

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

Joe Manchin III Governor

May 19, 2008

c/o

Dear Mrs. \_\_\_\_:

Attached is a copy of the findings of fact and conclusions of law on your hearing held May 15, 2008. Your hearing request was based on proposal to discharge you from the nursing facility.

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.

The State and Federal regulations that govern the Medicaid Long-Term Care Program state that the transfer and discharge of an individual includes movement of a resident to a bed outside of the certified facility (area) whether or not that bed is in the same physical plant. A facility can recommend the transfer/discharge of a patient when that individual poses a safety risk to other residents. The Code of Federal Regulations provides notification requirements and states that a facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. If the policy was misapplied or another incorrect decision was made, the State Hearing Officer will reverse. [Code of Federal Regulations 42 CFR 483.12 & West Virginia Department of Health and Human Resources Common Chapters Manual, Chapter 780.D.1]

Information submitted at your hearing reveals that the transfer/discharge procedure implemented by fails to meet Federal regulatory requirements. Therefore, the proposed discharge cannot proceed.

It is the decision of the State Hearing Officer to reverse the proposal of Rosewood Center to discharge/transfer you from the nursing facility.

Sincerely,

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

Erika H. Young, Chairman, Board of Review cc:

Martha Yeager Walker Secretary

### WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES BOARD OF REVIEW

Claimant,

v.

Action Number: 08-BOR-762

**Respondent.** 

## **DECISION OF STATE HEARING OFFICER**

### I. INTRODUCTION:

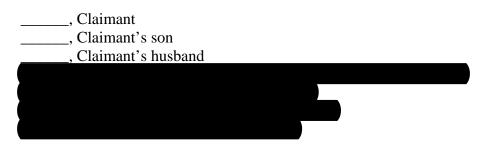
This is a report of the State Hearing Officer resulting from a fair hearing concluded on May 19, 2008 for \_\_\_\_\_\_. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing originally convened on April 8, 2008, but was continued at the request of the Claimant. It was rescheduled for April 28, 2008, but was continued at the request of the ombudsman. The hearing reconvened on May 15, 2008.

#### II. PROGRAM PURPOSE:

The program entitled Long-Term Care is set up cooperatively between the Federal and State governments and administered by the West Virginia Department of Health & Human Resources.

It is a medical service which is covered by the State's Medicaid Program. Payment for care is made to nursing homes which meet Title XIX (Medicaid) standards for the care provided to eligible recipients. In order to qualify for Nursing Home Care, an individual must meet financial and medical eligibility criteria.

# **III. PARTICIPANTS:**



Presiding at the hearing was Pamela L. Hinzman, State Hearing Officer and a member of the State Board of Review.

### **IV. QUESTIONS TO BE DECIDED:**

The question to be decided is whether **constant** is correct in its proposal to involuntarily discharge the Claimant from the nursing facility.

## V. APPLICABLE POLICY:

Code of Federal Regulations Section 42 CFR 483.12 WVDHHR Common Chapters Manual, 780, D.1

### VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

#### **Claimant's Exhibits:**

- C-1 Code of Federal Regulations 42 CFR 483.12
- C-2 Care Plans for Claimant

#### **Respondent's Exhibits:**

- R-1 30-Day Discharge Letter dated January 17, 2008
- R-2 Incident Report

#### VII. FINDINGS OF FACT:

- 1) On or about January 17, 2008, the Claimant was notified (via Exhibit R-1) that initiated involuntary 30-day discharge proceedings against her for displaying inappropriate behavior toward another resident.
- 2) The **Constitution** Administrator testified that the proposed discharge stemmed from an incident documented in Exhibit R-2 (Incident Report). The Administrator testified that a staff member had heard a slapping noise coming from the Claimant's room around 4:50 a.m. on January 17, 2008 and went into the room to investigate. The Claimant told the staff member that her roommate was making noise and she had told the roommate to "shut up." When the roommate continued to make noise, the Claimant reportedly struck her roommate on the leg. The Incident Report states that the Claimant's roommate had red areas on her upper right thigh, forehead and right cheek.

The Administrator testified that the nursing home had previously attempted to separate the Claimant and her roommate, but neither the Claimant nor the roommate's representative would consent to a move to an alternative room.

