July 10, 2024

[redacted]
[redacted]5

RE: [redacted]
ACTION NO.: 24-BOR-2318

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 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

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Resident,

v. **Action Number: 24-BOR-2318**

[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 28, 2024.

The matter before the Hearing Officer arises from the Facility's May 29, 2024 decision to discharge the Resident.

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

Facility's Exhibits:
F-1 Smoking Permitted Policy
F-2 Resident/Family Education Records
F-3 30-Day Discharge Notice
F-4 Smoking Permitted Policy
F-5 Physical Therapy records, signed by [redacted], on June 24 and June 25, 2024

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 May 28, 2024, the Respondent issued a notice advising the Resident she would be discharged from the Facility on June 28, 2024, to Salvation Army, because the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident (Exhibit F-3).

2) The Facility's May 28, 2024 decision to discharge the Resident to a community setting was an involuntary discharge.

3) On February 18, 2024, the Resident signed her understanding that the facility may initiate discharge planning for a smoking policy violation, for any unsafe smoking practices that pose a risk to the residents, and for repeated non-compliance with the facility's safe smoking policy/practices (Exhibit F-1).

4) On April 1, 2024, the Resident was verbally instructed on the Facility's smoking policy (Exhibit F-2).

APPLICABLE POLICY

Code of Federal Regulations 42CFR § 483.15(c)(1)(i)(C) provides in part: A 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.

West Virginia Code § 64-13-4(13)(b)(3) Admission, Transfer, and Discharge provides in part: A facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless the health or safety of persons in the nursing home is endangered.

Code of Federal Regulations 42CFR § 483.15(c)(2)(i) through 483.15(c)(2)(ii)(B) Documentation provides in part: When the facility discharges a resident because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, the facility must ensure that the discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

Documentation in the resident's medical record must include documentation made by the resident's physician and the basis for the discharge.

Code of Federal Regulations 42 CFR § 483.15(c)(3)(ii) Notice Before Transfer provides in part: Before a facility discharges a resident, the facility must record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section.

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 May 29, 2024, the Facility issued a notice advising the Resident that she would be discharged due to her clinical or behavioral status endangering the safety of individuals in the Facility. The Facility argued that the Resident's use of combustible smoking materials placed individuals in the Facility at risk of harm. The Resident did not dispute her violation of the smoking policy, was apologetic for violating the Facility's smoking policy, and argued that staff are permitted to retain their smoking devices without endangering the safety of others in the Facility.

Health and Safety

The Facility bears the burden of proof and had to demonstrate by a preponderance of the evidence that the Resident's violation of the Facility's smoking policy endangered the safety of others.

Submitted documentary evidence and testimony regarding incidents and actions occurring after the May 29, 2024 decision to discharge the Resident were given no weight in this decision as the information was not relevant or available for review at the time of the Facility's May 29, 2024 discharge decision.

Although the Facility's smoking policy advised that violation of the contract may result in the Resident's involuntary discharge, the submitted evidence failed to demonstrate how the Resident's violation of the policy placed others at risk of harm. The regulations do not explicitly permit or prohibit the Facility from discharging a resident for violation of smoking policies but is clear that a resident may be discharged for endangering the health and safety of others in the Facility. The submitted information revealed the policy had been reviewed with the Resident before the May 29, 2024 discharge decision but does not provide details of when the Resident violated the smoking policy before that date or how the violation endangered the health and safety of others in the Facility.

Documentation:
The Facility had to demonstrate by a preponderance of evidence that the reason for the Resident's discharge was documented in the Resident's medical record by the Resident's physician. 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
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 the Salvation Army, a homeless shelter. During the hearing, the Resident argued that she would be unable to meet her medical needs at the Salvation Army. The Facility witnesses testified regarding the Resident's completion of therapy but were unable to indicate during the hearing whether the Resident still required the Facility's services. No evidence was submitted to indicate how the Facility had determined the Resident's medical needs could be met in the community at the proposed location. Because the Facility failed to prove the basis for the Facility's discharge, the issue of the location of her discharge is moot.

CONCLUSIONS OF LAW

1) The Facility may involuntarily discharge a resident when the safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident 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) The preponderance of evidence failed to demonstrate that the safety of individuals in the facility was endangered by the Resident's violation of the Facility's smoking policies.

4) Because the Facility failed to prove that the Resident was eligible for discharge, the matter of discharge notice and location of discharge are moot.

5) The Facility incorrectly acted to discharge the Resident.

DECISION

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

ENTERED this 10th day of July 2024.

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Tara B. Thompson, MLS
State Hearing Officer