BEFORE THE WEST VIRGINIA INTERMEDIATE COURT OF APPEALS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES/ OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION,
Petitioner,

v.

DOCKET NO.: 22-ICA-277

HEART 2 HEART VOLUNTEERS, INC. dba SERENITY HILLS LIFE CENTER,
Respondent.

PETITIONER'S BRIEF

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Comes now the Petitioner, the West Virginia Department of Health and Human Resources ("Department") / Office of Health Facility Licensure and Certification ("OHFLAC") by counsel, James "Jake" Wegman, Assistant Attorney General, and pursuant to West Virginia Code §§ 51-11-1 *et seq.* and 29A-5-4 (Administrative Procedures Act), respectfully appeals the decision of the Department's Board of Review dated November 4, 2022.

The Board of Review's decision requiring OHFLAC to issue a renewal license and reverse assessment of a Civil Monetary Penalty is in violation of law, clearly wrong, arbitrary and capricious, and an abuse of discretion and/or a clearly unwarranted exercise of discretion.

STATEMENT OF THE CASE

I. Procedural History:

By letter dated March 17, 2022, OHFLAC denied the behavioral health licensure renewal for drug rehabilitation center Serenity Hills due to conduct which jeopardized the health, safety, welfare, and clinical treatment of consumers and failing or refusing to make records related to compliance with this rule available. OHFLAC also issued Serenity Hills a $10,000 civil monetary penalty ("CMP").

Serenity Hills appealed these findings before the Board of Review. An evidentiary hearing was held August 16-19, 2022. By decision dated November 4, 2022, the Board of Review reversed OHFLAC's decisions to deny licensure renewal and issue a CMP. The Department respectfully submits that the decision below is in violation of law, clearly wrong, arbitrary and capricious, and an abuse of discretion and/or clearly unwarranted exercise of discretion.

II. Statement of Facts:

1. W. Va. Code St. R. § 64-11-1 *et seq.*, charges OHFLAC with enforcing the provisions for the licensure of behavioral health centers ("BHC").

2. Under W. Va. Code. St. R. § 64-11-13.1.4., OHFLAC may deny a provider's application for relicensure if the provider conducts practices which jeopardize the health, safety, welfare, or clinical treatment of consumers.

3. Under W. Va. Code St. R. § 64-11-13.1.5, OHFLAC may deny a provider's application for relicensure if the provider fails or refuses to make records related to compliance with this rule available.

4. Under W. Va. Code. St. R. § 64-11-13.3.3, OHFLAC may impose a $10,000 civil monetary penalty to a BHC if their conduct jeopardizes the health, safety, welfare, or clinical treatment of consumers when such practices clearly give rise to imminent danger of serious harm.

5. On September 30, 2021, Serenity Hills submitted a renewal application for a BHC license. Appendix Page 3.

6. OHFLAC began the renewal survey for Serenity Hills on February 24, 2022.

7. By Statement of Deficiencies dated March 14, 2022, OHFLAC found numerous violations and deficiencies at Serenity Hills. App. 709-763, Exh. D-1.

8. Under W. Va. Code St. R. § 64-11-5.1.1.c., consumers have the right to treatment in "the least restrictive, most appropriate, and potentially most effective setting."

9. OHFLAC found that Serenity Hills did not meet this requirement as the facility required a keycard to exit the facility. Surveyors Claudia Pingley and Sandra Poling testified at the administrative hearing that Serenity Hills operated as a "lockdown" facility, which was confirmed by the facility's HR department and CEO. App. 1610, *see also* 710-11, 1214-15.

10. Surveyors Pingley and Poling testified that they received a keycard from Serenity Hills. App. 1517, 1609. The surveyors were not informed that the exits allegedly had a "green

button" that opened the door. App. 1517, 1610. Clinical therapist Staff X, and program manager, Staff R, both testified that an alarm sounded if the green button was utilized. App. 1709-10; 1805.

11. Therefore, OHFLAC determined that Serenity Hills violated the civil rights of all consumers by limiting egress from the facility. App. 710.

12. Under W.Va. Code St. R. § 64-11-5.1.1.i., consumers have the right to humane treatment in an environment in which personal dignity and self-esteem are promoted.

