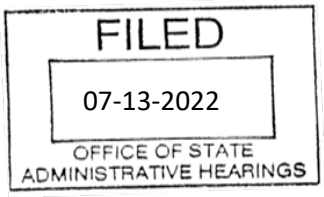
BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS

STATE OF GEORGIA

M[redacted] H[redacted],	**|Docket No.: [redacted]**
Petitioner,	**|[redacted]-OSAH-DCH-HFR-LTCBOR-Brown**
v.	**|**
PIONEER HEALTHCARE,	**|**
Respondent.	**|**



INITIAL DECISION

I. INTRODUCTION

Petitioner, M[redacted] H[redacted], appealed his involuntary discharge from Pioneer Healthcare, a long-term care facility, in Byromville, GA. (hereinafter, "Pioneer"). An evidentiary hearing was held via telephone conference on June 29, 2022. M[redacted] H[redacted], Petitioner, represented himself at the hearing. Karen Smiley, Esq. represented Pioneer Healthcare. Cynthia Reese, Interim Administrator of Pioneer Healthcare, was present for the facility. Annette Goodwin, Regional Vice President of Beacon Management, was present for any questions concerning facility rules or policy. Social Services Director, Ms. Arbie Byse, also was present and gave testimony. For the reasons indicated herein, Respondent's involuntary discharge of Petitioner is **AFFIRMED.**

II. FINDINGS OF FACT

1. Petitioner, as his own responsible party, was admitted to Pioneer Healthcare on March 9, 2022. Ms. Arbie Byse is the Social Services Director, who works with each resident to make certain that they are treated right and have their medical needs met. (Testimony of Ms. Byse)
2. Ever since he was admitted, Petitioner has been requesting to be transferred. He indicated to Ms. Byse that he needed the skilled care, but that he wanted more of a "community setting," so she began her research to locate another facility to transfer Petitioner. (Testimony of Petitioner and Ms. Byse)
3. Ms. Byse contacted another facility in Lumber City, as well as 10 other facilities in the surrounding area, but has not been successful in locating a facility that will take the

Petitioner as a new resident, citing his inappropriate behavior as the reason. (Testimony of Ms. Byse; Exhibit R-1)

4. In the first month of his admission, Petitioner was non-compliant with the smoking regulations. While there are designated smoking areas at the facility, Petitioner began smoking in areas that were not designated as smoking areas. Eventually, he was asked to "turn in" his cigarettes and lighter, but he refused. Petitioner did not refute this testimony. (Testimony of Ms. Goodwin)
5. In addition, Petitioner began engaging in inappropriate behavior of a sexual nature with a cognitively-impaired resident. Petitioner did not refute this testimony. (Testimony of Ms. Goodwin)
6. Ms. Goodwin testified further that during his first two months at Pioneer, Petitioner was ordered by the medical director to have a 1013 analysis[1], which occurred on April 9, April 13, and April 22. (Testimony of Ms. Reese)
7. Consequently, on April 11, 2022, Pioneer issued a Notice of Proposed Involuntary Discharge or Transfer. (Discharge Notice) The reason stated in the Involuntary Discharge Notice was as follows: "The safety of the Facility is endangered by your continued stay." (Testimony of Ms. Reese) (Exhibit R-1)
8. Petitioner responded immediately, questioning the legal grounds for discharge, and the reasonableness of the discharge plan, or rather, the discharge address, as the Discharge Notice indicated he was being discharged to a location in Missoula, Montana. He asked for a fair hearing to contest the Discharge Notice, not because he wanted to remain at the facility, but because he did not wish to be transported to Montana. (Testimony of Petitioner; Exhibit P-1)
9. Subsequently, on May 23, 2022, Pioneer discharged Petitioner on an emergency basis due to aggressive behavior because he "…broke the main entrance doorway by running his electric wheelchair into the door purposely to get out." (Testimony of Ms. Reese)(Exhibit R-2)
10. Cynthia Reese testified that she is the Interim Administrator at Pioneer, but she was not present at the facility when this incident occurred. The Director of Nursing told her about the Petitioner "ramming" his wheelchair into the door, cracking the glass and breaking the lock. (Testimony of Ms. Reese)
11. According to Ms. Reese, there are residents at Pioneer who are mentally/cognitively challenged; therefore, all residents are required to sign out and wait until a staff

[1] The 1013 analysis is conducted when an individual is determined to be suicidal or homicidal. The goal of a 1013 form is to help those who need to receive mental health treatment during an emergency. Law enforcement may be contacted if a resident is a danger to himself or others. It can also be an involuntary commitment coordinated with the medical director or physician at the facility or in conjunction with the facility's behavior health partners. (Testimony of Ms. A. Goodwin)

member, who must be notified, lets the resident(s) in and out of the door. (Testimony of Ms. Reese)

