October 3, 2024

[redacted]

RE: [redacted] v. [redacted]
ACTION NO.: 24-BOR-2985

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]

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Resident,

v. **Action Number: 24-BOR-2985**

[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 September 25, 2024.

The matter before the Hearing Officer arises from the Facility's August 5, 2024 decision to discharge the Resident.

At the hearing, the Facility was represented by attorney [redacted] Appearing as a witness on behalf of the Facility was [redacted], Chief Executive Officer of [redacted]; [redacted] Accounts Receivable Specialist; and [redacted] Chief Financial Officer. Attorney [redacted] represented the Resident. The Resident's daughters, [redacted] appeared as witnesses for the Resident. All representatives and witnesses were placed under oath. No documentary exhibits were submitted for 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 resident of [redacted], an affiliate of [redacted]

2) The Resident began accruing a balance owed for his cost of care at the Facility in 2020.

3) On August 25, 2023, the Resident's family transferred a piece of property to the Facility as payment toward the Resident's owed balance for 2020 and 2021.

4) Before the August 25, 2023 property transfer, [redacted] received monthly phone calls from the Facility regarding the owed balance.

5) The Resident made $500 payments to the Facility from February through June 2024.

6) On August 5, 2024, the Facility issued a 30-day Discharge Notice to the Resident and the Resident's representatives — [redacted]

7) The August 5, 2024 notice reflected incorrect email information for the Board of Review.

8) The August 5, 2024 notice was signed by the Facility's Chief Executive Officer, [redacted].

9) The August 5, 2024 notice advised the Resident would be discharged from the facility on September 5, 2024 because:

> The resident has failed, after reasonable and appropriate notice to pay, or to have the Medicare or Medicaid program pay on his or her behalf, for the care provided by the facility. Non-payment applies if the resident does not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.

10) The August 5, 2024 notice provided that the Resident would be discharged to:

> [redacted] to home if the resident or representative prefer. We will assist you in arranging for the resident's discharge…

11) The August 5, 2024 notice proposed an involuntary discharge.

12) In April 2024, the Resident was approved for Medicaid Long-Term Care benefits with back-dated eligibility to October 1, 2023.

13) The first Medicaid payment to the Facility was made in May 2024.

14) In August 2024, the Resident paid his $179 patient responsibility portion for his cost of care at the Facility.

15) The Facility's billing statements reflect late charges and interest to the Resident's overdue balance.

16) At the time of the hearing, a payment agreement was not in place between the Resident and the Facility addressing his past-due balance.

17) At the time of the hearing, the Resident was physically and mentally unable to care for himself and required total care from the Facility.

18) [redacted] had no direct knowledge of the Resident's Medicaid application process.

APPLICABLE POLICY

Code of Federal Regulations 42 CFR § 483.10(f)(10)(iii)(C) (October 2024) ***Accounting and Records*** provide that the individual's financial record must be available to the resident through quarterly statements and upon request.

Code of Federal Regulations 42 CFR § 483.10(g)(4) (October 2024) provides that the resident has the right to receive notices orally and in writing in a format and language he understands including;

(i) *Required notices as specified in this section* The facility must furnish to each resident a written description of legal rights which includes -- …
(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

Code of Federal Regulations 42 CFR § 483.10(g)(13) (October 2024) provides that the facility must display in the facility written information and provide to residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive funds for previous payments covered by such benefits.

Code of Federal Regulations 42 CFR § 483.10(g)(18) (October 2024) provides that the Facility must inform each resident periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges

Code of Federal Regulations 42 CFR § 483.15(a)(2)(ii) (October 2024) ***Admission, transfer, and discharge rights- Admissions policy*** provides that the facility must not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for Medicare or Medicaid benefits.

Code of Federal Regulations 42 CFR § 483.15(a)(3) (October 2024) provides that the facility must not request or require a third-party guarantee of payment to the facility as a condition for continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care or to sign a contract, without incurring personal financial liability, to provide financial payment from the resident's income or resources.

