Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2515522
Decision Date:	11/3/2025	**Hearing Date:**	10/31/2025
Hearing Officer:	Alexandra Shube		

Appearance for Appellant:

[redacted]

Appearance for Facility:

[redacted]

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 Safety of Individuals
Decision Date:	11/3/2025	**Hearing Date:**	10/31/2025
Nursing Facility's Rep.:	Alexandria Peltier	**Appellant's Rep.:**	[redacted]
Hearing Location:	Springfield MassHealth Enrollment Center, Remote	**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 Resident With Less Than 30 Days (Expedited Appeal) dated October 21, 2025, [redacted] (hereinafter, "the facility") informed the appellant of its intent to discharge the appellant on [redacted] because the health and safety of individuals in the facility is endangered (see 130 CMR 610.028 and Exhibit 1). The appellant filed this appeal in a timely manner on October 23, 2025 (see 130 CMR 610.015(B) and Exhibit 2). Notification of intent to discharge or transfer an individual from a nursing home facility is a valid basis for appeal (130 CMR 610.032).

Action Taken by Nursing Facility

The facility informed the appellant of its intention to discharge him because the health and safety of individuals in the facility is endangered.

Issue

The issue is whether the facility is justified in seeking to discharge the appellant, and whether it followed proper procedures in doing so.

Summary of Evidence

The facility appeared at hearing via telephone and was represented by its administrator. The appellant appeared at hearing via phone along with an attorney from [redacted] and a social worker from the facility who testified on his behalf.

The facility offered the following through testimony and documentary evidence: following the appellant's readmission to the facility on [redacted] the facility conducted a smoking assessment on July 16, 2025 and determined that he requires supervision and an apron while smoking. On September 19, 2025, the administrator observed him outside of the designated smoking area in close proximity to other residents and without a protective apron. The administrator approached the appellant and informed him that all smoking needs to occur within the gazebo for the safety of all residents. The gazebo has a fire extinguisher, fire blanket, and smoking attendant present. The appellant was initially resistant, but agreed to relocate once everything was explained. When the administrator was walking beside the appellant to the gazebo, she noticed a pack of cigarettes in an unzipped pouch tucked into his wheelchair. The appellant was educated regarding the facility smoking policy and importance of compliance for safety. The appellant indicated awareness and understanding and stated that he had just forgotten to turn over the cigarettes.

On September 25, 2025, the director of nursing services (DNS) was notified that the appellant was seen with smoking materials on his person. Pursuant to the facility's doctor's order, a room search was conducted by the administrator and DNS. Cigarettes were visible in an open zippered pouch on the appellant's wheelchair seat. A lighter was also found. The appellant was notified that any further violations of the smoking policy would result in the facility issuing a notice of intent to discharge. DNS and the administrator discussed the smoking policy and risks for both the appellant and other residents. The appellant verbalized understanding of the policy prior to signing the smoking policy document.

On October 1, 2025, a certified nursing assistant (CNA) observed the appellant stop in the courtyard and retrieve cigarettes and a lighter from a pouch tucked into his wheelchair and then begin smoking without a protective apron in place. The CNA remained with the resident for safety and notified DNS. When DNS approached, the appellant became agitated and left the facility with smoking materials on his person to attend a scheduled appointment. Upon returning to the facility, DNS observed the appellant enter the courtyard with cigarettes and a lighter visible. DNS requested the appellant turn over his smoking materials, but he refused despite attempts to

educate. The appellant stated that the smoking materials were “my personal property and you can’t take them… I do not care about your rules and there is nothing you can do about it.” At this time, the administrator and doctor were notified and requested 1:1 supervision until discharge to ensure safety of other residents due to the appellant’s repeated refusal to comply with facility policies.

The administrator explained that there are a lot of residents in the facility on oxygen. Additionally, there are residents with dementia or other altered mental states and if they were to wander and find his smoking materials, it would be dangerous. Per policy, smoking materials are to be secured in safe storage until designated smoking times. The appellant was fully aware of this policy having been re-oriented to it by the administrator and DNS after the previous incidents. The facility now has to have extra staff on every shift to provide 1:1 coverage for added safety support for the appellant.

