April 23, 2026

[redacted]

RE: [redacted] v. PINE LODGE
ACTION NO.: 26-BOR-1626

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. 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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

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

cc: Dave Conaway, Pine Lodge

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 26-BOR-1626**

PINE LODGE,

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 April 21, 2026.

The matter before the Hearing Officer arises from the March 23, 2026, decision by the Facility to discharge the Resident from Pine Lodge.

At the hearing, the Facility appeared by Pamela Sodosky, Social Worker with Pine Lodge. Appearing as a witness for the Facility was Megan Bragg, RN with Pine Lodge. The Appellant was self-represented. The 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 resides at Pine Lodge nursing facility.

2) On March 22, 2026, the Resident was smoking marijuana with another resident on the front porch of the nursing facility.

3) The Resident assisted the other facility resident, who is paralyzed, with smoking marijuana.

4) On March 23, 2026, the Facility issued a 30-Day Notice of Discharge to the Resident.

5) The Facility is pursing the discharge as the Resident's actions endanger the health and safety of the other residents.

APPLICABLE POLICY

Code of Federal Regulations – 42 CFR §483.15(c) provides that the nursing facility 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:

(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.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of

the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

(**2) *Documentation*. *When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, 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.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by

(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section*;* and

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must -

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the 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.

(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when -

- The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
- The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
- The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
- An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
- A resident has not resided in the facility for 30 days.

(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(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;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000; and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

DISCUSSION

Federal regulations permit the involuntary discharge of a resident if the discharge is appropriate because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident or the health of individuals in the facility would otherwise be endangered. The Facility issued a 30-Day Discharge notice to the Resident when it determined the Resident's behavior endangered the health and safety of other residents in the facility.

Megan Bragg, nurse with Pine Lodge, testified that she was caring for another resident on March 22, 2026, when she observed the Resident smoking marijuana on the outside porch. Ms. Bragg stated the Resident offered and assisted another resident with smoking marijuana. Ms. Bragg testified that when she confronted the Resident, he extinguished the marijuana cigarette and relinquished it to her care. Ms. Bragg stated the police were contacted about the incident.

Pamela Sodosky, social worker with Pine Lodge, testified that Resident's actions violated the no smoking policy of the Facility and endangered the safety of the resident with whom he provided the marijuana. Ms. Sodosky contended that referrals for the Resident to be transferred to another nursing facility have been made, but she has yet to find an alternate placement.

The Resident did not dispute that he was in possession of marijuana but argued that although he assisted the other resident with smoking marijuana, the resident accepted willingly. The Resident argued the unfairness of his proposed discharge when the other resident was not punished for smoking marijuana.

Federal regulations stipulate that the resident's medical record must include documentation by the physician if the involuntary discharge is appropriate because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the Resident or the health of individuals in the facility would otherwise be endangered. A facility must also provide and document sufficient preparation and orientation to ensure the Resident is safely discharged from the facility.

The Facility failed to provide any evidence for the hearing, including physician documentation in the Resident's medical record that his actions endangered the health or safety of others residing in the facility. No records were provided documenting the efforts made by the Facility to ensure a safe discharge.

Whereas the Facility failed to follow regulatory requirements in the involuntary discharge of the Resident, the Facility's proposed discharge cannot be affirmed.

CONCLUSIONS OF LAW

1) A resident's medical record must include physician documentation of the reason for an involuntary discharge.

2) There was no evidence presented of physician documentation in the Resident's medical record of the reason for the discharge.

3) A facility must provide and document sufficient preparation and orientation to a resident to ensure a safe and orderly transfer or discharge from the facility.

4) No records were provided documenting the efforts made by the Facility to ensure a safe discharge.

5) The Facility failed to follow federal regulations in the proposed discharge of the Resident.

DECISION

It is the decision of the State Hearing Officer to **reverse** the proposal of Pine Lodge in the involuntary discharge of the Resident from its facility.

ENTERED this 23rd day of April 2026.

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Kristi Logan
Certified State Hearing Officer