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

**Bill J. Crouch**
**Cabinet Secretary**

**Board of Review**
**416 Adams Street Suite 307**
**Fairmont, WV 26554**
**304-368-4420 ext. 79326**

**Jolynn Marra**
**Interim Inspector General**

June 16, 2020

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 20-BOR-1344

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, MLS
State Hearing Officer
State Board of Review

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

cc: [redacted], [redacted]

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**BOARD OF REVIEW**

[redacted],

**Resident,**

**v.** **ACTION NO.: 20-BOR-1344**

[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 June 4, 2020 an appeal filed March 6, 2020.

The matter before the Hearing Officer arises from the March 5, 2020 determination by the Facility to discharge the Resident from the Facility.

At the hearing, the Facility appeared by [redacted], Facility Executive Administrator. Appearing as witnesses on behalf of the Facility were [redacted], Facility Executive Nurse, and [redacted], Facility Director of Social Services. The Resident appeared and was represented by [redacted], Ombudsman. All witnesses were sworn and the following documents were admitted into evidence.

**Facility's Exhibits**:

F-1 **
F-2 Drug Screen Results, dated October 29, 2019
F-3 Facility Notes
F-4 Facility Progress Notes, dated October 29, 2019
F-5 Facility Note, dated December 3, 2019
F-6 Facility Resident Smoking Contract, signed December 23, 2019
F-7 Facility Resident Smoking Contract, signed February 17, 2020
F-8 Handwritten Note, unsigned and undated
F-9 Facility Progress Notes, dated March 4 through March 5, 2020
F-10 **
F-11 Facility Progress Notes, dated March 7 through March 12, 2020
F-12 Facility Note, dated March 13, 2020

**Resident's Exhibits:**

R-1 Code of Federal Regulations § 64-13-1
R-2 Bureau for Medical Services Manual Chapter 514
R-3 Electronic Code of Federal Regulations 42CFR §§ 483.15 and 483.21
R-4 West Virginia DHHR Pre-Admission Screening (PAS), dated July 11, 2019
R-5 Facility Order Review History Report, dated January 1, 2020 through March 31, 2020
R-6 Facility Progress Note, dated February 14, 2020
R-7 Minimum Data Set (MDS) Resident Assessment and Care Screening, dated January 8, 2020
R-8 Facility Progress Notes, dated January 6, 2020 through February 12, 2020
R-9 Facility Progress Notes, dated January 6, 2020
R-10 Facsimile Report, dated May 13, 2020
R-11 Resident Care Plan, updated January 16, 2020

**Joint Exhibits:**

J-1 Facility Discharge Notice, dated March 5, 2020
J-2 Facility Discharge and Transfer Policy

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.

** Relabeled as joint exhibits.

## FINDINGS OF FACT

1) The Resident was admitted to the Facility on July 12, 2019.

2) The Resident has diagnoses including Paraplegia, unspecified; Major Depressive Disorder, recurrent, severe with psychotic symptoms; Chronic Hepatitis, unspecified; Other Psychoactive Substance Abuse, uncomplicated; Chronic Pain; Neuromuscular Dysfunction of Bladder, unspecified; Generalized Anxiety Disorder; Hyperlipidemia, unspecified; Alcohol Abuse, uncomplicated; Obstructive and Reflux Uropathy, unspecified; Retention of Urine, unspecified; Nicotine Dependence, unspecified; and other diagnoses (Exhibits F-11 and R-4).

3) The Resident is wheel-chair dependent for ambulation and requires one-person physical assistance for transferring (Exhibits F-9, F-11, R-4, R-7, and R-11).

4) The Resident requires physical assistance with bathing, dressing, toilet use, and grooming (Exhibits R-4, R-7, and R-11).

5) The Resident is not capable of administering his own medications (Exhibit R-4).

6) The Resident has a urinary catheter (Exhibits F-9 and R-4).

7) As of July 11, 2019, the Resident's physician, Dr. [redacted], identified his rehabilitative potential as poor (Exhibit R-4).

