April 16, 2024

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 25-BOR-1530

Dear Mr. [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 Office of the Inspector General and DEPARTMENT OF HUMAN SERVICES. These same laws and regulations are used in all cases to ensure 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: Recourse to Hearing Decision
Form IG-BR-29

cc: Sheila Jones-Marino, Facility
[redacted] Appellant MPOA

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 25-BOR-1530**

[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 April 2, 2025.

The matter before the Hearing Officer arises from the Facility's February 26, 2025 decision to discharge the Resident from the Facility.

At the hearing, the Facility was represented by [redacted], Facility Administrator. Appearing as witnesses on behalf of the Facility were [redacted], Director of Nursing, and [redacted], Social Services Director. The Resident was represented by [redacted]. Appearing as witnesses for the Appellant were [redacted], MPOA for the Resident, and [redacted], the Resident's wife. All representatives and witnesses were placed under oath and the following exhibits were admitted as evidence:

Facility's Exhibits:
F-1 Facility Progress Notes November 29, 2024 to March 24, 2025

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) On September 26, 2025, the Resident was admitted to [redacted] (hereafter, Facility), a long-term care facility in [redacted] West Virginia (Exhibit F-1).

2) At admission, the Resident's primary physician was [redacted] Facility Director (hereafter, Dr. [redacted]) (Exhibit F-1).

3) On February 26, 2025, the Facility issued a notice advising that the Resident would be discharged from the Facility to [redacted], in [redacted], because the Resident's behavioral status endangers the safety of individuals in the Facility.

4) The Resident lacks the capacity to make his own decisions and requires the services provided by the Facility (Exhibit F-1).

5) Because of the distance, discharging the Resident to [redacted] would impede the Resident's family's ability to visit him.

6) On January 5, 2025, the Resident was verbally aggressive towards staff by threatening to kill a physician's dog, any animal, or anyone who has an animal. During the same episode, the Resident was physically aggressive towards staff by lunging and attempting to corner staff (Exhibit F-1).

7) The January 5, 2025 incident was witnessed by [redacted], Licensed Practical Nurse (hereafter LPN [redacted]), and Dr. [redacted] (Exhibit F-1).

8) Facility staff called law enforcement during the January 5, 2025 episode but the Resident calmed before police arrived (Exhibit F-1).

9) On January 7 and January 13, 2025, Dr. [redacted] documented that the Resident may require a locked-down psychiatric unit for the Resident's safety (Exhibit F-1).

10) On January 15, 2025, Facility Social Services Director [redacted] (hereafter Ms. [redacted]) participated in a conference call with the Resident's wife, his stepdaughter, and his Power of Attorney (Exhibit F-1).

11) Ms. [redacted] documented:

> Reviewed that resident can be referred to PCH or ALF but this may be a challenge to get him admitted due to his Dementia and behaviors. Reviewed that we can start with referrals in the [redacted] area but that there is [sic] limited options for Medicaid approved facilities. Reviewed that we may need to expand the search to [redacted] (Exhibit F-1).

12) On January 15, 2025, [redacted] (hereafter Ms. [redacted]) agreed with a referral to "[redacted]" and Ms. [redacted] referred the Resident (Exhibit F-1).

13) On February 4, February 5, and February 8, 2025, the Resident was verbally aggressive to staff (Exhibit F-1).

14) On February 8, 2025, the Resident attempted to back his wheelchair into LPN [redacted] (Exhibit F-1).

15) On February 9, 2025, the Resident kicked another resident and was verbally aggressive to staff and other residents (Exhibit F-1).

16) On February 9, 2025, the Resident swung at LPN [redacted] (hereafter LPN [redacted]) and struck LPN [redacted] on the left shoulder by slamming the door shut (Exhibit F-1).

17) On February 10, 2025, Ms. [redacted] called to inquire about referrals for the Resident and was advised by Ms. [redacted] that "aside from the [redacted] no other referrals were made" (Exhibit F-1).

18) On February 11, 2025, Dr. [redacted] documented "increase risperdol [sic] and [continue] to attempt to find a more appropriate facility to meet the pt's [sic] complex psych needs" (Exhibit F-1).

19) On February 13, 2025, the Resident was verbally aggressive towards staff (Exhibit F-1).