Code of Federal Regulations 42 CFR § 483.15(a)(4) (October 2024) provides that in the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of continued stay in the facility. However –

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's continued stay on the request for and receipt of such additional services…

Code of Federal Regulations 42 CFR § 483.15(c)(1)(i)(E) (October 2024) ***Transfer and Discharge – Facility Requirements*** provides that the facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

Code of Federal Regulations 42 CFR § 483.15(c)(2)(i) through (iii) (October 2024) ***Documentation*** provides 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 appropriate information is communicated to the receiving health care institution or provider.

Documentation in the resident's medical record must include the basis for the transfer per paragraph (c)(1)(i) of this section.

Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident
(B) Resident representative information including contact information
(C) Advance Directive information.
(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

Code of Federal Regulations 42 CFR § 483.15(c)(3) (October 2024) ***Notice before transfer*** provides that before a facility discharges the resident, the facility must –

(i) Notify the resident's representatives of the discharge and the reason for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Ombudsman.
(ii) Record the reasons for the transfer or discharge in the 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) (October 2024) ***Contents of the notice*** provides that the written notice must include the following:

(i) The reason for the discharge;
(ii) The effective date of discharge;
(iii) The location to which the resident is discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity that 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;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities ….
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder ….

Code of Federal Regulations 42 CFR § 483.15(c)(6) (October 2024) ***Changes to the notice*** provides that if the information in the notice changes before the discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

Code of Federal Regulations 42 CFR § 483.15(c)(7) (October 2024) ***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)(2) (October 2024) ***Discharge Summary*** provides that when the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1) of § 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and with the resident's consent, the resident representatives, which will assist the resident to adjust to his new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and non-medical services.

West Virginia Code of State Rules (W. Va. Code R.) 64 CSR 13 § 2.51 (July 2021) ***Resident Resource Amount*** is the portion of a resident's income determined by the Department in which a resident who receives Medicaid long-term care assistance contributes to the cost of care every month.

W. Va. Code R. 64 CSR 13 § 4.7.2 and § 4.7.3 (July 2021) ***Written Information*** provides that a nursing home shall provide residents with a written description of their legal rights including:

- A description of the financial obligation as explained to the resident before or at the time of admission, including charges for services available, charges not covered under the Medicaid Program, or charges not included in the nursing home basic rate; and
- A description of the requirements and procedures for Medicaid eligibility including information about the availability of asset assessments upon request at the county Department office;

W. Va. Code R. 64 CSR 13 § 4.10.7.h (July 2021) ***Management of Residents' Personal Funds – Assurance of financial security*** provides that if a nursing home determines, based on professional judgment, that a resident is unable to manage his financial affairs and that his financial representative is not using the resident's funds to pay for his stay, before initiating an involuntary transfer or discharge based on non-payment, a nursing home shall notify the appropriate authorities.

W. Va. Code R. 64 CSR 13 § 4.13.2.d (July 2021) ***Admissions, Transfer, and Discharge – Transfer and discharge requirements*** provide that the nursing home shall permit each resident to remain in the nursing home unless the resident has failed, after reasonable and appropriate notice, to pay for a stay at the nursing home.

W. Va. Code R. 64 CSR 13 § 4.13.3 (July 2021) ***Admission, transfer, and Discharge - Documentation*** provides that documentation shall be made by the resident's physician when discharge is necessary under the provisions of this rule.

W. Va. Code R. 64 CSR 13 § 4.13.6.b (July 2021) ***Involuntary Transfer*** provides that in the event of an involuntary transfer, the nursing home shall assist the resident, legal representative, or both in finding a reasonably appropriate alternative placement before the proposed transfer or discharge and by developing a plan designed to minimize any transfer trauma to the resident. The play may include counseling the resident, a legal representative, or both regarding available community resources and taking steps under the nursing home's control to ensure safe relocation.

W. Va. Code R. 64 CSR 13 § 4.13.7.a (July 2021) ***Discharge to a Community Setting*** provides that a nursing home shall not discharge a resident requiring the nursing home's services to a community setting against his will.

