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 17, 2023

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 23-BOR-2281

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,

Pamela L. Hinzman
State Hearing Officer
Member, State Board of Review

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

cc: [redacted]

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 23-BOR-2281**

[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 9, 2023.

The matter before the Hearing Officer arises from the July 18, 2023, decision by the Facility to discharge the Resident.

At the hearing, the Respondent appeared by [redacted], Administrator, [redacted]. The Appellant was represented by his stepdaughter, [redacted]. All witnesses were sworn 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] on July 17, 2023.

2) On the night of his admission, the Resident became combative and punched a certified nursing assistant in the face, giving her a black eye.

3) When questioned about the incident, the Resident indicated that he would do it again.

4) The Facility proposed discharge of the Resident based on health and safety concerns.

5) Written documentation summarizes the Facility's verbal notice of discharge to the Appellant; however, there is no indication that a written notice was provided to the Appellant as required following urgent discharge.

6) The Resident was discharged from the Facility on July 18, 2023, and has been a patient at [redacted] since that time.

APPLICABLE POLICY

Code of Federal Regulations Title 42 §483.15(c)(1)(i) provides 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 -

- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
- (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
- (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
- (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
- (E) 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 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); 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.

(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.

(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

DISCUSSION

Federal regulations permit the involuntary discharge of an individual from a Long-Term Care facility when the health and safety of individuals in the facility would be endangered. When urgent discharge is deemed necessary due to health and safety concerns, a facility must provide written notice to the resident and his representative as soon as practical. Medical record documentation must be made by **a physician** [emphasis added] when the health and safety of other residents is endangered by the resident's clinical or behavioral status.

[redacted] Facility Administrator, testified that the Facility feared the Resident would become a health and safety risk to other patients after he physically assaulted a Facility employee.

The Resident's stepdaughter, [redacted], testified that she understands why the Appellant cannot reside at the Facility based on his behavior, and she is uncertain why [redacted] transferred him to the Facility since he was combative with emergency personnel during his transport. [redacted] stated that her stepfather's legs have been amputated, he had a stroke which affected his behavior, and he can only move one arm. She testified that she spoke with [redacted] an employee of the Facility, by telephone regarding the Facility's plan to discharge her stepfather. She alleged that [redacted] informed her that her stepfather would be sitting outside awaiting pick up by his family because he was "not her problem." [redacted] indicated that she contacted law enforcement and the West Virginia Department of Health and Human Resources about the situation but testified that her stepfather was in a room when her niece arrived at the Facility to transport him to [redacted]. [redacted] stated that her stepfather has been at [redacted] since that time and will be admitted to a nursing facility in Ohio upon his release.

Written documentation provided in conjunction with the Appellant's hearing request states that the Resident was provided with verbal notification of the discharge by [redacted] on July 18, 2023, but there is no indication that the Facility sent the Appellant a written discharge notice.

[redacted] testified that placing the Resident outside of the Facility would have never been permitted. She stated that she was unaware of the allegations and indicated that [redacted] is no longer employed at the Facility because she chose other employment when a new company took ownership of the nursing home. [redacted] testified that the Facility would launch an investigation into the matter.

While the Resident's combative behavior was a safety concern and a reason for potential discharge, there is no evidence that the Facility provided written notice of discharge to the Resident or his representative as soon as practical as required by federal regulations. In addition, no physician documentation was provided to verify that the safety of other residents was endangered by the Resident's clinical or behavioral status.

Based on information provided during the hearing, the Facility's discharge of the Resident did not meet regulatory requirements and cannot be affirmed.

CONCLUSIONS OF LAW

1) Federal regulations require nursing facilities to provide written notification of transfer or discharge to the resident and the resident's representative. Written notification must be provided as soon as practical in instances of discharges for health and safety issues.

2) There is no evidence to verify that the Resident or his representative were provided with any written notice following his verbal notice of discharge.

3) Federal regulations require that physician documentation be provided in a resident's medical record when the health and safety of other patients is endangered by the resident's clinical or behavioral status.

4) The Facility provided no evidence to demonstrate that the need for discharge was documented in the Resident's medical record.

5) As the Resident's discharge did not meet regulatory requirements, the Facility's decision to discharge him cannot be affirmed.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Facility's action to discharge the Resident.

ENTERED this 17th day of August 2023.

Pamela L. Hinzman
State Hearing Officer