STATE OF MINNESOTA
IN COURT OF APPEALS
A24-0136

In the Matter of the Appeal of the Discharge of M.W.
from the Minnesota Veterans Home - Minneapolis.

Filed October 7, 2024
Affirmed
Ross, Judge

Minnesota Department of Veterans Affairs
File No. 22-3100-38984

Steven C. Schmidt, Mid-Minnesota Legal Aid Mid-Minnesota Disability Law Center, Minneapolis, Minnesota (for relator M.W.)

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Considered and decided by Ross, Presiding Judge; Bjorkman, Judge; and Schmidt, Judge.

NONPRECEDENTIAL OPINION

ROSS, Judge

M.W. is an 81-year-old military veteran living in a veterans home and suffering from dementia and Alzheimer's. His health-care agent refused to consent to a dosage of medication prescribed to reduce M.W.'s almost daily episodes of extreme emotional instability, causing the home to conclude that it could no longer meet M.W.'s care needs. M.W. appeals from the Minnesota Department of Veterans Affairs's order affirming the home's decision to discharge him involuntarily. We hold that substantial evidence supports

the department's finding that the home could not meet M.W.'s care needs, that the home sufficiently implemented other treatment options before turning to involuntary discharge, and that the home complied with federal regulations governing nursing-home discharges and transfers. We therefore affirm.

FACTS

Relator M.W. is an 81-year-old United States military veteran who suffers from dementia and Alzheimer's. He has been admitted to the memory-care unit at the Minnesota Veterans Home - Minneapolis since October 2021. M.W. experiences episodes of extreme emotional instability because of these conditions. The episodes include his physical and verbal aggression, anxiety, tearfulness, agitation, and restlessness.

M.W.'s prescribed nightly medication includes 37.5 milligrams of quetiapine, an antipsychotic medication. The medication is not approved by the FDA, but physicians nevertheless often prescribe it as the first line of treatment for dementia patients. Because the home's staff found that M.W. responded well to the drug in the evenings, his care team suggested to his health-care agent (M.W.'s son-in-law) that M.W. receive an additional 12.5-milligram dose each morning to reduce his episodes during the day. But M.W.'s health-care agent refused consent, citing his concerns about the drug's potential side effects. The home consequently determined that it could not meet M.W.'s care needs, so the committee tasked with determining the appropriateness of discharges voted unanimously to recommend that M.W. be discharged from the home.

The home issued multiple notices of involuntary discharge to M.W. in November and December 2022 and in January and July 2023. The November 2022 notice failed to

identify alternative housing options for M.W., and the December 2022 and January 2023 notices identified Epiphany Care Home as an option for safe discharge.

M.W.'s health-care agent asked respondent Minnesota Department of Veterans Affairs to reconsider the discharge, and in December 2022 the department held a reconsideration hearing. The department upheld the decision to discharge M.W. The health-care agent then appealed the decision, and an administrative-law judge (ALJ) held a two-day contested-case hearing.

Evidence at the hearing established that M.W.'s behavioral disturbances are frequent and can last many hours. The disturbances occur nearly daily and often begin with a regular and calm conversation before escalating into passionate yelling and nonsensical, repeated words. M.W.'s yelling often leaves him hoarse and causes him to weep inconsolably. His emotional disturbances in turn have distressed other residents, leading two of them to transfer from M.W.'s unit. Witnesses at the hearing discussed the feasibility of medication other than quetiapine to treat M.W. Dr. Bruce Meyer, the medical director for the Minnesota Department of Veterans Affairs, testified that home physicians had considered administering gabapentin, another medication. But they determined that quetiapine was more suitable because gabapentin is typically prescribed only when antipsychotics are ineffective, and the circumstances had shown that M.W. responds positively to quetiapine. They had also considered using mirtazapine, an antidepressant, but medical staff dismissed the option because M.W. was already taking a different antidepressant and because depression was not causing his episodes. Dr. Meyer also discussed an alternative medication that the home previously implemented—Nuedexta.

But after a trial period, staff discontinued using Nuedexta when they saw that it failed to improve M.W.'s behaviors and that it caused side effects that outweighed the minimal benefit.