13. OHFLAC found that Serenity Hills did not meet this requirement as the facility violated consumer's civil rights. App. 711. OHFLAC found that Consumer #11 was smacked by a staff member in the kitchen in the back of the neck. App. 711-12, 964-66. Additionally, Consumer #8 was physically abused by the CEO during a Valentine's Day party. App. 712.

14. OHFLAC further found that Serenity Hills also violated consumers' civil rights with strict rules that prohibited consumer interactions. *Id.* Therapist Staff X reported to OHFLAC that consumers are told that they will go back to prison if they do not follow the rules. *Id.*, 1021.

15. Staff X testified that if a consumer receives three write-ups, they could be kicked out of the program and returned to prison. App. 1697. She explained that Serenity Hills issued write-ups for minor issues, such as sugar packets being found in a consumer's room. App. 1698-99.

16. Staff A testified that write-ups result in consumers losing privileges and that the consumers could be written up for being in another consumer's room. App. 1757-58.

17. Under W.Va. Code. St. R. § 64-11-5.1.1.m., BHC's are required to have a consumer advocate.

18. OHFLAC found that Serenity Hills did not protect the rights of the consumers by failing to provide an unbiased advocate. App. 714, 1518. OHFLAC found that Serenity Hills' consumer advocate, Staff I, lacked a job description and actively dissuaded Consumer #8 from filing a grievance regarding the Valentine's Day party incident. App. 714-16, 1129-30, 1135, 1519, 1521-1523.

19. Case manager Staff A reported to surveyors and testified that she witnessed Staff I, the consumer advocate, dissuade Consumer #8 from filing a grievance against the CEO regarding the Valentine's Day party incident. App. 1131-34, 1136, 1739. Staff A testified that Staff I told Consumer #8 that if she filed a grievance, it could delay the OHFLAC survey and "did she really want to do that." App. 1739. Staff A testified that "it felt like" the consumer advocate was dissuading Consumer #8 from filing a consumer grievance. *Id.* Staff A further testified that Consumer #8 stated "I feel like the [consumer advocate's] trying to talk me out of doing anything, and we've been taught in this program that we have to set healthy boundaries, and I feel that this is a healthy boundary for me." *Id.*

20. Staff I "confirmed her own prejudice" by telling surveyors that Consumer #8 only filed a complaint against the CEO due to being set back a level in her treatment. App. 716-17.

21. Consumer #8 told surveyors that the advocate stated, "You did not see the nurse for anything [meaning injury]," and "You know if we do this the CEO won't be allowed here" when she attempted to file a grievance. App. 717, 1125-28.

22. Under W.Va. Code St. R. § 64-11-5.1.1.r., consumers shall be free from physical abuse. "Abuse" is defined as the "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." W.Va. Code St. R. § 64-11-3.1.

23. OHFLAC found that Serenity Hills failed this mandate after viewing video footage of the CEO grabbing Consumer #8 during a Valentine's Day party held on February 11, 2022. App. 719-20.

24. This incident had not been reported to OHFLAC or other regulatory agencies as required by W. Va. Code St. R. § 64-11-12.14.1 and W.Va. Code St. R. § 64-11-12.15.1. App. 1525, 1531, 1545, 1619.

25. The video revealed that the CEO grabbed Consumer #8's right arm, and forcefully pulled and shoved Consumer #8 causing her to stumble. App. 720 *See video,* Exh. D-4. Surveyor Pingley testified that the video showed the CEO "grabbing [Consumer #8] by the arm in a forceful manner, swinging her...going back and stumbling." (App. 1616.) Video evidence was provided at the hearing depicting this intimidating behavior by the CEO. Exh. D-4.

26. Program coordinator Staff R testified that later that day, Consumer #8 came to her office and stated that she wanted to leave Serenity Hills because the CEO had placed her hands on her. App. 1807. Consumer #8 stated she did not feel safe. *Id.* During this conversation, the CEO came into the office and "stared" at Consumer #8. Staff R testified that she ended the conversation because of Consumer #8 change of body language after the CEO entered the office. App. 1807-08, 1189 *see also* video Exh. D-4.

