# Office of Medicaid
# BOARD OF HEARINGS

**Appellant Name and Address:**

[redacted]

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| **Appeal Decision:** | Denied | **Appeal Number:** | 2503611 |
| **Decision Date:** | 4/14/2025 | **Hearing Date:** | 03/17/2025 |
| **Hearing Officer:** | Thomas Doyle | **Record Open to:** | N/A |

**Appearance for Appellant:**
Pro se

**Appearance for Respondent:**
Darly Joseph, Administrator
Norma Robertson, Assistance Director of Nursing
Debra DeFimone, Director of Nursing
Kristen Lumsden, Director of Social Services

*The Commonwealth of Massachusetts*
*Executive Office of Health and Human Services*
*Office of Medicaid*
*Board of Hearings*
*100 Hancock Street, Quincy, Massachusetts 02171*

# APPEAL DECISION

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| **Appeal Decision:** | Denied | **Issue:** | Nursing Home Discharge – Safety of Individuals |
| **Decision Date:** | 4/14/2025 | **Hearing Date:** | 03/17/2025 |
| **Respondents Rep.:** | Darly Joseph<br>Norma Robertson<br>Debra DeFimone<br>Kristen Lumsden | **Appellant's Rep.:** | Pro se |
| **Hearing Location:** | Remote (phone) | **Aid Pending:** | No |

## Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

## Jurisdiction

Through a Notice dated February 5, 2025, Regal Care of Worcester (hereinafter "respondent" or "facility") issued a Notice of Intent to Discharge Resident with 30 Days' Notice to appellant because the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident. (130 CMR 456.701 (A) (B); 130 CMR 610.028(A) and (B); Ex. 1). Appellant filed this appeal in a timely manner on February 5, 2025. (130 CMR 610.015(F); Ex. 2). Notice of transfer or discharge from a nursing facility is valid grounds for appeal. (130 CMR 456.703; 130 CMR 610.032(C)).

## Action Taken by Respondent

The facility issued a notice of intent to discharge the resident with 30 days' notice.

## Issue

The appeal issue is whether the facility satisfied its statutory and regulatory requirements pursuant to 130 CMR 456.701 (A), (B), when it issued appellant the 30-day notice of intent to discharge.

## Summary of Evidence

The nursing facility was represented telephonically at the hearing by its Administrator, Assistant Director of Nursing, Director of Nursing and Director of Social Services. Appellant also appeared by phone. All were sworn. Appellant is a female in her [redacted] (Ex. 4, p. 12). Appellant was admitted to the facility in [redacted] (Ex. 4, p. 12). On February 2, 2025, the facility issued appellant a Notice of Intent to Discharge Resident with 30-Days' Notice. (Ex. 1). Appellant timely appealed on February 5, 2025. (Ex. 2).

The Administrator testified that appellant was given the notice of discharge for several reasons. In November 2024, appellant was seen smoking outside the front door of the facility. She was yelling and cursing with a facility visitor. Appellant was redirected to smoking area and asked to lower her voice. Appellant became agitated and told the nurse to "fuck off". (Ex. 4, p. 53). At some point in early January 2025, appellant "became very behaviorally abnormal. She was refusing to follow the safe protocol while she was smoking. She also started to swear at the staff members and could not be redirected, so she is required to be Section 12." (Ex. 4, p. 42). On January 27, 2025, appellant convinced another resident, who is older than appellant and dependent on oxygen, to smoke in the bathroom with her. (Testimony; Ex. 4, p. 36). On February 10, 2025, appellant was reminded not to light a cigarette in front of another resident with an Oxygen tank and was redirected to the smoking area outside the building. (Ex. 4, p. 34). On February 13, 2025, housekeeping found 1 vape pen, 2 lighters and 1 empty blue vape box under appellant's bed. (Ex. 4, p. 34). The Administrator testified the lighters are fire hazards. (Testimony). In early March 2025, as appellant wheeled herself by a nurse on the 3-11 shift, a marijuana blunt in a clear plastic container fell from appellant. Appellant denied it belonged to her. (Ex. 4, p. 32). The Administrator testified marijuana is illegal in the facility as it is in a federal building. (Testimony). The Administrator testified that appellant was notified of the facility smoking policy upon admission in writing and verbally. (Testimony).

