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

March 23, 2023

[redacted]

RE: [redacted]
ACTION NO.: 23-BOR-1145

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]

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 23-BOR-1145**

[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 March 8, 2023.

The matter before the Hearing Officer arises from the Facility's January 31, 2023 decision to discharge the Resident from the Facility.

At the hearing, the Facility appeared by [redacted] Facility Administrator. Appearing as a witness on behalf of the Facility was [redacted], Facility Director of Nursing. The Resident was represented by [redacted], her nephew. All attendees were sworn in and the following documents were admitted into evidence.

Facility's Exhibits:

F-1 Notice of Transfer or Discharge
Dated January 31, 2023

F-2 [redacted] Incident Log
Dated May 20, 2022 through January 30, 2023

F-3 Facility Contact Notes
Dated December 9, 2022 through January 31, 2023

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 31, 2023, the Facility issued a Notice of Transfer or Discharge advising the Appellant "a discharge or transfer from this Facility will be necessary," and indicated "the transfer or discharge is necessary for your welfare and your needs cannot be met in this facility" (Exhibit F-1).

2) The January 31, 2023 notice advised that a transfer to the Resident's representative's home would take effect March 2, 2023 (Exhibit F-1).

3) The January 31, 2023 notice contained inaccurate contact information for the Board of Review (Exhibit F-1).

4) The Facility's January 31, 2023 decision to discharge the Resident was involuntary.

5) The Facility's record reflects nine incidents of resident-to-resident altercations with alleged abuse by the Appellant (Exhibit F-2).

APPLICABLE POLICY

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

> The facility must permit each Resident to remain in the facility and not transfer or discharge the Resident from the facility unless the discharge is appropriate because the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, or the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

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

> When transferring or discharging a resident is necessary because the resident's needs cannot be met in the facility, the facility must ensure that the transfer or 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)(A) and 483.15(c)(2)(ii)(B) provide in pertinent parts:

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

West Virginia Code of State Rules §§ 64-13-4(13)(6)(b) and 64-13-4(13)(7)(a) 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.
>
> A nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his or her will.

DISCUSSION

The Facility determined the Resident's needs could not be met at the facility and the safety of the individuals in the facility was endangered due to the clinical or behavioral status of the Resident. On January 31, 2023, the Facility decided to discharge the Resident to the Resident's representative's home. The Resident's representative contested the proposed discharge. The Resident's representative argued that the Resident was not a danger to other residents of the Facility. The Resident's representative contended that the Facility failed to attempt treatment interventions to meet the Resident's needs before they decided to discharge her.

The regulations permit facilities to transfer or discharge residents when their needs cannot be met in the facility. The regulations also permit facilities to transfer or discharge residents when the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. When residents are discharged for these reasons, documentation in the resident's medical record must include the basis for discharge, the specific resident's needs that cannot be met, the facility's attempts to meet the resident's needs, and the services available at the transfer or 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 31, 2023 decision to discharge the Resident, the Resident's needs could not be met by the Facility and that the Resident's behavior endangered other individuals in 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 services available at the transfer or discharge location to meet the Resident's needs.

Resident Needs and Safety of Others

Pursuant to the evidence, the Facility believed that due to the Resident's increased behaviors, the facility could not meet the staffing needs required to ensure the safety of the other residents. The Facility's record reflected nine resident-to-resident altercations with alleged abuse by the Appellant. The Facility's evidence reflected vague reference to hitting and scratching, however, no evidence was submitted to establish details of the incidents — including the severity of the incidents and whether the allegations were investigated and substantiated.

The submitted evidence did not contain physician documentation of specific needs of the Resident that could not be met at the facility, the Facility's attempts to meet the resident's needs, or documentation that the Resident's behavior endangered the individuals in the Facility. Without evidence of physician documentation, as required by the regulations, the Respondent's decision to transfer or discharge the resident cannot be affirmed.

Discharge Location

The Facility has a responsibility to assist the Resident with aligning appropriate discharge arrangements. The Facility argued that the Facility offered to transfer the Resident to a facility better suited to meet the Resident's needs by offering treatment programs for individuals with similar behavioral needs. During the hearing, the Facility argued that the Resident's representative declined to transfer to an alternative facility and that discharge to the Resident's representative was necessary. No evidence was presented to indicate that Facility had made any effort to identify services available at the Resident's representative's home before deciding to discharge her there.

Because the preponderance of evidence revealed that the Facility incorrectly acted to discharge 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 transfer or discharge a resident when the resident's needs cannot be met in the facility.

2) A facility may transfer or discharge a resident when the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

3) The facility must ensure that the resident's medical record includes physician documentation of the basis for the discharge, the specific resident's needs that cannot be met, the facility's attempts to meet the resident's needs, the service available at the transfer or discharge location to meet the resident's needs, and documentation that the Resident's behavior endangered the individuals in the Facility.

4) The preponderance of evidence failed to demonstrate that the Facility was unable to meet the Resident's needs.

5) The preponderance of evidence failed to demonstrate that the safety of individuals in the facility was endangered due to the clinical or behavioral status of the Resident.

6) The preponderance of evidence failed to prove that the Resident's medical record contained the required physician documentation.

7) The Facility's January 31, 2023 decision to discharge the Resident, effective March 2, 2023, was incorrect.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Facility's January 31, 2023 decision to discharge the Resident.

Entered this 23rd day of March 2023.

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Tara B. Thompson, MLS
State Hearing Officer