W. Va. Code R. 64 CSR 13 § 4.15 (July 2021) ***Admissions and Payment Policy,*** **§ 4.15.2** ***Third Party Guarantee*** provides that a nursing home shall not require a third-party guarantee of payment to the nursing home as a condition of continued stay in the nursing home. A nursing home, however, may require for the continued stay of the resident, that a person —who has the legal right and access to a resident's income or resources available to pay for care — sign a contract, without incurring personal financial liability, to provide payment from the resident's income or resources.

W. Va. Code R. 64 CSR 13 § 4.5 ***Admissions and Payment Policy,*** **§ 4.15.3 (July 2021)** provides that a nursing home shall fully inform each resident before or at the time of admission and during his stay, of services available in the nursing home and of related charges, including any charge for services not covered under Medicare or Medicaid, or not covered by the nursing home's basic per diem rate.

a. A nursing home may charge any amount for services furnished to non-Medicaid residents consistent with this paragraph.

Code of Federal Regulations 42 CFR § 431.223 (October 2024) ***Denial or dismissal of request for a hearing*** provides that the agency may dismiss a request for a hearing if

(a) The applicant or beneficiary withdraws the request …
(b) The applicant or beneficiary fails to appear at the scheduled hearing without good cause.

W. Va Common Chapters Manual § 710.20.A ***Dismissal; Withdrawal; or Abandonment of a Hearing*** provides that a request for a hearing may be dismissed if:

1. The request for a hearing was not filed within the allowable time frame specified in the notice of adverse action.
2. The issue of the appeal has been resolved or becomes moot;
3. There has been no adverse action taken in relation to the recipient's benefits; or
4. In hearings involving Medicaid, … the sole issue is a federal or state law, including a law or policy requiring an automatic change adversely affecting some or all recipients.

DISCUSSION

The Facility initiated an involuntary discharge of the Resident. The Resident contested the discharge from the Facility and asserted the Facility failed to follow policy when notifying the Resident, documenting the discharge, and identifying a discharge location.

Motion to Dismiss

During the hearing, the Resident's representative made an oral Motion to Dismiss. This Hearing Officer deferred ruling on the request until a comprehensive consideration could be made. According to the guiding rules, the Resident's Motion to Dismiss the matter cannot be granted as it does not satisfy any of the criteria for dismissing a hearing request.

Evidence

Before the hearing, a packet of documents was sent to the Board of Review on behalf of the Facility. During the hearing, the Facility was provided an opportunity to enter the documents as exhibits for evidentiary consideration. The Facility moved to admit the documentary evidence. Upon the Resident's objection to not receiving the records for review, the Facility's representative indicated he had reviewed the information and believed admission of the pages was unnecessary; therefore, no documentary evidence was entered on the Facility's behalf or considered by this Hearing Officer.

Issue

During the hearing, testimony by both parties verified the Facility is where the Resident lives. Testimony demonstrated the Facility is an affiliate of [redacted] The Facility's representative contended that for two years, the Facility has attempted to collect payment for the overdue balance owed for the Resident's cost of care at the Facility. The Resident's representative did not dispute that the balance owed for the Resident's cost of care has increased over time.

A facility must permit each resident to remain in the facility, and not discharge the resident from the facility, unless the resident has failed after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. The policy stipulates that non-payment applies if the resident does not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

The Facility bears the burden of proof and had to demonstrate by a preponderance of evidence that the Resident received reasonable and appropriate notice to pay for his stay at the facility and refused to pay. According to the policy, non-payment includes failure to apply for third-party payment, denial of the Medicaid claim, and refusal to pay for his stay.

Reasonable Notice

The regulations stipulate that the Resident should be informed at admission and periodically of charges for services provided at the Facility.

During the hearing, the Facility's witness, [redacted], testified that the Resident failed to pay after being given plenty of notice and after attempts were made to resolve the balance. [redacted] testified that for two years, the Facility made efforts to collect the due balance via emails, phone calls, mail correspondence, and meetings. Evidence was not provided to demonstrate when the Facility began making these efforts or that charges were properly communicated.

