STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

APPEALS OFFICE

[redacted]

v. DOCKET No. 25-1268

[redacted]

DECISION

I. INTRODUCTION

A Microsoft Teams hearing on the above-entitled matter was held on April 16, 2025. The matter was initiated on behalf of [redacted] ("Appellant") to appeal a "Rhode Island Department of Human Services Pre-Transfer or Pre-Discharge Notice" ("30-Day Notice") issued by [redacted] ("Facility"), on March 7, 2025. The Appellant seeks to have the Pre-Discharge Notice nullified. For the reasons discussed in detail below, the Appellant's appeal is denied.

II. JURISDICTION

The Executive Office of Health and Human Services ("EOHHS") is authorized and designated by R.I.G.L. § 42-7.2-6.1 and EOHHS regulation 210-RICR-10-05-2 § 2.4.8 to be the

entity responsible for appeals and hearings related to involuntary transfers or discharges of all residents of Nursing Facilities, regardless of whether or not they are Medicaid recipients. The Administrative Hearing was held in accordance with the Administrative Procedures Act, R.I.G.L. §42-35-1 et. seq. and EOHHS regulation 210-RICR-10-05-2.

III. ISSUE

The issue on Appeal is whether there is sufficient evidence and compliance with the rules and regulations, to permit the involuntary discharge of the Appellant.

IV. PARTIES AND EXHIBITS

[redacted], Administrator, and [redacted], Director of Nurses, attended the hearing and provided testimony on behalf of the Facility. The Facility offered the following into evidence:

- Facility Exhibit #1: 30-day Notice.
- Facility Exhibit #2: Nurses/Progress Notes.
- Facility Exhibit #3: Signed document entitled Smoking Strike Form.

Charline Scanlon, Long-Term Care Ombudsman, appeared and provided testimony on behalf of the Appellant. The Appellant did not attend the hearing.

V. RELEVANT LAW/REGULATIONS

Under 210-RICR-50-00-7, there is a set of requirements, both procedural and substantive, an institution, such as a nursing home or an assisted living facility, must take to involuntarily discharge a patient. This process is not limited to Medicaid patients.

210-RICR-50-00-7.6 specifically lays out the notice requirements to involuntarily discharge someone from a nursing home. These include:

1. Written notice being given to the patient (and, if known, a patient representative)

   The notice must:

   a. Be in a language and manner the patient understands.

   b. List the reason for the transfer/discharge.

   c. List the effective date of the transfer/discharge.

   d. List the location the patient is being transferred/discharged to.

   e. Contain a statement of the patient's appeals rights including the name, mailing address, email address, and telephone number of the entity that receives such appeals.

   f. Contain information on how to obtain the appeal form and on how to get assistance in completing the appeal if needed.

   g. Contain the name, mailing address, email address, and telephone number of the Office of the State Long-Term Care Ombudsman.

   h. Be provided at least 30 days in advance of the transfer, except in certain cases.

2. Notification of the pending discharge must be provided to the Office of the State Long-Term Care Ombudsman. The Ombudsman is part of and operates out of the Alliance for a Better Long-Term Care.

3. The patient also needs to receive a notice of appeal rights at the time of the discharge notice.

Finally, there is a requirement for the discharge to be a safe one. Federally, 42 C.F.R 483.15(c)(7) requires the facility to provide (and document) sufficient preparation and

orientation to the resident to ensure a safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

VI. FINDINGS OF FACT

1. The Appellant has been a resident of the Facility since April 3, 2023.
2. A Pre-Transfer or Pre- Discharge 30-Day Notice was issued by the Facility to the Appellant on March 7, 2025. It stated the reason for discharge was that the health and/or safety of other individuals in the Facility was endangered.
3. The Facility maintains that the Appellant was violating the Facility's smoking policy by sneaking cigarettes in and coercing other patients to purchase/sneak cigarettes in for him, and that he had made physical threats towards staff.
4. The Appellant filed a timely appeal, received in the EOHHS Appeals Office on March 17, 2025.
5. The Appellant was made aware of the smoking policy upon admission to the Facility on April 3, 2023, and again upon re-admission on October 18, 2024. Per the Facility, a smoking assessment is completed to determine if a patient is safe to go outside and smoke. The Appellant was made aware that he could not have cigarettes at his bedside or in the Facility, that cigarettes had to remain locked up, and that he could not have any type of lighters in his possession.
6. A copy of the Smoking Strike Form, signed by the Appellant and submitted by the Facility clearly states that any violation of the Smoking Policy will result in a "strike". After a resident has received 3 strikes, further action may be taken regarding a specific plan including but not limited to issuing of a 30-day notice.

