Maine Human Rights Commission

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INVESTIGATOR'S REPORT
H14-0500
HUD No. 01-14-0571-8

January 7, 2015

[redacted] **(Augusta)**

v.

[redacted] **Inc. (Corinth)**

I. Complainant's Complaint:

Complainant [redacted] alleged that Respondent [redacted] discriminated against him on the basis of his mental disability when it involuntarily discharged him from its assisted living facility and refused to let him return to the facility.

II. Respondent's Answer:

[redacted] stated that it did not involuntarily discharge Mr. [redacted] rather, he discharged himself from the facility and did not want to return to the facility.

III. Jurisdictional Data:

1) Dates of alleged discrimination: December 3-14, 2013.

2) Date complaint filed with the Maine Human Rights Commission ("Commission"): September 19, 2014.

3) Respondents are subject to the Maine Human Rights Act ("MHRA") and the federal Fair Housing Act, as well as state and federal housing regulations.

4) Complainant is represented by [redacted], Esq. Respondent is represented by [redacted], Esq.

5) Investigative methods used: A thorough review of the written materials provided by the parties and a request for additional information from Respondent. This preliminary investigation is believed to be sufficient to enable the Commissioners to make a finding of "reasonable grounds" or "no reasonable grounds" here.

IV. Development of Facts:

1) The parties in this case are as follows:

   a) Mr. [redacted] has physical and mental disabilities.

   b) [redacted] is an 18 bed assisted living facility located in Corinth, Maine.

2) Complainant provided the following in support of his position:

   a) Mr. [redacted] physical and mental disabilities include anxiety disorder, post-traumatic stress disorder, and bipolar disorder. He is substantially limited in brain functions, thinking, concentration, focus, and other major life activities including working. Mr. [redacted] has a record of mental disability and has been regarded as having a mental disability. He also has physical impairments which cause a substantial limitation in mobility. He uses a wheelchair or a motorized scooter and has a record of a physical disability, and has been regarded as physically disabled.

   b) [redacted] was aware of Mr. [redacted] disabilities at the time he was admitted to the facility on October 7, 2013.

   c) On December 3, 2013, Mr. [redacted] had a phone conversation with Administrator about getting transportation so that he could deposit a check at his bank. Administrator told Mr. [redacted] that [redacted] would not provide him with special transportation to the bank, and that he would have to wait until a group trip was planned.

      i. On December 3, 2013, Mr. [redacted] was never spoken to by anyone at [redacted] regarding their concern for his safety.

   d) On the afternoon of December 3, 2013, Emergency Medical Technicians ("EMTs") came to Mr. [redacted] room and told him that Administrator had filed a report claiming he was suicidal. Mr. [redacted] told the EMTs that he was not suicidal and had no intention of hurting himself.

      i. Later law enforcement officers came to Mr. [redacted] room and told him that Administrator had called them and told them she wanted him off of the premises. Law enforcement told Mr. [redacted] that if he did not leave he would be "blue papered."[1] Mr. [redacted] had been "blue papered" about 10 years prior and did not want it to happen again, so he agreed to leave with law enforcement.

   e) Mr. [redacted] was taken to the emergency room where he was assessed by a nurse at the hospital ("Nurse"). Nurse determined that Mr. [redacted] was not a danger to himself or others and contacted Administrator to find out about Mr. [redacted] return to [redacted]

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[1] Being "blue papered" is short hand for the procedure to involuntarily commit an individual to a psychiatric hospital on an emergency basis.

f) Administrator told Nurse that Mr. [redacted] was not coming back to [redacted][2]

g) On December 13, 2013, Mr. [redacted] attorney informed Administrator by letter that Mr. [redacted] had not discharged himself from [redacted] and that doctors had cleared him medically and psychiatrically to return to [redacted]

h) On or about December 14, 2014, Administrator told Mr. [redacted] attorney that she had filled Mr. [redacted] bed at [redacted] and that he was not allowed to return to the facility.

i) [redacted] brochure states: "Unlike most other facilities our rates don't go up as your condition declines. Also, you are not at risk of having to **move** merely because your condition declines, ensuring you or your loved one can truly 'age in place.'" (Emphasis in original.)

j) Mr. [redacted] appealed to the Maine Department of Health and Human Services ("DHHS") regarding [redacted] decision to not allow him to return to the facility.[3] A DHHS hearing was held on January 13, 2014, at which the following exchange occurred:

> Mr. [redacted] attorney: "If Mr. [redacted] condition declined because you thought he was suicidal he wouldn't be require to move, is that right?"
>
> Administrator: "He would need placement, we're not a mental health facility if that's what you're asking me. We take care of mostly geriatric patients meaning if they have strokes we don't send them away we keep them, that's why we took him in a wheelchair."

k) Also during the DHHS hearing Administrator testified that the sole reason that she did not consider Mr. [redacted] request for readmission was his mental health history.[4]

l) The DHHS hearing officer's ruling regarding Mr. [redacted] appeal (the "Decision") provided the following information:

i. During his residency at [redacted] Mr. [redacted] had been admitted to the hospital for physical problems and returned to [redacted] after discharge from the hospital.

ii. On December 2, 2014, Mr. [redacted] told the Resident Coordinator that he intended to pack his belongings and move out of [redacted] The Resident Coordinator told Administrator and the Medical Care Provider what Mr. [redacted] had told her.