M.W.'s care providers also testified about nonpharmacological interventions they had attempted. These included music, faith-based activities, therapeutic touch, a mechanical dog, a sensory blanket, and food. None provided more than short-term relief and none reduced the frequency of M.W.'s episodes. The care providers testified that they had not utilized one-on-one staff care, which is a nonpharmacological treatment involving "one staff member provid[ing] care[] only to one resident." A home behavior analyst, Laura Heezen, testified that an ongoing one-on-one care regimen would not benefit M.W. because his outbreaks occur even when staff has devoted considerable one-on-one attention to him.

Rebecca Long, M.W.'s social worker at the home, testified about her efforts to find a suitable replacement home. She recounted making phone calls to at least 60 different long-term care facilities to find a suitable replacement home. She said that, although she found locations willing to admit M.W., none were viable options because of either financial constraints or M.W.'s health-care agent's unwillingness to engage in the admission process. Long eventually identified White Pine Advanced Memory Care as an appropriate discharge location while the contested case was pending. After determining that White Pine could meet M.W.'s needs, Long sent the facility information that included his diagnoses and behavioral disturbances. She testified that, because White Pine accepted the transfer, she inferred that the facility had determined it could meet M.W.'s needs.

M.W. called four witnesses to testify at the contested-case hearing. His health-care agent stated his concerns with quetiapine and its side effects. M.W.'s daughter recounted her experiences with M.W. after taking quetiapine, testifying that he becomes "sedated" and loses his "independence" and "speech." M.W.'s friend testified that M.W. was often calm during visits. Brett Jagodzinski, the regional ombudsman for long-term care, testified that he had visited M.W. many times at the home after M.W.'s health-care agent requested his assistance and that M.W. does not have "the worst dementia behaviors [he's] seen."

The ALJ concluded that the home had failed to meet the notice-and-discharge requirements under the federal regulations. The department's chief of staff in January 2024, acting as the commissioner's delegate, issued an order rejecting the ALJ's recommendation and affirming the original order of involuntary discharge. The chief of staff concluded that the home had established a lawful basis to discharge M.W. and complied with the federal regulations' notice-and-discharge requirements.

M.W. appeals.

DECISION

M.W. raises four arguments in this *certiorari* appeal challenging the department's order affirming the home's decision to involuntarily discharge him. He argues first that substantial evidence does not support the department's decision based on the home's inability to meet his care needs. He argues similarly that substantial evidence does not support the department's decision because he does not pose an immediate threat to the health or safety of himself, other residents, or staff. M.W. argues third that the home failed to exhaust all treatment options before requiring him to choose between consenting to

another dose of quetiapine and involuntary discharge. M.W. argues fourth that the home disregarded federal regulations governing nursing-home transfers and discharges. The arguments do not lead us to reverse.

M.W.'s challenge faces a deferential standard of review. Because this *certiorari* appeal comes from a contested-case hearing, we may affirm the commissioner's decision or remand for additional proceedings, or we may reverse or modify the decision if we conclude that M.W.'s substantial rights "have been prejudiced because . . . administrative finding, inferences, conclusion, or decisions" violate a constitutional provision, exceed the department's statutory authority or jurisdiction, rest on unlawful procedure, arose from legal error, are unsupported by substantial evidence in view of the full record, or are otherwise arbitrary or capricious. Minn. Stat. § 14.69 (2022). Our role on appeal is to determine whether the agency took a "hard look" at the problems involved and whether the agency "genuinely engaged in reasoned decision-making." *Rsrv. Mining Co. v. Herbst*, 256 N.W.2d 808, 825 (Minn. 1977) (quotation omitted). When the agency engaged in reasoned decision-making, we will affirm the agency's decision, even if we may have reached a different result. *Cable Commc'ns Bd. v. Nor-West Cable Commc'ns P'ship*, 356 N.W.2d 658, 669 (Minn. 1984). M.W.'s arguments include questions about the application of statutes or rules. We review *de novo* the interpretation of statutes and rules. *Minnesotans for Responsible Recreation v. Dep't of Nat. Res.*, 651 N.W.2d 533, 538 (Minn. App. 2002). M.W.'s challenge fails under these standards.

I

M.W.'s argument does not persuade us that the department's conclusion that the home cannot meet his care needs lacks substantial supporting evidence. Under the operative rule, "[d]ischarge procedures must be instituted with regard to a resident if one" of seven grounds exist, including that "the facility operated by the commissioner of veterans affairs is unable to meet the care needs of the resident." Minn. R. 9050.0200, subp. 3(C) (2023). The department determined that the facility could no longer meet M.W.'s care needs because the facility could not safely control M.W.'s behavior in an appropriate manner. This is because adding a small dose of quetiapine in the mornings is the "first line" for pharmacological treatment and M.W.'s care agent refused to consent to the treatment. The question on appeal is not whether the department's conclusion is the only possible conclusion but whether the conclusion finds substantial support in the record. We hold that it does.

