



**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**

April 12, 2023



RE:

ACTION NO.: 23-BOR-1383

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,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc:



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

[REDACTED]

Resident,

v.

Action Number: 23-BOR-1383

[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 April 5, 2023, on an appeal filed on March 15, 2023.

The matter before the Hearing Officer arises from the February 28, 2023, decision by the Facility to propose a discharge of the Resident due to nonpayment.

At the hearing, the Facility appeared by [REDACTED], Facility Administrator. Appearing as witnesses for the Facility were [REDACTED] Social Worker; [REDACTED] and [REDACTED], Financial Office. The Resident was self-represented. Appearing as a witness for the Resident was [REDACTED], Medical Attorney-in-Fact. The witnesses were placed under oath, 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 Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

- 1) The Resident was admitted to [REDACTED] (Facility) on July 7, 2022.
- 2) The Resident was a recipient of Long Term Care Medicaid benefits.
- 3) The Resident contacted the Department of Health and Human Resources (DHHR) in December 2022 and requested closure of his Long Term Care Medicaid benefits.
- 4) The Resident's Long Term Care Medicaid eligibility ended, effective December 31, 2022.
- 5) The Facility's request for Medicaid payment for the Resident's care for January 2023 was denied.
- 6) The Facility confirmed with the Resident's DHHR caseworker that his Long Term Care Medicaid benefits had been terminated at his request, effective December 31, 2022.
- 7) Facility employees met with the Resident on February 10, February 17, and February 20, 2023 to discuss his outstanding bill and payment arrangements.
- 8) The Resident owes the Facility \$40,200 for his care from January through April 2023.

APPLICABLE POLICY

Code of Federal Regulation – 42 CFR §483.15 provide that the nursing facility administrator or designee must permit each resident to remain in the facility, and not be transferred or discharged from the facility unless one of the following conditions is met:

(1) Facility requirements

- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
 - (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
 - (B) 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;
 - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
 - (D) The health of individuals in the facility would otherwise be endangered;
 - (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the

third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, 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.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by

(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must -

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when -

- The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
- The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
- The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
- An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
- A resident has not resided in the facility for 30 days.

(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section 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 of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000; and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

Code of Federal Regulations - 42 CFR §483.21(c) describes discharge planning:

(1) Discharge planning process. The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at §483.15(b) as applicable and—

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

DISCUSSION

Federal regulations permit the involuntary discharge of an individual if the individual has failed, after reasonable and appropriate notice, to pay for a stay at a nursing facility.

The Resident testified that he does not have a place to go if he is discharged from the Facility. The Resident stated that his Workers Compensation case has not been settled, and he has an attorney handling his case. The Resident's representative, [REDACTED] testified that the Resident began receiving Workers Compensation of \$635 weekly in January 2023 and he is expecting a large lump sum as part of his settlement. [REDACTED] contended that once the Resident receives the lump sum, the Facility will be paid what is owed. [REDACTED] stated she would be unable to care for the Resident in her home.

[REDACTED], Social Worker for the Facility, testified the Facility has offered to assist the Resident in reapplying for Long Term Care Medicaid benefits and creating a payment plan for his outstanding balance. [REDACTED] stated that the Facility only learned of the onset of the Resident's Workers Compensation income the previous week and there have been no assurances from the Resident's attorney that a settlement is forthcoming. [REDACTED] purported that the Resident has refused to reapply for Medicaid and has refused all efforts in assisting him with finding a safe and appropriate discharge location.

The Facility has met the regulatory requirement in providing the Resident with reasonable and appropriate notice of his outstanding balance at the facility. The Resident has not made any payments towards his balance since voluntarily closing his Long Term Care Medicaid benefits and the onset of his Workers Compensation income.

Federal regulations state that the notice of discharge must state the location of which the resident is to be discharged. Testimony from the Facility indicated that the Resident has been uncooperative in finding an appropriate discharge location and the Resident's representative testified that she was unaware of any efforts on behalf of the Facility to find alternative placement. The Facility must provide sufficient preparation and orientation to ensure a safe and orderly transfer or discharge from the facility, involving the Resident and the Resident's representative in the development of the discharge plan and inform the resident and resident representative of the final plan. The Resident and his representative have an obligation to participate in his discharge planning process and in the cooperation of potential resources available to assist in this process.

Whereas the preponderance of evidence showed that the Facility followed federal regulations in the proposed discharge of the Resident from its facility due to non-payment, the proposed discharge of the Resident is affirmed.

CONCLUSIONS OF LAW

- 1) Federal regulations permit the involuntary discharge of an individual if the individual has failed, after reasonable and appropriate notice, to pay for a stay at a nursing facility.
- 2) The Resident owes an outstanding balance of \$40,200 to the Facility.
- 3) The Facility notified the Resident several times of his outstanding balance.
- 4) The Facility followed federal regulations in the proposed discharge of the Resident.

DECISION

It is the decision of the State Hearing Officer to **uphold** the decision of [REDACTED] to discharge the Resident from its facility due to non-payment.

ENTERED this 12th day of April 2023.

Kristi Logan
Certified State Hearing Officer