27. Staff R testified that she later discussed the Valentine's Day party incident with the CEO, who commented "it didn't matter if [Consumer #8] did tell anyone, no one would believe her because she was in treatment." App. 1809. The CEO also commented that she hoped Consumer #8 did not get her children back. *Id.*

28. Additionally, case manager Staff A testified that she heard the CEO question Consumer #8's credibility during discussions of the incident. App. 1741. Indeed, the CEO told Staff A "who's gonna take her word for it being like an abusive type situation. This girl's in treatment, you know? I didn't do anything wrong." App. 1741.

29. By grievance form dated February 18, 2022, Consumer #8 filed a grievance regarding the incident. App. 720, 1192-93. Consumer #8 reported that the incident "hurt me, publicly in front of everyone...the [CEO] totally broke me inside when she did that. I want transferred to a different facility. I don't feel this is a safe place anymore." *Id.*

30. OHFLAC surveyors discussed the incident with the CEO who reported that she "screamed at [Consumer #8] and pulled her away. I grabbed her to pull her. I did something that I did instantly and I know it was bad...maybe I pulled her more than I should." App. 722, *see* App. 1530, 1617.

31. Therapist Staff X testified that she was not at the Valentine's Day party, but the incident between Consumer #8 and the CEO was brought to her attention. Staff X testified that she observed Consumer #8 to be "withdrawn and quiet" following the incident. App. 1700. Staff X testified that she spoke with the CEO who admitted that she "pulled [Consumer #8] away." App. 1701. Staff X testified that it is not appropriate for staff to place their hands on a consumer. *Id.*

32. Program coordinator Staff R testified that she viewed the Valentine's Day party incident and considered it to be abuse because the CEO made physical contact with the consumer. App. 1810. Likewise, medical director Staff L testified that she viewed the video and considered the CEO's conduct to be abuse. App. 1839.

33. Staff A testified that the incident "retraumatized [Consumer #8]...I don't care how bad she was, it just set her back. It retraumatize." App. 1790.

34. Under W.Va. Code St. R. § 64-11-5.1.1.w., consumers are afforded basic rights, including the right to communication by mail and telephone.

35. OHFLAC determined that Serenity Hills failed this mandate by unreasonably restricting private telephone communications and mail correspondence and prohibiting consumers from interacting with each other during their free time at the facility. App. 723.

36. Serenity Hills' rulebook prohibits consumer interaction and also restricts telephone and mail access. App. 724-25, 1532. Case manager Staff A reported that consumers are granted two, 10-minute phone calls per week that are monitored by staff. App. 725, 1144-47. She also reported that the facility restricts consumers' mail. App. 726. Staff A and Staff X testified that the strict rules delayed mail from being delivered to consumers. App. 1709, 1756. Staff A testified that consumers complained and "didn't like" the strict mail rules. App. 1755.

37. Staff A testified that consumers were only authorized to communicate with "good" people. *Id.* She explained that staff searched the internet and social media to determine if a person was "healthy" and therefore authorized to communicate with a consumer. *Id.*

38. Staff A testified that consumers "definitely wanted to be able to talk to whoever they wanted to, and they felt like the time limit was really constricting. They just didn't have a lot of time for phone calls." App. 1752. Similarly, therapist Staff X testified that consumers often complained about the strict telephone rules. App. 1707

39. Program coordinator Staff R testified that she received complaints that mail was lost at Serenity Hills. App. 1803. She also explained that Serenity Hills prohibited consumers

from receiving any mail from the jail system, even from a spouse. *Id. See also* Staff A testimony, App. 1754.

40. OHFLAC surveyors observed consumers in assigned rooms speaking to each other through open doors. Surveyors asked the consumers why they were not intermingling with each other and were informed that the consumers were not "allowed to come out of their rooms." App. 1532-1533. Surveyor Pingley testified that a consumer told her "we're not allowed to speak to each other. If we poke our head out the door, we will be wrote up." App. 1613. Consumer #10 reported that interaction was prohibited and was "worse than being in prison." App. 724, 1148, 1534, 1614.