M.W.'s argument to the contrary essentially asks us to reweigh the evidence. He points to a video that depicts him exhibiting only a mild emotional outbreak, and he maintains that his symptoms mirror those of a typical advanced dementia patient. He emphasizes too that his basic needs of "eating, dressing, bathing, and grooming . . . are being met" at the home. Yet six facility employees testified about their experience with M.W., each recounting episodes of much greater severity than the mild episode depicted in the video. One of them spoke of M.W.'s "mental anguish" when these episodes occurred. For example, the home's administrator testified that the nearly daily outbursts included "crying out," sadness, and "yelling" and that they "can last hours, multiple hours in a row."

The nursing director said, "[M.W.] . . . displays vocalizations, crying, weeping, yelling, some aggressive tendencies, some very sad tendencies that are very difficult to manage for the staff." And the behavioral analyst testified that the incidents involved "real sobbing . . . like full sobbing." It is true that the ombudsman testified that M.W.'s behavior is akin to that of the typical dementia sufferer, but the repeated testimony of the home staff supports the conclusion that M.W.'s behavior is more intense. The medical director testified that M.W.'s behaviors are uniquely severe and persistent. Most of the hearing testimony from the contested case distinguished M.W.'s behavior as demonstrating severe emotional distress. Deferring to the department's weighing of the evidence under our review standard, we hold that substantial evidence supports the department's conclusion that the home cannot meet M.W.'s care needs.

We are not persuaded to a different result by M.W.'s additional legal argument. He contends that the home's involuntary discharge contravenes this court's decision in *In re Involuntary Discharge or Transfer of J.S. by Ebenezer Hall*, 512 N.W.2d 604 (Minn. App. 1994). In that case, a 74-year-old woman diagnosed with chronic schizophrenia was involuntarily discharged from a nursing home after she refused nearly all psychiatric treatment. *Id.* at 607–08. After the commissioner denied the nursing home's involuntary discharge based on the home's inability to meet the woman's needs, it appealed to this court. *Id.* at 608. We began by acknowledging a nursing-home resident's right to refuse treatment based on federal regulations and the nursing-facility resident's bill of rights. *Id.* at 610–11 (citing 42 C.F.R. § 483.10(b)(4) (1994); Minn. Stat. § 144.651, subd. 12 (1990)). In light of that right, this court reasoned that "[t]he involuntary transfer or discharge of a

nursing facility resident must be the last resort" and that "[a] facility must first exhaust the options available to it within the level of care it is authorized to provide." We added, "In the absence of the comprehensive evaluation of a resident's condition and needs, the nursing facility is not entitled to elect the final option, involuntary transfer or discharge of the resident." *In re J.S.*, 512 N.W.2d at 612. Because the nursing facility in that case had failed to develop a comprehensive evaluation of the patient's condition and needs, we affirmed the commissioner's denial of her involuntary discharge. *Id.* at 613. M.W.'s argument analogizing this case with *J.S.* fails for the following two reasons.

The first reason M.W.'s argument fails is that, unlike the nursing home in *J.S.*, the veterans home implemented numerous nonpharmacological treatments and considered alternative medications to treat M.W.'s episodes of mental anguish. The record demonstrates that the veterans home created a comprehensive-care plan, tried multiple nonpharmacological options, and found that only an additional dose of quetiapine would limit M.W.'s behavioral outbursts. The second reason M.W.'s argument analogizing his case to *J.S.* fails is that, in *J.S.*, our deferential review began with the department's determination that the evidence did not support the conclusion that the nursing facility failed to implement an "adequate comprehensive care plan." M.W.'s case involves similar procedural issues, so we deferentially consider the department's weighing of the evidence and its conclusion that discharge is necessary. *Id.* at 608–09. We conclude that *J.S.* offers no ground to reverse.

