ms. Starcher and Dr. Bartling's hearing testimony.

slapped her on the buttocks. Ms. Webb also recalled being told by another staff member that Ms. W had slapped him on the buttocks.[8]

- Erin Starcher, an R.N. with Denali, testified that she heard Ms. W ask her roommate's husband offensive questions about his sexuality and sexual experience on January 5, 2018. In addition, a fellow staff nurse informed Ms. Starcher on April 6, that Ms. W had grabbed her buttocks.[9]

Denali presented the following evidence regarding Ms. W's interaction with fellow residents:

- Resident A is wheelchair bound but can propel himself. He speaks loudly and does not make sense. He has a brain injury. On April 13, 2018, Michael Nolan, a certified nursing assistant (CNA) heard Ms. W complaining about Resident A speaking loudly and then saw Ms. W hit Resident A "on the back of the head."[10] Ms. Starcher, who was the charge nurse, prepared a critical incident report and filed it with the Department of Health and Social Services (DHSS).[11]
- Paris Stephens, a R.N. with Denali, observed Ms. W hit Resident A on the top of his head in a separate incident on May 3, 2018.[12] Ms. Starcher, who was the charge nurse, prepared a critical incident report and filed it with DHSS.[13]
- Resident B is a completely disabled resident. He is a spastic quadriplegic, severely intellectually disabled, not mobile, non-verbal, and spends most of his time lying on his right side in a fetal position.[14] On September 20, 2018, at approximately 7 p.m., Rosette Hall, a CNA with Denali, was in the Birch wing, where both Resident B's and Ms. W's rooms were located. Ms. Hall was in the sun room, approximately 25 feet away from Resident B's room, when she heard a slapping noise coming from Resident B's room. She went into Resident B's room, and observed Ms. W standing over him with her back to Ms. Hall. She saw the back of Ms. W's hand raising twice, and asked her what she was doing, and Ms. W said she was just watching Resident B.

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8 Angelia Webb's prefiled testimony, sections 4 and 5.
9 Ms. Starcher's prefiled testimony, sections 4 and 5.
10 Michael Nolan's prefiled testimony, sections 4 – 6.
11 Ms. Starcher's prefiled testimony, section 7; Ex. C, pp. 21 – 30.
12 Paris Stephens's prefiled testimony, section 6.
13 Ms. Starcher's prefiled testimony, section 8; Ex. C, pp. 10 – 20.
14 Ms. Starcher's hearing testimony; Dr. Bartling's prefiled testimony, section 34.

Ms. Hall saw that Resident B's face was very red on one side, all the way to his left ear.[15] Ms. Starcher, who was the charge nurse, was informed of the incident by Ms. Hall. She went and saw Resident B and observed that the side of his face was beet red all the way from the ear down. She told Ms. W not to go back into Resident B's room. Ms. Starcher prepared a critical incident report and filed it with DHSS [16]

- David Blaska, a licensed practical nurse (LPN) with Denali, observed Ms. W enter Resident B's room the very next day. He told her she was not allowed in the room without permission and he observed Resident B's roommate appear fearful of Ms. W, including grimacing and crying.[17]
- On October 19, 2018, Ms. Stephens observed Ms. W "approach another resident, who was in a wheelchair, and kick the wheelchair."[18]
- On October 20, 2018, Brenda Schmidt, an R. N. with Denali, was told by another nurse, Rosalyn Cowan, that she saw Ms. W pull another resident's hair.[19]
- On December 26, 2018, Ms. W threw another resident's glasses across the room.[20]

The incidents with Residents A and B, and the October 19 and 20, 2018 incidents are all reflected in Denali's case progress notes.[21]

Following the April 13, 2018 incident with Resident A, the nursing staff instituted a line of sight protocol for Ms. W, where she was supposed to be under visual observation when she was out of her room. Sometime thereafter, the line of sight protocol was abandoned.[22] Ms. Archer testified that there was not always enough staff present to constantly monitor Ms. W. After the Resident B incident, sensors were placed in Ms. W's room to alert staff when she left her room, and a sensor was also placed in Resident B's room. There was not any repeat assaultive behavior against Resident B.[23]

