State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
1027 N. Randolph Ave.
Elkins, WV 26241

Bill J Crouch
Cabinet Secretary

Jolynn Marra
Interim Inspector General

October 30, 2020

[redacted]

RE: [redacted] V. [redacted]
ACTION NO.: 20-BOR-2198

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,

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

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

cc: [redacted], MPOA
[redacted], Administrator, [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 20-BOR-2198**

[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 October 27, 2020, on an appeal filed September 21, 2020.

The matter before the Hearing Officer arises from the September 15, 2020 decision by the Facility to propose involuntary discharge of the Resident.

At the hearing, the Facility appeared by [redacted], Administrator, [redacted]. Appearing as a witness for the Facility was [redacted], Social Worker, [redacted]. The Resident was represented by [redacted], Regional Ombudsman, Legal Aid of West Virginia. Appearing as a witness for the Resident was [redacted], Resident's son and Medical Power of Attorney.

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

Nursing Facility's Exhibits:
NF-1 Nursing Notes
NF-2 Social Notes

Resident's Exhibits:
R-1 Physician's Determination of Capacity
R-2 Notice of Discharge dated September 15, 2020
R-3 Psychiatric Diagnostic Evaluation dated May 14, 2020
R-4 Letter from [redacted], M.D., dated August 8, 2020
R-5 Medical Power of Attorney Order dated August 14, 2013
R-6 Admission Agreement dated June 8, 2020
R-7 Resident's Plan of Care

FINDINGS OF FACT

1) [redacted], hereinafter Facility, provided written notification to the Resident of its intent to initiate involuntary transfer or discharge proceedings on September 15, 2020 (R-2).

2) The Notice of Discharge advised the Resident, who is mentally incapacitated (R-1), that involuntary discharge from the Facility was necessary because of the Resident's attempts at self-harm and elopement and the Facility's inability to provide one-on-one care.

3) The Notice of Discharge states that the Resident will be discharged on October 16, 2020. No discharge location was noted.

4) The Facility contends that the transfer is necessary because the Resident has attempted self-harm and elopement from the Facility. As a result, the Facility believes it can no longer meet the Resident's safety needs.

5) On September 6, 2020, the Resident climbed onto her dresser and removed a clock from the wall (NF-2). She stomped on the clock face in her socks, breaking the glass, and stated, "If I break my feet, I can get out of here."

6) On September 11, 2020, the Resident climbed onto her bed and removed the screen from her window (NF-2). The Resident had packed her belongings and stated that she was "going to get out of here if I have to break my neck. It would be better than living here for the rest of my life."

7) On September 15, 2020, the Resident removed the screen and crank from her window and struck the window with her tennis shoe, indicating that she was "going to escape from here" (NF-2). The Resident poured water on the floor so that staff members would fall if they attempted to enter the room.

8) The Resident's medication was adjusted as a result of the incidents and no further safety or self-harm-related incidents have been reported since that time.

APPLICABLE POLICY

Medicaid regulations, found in the Code of State Regulations (64 CSR 13) and 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:

- 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.

Physician documentation must be recorded in the resident's medical record regarding the specific reason the resident requires transfer or discharge. Discharge documentation is required regardless of the reason for discharge.

Before the nursing facility transfers or discharges a resident, the administrator or designee must notify the resident and/or the responsible party in writing, in a language that is understandable to the parties, of the intent and reason for transfer or discharge. The same information must be recorded in the resident's medical record, and a copy of this written notice must be sent to the State Long-Term Care Ombudsman or his/her designee. Except in the case of immediate danger to the resident and/or others as documented, the notice of transfer or discharge must be provided at least 30 days prior to the anticipated date of transfer or discharge.

Waiver of this 30-day requirement may be appropriate if the safety of individuals in the facility would be endangered, the immediate transfer is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days.

The written notice must include the following:

- The effective date of the transfer or discharge;

- Reason for the discharge;

- The location or person(s) to whom 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 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.

DISCUSSION

State and federal regulations specify that a nursing facility can involuntarily transfer/discharge an individual if the transfer or discharge is necessary due to health and safety risks or because a facility cannot meet a resident's needs. Documentation must be recorded in the resident's medical record - by a physician - of the specific reason requiring the transfer or discharge. The Notice of Discharge must include the location to which the resident will be discharged, as well as contact information for advocacy agencies.

The Facility contended that it issued the Notice of Discharge because it could not provide one-on-one care to the Resident to ensure her safety. [redacted], Social Worker, testified that the Resident's behavior has improved since her medication was adjusted.

[redacted], Ombudsman for Legal Aid of West Virginia, indicated that there is no physician documentation in the Resident's record concerning the reason for transfer or discharge. In addition, the Notice of Discharge contains no appeal information, provides no contact information for the ombudsman, and includes no contact information for advocacy agencies. The Notice contained no information about the location to which the Resident would be discharged, but indicated that the Facility would assist with discharge arrangements.

CONCLUSION OF LAW

1) State and federal regulations require that physician documentation – including the specific reason a nursing facility resident requires transfer or discharge - must be included in the resident's medical record.

2) There is no physician documentation of the reason for the Resident's discharge in her case record.

3) The Notice of Discharge must include the location to which a resident will be transferred or discharged, must contain appeal information, and must provide contact information for the regional ombudsman and agencies that provide advocacy for developmentally disabled or mentally ill persons. None of this information was included in the Notice of Discharge issued by the Facility.

4) As the Resident did not receive a proper Notice of Discharge - and there is no specific physician documentation concerning why the Resident requires transfer or discharge - the Facility's proposal to discharge the Resident cannot be affirmed.

DECISION

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

ENTERED this _____ Day of October 2020.

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Pamela L. Hinzman
State Hearing Officer