June 4, 2024

[redacted]

RE: [redacted]
ACTION NO.: 24-BOR-2015

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 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

[redacted]

Resident,

v. **Action Number: 24-BOR-2015**

[redacted]

Facility.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted] Jr. 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 May 8, 2024.

The matter before the Hearing Officer arises from the Facility's April 19, 2024 decision to discharge the Resident.

At the hearing, the Facility was represented by [redacted] Director of Social Services. [redacted] Social Worker; [redacted] Director of Nursing; and [redacted] RN, Unit Manager, appeared as witnesses for the Facility. The Resident was represented by his spouse, [redacted] a family friend, appeared as a witness for the Resident. All witnesses were placed under oath and the following exhibits were entered into the record.

Facility's Exhibits:
F-1 [redacted] Medical Records
F-2 [redacted] Progress Notes
F-3 Placement Denial Emails
F-4 Placement Denial Emails
F-5 [redacted] Five Day Follow-Up, dated June 27, 2023

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 did not have capacity due to dementia and inability to process information (Exhibit F-5).

2) On April 19, 2024, the Facility decided to involuntarily discharge the Resident.

3) On April 19, 2024, the Facility issued a notice advising the Resident would be discharged to [redacted] residence on May 18, 2024, because the safety of individuals in the facility was endangered due to the clinical or behavioral status of the Resident.

4) The Facility's April 19, 2024 notice did not reflect information for filing an appeal with the West Virginia Office of the Inspector General Board of Review.

5) The Facility's April 19, 2024 notice stated, "If mentally ill or developmentally disabled, you or your family member or legal representative may wish to contact: DISABILITY RIGHTS [redacted]" and provided [redacted] contact information.

6) The Resident was at [redacted], a senior psychiatric facility, for assessment and treatment from March 28 through April 10, 2024 (Exhibit F-1).

7) On March 28, 2024, the Resident was admitted to [redacted] for reasons including "dementia with behaviors," "paranoid delusions," "physically aggressive at the nursing home," "barricaded himself in a room," "refusing his medications and being aggressive if they attempted to medicate him," and "threatening to punch them" (Exhibit F-1).

8) While at [redacted], the Resident was periodically non-compliant with medications and displayed verbal and physical aggression to staff (Exhibit F-1).

9) On March 31 and April 4, 2024, the Resident was verbally aggressive and threatening to staff (Exhibit F-1).

10) On April 2 and April 3, 2024, the Resident was recorded as "safety level 2 with 15 minute safety and fall checks" (Exhibit F-1).

11) While at [redacted], the Resident was confused, oriented to self only, wandered, was intrusive, and needed frequent redirection (Exhibit F-1).

12) The Resident's medication compliance improved at [redacted] (Exhibit F-1).

13) No physical or verbal aggression was noted from April 5 through April 9, 2024 (Exhibit F-1).

14) On June 27, November 23, 2023, and March 23, 2024, the Resident was physically aggressive toward another resident (Exhibit F-5).

15) On April 9, 2024, the Resident's record reflected he "became aggressive and was refusing insulin this morning, but the pt finly let us give the insulin" (Exhibit F-1).

16) On April 10, 2024, the Resident drew back his fist to staff. The Resident's record reflected he was "a safety level II. Q 15 min safety checks and fall precautions." (Exhibit F-1).

17) On April 4, 2024, the Resident's placement at [redacted] was declined (Exhibit F-2).

18) On April 11, 2024, [redacted] declined the Resident's placement (Exhibit F-2).

19) On April 16, 2024, [redacted] denied the Resident's placement (Exhibit F-2).

20) On April 18, 2024, the Resident was re-admitted to the Facility (Exhibit F-2).

21) On April 19, 2024, the Resident was agitated and raised his fist toward staff (Exhibit F-2).

22) On April 18, 2024, the Resident refused to shower and take medication (Exhibit F-2).

23) On April 19, 2024, [redacted], RN, completed a note stating, "[redacted] in to see Resident d/t readmission from [redacted]. Physical assessment completed. Resident denied pain or distress" (Exhibit F-2).

24) On April 18, 2024, [redacted] RN, completed a note stating, "[redacted] made aware of Pharmacy Automated Messages in regard to medication" (Exhibit F-2).

25) On April 18, 2024, the Resident was incontinent and required physical assistance for toileting and hygiene (Exhibit F-2).

26) On April 18, 2024, the Resident was at risk for elopement or unsafe wandering (Exhibit F-2).