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[2] Administrator stated that she thought Mr. [redacted] wanted to discharge himself.

[3] In his DHHS hearing, Mr. [redacted] characterized what happened to him as an involuntary emergency discharge. In response to Mr. [redacted] claim, [redacted] stated that Mr. [redacted] voluntarily discharged himself from the facility.

[4] The investigator's reliance on the DHHS transcript in this report relates only to the facts/testimony presented by the parties in that proceeding. The transcript is not being relied on for its ultimate decision as it is separate and apart from the Commission's purpose of determining if there is, or is not, reasonable grounds to find that discrimination occurred.

iii. Administrator and the Medical Care Provider are responsible for preparing discharge paperwork which includes an inventory sheet and a discharge sheet explaining the reason for a resident's discharge. The inventory sheet is started when a resident is admitted and lists the resident's belongings at the time he/she is admitted. The sheet is completed when the resident is discharged.

iv. Administrator advised Mr. [redacted] that it would be good for [redacted] to arrange a Goold Health Systems evaluation to assess Mr. [redacted] eligibility for MaineCare reimbursement for various levels of care before he left [redacted] The assessment was scheduled for December 5, 2013.

v. On December 3, 2014, Mr. [redacted] was upset because one of the doctors discontinued one of his ADHD medications without consulting with Mr. [redacted] Mr. [redacted] informed one of the Certified Registered Medication Aides ("CRMA") that he was going to find a taxi and motel that accepted debit cards. Mr. [redacted] stated, "I'll go to a motel and if God takes me, it's His will." The CRMA understood Mr. [redacted] comments as indicating his intent to commit suicide, so she told Administrator who contacted EMTs as well as the State Police.

vi. At first Mr. [redacted] was not cooperative with the EMTs or State Police, but he was eventually persuaded to allow EMTs to transport him to the hospital after he was told that the alternative would be to seek involuntary psychiatric hospitalization for him.

   i. The EMTs and State Police requested and received boxes from [redacted] which they filled with items at Mr. [redacted] direction. State Police photographed the remaining items in Mr. [redacted] room, including Mr. [redacted] wheelchair and slide board.

vii. The hospital's discharge summary for Mr. [redacted] dated December 13, 2013, stated, "... was called to evaluate the patient [Mr. [redacted]. They did not feel that he will require any voluntary or involuntary psychiatric facility placement. He was not showing any signs of depression or psychosis. No suicide or homicide ideation... the patient is medically free to be discharged and it was stated clearly by an order that was put in patient's charge on 12/6/13 [healthcare provider], patient not at observation level of care, nor the acute level of care, nor the skilled level of care..."

viii. [redacted] never began or completed discharge paperwork for Mr. [redacted] and a discharge notice was never issued.

3) Respondent provided the following in response to Complainant's allegations:

a) During Mr. [redacted] first month at [redacted] both Mr. [redacted] and [redacted] appeared to assess the relationship as going well. Mr. [redacted] was sent to the emergency room on October 21, 2013, due to an apparent seizure. After his seizure, [redacted] observed him to be more needy/ demanding.

b) Administrator spoke to Mr. [redacted] about his outbursts of attention-seeking behavior. At one point in November, 2013, Mr. [redacted] stated that he was packing and leaving after Administrator told him that his behavior was becoming totally unreasonable and inappropriate. At the time, Administrator told Mr. [redacted] that she would assist him in finding another placement. Administrator later contacted Mr. [redacted] and told him that she had found two openings for him. He replied that he had spoken to his mom and she had talked him into staying at [redacted]

   i. Administrator told Mr. [redacted] that if he was going to continue being overly critical of staff and other residents he should consider moving, because she did not want him to be unhappy or make others unhappy. Mr. [redacted] apologized for his behavior and said that he was not normally difficult to deal with. Administrator told him that she would give it another try and appreciated his cooperation.

c) On November 19, 2013, Mr. [redacted] was sent to the emergency room for chest pains and came back that same evening. Mr. [redacted] became more demanding after this visit to the emergency room.

d) In the DHHS hearing (as recorded on the transcript), employees of [redacted] who were involved with the situation with Mr. [redacted] stated that no employee of [redacted] assisted Mr. [redacted] in packing or indicated to him that they wanted him out of the facility. The Resident Coordinator and/or Administrator at one point tried to convince Mr. [redacted] to stay at [redacted] so that an assessment could be conducted to determine a proper placement for Mr. [redacted] which he voluntarily sought.

   i. [redacted] stated that Mr. [redacted] packed up his own belongings and his mom was going to pick up the things he could not take with him.[5] Administrator spoke to the Medical Care Provider because Mr. [redacted] stated he was leaving so the Medical Care Provider could make some recommendations about Mr. [redacted] medications since he was leaving the facility.

e) Once Mr. [redacted] made suicidal statements[6] and threatened employees of [redacted] for interfering with his medication, [redacted] felt it was appropriate for it to discharge Mr. [redacted] from the facility under the rules and regulations and guidelines of the facility and the State.

   i. [redacted] was concerned about the safety of Mr. [redacted] and others at the facility. Administrator is a registered nurse and is legally obligated to contact EMTs if she comes to the reasonable conclusion that some might be suicidal.

f) Nurse testified in the DHHS hearing that Mr. [redacted] refused to return to [redacted] when he was in the emergency room. She also testified that she felt Mr. [redacted] had given her the impression that he was not wanted to [redacted]

   i. Nurse further testified that she was under the assumption that Mr. [redacted] had not packed his own boxes and had been forced to leave [redacted] Nurse also testified that on more than

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[5] Mr. [redacted] had shown a nurse that day that he cleaned out his drawers, and he was all packed up.

