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

Bill J. Crouch
Cabinet Secretary

Board of Review
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Jolynn Marra
Inspector General

October 11, 2022

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 22-BOR-1904

Dear [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]

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **ACTION NO.: 22-BOR-1904**

[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 of Chapter 700 of the West Virginia Department of Health and Human Resources' (DHHR) Common Chapters Manual. This fair hearing was convened September 7, 2022 on an appeal filed with the Board of Review on July 29, 2022.

The matter before the Hearing Officer arises from the July 29, 2022 decision by the Facility to propose an involuntary discharge of the Resident.

At the hearing, the Facility appeared by [redacted]. Appearing as a witness for the Facility was [redacted]. The Resident appeared *pro se*. All witnesses were sworn in. No exhibits were entered by either party.

Department's Exhibits:
None

Resident's Exhibits:
None

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 has resided at the Facility since February 2022.

2) On July 29, 2022, the Facility notified the Resident he was being involuntarily transferred, effective August 28, 2022, because, "the transfer or discharge is appropriate because the [Resident's] health has improved sufficiently that [he] no longer needs the services provided by this facility."

3) The July 29, 2022 notice failed to include a destination of discharge.

4) The July 29, 2022 notice reflected incorrect contact information for the Board of Review.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.10(c)(1) provides in pertinent parts:

> The resident has the right to be informed of, and participate in, his treatment, including:
> The right to be fully informed in language that he can understand of his total health status, including but not limited to, his medical condition.

Code of Federal Regulations 42 CFR § 483.15(c)(1)(i)(B) and West Virginia Code § 64-13-4(13) (2)(b) provide in pertinent parts:

> The Facility must permit the Resident to remain in the facility, and not transfer or discharge the resident from the facility unless 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.

Code of Federal Regulations 42 CFR §§ 483.15(c)(2) through 483.15(c)(2)(ii)(A), West Virginia Code § 64-13-4(13)(3)(b), and 64-13-4(13)(4) provide in pertinent parts:

> When the facility transfers or discharges a resident due to improved health, 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.
> Documentation in the resident's medical record must include: the basis for the transfer per paragraph (c)(1)(i) of this section and must be made by the Resident's physician when transfer or discharge is necessary due to the Resident's improved health.

Code of Federal Regulations 42 CFR §§ 483.15(c)(3)(ii)-(iii), and 483.15(c)(5)(ii)-(iv) provide in pertinent parts:

> Before a Facility transfers or 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. The notice must include the following:
>
> - The effective date of transfer or discharge.
> - The location to which the resident is transferred or discharged.
> - A statement of the Resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests.

West Virginia Code § 64-13-4(6)(b) provides in pertinent parts:

> 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 transfer or discharge and by developing a plan designed to minimize any transfer trauma to the resident. The plan may include counseling the resident regarding available community resources and taking steps under the nursing home's control to assure safe relocation.

DISCUSSION

The Facility initiated an involuntary discharge of the Resident because the Resident's health had sufficiently improved as to no longer require the services of the Facility. The Resident contested the Facility's discharge and requested that he be able to remain in the Facility until his balance improved. The Resident also contested the Facility's decision to discharge him on the basis that he has no identified discharge location.

The Facility bears the burden of proof. The Facility had to demonstrate by a preponderance of the evidence that the Resident's health had improved sufficiently such that the Resident no longer needed services provided by the Facility. Further, the Facility had to prove that a discharge location was identified according to the policy and that the Resident had been properly notified of discharge.

The Facility testified that the Resident was admitted in February 2022 and the Resident did not dispute he was admitted at that time. No evidence was submitted to establish what medical condition the Resident was admitted for or what the Resident's medical needs were at admission.

When transfer or discharge from the Facility is necessary due to improved health, regulations require that the basis for discharge be documented by the Resident's physician and recorded in the Resident's record. No evidence was submitted to establish that this regulatory requirement was met. Further, no evidence was submitted to indicate how the Resident's health had improved or what the Resident's medical needs were at the time the Facility initiated his discharge.

There was testimony about what abilities the Resident has regarding ambulation and vague

reference to the Resident not having sufficient deficits to have a Medicaid Pre-Admission Screening approved; however, without a preponderance of reliable evidence to establish that the Resident's health has improved sufficiently such that he no longer requires services provided by the Facility, the Facility's action cannot be affirmed.

Insufficient Notice

Even if the Facility had proved by a preponderance of the evidence that the Resident's health had improved sufficiently to be eligible for discharge, the Respondent's July 29, 2022 notice of discharge failed to meet multiple regulatory requirements.

The notice of discharge must specify the action being taken and the reason for the transfer or discharge. The Facility argued that discharge was appropriate for the Resident. However, the notice indicated an effective date of transfer and referred to a destination of transfer, not of discharge. The Facility failed to properly notice the Resident of the action being taken.

The Facility is required to take steps under its control to assist the Resident in finding a reasonably appropriate alternative placement before the Resident's discharge. Regulations require that the Facility include the location of discharge on the notice of discharge. The evidence did not establish that the Respondent met its responsibility identifying a reasonably appropriate discharge location.

The Facility is required to reflect accurate Board of Review contact information to ensure the Resident is able to exercise his right to file an appeal. The notice reflected outdated information for the Board of Review — including an incorrect Chairman, telephone number, and fax number.

CONCLUSIONS OF LAW

1) A Resident may be discharged from the Facility when the Resident's health has sufficiently improved such that he no longer requires the services provided by the Facility and when the reason for the Resident's discharge is documented by the Resident's physician in the Resident's medical record.

2) The preponderance of evidence failed to verify that the Resident's health had improved sufficiently that he no longer requires the services provided by the Facility.

3) The preponderance of evidence failed to verify that the reason for the Resident's discharge was documented by the Resident's physician in the Resident's medical record.

4) The Respondent incorrectly acted to discharge the Resident, effective July 29, 2022.

5) Because the Facility's action to discharge the Resident, effective July 29, 2022, cannot be affirmed, the issue of improper 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 11th day of October 2022.

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Tara B. Thompson, MLS
State Hearing Officer