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

January 24, 2019

[redacted]

RE: [redacted] V. [redacted]
ACTION NO.: 19-BOR-2669

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: Administrator, [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 19-BOR-2669**

[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 originally convened on December 5, 2019, and was reconvened on January 9, 2020 on an appeal filed November 4, 2019.

The matter before the Hearing Officer arises from the October 21, 2019 decision by the Facility to propose involuntary discharge of the Resident.

At the hearing, the Facility appeared by [redacted], Social Worker; [redacted], Registered Nurse/Assessment Coordinator; [redacted], Social Worker; [redacted], Facility Rehabilitation Coordinator; [redacted], Clinical Care Specialist; [redacted], Nurse Coordinator; [redacted], RN; and [redacted], Director of Nursing. The Resident was present at the hearing and was represented by [redacted], his wife.

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

Nursing Facility's Exhibits:

- NF-1 Progress Notes
- NF-2 30 Day Notice of Discharge dated October 21, 2019
- NF-3 Progress Notes
- NF-4 Application for Involuntary Custody for Mental Health Examination dated October 14, 2019
- NF-5 Documentation signed by [redacted], DO, concerning telephone call he received from [redacted]

Resident's Exhibits:

- R-1 Medical Consultations Reports
- R-2 Nursing home discharge information

FINDINGS OF FACT

1) [redacted], hereinafter Facility, provided written notification to the Resident of its intent to initiate involuntary transfer or discharge proceedings on October 21, 2019 (NF-2).

2) The Notice of Discharge advised the Resident, who has been diagnosed with bipolar disorder, that involuntary discharge from the Facility was necessary because "the resident endangers the health and/or safety of other residents in the facility." (NF-2)

3) The Notice of Discharge states that the Resident will be discharged to his home.

4) The Facility documented numerous incidents on its Progress Notes (NF-3) in which the Resident's behavior was disruptive, inappropriate, verbally abusive or threatening.

5) On October 7, 2019, the Resident became verbally abusive with Social Worker [redacted]. The Resident was non-compliant with a medical order concerning the amount of weight he could bear, and refused to use his walker or allow staff to assist him.

6) On October 10, 2019, the Resident screamed from his room for assistance and was advised to use his call button. The Resident threatened to strike a nurse if he was not allowed to go to the vending machine for candy.

7) On October 11, 2019, the Resident demanded that antifungal medication be applied repeatedly to his scrotum above the prescribed daily limit. The Resident refused to turn down his loud television set, and yelled instead of using his call bell.

8) On October 12, 2019, the Resident yelled at staff and demanded snacks throughout the night. The Resident demanded that antifungal powder be applied to his scrotum multiple times beyond the prescribed daily limit.

9) On October 13, 2019, Clinical Care Supervisor [redacted] was called to the Facility due to the Resident's explosive behavior, including yelling and cursing at staff and attempting to elope barefoot out of the building. The Resident indicated that he wanted to get to the road so that he could be hit by a car. The [redacted] Emergency Squad was called; however, the Resident refused to be transferred to [redacted] for an evaluation and said that he would go live under a bridge or jump off a bridge. The behavior prompted the Facility to file a petition for a mental hygiene hearing for the Resident due to his threats of self-harm (NF-4). The Resident was determined to be competent and returned to the Facility.

10) On October 14, 2019, a nurse assisted the Resident in the restroom. The Resident bent over and rubbed fecal matter from his bottom onto the nurse's shirt.

11) On October 16, 2019, the Resident was argumentative with physical therapy staff.

12) On October 17, 2019, the Resident was argumentative with staff and ambulated without his walking boot. The Resident ambulated without assistance to the restroom.

13) On October 18, 2019, the Resident had made requests for a certified nursing assistant (CNA) to get him snacks and drinks throughout the night. The Resident yelled at the CNA and demanded ice. The Resident requested that he be sent to the hospital due to shortness of breath. He refused to put on pants or briefs, but was taken to the hospital and left the Facility on a gurney with a sheet covering him.