We are similarly unpersuaded by M.W.'s argument that the home failed to exhaust all options because it did not agree to try gabapentin instead of quetiapine. The home

considered the health-care agent's request for gabapentin and determined the medication was not a reasonable option because it is prescribed only when other medications have been proven ineffective, and quetiapine has been shown to relieve M.W.'s symptoms. And even M.W.'s treating physician, who is not affiliated with the home, determined that another dose of quetiapine was a "reasonable" treatment option. The record likewise establishes that the home considered and administered a trial run of an alternative medication, which was ultimately discontinued due to M.W.'s adverse reaction. The home's care plan went beyond that in *J.S.*, and it considered and utilized alternative medications to treat M.W.'s emotional outbursts. We hold that substantial evidence supports the department's conclusion that the home cannot meet M.W.'s care needs and that its involuntary-discharge decision complied with our precedent requiring nursing homes to develop a comprehensive-care plan before turning to discharge as a last resort.

We are not unsympathetic to the health-care agent's preference to avoid the recommended medication and his desire to continue M.W.'s care at the veterans home. But after carefully considering his arguments, we hold that substantial evidence supports the department's finding that the home can no longer meet M.W.'s care needs.

M.W. also contests the department's determination that discharge is necessary because his "behavior poses an immediate threat to the health or safety of the resident, other residents, or staff of a facility operated by the commissioner of veterans affairs." *See* Minn. R. 9050.0200, subp. 3(E) (2023). But the operative rule provides that "[d]ischarge procedures must be instituted with regard to a resident if *one of the* [listed] grounds or circumstances exist." *Id.*, subp. 3 (2023) (emphasis added). Because the department's

determination that the home is unable to meet M.W.'s care needs finds substantial support in the record, we do not reach M.W.'s challenge to this second ground for discharge.

II

M.W. argues alternatively that the home failed to comply with federal regulations governing nursing-home discharges and transfers. He presents four arguments relating to the federal discharge and transfer requirements: that the department erroneously concluded that the home issued a proper discharge notice; that the home's preparation and planning for discharge were insufficient; that substantial evidence does not support the department's finding that White Pine could meet his care needs; and that the home did not engage in sufficient discharge planning. Our *de novo* review leads us to hold that the home complied with federal regulations governing nursing-home discharges and transfers.

Discharge Notice

We first address M.W.'s argument that the department erroneously concluded that the home issued a proper discharge notice under federal law. Because the home qualifies as a nursing "facility," it is subject to federal discharge and transfer regulations. *See* 42 C.F.R. § 483.15 (2023). The home must therefore notify a resident before it transfers or discharges him, and the notice must include "[t]he location to which the resident is transferred or discharged." *Id.* (c)(3), (c)(5)(iii). M.W. argues that, because the home's initial notice failed to identify the place where he would be transferred to, the department erred as a matter of law by failing to prohibit the discharge.

It is true that the home's first notice to M.W. in November 2022 failed to include his discharge location, but the home's three amended notices to M.W. listed Epiphany

Care, Geneva Suites, and White Pine as discharge locations, respectively. This defeats M.W.'s notice argument because the regulations mandate that the notice of transfer or discharge be made "at least 30 days before the resident is transferred or discharged," *id.* (c)(4)(i), and M.W. has yet to be discharged. The regulations allow nursing facilities to amend their notices "as soon as practicable" when the proposed discharge location changes. *See id.* (c)(6). Because M.W. has not been discharged and nursing facilities may amend their notices, the home's amended notices cured the initial defect of failing to include the discharge location.

M.W. cites two nonprecedential office-of-administrative-hearings decisions dealing with the federal regulations' notice requirements, but neither supports M.W.'s argument for a different result. Those decisions do not bind this court, but we will nevertheless address them. The first is *Involuntary Discharge/Transfer of V.M. by Lakeside Health Care Center*, OAH Docket No. 8-0900-19416-2, 2008 WL 642734 (Feb. 11, 2008). In that case, the ALJ concluded that the nursing facility had violated the notice requirements, observing that the notice "f[ell] short because it d[id] not detail the location to which [the resident] w[ould] be transferred." *Id.* at *6. The ALJ therefore reversed the involuntary discharge but did so expressly without prejudice to any later discharge notice. *Id.* at *7. The second decision M.W. cites is *Involuntary Discharge/Transfer of M.E. by St. Francis Nursing Home*, OAH Docket No. 6-0900-16303-2, 2005 WL 275762 (Jan. 21, 2005). In that case, the facility also failed to include the location to which it was involuntarily discharging its resident, and the ALJ therefore denied the proposed discharge. *Id.* at *5. But unlike the veterans home in this case, at the time of the hearing in *M.E.* the nursing home still had not

identified the location where the resident would be transferred to. *Id.* at *4. As we have emphasized, here the veterans home had amended its notice and complied with the regulatory requirement to identify the discharge location.