12. Ms. Reese explained that there is no staff person standing at the door, however, to let residents/visitors in and out. There is a doorbell at the door, that alerts staff that someone is at the door who wants in or out of the facility. Consequently, a resident who wants in and/or out must wait until a staff member arrives at the door to assist him/her in coming or going. (Testimony of Ms. Reese)
13. On May 22, 2022,at approximately 5:15 AM, Petitioner testified that he has was asked to sign out, as he typically does, but that Buzz refused to open the door, and instead walked away, so when no one was around, and he was being held against his will, he rammed his electric wheelchair into the glass door. According to Ms. Reese, Petitioner repeated this process several times until the glass in the door cracked, and the lock mechanism on the door was broken, leaving the entire building unsecured. (Testimony of Ms. Reese and Petitioner).
14. As a result, the facility called law enforcement, but law enforcement was reluctant to transport the Petitioner to jail, as he is in an electric wheelchair. Therefore, the facility had EMS transfer Petitioner to an acute-care hospital for a 1013 analysis. (Testimony of Ms. Goodwin)
15. According to Petitioner, he was never declared a "1013." Respondent did not refute that testimony. (Testimony of Petitioner)
16. Petitioner does not wish to return to Pioneer Healthcare. He testified that he needs the wound care he cannot provide for himself, and therefore he wants a discharge plan so he can be transferred to another facility. (Testimony of Petitioner)
17. Ms. Byse indicated that a hospital case manager as well as a DFCS case manager are attempting to locate a facility to transfer Petitioner, but that Pioneer would not be providing a discharge plan as Petitioner was discharged on an emergency basis. (Testimony of Ms. A. Byse)

III. CONCLUSIONS OF LAW

Respondent bears the burden of proof in this matter and must show by a preponderance of the evidence that its involuntary discharge of Petitioner was proper. OSAH Rule 7; OSAH Rule 21.

1. Georgia law provides that a resident of a nursing facility may be involuntarily discharged for various reasons, one of which is if the resident is a danger to himself or others. O.C.G.A. §31-8-116 states as follows: (a) Except in an emergency, where the resident or other residents are subject to an imminent and substantial danger that only immediate transfer or discharge will relieve or reduce, a facility may involuntarily transfer a

resident only in the following situations and after other reasonable alternatives to transfer have been exhausted:

i. A physician determines that failure to transfer the resident will threaten the health or safety of the resident or others and documents that determination in the resident's medical record;
ii. The facility does not participate in or voluntarily or involuntarily ceases to operate or participate in the program which reimburses the cost of the resident's care;
iii. Nonpayment of allowable fees has occurred; or
iv. When the findings of a Medicare or Medicaid medical necessity review determine that the resident no longer requires the level of care provided at the facility.

2. Before a long term care facility may involuntarily transfer or discharge a patient, the facility must notify the patient of the transfer or discharge in writing. (O.C.G.A. § 31-8-116(a)(d); 42 C.F.R. § 483.12(6)). In this case, the Notice of Proposed Involuntary Discharge or Transfer was issued on April 11, 2022, citing as the reason for the discharge, the safety of the facility that was "endangered" by Petitioner's continued presence in the facility. (Exhibit R-1).
3. Again, the Long Term Care Facilities, Resident's Bill of Rights Rules and Regulations, Rule 111-8-50-.15(d) states as follows:
    a. Except in the event of an emergency situation in which the resident or other residents are subject to imminent and substantial danger that only immediate transfer will reduce,…no transfer shall take place until all appeal rights are exhausted. However, if a resident is transferred before exhaustion of all appeal rights, such resident in no way relinquishes any appeal rights under these rules and regulations.
4. Petitioner created an emergency situation when he rammed his wheelchair into the main door of the facility several times in an aggressive manner in order to "get out." While he indicated that he was being "held against his will" Petitioner had just returned from the outside at 5:00 AM, and at 5:15 AM he was back at the door desiring to go outside again. In the meantime, the staff member assigned to the front desk was not present, as he had "rounds" to make, so when Petitioner asked to go outside 15 minutes after he had just returned, the staff member said, "wait," and left momentarily. (Rule 111-8-50-.15(d).
5. Leaving the main door in that condition created an unsafe environment for the other residents, as there was no security at all at the door without a lock and a huge crack in the glass. Petitioner was not being held against his will, except in his opinion. The staff

member was working and asked Petitioner to wait. Petitioner would not wait and created an unsecured, unsafe environment for himself and the other residents in the facility. The reasonable action taken by the facility was to remove the Petitioner from said environment immediately, so that repairs could be made, ensuring the safety of all residents therein. (Long Term Care Facilities, Resident's Bill of Rights, Rule 111-8-50-.15(d)).

IV. DECISION

The Respondent's decision to discharge Petitioner from its facility was proper and is AFFIRMED.

SO ORDERED, this 13th day of July, 2022.

Barbara A. Brown
Administrative Law Judge