[redacted] testified that she was aware of a balance and that for over a year, she received monthly calls from the Facility requesting to have the Resident's property transferred. She testified that she complied with the request in August 2023 and was confused about why the Facility is discharging the Resident now that he has Medicaid coverage and is actively paying. The submitted testimonial evidence did not verify what charges the Resident's representative was notified of or when she was notified.

During the hearing, [redacted] testified that Medicaid determined the Resident's patient responsibility amount and has been billing the amount as a separate line item on every Facility statement since Medicaid was approved and backdated. Testimony was provided regarding the onset of the Resident's Medicaid eligibility; however, sufficient documentary evidence to corroborate that the Facility began noticing the Resident in April 2024 — the month of the Resident's Medicaid approval — was not submitted.

The Facility's witness testified that late charges and interest were applied to the Resident's balance that remained before Medicaid was approved. [redacted] testified that late charges and interest were not applied to the Resident's patient responsibility amount after his Medicaid approval. Balance statements were not provided to establish when the Resident was notified of his balance, what balance remained, or how payments were applied to the Resident's account before and after his Medicaid approval. The submitted testimonial evidence failed to corroborate the Facility's efforts to reasonably notify the Resident or his representative of the payment owed.

Refusal to pay

[redacted] testified that approximately two years ago, the Facility began requesting she transfer the Resident's property to pay for the Resident's cost of care balance. During the hearing, [redacted] affirmed the Resident's family transferred a piece of property to the Facility as payment on August 25, 2023. [redacted] testified that the agreed property value was applied to the Resident's balance accrued in 2020 and 2021 and that an owed balance for 2021 and ongoing remained after the payment was applied.

Testimony demonstrated the Resident was approved for Medicaid eligibility retroactively to October 2023. [redacted] testified that Medicaid eligibility was established in April 2024 and the first Medicaid payment was made in May 2024. Information was not provided to indicate whether the late charges and interest applied to the Resident's balance for that period were affected by the Medicaid coverage. The submitted testimonial evidence did not reveal what charges remained on the Resident's balance after retroactive Medicaid eligibility was applied or whether the Facility notified the Resident or his representative of the remaining balance. The submitted testimonial evidence did not demonstrate what efforts were made to collect the balance after Medicaid was approved.

During the hearing, [redacted] testified that the Facility's record reflected a history of $500 payments from February through June 2024. [redacted] could not verify what portion of the payment was intended for the owed balance and which portion was intended for the Resident's cost of care that month. Reliable evidence was not submitted to verify whether the $500 payments were attributed entirely to the historical balance or divided between the balance and the current month's charges. During the hearing, [redacted] testified that in August 2024, the Resident began paying $180 toward his patient responsibility amount. The submitted testimony did not indicate whether the Resident was making ongoing lump sum payments after August 2024 in addition to his $180 payments.

The policy does not state that a resident may be discharged when a balance is owed. The regulations specify that the Resident must receive reasonable and appropriate notice and refuse to pay. While the Facility argued that no agreement for repayment had been entered, the submitted testimony did not establish that the Facility requested an agreement be entered or that the Resident refused to pay for his stay.

The federal regulations stipulate that the Facility must not request or require assurance that the Resident will apply for Medicaid benefits. The facility must not request or require a third-party guarantee of payment to the facility as a condition for continued stay in the facility. However, the regulations permit the Facility to request and require the Resident's representative who has legal access to the Resident's income or resources to pay for facility care or to sign a contract to provide financial payment from the Resident's income or resources.

While the provided testimony indicated that the Facility made efforts to seek payment, the testimony did not verify when and what efforts were made. The testimonial evidence did not provide sufficient details to affirm that the Facility requested that the Resident's representative who has legal access to his income pay for his facility care or sign a contract to provide financial payment from the Resident's income or resources.