[6] During the hearing, a nurse testified that Mr. [redacted] told her that he was going to a hotel to kill himself.

one occasion she had seen some patients returned to [redacted] after going to the hospital and others did not. Nurse agreed that if a patient did not want to go back to a facility, it would be a violation of his/her rights for the hospital to force that person to go back to the facility they had come from.

ii. When Administrator spoke to Nurse while Mr. [redacted] was in the hospital, she learned that Nurse was not calling to inquire about whether [redacted] would readmit Mr. [redacted] but was calling to find out about Mr. [redacted] wheelchair. Nurse told Administrator that Mr. [redacted] was not coming back to the facility.

g) Mr. [redacted] residency at [redacted] was not terminated by the facility. Mr. [redacted] voluntarily left [redacted] and he only asked to be returned there after he was not able to be placed in a new facility on or before December 13, 2013. By the time Mr. [redacted] attorney contacted [redacted] the bed had been filled.

h) Respondent is not a mental healthcare facility. The language in the brochure refers to the decline in a "physical" condition of a patient.

i) Residential Coordinator testified in the hearing that Mr. [redacted] left before discharge papers could be prepared. Administrator also testified that a discharge summary was prepared contemporaneously.

j) Mr. [redacted] was not allowed readmission to [redacted] but he was also denied admission to other facilities as well. [redacted] believed this was due to his behavior.[7]

k) Mr. [redacted] was denied readmission to [redacted] due his mental health history as well as the fact that he "made a voluntary discharge and threatened others."

l) In the past five years, there was a discharge somewhat similar (but not exactly similar) to that of Mr. [redacted] A 90 year old resident threatened her roommate on numerous occasions and was involuntarily discharged. DHHS found in that instance that the resident could properly be discharged.

m) While Complainant may have some level of mental impairment, Complainant is capable of making substantial life decisions, including decisions about where he wants to live or whether he could voluntarily discharge himself from any facility where he is housed.

4) The Contract for services signed by Mr. [redacted] and [redacted] provides that, "... if [the resident's] needs exceed [redacted] ability to provide services, [redacted] will assist [the resident] in making other arrangements including moving somewhere else, if necessary."

5) The Contract also provides that [redacted] will help Mr. [redacted] arrange transportation but costs of transportation are not included in this assistance.

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[7] In the hearing transcript Administrator testified that Mr. [redacted] told her that he had 10 other prior placements and no one would take him back after he left [redacted]

6) The Contract states that residents' rights related to discharge are attached at Appendix B, but there was no Appendix B attached to Respondent's submission.[7]

7) The following exhibits are attached to this Report:

   a) Exhibit 1: nursing notes related to Mr. [redacted] residency at [redacted]

   b) Exhibit 2: pre-treatment and during treatment hospital notes for Mr. [redacted]

   c) Exhibit 3: transcript of a voice mail message from Administrator to Mr. [redacted] attorney.

   d) Exhibit 4: [redacted] discharge policy.

8) The nursing notes for December 3, 2013, stated that the EMTs who showed up for Mr. [redacted] had to wait outside for law enforcement, which is their standard practice. The pre-hospital notes from the EMTs that dealt with Mr. [redacted] state that [redacted] director wanted the EMTs to stay outside until law enforcement showed up.

   a) During the hearing, Administrator testified that she thought this part of the pre-hospital notes was false because she did not stop the EMTs from entering the facility without law enforcement.

   b) The notes also state that "the state trooper states that the [Administrator] does not want [Mr. [redacted] there anymore". The transcript of the hearing shows that Administrator clarified her statement to mean that she did not want him there anymore because he was suicidal. Administrator further stated that Mr. [redacted] was leaving [redacted] on his own, but when he became suicidal she had to call and intervene because she was afraid he would hurt himself.

9) The hearing transcript reflects that Administrator stated that when someone decides to leave the facility, [redacted] does not just immediately say you have to leave.

10) Administrator began placing calls to fill Mr. [redacted] bed the day he told [redacted] he was leaving.

11) Respondents did not provide any documentation showing that Mr. [redacted] had a prior history of being suicidal.

V. Analysis:

1) The MHRA provides that the Commission or its delegated investigator "shall conduct such preliminary investigation as it determines necessary to determine whether there are reasonable grounds to believe that unlawful discrimination has occurred." 5 M.R.S. § 4612(1)(B). The Commission interprets the "reasonable grounds" standard to mean that there is at least an even chance of Complainant prevailing in a civil action.

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[7] Respondent provided its discharge procedures as part of a request for additional information.

2) The MHRA provides, in part, that any person has the right to rent or lease a housing accommodation or partake in the facilities or services of a housing accommodation without discrimination on the basis of disability. 5 M.R.S. § 4581-A(1)(D); 94-348 CMR. Ch. 8, § 8.04(a)(3).