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15 Ms. Hall's prefiled testimony, section 4, and her hearing testimony.
16 Ms. Starcher's testimony; Ex. C, pp. 1 – 9.
17 Mr. Blaska's prefiled testimony, section 5 and his hearing testimony.
18 Ms. Stephens prefiled testimony, section 10.
19 Ms. Schmidt's prefiled testimony, section 4, and her hearing testimony.
20 Ms. Hodges's testimony.
21 Ex. B, p. 85 (April 13, 2018); Ex. B, p. 89 (May 3, 2018); Ex. B, p. 127 (September 20 and 21, 2018); Ex. B, p. 139 (October 19 and 20, 2018);
22 Ms. Hall's and Ms. Starcher's hearing testimony.
23 Ms. Starcher's hearing testimony.

On January 7, 2017, Denali issued a new discharge notice, where it changed the discharge location to Harbor House in Wrangell, with an effective date of the same day.[28]

2. The Discharge Location

It is undisputed that Ms. W cannot safely live independently. Jennifer Hodges is a case manager with Denali. She was responsible for finding a suitable location to discharge Ms. W to, because Ms. W should not live independently.

Ms. Hodges took several factors into account when she looked for a placement for Ms. W. She only looked at assisted living facilities that were certified for residents with both mental health issues and physical care issues. She received a list of facilities that are licensed by the state for both types of residents from the Elder Care Ombudsman's office. Her next criteria were whether Ms. W could have her own room, rather than sharing one, and whether the facility would accept the funding available to Ms. W. Ms. W is only eligible for general relief assisted home funding, which pays less per day than the federal Medicaid Home and Community-Based Waiver program. She then contacted these facilities.[29]

In Fairbanks, Ms. Hodges found and contacted both the Pioneer Home, and Eagles Wings. Eagles Wings declined placement. The Pioneer Home also declined placement, while it had an available bed, it stated it did not have adequate staffing to take Ms. W. Ms. Hodges also contacted other facilities throughout the state. The only assisted living facility that was dually certified, had a single room available, and would accept the funding available for Ms. W was Harbor House in Wrangell. Harbor House is owned by a retired registered nurse, who lives on site, and keeps a registered nurse on staff. It has both a senior living component and an assisted living component, which is potentially available to Ms. W in the event her care needs became more extensive.[30]

Ms. W objected strenuously to the Harbor House placement, due to its location. She has resided in Fairbanks for over 50 years. Her community connections and friends are in Fairbanks.[31] Emily C and Ms. Humphrey concurred.[32]

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28 Ex. A, pp. 4 – 6.
29 Ms. Hodges's testimony.
30 Ms. Hodges's testimony.
31 Ms. VonRonCeilier's testimony.
32 Emily C and Ms. Humphrey's testimony.

resident is to be discharged.[38] A resident must be given thirty days advance notice of the discharge. However, if the ground for discharge is that the resident is endangering the safety of other individuals in the facility, the notice "must be made as soon as practicable before transfer or discharge."[39] The information contained in the discharge notice may be changed.[40]

On January 7, 2019, Denali changed the discharge notice, providing Harbor House as the discharge location. Ms. W was given that notice the same day.[41] Denali included the changed notice in its exhibits, which were filed on January 8, 2019. On January 8 and 9, 2019 Ms. W's counsel engaged in a series of emails asking for a continuance of the hearing and argued that Ms. Wwas entitled to a new notice with a full 30 days prior to discharge.

A short status conference was held on January 10, 2019 to address Ms. W's request for continuance and objection to the changed discharge notice. The request for continuance and objection was denied, for the following reasons:

- The record shows that Ms. Ws power-of-attorney, Emily C, was informed by Denali that Harbor House was a possible placement as early as December 5, 2018, Ms. W was herself told on December 17, 2018, and her counsel was emailed that Harbor House was a possible placement on December 27, 2018.[42]
- The federal regulations allow for a change to the discharge notice. [43]
- In the event the underlying ground for discharge consists of an allegation that the resident is endangering others in the facility, a full 30-day notice is not required.[44]

B. Grounds for Discharge

Denali has the burden of proof in this case.[45] It must establish, by a preponderance of the evidence, that Ms. W's actions have endangered other individuals in Denali.