8) As of July 11, 2019, Dr. [redacted] recommended a nursing home level of care for the Resident and indicated that the Resident would not eventually be able to return home or be discharged (Exhibit R-4).

9) The Resident's Facility physician is [redacted] (Exhibits F-11 and R-6).

10) On March 5, 2020, the Facility issued a notice advising the Resident that he would be discharged from the facility, effective April 6, 2020, to the [redacted] due to the safety of individuals in the Facility being endangered by the Resident's clinical or behavioral status (Exhibit J-1).

11) The March 5, 2020 notice advised that on March 5, 2020, the Resident violated a smoking contract he signed February 17, 2020 (Exhibit J-1).

12) The March 5, 2020 notice advised that the decision to discharge the Resident was being made by the Facility pursuant to 42 CFR § 483.15(c)(i)(C) (Exhibit J-1).

13) The Resident's clinical record did not contain a physician documented reason for the Resident's discharge.

14) The Resident's clinical record contained a July 12, 2019 active physician discharge order for "uncertain long-term placement discharge home" (Exhibit R-5).

15) The Resident's discharge goals were last updated on his care plan on July 24, 2019 (Exhibit R-11).

16) The Resident's January 1, 2020 through March 31, 2020 clinical record did not reflect a physician discharge order to discharge the Resident to the [redacted] (Exhibit R-5).

17) On January 8, 2020, the Facility assessed the Resident as having verbal behavioral symptoms directed toward others occurring 4 to 6 days per week, but less than daily (Exhibit R-7).

18) On January 10, 2020, the Resident's care plan was updated to include treatment interventions for demonstration of "verbal behaviors related to: history of verbal outbursts directed toward others (e.g., use of abusive language, pattern of challenging confrontational behavior) (Exhibit R-11).

19) On October 23, 2019, the Resident submitted to a drug screen and tested positive for THC and Methadone (Exhibit F-2).

20) The Resident is prescribed methadone.

21) On October 29, 2019, March 4 and March 5, 2020, the Resident was verbally agitated and made statements to staff including "everyone here does not like you," "you are a liar and can't be trusted," "fuck the rules I'm going outside to smoke," and "pull the fucking thing out if it didn't stop" (Exhibits F-4 and F-9).

22) On September 9, 2019, the Facility Executive Administrator and Facility Director of Social Services counseled the Resident and advised that he would be discharged from the Facility following future occurrences of illegal drugs (Exhibit F-3).

23) On December 3, 2019, the Facility Executive Administrator met with the Resident to discuss the Resident's non-specific behavior (Exhibit F-5).

24) On December 3, 2019, the Resident reported to the Facility Executive Administrator that if he were discharged, "he had enough money to stay at a hotel for at least if such occurrence took place" (Exhibit F-5).

25) On December 23, 2019, the Resident signed a Facility Smoking Contract which acknowledged his agreement to smoke in designated areas, return his lighter to staff, and abide by smoking procedures and timeframes (Exhibit F-6).

26) On February 17, 2020, the Facility conducted a facility-wide revision of the Resident Smoking Contract and the Resident signed his acknowledgement of understanding and agreement to the changes (Exhibit F-7).

27) The December 23, 2019 and February 17, 2020 Facility Smoking Contracts advised that the Resident would lose smoking privileges and receive an involuntary discharge notice if he violated any of the smoking guidelines listed (Exhibits F-6 and F-7).

28) On March 5, 2020, the Resident smoked outside of the smoking hours identified in the Facility's Resident Smoking Contract (Exhibits F-8 and F-9).

29) On March 13, 2020, the Facility Executive Administrator verbally offered to transfer the Resident to [redacted] or [redacted] and the Resident declined (Exhibit F-12).

30) On March 18, 2020, the Facility assisted the Resident with searching the internet for an apartment with no success (Exhibit F-11).