3) The MHRA also provides, in part, that it is "unlawful for a person to coerce, intimidate, threaten or interfere with any individual in the exercise or enjoyment of the rights granted or protected by this Act", 5 M.R.S. § 4633(2), or to "evict... any tenant of any housing accommodations because of physical or mental disability." 5 M.R.S. § 4581-A(1)(E).

4) The Commission's housing regulation, which interprets § 4633(2), provides that:

   A. It shall be unlawful to coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of, or on account of that person having aided or encouraged any person in the exercise or enjoyment of, any right granted or protected by this part.

   B. Conduct made unlawful under this section includes, but is not limited to...

      (2) Threatening, intimidating or interfering with persons in their enjoyment of a dwelling because of the race or disability... of such persons...

   94-348 C.M.R. Ch. 8, § 8.09.

5) Here, Complainant alleged that he was discharged/evicted from his housing facility and denied readmittance and the ability to "age in place" on the basis of his mental disability. Respondent stated that Complainant voluntarily discharged himself and that it had had filled his bed by the time he asked to be readmitted to the facility.

6) Because the disability discrimination claim does not involve direct evidence[8], Complainant establishes a prima-facie case of unlawful housing discrimination with respect to his eviction by proving (1) he was a member of a class protected under the MHRA; (2) Respondent was aware of his membership in that class at the time of the eviction; (3) he was willing and qualified to continue the housing accommodation; and (4) Respondent refused to permit him to continue the housing accommodation. *See Radecki v. Joura*, 114 F.3d 115, 116 (8th Cir. 1997).

7) Complainant establishes a prima-facie case of unlawful housing discrimination with respect to being refused readmission[9] to the housing accommodation by proving (1) he is a member of a protected class; (2) he applied for and was qualified to live at [redacted] (3) that Respondent rejected him for admission;

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[8] Complainant argues that Administrator's testimony at the DHHS hearing ("When the hospital said would you ever consider a readmission, I said no based on his mental health history") was itself direct evidence of discrimination. We do not decide here that it is, or is not, direct evidence; instead, we utilize the traditional burden-shifting analysis.

[9] Complainant also alleged that he was not allowed to "age in place" due to his mental disability. Because this claim is, in essence, identical to the claim that Respondent would not readmit him – which had the effect of denying him the opportunity to "age in place" – this claim is not analyzed separately, but is considered part of the readmission issue.

and (4) that the housing accommodation remained available thereafter. *See United States v. Grishman*, 818 F. Supp. 21, 23 (D.Me. 1993); *HUD v. Blackwell*, 908 F.2d 864, 870 (11th Cir. 1990).

8) Once Complainant has established a prima-facie case, the burden of production, but not of persuasion, shifts to Respondent to articulate a legitimate, nondiscriminatory reason for its action. *See United States v. Grishman*, 818 F. Supp. at 23; *HUD v. Blackwell*, 908 F.2d at 870; *Doyle v. Dep't of Human Servs*, 2003 ME 61, ¶ 15, 824 A.2d 48, 54. After Respondent has articulated a nondiscriminatory reason, Complainant must (to prevail) demonstrate that the nondiscriminatory reason is pretextual or irrelevant and that unlawful discrimination brought about the adverse housing action. *See id.* Complainant's burden may be met either by the strength of Complainant's evidence of unlawful discriminatory motive or by proof that Respondent's proffered reason should be rejected. *See Cookson v. Brewer School Department*, 2009 ME 57, ¶ 16; *City of Auburn*, 408 A.2d at 1262, 1267-68. Thus, Complainant can meet his overall burden at this stage by showing that (1) the circumstances underlying the articulated reason are untrue, or (2) even if true, those circumstances were not the actual cause of the decision. *Cookson v. Brewer School Department*, 2009 ME 57, ¶ 16.

9) In order to prevail, Complainant must show that he would not have suffered the adverse action but for membership in the protected class, although protected-class status need not be the only reason for the decision. *See Maine Human Rights Comm'n v. City of Auburn*, 408 A.2d 1253, 1268 (Me. 1979).

10) Complainant has stated a prima-facie case of discrimination based on disability both with regard to his eviction and with regard to the refusal to readmit him. Complainant has shown that he was a member of a protected class, Respondent was aware of his disability, Complainant was qualified and willing to continue staying at the facility, and Respondent refused to allow him to continue to stay at the facility. With regard to Complainant's efforts to return to the housing, Complainant was eligible for the housing and was rejected, while a bed may have been available.

11) Respondent has stated a legitimate non-discriminatory reason for Complainant's discharge and its decision not to readmit him: Complainant voluntarily discharged himself and was not readmitted because of his behavioral issues and his bed was already filled when he sought to return to the facility.

