# Office of Medicaid
# BOARD OF HEARINGS

**Appellant Name and Address:**

[redacted]

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| **Appeal Decision:** | Denied | **Appeal Number:** | 2504991 |
| **Decision Date:** | 4/15/2025 | **Hearing Date:** | 04/08/2025 |
| **Hearing Officer:** | Scott Bernard | | |

**Appearances for Appellant:**

[redacted]

**Appearances for Respondent:**

Carlos Bonilla, Executive Director; Betty Chan, Director of Social Services *via* telephone

*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 |
| **Decision Date:** | 4/15/2025 | **Hearing Date:** | 04/08/2025 |
| **Respondent's Reps.:** | Carlos Bonilla; Betty Chan | **Appellant's Reps.:** | [redacted] |
| **Hearing Location:** | Quincy Harbor South | **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 of intent to discharge with less than 30 days' notice dated March 28, 2025, the nursing facility informed the appellant that he would be discharged to the [redacted] on [redacted] 2025, because his health improved sufficiently so that he no longer needs the services provided by the facility. (130 CMR 610.029(B)(2); 610.015(F) and Exhibit 1). The appellant filed this appeal on March 27, 2025 (prior to the date on the notice) and included with the appeal a copy of the clinical screening dated March 19, 2025; the appeal stated the "discharge plan is unsafe. My mobility and sobriety are in jeopardy". (see 130 CMR 610.015(F); 610.015(B)(5); and Exhibit 2). By notice dated April 2, 2025, the Board of Hearings (BOH) dismissed the appeal because no discharge notice was included. (Exhibit 4). On April 3, 2025, BOH received the notice of discharge and scheduled the appeal for hearing. (Exhibits 5, 6). Notice of discharge from a nursing facility is valid grounds for appeal (see 130 CMR 610.032).

## Action Taken by the Nursing Facility

The nursing facility issued a notice of intent to discharge the appellant with less than 30 days' notice.

## Issue

The appeal issue is whether the facility satisfied its statutory and regulatory requirements pursuant to 130 CMR 610.028; 610.029(B), when it issued the appellant the notice of intent to discharge.

## Summary of Evidence

The appellant and his authorized representative appeared telephonically at the hearing. The appellant's identity was confirmed by date of birth and Social Security number. The skilled nursing facility (hereinafter the "SNF") was represented telephonically by its Executive Director, and its Director of Social Services (hereinafter "the Social Worker" or the "Director of Social Services"). The SNF submitted pages from the appellant's nursing facility record which were entered into the hearing record. (Exhibit 7, pp. 1-67)[1].

The appellant is over age 65 and was admitted to the SNF on [redacted] 2024, from the hospital for short term rehabilitation. (Exhibit 7, p. 2, testimony). The appellant was screened clinically eligible for short term care until [redacted] 2025. (Exhibit 7, pp. 4-5; testimony). The appellant's diagnoses included orthostatic hypotension, pain in right ankle and joint of right foot after a fall, alcohol dependence with withdrawal. (Exhibit 7, p. 2). The appellant was admitted to the hospital from [redacted] to [redacted] 2024, for orthostatic hypotension and was treated for falls with alcohol intoxication, resulting in ankle pain and the inability to walk. (Exhibit 7, pp. 16, 20). The appellant received physical therapy for a decrease in activities of daily living (ADLs), decrease in function, and decrease in mobility. (Exhibit 7, p. 20). By January 2, 2025, the appellant was ambulating with a walker. (Exhibit 7, p, 20).

The appellant had several discharge planning meetings with the Director of Social Services. (Exhibit 7, pp. 7, 9, 46, 66, 67). The appellant has a history of homelessness and previously lived in a shelter with a friend. (Exhibit 7, p. 9). In a Social Services note, the Social Worker writes that during the appellant's initial psychosocial assessment in December 2024, the appellant informed the Social Worker that after his short-term rehabilitation, his goal was to return to [redacted] and stay with a friend. (Exhibit 7, p. 7). It was later learned that the friend could not take the appellant in, and the Social Worker met with the appellant many times to develop a discharge plan and discuss the option of a temporary shelter until he could find permanent housing. (Exhibit 7, p. 7). The appellant insisted on staying in [redacted] but did not want to return to a particular [redacted] shelter. (Exhibit 7, p. 7). A clinical assessment was done in March, 2028 at which time the nurse evaluator determined that the appellant is independent with ADLs and was eligible for short term care only

[1] 2 packets were submitted; one with 65 pages and one with 67 pages. The packets were identical except for pages 66 and 67. The packet with pages 1-67 was entered into the record at exhibit 7.