Preparation and Orientation Planning

We next address M.W.'s contention that the department erroneously concluded that the home engaged in sufficient preparation and orientation to ensure his safe and orderly discharge from the facility. In recommending that the involuntary discharge be reversed, the ALJ concluded that the home had failed to comply with federal regulations requiring it to "provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." The department rejected this recommendation, concluding that the law does not require such preparation and orientation until discharge is "imminent."

M.W. contends that the department erred as a matter of law when it concluded that documentation of sufficient preparation and orientation is required only when discharge is "imminent." The relevant regulation states, "A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." 42 C.F.R. § 483.15(c)(7). The ALJ had interpreted this provision to prohibit the home from discharging M.W., reasoning that because the home "did not establish that it provided updated information about M.W.'s increased care needs to White Pine" and "did not confirm that White Pine has adequate staff to accommodate M.W.'s increased need," it therefore had "not established that White Pine can meet M.W.'s care needs" and could not discharge him. We believe the department properly interpreted

section 483.15 to not require the home's planning and documentation to occur before the hearing challenging a discharge. The regulation does not mandate when the facility must "provide and document sufficient preparation and orientation to residents," but the context indicates only that it must occur before the discharge actually occurs. This is because the regulation's purpose is "to ensure safe and orderly transfer or discharge from the facility." The department reasons persuasively that, because a resident's health-care plan is fluid, the documentation is accurate and meets the objective stated in the regulation only if planning and consequent documentation occurs close to the actual discharge event. The actual discharge event did not occur here, as the ongoing dispute put the discharge into abeyance.

M.W. relies on two nonprecedential cases from the office of administrative hearings and a nonprecedential case from the Massachusetts Appeals Court. Because we do not believe any of those cases are sufficiently similar to this one and because those decisions are not binding on our decision, we do not discuss them further. We hold that the home engaged in sufficient discharge planning to ensure M.W.'s eventual safe discharge and that any deficiencies can be cured before the actual discharge date.

Suitable Discharge Location

M.W. also argues that substantial evidence does not support the conclusion that White Pine is an appropriate discharge location. This argument fails. As an assisted-living facility, White Pine is prohibited from accepting a resident without first ensuring that it can meet the individual's care needs. Minn. R. 4659.0140, subp. 1 (2023). And M.W.'s social worker testified about her efforts to find a suitable discharge location for M.W., including learning that White Pine indicated that it would accept M.W. into its memory-care unit

after she disclosed his mental-health condition and behavioral difficulties. The social worker's research satisfied her that White Pine is a safe and suitable location for M.W.'s transfer, and M.W. offers no evidence that convincingly contradicts her testimony or that persuasively calls into question the department's reliance on it. Substantial evidence supports the department's conclusion that White Pine is a suitable discharge location for M.W.

Appropriate Discharge Planning

We last address M.W.'s related argument that the department erred as a matter of law by concluding that the home complied with the federal regulations requiring it to engage in appropriate discharge planning. "When the facility transfers or discharges a resident" due to its inability to meet a resident's care needs, "the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider." 42 C.F.R. § 483.15(c)(2). The social worker's testimony, discussed above, is sufficient evidence on this provision. M.W. contends more specifically that, because the home failed to include in its care plan that M.W. requires two-person assistance in transfers, the discharge should be denied. The contention reads too much into the regulation, which requires only that the facility provide "appropriate" information to the receiving facility, a requirement that is triggered solely "[w]hen the facility transfers or discharges a resident." In any event, the record indicates that the home provided White Pine with M.W.'s medical records, presenting issues, care plan, and medication list.

M.W. adds that the home failed to consult his health-care agent about the discharge plan. Discharge planning must "[i]nvolve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan." 42 C.F.R. § 483.21(c)(1)(v) (2023). And it requires facilities to conduct an "evaluation of the resident's discharge needs," and to discuss the results of the evaluation "with the resident or resident's representative." *Id.* (c)(1)(ix). The hearing testimony suggests that M.W.'s health-care agent repeatedly failed to cooperate in the development of a discharge plan. And he continued to object to M.W.'s discharge. While we understand the health-care agent's preference that M.W. remain at the home rather than be discharged to some other facility, his choice not to engage in the discharge process cannot prevent the discharge.

Affirmed.