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

June 13, 2023

[redacted]

RE: [redacted]
ACTION NO.: 23-BOR-1520

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-1520**

[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 May 3, 2023.

The matter before the Hearing Officer arises from the Facility's March 24, 2023 decision to discharge the Resident from the Facility.

At the hearing, the Facility was represented by [redacted] Facility Administrator. Appearing as a witness for the Facility was [redacted] Facility Director of Nursing. The Resident appeared and was self-represented. 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 March 24, 2023, the Facility issued a notice advising the Resident he would be discharged on April 24, 2023, to "take me home WV apt [sic]," because:
    - The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the center.
    - 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 center.
    - The safety of individuals in the center is endangered due to the clinical or behavioral status of the resident.
    - The health of individuals in the center would otherwise be endangered.

2) The decision to discharge the Resident was an involuntary discharge.

3) Cigarette smoking is not permitted on Facility property.

4) The Resident must sign out of the Facility and leave the Facility property to smoke cigarettes.

5) The Facility requires cigarette smoking paraphernalia to be stored at the nurse's station.

6) On March 24, 2023, the Resident had cigarettes and a lighter in his possession while in his room.

7) On March 24, 2023, Nurse [redacted] was present at the Facility.

8) The Facility determined the Resident endangered other persons in the Facility by smoking cigarettes in his room on March 24, 2023.

9) The Resident is on a waiting list for an apartment through Take Me Home WV.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR 483.15(c) *Transfer and Discharge* provides in relevant parts:

(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 …

(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 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's need(s) that cannot be met, facility attempts to meet the resident's needs, and the services 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 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.

Code of Federal Regulations 42 CFR 483.10(e) ***Respect and Dignity*** **provides in relevant parts:**

The Resident has a right to be treated with respect and dignity, including: …
(2) The right to retain and use personal possessions, including furnishing and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
(3) The right to reside and receive services in the facility with reasonable accommodation of residents needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

West Virginia Code of State Rules §§ 64-13-4(13)(6)(b) and 64-13-4(13)(7)(a) provides in relevant 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 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 decided to involuntarily discharge the Resident for multiple reasons. The Resident disputed the discharge decision and the basis for discharge. During the hearing, testimony was received from the parties and no exhibits were submitted as evidence. The Facility has the burden of proof.

The Facility's representative testified that the Resident was admitted to the Facility approximately two years ago and began smoking cigarettes approximately six months ago. The Resident did not refute these approximations. The Facility's representative testified that [redacted] Health Department regulation prohibits smoking on health facility premises. To accommodate the Resident's smoking activity, the Facility arranged for the Resident to take a leave of absence and wheel to a location off the Facility's property to smoke. The Facility's representative testified that upon the Resident's return, smoking paraphernalia is required to be kept at the nurse's station, not in the Resident's room. The Resident did not dispute this Facility policy.

The Facility's representative testified that the Resident was provided with a 30-day discharge when he was found to have been smoking cigarettes in his room. The Facility's representative testified that the primary reason for discharge was the Resident's failure to follow rules when smoking cigarettes and endangering other residents in the Facility.

The Resident's Welfare and Needs Cannot be Met at the Facility

The regulations permit facilities to discharge residents when their needs cannot be met in the facility. When 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. The preponderance of the evidence had to demonstrate that the Resident's physician's documentation in the Resident's record included the basis for discharge, the Resident's specific needs that cannot be met by the Facility, the Facility's attempts to meet the Resident's needs, and the services available at the receiving facility to meet the needs.

No evidence was submitted that contained physician documentation of specific needs of the Resident that could not be met at the Facility or the Facility's attempts to meet the Resident's needs. Without evidence of the required physician documentation the Respondent's decision to discharge the Resident on this basis cannot be affirmed.

Resident's Health Has Improved

The regulations permit facilities to discharge residents when the resident's health has improved sufficiently such that they no longer require the services provided by the facility. The regulations prohibit facilities from involuntarily discharging a resident that still requires the nursing home's services. The preponderance of the evidence had to demonstrate that the Resident's physician's documentation included the Resident's health improvement as a basis for discharge. While the notice reflected improved health as a basis for the discharge decision, no evidence was submitted to establish that the Resident no longer required the Facility's services.