The Administrator stated appellant pushes other residents in their wheelchairs, which is prohibited. (Testimony; Ex. 4, p. 35). Appellant was seen pushing others in their wheelchairs on January 29 and 30, 2025. Appellant was told she cannot do that, and appellant stated, "I know but I am not pushing him." (Ex. 4, p. 35). The Administrator referenced a doctor's note in the record. The doctor is the facility's Medical Director. The doctor wrote appellant "is fully independent in all activities of daily living and does not require skilled medical services. They are able to manage their personal care, mobility, and basic needs without assistance. They have demonstrated the

ability to function in the community without the need for ongoing supervision or medical intervention." (Ex. 4, p. 74). The Director of Nursing stated appellant does not have her own primary care physician because when residents are admitted, they come under the care of the facility doctor. (Testimony). Regarding appellant's ADLs, as of March 10, 2025, she is independent with eating, bathing, and upper and lower body dressing. Appellant uses a manual wheelchair but can ambulate with supervision and was observed walking around without wearing her leg boot. (Ex. 4, pp. 324-326). The Administrator testified appellant's use of the wheelchair is a personal choice. (Testimony).

Regarding discharge planning with appellant, the Administrator stated the facility informed appellant the discharge location and appellant did not say anything. (Testimony). The Administrator stated appellant has no family involvement. (Testimony). The record reflects, on March 7, 2025, the facility social worker spoke to appellant regarding discharge planning. Appellant was interested in going to [redacted] The social worker provided appellant with information to contact [redacted] about her interest in placement. The facility would be able to send any clinical documentation if necessary to [redacted] Appellant reported she would call that day. The progress notes indicate other options for appellant are [redacted] in [redacted] The facility will continue to follow through per the note. (Ex. 4, p. 32). As to the discharge location, the Administrator stated the facility has used this location before and he believes it is a safe location. He stated it is a state sponsored shelter. He testified that if appellant cannot get to the shelter on her own, the facility would pay to transport her there. (Testimony).

Appellant testified and offered a written statement. (Ex. 5). She stated this was frustrating and she feels she is being targeted. Regarding pushing other residents of the facility in their wheelchairs, she stated "yeah, I own that." (Testimony). In her written statement, she writes she did push people after being told not to push them. (Ex. 5). Appellant admitted to raising her voice. (Testimony). Appellant stated she saw a doctor about a month and half before the hearing and was told she needed surgery on her left foot, the injury occurring before appellant was admitted to the facility. (Testimony; Ex. 5). The record indicates appellant had an Ortho consult and was proscribed Tylenol and ibuprofen, could bear weight on the foot as tolerated and was given an aircast boot to wear. (Ex. 4, p. 84). At hearing, the Assistant Director of Nursing stated appellant refuses to wear the boot and testified that appellant was not wearing the boot during the hearing. (Testimony).

# Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. Appellant is a female in her [redacted] who was admitted to the facility in [redacted] (Ex. 4, p. 12).

2. On February 2, 2025, the facility issued appellant a Notice of Intent to Discharge Resident with 30-Days' Notice. (Ex. 1). Appellant timely appealed on February 5, 2025. (Ex. 2).

3. Appellant was notified of the facility smoking policy upon admission in writing and verbally. (Testimony).

4. In November 2024, appellant was seen smoking outside the front door of the facility. She was yelling and cursing with a facility visitor. Appellant was redirected to smoking area and asked to lower her voice. Appellant became agitated and told the nurse to "fuck off". (Ex. 4, p. 53).

5. At some point in early January 2025, appellant's behavior became abnormal. She was refused to follow the safe protocol while she was smoking. She also started to swear at the staff members and could not be redirected. (Ex. 4, p. 42).

6. On January 27, 2025, appellant convinced another resident, who is older than appellant and dependent on oxygen, to smoke in the bathroom with her. (Testimony; Ex. 4, p. 36).

7. On February 10, 2025, appellant was reminded not to light a cigarette in front of another resident with an Oxygen tank and was redirected to the smoking area outside the building. (Ex. 4, p. 34).

8. On February 13, 2025, housekeeping found 1 vape pen, 2 lighters and 1 empty blue vape box under appellant's bed. (Ex. 4, p. 34). The lighters are a fire hazard. (Testimony).

9. In early March 2025, as appellant wheeled herself by a nurse on the 3-11 shift, a marijuana blunt in a clear plastic container fell from appellant. (Ex. 4, p. 32).

10. Marijuana is illegal in the facility as it is in a federal building. (Testimony).

11. Appellant pushes other residents in their wheelchairs, which is prohibited. (Testimony; Ex. 4, p. 35). Appellant was seen pushing others in their wheelchairs on January 29 and 30, 2025.

12. Appellant is fully independent in all activities of daily living and does not require skilled medical services. She can manage her personal care, mobility, and basic needs without assistance. She has demonstrated the ability to function in the community without the need for ongoing supervision or medical intervention. (Ex. 4, pp. 74, 324-326).

13. Appellant does not have her own primary care physician because when residents are admitted, they come under the care of the facility doctor. (Testimony).