41. Therapist Staff X reported to surveyors that consumers are written up for standing in doorways or sticking their heads out from their assigned room. App. 725. Staff X testified that consumers complained about the strict rules. She also testified that she personally observed a staff member yell at a consumer for sticking her head past her bedroom doorway. App. 1699. Staff X testified that "this has gone way beyond COVID and this is just flat out a patient right violation." *Id.*

42. Therefore, OHFLAC determined that Serenity Hills violated the consumers' right to have mail and telephone communications, communications with fellow consumers, and to have access to other consumers and daily activities outside of their bedrooms.

43. Under W. Va. Code. St. R. § 64-11-5.2.2., a BHC must investigate allegations of consumer abuse.

44. OHFLAC determined that Serenity Hills failed these mandates by not investigating or reporting two alleged incidents of physical abuse. App. 726. Serenity Hills also

failed to investigate or report the efficacy of medication left outside during a snowstorm. App. 726-27.

45. Regarding the physical abuse, OHFLAC determined that Serenity Hills did not investigate or report the allegation that the CEO abused Consumer #8 during the Valentine's Day party incident. App. 727. Additionally, Serenity Hills staff confirmed that the facility did not investigate or report the allegation that Staff Z slapped Consumer #11 in the kitchen. App. 727, 1032, 1611-12.

46. OHFLAC determined that the Serenity Hills board of directors did not conduct an investigation of the Valentine's Day party incident until required by OHFLAC. After being required, the investigations purported to exonerate the CEO in written reports dated February 25, 2022, and March 6, 2022; however, these reports were still not comprehensive. App. 727-28, 1180-86, 1601-02. Board of director members confirmed to surveyors that they did not have training regarding Serenity Hills' policies or regarding consumer rights and failed to watch any video of the incident or meet with witnesses during their first investigation. App. 1534, 1547, 1620. Board of director members further confirmed to surveyors that during their second investigation, they watched one video with one angle of the incident, despite other angles being available. The board of director investigations were incomplete and not thorough. App. 729-731, 1259-63, 1621-1622.

47. Serenity Hills' policy requires that steps be taken to ensure consumer safety if there is an allegation of abuse. App. 753. Because the CEO was not removed pending an investigation, on February 24, 2022, an immediate plan of correction was issued by Serenity Hills' clinical director, and approved by OHFLAC, requiring any staff member under investigation to be suspended pending an investigation. App. 755, 982, 1529.

48. Clinical director Staff M confirmed to OHFLAC that he told the CEO that she was required to be on administrative leave; however, the CEO remained fully in charge and directing the Serenity Hills' workforce at all times. App. 754, 1003. Other staff reported that they also notified the CEO that she was required to be on administrative leave during an investigation and she refused to comply. App. 754, 1004-07.

49. Medical director Staff L reported that she filed an additional complaint against the CEO for her failure to leave the premises and for making statements detrimental to consumer care. App. 753, 763. Staff L testified that she spoke with the CEO multiple times about leaving the facility on administrative leave during an ongoing investigation. App. 1831-32. After Staff L filed a new complaint against the CEO, the CEO remained at Serenity Hills and failed to abide with the February 24, 2022, immediate plan of correction. Staff L testified that because the CEO would not leave the premises, the clinical team discharged the consumers as concern for their safety was paramount. App. 1833 Medical Director Staff L also had concerns of the CEO having a gun on the premises, and the West Virginia State Police were called to assist. App. 1855, *see also* Staff X testimony App. 1726. The Serenity Hills BHC was chaotic during this time. On discharge, residents left through their bedroom windows instead of leaving through the front door. App. 2230. This is further indicative that Serenity Hills was being ran as a "lockdown" facility.

50. Regarding the incident in the kitchen, therapist Staff X testified that Consumer #11 was employed in the Serenity Hills kitchen and was still receiving counseling services from Serenity Hills when the slapping incident occurred. App. 1703. Staff X was told she was "instigating" when she inquired to Staff I, HR department / consumer advocate, regarding the incident. App. 1702, s*ee also* 1034.

51. The kitchen incident was not reported to OHFLAC or other regulatory agencies as required by law. App. 1548.

52. Staff A testified that the kitchen employee was not placed on administrative leave as required by Serenity Hills policy. App. 1744. Staff A testified "there's supposed to be an investigation. The person's supposed to go home and not come back until they're cleared. That didn't happen." *Id.*

53. Regarding the medication storage incident, OHFLAC determined that Serenity Hills suffered a complete power outage from February 4-5, 2022. App. 727, *see also* 749-52. During this time, the medications Insulin and Vivitrol, which require refrigeration, were left outside in the snow due to lack of inside refrigeration. App. 727, 1187-88, 1203. Medical records revealed that Serenity Hills continued to use this medication and never investigated the unsafe practice. App. 727, 1241-51.