The Social Worker testified that the Claimant had complained about her roommate's noises in November 2007, but she found no information to confirm that the Claimant

had raised continuous concerns about the issue. The Social Worker testified that nursing home records revealed 12 documented instances in which staff had considered the roommate noisy.

- 3) The Claimant testified that she struck her roommate on the knee only and denied hitting any other part of the roommate's body. She testified that she knew the action was wrong, but she had reacted out of frustration. She testified that she had been in her room for years and did not want to move to a different room. The Claimant's son testified that his mother had complained to him numerous times about the roommate's noise. He stated that the roommate slept all day, stayed up all night, and disrupted his mother's sleep. He also testified that he knows of no other instance in which his mother has been physically aggressive toward another individual.
- 4) The Legal Aid Ombudsman contended that the Claimant has no history of violence and that she should not be discharged from the nursing facility based on an isolated incident. The Ombudsman also maintained that the discharge notice (R-1) issued by the nursing facility is non-compliant with Federal regulations. She testified that the Notification of Transfer/Discharge does not list the effective date of the proposed 30-day discharge and does not specify a location to which the Claimant will be discharged/transferred.

The letter indicates that the Claimant would be moved to another room for safety purposes, however, the Ombudsman stated that the Claimant had roommates in the alternative room. She stated that the nursing home would not have allowed the Claimant to have other roommates if she was viewed as a safety threat. The Administrator responded that the new roommates assigned to the Claimant were considered "capable" residents, while the Claimant's former roommate (the alleged victim) was incapable of attending to her needs. The Administrator stated that the Notification of Transfer/Discharge does not list a location to which the Claimant will be discharged because nursing home staff had not discussed the issue with the Claimant and her representatives at the time the notice was issued. She contended that the letter portion of the notice is dated January 17, 2008 so that date should be considered in computing the 30-day discharge period.

The Administrator testified that the Claimant's doctor was informed of the matter, however, the Ombudsman maintained that nursing home records contain no documentation from the Claimant's physician regarding the proposed transfer/discharge and no justification concerning why cannot meet the Claimant's needs.

5) Code of Federal Regulations, 42 CFR 483.12(a) (C-1) provides regulatory guidelines regarding admission, transfer and discharge rights for the Medicaid Long-Term Care Program. These regulations state:

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless\_\_\_\_\_

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) 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;

- (iii) The safety of individuals in the facility is endangered;
- (iv) The health of individuals in the facility would otherwise be endangered;
- (v) The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility.
- (vi) The facility ceases to operate.
- 6) Code of Federal Regulations, 42 CFR 483.12(a) (4&6), addresses written notification regarding transfer/discharge and states that the notice 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 that the resident has the right to appeal the action to the State;
  - (v) The name, address and telephone number of the State long term care ombudsman;
  - (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
  - (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
- 7) Code of Federal Regulations, 42 CFR 483.12(a) (7) Orientation for transfer or discharge, states that a facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
- 8) West Virginia Department of Health and Human Resources Common Chapters Manual Chapter 780.D.1 states that if the policy was misapplied or other incorrect decision was made, the State Hearing Officer will reverse.

#### VIII. CONCLUSIONS OF LAW:

- 1) Regulations that govern the Medicaid Long-Term Care Program state that a resident can be transferred/discharged from a nursing facility when the resident endangers the safety of individuals in that facility.
- 2) While the decision to initiate involuntary discharge due to safety concerns is in compliance with the Code of Federal Regulations, notification and discharge requirements have not been met. The January 17, 2008 notice fails to include a clear effective date of

discharge and fails to list a location to which the Claimant will be transferred/discharged. Therefore, the facility has failed to demonstrate sufficient preparation and orientation to ensure a safe and orderly transfer/discharge of the Claimant from the facility.

3) Whereas the evidence submitted by **the second se** 

## IX. DECISION:

It is the decision of the State Hearing Officer to **reverse** the proposal of Rosewood Center to discharge the Claimant from the nursing facility based on the January 17, 2008 transfer/discharge notice.

## X. RIGHT OF APPEAL:

See Attachment

# XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

## ENTERED this 19th Day of May, 2008.

Pamela L. Hinzman State Hearing Officer