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

Bill J. Crouch
Cabinet Secretary

BOARD OF REVIEW
Raleigh County District
407 Neville Street
Beckley, WV 25801

Jolynn Marra
Interim Inspector General

June 16, 2021

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 21-BOR-1642

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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

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

cc: [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 21-BOR-1642**

[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 June 15, 2021, on an appeal filed May 26, 2021.

The matter before the Hearing Officer arises from the May 3, 2021, decision by the Facility to discharge the Resident from [redacted].

At the hearing, the Facility appeared by [redacted], Facility Administrator. Appearing as witnesses for the Facility were [redacted], Director or Nursing and [redacted], Licensed Social Worker. The Resident appeared by [redacted] and [redacted], Regional Ombudsmen. Appearing as a witness for the Resident was [redacted], his daughter. The witnesses were sworn and the following documents were admitted into evidence.

Facility's Exhibits:

F-1 Pre-Admission Screening dated January 27, 2021
F-2 30-Day Discharge Notice dated May 3, 2021
F-3 Nursing Notes from February 10 to June 7, 2021
F-4 Physician Progress Notes from February 11 to May 24, 2021
F-5 Social Service Notes from February 11 to June 3, 2021

Resident's Exhibits:

R-1 30-Day Discharge Notice dated May 3, 2021
R-2 Pre-Admission Screening dated January 27, 2021

R-3 Code of Federal Regulations – Title 42 §483.15 and Code of State Rules – Title 64, Series 13, §4.13
R-4 Social Service Notes from April 6 to May 14, 2021

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 was admitted to [redacted] (Facility) on February 10, 2021.

2) The Resident has a diagnosis of dementia and has exhibited aggressive behaviors towards staff and other residents throughout his stay in the Facility.

3) The Resident wanders throughout the Facility and enters other residents' rooms uninvited.

4) The Facility issued a 30-Day Notice of Discharge to the Resident's daughter on May 3, 2021, advising that the Resident would be discharged to her care because the Resident's welfare and needs could not be met at the Facility and the safety of individuals in the Facility was endangered due to the Resident's behaviors (Exhibits F-2 and R-1).

5) The Facility began providing one-on-one staffing in May 2021 when the Resident's behaviors increased in frequency.

APPLICABLE POLICY

Code of Federal Regulation Title 42 §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:

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

- (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.

The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

(**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.

(i) Documentation in the resident's medical record must include:

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

- (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by -

- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and

- (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

- (A) Contact information of the practitioner responsible for the care of the resident

- (B) Resident representative information including contact information.

- (C) Advance Directive information.

- (D) All special instructions or precautions for ongoing care, as appropriate.

- (E) Comprehensive care plan goals,

- (F) All other necessary information, including a copy of the resident's discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(3) Notice before transfer. Before a 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. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(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 (c)(5) of this section.

(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (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.

(ii) Notice must be made as soon as practicable before transfer or discharge when -

- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
- (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
- (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
- (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
- (E) A resident has not resided in the facility for 30 days.

(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.

(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

Code of State Rules – 64CSR13 §4.13.7.a states that a nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his or her will.

DISCUSSION

Federal regulations permit the involuntary discharge of a nursing home resident if the resident's needs cannot be met in the nursing home or if the discharge is necessary because safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. In the case that the resident's needs cannot be met, documentation in the resident's medical record must include the facility's attempts to meet the resident's specific needs, and the services available at the receiving facility that would meet those needs. When the discharge is due to the resident's behaviors endangering others in the facility, physician documentation in the resident's medical record is required.

The Facility initiated involuntary discharge proceedings for the Resident because of behaviors associated with his dementia. The Facility contended that the Resident is combative and threatening with staff and has been physically aggressive with other residents. The Facility stated attempts to accommodate the Resident have been made including changing his medications, placing stop signs on residents' doors and redirecting undesirable behaviors. The Facility stated that because of the increased frequency of the Resident's behaviors, one staff member has been assigned to the Resident, which is not something that can continue indefinitely. Referrals have been made to other facilities that have specialized dementia care units, but the Resident is currently on a waiting list.

Representatives for the Resident argued that the Facility failed to follow federal and state regulations involving the involuntary discharge of the Resident. The Resident's medical record did not specifically state how the Resident's needs were not met, the attempts that were made to meet his needs or how his needs would be met at another facility. The 30-Day Discharge notice was ambiguous regarding the effective date of the discharge and location of the discharge, did not have an accurate phone number for the Board of Review, and did not have a name, address or phone number for the Ombudsman. Furthermore, the Resident's representatives argued that state regulations prohibit the discharge of an individual to a community setting who requires nursing home level of care.

The documentation provided noted the Facility's attempts to curb the Resident's behaviors in using stop signs on other patients' doors, redirecting him when he exhibited undesirable behaviors and changes to his medications. However, information detailing what the Resident's specific needs were that could not be provided by the Facility, or how they would be met at another Facility, was not in the Resident's record. The Resident's physician made a notation in a Progress Note on May 24, 2021 that the Resident "was a threat to [patient] and staff". This physician note was made after the 30-Day Discharge notice and is insufficient documentation regarding the need to discharge the Resident. The notice of discharge failed to provide contact information for the long-term care Ombudsman and listed the date of the discharge notice as the effective date of discharge. The Facility failed to adhere to federal regulations in the involuntary discharge of the Resident.

State code prohibits the involuntary discharge of an individual to a community setting who continues to require nursing home level of care. Although the Facility has documented numerous attempts to find placement for the Resident in another nursing facility, the Resident cannot be discharged to a community setting while requiring nursing facility services.

CONCLUSIONS OF LAW

1) Federal regulations permit the involuntary discharge of a nursing home resident if the resident's needs cannot be met in the nursing home or if the discharge is necessary because safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

2) The Facility failed to properly document how the Resident's needs were not met at the facility and would be met elsewhere.

3) The Facility failed to provide sufficient physician documentation of the need to discharge the Resident due to the safety of others.

4) The Facility failed to provide adequate notice of the discharge pursuant to federal regulations.

5) Pursuant to state code, the Resident cannot be discharged to his daughter's home while he continues to require a nursing home level of care.

6) The Facility improperly initiated discharge proceedings for the Resident.

DECISION

It is the decision of the State Hearing Officer to **reverse** the decision of [redacted] to discharge the Resident from its facility.

ENTERED this 16th day of June 2021.

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Kristi Logan
Certified State Hearing Officer