STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the Inspector General
Board of Review

Jeffrey H. Coben, MD
Interim Cabinet Secretary

Sheila Lee
Interim Inspector General

February 28, 2023

[redacted]

RE: [redacted]
ACTION NO.: 23-BOR-1072

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 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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

Encl: Decision Recourse
Form IG-BR-29
cc: [redacted], Facility Administrator

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 23-BOR-1072**

[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 February 1, 2023.

The matter before the Hearing Officer arises from the Facility's January 4, 2023 decision to discharge the Resident from the Facility.

At the hearing, the Facility appeared by [redacted], Facility Administrator. Appearing as witnesses for the Respondent were [redacted], Facility Director of Rehabilitation; [redacted], Facility Director of Social Services; [redacted], Facility Social Worker; and [redacted], RN, Facility Unit Manager. The appeared and was represented by [redacted] (hereafter, [redacted], the Resident's daughter. Appearing as a witness on behalf of the Resident was [redacted], the Resident's daughter. All witnesses were sworn in and the following documents were admitted into evidence.

Facility'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) On January 4, 2023, the Facility issued a notice advising the Resident that she would be discharged from the Facility to [redacted] home, effective February 3, 2023.

2) The Facility and the proposed discharge location are in [redacted]

3) The Facility's January 4, 2023 decision to discharge the resident was an involuntary discharge.

4) The notice advised that the reason for discharge was because "discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility."

5) The notice indicated that "the facility's ambulance partner, [redacted], is unable to continue to accommodate your transportation needs due to your size. Therefore, the facility can no longer meet your needs."

6) The notice reflected incorrect contact information for the Board of Review.

7) The Resident requires the use of a bariatric wheelchair.

8) The Facility utilized [redacted] to facilitate the Resident's transportation to non-emergency medical appointments.

9) On January 4, 2023, [redacted] notified the Facility that they could no longer facilitate the Resident's non-emergency medical transportation.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.15(c)1(i)(A) provides in pertinent parts:

> The facility must permit each Resident to remain in the facility and not discharge the Resident from the facility unless the discharge is appropriate because the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

Code of Federal Regulations 42 CFR §§ 483.15(c)(2)(i)(A) and (483.15(c)(2)(i)(B) provide in pertinent parts:

> When discharging a resident is necessary because the resident's needs cannot be met in the facility, the facility must ensure that the discharge is documented in the

resident's medical record. Documentation in the resident's medical record must include:

The basis for the transfer per paragraph (c)(1)(i) of this section, the specific resident needs that cannot be met, the facility's attempts to meet the resident's needs, and the service available at the receiving facility to meet the needs.

Code of Federal Regulations 42 CFR § 483.15(c)(2)(ii) provides in pertinent parts:

The documentation required by paragraph (c)(2)(i) of this section must be made by the resident's physician when discharge is necessary under paragraph (c)(1)(A).

West Virginia Code of State Rules §§ 64-13-4(13)(6)(b) and 64-13-4(13)(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 before the proposed discharge and by developing a plan designed to minimize any transfer trauma to the resident. The plan may include counseling to the resident regarding available community resources and taking steps under the nursing home's control to assure safe relocation.

DISCUSSION

On January 4, 2023, the Facility issued a written notice advising the Resident that she would be discharged to [redacted] residence, effective February 3, 2023, because discharge was necessary for the Resident's welfare and the Resident's needs could not be met at the facility. The Facility testified that the Resident's non-emergency medical transportation needs could not be met because the Facility's van was unable to accommodate her bariatric wheelchair and no other resources were available to facilitate bariatric transportation. The Resident's representative argued that the Resident could be accommodated by non-bariatric wheelchairs for transportation purposes and contested the proposed discharge location. The Resident's representative testified that she preferred the Resident not be transferred to another facility because of the Facility's proximity to her home.

The regulations permit facilities to discharge residents when their needs cannot be met in the facility. When a resident is discharged for this reason, documentation in the resident's medical record must include the basis for discharge, the specific resident needs that cannot be met, the facility's attempts to meet the resident's needs, and the service available at the discharge location to meet the resident's needs. The regulations specify that the documentation must be made by the resident's physician.

The Facility has the burden of proof. The Facility had to demonstrate by a preponderance of the evidence that at the time of the January 4, 2023 decision to discharge the Resident, the Resident's transportation needs could not be met by the facility. The evidence had to reveal that the Resident's

physician documented the basis for discharge, the Resident's needs that cannot be met, the Facility's attempts to meet the resident's needs, and the service available at the discharge location to meet the Resident's needs.

Transportation Needs

The Facility's representative and witnesses provided reliable testimony regarding the necessity for the Resident to utilize a bariatric wheelchair. The testimony reflected that due to the Resident's bariatric needs, she could not safely utilize a non-bariatric wheelchair. The Facility's representative and witnesses provided reliable testimony regarding the inability of the Facility's van to accommodate a bariatric wheelchair. The Resident's representative did not dispute that [redacted] informed the Facility that they could no longer facilitate the Resident's non-emergency medical transportation needs.

Discharge Location

The Facility has a responsibility to assist the Resident with aligning appropriate discharge arrangements. The Facility testified that [redacted] services were unable to facilitate the Resident's transportation needs. No evidence was presented to indicate what other efforts the Facility had made to identify services available at the proposed [redacted] discharge location. Because the preponderance of evidence revealed that the Facility incorrectly discharged the Resident, the issue of discharge location is moot. However, the Facility should take note of the regulatory requirement to make reasonable efforts to align appropriate discharge arrangements upon involuntary discharge of a resident.

Notice

The Facility's notice reflected incorrect contact information for the Board of Review. The Resident was not prejudiced by this error as she was able to request and receive a fair hearing. However, the Facility should ensure that future notices of transfer or discharge reflect accurate contact information for the offices listed on the notice.

CONCLUSIONS OF LAW

1) A facility may discharge a resident when the resident's needs cannot be met in the facility.

2) The preponderance of evidence revealed that the Facility was unable to meet the Resident's non-emergency medical transportation needs.

3) When discharging a resident is necessary because the resident's needs cannot be met in the facility, the facility's medical record must include physician documentation of the basis for the discharge, the specific resident needs that cannot be met, the facility's attempts to meet the resident's needs, and the service available at the discharge location to meet the resident's needs.

4) The preponderance of evidence failed to prove that the Resident's medical record contained required physician documentation of the basis for the Resident's discharge, the Resident's specific needs that cannot be met, the Facility's attempts to meet the Resident's needs, and the service available at the discharge location to meet the Resident's needs.

5) The Facility's January 4, 2023 decision to discharge the Resident, effective February 3, 2023, was incorrect.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Facility's January 4, 2023 decision to discharge the Resident.

Entered this 28th day of February 2023.

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Tara B. Thompson, MLS
State Hearing Officer