The state regulations provide that if the Facility determines that the resident's financial representative is not using the resident's funds to pay for his stay, before initiating an involuntary discharge based on non-payment, the Facility is instructed to notify the appropriate authorities. No evidence was submitted to indicate the Facility explored this procedural step.

Based on the submitted testimonial evidence, it appears that the Facility is seeking to discharge the Resident for retroactive failure to resolve his longstanding balance even though the testimonial evidence revealed the Resident's compliance with requests to apply for Medicaid, transfer property, and make monthly payments. As the evidence demonstrated that the Resident was not reasonably informed and the submitted information revealed a history of attempts by the Resident's family to comply with the Facility's request for payment, it cannot be affirmed that the Resident or his representative refused to pay for his stay.

Documentation

The Resident contended that the Facility was required to prove that appropriate documentation was in the Resident's medical record as required by the regulations. Specifically, the Resident

argued the missing information included evidence that the appropriate information had been communicated to the receiving institution. The Facility argued that the provided notice contained the reason for discharge, effective date, discharge location, information regarding the Resident's right to appeal, and contact information for the required parties. Although the discharge notice reflected inaccurate email information for the Board of Review, the Resident was not prejudiced in his ability to obtain a fair hearing in this matter; however, the Facility should note the error.

Before initiating the Resident's discharge, the Facility was required to ensure that appropriate information was communicated to the receiving healthcare institution or provider and to ensure that the reason for the Resident's discharge was recorded in the Resident's record. The regulations provide a list of items that must be provided to the receiving provider. The state regulations stipulate that documentation shall be made by the Resident's physician when discharge is necessary under the provisions of the rule. The submitted testimonial evidence failed to verify that the required documentation was reflected in the Resident's record before initiating the Resident's discharge. However, because the Facility failed to prove the basis for the Resident's discharge, the issue of discharge documentation is moot.

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 supplied by the Facility reflected multiple discharge locations. The notice reflected the Facility was planning to discharge the Resident to [redacted]

During the hearing, [redacted] convincingly testified that the Resident is physically and mentally unable to care for himself and requires total care from the Facility. The Facility did not dispute that the Resident continued to require the Facility's services. The state regulations preclude a facility from involuntarily discharging a resident requiring the nursing home's services to a community setting against his will. The Facility's inclusion of the Resident's home as a discharge location was incorrect.

The Facility is required to take steps under its control to assist the Resident with finding a reasonably appropriate alternative placement before the Resident's discharge. The submitted information did not verify that the required information was sent by the Facility to a receiving institution or provider. The testimonial evidence did not verify how the locations identified were reasonably appropriate alternative placements for the Resident or which specific location the Resident would be discharged to. The regulations require that the Facility provide and document sufficient preparation and orientation to the Resident to ensure safe and orderly discharge from the Facility. The submitted information failed to verify that this criterion was met. As a specific location for discharge was not identified on the notice, the Facility's compliance with proper discharge procedure cannot be affirmed. However, because the Facility failed to prove the basis for the Facility's discharge, the issue of the location of his discharge is moot.

CONCLUSIONS OF LAW

1) The facility must permit each resident to remain in the facility, and not discharge the resident from the facility, unless the resident has failed after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.

2) Non-payment applies if the resident does not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his stay.

3) The preponderance of evidence failed to verify that the Facility reasonably and appropriately notified the Resident or his financial representative of charges and payments applied to the Resident's account balance.

4) The preponderance of evidence failed to verify that Medicaid denied a claim to pay for the Resident's cost of care at the Facility.

5) The preponderance of evidence failed to verify that the Facility requested an agreement be entered and that the Resident refused to pay for his stay.

6) The basis for the Respondent's decision to discharge the Resident cannot be affirmed. The Facility incorrectly initiated the Resident's discharge from the Facility.

7) As the basis for the Resident's discharge was not proven by a preponderance of evidence, the issues of discharge documentation and location are moot.

DECISION

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

ENTERED this 3rd day of October 2024.

_____

Tara B. Thompson, MLS
State Hearing Officer