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.15(c)(1)(i)(C) ***Transfer and Discharge requirements*** provide that the Facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless 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) ***Documentation*** stipulates that when the facility discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the discharge is documented in the resident's medical record and ensure appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include: …

(A)The basis for the transfer per paragraph (c)(1)(i) of this section …

(ii) The documentation required by paragraph (c)(2)(1) of this section must be made by —
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

Code of Federal Regulations 42 CFR § 483.15(c)(3) ***Notice before transfer*** instructs that before a facility discharges a resident, the facility must — …

(ii) Record the reasons for the transfer or discharge in a resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

Code of Federal Regulations 42 CFR § 483.15(c)(5) ***Contents of the Notice*** provides that the written notice must include:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; …

West Virginia Code of State Rules §§ 64-13-4(13)(6)(b) and 64-13-4(13)(7)(1) provide that when involuntarily discharging a resident, the nursing home must assist the resident in finding a reasonably appropriate alternative placement before the proposed discharge and develop 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 19, 2024, the Facility determined the Resident must be discharged because the safety of the individuals in the facility was endangered due to the behavioral status of the Resident. The Facility decided to discharge the Resident home to his wife's care. The Resident's representative and witness contested the proposed discharge and argued that she did not reside at home and could not provide for the Resident's medical needs.

The regulations permit facilities to discharge a resident when the safety of individuals in the facility is endangered due to the 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.

The Facility has the burden of proof and must demonstrate by a preponderance of the evidence that at the time of the April 19, 2024 discharge decision, the Resident's behavior endangered other individuals in the facility. The evidence had to reveal that the Resident's physician documented the basis for discharge.

During the hearing, the Hearing Officer inquired whether the Resident still required the services provided by the Facility and whether the submitted evidence demonstrated that the Resident's medical needs could be met in the community. The Facility's representative testified that she did not have a response to those questions. The Facility's representative provided testimony and records regarding the Resident's behavior after the Facility's decision. The Hearing Officer may only consider information relevant to the circumstances present at the time of the Facility's decision to discharge the resident. Evidence regarding the Resident's behaviors, treatment provided, and attempts to align placement after the April 19, 2024 decision was given little weight as they could not have contributed to the April 19, 2024 Facility decision.

Discharge Basis

During the hearing, the Facility's representative testified that the Resident was sent to [redacted], a senior psychiatric facility. The Facility's representative testified to the vulnerability of the other facility residents and argued the Resident has demonstrated aggressive behavior since returning from [redacted] The Facility provided testimony regarding the Resident's history of behaviors which included: drawing his fist back, becoming irritable, becoming aggressive and refusing insulin, being hostile and refusing vitals, becoming agitated and stomping on a staff member's foot, voiding in the physical therapy room, punching at staff members, threatening to "bust your damn head in," drawing back his fist, kicking at staff during the night shift, wandering into other people's rooms, being irritable, threatening and agitated, and becoming physically aggressive when blood pressure readings are attempted.

The regulations stipulate that when a resident is discharged because his behavioral status endangers other individuals in the facility, the Facility must ensure that the basis for discharge is documented by the Resident's physician in the Resident's medical record. While the submitted evidence reflected documentation by various Facility providers, the preponderance of evidence failed to establish that the Facility ensured that the Resident's physician documented that he must be discharged because his behavior status endangers others in the facility.

When specifically asked whether the submitted records contained the required physician documentation, the Facility's representative testified that "we" discussed with "him" but did not have anything signed by the physician. The submitted evidence failed to reveal physician documentation that the Resident's behavior endangered the individuals in the Facility. Without the required physician documentation, the Facility's basis for discharging the Resident cannot be affirmed.

Discharge Location

The Resident's representative testified that she could not meet the Resident's needs and that she no longer resided in her home. The Facility has a responsibility to align appropriate discharge arrangements. The submitted evidence revealed the Facility's efforts to align a discharge placement with another facility and the refusal of those facilities to accept the Resident. The submitted evidence did not reveal any efforts to identify services available to meet the Resident's needs at the proposed community discharge location.

Because the preponderance of evidence failed to affirm the basis of the Respondent's decision to discharge the Resident, the issue of discharge location is moot. However, the Facility should take note of the regulatory requirement to make reasonable efforts to align discharge arrangements upon the involuntary discharge of a resident to the community. The West Virginia Code of State Rules prohibits the Facility from involuntarily discharging a resident requiring the nursing home's services to a community setting.

Notice

The Resident's representative argued that the notice issued by the Facility was illegal because it pertained to information regarding [redacted] not West Virginia. The Resident's representative testified that the notice should not have been issued without listing the name of a receiving discharge facility.

The Facility's notice omitted information for requesting a fair hearing and reflected [redacted], rather than West Virginia as the relevant state. Although the notice contained multiple errors, the Resident was not prejudiced as he was able to request and receive a fair hearing. However, the Facility should ensure that future notices of discharge reflect all required information relevant to West Virginia's noticing policies.

CONCLUSIONS OF LAW

1) A facility may discharge a resident when the safety of individuals in the facility is endangered due to the behavioral status of the resident.

2) The Facility must ensure that the Resident's medical record includes physician documentation of the basis for the discharge — that the Resident's behavior endangered the individuals in the Facility.

3) The preponderance of evidence failed to demonstrate that the Resident's physician documented the basis for discharge.

4) A nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his will.

5) The Facility's April 19, 2024 decision to discharge the Resident was incorrect.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's April 19, 2024 decision to discharge the Resident from the Facility.

ENTERED this 4th day of June 2024.

_____

Tara B. Thompson, MLS
State Hearing Officer