20) On February 13, 2025, the Resident picked up his walker and struck Facility Director of Nursing [redacted] (hereafter Nurse [redacted]) (Exhibit F-1).

21) On February 14, 2025, Ms. [redacted] contacted Ms. [redacted] by telephone and provided the option of transferring the Resident to [redacted], a sister facility. Ms. [redacted] explained that if the family did not agree to the transfer, the Resident would have to be discharged to the family's care (Exhibit F-1).

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.15(c)(1)(i)(C) (March 2025) ***Transfer and Discharge — Facility Requirements*** provides that the facility must permit each Resident to remain in the facility and not transfer or discharge the Resident from the facility unless the discharge is appropriate because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

Code of Federal Regulations 42 CFR § 483.15(c)(2)(i) (March 2025) ***Transfer and Discharge — Documentation*** provides that when the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F), 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.

The documentation in the resident's medical record must include physician documentation of the basis for the discharge per paragraph (c)(1)(i) of this section.

Code of Federal Regulations 42 CFR § 483.15(c)(7) (March 2025) ***Orientation for transfer or discharge*** provides that a facility must provide and document sufficient preparation and orientation to the resident to ensure safe and orderly discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

Code of Federal Regulations 42 CFR § 483.21(c)(1)(v) and (March 2025) ***Discharge planning — Discharge planning process*** provides that the facility must develop and implement an effective discharge planning process that involves the interdisciplinary team in the ongoing process of developing the discharge plan.

West Virginia Code of State Rules (W. Va. Code R.) 64 CSR 13 § 4.13(c)(1) – § 4(13)(d)(3) (July 2021) provides that when a nursing home discharges a resident, the resident's clinical record shall contain the reason for the transfer or discharge. The documentation shall be made by the resident's physician when discharge is necessary under the provisions of this rule.

Before a nursing home transfers or discharges a resident, it shall provide written notice to the resident of the discharge. The notice shall include the reason for the proposed discharge and the location to which the resident is being discharged.

W. Va. Code R. 64 CSR 13 § 4.13.6.b (July 2021) ***Involuntary Transfer*** provides that in the event of an involuntary transfer, the nursing home shall assist the resident, legal representative, or both in finding a reasonably appropriate alternative placement before 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, a legal representative, or both regarding available community resources and taking steps under the nursing home's control to ensure safe relocation.

W. Va. Code R. 64 CSR 13 § 4.13.7.a (July 2021) ***Discharge to a Community Setting*** provides that a nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his will.

DISCUSSION

On February 26, 2025, the Facility issued a notice advising the Resident that he would be discharged to [redacted] because his behavior endangered the safety of others in the Facility. The Resident's representative contested the discharge location and argued that the identified location would prevent the family from visiting with the Resident. The Facility argued that referrals to closer facilities were not accepted.

The regulations permit facilities to transfer or discharge residents when the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. When residents are discharged for this reason, documentation in the resident's medical record must include the basis for the resident's discharge. The regulations specify that the resident's physician must make

the documentation. Further, the evidence had to establish that the Facility assisted the resident, legal representative, or both in finding a reasonably appropriate alternative placement before the proposed transfer or discharge.

Behavior Endangers the Safety of Other Individuals in the Facility

The Facility has the burden of proof. The Facility had to demonstrate by a preponderance of the evidence that at the time of the February 26, 2025 decision to discharge the Resident, the Resident's behavior endangered other individuals in the Facility.

During the hearing, evidence was presented regarding the Resident's history of verbal and physical aggression towards staff and other residents. The submitted documentary evidence corroborated that the Resident has demonstrated continued aggression toward others at the Facility. During the hearing, the Resident's representative did not dispute the Resident's history of aggressive behavior towards others.

Documentation:
The Facility had to demonstrate by a preponderance of evidence that the reason for the Resident's discharge was documented in the Resident's medical record by the Resident's physician. The submitted evidence reflected documentation by the Resident's physician that the Resident may require a locked-down psychiatric unit for the Resident's safety and indicated referrals to other facilities should be made. The evidence established that the Resident's physician documented the reason for the Resident's discharge in the Resident's medical record.