12) At the final stage of the analysis, Complainant has demonstrated at least an even chance of success in a lawsuit and that Respondent's reason for the adverse housing action was pretextual and/or irrelevant, with reasoning as follows:

    a. The record in this case shows that Complainant stated he was going to leave the facility on at least one prior occasion while he was a resident at Respondent's facility. In the prior instance, Respondent researched other placement opportunities for Complainant and communicated his options to him, but Respondent did not start discharge paperwork for Complainant. Complainant ultimately decided that he was going to stay at the facility.

    b. In contrast, during the days leading up to Complainant's discharge in December 2013, Complainant again indicated that he was planning to leave the facility. In this instance, Respondent did provide documentation to show that a discharge summary had been started for Complainant, but it did not follow its express discharge policies and procedures with Complainant. It is not at all clear prior to December 3, 2013 that Respondent was in the process of discharging Complainant.

c. The evidence here does support Respondent's claims that Complainant had indicated his desire to leave the facility, but it is clear he did not leave on his own accord; it was Respondent's actions that forced him to leave the facility. Even though Administrator discharged Complainant after he was told he had to leave with EMTs and law enforcement or be "blue papered", Respondent disputed in the DHHS hearing that Complainant was discharged from the facility under emergency circumstances. This is not persuasive.

d. Administrator stated in the DHHS hearing transcript that Complainant had expressed suicidal ideations in the past, and that his history, his December 3, 2013 expression of suicidal ideation, and his mental health were among the reasons he was taken from the facility on December 3, 2013, and then denied readmission to the facility. While Complainant may have been a difficult resident, the record does not reflect or show that Complainant had past suicidal ideations. In particular there is no mention of past suicidal ideations in the nursing notes provided by Respondent, and Respondent did not provide additional documentation related to past incidents of Complainant's suicidal ideations.

e. Complainant did not leave the facility on his own terms, and was forced to leave in part due to his mental disability. Complainant did not have or get a chance to come back. Further, Respondent's actions in not following its own discharge policies and the changing classification of Complainant's departure from the facility creates pretext.

f. Respondent had admitted Complainant to its facilities with the knowledge of his disabilities, but it appears that Respondent effectively changed its mind once Complainant's disabilities became more pronounced. It also appears that Administrator's decision to discharge Complainant and refuse to allow him to return was influenced by his mental disability. Administrator testified to the effect that while individuals with physical disabilities would not be removed from the facility, the promise to "age in place" did not apply to mental disabilities. Respondent's decisions here – to remove Complainant involuntarily without following its own discharge processes, and to not allow him to return – were influenced by Complainant's mental disability.

g. The fact that Complainant had notified Respondent of his intention to leave remains a factual hurdle for Complainant; based on the record, however, Complainant has shown that he has at least an even chance of success in a lawsuit.

13) Disability discrimination in housing is found.

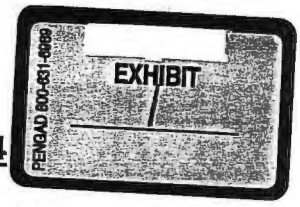
VI. Recommendation:

For the reasons stated above, it is recommended that the Maine Human Rights Commission issue the following findings:

There are **Reasonable Grounds** to believe that Respondent [redacted] Inc. discriminated against Complainant [redacted] in housing on the basis of disability, and conciliation should be attempted in accordance with 5 M.R.S. § 4612(3).

Amy M. Sneirson, Executive Director

Victoria Ternig, Chief Investigator



Nursing Notes **Bob Turton** **2013/14**

Month 1- Oct: New admit on 10/7. Pleasant man with a good sense of humor. States he is very Private, can take care of himself and prefers to be left alone. States he "Likes to be left alone and will let staff know if he needs anything." 10/10 spoke with the resident as we were assisting him to get his personal belongings from his nephew. The nephew had assisted with the move from Bwr Rhab. Seems to be settling in well and is using the handicap BR independently. States the staff are nice and the food is good "So I'm happy except for that nephew of mine." Sent to ER on 10/21 after what appeared to be a seizure. Sent back same evening on Macrobid for a UTI, which he has a history of. Did well the rest of the month.

Month 2- Nov- Resident has been progressively becoming more needy/demanding since last months ER visit. spoke with him about his approach with staff and now even other residents. 11/8. Increasing outbursts of attention seeking behaviors, such as on 11/11 when he came into the dining room and loudly accused a profoundly impaired female of "Taking " his teddy bear. I spoke with him and he stated he would be calling an "Advocate". I told him calling an advocate over a teddy bear was ridiculous, but he could do whatever he wanted to. The staff later found the item ***hidden*** under his own mattress. again spoke with the resident and told him that his behavior was becoming totally unreasonable and inappropriate. He stated he was calling Ombudsmen and then packing and leaving. I told him that I would assist him in finding another placement. I called him later that day to tell him I had found 2 openings and he stated "Well, I spoke to my mom and she talked me in to staying." I told him that if he were going to continue to be increasingly overcritical of staff and other residents that he really should consider moving as I did not want him to be unhappy and thus his behavior may make everyone else unhappy also. He stated that he was "Sorry" about his recent behavior and that he "normally" wasn't that difficult to deal with. I told him we would give it another try and appreciated his cooperation. On 11/19 he was sent to the ER for chest pain.

