October 15, 2024

[redacted]

RE: [redacted]
ACTION NO.: 24-BOR-3188

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-3188**

[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 October 8, 2024.

The matter before the Hearing Officer arises from the Facility's August 28, 2024 decision to discharge the Resident.

At the hearing, the Facility Executive Director [redacted] represented the Respondent. [redacted], the Facility Social Services Director, appeared as a witness for the Facility. The Resident was represented by [redacted], the Resident's Co-Guardian. All were placed under oath and the following exhibits were admitted as evidence:

Facility's Exhibits:
F-1 Discharge Notice, dated August 28, 2024
[redacted] Progress Notes:
Behavior Notes, dated April 29, 2023 through September 24, 2024
Social service Notes, dated April 19, 2023 through September 26, 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) The Resident was readmitted to the Facility from [redacted] on April 12, 2024 (Exhibit F-1).

2) The Resident's physician is [redacted] (Exhibit F-1).

3) Behavior Notes were authored by nursing and social services staff (Exhibit F-1).

4) On August 28, 2024, Facility Social Worker [redacted] informed [redacted] by telephone that the Resident would be discharged due to his ongoing behaviors (Exhibit F-1).

5) On August 28, 2024, the Facility issued a notice advising the Resident he would be discharged on September 28, 2024, to the residence of his Guardian and Co-Guardian (Exhibit F-1).

6) "The safety of individuals in the center is endangered due to the clinical or behavioral status of the resident," was reflected as the basis for discharge on the notice (Exhibit F-1).

7) The Discharge Notice was signed by [redacted] Executive Director of the Facility (Exhibit F-1).

8) On June 7, 2024, [redacted] RN, recorded "Resident was witnessed exiting the door from activities department alone. Physical therapist watched him go out the door then walked outside. Several staff members ran outside and assisted him back into the building" (Exhibit F-1).

9) On June 2, 2024, [redacted] LPN, recorded that a verbal order was given to send the Resident to the emergency room for the safety of staff and residents (Exhibit F-1).

10) On August 15, 2024, [redacted] reported that the Resident's guardians did not agree with referring the Resident to [redacted], for inpatient geriatric psych services (Exhibit F-1).

11) The nursing staff recorded episodes of the Resident's physical aggression toward staff on August 27, July 20, July 8, July 6, June 5, June 4, June 2, June 1, June 3; June 2; June 1; May 31; May 30; May 2; April 28; April 27; April 4, 2024, and other events preceding his April 2024 Facility readmission (Exhibit F-1).

12) The nursing staff recorded episodes of the Resident's physical aggression toward other residents on July 20, June 4, June 1, June 2; June 1; April 27, and other events preceding his April 2024 Facility readmission (Exhibit F-1).

13) The nursing staff recorded episodes of the Resident's verbal aggression or threats on July 20, July 8, July 6, June 4, May 30; April 15; April 14, 2024, and other events preceding his April 2024 Facility readmission (Exhibit F-1).

14) The referrals made by the Facility on behalf of the Resident to [redacted] were denied (Exhibit F-1).

APPLICABLE POLICY

West Virginia Code of State Rules (W. Va. Code R.) 64 CSR 13 § 4.13(c)(1) – § 4(13)(d)(3) (July 2021) provides that 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.

Code of Federal Regulations 42 CFR § 483.15(c)(3) (August 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) (August 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)(7) (August 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) (August 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.

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.

DISCUSSION

On August 28, 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 guardians' care. The Resident's representative contested the proposed discharge.

The progress notes submitted by the Facility reflected documentation of events after the Facility's August 28, 2024 discharge decision. The Board of Review may only consider information and events relevant at the time of the discharge decision. As incidents occurring after August 28, 2024, cannot be attributed to the Facility's August 28, 2024 discharge decision, incidents occurring after August 28, 2024 could not be considered.

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.

Basis of Discharge

The Facility has the burden of proof and must demonstrate by a preponderance of the evidence that at the time of the August 28, 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 Facility testified regarding the Resident's history of aggression towards staff and other residents. The submitted documentary evidence corroborated that the Resident has demonstrated continued aggression toward others at the Facility since his readmission. During the hearing, the Resident's representative affirmed that the Resident has a history of aggressive behavior toward others.

Documentation:

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 in the Resident's medical record by the Resident's physician. 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.

While the submitted documentary evidence demonstrated records made by various Facility nursing and social services staff, 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. Without physician documentation of the reason for the Resident's discharge, the Facility's decision to discharge the Resident cannot be affirmed.

Discharge Location

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 conversations were had with the Resident's physician affirming that his needs could be met in a home environment.

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 evidence demonstrated that the Facility made reasonable efforts within its control to align an appropriate transfer location for the Resident. However, an appropriate placement was not identified. The submitted evidence did not reveal how the Resident's medical needs could be met by providers in the community or disclose what efforts were made by the Facility to align the Resident with outpatient treatment at the co-guardian's residence.

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 discharge is moot. However, the Facility should take note of the regulatory requirement to make a reasonable effort 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.

CONCLUSIONS OF LAW

1) 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 in the Resident's medical record by the Resident's physician.

2) The preponderance of evidence failed to demonstrate that the basis for discharging the resident was documented in the Resident's medical record by the Resident's physician.

3) Because the evidence failed to prove that the Resident's physician recorded the basis for the discharge in the Resident's record, the Facility's decision to initiate the Resident's discharge was incorrect.

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

DECISION

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

ENTERED this 15th day of October 2024.

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Tara B. Thompson, MLS
State Hearing Officer