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

Bill J. Crouch
Cabinet Secretary

Board of Review
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Fairmont, WV 26554
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Jolynn Marra
Interim Inspector General

February 24, 2020

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 19-BOR-2865

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 Board of Review 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 that may be taken if you disagree with the decision reached in this matter.

Sincerely,

Tara B. Thompson
State Hearing Officer
State Board of Review

Enclosure: Resident's Recourse
Form IG-BR-29

cc: [redacted] Facility Administrator
[redacted], Resident's Relative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **ACTION NO.: 19-BOR-2865**

[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' (DHHR) Common Chapters Manual. This fair hearing was convened on January 22, 2020 an appeal filed December 17, 2019.

The matter before the Hearing Officer arises from the November 22, 2019 determination by the Facility to discharge the Resident from [redacted].

At the hearing, the Facility appeared by [redacted], Facility Administrator. Appearing as a witness on behalf of the Facility was [redacted], Facility Administrator in Training. The Resident was represented by [redacted], Ombudsman. Appearing as a witness on behalf of the Resident was [redacted], the Resident's medical attorney in-fact. All witnesses were sworn and the following evidence was entered into the record.

Facility's Exhibits:
F-1 Facility Administrator Summary Notes
F-2 WVU Medicine Progress Note, dated November 15, 2019
F-3 Facility Administrator Summary Notes
F-4 [redacted] Progress Notes, dated through August 30 through November 19, 2019
F-5 [redacted] Admission Record
F-6 Care Plan, completed December 15, 2019

Resident's Exhibits:
R-1 [redacted] Notice of Transfer or Discharge, dated November 22, 2019
R-2 West Virginia 64CSR13
R-3 Bureau for Medical Services Manual Chapter 514

R-4 Electronic Code of Federal Regulations § 483.15 and § 483.21
R-5 West Virginia DHHR Pre-Admission Screening (PAS), dated November 27, 2013
R-6 Minimum Data Set (MDS) Resident Assessment and Care Screening, dated September 7, 2019

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 following Findings of Fact are set forth.

FINDINGS OF FACT

1) The Resident was admitted to the Facility on April 8, 2019, with a primary diagnosis of Bipolar Disorder, unspecified (Exhibit F-5).

2) On June 6, 2019, the Resident was given the primary diagnosis of Unspecified Dementia with Behavioral Disturbance (Exhibit F-5).

3) On November 22, 2019, the Facility issued a notice advising the Resident that effective December 22, 2019, he would be discharged to the community setting of [redacted], due to the health and safety of other individuals in the Facility being endangered (Exhibit R-1).

4) On November 1 and November 13, 2019, the Facility's documentation reflected that the Resident had "verbal behavior directed at others" occurring 5 days per week (Exhibit F-4).

5) On November 14, 2019, the Facility's documentation reflected that the Resident had "verbal behaviors toward others daily or almost daily" (Exhibit F-4).

6) On August 31, September 30, November 1, November 9, November 11, November 12, and November 14, 2019, the Resident exhibited verbal aggression toward staff or peers in the Facility by making inappropriate comments, yelling, name-calling, or cursing (Exhibit F-4).

7) On September 1, 2019, the Resident threatened to slap/hit another resident (Exhibit F-4).

8) On September 30, 2019, the Resident threatened to break the staff's fingers if they touched his radio (Exhibit F-4).

9) On November 1 and November 14, 2019, the Facility's documentation reflected that the Resident had "physical behaviors directed at others" up to 5 days per week (Exhibit F-4).

10) On November 13, 2019, the Facility's documentation reflected that the Resident had no physical aggression toward others in the last 30 days (Exhibit F-4).

11) From October 1 through October 3, 2019, the Facility's records reflect that interventions were in place due to "resident to resident altercation" (Exhibit F-4).
12) On October 31 and November 2, the Facility's documentation reflected "behaviors" as the "reason for stay." The notes also read, "no behaviors" (Exhibit F-4).

13) On November 12, 2019, the Resident threatened to slit the throats of other Facility residents with a butter knife (Exhibit F-4).

