May 13, 2025

REMOVED

RE: REMOVED
ACTION NO.: 25-BOR-1640

Dear REMOVED

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: [redacted] – Facility
REMOVED — MPOA for the Resident

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

REMOVED

Resident,

v. **Action Number: 25-BOR-1640**

,

Facility.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for REMOVED 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 15, 2025.

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

At the hearing, the Facility was represented by Facility administrator. Appearing as witnesses for the Facility were Regional Vice President of Clinical Services, and Facility Social Worker. The Resident was represented by REMOVED who retains Medical Power of Attorney authorization for the Resident. Appearing as a witness on the Resident's behalf was REMOVED the Resident's brother. All representatives and witnesses were placed under oath and the following exhibits were admitted as evidence:

Facility's Exhibits:
F-1 Admission Record
Records:
pp. 2, 15, 19, 20, 49, 53, 58, 61-63, 66, 68, 108, 109, 117-123, 125, and 126

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 August 2, 2024, the Resident was admitted to [redacted] (hereafter, the Facility), a long-term care facility (Exhibit F-1).

2) On November 25, 2024, the Resident was admitted to the [redacted] for inpatient psychiatric treatment (Exhibit F-1).

3) On December 6, 2024, the Resident was readmitted to the Facility (Exhibit F-1).

4) Upon the Resident's re-admission to the Facility, [redacted] unspecified severity, with other behavioral disturbance as a secondary diagnosis (Exhibit F-1).

5) On February 26, 2025, the Facility issued a *Thirty-Day Discharge Notice* that advised the Resident's representative that the Resident would be discharged from the Facility on March 26, 2025, to REMOVED [redacted]

6) REMOVED [redacted] an affiliate of the Facility.

7) The February 26, 2025 notice indicated the Resident's discharge was necessary because his behavioral status endangered the safety of individuals in the Facility.

8) The Resident's primary physician was REMOVED [redacted] (Exhibit F-1).

Resident's Behavior

9) On November 5, 2024, Certified Physician's Assistant REMOVED [redacted] recorded the Resident "increased behaviors in the past week. He has repeated sexually inappropriate comments with female staff" (Exhibit F-1).

10) REMOVED recorded on November 5, 2024, that the Resident's plan included maintaining safe behaviors, looking for inpatient psychiatric management due to inappropriate sexual behaviors, and continuing medication to reduce anxiety and sexual symptoms (Exhibit F-1).

11) On November 13, 2024, the Resident engaged in unwanted touching of another resident's buttocks. The incident was documented by Licensed Practical Nurse REMOVED REMOVED [redacted] and Director of Nursing REMOVED [redacted] (Exhibit F-1).

12) On November 14, 2024, the Resident engaged in unwanted touching of another resident's back. The incident was documented by Nurse REMOVED and LPN REMOVED (Exhibit F-1).

13) On November 18, 2024, the Resident engaged in unwanted poking of a female resident's side and verbally made inappropriate comments to the female resident, including "perverted things" and "derogatory names – "bitch," "cunt;" and made comments about a

female staff member's weight. The incident was recorded by Licensed Practical Nurse REMOVED (Exhibit F-1).

14) On November 18, 2024, Nurse REMOVED recorded that the Resident's representative was informed of "concerns with behaviors and current incidents" (Exhibit F-1).

15) On November 25, 2024, the Resident engaged in unwanted touching of another male resident that included "running his finger across an emblem located on his shorts that happened to be on his private area." The incident was recorded by LPN REMOVED

16) On December 10, 2024, REMOVED completed a *Provider Note* and reflected narrative repeating REMOVED November 5, 2024 note that stated, "Looking for inpatient psychiatric management due to inappropriate sexual behaviors" (Exhibit F-1).

17) On February 4, 2025, Nurse REMOVED completed a *Progress Note* and recorded, "The pt [redacted] has ongoing inappropriate sexual behaviors," "the pt [redacted] has been eval [redacted] by psych," and "the pt [redacted] likely has frontal release dementia and is not able to refrain fro [redacted] inappropriate behavior" (Exhibit F-1).

