June 11, 2025

[redacted]

RE: [redacted]
ACTION NO.: 25-BOR-1932

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 Office of the Inspector General and DEPARTMENT OF HUMAN SERVICES. These same laws and regulations are used in all cases to ensure that all people 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

[redacted]

Resident,

v. **Action Number: 25-BOR-1932**

[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 June 4, 2025.

The matter before the Hearing Officer arises from the Facility's April 15, 2025 decision to discharge the Resident.

At the hearing, the Facility was represented by [redacted] Appearing as a witness on behalf of the Facility was [redacted]. 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:
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 a long-term care facility resident of [redacted] (hereafter, the Facility).

2) On April 15, 2025, the Facility issued a notice advising the Resident he would be discharged to "Home/Appt. [sic]" because the Resident's health had improved sufficiently such that he no longer required the services provided by the Facility, the safety of individuals in the center was endangered due to the clinical or behavioral status of the Resident.

3) At the time of the April 15, 2025 discharge decision, the Resident did not have a home or an apartment outside of the Facility.

4) On January 20, 2025, Facility staff reported a strong marijuana odor in the Resident's room.

5) On April 10, 2025, relatives visiting another resident complained of marijuana odor and threatened to withdraw the other resident from the Facility.

6) Law enforcement came to the Facility to speak with the Resident.

7) The Facility has not received any additional complaints about marijuana use or odor since the Resident spoke with law enforcement.

8) The Facility is actively working with the Resident and Take Me Home Transition Program to identify an appropriate residence.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.15(c)(1(i)(B) and (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 resident's health has improved sufficiently so the resident no longer needs the services provided by the facility or because the safety of individuals in the facility is endangered due to clinical or behavioral status of the resident.

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 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.

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 April 15, 2025, the Facility issued a notice advising the Resident that he would be discharged to "Home/Appt." because his health had improved and his behavior endangered the safety of others in the Facility. The Resident testified that he has not had any issues using marijuana in the Facility since he spoke to law enforcement and requested to remain in the Facility until an appropriate discharge location is identified.

The regulations permit facilities to discharge residents when their health has improved sufficiently such that they no longer require the services provided by the Facility or when the clinical or behavioral status of the resident endanger others in the Facility. When residents are discharged for these reasons, documentation in the Resident's medical record must include the basis for discharge and be made by the Resident's physician. Further, when an individual is involuntarily discharged, the Facility is required to assist the Resident with finding a reasonably appropriate placement before the proposed discharge.

The Facility argued that the Resident's marijuana use endangered others in the Facility. The Facility has the burden of proof and had to demonstrate by a preponderance of evidence that at the

time of the April 15, 2025 discharge decision, the Resident's record reflected physician documentation that he no longer required the Facility's services because his health had improved and that his behavior endangered other individuals in the Facility. No records were presented to demonstrate that the Resident's record reflected the required documentation at the time of the April 15, 2025 discharge decision.

The Facility's witness testified that the Facility was actively assisting the Resident with identifying a discharge location. Because the evidence failed to prove that the basis for the proposed discharge was recorded in the Appellant's record by his physician, the issue of discharge location is moot. However, the Facility should take note of the regulatory requirement for the Facility to identify an appropriate discharge location before initiating the Resident's discharge and ensure the appropriate information is communicated to the Resident's receiving healthcare institution or provider.

CONCLUSIONS OF LAW

1) The Facility may involuntarily discharge a resident when the resident's behavior endangers the safety of individuals in the facility or 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 discharging the resident 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 11th day of June 2025.

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Tara B. Thompson, MLS
State Hearing Officer