Denali's witnesses' evidence and testimony were credible. It demonstrated that Ms. W has engaged in offensive and assaultive behavior against both staff and residents. In contrast, Ms. W's testimony was not credible. It explained her behavior with

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38 42 C.F.R. § 483.15(c)(3) and (5).
39 42 C.F.R. § 483.15(c)(4)(i) and (ii)(A).
40 42 C.F.R. § 483.15(c) (6).
41 Ex. A, pp. 4 – 5.
42 *See* Denali's *Notice of Objection to Postponement of January 14, 2019 Hearing*, Ex. B, pp. 8 – 9; Ex. C.
43 42 C.F.R. § 483.15(c) (6).
44 42 C.F.R. § 483.15(c)(4)(i) and (ii)(A).
45 7 AAC 49.135.

staff as joking and flirting, minimized her interaction with Resident A and explained her interaction with Resident B as at first just checking on him, and then just pinching his cheek as a "thank you." While Ms. W may genuinely believe that her actions were either benign or minimal, her testimony does not alter the conclusion that she assaulted other residents. Neither does the testimony of either of Ms. W's witnesses, who were not present during the incidents at issue.

Denali is not seeking to discharge Ms. W due to her offensive behaviors, which include sexual harassment and offensive touching. Instead, it is requesting that she be discharged due to her assaultive behavior against several residents. Specifically, she has assaulted Resident A on two occasions, assaulted Resident B once, kicked a resident's wheelchair, and pulled a resident's hair.

The assault on Resident B is particularly troubling. Resident B is totally vulnerable. He is non-communicative, not mobile, and spends his time lying down in a fetal position. The evidence shows that Ms. W entered his room, slapped him hard enough to be heard from 25 feet away, and that slap rendered the entire side of his face, up to his ears, completely red on September 20, 2018. She then, after being expressly told not to go into his room, went into it the very next morning.

Resident A is also vulnerable, although not to the same extent as Resident B. Resident A, who has a brain injury, was hit twice on the head by Ms. W.

Further, one month after the incident involving Resident B, Ms. W kicked another resident's wheelchair and pulled another's hair, and in late December 2018, she threw a resident's glasses across the room.

The evidence shows that Ms. W is not able to control her behavior towards other Denali residents. The assaults recited above were not committed against someone she was sharing a room with, but other residents, and in the case of Resident A did not occur in the common areas but involved her going into his room.

Ms. W argues that Denali has a duty to place safeguards in place to protect the other residents and that the facts do not support her being discharged.

Ms. W cites to several administrative cases in support of her position that Denali cannot discharge her:[46]

- *In re E.R.* (Washington 1994). E. R., who was wheelchair bound, had a history of sexually assaulting other patients including his roommate. The facility put him in a separate room and installed a physical barrier at the entrance to the room, which limited his ability to leave his room. After those measures were taken, he would still ogle other individuals. If he left his room, then it would be necessary to monitor him. The ALJ found that the facility could undertake additional measures to control E. R.'s behavior and that the facility was impermissibly taking financial costs in account, and denied the facility's request to discharge E. R.
- *In re Parker* (California 2001) involved a resident who was primarily assaultive towards facility staff, and had three relatively minor incidents involving other residents, and the facility had not taken any actions to address her behavior. In that case, the hearing officer denied discharge.
- *In re Quintero* (Ohio 2001) involved a resident who was sexually and physically assaultive to other residents and facility staff. However, the facility was able to rectify the risk to other residents, but not to staff. The hearing officer denied the discharge because the risk to staff was "not unusual or unexpected and [did] not rise to the level of 'endangerment' required for a discharge or transfer."
- *Appeal No. 98N-0008* (Florida 1998) involved a resident who had assaulted two persons who had come into her room. The incidents did not recur after the facility took action to limit access to the resident's room, and the facility took no further actions. The hearing officer did not find sufficient grounds for discharge.
- *In re L. R.* (California 1993) involved a resident who had sexually assaulted (fondling/kissing) fellow residents. The hearing officer did not find sufficient grounds for discharge because the facility had not taken any stronger measures other than "passively monitor[ing] the resident when he is seated near the nurses station."