## APPLICABLE POLICY

**Code of Federal Regulations 42CFR § 483.15(c)(1)(i)(C) provides in part:**

> A facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

**Code of federal Regulations 42CFR § 483.15(c)(2)(i) through 483.15(c)(2)(ii)(B) Documentation provides in part:**

> When the facility discharges a resident because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, the facility must ensure that the discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
>
> Documentation in the resident's medical record must include documentation made by the resident's physician and the basis for the transfer.

**Code of Federal Regulations 42 CFR § 483.15(c)(3)(ii) Notice Before Transfer provides in part:**

> Before a facility discharges a resident, the facility must record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section.

**West Virginia Code § 64-13-2(47) Definitions provides in part:**

> Plan of Care: The overall profile of services and expected outcomes of care that may include those plans to meet the person's needs after discharge to the community. This includes all care and services outlined in the Resident's medical record.

**West Virginia Code § 64-13-4(13)(b)(3) Admission, Transfer, and Discharge provides in part:**

> A facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless the health or safety of persons in the nursing home is endangered.

**West Virginia Code §§ 64-13-4(13)(c)(1) – 64-13-4(13)(d)(3) Documentation provides in part:**

> When a nursing home discharges a resident, the resident's clinical record shall contain the reason for the transfer or discharge. The documentation shall be made by the resident's physician when discharge is necessary under the provisions of this rule.
>
> Before a nursing home transfers or discharges a resident, it shall provide written notice to the resident of the discharge. The notice shall include the reason for the proposed discharge and the location to which the resident is being discharged.

**West Virginia Code §§ 4-13-4(13)(f)(2)- 4-13-4(13)(g)(4) Involuntary Transfer/ Discharge to a Community Setting provide in part:**

> In the event of an involuntary transfer, the nursing home shall assist the resident in finding a reasonably appropriate alternative placement prior to the proposed discharge and by developing a plan designed to minimize any transfer trauma to the resident. The plan may include taking steps under the nursing home's control to assure safe relocation.
>
> A nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his will …. A nursing home shall provide information and referral to the appropriate social service agencies and community resources offering

assistance in facilitating a resident's return to the community, as necessitated by the resident's individual needs.

## DISCUSSION

On March 5, 2020, the Facility issued a notice advising the Resident that he would be discharged from the Facility due to the safety of individuals in the facility being endangered because he violated a smoking contract. The Resident contended that the evidence presented by the Facility did not corroborate that individuals in the facility were endangered due to his March 5, 2020 violation of the smoking contract and that the discharge notice, location, and documentation were insufficient according to regulatory requirements.

*Health and Safety*

The Facility had to prove by a preponderance of evidence that the Resident was correctly discharged because the safety of individuals in the facility was endangered due to the clinical or behavioral status of the Resident. The Facility's evidence reflected that in October 2019, the Resident tested positive for illegal substances. The parties were in agreement that this was a one-time occurrence that resulted from Facility staff providing substances to the Resident. Therefore, this one-time October 2019 incident is insufficient for establishing cause for the March 5, 2020 decision to discharge the Resident due to health and safety of others in the Facility being at risk.

Although the Facility's F-3 and F-5 exhibits contained redaction, the Facility Administrator testified that she was the author of the notes and provided the redacted names in her testimony. The Resident did not dispute the authenticity of the named participants. The Facility's exhibit F-5 reflected that the Facility Administrator had discussed the Resident's "behaviors toward staff" and described the Resident's agreement "not to continue to harass staff and make inappropriate comments." The Facility's evidence was insufficient to establish that the Resident's behaviors were a danger to himself or others. The terms "behavior," "harass," and "inappropriate comments" are vague and are not supported by evidence of regularly kept Facility documentation and progress notes which specifically describe the behaviors and subsequent threat to others' safety.

To prove that the Facility correctly discharged the Resident due to health and safety reasons, the Facility must prove by a preponderance of evidence that the Resident's presence in the Facility threatened the health and safety of others within the facility, not that the Resident violated a smoking contract. Although the Facility's December 23, 2019 and February 17, 2020 Smoking Contract advised that any violation of the contract would result in the Resident receiving an involuntary discharge notice, the supporting evidence failed to demonstrate how his violation of the contract placed others at risk of harm. The regulations do not explicitly permit the Facility to discharge a resident for violation of smoking or behavior contracts.

