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

September 7, 2023

[redacted]

RE: [redacted]
ACTION NO.: 23-BOR-2379

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]

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 23-BOR-2379**

[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 September 5, 2023.

The matter before the Hearing Officer arises from the July 17, 2023, decision by the Facility to discharge the Resident.

At the hearing, the Facility appeared by [redacted] Administrator, [redacted] The Resident appeared *pro se*. Appearing as a witness for the Resident was [redacted] resident. All witnesses were sworn and the following documents were admitted into evidence.

Nursing Facility's Exhibits:

NF-1 Excerpts from Resident's Plan of Care
NF-2 Resident's Progress Notes

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 January 20, 2023.

2) The Resident has been diagnosed with schizophrenia and exhibits or is at risk for distressed and/or fluctuating mood symptoms (Exhibit NF-1).

3) Progress Notes recorded by Social Services worker [redacted] on April 24, 2023, state that the Resident "exhibits or has the potential to demonstrate verbal behaviors such as yelling, threatening, expressing his anger by hitting walls, and or history of verbal altercation/outbursts directed toward others (e.g., use of abusive language, pattern of challenging/confrontational verbal behaviors). The Notes list several interventions to assist the Resident in controlling his emotions (Exhibit NF-1).

4) The April 24, 2023, Progress Notes state that the Resident should be educated about the consequences of his actions and that he should be offered assistance to find other housing. In addition, the Notes state that the Resident should be reminded to walk away when other residents make him angry, upset, or anxious (Exhibit NF-1).

5) The Resident has had repeated verbal outbursts at the Facility (Exhibit NF-2).

6) On May 17, 2023, the Resident became angry and punched a wall at the Facility (Exhibit NF-2).

7) On July 15, 2023, the Resident got into a verbal altercation with his roommate (Exhibit NF-2).

8) On July 15, 2023, the Resident got into a second verbal altercation with an incapacitated Resident (Exhibit NF-2).

9) Following the July 15, 2023, incidents, the Facility's nursing staff initiated 15-minute monitoring of the Resident's behavior for 72 hours. The Resident had no observed behaviors during the 72-hour period (Exhibit NF-2).

10) The Facility issued a Notice of Transfer or Discharge to the Resident on July 17, 2023, due to the safety risk to other residents.

11) The Notice of Transfer of Discharge indicates that the Resident would either be transferred to [redacted] or a homeless shelter in [redacted]

12) [redacted] M.D., completed and signed a medical evaluation for the Resident on July 31, 2023. The physician wrote that the Resident "is currently doing well, and his medical problems are stable. His medications are being continued, including metoprolol 100 mg bid for hypertension" (Exhibit NF-2).

APPLICABLE POLICY

Code of Federal Regulation 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 a resident from a Long-Term Care facility when the safety of individuals in the facility would be endangered. Medical record documentation must be made by **a physician** [emphasis added] when the safety of other residents is endangered by the resident's clinical or behavioral status.

[redacted] Facility Administrator, testified about incidents that occurred in May 2023 and July 2023 in which the Resident punched a wall and had verbal altercations with other residents, allegedly threatening an incapacitated patient.

The Resident testified that he punched a wall in May 2023 after another resident accused someone of cheating at a game. He stated that he had "a lot on his mind" at that time. The Resident indicated that he had a verbal altercation with his roommate on July 15, 2023, because his roommate frequently talked about his time in prison, constantly talked about sex, and swore in front of women. Later that day, the Resident got into a verbal altercation with an incapacitated resident, [redacted] because [redacted] engaged in "filthy talk." He stated that he told [redacted] to go back to his room. The Resident's witness, [redacted] testified that the Resident did not threaten [redacted] during the incident. The Resident testified that he was previously unaware that he had schizophrenia and felt that some of his behaviors could have been prevented with proper medication. He stated that he participates in therapy and is currently taking [redacted]

While combative behavior constitutes a safety concern and a reason for potential nursing home discharge, no physician documentation was provided to verify that the safety of other residents was endangered by the Resident's clinical or behavioral status. Information concerning the Resident's behaviors was recorded by nursing facility staff members and a family nurse practitioner; however, the only physician documentation provided by the Facility was the July 31, 2023, report by [redacted]. In the report, the physician indicated that the Resident was "doing well," and no safety risks to other residents were cited.

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 state that physician documentation must be provided to verify that the safety of other nursing facility residents is endangered by a Resident's clinical or behavioral status.

2) The Facility provided no evidence to demonstrate that a need for discharge based on safety concerns was documented in the Resident's medical record by a physician.

3) As the Resident's proposed discharge does 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 proposal to discharge the Resident.

ENTERED this 7th day of September 2023.

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Pamela L. Hinzman
State Hearing Officer