14) The Facility's physician issued an order for the Resident to be transported to the Emergency Room for evaluation following the Resident's November 12, 2019 threat to harm other Facility residents (Exhibits F-3 and F-4).

15) The Resident's medical attorney-in-fact refused to consent to the Resident's transport to the Emergency Room (Exhibits F-3 and F-4).

16) The Facility initiated a 1:1 observation intervention through November 15, 2020 (Exhibits F-2 through F-4).

17) On November 15, 2019, the Resident's [redacted] physician prescribed the Resident medication to address "symptoms of mood lability and severe agitation" (Exhibit F-2).

18) On November 19, 2019, the Resident's medical attorney-in-fact refused to give consent for the Facility to administer the medication prescribed by the Resident's [redacted] physician (Exhibit F-4).

APPLICABLE POLICY

West Virginia (2015) 64 CSR § 13.2.18 Provides in part:

> *Discharge* is defined as moving a resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care.

West Virginia (2015) 64 CSR § 13.4.2.c Provides in part:

> When the nursing home staff limits or restricts the rights of a resident for medical reasons, the staff will document the specific reasons for the limitation or restriction in the resident's medical record and the specified period of time the limitation or restriction will be in place.

West Virginia (2015) 64 CSR § 13.4.6.a-13.4.6.a.1.C provides in part:

> A resident has the right to refuse treatment. When a refusal of treatment occurs, the nursing home shall assess the reasons for the refusal, clarify and educate the legal representative as to the consequences of the refusal, and offer alternative treatments, and continue to provide all other services. The nursing home shall

maintain documentation in the resident's medical record of the resident's refusal and the actions taken.

West Virginia (2015) 64 CSR § 13.4.6.b provides in part:

A nursing home shall not transfer or discharge a resident for refusing treatment unless criteria for transfer or discharge are met under the provisions of this rule.

West Virginia (2015) 64 CSR § 13.4.13.b- 13.4.13.b.3 provides ion part:

The nursing home shall permit each resident to remain in the nursing home, unless the health or safety of persons in the nursing home is endangered.

West Virginia (2015) 64 CSR § 13.4.13.c- 13.4.13.c.2 provides in part:

When a nursing home discharges a resident, the resident's clinical record shall contain the reasons for the transfer or discharge and documentation shall be made by the resident's physician when discharge is necessary under the provisions of this rule.

West Virginia (2015) 64 CSR § 13.4.13.f- 13.4.13.f.2 provides in part:

A nursing home shall provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the nursing home. In the event of involuntary transfer, the nursing home shall assist the resident's legal representative in finding a reasonably appropriate alternative placement prior to the proposed discharge and develop a plan designed to minimize any transfer trauma to the resident. The plan may include counseling the legal representative regarding available community resources and taking steps under the nursing home's control to assure safe relocation.

Code of Federal Regulations 42CFR §483.12(a)(4) provides in part:

Before a facility discharges a resident, the facility must notify the resident of the discharge and reason for the move in writing and include in the notice the items described in paragraph (a)(6) of this section.

Code of Federal Regulations 42CFR §483.12(a)(6)(iii) provides in part:

The written notice must include the location to which the resident is discharged.

DISCUSSION

The Resident disputed the Facility's action to discharge the Resident from the Facility due to the health and safety of others being endangered by the Resident. The Resident argued that the Facility's action to discharge the Resident was not supported by a physician-documented reason in the Resident's record as required by policy. Further, the Resident argued that the Facility failed

to act according to the policy requirements when identifying a discharge location and that, therefore, the Facility's discharge notice was insufficient.

To demonstrate that the Facility correctly discharged the Resident, the Facility had to prove by a preponderance of evidence that the Resident endangered the health and safety of other individuals in the Facility. The Facility was also required to demonstrate that the Resident was properly notified of his impending discharge, that the Facility had met its responsibility to align an appropriate discharge location for the Resident, and that the reason for the Resident's discharge was appropriately documented in the Facility's record.