18) On February 4, 2025, Nurse REMOVED recorded, "inappropriate sexual behavior will start depoprovera [redacted] the mpoa [redacted] confirmed that this is preferable to transfer to [redacted] lock down facility" (Exhibit F-1).

19) On February 5, 2025, Licensed Practice Nurse REMOVED recorded a *Behavior Note* indicating, "resident put his hands up another female resident's shirt in the dining room during lunchtime. resident [redacted] removed from area. family [redacted] and provider notified…." On February 6, 2024, Nurse REMOVED entered a *Behavior Note* clarifying that the event occurred, "in common area between both nurses' stations" (Exhibit F-1).

20) On February 6, 2025, REMOVED completed a *Progress Note* that reflected the Resident received an injection to reduce the Resident's sexual advances toward other residents. The note also stipulated that the Resident requires one-to-one (1:1) monitoring for the safety of other residents (Exhibit F-1).

21) REMOVED noted that the effects of the injection would "be expected to work within several days/weeks and the data that this reduces inappropriate sexual behaviors is very limited and there is known risks, but the mpoa [redacted] want to have the pt [redacted] have the dignity of remaining in the area instead of a transfer to [redacted] [redacted] with limited support" (Exhibit F-1).

22) Beginning on February 6, 2025, the Resident had an active physician order for 1:1 care in public spaces to keep the Resident separate from female residents (Exhibit F-1).

Discharge Location

23) On March 18, 2025, Facility Social Worker, REMOVED recorded "Resident's daughter spoke with facility Administrator and requested that resident's referral be sent to additional SNF's in the surrounding area prior to resident discharging to REMOVED Faxed the referrals to [redacted] and [redacted] facilities. Awaiting replies" (Exhibit F-1).

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.15(c)(1)(i)(C) (February 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) (February 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) (February 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 (February 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.

DISCUSSION

On February 26, 2025, the Facility issued a notice advising the Resident that he would be discharged to REMOVED because his behavior endangered the safety of others in the Facility. The Resident's representatives requested a fair hearing to dispute the Facility's decision to discharge the Resident to REMOVED

The regulations permit facilities to 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, the resident's medical record must include physician documentation of the basis for the resident's discharge. Pursuant to the regulations, the Facility must take steps within its control to assist the Resident's legal representative with finding a reasonably appropriate alternative placement before initiating the proposed discharge.

Behavior episodes that occurred after February 26, 2025 could not be considered by the Facility when making the February 26, 2025 discharge decision. Therefore, evidence related to these incidents was given no weight in this *Decision*.

Behavior Endangering the Safety of Other Individuals in the Facility

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

The Facility's submitted documentary evidence was comprised of excerpts from the Resident's record that verified the Resident has demonstrated verbal aggression and unwanted physical touching of other residents in November 2024 and February 2025. The submitted records do not reveal any behavior episodes between the February 5, 2025 incident and the February 26, 2025 decision to discharge the Resident.

Documentation:

The Facility had to demonstrate by a preponderance of evidence that when the Facility initiated the Resident's discharge, the reason for his discharge was documented in his medical record by his physician.

The Facility's submitted records jump page numbers. The submitted Facility record pages 53 and 58 of 127 do not reflect the record title or author. According to the reliable submitted records, the

physician documented the Resident's need for inpatient psychiatric treatment in December 2024. However, the physician's February 6, 2025 physician note did not indicate continued search for inpatient psychiatric treatment but noted that the Resident's representative's preference was for the Resident to remain in the area and not transfer to REMOVED The February 6, 2025 physician documentation did not indicate that the Resident should be discharged because his behavior endangered others in the Facility.