14) On October 19, 2019, the Resident wheeled himself to the nurse's station naked and asked to use the telephone. A staff member handed him the telephone, and he walked behind the nurse's desk and sat on the floor. The staff tried to get the Resident off the floor and he attempted to hit them. The Resident had a bowel movement and refused care and the Resident urinated on the floor on this date. The Resident pushed blankets onto the floor and was exposed when staff entered his room.

15) Progress Notes document the measures used by the Facility to educate the Resident on why his behaviors were dangerous or inappropriate (NF-3).

16) The clinical record includes a written notation from [redacted], D.O., regarding a telephone call received from [redacted] on October 14, 2019 in which Dr. [redacted] was informed of the Resident's threats of self-harm, his refusal to obtain medical treatment, and the mental hygiene commissioner's refusal to pursue the Resident's commitment (NF-5). In the documentation, Dr. [redacted] indicated that attempts to resolve the conflict would continue and efforts would continue to assist the Resident.

17) Facility staff met with the Resident and his wife on October 21, 2019 for discharge planning purposes (NF-3).

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:

- 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 due to the clinical or behavioral status of the resident; 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 verbally 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

Federal regulations specify that a nursing facility can involuntarily transfer/discharge an individual if the transfer or discharge is necessary when the safety of individuals in the facility is endangered.

The Resident and his wife responded to accusations made by the Facility and contended that many of the incidents did not happen or were blown out of proportion. The Resident's wife admitted that the Resident can become verbally abusive when he does not feel well; however, she has not witnessed him become physically abusive. The Resident testified that he could not remember some of the incidents, but denied that he went to the nurse's station naked and said that he only sat on the floor to get the staff's attention because they would not allow him to go to the hospital. The Resident's wife testified that the Resident had severe skin chafing on his scrotum/legs and a rash on his bottom that caused pain. She stated that she believes he kept requesting that antifungal medication be applied because he felt that it provided pain relief.

The Resident contended that he yelled for assistance and knocked on walls because he did not receive timely attention when he pushed the call button. He also testified that he used the bathroom unassisted at times because one of his medications causes frequent urination and staff did not arrive quickly enough. The Resident denied threatening or attempting to strike nursing home staff, and denied rubbing feces from his bottom onto nurse [redacted] shirt despite testimony from Ms. [redacted] to the contrary.

The Resident's wife voiced complaints about the facility's actions and testified that the Resident was left to sit in soiled pants for several hours. She stated that she cannot take care of the Resident at home because he weighs 315 pounds, cannot walk upstairs to the bathroom, has poor balance and is a fall risk. Nursing home staff offered to obtain a potty chair and a lift for use in the Resident's home, and the Facility has also sought alternative placements. The Resident's wife indicated that she would prefer her husband be moved to a facility in Bridgeport that is closer to her home.

The Facility provided detailed documentation and credible witness testimony concerning the Resident's behavior. The Resident - while denying some of the Facility's allegations - could not recall all of the interactions, and the Resident's wife was not present at the Facility to witness many of the incidents. Based on information provided during the hearing, the Facility's decision to discharge the Resident is correct.

CONCLUSIONS OF LAW

1) Federal regulations specify that a nursing facility can involuntarily transfer/discharge an individual if the transfer or discharge is necessary when the safety of individuals in the facility is endangered.

2) The Facility documented several incidents in October 2019 in which the Resident was disruptive, exhibited explosive behavior, was verbally abusive, threatened self-harm, threatened staff with physical harm, refused to cover his genitals, and had personal hygiene issues.

3) The Resident suffers from both mental and physical health issues, but was deemed to have mental capacity.

4) It is clear that the Resident's disruptive behavior, threats of harm to self and others, and hygiene issues pose a danger to the mental or physical wellbeing of individuals at the Facility.

5) The Facility's decision to discharge the Resident is correct.

DECISION

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

ENTERED this 24th Day of January 2020.

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Pamela L. Hinzman
State Hearing Officer