Eligibility for Discharge

Health and Safety:
The Facility's documented assessments of how frequently the Resident engaged in verbal behaviors toward others conflicted. The Facility's documentation on November 1 and November 13, 2019, reflected that the Resident was experiencing "verbal behaviors" five (5) times per week. The Facility's documentation on November 14, 2019, claimed that the Resident was experiencing "verbal behaviors" daily. Not only is the rate of assessed frequency of verbal behaviors inconsistent, but the supporting documentation does not meet a five times per week or daily threshold. During the evidence period of August 30 through November 19, 2019, only seven Facility-documented instances were recorded of the Resident's verbal aggression toward staff or peers by making inappropriate comments, yelling, name-calling, or cursing and only three Facility-documented instances were recorded of the Resident's verbal threats of harm toward staff or peers. The Facility administrators typed summary reflected that the Resident had "verbally assaulted" or threatened harm to others on August 19, October 4, October 30, and October 31, 2019, however, no facility-documentation of these verbal threats were recorded in the evidence.

The Facility's documented assessment of how frequently the Resident engaged in physical behavior directed toward others conflicted. The Facility's documentation on November 1 and November 14, 2019, reflected that the Resident was experiencing physical behavior toward others up to five (5) times per week. The Facility's documentation on November 13, 2019, reflected that the Resident had not experienced any physical aggression toward others in the previous 30 days. The Facility administrator's typed summary note reflected that on August 11, 2019, the Resident touched a female resident inappropriately without permission; however, no documentation regarding this incident was entered as evidence. The Facility administrator's typed summary note reflected that on September 30, 2019, that the Resident had used his wheelchair to hit another resident's wheelchair "on purpose due to a verbal altercation;" however, no documentation regarding this incident was entered as evidence.

From October 1 through October 3, 2019, the Facility's records reflect that interventions were in place due to "resident to resident altercation;" but no documented evidence regarding the resident-to-resident altercation was submitted. The Facility's notes on October 31 and November 1, 2019, were unclear and conflicting as they reflected both "behaviors" as the "reason for stay" and also recorded "no behaviors." The regulations require that when the Facility applies safety interventions that limit or restrict the rights of a resident, the staff must document the specific reasons for the limitation in the medical record and the specified time period the limitation or restriction will be

in place. Because the purpose and nature of the "reason for stay" was not established in the Facility's record, it cannot be discerned that the "reason for stay" was a safety intervention directly related to the alleged September 30, 2019 incident.

Due to the inconsistency of the Facility's documentation regarding the nature and frequency of the Resident's verbal and physical behavior toward others, the Facility's documentation is unreliable. As the Facility's evidence is unreliable, this Hearing Officer cannot discern that the Resident endangered the health and safety of other individuals in the Facility.

Medical attorney-in-fact Refusal to Consent to Physician-Recommended Treatment:
The Facility argued that the Resident's medical attorney-in-fact refused to consent to medication treatments recommended by the Resident's physician to decrease symptoms of the Resident's illness which made him a safety risk to others. Although the Resident's [redacted] physician's documentation established that the Resident was prescribed medications to address "symptoms of mood lability and severe agitation" and the Resident's medical attorney-in-fact did not dispute her refusal to consent to the treatment, the evidence failed to verify how the Resident's failure to participate in the physician-recommended treatment endangered the health and safety of other individuals in the facility.

The regulations provide that the Resident's representative has a right to refuse medical treatment. The Facility had the burden of proof to demonstrate that the medical attorney-in-fact's refusal to consent to physician-recommended treatment endangered the health and safety of other individuals in the Facility. Pursuant to the regulations, when a resident refuses treatment, the Facility is required to educate the legal representative as to the consequence of the refusal, continue to provide all other services, and maintain documentation in the medical record of the refusal and the actions taken. No evidence was entered to establish that the Facility had met these policy requirements.

Following the November 12, 2019 threat by the Resident to harm another resident with a butter knife and the medical attorney-in-fact's subsequent refusal to comply with the Facility physician's orders to transport the Resident to the ER for evaluation, the Facility placed the Resident "on 1:1" through November 15, 2019, as a safety precaution. Although there was no facility-documented record submitted as evidence, the Facility administrator's record reflected that on November 19, 2019, the Facility's safety intervention was reduced to 15-minute checks "due to no continuing/escalating threats of physical aggression" and that the following day —on November 20, 2019— the Resident's 15-minute checks were discontinued. There was no Facility documentation or other evidence submitted to demonstrate that the Resident had engaged in any behavior that endangered the health and safety of other individuals following the documented November 12, 2019 threat to harm another resident or subsequent November 19, 2019 medical attorney-in-fact's refusal to consent to physician-recommended medication. There had been no Facility-documented incidents of other individuals in the Facility being endangered by the Resident following the November 20, 2019 discontinuation of 15-minute checks. As such, the Facility incorrectly acted to discharge the Resident on November 22, 2019.