Discharge Location
Under the regulations, when a resident is involuntarily discharged, the Facility must assist the Resident in finding a reasonably appropriate alternative placement before the proposed discharge and include the location on the discharge notice. The notice reflected the Facility was planning to discharge the Resident to [redacted] in [redacted] During the hearing, the Respondent's witnesses provided testimony regarding the appropriateness of the proposed facility to meet the Resident's needs. The Resident's representative did not dispute that the proposed facility met the Resident's needs but argued that more referrals should have been made in the local area. Ms. [redacted] testified that she felt she had no other choice but to give permission for [redacted] placement because she received a phone call stating that the Resident would need to be sent there or be discharged into the community to his residence.

While the discharge notice did not indicate a proposed discharge to the Resident's family member's home, the hearing testimony indicated that Ms. [redacted] was verbally advised the Resident would be discharged to the community if the [redacted] placement was declined. According to the regulations, a facility may not involuntarily transfer a resident into the community. The preponderance of evidence did not indicate how the Facility determined the Resident's needs would be met in the community.

The federal regulations require the Facility to include the interdisciplinary team in the ongoing process of developing the discharge plan. The Facility was required to consider the Resident's needs and preferences when aligning an appropriate discharge location. According to the state

regulations, when a resident is involuntarily transferred, the nursing home shall assist the resident, legal representative, or both in finding a reasonably appropriate alternative placement before the proposed transfer or discharge. The Facility was required to take steps under the nursing home's control to ensure the Resident's safe relocation. The evidence had to establish that the Facility included the Resident's representative in discharge planning, considered the Resident's preferences when proposing the discharge location, and took steps within the Facility's control to ensure the Resident's safe relocation.

On January 15, 2025, Ms. [redacted] conducted a conference call with the Resident's representative and documented the agreement to begin with [redacted] West Virginia, area referrals and that the Facility advised the Resident's representative there are limited options for Medicaid-approved facilities. The note indicated that potential referrals may need to be made in the [redacted], West Virginia area. The evidence indicated that Ms. [redacted] agreed to a referral at [redacted] and that Ms. [redacted] referred the Resident.

According to the submitted records, on February 10, 2025, Ms. [redacted] called to check on the Resident's referrals and was advised by Ms. [redacted] that no other referrals had been made. Although the records reveal Ms. [redacted] noted the Resident may need to be referred to the [redacted] or [redacted], West Virginia areas, the records do not indicate that Ms. [redacted] made any referrals in the [redacted] or [redacted], West Virginia areas, before contacting Ms. [redacted] on February 14, 2025, to advise that the Resident must be transferred to [redacted] or be discharged into the community. Ms. [redacted] effort to make one referral to [redacted] does not constitute a reasonable effort to consider the Resident's preferences when aligning a discharge location.

During the hearing, Ms. [redacted] testified that she worked with the Facility to make additional referrals the day before the hearing. Ms. [redacted] provided testimony that she sent additional referrals to other facilities within the weeks before the hearing and that she had not received responses from all facilities. As the new referrals were not made before the Facility's February 2025 decision to discharge the Resident to [redacted], they cannot be considered when determining whether the Facility met its responsibility to make reasonable efforts before initiating the Resident's discharge. The Facility must consider the Resident's representatives' preferences and act within its control by making reasonable efforts to align a discharge location before issuing a discharge notice to the Resident.

CONCLUSIONS OF LAW

1) The Facility may discharge a resident when the resident's behavior endangers the safety of individuals in the facility and the reason for discharge is documented in the Resident's medical record by a physician.

2) The preponderance of evidence demonstrated that the reason for discharging the resident was documented in the Resident's medical record by a physician.

3) When a resident is involuntarily discharged, the Facility must assist the resident in finding a reasonably appropriate alternative placement before the proposed discharge.

4) The preponderance of evidence failed to demonstrate that the Facility made reasonable efforts to align a discharge location with consideration of the Resident's preferences before deciding to discharge the Resident to [redacted] in [redacted]

5) Because sufficient efforts were not made by the Facility to identify a reasonable discharge location before initiating the Resident's discharge, the Facility's decision to discharge the Resident to [redacted] cannot be affirmed.

DECISION

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

ENTERED this 16th day of April 2025.

_____

Tara B. Thompson, MLS
State Hearing Officer