14. The facility informed appellant of the discharge location and appellant did not say anything. (Testimony). Appellant has no family involvement. (Testimony).

15. On March 7, 2025, the facility social worker spoke to appellant regarding discharge planning. Appellant was interested in going to [redacted] The social worker provided appellant with information to contact [redacted] about her interest in placement. The facility would be able to send any clinical documentation if necessary to [redacted] Appellant reported she would call that day. There were other options for appellant including [redacted] and [redacted] (Ex. 4, p. 32).

16. The discharge location is a state-sponsored shelter. If appellant cannot get to the discharge location on her own, the facility would pay to transport her there. (Testimony).

17. Appellant was given an aircast boot to wear for a left foot injury. (Ex. 4, p. 84). Appellant refuses to wear the boot and was not wearing the boot during the hearing. (Testimony).

# Analysis and Conclusions of Law

456.701: Notice Requirements for Transfers and Discharges Initiated by a Nursing Facility

(A) A resident may be transferred or discharged from a nursing facility only when

(1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;
(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;
(3) the safety of individuals in the nursing facility is endangered;
(4) the health of individuals in the nursing facility would otherwise be endangered;
(5) the resident has failed, after reasonable and appropriate notice, to pay for (or failed to have MassHealth or Medicare pay for) a stay at the nursing facility; or
(6) the nursing facility ceases to operate.

(B) When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 456.701(A)(1) through (4), the resident's clinical record must contain documentation to explain the transfer or discharge. The documentation must be made by

(1) the resident's physician or PCP when a transfer or discharge is necessary under 130 CMR 456.701(A)(1) or (2); and
(2) a physician or PCP when the transfer or discharge is necessary under 130 CMR 456.701(A)(3) or (4).

The issue on appeal is whether the facility was correct in issuing the 30 days' notice of intent to discharge because the safety of individuals in the facility is endangered due to the clinical or

behavior status of the resident. The facility has provided support for this claim in the hearing record.

The appellant does not follow the nursing facility smoking policy prohibiting smoking material or lighters in her possession. She was given notice of the facility smoking policy in writing and verbally when admitted. Appellant was found smoking outside the designated smoking areas. She was in possession of lighters and a marijuana blunt, which is illegal in the facility. Possessing lighters outside of the designated smoking areas is a fire hazard. Appellants' disregard for the facility's smoking policy is all the more dangerous because oxygen is present in the facility and therefore, designated smoking locations have been established. Other actions taken by appellant show individuals in the facility are endangered by appellant's actions. Appellant pushed other residents in their wheelchairs on multiple occasions, which is prohibited. She has been admonished for yelling at visitors to the facility and telling staff to "fuck off."

Appellant's nursing facility record supports that the health and safety of individuals in the nursing facility is endangered by appellant's actions and thus the nursing facility has met the requirements of 130 CMR 610.028(A).

The second issue is whether the nursing facility has met the requirements of MGL Chapter 111, Section 70E and 42 CFR 483.12(a)(7) in providing sufficient preparation and orientation to the appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place. The Federal Centers for Medicare and Medicaid defines "sufficient preparation" within the meaning of 42 CFR 483.12(a)(7) to mean that the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation; the facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence. Centennial Healthcare Investment Corp. v. Commissioner of the Division of Medical Assistance, 61 Mass. App. Ct. 320 (2004).

The nursing facility has met its burden of providing sufficient preparation and orientation to appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place. The nursing facility intends to discharge appellant to the [redacted] a state sponsored shelter. The facility medical director has stated appellant is fully independent in all activities of daily living and does not require skilled medical services. Appellant has no family involvement to be able to include them in discharge planning. Appellant indicated interest in going to [redacted] in [redacted] The facility social worker provided appellant with information to contact [redacted] about her interest in placement. The facility offered to send any clinical documentation to [redacted] There were other discharge options for appellant including [redacted] in [redacted] The facility will provide appellant with transportation to the discharge facility if she cannot obtain transportation herself.

I determine that the place to which the nursing facility intends to discharge appellant is safe and appropriate based on appellant's nursing facility record. The facility involved appellant, to

the extent possible, in discharge planning. The nursing facility's notice of discharge dated February 5, 2025 meets the requirements of 130 CMR 456.071 (A) (B), 610.029, and MGL Chapter 111, section 70E. The appeal is denied.

## Order for Respondent

Proceed with the discharge as set forth in the notice dated February 5, 2025 after the 30-day stay (from the date of this decision).

## Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Thomas Doyle
Hearing Officer
Board of Hearings

cc: Respondent: RegalCare Worcester, Attn: Administrator, 25 Oriol Drive, Worcester, MA 01605, 508-852-3330