July 31, 2024

[redacted]

RE: [redacted]
ACTION NO.: 24-BOR-2633

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 July 31, 2024.

The matter before the Hearing Officer arises from the Facility's June 25, 2024 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], Facility 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:
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) On June 25, 2024, the Facility issued a notice advising the Resident he would be discharged from the Facility on July 25, 2024, because the Resident's welfare and needs could not be met at the Facility.

2) The notice did not identify a discharge location.

3) The Resident requires twenty-four hours of care, seven days per week.

4) The notice contained inaccurate email information for the Board of Review.

5) The June 25, 2024 decision to discharge the Resident was involuntary.

6) On June 25, 2024, the Resident was verbally aggressive and made homicidal statements to his roommate.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR §§ 483.15(c)1(i)(A) and 483.15(c)(1)(i)(C) provide in pertinent parts: 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 transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, or 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)(i)(A) and (483.15(c)(2)(i)(B) provide in pertinent parts: When transferring or discharging a resident is necessary because the resident's needs cannot be met in the facility, the facility must ensure that the transfer or discharge is documented in the resident's medical record. Documentation in the resident's medical record must include:

The basis for the transfer per paragraph (c)(1)(i) of this section, the specific resident needs that cannot be met, the facility's attempts to meet the resident's needs, and the service available at the receiving facility to meet the needs.

Code of Federal Regulations 42 CFR §§ 483.15(c)(2)(ii)(A) and 483.15(c)(2)(ii)(B) provide in pertinent parts: The documentation required by paragraph (c)(2)(i) of this section must be made by the resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (c)(1)(i)(C).

West Virginia Code of State Rules §§ 64-13-4(13)(6)(b) and 64-13-4(13)(7)(a) provides in pertinent parts: 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 or her will.

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 25, 2024, the Facility issued a notice advising the Resident he would be discharged because his needs could not be met in the Facility. The Resident did not refute that he was verbally aggressive to his roommate on June 25, 2024, but argued that the issue with his roommate arose because the staff was not performing their duties adequately. The Resident denied that others were endangered due to his behavior.

The Board of Review can only determine if the Facility's discharge decision was conducted according to the controlling regulations. During the hearing, the Facility provided testimony regarding the Resident's behavior that endangered others in the Facility. The notice only indicated that the discharge basis was due to the Facility being unable to meet the Resident's needs. As the Facility is required to notify the Resident in writing of the basis for his discharge and the notice did not reflect that the discharge basis was due to the Resident's behavior endangering others, arguments regarding this basis were given no weight in the decision of this Hearing Officer. If the Facility wishes to discharge the Resident because his behavior endangers others, the Facility must issue proper notice to the Resident informing him of the basis for discharge.

Basis for Discharge

The regulations permit facilities to discharge residents when their needs cannot be met in the facility. When residents are discharged for this reason, documentation in the Resident's medical record must include the basis for discharge, the specific resident's needs that cannot be met, the facility's attempts to meet the resident's needs, and the services available at the discharge location to meet the Resident's needs. The regulations specify that the documentation must be made by the Resident's physician.

The Facility has the burden of proof and had to demonstrate by a preponderance of the evidence that the Resident's needs could not be met by the Facility and that the Resident's physician documented the basis for discharge, the Resident's needs that cannot be met, the Facility's attempts to meet the Resident's needs, and the services available at the discharge location to meet the Resident's needs. During the hearing, the Facility's representative testified that the Resident required facility care twenty-four hours per day, seven days per week. 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 Facility testified to attempts made at finding the Resident community placement. No evidence was presented to indicate that the Facility had identified a discharge location or made an effort to align services to meet the Resident's needs in the community. Because the Facility failed to prove the basis for the Facility's discharge, the issue of the location of her discharge is moot. However, the Facility should take note of the regulatory requirement to make reasonable efforts to align appropriate discharge arrangements upon the voluntary discharge of a resident.

Notice

The Facility's notice reflected incorrect information for the Board of Review. The Resident was not prejudiced by this error as he was granted a fair hearing. However, the Facility should ensure that future notices of discharge reflect accurate contact information for the offices listed on the notice.

CONCLUSIONS OF LAW

1) The Facility may involuntarily discharge a resident when the resident's needs cannot be met in the facility.

2) The facility must ensure that the resident's medical record includes physician documentation of the basis for the discharge, the specific resident's needs that cannot be met, the facility's attempts to meet the resident's needs, and the service available at the discharge location to meet the resident's needs.

3) The preponderance of evidence failed to demonstrate that the Facility was unable to meet the Resident's needs.

4) 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.

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

6) 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 31st day of July 2024.

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Tara B. Thompson, MLS
State Hearing Officer