Came back the same evening. Dx with a possible muscle strain and he was to wear a sling for 7 days. Demands increased significantly and desired to be bathed in bed. evaled his mobility and found this totally unnecessary. After a week told him he needed to stop wearing the sling and resume his normal level of activities. Resident disregarded this and continued to demand that staff do essentially everything for him. Regrettably, the harder the staff tried to assist and ensure his needs were met the more he criticized them. Meanwhile had been spending a significant amount of time trying to discover what could be done to help this resident and consulted with mental health practitioners in hopes of stabilizing his physical and psychological condition. had met with him and discussed what she believed would help him, along with the advice of other practitioners, but this resident was clearly not willing to do anything that he did not "want" to do. Which seemed to be a philosophy of "you can **add** any med you want, but no one is going to **take away/change** any meds." The resident stated that he would "Get rid of if she tried to take away or change his meds." He was referring to the pain med that he had received in the ER and was only suppose to use for a few days. I explained this was unreasonable.

spoke with him and explained that was bending over back words, even listening to everything he had asked from her :Ex; allowing him to stay on his vicodin, which he was only suppose to be on for a week and he should at least speak to her about switching his "normal" pain med if he feels the Vicodin is more effective, but expecting to stay on both was unacceptable and unreasonable. And if he were more reasonable and not resistive to professional medical advice he may feel better-11/29.

11/30 received a call from staff stating the resident was seen in the closet that I had asked him not to go into due to the size of his electric W/C and proximity to some pipes under construction. Mr. [redacted] had stated "No problem, I'll just get one of the girls if I need anything but I shouldn't because I don't put much in there anyway." I decided to let it go and speak to him the next day as he had been being very confrontational/critical of staff, and it was becoming very clear that Mr. [redacted] actions/behaviors were significantly increased after were not on site.

About 30 min later I received a call from the staff about how he was shouting "Heads were going to roll and he was a black belt.!" This all due to him missing his purple sheets. I spoke with him and told him that the staff would find his sheet and he was to stop his threatening behavior which was frightening to my other elderly residents. After the staff had spent an hr looking to no avail, with the resident following them around in his W/C they called me to say they could not figure it out.

I remembered the teddy bear incident and instructed them to check the closet as he had been seen going in there despite agreeing not to. The staff stated that they never put the sheets in that closet, but put his sheets in his lower dresser draw where he ***insisted*** staff place them. They did go back and check and discovered the purple sheets were indeed hidden underneath items in that closet on the low shelf.

I called and again explained how bizarre/threating and disruptive the resident's behavior was becoming. My residential coordinator has been unable to do her job due to this resident sitting outside her office door and refusing to leave, as he verbalizes how the practitioner(s) were all incompetence.

When would arrive he would leave and then focus on the floor staff who came into his room. It is clear to me that this resident thrives on attention and making the staff feel he is going to "report" them to whomever because they are not doing right by him in some way. came to he to say that he "Shook a book in her face and told her he was writing things down and the staff had better watch it.!" I went to Mr. [redacted] and asked if there was anything he 'needed that he was not receiving" and he said "No,why?" I stated the staff member had told me he was writing them up in a book and that if he had an specific issues I would be happy to address them. Mr. [redacted] stated "No it's just a personal diary that I have always kept about my life, not a bitch book.!" I said "Great" the staff member must have misunderstood, and he said " , you know me well enough to know that if I had a problem I would come to you and tell you not hide it in a book." "My only issue has been my BS's like I told but the staff, you and . I have no problem with."

Month 3-.Dec: 2 Resident spoke with about his desire to that go back to "Brewer". I called and she understood his right to be assessed and agreed if he wanted to get a GOULD she would be willing to help with that. I went back to the resident and he stated "I've had a GOULD a lot of times and I shouldn't need another one. I explained that a GOULD was necessary to get alternate placement. That I couldn't just "call" and get him into Bwr Rehab (Where he had been when I admitted him.) Mr. [redacted] then stated he would like to go live in the "freezers" facility because it was "Down Town" and he had friends in that area. I explained that once he had the GOULD he may have that as an option. He stated "Ya but I know how the system works and they like Bwr must have a bed and ***want*** to admit you." I agreed but told him that once we had the ball rolling we could get him on a waiting list. Mr. [redacted] stated " I'm not waiting till spring to get back in town and I'm not going to probably even pass the GOULD because even though my BS's are out of control I can do everything like move myself around and bath, dress and go to the bathroom myself except when things happen to go wrong." He continued by saying ", this is a really nice facility and my mom keeps telling me to stay, but I just want to be in civilization not in the woods!" I told him I understood his dilemma and if he wanted me to make calls to other facilities in town I would do this. Mr. [redacted] stated " , I'm no dummy and I have a computer and phone I make my own appointments and can call myself." I agreed he was very capable and if he changed his mind and wanted me or to assist that "All he had to do was ask." I called to let he know that Mr. [redacted] was unsure about what he wanted to do and was going to let us know if he needed further assistance with the matter. I remarked to if it was at all possible his seeming "displeasure" with things such as his BS's was not a way to ty to get placed back in town. stated "If that's true it's too bad because we could help him do that and he wouldn't have to stress himself or the staff out like he does." I agreed.

12/3- [redacted] explained to me that he was "all set" and to "just leave the rest of his things in the room, if possible, and his mom would be right in to pick it up for him." I reminded him that we had discussed the issue of a GOULD assessment again he said "No, I told you I was leaving today." I remarked that he had actually said "I'm leaving as soon as he got packed", but I thought he was going to rethink the timing to do the GOULD. Mr. [redacted] stated "Well I'm all packed. it's not any fault of yours and my mom doesn't want me to leave either, but I have done this a million times; I know how to take care of myself." I asked Mr. [redacted] how he "felt" and he said "Same as usual: anxious" I told him I was going to call and let her know he was not leaving tonight. explained that she had spoken with mental health practitioners that had been involved with his care in the past and they agreed that his ADHD medication could be the source of increased anxiety and if he was leaving before the GOULD she wanted to let him know she wanted him to stop taking the med.

