



January 22, 2026

[REDACTED]

RE: [REDACTED] v. POCAHONTAS CENTER  
ACTION NO.: 25-BOR-3364

Dear [REDACTED]

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Office of the Inspector General and Department of Human Services. These same laws and regulations are used in all cases to ensure that all people are treated alike.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Pamela L. Hinzman  
State Hearing Officer  
Member, State Board of Review

Encl: Recourse to Hearing Decision  
Form IG-BR-29

cc: Scylar Fortin, Pocahontas Center

**WEST VIRGINIA OFFICE OF INSPECTOR GENERAL  
BOARD OF REVIEW**

[REDACTED]

**Resident,**

v.

**Action Number: 25-BOR-3364**

**POCAHONTAS CENTER,**

**Facility.**

**DECISION OF STATE HEARING OFFICER**

**INTRODUCTION**

This is the decision of the State Hearing Officer resulting from a fair hearing for [REDACTED]. This hearing was held in accordance with the provisions found in Chapter 700 of the Office of Inspector General Common Chapters Manual. This fair hearing was convened on January 14, 2026.

The matter before the Hearing Officer arises from the Facility's November 18, 2025, decision to discharge the Resident.

At the hearing, the Facility was represented by Scylar Fortin, Administrator. Appearing as a witness on behalf of the Facility was Serena Robinson, Director of Nursing. The Resident was represented by her daughter/Medical Power of Attorney, [REDACTED]. All representatives and witnesses were placed under oath and the following exhibits were admitted as evidence:

**Nursing Facility's Exhibits:**

- NF-1 Witness Statements
- NF-2 Pocahontas Center Progress Notes
- NF-3 Care Plan Meeting documentation
- NF-4 Care Plan Reports
- NF-5 MediTelecare documentation

**Resident's Exhibits:**

- R-1 Written statement of [REDACTED]
- R-2 Timeline of events
- R-3 Written statements from care providers
- R-4 Photos of Resident's bruising and wounds

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

### **FINDINGS OF FACT**

- 1) The Resident has been a patient at Pocahontas Center, a long-term care facility (hereafter, Facility) since 2024.
- 2) The Resident is 94 years old and has numerous medical diagnoses, including “Unspecified Dementia, Unspecified Severity with other Behavioral Disturbance” and “Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms” (Exhibit NF-2).
- 3) The Resident also has diagnoses of heart disease, chronic respiratory failure, chronic kidney disease, abdominal aortic aneurysm, emphysema, diverticulitis, and a history of urinary tract infections (UTIs) (Exhibit NF-2).
- 4) On November 18, 2025, the Facility issued a notice advising the Resident she would be discharged to “[REDACTED]” the residence of her daughter, [REDACTED].
- 5) The notice states that the discharge is necessary because the Resident’s needs can no longer be met at the Facility and the safety of individuals in the center is endangered due to the clinical or behavioral status of the Resident.
- 6) The Facility contends that the discharge is necessary because the Resident has refused care and has been physically and verbally combative with staff.
- 7) The Facility contends that the Resident’s daughter is not agreeable to treating the Resident with the recommended psychotropic medications to help control her behavior (Exhibit NF-3).
- 8) The Resident’s daughter has allowed the Resident to be treated with Rexulti (0.5 milligrams, once daily), an atypical antipsychotic medication, to address the Resident’s combativeness, agitation, and yelling out behaviors (Exhibit NF-3).
- 9) During her time at Pocahontas Center, the Resident had a brief stay at the [REDACTED] WV, a psychiatric treatment center, due to increased behavioral issues and multiple suicide threats (Exhibit NF-3).
- 10) The Resident has a history of refusing treatment (Exhibit NF-5).
- 11) On July 19, 2025, the Resident threw her tea at a facility employee (Exhibit NF-2).

- 12) On September 12, 2025, the Resident swung and struck a facility employee in the right cheekbone (Exhibit NF-3).
- 13) On September 24, 2025, the Resident threw her tea and lunch tray, clawed at a certified nursing assistant, and swung at the employee (Exhibit NF-3).
- 14) On September 25, 2025, the Resident was agitated and had behavioral outbursts at the facility, which included wandering the halls, yelling, and combativeness with staff members. She pulled a fire alarm and wheeled down the hallway yelling, "Fire! Fire!" The Appellant's daughter declined the Facility physician's recommendation of treatment with the antipsychotic medication Zyprexa due to its side effects (Exhibit NF-3).
- 15) On October 7, 2025, the Resident displayed combative behaviors with staff, including kicking, pinching, digging her fingernails into employees, and yelling. She threw objects, attempted to break décor at the nurse's station, and cursed staff loudly in the hallways.
- 16) The Resident was treated at [REDACTED] following the incident and was diagnosed with a UTI during her stay (Exhibit NF-3)
- 17) The Resident had a follow-up visit at [REDACTED] on November 12, 2025, at which time she was being treated for a UTI with Macrobid. It was noted that the Resident had previously grown extended-spectrum beta-lactamases (ESBL) bacteria in her urine and had required daily carbapenem injections for treatment of the previous infection (Exhibit NF-3).
- 18) The Resident was seen at [REDACTED] on November 13, 2025, with complaints of altered mental status, pain with urination, and agitation (Exhibit NF-3).
- 19) On November 15, 2025, the Resident grabbed a nurse by the back of her head, pulled her hair, and struck her in the right side of the face (Exhibit NF-2).
- 20) The Resident was seen at [REDACTED] on November 15, 2025, because of combativeness with nursing facility staff (Exhibit NF-3).
- 21) The Resident has chronic UTIs with changes in behavior and episodes of lethargy (Exhibit NF-4).

