Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2509540
Decision Date:	7/28/2025	**Hearing Date:**	07/18/2025
Hearing Officer:	Thomas Doyle	**Record Open to:**	N/A

Appearance for Appellant:
Pro se

Appearance for Respondent:
James Dillon, Administrator
Angela Oriakhi, Director of Nurses
Allyson Witt, Director of Social Services
Pam Shell, Unit Manager

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

Appeal Decision:	Approved	**Issue:**	Nursing Facility Discharge – Endangering the Safety of Others
Decision Date:	7/28/2025	**Hearing Date:**	07/18/2025
Respondent's Rep.:	James Dillon	**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 June 10, 2025, the nursing facility informed appellant that he would be discharged to [redacted] on [redacted] 2025 because the safety of the individuals in the nursing facility is endangered. (130 CMR 610.028(A)(3); 130 CMR 456.701(A); Ex. 1). Appellant filed this appeal in a timely manner on June 23, 2025. (130 CMR 610.015(B); Ex. 2). Notice of discharge from a nursing facility is valid grounds for appeal (see 130 CMR 610.032).

Action Taken by Respondent

The nursing facility issued a notice of discharge to the appellant.

Issue

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

Summary of Evidence

The nursing facility (facility) was represented telephonically at the hearing by its Administrator, the Director of Social Services, the Director of Nurses, and a Unit Manager. Appellant also appeared by phone. The hearing commenced, documentary evidence from the facility, a half-page narrative signed by the facility Administrator and 9 pages of progress notes, was marked, and all were sworn. On June 10, 2025, the facility issued appellant a Notice of Intent to Discharge with 30 Days' Notice to the [redacted] (Ex. 1). Appellant timely appealed on June 23, 2025. (Ex. 2).

The Administrator testified appellant was initially admitted to the facility on [redacted] 2024. Appellant was discharged on [redacted] 2025 to the hospital and then readmitted to the facility on [redacted] 2025. (Ex. 4, p. 1). The Administrator stated appellant had engaged in disruptive and abusive behavior between January 2025 to June 2025. He specifically mentioned two incidents involving appellant where appellant allegedly inappropriately touched a female resident and assaulted another male resident. After this assault on the other male resident, the Administrator stated appellant was sent to the hospital. (Ex. 4, p. 7). The Administrator stated both incidents were reported to the Department of Public Health (DPH). The Administrator stated the facility did not submit any documentary evidence regarding the alleged inappropriate touching or the assault because it is not permitted per regulation.[1] (Testimony).

The Director of Nurses testified regarding the two incidents. In the first incident, on [redacted] 2025, she stated staff were present when appellant and the other male resident were arguing. Appellant then hit the other resident in the arm and the abdomen. Appellant was then sent to the hospital. Regarding the second incident, the Director of Nurses stated a female resident, in her late fifties, came to her and stated she was leaving the smoking section and appellant was behind her and grabbed her "butt." The Director of Nurses stated no staff witnessed the incident, but other residents of the facility told her they saw the incident. The Director of Nurses said she reported this incident to DPH. (Testimony).

Regarding other behaviors of appellant, the Director of Nurses stated the facility has one resident who has issues with excessive weight. She stated appellant was told not to give extra food to the resident but appellant keeps going into the room of the resident with the weight problem and giving that resident food the resident is prohibited from eating. (Ex. 4, p. 4). The Director of Nurses stated appellant is rude and abusive to staff. (Testimony; Ex. 4, p. 5).

The Unit Manager testified that appellant continues to verbally abuse staff and uses profanities

[1] Notwithstanding the Administrator's testimony, the record includes a progress note that states appellant "out to ER yesterday after hitting a peer." (Ex. 4, p. 7).

when speaking to staff. She stated he keeps closing the door to his room when he has been repeatedly told to keep the door open because his roommate is a fall risk. (Testimony; Ex. 4, p. 9).

Appellant testified on his own behalf. He stated a lot of what was said by the facility employees was not true. He stated, "some of it is true" and he stated "my behavior has been terrible." (Testimony). He stated he was on opioids when he was admitted due to a back injury. He further testified he was taken off opioids and placed on another medication. He stated he believed his behavior is getting "progressively better." Appellant said as far as his swearing, "my vocabulary is not very good from time to time due to the fact I have a hard time getting along with things." (Testimony). Appellant testified that swearing at stuff "was bad" and then stated, "I did that." Regarding his closing the door to his room, appellant stated he has a medical condition in his right eye that makes him sensitive to bright light and that is why he was closing his room door.

