May 6, 2025

REMOVED

RE: REMOVED
ACTION NO.: 25-BOR-1683

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]

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

REMOVED
Resident,

v. **Action Number: 25-BOR-1683**

[redacted],

Facility.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for REMOVED [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 9, 2025 and reconvened for final statements on April 14, 2025.

The matter before the Hearing Officer arises from the Facility's March 25, 2025 decision to discharge the Resident.

At the hearing, the Facility was represented by [redacted] Facility Administrator. Appearing as a witness on behalf of the Facility was [redacted] Licensed Social Worker. The Resident appeared and represented himself. All representatives and witnesses were placed under oath and the following exhibits were admitted as evidence:

Facility's Exhibits:
F-1 Pre-Admission Screening (PAS), dated March 25, 2025
Acentra Notice, dated March 27, 2025
Facility Physical Therapy Discharge Summary and Progress Notes
Facility Discharge Notice, dated March 25, 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) The Resident was a long-term care facility resident of [redacted] (hereafter, the Facility).

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

3) The Resident has the capacity to make his own decisions.

4) On March 25, 2025, the Facility issued a notice advising the Resident he would be discharged from the Facility to "[redacted]" The basis for the discharge included:
    1. The transfer or discharge is appropriate because your health has improved sufficiently that you no longer need the services provided by the facility. As of today, you are also being discharged from therapy services.
    2. Several incidents have occurred at [redacted] showing potential threat to yourself or others, creating safety concerns (Exhibit F-1).

5) On March 25, 2025, REMOVED electronically signed the PAS and certified the Resident's medical and related needs are as indicated within the PAS (Exhibit F-1).

6) REMOVED physician recommendations indicated the Resident's prognosis was stable and that his rehabilitative potential was good (Exhibit F-1).

7) REMOVED physician recommendations were "FOR NURSING PLACEMENT ONLY" (Exhibit F-1).

8) [redacted] indicated that the Appellant may eventually be able to return home or be discharged and indicated a length of facility stay spanning "3-6 months" (Exhibit F-1).

9) On March 27, 2025, the West Virginia Department of Human Services Bureau for Medical Services (BMS) denied the Appellant's medical eligibility for long-term care admission because the PAS only revealed one of the five required areas of care that met the deficit severity criteria (Exhibit F-1).

APPLICABLE POLICY

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

Code of Federal Regulations § 42 CFR 483.15(c)(2)(i) through (iii) (March 2025) ***Transfer and Discharge — Documentation*** provides that when the Facility transfers or discharges a

resident for health improvement, 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 healthcare institution or provider. The documentation in the resident's medical record must include the basis for transfer

West Virginia Code §§ 64-13-4(13)(c)(1) – 64-13-4(13)(d)(3) Documentation provides in part: 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.

West Virginia Code §§ 64-13-4(13)(6)(b) and 64-13-4(13)(7)(a) (July 2021) provides in pertinent part: In the event of an involuntary transfer, the nursing home shall assist the resident in finding a reasonably appropriate alternative placement before the proposed 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 ensure safe relocation. A nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his will.

DISCUSSION

On March 25, 2025, the Facility issued a written notice of discharge advising the Resident would be discharged from the Facility because his health had improved sufficiently that he no longer required the services provided by the Facility. The Resident requested a fair hearing to dispute the Facility's decision to discharge him.

Improved Health

The regulations permit a Facility to discharge a Resident when their health has improved sufficiently such that they no longer require the services provided by the Facility. When a Resident is discharged for this reason, documentation in the Resident's medical record must include the basis for discharge and be made by the Resident's physician.

During the hearing, the Facility administrator testified that the main reasons the Resident was being discharged were because the it was determined that the Resident did not qualify for Medicaid Long-Term Care (LTC) admission, based on the PAS results, and because the Resident had fully completed physical therapy.

The Facility administrator testified during the hearing that the Resident's behavior endangered other residents and staff in the Facility at times. Because the Facility was required to list each basis for discharge on the notice and the issued notice did not identify safety issues as a foundation for discharging the Resident, the submitted evidence related to the Resident's behavior received no weight in the decision of this Hearing Officer.

The Facility has the burden of proof and had to demonstrate by a preponderance of evidence that at the time of the March 25, 2025 decision to discharge the Resident, the Resident's physician had documented that his health had improved sufficiently such that he no longer required the services provided by the Facility. During the hearing, the Appellant did not contest the reliability of the PAS.

The Appellant argued that he was unable to make further progress with physical therapy because he was unable to participate with the prosthetic he had at the time. The Appellant testified that when he receives his new prosthetic, he will be able to continue participating in physical therapy.

The PAS indicated the Resident's prognosis was stable and that his rehabilitative potential was good. However, the physician recommended nursing placement only for a period of three to six months. The submitted physician documentation does not establish that the Resident should be discharged from the Facility because his health has improved sufficiently such that he no longer requires the services provided by the Facility. Because the submitted information does not establish that the Resident's record contained his physician's documentation of his health having improved sufficiently such that he no longer required nursing facility services, the Facility's decision to discharge the Resident cannot be affirmed.

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 a hotel. During the hearing, the Facility's witness testified that the Resident was instructed on how to schedule outpatient appointments and physical therapy.

During the hearing, the Appellant testified that he did not feel healthy enough to live on his own. He testified that he has weakness in his arms and left leg. The Resident argued that he would not be able to vacate the Facility in the event of an emergency. The Appellant testified that he requires assistive devices, such as grab bars, to transfer from a bed, chair, or toilet. During the hearing, the Resident testified that he requires staff assistance in the shower and when transferring from the shower to his wheelchair. The Resident testified that he has fallen and not asked for help from Facility staff. The Resident testified that he tries to do as much as he can independently but would be unsafe if he was discharged to a location where he could not receive staff assistance. The Resident testified that if he is discharged from the Facility, he will be unable to make it to his medical appointments.

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 regulatory requirement for the Facility to ensure the appropriate information is communicated to the Resident's receiving healthcare institution or provider. Verbally instructing the Resident how to align his own healthcare does not meet this regulatory threshold.

CONCLUSIONS OF LAW

1) A facility may involuntarily discharge a resident when the resident's health has improved sufficiently such that they no longer require the services provided by the facility and the reason for discharge is documented in the Resident's medical record by a physician.

2) The preponderance of evidence failed to demonstrate that the reason for Resident's proposed discharge was documented in the Resident's medical record by a physician.

3) 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.

4) Because the preponderance of evidence failed to affirm the Facility's decision to discharge the Resident, the matter 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 6th day of May 2025.

_____

Tara B. Thompson, MLS
State Hearing Officer