Clinical or Behavioral Status of the Resident Endangers Individuals in the Center

The regulations permit facilities to discharge residents when the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The preponderance of the evidence had to demonstrate that the Resident's record contained physician documentation of the Resident's clinical or behavioral status endangering individuals at the Facility as a basis for discharge.

The Facility's representative testified that on one occasion, the Resident provided another vulnerable resident with a cigarette. The Facility's witness, Nurse [redacted] testified that there is oxygen in the building and that having an open flame in the Facility endangers the other residents in the building.

The Facility contended that the Resident did not follow Facility procedures and testified that the day the notice was provided, the Appellant had been smoking cigarettes in his room. During the hearing, the Resident disputed that he was smoking in his room and argued that smoke could have blown in from outside the window. The Resident's later testimony indicated that he had "stepped over the line" but after he was told not to smoke in the Facility, he has complied with procedures since then.

The preponderance of evidence revealed the Resident failed to follow a Facility policy by keeping smoking paraphernalia, including lighters, in his room. Nurse [redacted] compelling testimony regarding the danger of open flames around oxygen indicates a reasonable basis for discharging the Resident. However, the basis for discharge must be documented in the Resident's record by a physician. No evidence was submitted that contained physician documentation that the Resident must be discharged because his behavior endangered the individuals in the Facility. Therefore, the Facility's decision to discharge the Resident on this basis cannot be affirmed.

The Health of Individuals in the Center Would Otherwise Be Endangered

The regulations permit facilities to discharge residents when the health of individuals in the Facility would be otherwise endangered. The preponderance of the evidence had to demonstrate that the Resident's record contained physician documentation that discharge was necessary because the health of individuals in the center would be otherwise endangered. No evidence was submitted that contained physician documentation that the health of individuals in the center would be otherwise endangered if the Resident was not discharged.

Discharge Location

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 requirements regarding involuntary discharges.

The notice to discharge the Resident indicated that the Resident would be generally discharged to a Take Me Home WV apartment. During the hearing, the Facility's representative testified that Take Me Home WV has offered apartments to the Resident, that the Resident declined, and that

the Resident is currently on a waiting list for the next available apartment. The Resident denied declining discharge placements and testified that he is willing to be discharged when possible. Testimony by the parties was provided regarding the Resident's current position on a waitlist for an apartment.

The Facility has a responsibility to assist the Resident with aligning appropriate discharge arrangements. The preponderance of the evidence failed to establish a specific proposed discharge location or identify services available at the proposed location that meet the Resident's medical needs. The regulations prohibit the Facility from involuntarily discharging a resident to the community when the resident continues to require the services provided by the facility. No evidence was submitted to establish that the Resident no longer required the Facility's services.

CONCLUSIONS OF LAW

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

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

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

4) A facility may discharge a resident when the resident's health has sufficiently improved such that he no longer requires the services provided by the facility.

5) When discharge of a resident is necessary because the resident's health has improved, the resident's medical record must include physician documentation of the basis for discharge.

6) The preponderance of evidence failed to demonstrate that the Resident's health had improved sufficiently such that he no longer required the services provided by the Facility.

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

8) When discharge of a resident is necessary because the resident's clinical or behavioral status endangers individuals at the facility, the resident's medical record must include physician documentation of the basis for discharge.

9) The preponderance of evidence revealed that the Resident's use of flame while oxygen is present at the Facility could endanger individuals in the Facility.

10) A facility may discharge a resident when the health of individuals in the Facility would be otherwise endangered.

11) When discharge of a resident is necessary because the health of individuals in the center would be otherwise endangered, the resident's medical record must include physician documentation of the basis for discharge.

12) The preponderance of the evidence failed to prove that the Resident's medical record contained the required physician documentation for each of the discharge bases outlined in the Respondent's March 24, 2023, discharge notice.

13) The Facility's March 24, 2023 decision to discharge the Resident, effective April 24, 2023, was incorrect.

14) Because the Facility's act to discharge the Resident was incorrect, the issue of discharge location is moot.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Facility's March 24, 2023 decision to discharge the Resident.

Entered this 13th day of June 2023.

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Tara B. Thompson, MLS
State Hearing Officer