through [redacted] 2025. (Exhibit 7, pp. 4-5). The Social Worker again met with the appellant, after this screening, to discuss shelter options and the appellant requested to go to the [redacted] in [redacted] (Exhibit 7, p. 7). The Social Worker was unsuccessful in getting the appellant into the [redacted] but made a referral to the [redacted] which collaborates with [redacted] intake at [redacted] informed the Social Worker that the appellant could stay at [redacted] while [redacted] worked on getting him placed at [redacted] (Exhibit 7, p. 7). The appellant agreed to be discharged to the [redacted] to wait for a [redacted] bed. (Exhibit 7, p. 7). On March 28, 2025, the Social Worker met in person with the appellant and the facility's Veteran Affairs (VA) liaison, Sarah, RN to refer the appellant for VA services, but was told that the appellant does not qualify for VA services to assist with emergency housing placement in a VA shelter. (Exhibit 7, p. 66). The Social Worker followed up with a referral to a VA hospital for a VA PCP, but was told the appellant does not qualify for a VA PCP. (Exhibit 7, p. 66). The Social Worker noted that the appellant's discharge was postponed because he appealed the clinical screening notice. (Exhibit 7, p. 7). The Social Worker spoke with the community VA liaison who agreed that discharge to the [redacted] to await placement at [redacted] was the best option. (Exhibit 7, p. 7). The appellant agreed with this plan, but the discharge was postponed to [redacted] 2025 to give the appellant time to speak with his case manager. (Exhibit 7, p. 7). On April 4, 2025, the appellant filed an appeal of the notice of discharge. (Exhibit 7, p. 7). The appellant's appeal of the clinical screening was denied. (Exhibit 7, p. 66).

In a physician order dated [redacted] 2025, [redacted] the SNF's Medical Director, wrote that the appellant is fully independent with all ADLS and requires no assistance. (Exhibit 8). [redacted] wrote further that the appellant can ambulate over 200 feet safely with a steady gait using a walker. (Exhibit 8).

The Executive Director spoke first and stated the following. (Testimony). The appellant was admitted to the nursing facility on [redacted] 2024, for a stint of short-term rehab. (Testimony). The appellant did well with rehabilitation and was eventually determined to be independent with all activities of daily living (ADLs). (Testimony). The appellant was able to ambulate with a steady gait and could walk over 200 feet with the use of a walker. (Testimony). He was discharged from his rehab on [redacted] 2025. (Testimony). At that time, the Director of Social Services worked on creating a safe discharge plan for the appellant. (Testimony). The facility was eventually able to find [redacted] as a potential placement.

The Social Worker testified that an Aging Services Access Point (ASAP) registered nurse did a clinical evaluation in March 2025. On March 19, 2025, the ASAP nurse issued an assessment of clinical eligibility, finding that the appellant was clinically eligible for a short term stay through [redacted] 2025, because nursing facility services are medically necessary for that period of time. (Exhibit 7, p. 4). The Social Worker noted that the appellant was no longer clinically eligible for MassHealth coverage of nursing facility services as of [redacted] 2025. The Social Worker testified that it does not appear that the appellant qualifies for VA services at this time and, further, it is difficult to find a VA shelter with openings. The Social Worker stated that the [redacted] works with the VA

housing at [redacted] and agreed to have the appellant stay there while they work with [redacted] The Social Worker noted that the appellant had agreed to this plan.

The appellant's representative stated that the appellant has lost his VA paperwork and is seeking to get copies so that he can get VA benefits. The appellant's representative noted that the appellant was homeless prior to his admission to the SNF and they are seeking more time to find him housing. The appellant's representative stated that the appellant is early in his sobriety and there is concern that he will start drinking again. The appellant's representative stated that the less than 30 days notice did not give them enough time to find an alternate living situation for him.

# Findings of Fact

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

1. The appellant is over age 65 and was admitted to the SNF on [redacted] 2024, from the hospital for short term rehabilitation; the appellant was admitted to the hospital from [redacted] to [redacted] 2024 for orthostatic hypotension and was treated for falls with alcohol intoxication, resulting in ankle pain and the inability to walk.

2. The appellant received physical therapy for a decrease in ADLs, decrease in function, and decrease in mobility; by January 2, 2025, the appellant was ambulating with a walker and he was discharged from rehabilitation on [redacted] 2025.

3. The appellant was screened clinically eligible for short term care until March 28, 2025.

4. In a physician order dated April 8, 2025, [redacted] the SNF's Medical Director, wrote that the appellant is fully independent with all ADLS and requires no assistance; [redacted] wrote further that the appellant can ambulate over 200 feet safely with a steady gait using a walker.

5. The appellant had a number of discharge planning meetings with the Director of Social Services.

6. The appellant has a history of homelessness and previously lived in a shelter and with a friend.

7. During the appellant's initial psychosocial assessment in December, 2024, the appellant informed the Social Worker that after his short term rehabilitation, his goal was to return to [redacted] and stay with a friend; it was later learned that the friend could not take the appellant in, and the Social Worker met with the appellant many times to develop a discharge plan and discuss the option of a temporary shelter until he could find permanent housing.