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[46] These decisions are attached to Ms. W's January 18, 2019 supplemental filing. The last decision in that packet, *In re V. P.* (Washington 1993) is not addressed because it is not on point. It does not make any conclusions regarding whether V. P. should have been discharged but addresses the failure of the facility to comply with procedural discharge requirements and required the facility to readmit him.

- *Appeal No. 97N-0133* (Florida 1997) involved a resident who had made offensive sexual and threatening comments to staff, did not follow instructions, and even locked staff out from the facility, and hit a staff member with his scooter. The hearing officer did not find sufficient grounds for discharge due to a lack of corrective measures and a failure to specifically allege safety concerns.
- *In re D. P.* (Minnesota 1993) involved a resident who was wheelchair bound, who became frustrated, and assaulted other residents, including using his wheelchair offensively. Most of those incidents occurred when people were blocking his way. However, they did not occur if staff was pushing his wheelchair. The hearing officer recommended a denial of discharge for a number of reasons, the most notable of which was that the facility had not shown that the discharge was necessary for the safety of individuals in the facility, and that it had not taken sufficient corrective measures.
- *Appeal No. 525-16-1061* (New Mexico 1997) involved a significantly demented resident who had assaulted another resident and had a history of other incidents. The hearing officer found that the evidence was lacking and "vague", and recommended that the resident not be discharged because "[t]he proposed discharge appears to be based upon a perceived threat of danger to others rather than on actual evidence of injury" and no indication that any threat could not be addressed through "an appropriate plan of care."
- *In re G. H.* (California 1994) involved a mentally ill resident who would repeatedly ram other individuals with his wheelchair. No serious injuries were reported. The hearing officer denied discharge, stating, among other reasons, that the resident did not pose an "unusual" risk.
- *In re T. K.* (Washington 1991) involved a wheelchair bound resident with traumatic brain injury. He sexually assaulted other residents on multiple occasions. After discharge proceedings were started, the facility instituted some protective measures and mental health treatment. After those were implemented, the resident did not initiate any inappropriate sexual behavior. The hearing officer denied discharge because any threat to other residents could be addressed by the facility implementing security measures and treatment for the resident.

The parties also supplied three reported cases:

- *Ingle v. Robinson Healthcare Center, Inc.*[47] involved a case where the resident had physically and sexually assaulted other residents. The ALJ found that the resident could not be discharged due to the facility's failure to show that it had taken sufficient measures to modify or control the resident's behalf. On appeal, the Circuit Court reversed, finding that the resident was a safety threat to other residents and to staff, and remanded the case to the ALJ to find an appropriate transfer option, and allowing the facility to discharge the resident if no appropriate option could be found.[48] Mr. Ingle then appealed the Circuit Court's ruling to the Arkansas Court of Appeals, which dismissed the appeal as premature.[49]
- *Edgewater at Waterman Village v. Youngren* was an appeal by a facility of an administrative hearing decision that found that the facility had not shown grounds for discharge. The Florida District Court of Appeal upheld the hearing officer's decision. In Florida, however, a facility must establish its grounds for discharge by clear and convincing evidence. [50]
- *ITMO Involuntary Discharge of Transfer of J. S.* involved an elderly mentally ill patient who refused treatment. An ALJ found three grounds supporting discharge, that it was necessary for the resident's health, that the resident's behavior endangered others, and that there were alternative placements better suited to her care. The Minnesota Commissioner of Health reversed the ALJs decision, and the facility appealed. The Minnesota Court of Appeals upheld the denial of discharge on all grounds. In that case, the only evidence of endangerment consisted of verbal abuse, and one incident where the resident pushed another resident's wheelchair into a nurse's desk.[51]

A review of these cases shows that discharge is allowed, if the resident is actually endangering other residents, and if the facility has unsuccessfully initiated appropriate protective measures. A facility's financial issues, *i.e.* the expenses accompanying the protective measures, are not grounds for discharge.

