STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
Board of Review
State Capitol Complex
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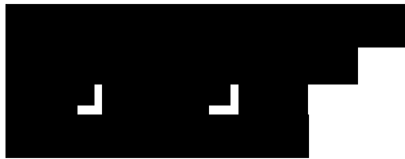
July 12, 2019



RE: V.
ACTION NO.: 19-BOR-1583

Dear Ms.

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 Health and Human Resources. These same laws and regulations are used in all cases to assure 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,

Todd Thornton
State Hearing Officer
Member, State Board of Review

Encl: Resident's Recourse to Hearing Decision
Form IG-BR-29

cc: Administrator,

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[REDACTED],

Resident,

v. **Action Number: 19-BOR-1583**

[REDACTED],

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 West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on May 29, 2019, on an appeal filed April 16, 2019.

The matter before the Hearing Officer arises from the April 1, 2019 decision by the Facility to propose involuntary discharge of the Resident.

At the hearing, the Facility appeared by [REDACTED]. Appearing as witnesses for the Facility were [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. The Resident was represented by [REDACTED], Regional Ombudsman. Appearing as witnesses for the Resident were [REDACTED] and [REDACTED].

All witnesses were sworn and the following documents were admitted into evidence.

Nursing Facility's Exhibits:

F-1 [REDACTED] Progress Notes and medical documentation
F-2 Pre-Admission Screening (PAS) dated February 11, 2019
F-3 Pre-Admission Screening (PAS) dated February 19, 2019
F-4 [REDACTED] medical documentation

Resident's Exhibits:

R-1 30 Day Notice of Discharge, dated April 1, 2019
R-2 Code of Federal Regulations, 42 CFR §483.15
R-3 Code of State Regulations, §64-13-4 (excerpt)
R-4 [REDACTED] Progress Notes
R-5 Pre-Admission Screening (PAS) dated February 19, 2019
R-6 Medical examination notes, [REDACTED], MD
Visit dates March 21, 2019 and March 28, 2019

FINDINGS OF FACT

1) [redacted] (hereinafter "Facility") advised the Resident by notice dated April 1, 2019 (Exhibit R-1) of its intent to initiate involuntary transfer or discharge proceedings.

2) The Notice of Discharge (Exhibit R-1) advised the Resident that involuntary discharge from the Facility was necessary because "The resident's needs cannot be met by the facility."

3) The Notice of Discharge (Exhibit R-1) makes the following unclear statement:

   The above named [*sic*] resident will be discharged to:
   placement can meet all safety and health care needs of resident or home.

4) The Notice of Discharge (Exhibit R-1) does not include the location or other nursing home to which the resident is being transferred or discharged.

5) Facility staff documented three (3) observations of the Resident which were characterized as "persistent anger with self or others" prior to the April 1, 2019 decision to discharge. (Exhibit F-1, Mood Indicators table, entries dated March 28, 2019, March 29, 2019, and March 30, 2019)

6) Facility staff documented at least seven (7) observations of the Resident prior to the decision to discharge which were characterized as "physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)." (Exhibit F-1, entries dated March 22, 2019, March 23, 2019, March 24, 2019, March 28, 2019, March 29, 2019, and March 30, 2019)

7) Facility staff attempted non-pharmaceutical methods for redirecting the Resident and reducing these behaviors by the Resident.

8) Facility staff recommended the Resident's family visit the Resident more frequently based on their belief it would reduce the behaviors by the Resident.

9) Progress Notes from the Facility indicate the Resident was admitted to the Facility on February 13, 2019. (Exhibit R-4)

10) Progress Notes from the Facility also indicate the Resident was readmitted to the Facility on March 14, 2019. (Exhibit F-1)

11) Pre-Admission Screenings (Exhibits F-2 and F-3) of the Resident from February 11, 2019 and February 19, 2019, documented the Resident's diagnosis of dementia.