7. According to the nursing notes, the Appellant received his first strike on February 26, 2024, for smoking outside the designated smoking area and for having a lighter in his possession. His second strike was given on April 28, 2024, for being verbally aggressive with the smoking attendant and refusing to follow the facility smoking policy. The third strike was given on June 24, 2024, for having cigarettes at his bedside, rather than being locked up, as the policy requires.
8. Per a nurse's note that was dated October 15, 2024, the Appellant became very upset with a male smoking attendant. He began to use inappropriate language and made threats that he would "get some people who will take him out". The Appellant continued with the inappropriate language, throwing pens and writing materials, and was disrupting the other residents who were taking a smoking break. The Assistant Director notified the police regarding the threats. The police, after interviewing the Appellant, decided to send him to the hospital because of his behaviors.
9. The Director testified that prior to the 30-Day Notice the Appellant has been consistently not complying with Facility's smoking policies. The Facility also reports he is cognitively intact and knows right from wrong and makes a conscious decision not to comply, which puts the Facility and its residents at risk.
10. The Notice on appeal states the location to which the resident is to be transferred, or discharge to is to be determined with the patient. The Facility testified that they have sent referrals out to every facility that the Appellant has not already been a resident of and have not had any offers for a bed for him. The Facility further testified that discharge to a homeless shelter is an option which was discussed with the Appellant, as they have not been able to find an available bed for him.

11. The Facility's Director of Nursing testified that the Appellant is independent and does not require care in a skilled Nursing Facility. Other than the Appellant being a double amputee, he is able to complete all activities of daily living on his own and is fully aware of his medications and how to self-administer. She also testified that there are no safety concerns with discharging the Appellant to the community or shelter.
12. Ombudsman Scanlon does not dispute that given the Appellant's continued non-compliance with the smoking policy, the Appellant's behavior poses safety risks to others in the Facility.
13. Ombudsman Scanlon testified that discharge to a shelter is not appropriate or safe as the Appellant is an amputee. The Ombudsman concedes a shelter would be appropriate if he was guaranteed a place to stay. However, the Ombudsman argues that shelter housing is not stable or promised.

VII. DISCUSSION

Facilities are allowed to involuntary discharge residents, when the resident's continued presence in the Facility endangers the safety of other individuals in the Facility. Prior to the transfer/discharge, the Facility must provide the resident with a formal written notice of intent to transfer/discharge; provide a copy of that notice to the Office of the State Long Term Care Ombudsman; and have the reasons for the transfer/discharge documented in the resident's medical record by a physician.

A review of the record of hearing finds that a Pre-Transfer/Pre-Discharge 30 Day Notice was given to the Appellant on March 7, 2025. The Notice informed the Appellant that he would be discharged due to the endangerment of the health and/or safety of other individuals in the

Facility. The Notice was dated and signed by a physician on March 6, 2025, with a brief explanation for the discharge which stated that the Appellant has not complied with the building smoking policies. The Facility asserts and provides documentation that the Appellant has violated the Facility's smoking policy on several occasions. The Appellant does not dispute that he has violated the smoking policy and that his actions put others in the Facility at risk. The Appellant argues, however, that the discharge should not be allowed because the intended place of discharge is not appropriate or is unsafe.

While Ombudsman Scanlon argued that any such discharge to a shelter from a LTC Facility is not appropriate and/or safe, she did not present any specific medical needs of the Appellant, other than being a double amputee, that would prevent discharge to a shelter.

In summary, the Appellant's non-compliance, specifically his refusal and/or failure to abide by the Facility's rules and policies related to smoking, endangers the safety of others in the Facility in several ways. Especially when he becomes upset. The Appellant becomes verbally abusive and makes homicidal threats towards staff, the availability and access to lighters in his room and/or the Facility, without any oversight by staff members, presents a fire hazard and a danger to all individuals in the Facility. Despite the Facility's multiple attempts to inform and instruct the Appellant as to the Facility's rules and policies, the evidence establishes that the Appellant continued to be defiant and noncompliant, further evidence that discharge from the Facility is necessary to ensure the safety of the other residents.

VIII. CONCLUSION OF LAW

As to the Facility's issuance of the Pre-Discharge Notice, the intended involuntary discharge of the Appellant from the Facility for endangering the safety of other residents is supported by the evidence and allowed per State and Federal regulations. The Appellant was

given adequate, proper, and timely notice of the intended discharge in accordance with State and Federal regulations by means of the Pre-Discharge Notice. Furthermore, the Facility has taken appropriate steps to ensure a safe discharge.

IX. DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, it is found that a final order be entered that the regulatory criteria for involuntary discharge from a Nursing Facility has been met. The Appellant's request to nullify the 30-Day Notice is denied.

APPEAL DENIED

/s/ *Velmont Richardson*

Appeals Officer

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

CERTIFICATION

I hereby certify that I mailed, via regular mail, postage prepaid, a true copy of the foregoing to

[redacted]

[redacted]; and to Charline Scanlon, Alliance for Better Long Term Care, 422 Post Road, Suite 204, Warwick, RI 02888 on this 23rd day of APRIL, 2025.