The submitted evidence did not reflect any documentation by the Resident's physician that indicated the basis for the discharge. Without physician documentation of the reason for the Resident's discharge, the Facility's decision to discharge the Resident cannot be affirmed.

Discharge Location

The Resident's representatives argued that the proposed discharge location was too far away from the Resident's family to permit regular visits and allow them to be present when incidents occur. REMOVED testified that she was not contacted by the Facility to participate in the Resident's discharge planning. The Facility representative's testimony affirmed that REMOVED did not have contact with the Facility until February 2025. During the hearing, the Facility argued that referrals to closer facilities were not accepted.

Because the evidence failed to establish that the basis for the Resident's proposed discharge was recorded in the Resident's record, the issue of discharge location is moot. Although the issue of discharge location is moot, the Facility should take note of the Facility's regulatory requirements when discharge planning. Under the regulations, 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 REMOVED During the hearing, the Facility affirmed that REMOVED is an affiliated facility.

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 the preferences of his representatives when aligning an appropriate discharge location. According to the state regulations, when a resident is involuntarily discharged, the nursing home shall assist the Resident's legal representative with finding a reasonably alternative placement before the proposed discharge. The Facility was required to take steps under the nursing home's control to ensure the Resident's safe relocation.

During the hearing, REMOVED testified that referrals were made to all [redacted] facilities in West Virginia and that all referrals were denied due to the Resident's behaviors. During the hearing, [redacted] REMOVED inquired about whether any closer facilities existed in surrounding states that would be appropriate for the Resident and whether the Facility had referred the Resident to any closer facilities in surrounding states. REMOVED testified that the Resident's family did not request referrals to REMOVED facilities until the Resident's representative's inquiry during the hearing. [redacted] REMOVED testified that generally, when a resident is denied by one facility, they are denied by others, so, she didn't see the need to make additional referrals.

The Facility's representative responded that the Facility is not aware of *all* facilities in REMOVED testified that it was unreasonable to expect the Facility to find out how many facilities there are in each surrounding state and to have to send referrals to those facilities. During the hearing, REMOVED testified that the Facility would send referrals to specific locations upon the Resident's representatives' request but that additional referrals would cause delay and increase the opportunity for risk to the other residents in the Facility.

According to the regulations, the Facility, not the Resident's representative, has the responsibility of identifying an appropriate discharge location. The Facility's argument that referrals to additional specific facilities were not made because the Facility's representative did not request them does not demonstrate that the Facility took steps within its control to consider the preferences of the Resident's representative before deciding to discharge the Resident to REMOVED

The submitted records indicated the Facility made referrals for alternative discharge locations in March 2025, after the February 26, 2025 decision to discharge him to REMOVED Referrals made upon the Resident's representative's request in March 2025 do not constitute a reasonable effort to consider the preferences of the Resident's representative when aligning a discharge location. As the new referrals were not made before the Facility's February 26, 2025 discharge decision, 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, involve the interdisciplinary team, and act within the Facility's control by making reasonable efforts to align a discharge location before issuing a discharge notice to the Resident's representatives.

The Facility argued that it was unreasonable to expect the Facility to find out information about *all* facilities in REMOVED However, it is reasonable to expect the Facility to take steps within its control to include the Resident's representative in discharge planning, research appropriate facilities in the Resident's vicinity, and make referrals to appropriate facilities with consideration of the Resident's representative's preferences before deciding to discharge the Resident to REMOVED.

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

3) The preponderance of evidence failed to demonstrate that the reason for discharging the resident was documented in the Resident's medical record by a physician at the time of the February 26, 2025 discharge decision.

4) Because the Facility failed to prove that the basis for the proposed discharge was affirmed in the Resident's record by the required physician documentation, the Facility's decision to discharge the Resident cannot be affirmed.

5) Because the Facility failed to prove that the Resident was eligible for discharge, the issue of discharge location is moot.

DECISION

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

ENTERED this 13th day of May 2025.

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Tara B. Thompson, MLS
State Hearing Officer