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47 *Ingle v. Robinson Healthcare Center, Inc,* 199 WL 72847700 (Ct. of Appeals Arkansas, 1999).
48 *Ingle,* p. 2.
49 *Ingle,* p. 3.
50 *Edgewater at Waterman Village v. Youngren*, 803 So.2d 900 (5 D. Fla, 2002).
51 *ITMO Involuntary Discharge of Transfer of J. S*, 512 N.W.2d 604 (Minnesota Ct. App., 1994).

The facts in this case show that Ms. W engages in offensive behavior. That is not grounds for discharge. However, she has also been physically assaultive to other residents, to wit Resident A, Resident B, and other residents. Denali did undertake initial protective measures. After the Resident A incidents, Denali instituted a line of sight protocol for Ms. W. That protocol had been abandoned by the time the Resident B incident occurred. Denali averted any further assaults against Resident B by placing sensors on Ms. W's room and his room. However, a month after the Resident B incident, Ms. W was observed by Denali staff, *i.e.* while in line of sight, to kick another resident's wheelchair and to pull another's hair. In December 2018, Ms. W threw another resident's glasses across the room. Visual observation of Ms. W did not change her behavior. It is also important to note the primary difference between Ms. W and other residents. She is fully physically functional and can move without assistance. Most of the other residents are not fully physically functional. While continual observation might lessen the severity of an assault, it, however, as demonstrated by Ms. W's behavior, cannot completely prevent it. As a result, Denali has demonstrated that it is entitled to discharge Ms. W because she endangers the safety of other residents.

C. Discharge Planning

By federal regulation, a nursing facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly . . . discharge from the facility."[52] Ms. Hodges's uncontroverted testimony supports a finding by the preponderance of the evidence that Denali made extensive efforts to find an appropriate placement for Ms. W. The factors affecting Ms. W's placement severely limited the options available. There were no beds available in Fairbanks, Ms. W's home for the past 50 years. The only available bed that met Denali's criteria for a dually certified facility and Ms. W's need for her own room, that would accept the funding available for Ms. W was in a facility in Wrangell. That location is far from ideal. It places Ms. W in a community where she has no connections and no friends. It is highly unlikely that her close friends will visit her frequently, if at all. But given the constraints surrounding Ms. W's care needs, it is an appropriate placement and Denali offered to fly her and her

[52] 42 U.S.C. § 1396r(c)(2)(C); 42 C.F.R. § 483.15(c)(7).

power-of-attorney Emily C, to visit the facility. Given these facts, Denali has met its obligation.

V. Conclusion

Denali has met its burden of proof. Ms. W's actions, despite Denali's attempts to control her behavior, constitute a danger to other residents. Denali has made extensive attempts to locate an appropriate placement, and has found a suitable placement, although the location is far from Ms. W's home of Fairbanks. Denali's decision to discharge Ms. W is upheld.

DATED this 12th day of February, 2019.

Lawrence A. Pederson
Administrative Law Judge

Non-Adoption

B. The undersigned, by delegation from the Commissioner of Health and Social Services and in accordance with AS 44.64.060(e)(3), revises the enforcement action, determination of best interest, order, award, remedy, sanction, penalty, or other disposition of the case as follows and adopts the proposed decision as revised:

After review, the factual findings in the proposed decision are not changed. However, those facts do not support the conclusion that Denali undertook adequate protective measures to ameliorate Ms. W's behavior. Instead, the facts support a conclusion that Denali's supervision and protective measures were inadequate. As a result, Denali, which had the burden of proot: did not meet that burden and may not discharge Ms. W from its facility for endangering the safety of other individuals in its facility.

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 15th day of March, 2019.

/s/
Name: LauraRussell
Title/Agency: Policy Advisor, DHSS

[Note: this decision has been redacted and modified for publication]