I called the facility and explained to Mr. [redacted] that wanted him to stop taking the med and see if his anxiety/depression eased. Mr. [redacted] immediately went into a loud rant about how "None" of the medical professionals who have cared for him over the past several years "Knew anything" and had "Tried to take that med away and he wouldn't let them." I explained that perhaps if he would listen more to the professionals he may find that his condition/anxiety would improve. At that time he was totally irrational and said that "This is why I need to be living on my own! " Mr. [redacted] stated the he was 'OUT! I asked him to please just stay and "Try" the order to see if his anxiety improved and to get the GOULD done so he would have more placement options. He said "No way! I'm already packed and my mom is going to be here to get my other things for me." I then hung up and called to ensure she remembered to give Mr. [redacted] all of the personal medications that he brought with him upon admitted.

said she would do this and hung up. called back minutes later and stated that Mr. [redacted] was refusing to take his meds with him and had stated he "Would not be needing them where here he was going." I then asked her to hold off giving him his medications to take with him when he left as I was concerned about him possibly OD-ing. I then had give the phone to Mr. [redacted] as to

speak to him and try to evaluate his mood. I asked Mr. [redacted] if he had indeed refused to take his meds with him when he left and he stated "Yup, I won't be needing any meds tonight or any other night and if God decided to take him than that's the way it wil be!." I told Mr. [redacted] that he obviously needed his meds and would become very ill if he went without them. Mr. [redacted] then told me he was a "Grown man", and hung up. I called . back and we both agreed that these statements and his action regarding his refusal to take his medications with him we cause for concern and with his past history of suicidal behaviors I did not feel comfortable with him getting into a cab and being alone. I called and explained what had been said, she agreed that the resident was indeed capable and had a past history of suicide attempts, and that we needed to intervene. I told her I was calling an ambulance and wanted him taken to hosp for safety eval. The ambulance arrived and waited for the State Police as is their standard practice according to the dispatcher. stated that she would watch the resident and help the amb personnel.

called back a few minutes later and explained that when Mr. [redacted] saw the police his behavior completely changed, and he denied having any suicidal thoughts or making any statements which could be misconstrued as such. The officer spoke with me and stated it was difficult for him because he was now denying everything. I explained to the officer that this resident was serious, capable and had a history of suicide attempts. He told me that while both and I were telling him the same thing and he believed he could harm himself especially if he were going to be alone in a motel that evening as planned. I then asked the officer if I could speak to . again. While I was on the phone with her could hear Mr. [redacted] yelling "Is that ? Tell her I'm going to sue her ass!". "She had no right to call the cops on me!," I told that I hadn't called the "cops" I had called the ambulance and that it was their policy to involve the police for every ones protection because they never knew how serious/dangerous a person was going to be.

Mr. [redacted] was taken to the hospital for eval.

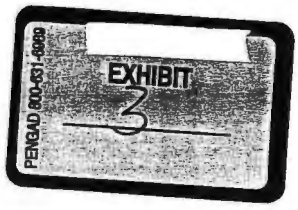
Later that evening I spoke with at ' 's ER and explained physical and psychological had been declining and that he had been blaming for this decline. He had been critical of how his BS had always been in control, and how "we" were clearly responsible for them becoming unstable. I also explained that Mr. [redacted] was very non-compliant with his diet and actions which contributed to his fluctuations. I also told the nurse that he had arranged for his "mom" to come in and pick up the rest of his things.

s ER was surprised to learn that I, unlike other healthcare worker's recognized the described behaviors were this resident's "Normal" pattern of behaviors. Apparently, this resident is not only well known, but notorious within the hospital system. At this point I realized the admission had been inappropriate from the start. While sad but true, the practice of information being withheld, which should have been offered up by the facility looking for placement is ***not*** being done more and more frequently. Facilities know if they gave a clear picture to the receiving facility they probably would not take that resident, when the placing facility so desperately wants that resident out. According to (RN) the resident had been at hospitalized some 21 times in the past year and was also well known to hosp. He also had apparently been in approx. 9 different facilities who, for whatever reason, would not/could not keep him or he "chose" to leave for various reasons. I explained that I had only had Mr. [redacted] for two months and that information was not offered to me at the time of his admission. I explained he had left his manual W/C and slide board and I would help get these items to him. The nurse stated asked why he had so many boxes/bags of personal belongings with him and I explained that he was "Leaving" at the time I called the amb due to his statements. She stated that if he was cleared he would be continuing on his way and that he had stated "He was not going back to [redacted]." I explained that made perfect sense because he had been leaving and was going to be making other living arrangements from a motel. I also explained that he had refused to stay long enough to get a GOULD eval. The nurse stated that if he was refusing to come back to [redacted] and was cleared then we would work to ensure he got his W/C & slide board. I made several "Follow-up" calls to ensure the hosp had any info they needed.

