STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL

Bill J. Crouch
Cabinet Secretary

Board of Review
State Capitol Complex
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Jolynn Marra
Interim Inspector General

June 3, 2020

Delivered to Resident via email

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 20-BOR-1290

Dear Ms. [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 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: [redacted], Facility Administrator

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 20-BOR-1290**

[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 April 24, 2020, on an appeal filed February 26, 2020.

The matter before the Hearing Officer arises from the January 28, 2020 decision by the Facility to discharge the Resident from the Facility based on the safety of other individuals.

At the hearing, the Facility appeared by [redacted]. Appearing as a witness for the Facility was [redacted]. The Resident was present and represented by [redacted], Regional Ombudsman, Legal Aid of West Virginia. All witnesses were sworn and the following documents were admitted into evidence.

EXHIBITS

Nursing Facility's Exhibits:

None

Resident's Exhibits:

R-1	[redacted] Notice of Transfer or Discharge, dated January 28, 2020
R-2	Code of Federal Regulations, 42 CFR 483 §483.15(c)
R-3	Code of State Rules, 64 CSR 13 §§64-13-4.13.b - §§64-13-4.13.g

R-4 Pre-Admission Screening (PAS) form
Date of Physician Assessment: December 7, 2011

R-5 [redacted] (WV) Progress Notes regarding the Resident
Entry dates: January 1-4, 2020; February 21-24, 2020

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 in a nursing facility, [redacted] (hereinafter "Facility").

2) The Facility conducted a search of the Resident's room on January 27, 2020.

3) During this search, Facility staff discovered a cigarette lighter, a pipe, and a "small quantity of marijuana" in the Resident's possession.

4) The Facility reported this information to the [redacted] Police Department ([redacted]).

5) On January 28, 2020, Facility staff and an [redacted] Officer discovered the Resident smoking marijuana outside the facility.

6) The Facility issued a 30-day notice of discharge to the Resident on January 28, 2020. (Exhibit R-1)

7) This notice (Exhibit R-1) reads, "Due to reason indicated below a discharge or transfer from this facility will be necessary," and a checkbox is marked for the reason, "The safety of other individuals in the facility is endangered."

8) The notice (Exhibit R-1) indicates the Resident was advised verbally and in writing on January 28, 2020 and lists the "effective date of the transfer" as February 29, 2020.

9) The notice (Exhibit R-1) shows the "destination of transfer" as "unknown."

10) Subsequent to the discharge notification, the Facility has conducted "thirty-minute safety checks" to confirm the Resident does not have smoking materials in his possession while in his room.

11) The Resident has complied with the safety checks, and the safety checks have not revealed any further infractions of the Facility's smoking policy.

12) On December 7, 2011, [redacted], MD, certified the medical needs of the Resident on a Pre-Admission Screening (PAS) form. (Exhibit R-4)

13) The physician's recommendations section of the PAS regarding the Resident includes the following prompt regarding nursing facility placement, "On the basis of present medical findings, the [Resident] may eventually be able to return home or be discharged," and is marked, "No." (Exhibit R-4, Item #38.A)

14) The second physician's recommendation section from the December 7, 2011 PAS regarding the Resident includes the statement, "I recommend that the services and care to meet these needs can be provided at the level of care indicated," and is marked, "Nursing Home." (Exhibit R-4, Item #38.B)

15) The Facility referred the Resident to the Take Me Home, West Virginia – or Take Me Home (TMH) Transition Program – on two separate occasions.

16) Both TMH referrals were unsuccessful, and the second referral was concluded on or about July 25, 2019.

17) Facility Progress Notes (Exhibit R-5) regarding the Resident include a February 21, 2020 entry which reads, "Referral for City Mission sent. Ombudsman updated and suggested this SW contact DHHR Home Finder. Attempted to contact and left voicemail for return call. Also attempted to contact Rapid Rehousing staff from [redacted]. Voicemail left for return call."

18) The Facility Progress Notes regarding the Resident did not include physician documentation that the proposed discharge is necessary. (Exhibit R-5)

19) The Facility Progress Notes regarding the Resident did not include or reference a plan to minimize the transfer trauma to the Resident. (Exhibit R-5)

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.3. The health or safety of persons in the nursing home is endangered;
…
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 the provisions of this rule.
…
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. 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 has appealed the Facility's decision to discharge the Resident. The Facility's decision is based on its determination that (Exhibit R-1) the "safety of other individuals in the facility is endangered." The Facility must show by a preponderance of the evidence that it properly implemented all discharge procedures on this basis.

The Resident was found in possession of marijuana and smoking materials on January 27, 2020. The Resident was discovered smoking marijuana outside the nursing facility the following day. The Resident has complied with "safety checks" since that time without any further infractions of the Facility's smoking policy. Smoking presents a risk of fire and nursing facilities regularly house individuals with breathing difficulties. The actions of the Resident indicate an apparent risk to the safety of other individuals in the nursing facility; however, this risk must be documented by a physician in the Resident's documentation. It is also unclear from evidence and testimony that the Resident's behavior presents an ongoing risk, since he has been compliant with Facility requirements since the second violation.

Before discharging an individual for any reason, a nursing facility must provide notice to a resident which includes several elements. The notice to the Resident (Exhibit R-1) was deficient because it listed a transfer location of "unknown," which is effectively the same as no location at all. The physician recommendations for the Resident (Exhibit R-4) noted the Resident would not be able to return home or be discharged, and additionally certified the Resident as requiring a nursing home level of care. These factors suggest a medical need for transfer to another nursing facility.

For an involuntary transfer, the Facility was required to assist the Resident in locating "…reasonably appropriate alternative placement," develop a plan to minimize transfer trauma, and include physician documentation of the safety threat posed by the Resident to others in the facility. Testimony confirmed the Facility's attempts to find alternative placement in 2019, and indicated the Resident was uncooperative with more recent attempts. Testimony and evidence did not show a plan to minimize the Resident's transfer trauma or the required physician documentation.

Because it is unclear that the Resident has established an ongoing pattern of behavior requiring nursing facility transfer – established by physician documentation as a threat to the safety of other individuals – and because the Facility did not develop a plan to address transfer trauma, and because the Facility did not provide adequate notification, the Facility's decision to discharge the Resident cannot be upheld.

CONCLUSIONS OF LAW

1) Because the Facility notification to the Resident is deficient, the Facility must not discharge the Resident.

2) Because the Resident requires a nursing home level of care, the Facility must specify a transfer location meeting that requirement.

3) Because the Facility did not develop a plan to minimize transfer trauma to the Resident in conjunction with an involuntary transfer, the Facility must not discharge or transfer the Resident.

4) Because the Facility did not document a physician statement regarding the safety threat posed by the Resident's actions, the Facility must not discharge or transfer the Resident based on the safety of other individuals in the facility.

DECISION

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

ENTERED this ____Day of June 2020.

_____

Todd Thornton
State Hearing Officer