### **APPLICABLE POLICY**

#### **Code of Federal Regulations 42 CFR 483.15(c)(1):**

- (c) *Transfer and discharge* —
- (1) *Facility requirements* —

- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
- (A) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;
  - (B) The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility;
  - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
  - (D) The health of individuals in the facility would otherwise be endangered;
  - (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
  - (F) The facility ceases to operate.

**Code of Federal Regulations 42 CFR § 483.15(c)(2)(i) through (iii) *Transfer and Discharge* — *Documentation*** provides that when the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F), the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider.

The documentation in the resident’s medical record must include physician documentation of the basis for the discharge per paragraph (c)(1)(i) of this section.

**Code of Federal Regulations 42 CFR § 483.15(c)(7) *Orientation for transfer or discharge*** provides that a facility must provide and document sufficient preparation and orientation to the resident to ensure safe and orderly discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

**Code of Federal Regulations 42 CFR § 483.21(c)(1)(v) and (March 2025) *Discharge planning* — *Discharge planning process*** provides that the facility must develop and implement an effective discharge planning process that involves the interdisciplinary team in the ongoing process of developing the discharge plan.

**Bureau for Medical Services Provider Manual Section 514.8.2, Transfer and Discharge Policies:**

According to 42 CFR 483.15, transfer and discharge of an individual includes movement of a resident to a bed outside of the Medicaid-certified portion of the facility, whether that bed is in the same physical plant or not. Transfer and discharge do not refer to movement of a resident to a bed within the Medicaid-certified portion of the facility. The administrator or designee must permit each resident to remain in the facility, and not be transferred or discharged from the facility unless one of the following conditions is met:

- The transfer or discharge is necessary for the resident's welfare when the needs of the resident cannot be met in the facility; or
- The transfer or discharge is appropriate because the health of the resident has improved sufficiently that the individual no longer meets the medical criteria for nursing facility services; or
- The safety of individuals in the facility is endangered; or
- The health of individuals in the nursing facility would otherwise be endangered; or
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicaid) a stay at the nursing facility, including but not limited to, the amount of money determined by the financial eligibility evaluation as co-payment for the provision of nursing facility services; or
- The facility ceases to operate.

Documentation must be recorded in the resident's medical record by a physician of the specific reason requiring the transfer or discharge. Discharge documentation is required regardless of the reason for discharge.

**DISCUSSION**

Regulations state that nursing facility residents can be transferred or discharged when the facility can no longer meet a resident's needs and the resident's behavior endangers the safety of others in the facility. Regulations also stipulate that a resident's medical record must include physician documentation of the specific reason for discharge. In the event of an involuntary transfer, the nursing home shall assist the resident in finding a reasonably appropriate alternative placement before the proposed discharge and by developing a plan designed to minimize any transfer trauma to the resident.

On November 18, 2025, the Facility issued a notice advising the Resident that she would be discharged to her daughter's residence because the Facility could no longer meet her needs and her behavior endangered the safety of others in the Facility.

The Appellant's daughter testified that the Appellant had eight UTIs in 2025 and that UTIs are known to cause confusion, agitation, and dramatic behavior changes in some individuals. She

stated that the Appellant's UTI diagnoses coincided with the times she exhibited aggressive behaviors. She believes that the Facility should focus on the prevention of her mother's UTIs instead of suggesting psychotropic medications, which cause unwanted side effects. [REDACTED] stated that in November 2025, the facility's medical director/physician, Dr. Kelby Faulkner, did not want her mother to return to the facility and wanted to send her to the [REDACTED] for psychiatric assistance. [REDACTED] refused to send her mother to the [REDACTED] indicating that her mother's health worsened after a previous admission to that facility. [REDACTED] purported that she cannot take care of her mother at her residence, which has several stairs and utilizes a "hose and creek" water system. She stated that Pocahontas Center is the only nursing facility in the county and the only one in the area close enough for her to make daily visits.

While there are examination reports signed by the Facility's physician in the documentation provided for review, there is no specific physician documentation in the Resident's medical record concerning the basis or need for discharge from the Facility as required by policy. Therefore, the Facility's proposal to discharge the Resident cannot be affirmed.

### **CONCLUSIONS OF LAW**

- 1) A facility may involuntarily discharge a nursing home resident when the resident's behavior endangers the safety of individuals in the facility or when the resident's needs cannot be met at the facility.
- 2) The basis for discharge must be documented in the resident's medical record by a physician.
- 3) Evidence fails to demonstrate that the basis for discharge was specifically documented in the Resident's medical record by her physician.
- 4) The Facility has failed to comply with regulations concerning the proposed discharge of the Resident.

### **DECISION**

It is the decision of the State Hearing Officer to **REVERSE** the Facility's action to discharge the Resident.

**ENTERED this 22nd day of January 2026.**

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**Pamela L. Hinzman  
State Hearing Officer**