12) A Progress Note from [redacted] regarding the Resident completed by [redacted], DO, on March 9, 2019, noted the Resident was "…calm and cooperative at this time however can quickly escalate, become agitated for not apparent reason and begin yelling." (Exhibit F-4)

13) A Physician Evaluation from [redacted] regarding the Resident completed by [redacted], MD, on February 15, 2019, noted the Resident "…has been yelling, hitting and spitting on staff since being admitted to the unit…She has had several minor episodes of agitation over the past few months, which were effectively treated with Risperdal 0.5mg twice daily as needed. Otherwise, she has never experienced an episode of agitation/psychosis as severe as this one." (Exhibit F-4)

14) [redacted], MD, a physician from the Facility, noted the following (Exhibit R-6) regarding a visit with the Resident on March 21, 2019:

> Today she responded to my questions and let me examine her without resisting. This seems to be an improvement. She is on maximal medical therapy for her dementia and I don't think I can make any changes. If her behaviors persist, she may be better suited for a dedicated Alzheimers [*sic*] unit. The quieter unit may help. There is a lot of activity here and she is getting skilled services. Our facility may be too stimulating for her.

15) Dr. [redacted] noted the following (Exhibit R-6) regarding a March 28, 2019 visit with the Resident:

> I had a long discussion with family today. [Resident] continues to display aggressive behaviors. She is already on quite a bit of psychiatric medication and I hesitate to increase anything due to risk of sedation/falls. I recommend transfer to another facility that is quieter. I think this facility is too stimulating and contributes to her agitation.

16) The Facility did not locate a reasonably appropriate alternative placement for the Resident prior to the proposed discharge.

17) The Facility did not develop a plan to minimize transfer trauma to the Resident or to ensure safe and orderly discharge.

APPLICABLE POLICY

Medicaid regulations, found in the Code of Federal Regulations (42 CFR §483.15) provide 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:

Section 483.15(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 when the needs of the resident cannot be met in the facility; or
- (B) The transfer or discharge is appropriate because the health of the resident has improved sufficiently so the resident no longer needs the services provided by the facility; or
- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; or
- (D) The health of individuals in the nursing facility would otherwise be endangered; or
- (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.

(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.

Documentation in the resident's medical record must include:

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

(3) **Notice before transfer**. Before the nursing 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.

(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 (b)(5) of this section.

(4) **Timing of the notice.**

(1) Except as specified in paragraphs (b)(4)(ii) and (b)(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.

(5) **Contents of the notice.**

The written notice specified in paragraph (b)(3) of this section must include the following:

The effective date of the transfer or discharge;

- Reason for transfer or discharge;
- The effective date of the discharge;
- The location to which the resident is transferred or discharged;
- A statement that the resident has the right to appeal the action to the State;
- The name, address and telephone number of the office of the State Long-Term Care Ombudsman;
- The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled and mentally ill individuals.

Title 64 – Legislative Rules, West Virginia Division of Health – Series 13, Nursing Home Licensure Rule, at §64-13-4, provide additional requirements regarding the rights of nursing facility residents.

4.13.b. Transfer and discharge requirements. The nursing home shall permit each resident to remain in the nursing home, unless:

…

4.13.b.1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home;

…

4.13.c. Documentation.

4.13.c.1. When a nursing home transfers or discharges a resident, the resident's clinical record shall contain the reason for the transfer or discharge.

4.13.c.2. The documentation shall be made by the resident's physician when transfer or discharge is necessary under paragraphs 4.13.b.1 through 4.13.b.3 of this Subsection.

…

4.13.f. Orientation for Transfer or Discharge.

4.13.f.1. A nursing home shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the nursing home.

4.13.f.2. Involuntary Transfer. In the event of an involuntary transfer, the nursing home shall assist the resident or legal representative or both in finding a reasonably appropriate alternative placement prior to the proposed transfer or discharge and by developing a plan designed to minimize any transfer trauma to the resident.

