March 10, 2026

[redacted]

RE: [redacted] GENESIS HEALTHCARE PIERPONT CENTER
ACTION NO.: 26-BOR-1233

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 DEPARTMENT OF HUMAN SERVICES (DoHS). These same laws and regulations are used in all cases to ensure that all persons 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,

Tara B. Thompson, MLS
Certified State Hearing Officer
Member, State Board of Review

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

cc: Brian Bazykak, Facility Administrator

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 26-BOR-1233**

GENESIS HEALTHCARE
PIERPONT 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 March 3, 2026.

The matter before the Hearing Officer arises from the Facility's February 2026 decision to discharge the Resident.

At the hearing, the Facility appeared by Brian Bazylak, Facility Administrator. Appearing as a witness for the Facility was Aimie Huggins (Ms. Huggins), Facility Social Worker. The Resident appeared by [redacted] All witnesses were placed under oath, and the following documents were admitted into evidence.

Facility's Exhibits:
None
Resident's Exhibits:
None

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 appointed durable power of attorney responsibilities to [redacted]

2) On February 2, 2026, the Facility informed [redacted] via telephone that the Resident would be discharged because of ongoing non-compliance with the Facility's smoking policy.

3) The Facility's February 2, 2026 decision to discharge the Resident was an involuntary discharge.

4) The Facility did not supply [redacted] or the State Long-Term Care Ombudsman with a copy of the Resident's discharge notice.

5) The Facility did not inform [redacted] of a proposed discharge location.

6) Ms. Huggins testified that the discharge decision was determined by Facility administration and the nursing director.

7) Ms. Huggins testified that the Appellant's discharge was safer for the other residents.

8) [redacted] discovered the appeal process through her own research.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.15(c)(1)(i)(C) ***Transfer and Discharge requirements*** **and West Virginia Code § 64-13-4(13)(b)(3)** ***Admission, Transfer, and Discharge*** provide that the Facility must permit each resident to remain in the facility and not discharge the resident from the facility unless the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

Code of Federal Regulations 42CFR § 483.15(c)(2)(i) through 483.15(c)(2)(ii)(B) ***Documentation*** provides that when the facility discharges a resident because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, the facility must ensure that the discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

Documentation in the resident's medical record must include documentation made by the resident's physician and the basis for the discharge.

Code of Federal Regulations 42 CFR § 483.15(c)(3) ***Notice before transfer*** instructs that before a facility discharges a resident, the facility must — …

> (ii) Record the reasons for the transfer or discharge in a resident's medical record in accordance with paragraph (c)(2) of this section; and
> (iii) Include in the notice the items described in paragraph (c)(5) of this section.

West Virginia Code §§ 64-13-4(13)(c)(1) – 64-13-4(13)(d)(3) ***Documentation*** provides that when a nursing home discharges a resident, the resident's clinical record shall contain the reason for the transfer or discharge. The documentation shall be made by the resident's physician when discharge is necessary under the provisions of this rule.

Before a nursing home transfers or discharges a resident, it shall provide written notice to the resident of the discharge. The notice shall include the reason for the proposed discharge and the location to which the resident is being discharged.

Code of Federal Regulations 42 CFR § 483.15(c)(5) ***Contents of the Notice*** provides that the written notice must include:

> (i) The reason for transfer or discharge;
> (ii) The effective date of transfer or discharge;
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
> (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; …

West Virginia Code of State Rules §§ 64-13-4(13)(6)(b) and 64-13-4(13)(7)(1) provide that when involuntarily discharging a resident, the nursing home must assist the resident in finding a reasonably appropriate alternative placement before the proposed discharge and develop a plan designed to minimize any transfer trauma to the resident. The plan may include counseling the resident regarding available community resources and taking steps under the nursing home's control to ensure safe relocation.

A nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his will.

DISCUSSION

On February 2, 2026, the Facility determined the Resident must be discharged because the safety of the individuals in the facility was endangered due to the Resident's non-compliance with the smoking policy. At the time of the decision, the Facility had not determined a proposed discharge location for the Resident. The Resident's representative contested the proposed discharge, argued that proper advanced notice was not issued, and contended that the Resident still required the Facility's services.

The Facility has the burden of proof and must demonstrate by a preponderance of evidence that at the time of the February 2, 2026 discharge decision, the Resident's behavior endangered other individuals in the facility and that the Resident's physician documented the basis for discharge.

The Facility had to prove that it assisted the Resident in finding a reasonably appropriate alternative placement before the proposed discharge decision and included the location on the discharge notice. Further, the Facility had to demonstrate that the discharge notice was properly issued and contained all of the required information.

Health and Safety

The Regulations permit facilities to discharge a resident when the safety of individuals in the facility is endangered due to the behavioral status of the resident. When residents are discharged for this reason, documentation in the resident's medical record must include the basis for the resident's discharge. Pursuant to the regulations, the resident's physician must make the documentation.

During the hearing, the Facility offered testimonial evidence regarding the Resident's non-compliance with the smoking policy. No documentary evidence was submitted to verify that the Resident's physician documented the basis for the Appellant's discharge in the medical record. Further, the testimonial evidence indicated that the Facility administrator and nursing director determined that the Resident should be discharged, not the Resident's physician.

The preponderance of evidence failed to demonstrate that the Resident's physician documented the reason for discharge in the Resident's record. Without physician documentation of the reason for the Resident's discharge, the Facility's decision to discharge the Resident cannot be affirmed.

Discharge Location

According to the regulations, when a resident is involuntarily discharged, the Facility must assist the Resident in finding a reasonably appropriate alternative placement before the proposed discharge and include the location on the discharge notice. During the hearing, the Facility witnesses testified that they were seeking a discharge location.

The Resident's representative argued that the Resident still required facility services and testified that she was attempting to identify an appropriate discharge location for the Appellant and had reached out for assistance from the Facility but received no response. Because the preponderance of evidence failed to prove the basis for the Facility's discharge, the issue of the location of discharge is moot. However, the Facility should take note of the regulatory requirement to make reasonable efforts to align discharge arrangements and include the proposed discharge location on the notice.

Notice

Pursuant to the regulations, the notice of discharge must include the reason for the discharge, the effective date of discharge, the location to which the resident will be discharged, information about the resident's appeal rights, and contact information for the State Long-Term Care Ombudsman. The Resident's representative testified that the Resident did not recall receiving the notice and that she was not provided with a copy.

During the hearing, the Facility witnesses testified that the Resident was provided with a copy of the notice but because he has capacity, his representative was not provided with a copy. Further, the Facility administrator testified that the State Long-Term Care Ombudsman was not copied on the notice.

A copy of the notice was not submitted for evidentiary review. Therefore, it cannot be affirmed that the Facility met the notification requirements outlined in the policy. As the basis for the Facility's discharge decision was not proven, the issue of proper notification is moot. However, the Facility should ensure that future notices of discharge reflect all required information relevant to the notification regulations.

CONCLUSIONS OF LAW

1) The Facility may involuntarily discharge a resident when the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident and the reason for discharge is documented in the Resident's medical record by a physician.

2) The preponderance of evidence failed to demonstrate that the reason for discharging the resident was documented in the Resident's medical record by a physician.

3) The preponderance of evidence failed to demonstrate that the safety of individuals in the facility was endangered by the Resident's violation of the Facility's smoking policies.

4) Because the Facility failed to prove that the Resident was eligible for discharge, the matter of discharge notice and location of discharge are moot.

5) The Facility incorrectly acted to discharge the Resident.

DECISION

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

ENTERED this 10th day of March 2026.

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Tara B. Thompson, MLS
Certified State Hearing Officer