The administrator testified that once the discharge notice was issued, she contacted the social worker at the facility to set up services for the appellant to ensure a safe discharge home. While nothing has been set up yet, the facility intends to set him up with adequate services, including visiting nurses, which will allow him to manage safely at home. The appellant can do most of his care himself although he requires occasional assistance in the shower. He can ambulate but chooses to use his wheelchair the majority of the time.

Clinical records provided by the facility indicate that the facility’s physician stated the “patient has been noncompliant with smoking policy and despite attempts at education he remains noncompliant and is endangering other residents, requiring 1:1 supervision until discharge.”

The social worker from the facility who testified on behalf of the appellant stated that prior to his most recent admission, he had been discharged from the facility and failed the trial at home. He had all the supports in place after the last discharge, but was still unsuccessful at home. He ended up hospitalized and back in the facility. He co-owns the home with his brother but it is an unsafe environment for him. His brother has addiction issues and has abused the appellant and stolen thousands from him. Last time the appellant was home, the social worker received daily phone calls from the appellant with him saying he is not safe and could not stay in his home. Additionally, she noted that visiting nurses only come once per week. The facility will make a referral to the local senior services, but that can take a few weeks to set up and they can’t begin the process until he is actually home. He does not do physical or occupational therapy at the facility any longer because he has plateaued and been determined at a custodial level of care. He is not in condition to return home safely. The social worker felt strongly that the appellant is at risk of death if he is discharged home.

The appellant’s attorney argued that there were structural issues with the discharge notice, mainly that it did not name [redacted] Instead, the notice listed [redacted] which does not provide services in the appellant’s area. Additionally,

there has been no discharge planning. The proposed discharge location is not safe or appropriate given his brother's abusive history and erratic behavior. There is no evidence that it is medically safe to discharge the appellant. He is struggling with liver disease (end stage cirrhosis) and requires paracentesis every two weeks. He has difficulty maintaining his health on his own and cannot manage his medications independently. He is cognitively able to comply with the smoking rules and has done so since the most recent incident, thirty days ago. The facility is supportive of him and the appellant considers the facility his second home. He is actively involved in the community and is the vice president of the resident's council. He wishes to remain at the facility.

The appellant's attorney pointed out that the initial smoking assessment and policy from July 16, 2025 was never signed by the appellant. He did not sign one until after the September incident. She explained that during his past admissions, the smoking policy was not enforced as it is now, so there was a learning curve. He did not realize he couldn't keep his cigarette and lighters on him in the pouch on his wheelchair. The appellant is in compliance now and is not an ongoing safety risk.

The appellant's attorney also had issue with the facility issuing an "expedited" discharge notice on October 21 when the incident occurred on October 1. If there was a three-week period between the incident and the notice, that does not seem like an emergency. The facility responded that the notice was delayed because the appellant was in the hospital for a period of time.

Findings of Fact

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

1. The appellant is a resident of a nursing facility and over the age of [redacted] (Testimony and Exhibit 5).

2. On October 21, 2025, the facility issues a Notice of Intent to Discharge Resident With Less Than 30 Days' Notice (Expedited Appeal) because the health and safety of the individuals in the facility is endangered (Testimony and Exhibit 1).

3. On October 23, 2025, the appellant timely appealed the discharge notice (Exhibit 2).

4. The appellant has been noncompliant with the facility's smoking policy, endangering other residents. This is documented by the facility's physician in the appellant's clinical records. (Testimony and Exhibit 5).

5. The proposed discharge location is the appellant's home that he shares with his brother (Testimony and Exhibit 1).

6. The appellant's brother has addiction issues and exhibits erratic behavior. He has abused the appellant in the past, in addition to stealing thousands of dollars from him. (Testimony).

7. The appellant, who has end-stage cirrhosis and requires paracentesis every two weeks, is a custodial level of care. He struggles to maintain his medication routine and health on his own (Testimony).

Analysis and Conclusions of Law

Pursuant to 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); (Emphasis added).

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).

