STATE OF WEST VIRGINIA
OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

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

Christopher G. Nelson
Interim Inspector General

January 24, 2024

[redacted]

Re: [redacted]
ACTION NO.: 23-BOR-3471

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. 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,

Angela D. Signore
State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29
cc: [redacted]

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BEFORE THE WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

IN THE MATTER OF:

[redacted],

Resident,

vs. ACTION NO.: 23-BOR-3471

[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 Office of Inspector General Common Chapters Manual. This fair hearing was convened on December 28, 2023, on an appeal filed November 20, 2023.

The matter before the Hearing Officer arises from the October 30, 2023 decision of [redacted] (Facility) to discharge the Resident from the Facility.

At the hearing, the Respondent appeared by [redacted]. Appearing as witnesses for the Facility was [redacted] The Resident appeared *pro se*. 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 is an occupant of [redacted] hereinafter Facility.

2) On October 30, 2023, the Facility issued a notice of discharge and transfer advising the Resident that he would be transferred or discharged from the center effective November 29, 2023, to a location to be determined or local homeless shelter, due to "The safety of individuals in the center is endangered due to the clinical or behavioral status of the Resident."

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

4) The Resident has repeatedly made sexually inappropriate behaviors and comments, and has exhibited aggressive behaviors towards staff and other residents throughout his stay in the Facility.

5) Progress notes or other physician signed documentation confirming the proposed discharge is necessary were not provided.

APPLICABLE POLICY

Code of Federal Regulation Title 42 §483.15(c)(1)(i) provides, in part:

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.

West Virginia Code §§ 4.13.2 - 4.13.3.b provides, in part:

The nursing home shall permit each resident to remain in the nursing home, unless:

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home;
- 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 nursing home;

- The health or safety of persons in the nursing home is endangered;
- The resident has failed, after reasonable and appropriate notice, to pay for a stay at the nursing home; or
- The nursing home ceases to operate.

Documentation:

- When the reason for the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home, the documentation must include the specific resident needs that cannot be met, the facility's attempt to meet the resident's needs, and the service available at the receiving facility to meet the resident's needs.
- The documentation shall be made by the resident's physician when transfer or discharge is necessary under the provisions of this rule.

West Virginia Code § 4.13.4 provides, in part:

Before a nursing home transfers or discharges a resident, it shall provide written notice to the resident and his or her legal representative as appropriate, of the transfer or discharge. The notice shall be in a language the resident understands and shall include:

- The reason for the proposed transfer or discharge;
- The effective date of the proposed transfer or discharge;
- The location or other nursing home to which the resident is being transferred or discharged;
- A statement that the resident has the right to appeal the action to the State Board of Review, with the appropriate information regarding how to do so;
- The name, address, and telephone number of the State Long-Term Care Ombudsman;
- For nursing home residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled persons;
- For nursing home residents with a mental health diagnosis, the mailing address and telephone number of the agency responsible for the protection and advocacy of persons or individuals with mental illness;
- A copy of the notice of proposed transfer or discharge shall be sent to the State Long-Term Care Ombudsman.

West Virginia Code § 64-13-4(6)(b) provides, in part:

> In the event of an involuntary transfer, the nursing home shall assist the resident in finding a reasonably appropriate alternative placement prior to the proposed transfer or 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.

DISCUSSION

On October 30, 2023, the Facility issued a notice informing the Resident that he would be transferred or discharged from the center, effective November 29, 2023, to a location to be determined or local homeless shelter, because "The safety of individuals in the center is endangered due to the clinical or behavioral status of the Resident." [redacted], Administrator of [redacted] argued that the Facility has "ongoing issues" with the Resident being sexually inappropriate and physically aggressive toward staff and other residents. [redacted] testified that the Resident has licked the ears of staff members, made sexually obscene comments, grabbed at the "private areas" of staff members, and has been abusive towards staff and other residents. She further testified that because the Facility has had numerous unsuccessful discussions and interventions with the Resident, and because his behavior has become "intolerable" to staff and their ability to provide care, discharge proceedings were initiated under the advisement of the Ombudsman. [redacted] testified that she has experienced the Resident's alleged behavior herself, and argued that his chart contains staff incident reports that go "months back."

The Resident refuted the Facility's accusations, and instead, counter argued that [redacted] staff have made sexual advances at and have threatened to hit him. The Resident alleged that: two (2) male staff members "messed" with him [sexually] in the shower, a female staff member asked the Resident if he "wanted some of her black vagina," and another female staff member purportedly "climbed up on top of" him during his bed bath and then "reported [the Resident] supposedly done something to her [*sic*]." The Resident further testified to becoming "aggravated" at staff members' treatment toward him and attributed his behavior to unanswered call lights, rolled up bed sheets, and the touching of his food tray with unwashed hands. The Facility's witness, [redacted], Director of Social Services at [redacted] refuted the Resident's testimony and argued that his chart documents multiple behavioral problems "as recent as this past week." [redacted] testified that because the Resident is uncooperative and refuses baths, doesn't allow staff to change sheets, provide daily care, or even move him, as contributors for his complaints.

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. The Facility bears the burden of proof and must demonstrate by a preponderance of evidence that the Resident's needs could not be met, and that his behavior endangered other individuals. The evidence had to contain physician documentation confirming that his needs cannot be met by the Facility, the basis for discharge, the Facility's attempts to meet the Resident's needs, plus the services available at the transfer or discharge location that do meet his needs. Neither party provided any documentary evidence to support the claims made at the hearing. Based on the limited reliable information without documentation from either party, it does appear that the Facility had the basis for a potentially

correct transfer or discharge, since combative and sexual behavior does constitute a safety concern. And though information concerning the Resident's behavioral occurrences may have been recorded in the chart by his physician and nursing facility staff members, it was not provided to this Hearing Officer in order to corroborate that the safety of other residents was endangered. Because the Facility's proposed discharge of the Resident did not meet the regulatory requirements, the decision to discharge or transfer the Resident cannot be affirmed.

CONCLUSIONS OF LAW

1) Federal regulations require physician documentation to be provided in order 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 October 30, 2023 decision to discharge the Resident.

ENTERED this *24th* day of January 2024.

Angela D. Signore
State Hearing Officer