Physician Documented Discharge Reason:
Regulations provide that when a nursing home discharges a resident, the resident's clinical record must contain the reasons for the Resident's discharge. No evidence was entered to demonstrate

that the Resident's physician had documented the reason for the Resident's discharge in the Resident's clinical record.

Notice

Regulations provide that the location of the Resident's discharge must be reflected on the Facility's discharge notice. The evidence demonstrated that the location the resident was to be discharged to was the home of the Resident's medical attorney-in-fact. The Resident argued that the medical attorney-in-fact had not agreed for her home to be the Resident's discharge location and that her home was not sufficient to address the Resident's medical needs.

Discharge Location
The regulations provide that in the event of an involuntary transfer, the Facility must assist the Resident's legal representative in finding a reasonably appropriate alternative placement prior to the proposed discharge and develop a plan designed to minimize any transfer trauma to the resident. Because the discharge location must be reflected on the Facility's discharge notice, the Facility's assistance aligning an appropriate alternative placement preceding the proposed discharge could only occur before the issuance of the discharge notice.

During the hearing, the Facility's witness testified that when the administrator had spoken with the Resident's medical attorney-in-fact following the November 12, 2019 incident with the butter knife that the Facility had recommended that the medical attorney-in-fact should tour dementia-specific facilities and that the medical attorney-in-fact had advised she would "look at" the recommendations. The Facility's witness testified that she had suggested [redacted] and memory care units in [redacted] and [redacted] West Virginia. The Facility administrator testified that she "believed" the name of one of the memory care units to be "[redacted]." No Facility-documented records were provided as evidence to verify that the Facility had issued referrals to the recommended facilities or assisted the Resident's medical attorney-in-fact with aligning placement for the Resident at any of the locations mentioned. The Facility's offering of a recommendation that the medical attorney-in-fact should tour other facilities is not sufficient to satisfy the regulatory requirement for the Facility to assist the Resident's legal representative in finding a reasonably appropriate alternative placement before the Resident's proposed discharge.

No evidence was entered to verify that the Facility had discussed discharge planning with the Resident's medical attorney-in-fact or that the medical attorney-in-fact had given consent for the Resident to be transferred to her residence. When the discharge of a Resident from a Facility is involuntary, regulations require the Facility to actively participate in aligning a discharge location for the Resident before the Resident's discharge. Regulations do not explicitly permit the Facility to arbitrarily assign a community discharge location on the discharge notice. As such, the Facility failed to demonstrate by a preponderance of evidence that the discharge notice sufficiently informed the Resident of his discharge location. Although the Facility failed to appropriately notify the Resident of discharge by aligning a discharge location as required by regulations, the issue of the notice is moot as the Facility failed to prove that the Resident was eligible for discharge.

CONCLUSIONS OF LAW

1. The Facility may discharge a resident when the health and safety of other individuals in the facility is endangered by the Resident.
2. Regulations provide that when a nursing home discharges a resident, the resident's clinical record must contain the reasons for the Resident's discharge.

3. No evidence was entered to demonstrate that the Resident's physician had documented the reason for the Resident's discharge in the Resident's clinical record.

4. Due to the inconsistency of the Facility's documentation regarding the nature and frequency of the Resident's verbal and physical behaviors toward others, the Facility's documentation was unreliable.

5. The preponderance of evidence failed to demonstrate that the Resident endangered the health and safety of other individuals in the Facility.

6. Because the Facility failed to prove that the Resident was eligible for discharge, the matter of the Facility's issuance of appropriate discharge notice is moot.

DECISION

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

ENTERED this 24th day of February 2020.

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Tara B. Thompson
State Hearing Officer