Although the Facility's exhibit F-8 handwritten statement is redacted, undated, unsigned, and not a document regularly kept in the course of routine Facility business and although the author of the Facility's exhibit F-9 is not documented, the Resident did not dispute that on one occasion — March 5, 2020— he took action to smoke outside of the smoking hours identified on the Facility's Resident Smoking Contract. The Facility's exhibit F-8 proffered that the Resident "has a history of these behaviors and continues to do them," however, the Facility's supporting evidence failed to establish a pattern of documented smoking behaviors that placed the health and safety of others inside the facility at risk.

*Notice, Documentation, and Location*:
The Facility had to prove by a preponderance of evidence that the Resident received proper notice before discharge. Pursuant to federal regulations regarding notice before transfer, the Facility must record documentation by the Resident's physician in the Resident's medical record which reflects the reason for the discharge. The Facility's own Discharge and Transfer Policy Section 3.4.1 provides that when a Resident is involuntarily discharged, physician documentation must be included in the clinical record pursuant to federal regulations. No evidence was entered to verify that the Resident's physician completed documentation in the Resident's record regarding the reason for the Resident's discharge from the facility.

The Resident argued that the hotel was an insufficient discharge location due to not being wheelchair accessible and no aftercare arrangements being made. Pursuant to regulations, the Facility had a responsibility to assist the Resident in finding a reasonably appropriate alternative placement prior to his proposed discharge and to include the location on the notice of discharge. The evidence established that the Resident requires use of a wheelchair; physical assistance with transferring, bathing, dressing, toileting, and grooming; and physical assistance with his catheter. The Facility's witness testified that under normal circumstances before discharge, the Facility aligns medical aftercare for the Resident at the discharge location. The Facility's witness testified that due to aligning discharge at a hotel, the Facility could not establish those arrangements prior to issuance of the discharge notice.

The Resident's conversation with Facility staff on December 3, 2019, does not meet the threshold of sufficient discharge planning. The Resident's documented comment that he "had enough money to stay at a hotel for at least if such occurrence took place" is unclear and fails to meet the policy requirement of ensuring that the Resident's discharge location be sufficient to meet his medical needs. The preponderance of evidence established that at the time the Facility issued the March 5, 2020 discharge notice, the Facility failed to meet its responsibility to fully consider whether the aligned discharge location met the Resident's medical needs.

The Facility's evidence demonstrated that the Facility offered to transfer the Resident to [redacted] or [redacted] and that the Resident declined. Although the [redacted] had a bed opening and was willing to accept the Resident, the Facility did not offer this discharge option to the Resident until following the March 5, 2020 notice of discharge.

Because the Facility failed to prove the basis for the Facility's decision to discharge the Resident from the Facility due to the health and safety of others being at risk, the issue of the location of his discharge his moot. However, the preponderance of evidence verified that even if the Facility had proven the basis for discharge, the Facility failed to act according to policy when identifying a location for the Resident's discharge on the March 5, 2020 notice of discharge.

## CONCLUSIONS OF LAW

1) The Facility may involuntarily discharge a resident when the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident and the reason for discharge is documented in the Resident's medical record by a physician.

2) The preponderance of evidence failed to demonstrate that the reason for discharging the resident was documented in the Resident's medical record by a physician.

3) The preponderance of evidence failed to demonstrate that the safety of individuals in the facility was endangered due to the Resident's March 5, 2020 violation of the Facility's Resident Smoking Contract.

4) Because the Facility failed to prove that the Resident was eligible for discharge, the matters of Facility issuance of appropriate discharge notice and location of discharge are moot.

## DECISION

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

ENTERED this 16th day of June 2020.

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**Tara B. Thompson**
State Hearing Officer