Appellant testified regarding the allegation he touched a female. He stated this was "bogus, I did not do that." He testified they were in line to go outside to smoke and he "bumped into that person, I did not touch that person." (Testimony). Regarding the other allegation he assaulted a male resident, appellant testified he "did not fight anybody, I did not touch anybody." He stated he was outside smoking and that other person "knocked my hat off my head." Appellant then testified the other person "came into the building and said to me, hey man, what's my problem?" Appellant continued and said the other person "had his closed fist four inches away from my face, he invaded my personal space." (Testimony).

In response to appellant's testimony, the Administrator stated that the assault committed by appellant on another male resident was verified by CNAs who saw it happen.

Appellant then testified he never ordered food from McDonalds. He did admit he shared his food but testified he had permission to do so. The Administrator then testified that no permission from the facility was given to appellant to give another resident food. The Unit Manager then stated appellant was told multiple times not to give the other resident any other food. (Testimony).

The facility provided no testimony regarding their duty to provide sufficient preparation and orientation to the appellant to ensure a safe and orderly discharge from the facility to the discharge destination. Within the facility's documentary evidence, there is an entry that states, "Discharge planning/Disposition: Will continue discussion with the therapy team, family and social worker. Will further determine as rehab progresses. Will follow the patient throughout rehabilitation course to manage rehabilitation and any barriers to therapies." (Ex. 4, p. 8).

The facility offered no testimony that a physician had documented appellant's clinical record as mandated by statute. In its documentary evidence, a doctor's name only appears twice, both instances regarding the medical diagnosis of appellant. (Ex. 4, p. 6, 8).

Findings of Fact

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

1. On June 10, 2025, the facility issued appellant a Notice of Intent to Discharge with 30 Days' Notice to the [redacted] (Ex. 1). Appellant timely appealed on June 23, 2025. (Ex. 2).

2. The facility entered documents into evidence consisting of a half-page narrative signed by the facility Administrator and 9 pages of progress notes. (Ex. 4).

3. The facility did not offer adequate evidence that they provided essential preparation and orientation to appellant to ensure safe and orderly discharge from the facility to another safe and appropriate place. (42 CFR 483.15 (c)).

4. The facility did not offer sufficient evidence that appellant's clinical record was documented by a physician. (Ex. 4).

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)

(3) or (4).

130 CMR 610.028(B).

There are two issues on appeal. The first 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.

Pursuant to regulation, when the facility 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. In this case, the documentation must be made by a physician. (130 CMR 610.028(B)). In the record before me, the only documentation by a physician appears twice, both times regarding the medical diagnosis of appellant. The facility failed to properly comply with this regulation.

The second issue is whether the nursing facility has met the requirements of 42 CFR 483.15(c) and MGL Chapter 111, Section 70E 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, during the times relevant here known as the Health Care Finance Administration, is the Federal agency charged with administering the Medicaid program and promulgating regulations. Sufficient preparation means, according to HCFA,[2] 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. 1124, n. 5, 2004 (Appeals Court Rule 1:28). Here, the facility informed appellant where he is going via the written June 10, 2025 notice, but there is no evidence the facility took steps under its control to assure safe transportation or that the facility actively involved, to the extent possible, appellant and his family. There is no evidence that the discharge location is a safe and appropriate place for appellant. The facility failed to properly comply with this federal regulation.

While the allegations against appellant regarding his behavior and language towards staff are troubling and his alleged nonconsensual touching of a female resident is concerning, these issues do not relieve the facility of their responsibility to follow the regulatory and statutory scheme when seeking to discharge a resident. The facility has failed to fulfill its obligations under the regulations and therefore, the appeal is approved.

Order for MassHealth

Rescind the Notice of Intent to Discharge Resident with 30 Days' Notice dated June 10, 2025.

[2] The Health Care Finance Administration is now known as the Centers for Medicare and Medicaid Services.

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.

Thomas Doyle
Hearing Officer
Board of Hearings

[redacted]