12/4- Myself and other staff found a ***large ,*** almost entirely empty jar of peanut butter and regular sugar packets hidden in his room while the acceptable non-sugar packets openly displayed on his table. and I also had repeatedly told him not to insist on drinking a glass of OJ every day with his meds. He continually would self check his BS's and complain, but given what we found hidden in his room it was clear that he was driving his BS's up himself then demanding Lisa and demanding he be give insulin: I notified of these findings as well.

12/5-The woman (that he calls "mom" came and picked up all the remaining belongings, with the exception of his electric W/C due to its weight and size. stated she/he would have to make other arrangements to pick the electric chair up. told me that she had tried to get him not to leave the facility but as before in his other placement he did not listen to her. She stated "This is what he does."

(b)

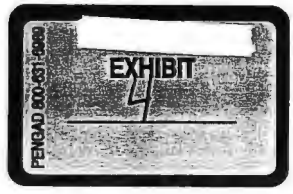


TRANSCRIPT OF DECEMBER 14, 2013 VOICE MAIL MESSAGE OF Administrator TO [redacted]

(SOUND RECORDING OF THIS VOICE MAIL IS BEING SUBMITTED AS MP3 TO EMAIL AND CD RECORDING AT HEARING)

Mark this is , with [redacted] My staff told me you called Friday late..uh..to leave a message that you were sending [redacted] back. First and foremost you're not my admissions coordinator, so don't act like it. Two, his bed has been filled. He is not a patient. I thought we had that clear. From now on it's pretty clear that you're going to have to go through my attorneys .

Thanks.



Assistance in Finding Alternative Placement: Residents who choose to relocate shall be given assistance by [redacted] and shall not be required to give advance notice in order to obtain a refund. [redacted] shall provide information to the resident regarding potential risks that may be inherent in the discharge plan and information that will support the resident's adjustment to his / her next residential setting.

Right to Communicate Grievances and Recommend Changes: Residents are encouraged and assisted to exercise their rights as residents and citizens. Each resident may freely communicate grievances and recommend changes in policies and services to the staff of the [redacted] Estates, and to outside representatives of their choice, without restraint, interference, coercion, discrimination or reprisal.

All grievances will be documented. [redacted] has an established and implemented procedure for the timely review and disposition of grievances. The procedure includes a written response to the grievant describing disposition of the complaint.

Right to Manage Financial Affairs: Residents shall manage their own financial affairs, unless there is a representative payee or other legal representative appointed.

Right to Freedom From Abuse, Neglect or Exploitation: Residents shall be free from mental, verbal and physical abuse, neglect and exploitation.

Rights Regarding Restraints and Aversive Conditioning: There shall be no use of physical, chemical, psychological or mechanical restraints or aversive conditioning. The only exception for [redacted] residents are half-length bedrails attached to the top half of the bed.

Right to Confidentiality: Resident's records and information kept by [redacted] pertaining to his / her personal, medical and mental health status are confidential. Residents and their legal representatives shall have access to all records pertaining to himself / herself at reasonable times, in the presence of the provider or his / her representative, within twenty-four (24) hours of the request. Written consent of the resident or his ; her legal representative shall be required for release of information to any other party except authorized representatives of the Department or the Long Term Care Ombudsman Program. DHS shall have access to the records for determining compliance with established State regulations. Records shall not be removed from Emilio [redacted] except as may be necessary to carry out these rules. Upon admission to [redacted] each resident shall be asked for a signed, dated and specific written consent which lists individuals with whom [redacted] may share information (e.g. family members, duly authorized licensed practitioners, visiting nurses, etc.) Consent may be withdrawn at any time.

Transfer, Eviction or Discharge: When [redacted] Estates, Inc transfers, evicts or discharges a resident in a non-emergency situation, the resident or his / her guardian shall be provided with at least thirty (30) days advance written notice to ensure adequate time to find an alternative placement that is safe and appropriate. [redacted] will assist in the transfer or discharge process and to reduce a safe and orderly discharge plan. Each notice will be written and include the following.

The reason for the transfer, eviction or discharge, and events which are the basis for such action;

The effective date of the transfer, eviction or discharge;

Notice of the resident's right to appeal the transfer or discharge.

The mailing address and telephone number of the Long Term Care Ombudsman Program. (See last page)

In the case of residents with developmental disabilities or mental illness, the mailing address and telephone number of the Office of Advocacy, Department of Metal Health, Mental Retardation and substance Abuse Services.

Local telephone number is: 941-4361.

The resident has the right to be represented by himself / herself or by legal counsel, a relative, friend or other spokesperson.

Emergency transfer or Discharge: When an emergency situation exists, no written notice will be given, but such notice as is practical under the circumstance will be given to the resident, resident's representative and family. [redacted] shall assist the resident and authorized representatives in locating an appropriate placement. Transfer to an acute hospital is not considered a placement, and [redacted] obligation in regard to such assistance does not necessarily terminate.

Leaves of Absence: When a resident is out of [redacted] Estates and continues to pay for services in accordance with the contract, the resident shall be permitted to return to the [redacted] Estates unless any of the reasons are present and the resident or resident's legal representative has been given notice as may be required.

12.15 **Discharge summary.** Discharge summaries must be completed in conjunction with the resident and/or guardian. Documentation shall be inclusive of, but not limited to the following:

12.15.1 Reason for discharge;

12.15.2 Targeted living arrangement;

12.15.3 Identification and coordination of skills and supports and steps necessary for discharge to occur.