August 6, 2025

[redacted]

RE: [redacted] v. GENESIS HEALTHCARE ROSEWOOD CTR
ACTION NO.: 25-BOR-2409

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
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Christina Kittle- Facility

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 25-BOR-2409**

GENESIS HEALTHCARE
ROSEWOOD CENTER,

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 August 6, 2025.

The matter before the Hearing Officer arises from the Facility's July 17, 2025 decision to discharge the Resident.

At the hearing, the Facility was represented by Christina Kittle, Facility Administrator. The Resident appeared and represented himself. Appearing as a witness for the Resident was [redacted], the Resident's brother. All parties were placed under oath and the following exhibits were admitted as evidence:

Facility's Exhibits:
F-1 Progress Note, dated June 2, 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 is a long-term care facility resident of Rosewood Center (hereafter, the Facility).

2) On June 17, 2025, the Facility issued a notice advising the Resident he would be discharged from the Facility and noted, "The social worker has worked on alternative placement and the Quality Inn in [redacted] could accommodate a 2 week stay with a handicapped accessible room …."

3) The June 17, 2025 notice provided that the reason for discharge was, "because your health has improved sufficiently that you no longer need the services provided by this facility."

4) On June 2, 2025, a one (1) page *Progress Note* was completed in the Resident's record (Exhibit F-1).

5) The visit type marked for the *Progress Note* was marked, "Regulatory" (Exhibit F-1).

6) The *Progress Note* reflected a narrative of the Resident's history of present illness that included, "[the Resident] is very independent and is able to perform every ADL without assistance" (Exhibit F-1).

7) The *Progress Note* provided a list of the Resident's medications (Exhibit F-1).

APPLICABLE POLICY

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

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 §§ 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 her will.

DISCUSSION

On June 17, 2025, the Facility issued a written notice of discharge advising that 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 disputed the Facility's decision to discharge him and argued that the discharge location was inadequate to meet his needs.

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.

The Facility has the burden of proof and had to demonstrate by a preponderance of evidence that at the time of the June 17, 2025 discharge decision, 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 Facility's resident reviewed a *Progress Note* indicating the Resident was educated regarding alcohol consumption on May 12, 2025. As alcohol consumption was not listed on June 17, 2025 notice as a basis for discharging the Resident, testimony regarding this issue was given no weight by the Hearing Officer.

Documentation:

The Facility submitted a one-page *Progress Note* as documentary evidence. During the hearing, the Facility's representative testified that the record was completed by the Resident's physician, Dr. [redacted] However, the submitted record did not indicate an author or corroborating signature. The record was marked "Page #1" and did not provide any indication that a second page followed that might contain the physician's signature.

During the hearing, the Facility's representative testified that [redacted] was present during Dr. [redacted] assessment of the Resident. The Resident refuted that [redacted] was present during Dr. [redacted] assessment of the Resident. From the submitted information, it could not be determined whether the Resident was referring to the Pre-Admission Screening assessment or another assessment. The submitted record did not indicate who was present when the *Progress Note* was completed. Neither the physician nor [redacted] were present as witnesses to provide testimony to validate that the record was completed by the physician.

During the hearing, the Facility's representative testified that the PAS corroborated that the Resident did not require the Facility's services. The Resident argued that the physician recommendation on the PAS indicated that he required nursing facility services for at least three to six months. As a copy of the PAS was not provided for review, the outcome and recommendations of the screening form cannot be affirmed.

The submitted evidence did not prove that documentation of the basis for discharge was made by the Resident's physician at the time of the June 17, 2025 discharge decision. Without physician documentation of the reason for the Resident's discharge, 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. According to the regulations, the Facility is required to develop and implement an effective discharge planning process that involves the interdisciplinary team. Further, to ensure orderly discharge, the Facility must document sufficient preparation and orientation of the resident.

During the hearing, the parties testified to failed attempts made to align the Resident with an apartment. The notice reflected that the Facility was planning to discharge the Resident to a hotel for two weeks with no indication of how the Resident's needs would be met after the end of the two-week period. The Resident argued that the identified location was not in an area with a homeless shelter.

Because the Facility failed to prove the basis for the Resident's proposed discharge, the issue of the location of discharge 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) 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 August 2025.

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Tara B. Thompson, MLS
Certified State Hearing Officer