8. The appellant insisted on staying in [redacted] but did not want to return to a particular [redacted] shelter.

9. The Social Worker again met with the appellant, after the clinical screening, to discuss shelter options and the appellant requested to go to the [redacted] in [redacted] the Social Worker was unsuccessful in getting the appellant into the [redacted] but made a referral to the [redacted] which collaborates with [redacted] intake at [redacted] informed the Social Worker that the appellant could stay at [redacted] while [redacted] worked on getting him placed at [redacted]

10. The appellant agreed to be discharged to the [redacted] to wait for a [redacted] bed.

11. On March 28, 2025, the Social Worker met in person with the appellant and the facility's VA liaison, Sarah, RN to refer the appellant for VA services, but was told that the appellant does not qualify for VA services to assist with emergency housing placement in a VA shelter; the Social Worker followed up with a referral to a VA hospital for a VA PCP, but was told the appellant does not qualify for a VA PCP.

12. The appellant's discharge was postponed because he appealed the clinical screening notice; the appellant's appeal of the clinical screening was denied.

13. The appellant's representative stated that the appellant has lost his VA paperwork and is seeking to get copies so that he can get VA benefits.

# Analysis and Conclusions of Law

Per 130 CMR 456.701(A) and 130 CMR 610.028(A), a nursing facility resident may be transferred or discharged 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 the MassHealth Agency or Medicare) a stay at the nursing facility; or
> (6) the nursing facility ceases to operate.

130 CMR 610.028(A); 456.701(A).

When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 610.028(A)(1) through (5), the resident's clinical record must be documented. The documentation must be made by

(1) the resident's physician when a transfer or discharge is necessary under 130 CMR 610.028(A)(1) or (2); and

(2) a physician when the transfer or discharge is necessary under 130 CMR 610.028(A)(4).

130 CMR 610.028(B).

In lieu of the 30-day-notice requirement set forth in 130 CMR 610.029(A), the notice of discharge or transfer required under 130 CMR 610.028 must be made as soon as practicable before the discharge or transfer in any of the following circumstances, which are considered to be emergency discharges or emergency transfers.

(1) The health or safety of individuals in the nursing facility would be endangered and this is documented in the resident's record by a physician.

(2) The resident's health improves sufficiently to allow a more immediate transfer or discharge and the resident's attending physician documents this in the resident's record.

(3) An immediate transfer or discharge is required by the resident's urgent medical needs and this is documented in the medical record by the resident's attending physician.

(4) The resident has not lived in the nursing facility for 30 days immediately before receipt of the notice.

130 CMR 610.029(B).

If a hearing is requested, in accordance with 130 CMR 610.015(B)(4), and the request is received before the discharge or transfer, then the nursing facility must stay the planned transfer or discharge until five days after the hearing decision.

130 CMR 610.030(B).

The issue on appeal is whether the appellant's health has improved sufficiently so that he no longer needs the services provided by the nursing facility and has improved to the extent that a more immediate discharge is allowed. (130 CMR 610.028(A)(2); 610.029(B)(2)). The appellant was admitted to the nursing facility for short term rehabilitation in December, 2024 because he was having difficulty with ADLs and mobility due to orthostatic hypotension and falls from this condition, as well as from alcohol intoxication. The appellant successfully completed rehabilitation and is now independent with his walker, independent with all ADLs, he has no skilled therapy needs, he is not receiving PT or OT, and he has no skilled care needs. The SNF Medical Director confirmed this. The evidence supports that the appellant's health has improved sufficiently so that he no longer needs the services provided by the nursing facility and has improved to the extent

that a more immediate discharge is allowed.

The second issue is whether the nursing facility has met the requirements of MGL Chapter 111, Section 70E and 42 CFR 483.15(c)(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 483.15(c)(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. (see *Centennial Healthcare Investment Corp. v. Commissioner of the Division of Medical Assistance*, Appeals Court No. 03-P-879, 2004)

The nursing facility has met its burden of providing sufficient preparation and orientation to the appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place. The nursing facility intends to discharge the appellant to the [redacted] which has a collaboration with [redacted] and will work with [redacted] to see if the appellant is eligible for placement there. The appellant's representative argued that they need more time to get the appellant housing. The appellant was homeless and living in shelters and with a friend prior to his hospitalization and SNF admission. While I sympathize with the appellant's homelessness, it appears he has been in this situation for some time and had time to work on seeking alternate housing options long before his SNF admission. As it is, the SNF Social Worker has been working on discharge planning with the appellant since a week after his admission. I determine that the place to which the nursing facility intends to discharge the appellant is safe and appropriate based on the appellant's nursing facility record. The appellant is receiving no skilled services currently. The appellant is independent with ADLs and self-care. The SNF Medical Director noted that the appellant is medically cleared for discharge and does not require skilled nursing facility level of care. The nursing facility involved the appellant, to the extent possible, in discharge planning and the fact that the appellant does not want to go to the shelter and hasn't found an alternative place to live does not negate this fact and is out of the control of the nursing facility. The nursing facility's notice of discharge dated March 28, 2025, meets the requirements of 130 CMR 610.028, 610.029, and MGL Chapter 111, section 70E. The appeal is denied.

# Order for the Nursing Facility

Proceed with the discharge as set forth in the notice dated March 28, 2025, with the 5 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.

## Implementation of this Decision

If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Scott Bernard
Hearing Officer
Board of Hearings

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[redacted]