4.13.f.2.A. The plan may include counseling the resident, or legal representative or both regarding available community resources and taking steps under the nursing home's control to assure safe relocation.

4.13.g. Discharge to a Community Setting.

4.13.g.1. A nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his or her will.

DISCUSSION

The Resident requested a fair hearing based on the decision of the Facility to propose involuntary discharge of the Resident. The Facility must show by a preponderance of the evidence that the Facility met all requirements for involuntary discharge of the Resident.

The Facility failed to meet the notification requirements to involuntarily discharge a nursing facility resident. The Facility may not discharge a resident to a community setting against their will, and "placement can meet all safety and health care needs of resident or home" is not a transfer or discharge location; at best, it is an unclear statement that alludes to a category of possible transfer or discharge locations. The Facility did not provide a discharge notice prior to the hearing or as evidence during the hearing. The copy of the discharge notice provided by the Resident (Exhibit R-1) not only fails to provide a specific discharge location but fails to do so "…in a language and manner they understand." (42 CFR §483.15(c)(3)(i))

The Facility proposed discharge of the Resident because the resident's "…needs cannot be met by the facility," (Exhibit R-1) which is an allowable basis for discharge when documentation from the Resident's physician provides the reason for discharge. Testimony and evidence provided examples of unwanted behaviors on the part of the Resident, and methods used to redirect those behaviors with varying degrees of success.

When the Resident was seen by [redacted], MD, on February 15, 2019, her behaviors were described as "minor episodes of agitation" which he indicated were effectively treated with medication. The Resident was seen twice by [redacted], MD, a physician from the Facility, prior to proposed discharge (Exhibit R-6) and commented on the Resident in a section of his reports under the heading "Plan." These comments are more of an equivocation than a recommendation. In his comments from the March 21, 2019 visit, the physician qualifies or questions his own assertions four times ("…**seems** to be an improvement…**I don't think** I can make any changes…she **may** be better suited for a dedicated Alzheimers [*sic*] unit…The quieter environment **may** help…facility **may** be too stimulating…") (emphasis added) before concluding one week later that the Resident should be involuntarily transferred "…to another facility that is

quieter…" because "…this facility is too stimulating and contributes to her agitation" without explanation of what changed his mind in the interim. Even if the recommendation from the Facility physician were convincing, it does not support discharge to an unspecified nursing facility.

The Facility did not provide sufficient preparation and orientation to the Resident to ensure safe and orderly transfer or discharge from the nursing home because there is no way to ensure safe discharge to an unspecified location when the Resident requires a nursing facility level of care. The Facility did not specify a location that met the apparent recommendation of Dr. [redacted] for a nursing facility that is "quieter" and less "stimulating." The Facility discussed possible nursing facilities with the Appellant's family; however, these locations either did not have beds available or were too far away for regular family visits. Such a facility would be able to provide all the methods used by this Facility to redirect the Resident's documented behaviors with the exception of regular family visits. It is contradictory to claim regular family visits help to reduce behaviors and to claim the Resident would be better served in a facility too distant to accommodate such visits.

Based on the Facility's failure to meet nursing facility discharge notification requirements, the Facility's unconvincing documentary support of its discharge basis, and its failure to provide sufficient preparation and orientation for discharge, the Facility's proposal to discharge the Resident is incorrect.

CONCLUSIONS OF LAW

1) Because the Facility did not meet the notification requirements for a discharge location or for language and a manner that can be understood, the Facility may not discharge the Resident.

2) Because the Facility did not provide documentary support for its claim that the needs of the Resident cannot be met in the Facility, the Facility may not discharge the Resident.

3) Because the Facility did not meet the requirements for sufficient preparation and orientation to ensure safe and orderly transfer or discharge, the Facility may not discharge the Resident.

DECISION

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

ENTERED this ______ Day of July 2019.

____

Todd Thornton
State Hearing Officer