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

Sherri A. Young, DO, MBA, FAAFP
Interim Cabinet Secretary

Christopher G. Nelson
Interim Inspector General

August 8, 2023

[redacted]

RE: [redacted]
ACTION NO.: 23-BOR-2140

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: [redacted]

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 23-BOR-2140**

[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 August 1, 2023, on an appeal filed July 6, 2023.

The matter before the Hearing Officer arises from the June 6, 2023, decision by the Facility to discharge the Resident from [redacted].

At the hearing, the Facility appeared by [redacted] Appearing as witnesses for the Facility were [redacted], Administrator and [redacted], Director of Nursing. The Resident appeared by his brother, [redacted]. Appearing as a witness for the Resident was his niece, [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence.

Facility's Exhibits:

F-1 Progress Note dated July 24, 2023
F-2 Progress Notes from January 5 through July 18, 2023
F-3 30-Day Discharge Notice dated June 5, 2023
F-4 Notice of Discharge and Transfer dated June 6, 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 Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Resident was admitted to [redacted], hereinafter referred to as Facility, on January 5, 2023.

2) The Resident suffered from a cardiac arrest, which required him to be resuscitated several times, resulting in an anoxic brain injury (Exhibit F-2).

3) Upon admission to the Facility, the Appellant was oriented to person, but was experiencing confusion to place and time (Exhibit F-2).

4) On January 10, 2023, the Resident was determined to lack capacity due to diagnoses of delirium and anoxic brain injury (Exhibit F-2).

5) On January 18, 2023, the Resident was found outside of the Facility, standing on the front porch with his luggage (Exhibit F-2).

6) The Resident was given a Wanderguard bracelet, a device that would alert staff if he approached certain doors (Exhibit F-2).

7) Several times a week since his admission, the Resident was found wandering the Facility attempting to exit the building, often with his luggage (Exhibit F-2).

8) The Resident's physician attempted to curb the Resident's behaviors through medications (Exhibit F-2).

9) The Resident became increasingly agitated when staff would redirect him from seeking exits from the building (Exhibit F-2).

10) One-on-one staffing was assigned to the Resident to redirect him when he attempted to leave the Facility (Exhibit F-2).

11) On June 6, 2023, the Facility notified the Resident's healthcare surrogate, [redacted] that the Resident would be discharged to [redacted] as his welfare and needs could not be met at the Facility (Exhibit F-4).

12) The Resident's physician, [redacted] recommended the Resident's transfer to a facility with a memory care unit due to repetitive episodes of aggressive behavior when redirected from attempts to exit the facility (Exhibit F-1).

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.

DISCUSSION

Federal regulations permit the involuntary discharge or transfer of a resident if the resident's welfare and needs cannot be met in the facility. Physician documentation in the resident's medical record must document the basis of the discharge or transfer, the specific needs that cannot be met, and attempts that were made to meet the resident's needs.

The Facility contended that it could no longer meet the Resident's needs due to his dementia and his continuous exit-seeking behaviors. [redacted] Administrator for the Facility,

testified that the Resident has exhibited increased confusion and elopement attempts since his admission and he has become aggressive when redirected by staff. [redacted] testified that the Resident's medications have been changed, he wears a Wanderguard bracelet and has been assigned one-on-one staffing to prevent him from exiting the building. [redacted] stated the Facility cannot continue to assign one staff member to the Resident on a twenty-four-hour basis due to staffing shortages and overtime. [redacted] stated that referrals were made to several facilities that have specialized memory care units that are more secure and more equipped to accommodate the Resident's behaviors. Attempts were made to find a facility closer to the Resident's family, however, [redacted] stated the closest facility that could accept the Resident was in a neighboring city.

[redacted], Director of Nursing, provided supporting testimony regarding the Resident's behaviors. [redacted] testified that the Facility is located near a highway and there is a pond located behind the property. The Resident has successfully exited the Facility on two occasions, and they cannot continue to provide twenty-four supervision to ensure the Resident's safety. [redacted] stated the Resident attempts to leave the Facility almost daily and his aggression has increased when staff try to redirect him.

[redacted], the Resident's brother, questioned the Resident's diagnosis of dementia, claiming he had no prior cognitive issues prior to his admission. [redacted] stated a door code is required to enter and exit the Facility, unsure of how [redacted] was a more secure facility. [redacted] stated the highway in question near the Facility is not as close as claimed and as long as the Resident was taken outside occasionally and treated well, he would give staff no problems.

The Facility met the regulatory requirements of physician documentation of how the Resident's needs could not be met, its attempts through medication management and twenty-four hour supervision to prevent the Resident from leaving the Facility and the physician recommendation of his transfer to a facility offering a secure memory unit. Whereas the preponderance of credible evidence showed that the Facility could not meet the Resident's needs and welfare, the Facility's involuntary discharge of the Resident to [redacted] is affirmed.

CONCLUSIONS OF LAW

1) Federal regulations permit the involuntary discharge or transfer of a resident if the resident's welfare and needs cannot be met in the facility.

2) The Resident's medical record documented the Facility's attempts to prevent the Resident from exiting the facility.

3) The Resident's physician recommended his transfer to a facility with a secure memory unit that could better accommodate the Resident's behaviors.

4) [redacted] Facility has a secure floor and has agreed to accept the Resident.

5) Whereas the Facility can no longer meet the Resident's welfare and needs, its decision to transfer the Resident to [redacted] Facility is upheld.

DECISION

It is the decision of the State Hearing Officer to **uphold** the decision of Glenwood Health Care Facility to transfer the Resident to Seneca Trail Healthcare Center.

ENTERED this 8th day of August 2023.

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Kristi Logan
Certified State Hearing Officer