130 CMR 610.028(C) lays out the discharge notice criteria as follows:

> (C) Before a nursing facility discharges or transfers any resident, the nursing facility must hand-deliver to the resident and mail to a designated family member or legal

representative, if the resident has made such a person known to the facility, a notice written in 12-point or larger type that contains the following, in a language the member understands:

(1) the action to be taken by the nursing facility;

(2) the specific reason or reasons for the discharge or transfer;

(3) the effective date of the discharge or transfer;

(4) the location to which the resident is to be discharged or transferred;

(5) a statement informing the resident of his or her right to request a hearing before the MassHealth agency, including:

(a) the address to send a request for a hearing;

(b) the time frame for requesting a hearing as provided for under 130 CMR 610.029; and

(c) the effect of requesting a hearing as provided for under 130 CMR 610.030; (6) the name, address, and telephone number of the local long-term-care ombudsman office;

(7) for nursing facility residents with developmental disabilities, the address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. § 6041 et seq.);

(8) for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act (42 U.S.C. § 10801 et seq.);

(9) a statement that all residents may seek legal assistance and that free legal assistance may be available through their local legal services office. The notice should contain the address of the nearest legal services office; and

(10) the name of a person at the nursing facility who can answer any questions the resident has about the notice and who will be available to assist the resident in filing an appeal.

(Emphasis added).

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 first issue that needs to be addressed here is whether the facility followed the proper procedures in issuing its notice. The appellant's attorney argued that there were structural issues with the discharge notice, mainly that it did not name [redacted] Instead, the notice listed [redacted] which does not provide services in the appellant's area. It appears that the facility should update its forms; however, this flaw is not fatal to the notice and, as the appellant appeared at hearing with his attorney from [redacted]

[redacted] it did not prejudice him in any way. As such, the notice meets the criteria listed in 130 CMR 610.028(C).

The next issue on appeal is whether the safety of individuals in the facility is endangered by the appellant's behavior. The record supports the facility's position. The appellant's argument that he wasn't aware of the smoking policies is not persuasive. He was found with smoking material multiple times and was clearly in violation of the facility's smoking policy. The facility had spoken with the appellant on more than one occasion about these issues, but the appellant still failed to abide by these basic safety measures, endangering the safety of individuals in the nursing facility.

The appellant does not have a right to remain in the nursing facility while violating the smoking policies and endangering vulnerable residents; however, in addition to the MassHealth-related regulations discussed above, the nursing facility also has an obligation to comply with all other applicable state laws, including M.G.L. c.111, §70E, which went into effect in November of 2008. The key paragraph of that statute provides as follows:

> A resident, who requests a hearing pursuant to section 48 of chapter 118E, shall not be discharged or transferred from a nursing facility licensed under section 71 of this chapter, unless a referee determines that the nursing facility has provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility to another safe and appropriate place.

The facility has proposed a discharge to the appellant's home which he owns with his brother and where he lived before he was re-admitted to the facility. The facility's own social worker who testified on behalf of the appellant emphasized that she was very concerned for the appellant's safety and welfare if he was discharged to this location. The last time he was discharged from the facility to his home, he had all the supports in place and still failed. He is a custodial level of care and is not able to be safely discharged. When on his own, he cannot manage his medications. This resulted in decompensation and a hospitalization that led to his most recent admission to the facility. Additionally, his brother has addiction issues and he is not a safe person for the appellant to be around. The brother is abusive, has stolen from the appellant in the past, and exhibits erratic behaviors. Last time the appellant was home, the social worker received daily phone calls from the appellant with him saying he is not safe and could not stay in his home. The social worker went so far as to say she felt strongly the appellant is at risk of death if he is discharged home.

Furthermore, the facility has not demonstrated that any discharge planning has occurred. While the appellant does not have a right to remain in the facility in violation of its safety policies, the facility has not shown that it has provided "sufficient preparation and orientation to ensure a safe and orderly discharge," nor has it shown that the appellant's home is a "safe and appropriate" discharge location.

For these reasons, the appeal is approved.

Order for Nursing Facility

Rescind the Notice of Intent to Discharge Resident with Less than 30 Days' Notice dated October 21, 2025.

Implementation of this Decision

If this nursing facility fails to comply with the above order, you should report this in writing to the Director of the Board of Hearings, at the address on the first page of this decision.

Alexandra Shube
Hearing Officer
Board of Hearings

[redacted]