54. Surveyor Pingley testified that this incident should have been reported because the medication was "stored inappropriately outside, and we don't know what temperature. The one medication was administered the whole entire rest of the month...after the storm." App. 1631. Medical Director Staff L agreed, and testified that the medication "is a type of insulin that needs to be refrigerated at all times...by putting it outside, we really don't know what the temperature got to." App. 1830.

55. Serenity Hills' policy requires that this incident be reported, however it was not reported to OHFLAC because nursing staff "didn't know I was supposed to." App. 752, 912, 1249. The CEO testified that she was not aware of this incident. App. 2198.

56. Therefore, OHFLAC determined that Serenity Hills failed to investigate or report two allegations of physical abuse and an allegation regarding improper medication storage; and

determined that the February 24, 2022, immediate plan of correction was not being followed as the CEO remained at Serenity Hills despite a new complaint being levied by medical director Staff L.

57. Under W. Va. Code St R. § 64-11-7.5.1., BHC's are to provide records and other information to regulatory agencies such as OHFLAC.

58. OHFLAC determined that Serenity Hills violated this mandate when the CEO instructed staff members to not speak to OHFLAC. App. 739.

59. Both the clinical and medical director reported to OHFLAC that they had been instructed not to speak to surveyors. App. 739, 1201-03.

60. Medical director Staff L provided an audio tape of a meeting wherein the CEO told Staff L she would be guilty of "insubordination" if she spoke to OHFLAC. App. 739, Exh. D-5 1281-1370, 1842.

61. Case manager Staff A also testified that she was instructed by the CEO to no longer speak to OHFLAC after the surveyors left the building. App. 1743.

62. Program Manager Patterson testified that facilities are "required to cooperate with our survey fully by presenting whatever records we require, and also interview; any information, and we saw clear evidence…I would call it coerce staff into not participating." App. 1891.

63. Under W. Va. Code St. R. § 64-11-8.2., BHCs are to have financial policies and procedures that follow generally accepted accounting principles (GAAP).

64. OHFLAC determined that Serenity Hills failed this mandate after a review of its policies and procedures revealed no financial records or financial policies. App. 740, 1537, 1628. The CEO confirmed to surveyors that there were no financial policies, no financial documentation that they could review, and that the facility had not been audited since 2017. *Id.*

65. Under W. Va. Code St. R. § 64-11-9.5.1.g., BHC's shall maintain current employee records.

66. OHFLAC determined that this mandate was not met as 5 out of the 6 employee personnel records reviewed by OHFLAC lacked job performance evaluations. App. 743, 875-94, 1539-40.

67. The HR director, Secretary of the Board, and the CEO all confirmed to surveyors that staff did not receive evaluations in 2020 and 2021 despite being required under policy. App. 744, 891-93, 1082, 1111-12.

68. Under W. Va. Code St. R. § 64-11-9.7.3., direct care staff must be trained in CPR and first aid.

69. OHFLAC determined this mandate was not met as personnel records revealed approximately 4 out of 7 direct staff lacked CPR and first aid training. App. 745-46, 895-99, 1541.

70. Under W. Va. Code St. R. § 64-11-11.2.3., BHC's shall inform consumers regarding their medication and treatment.

71. OHFLAC determined that this mandate was not met as Serenity Hills failed to obtain informed consent for 6 out of 6 consumers reviewed regarding their medication. App. 746, 1051-75, 1542-43. Staff K, director of nursing, confirmed that she could not provide documentation that the center obtained such informed consent. App. 747.

72. Under W. Va. Code St. R. § 64-11-11.2.4., Approved Medication Assistive Personnel ("AMAP") must follow all guidelines including being retrained every two years.

73. OHFLAC determined that Serenity Hills failed this mandate as Staff N, Mental Health Technician / AMAP, had not been retrained. App. 748, 1543-45. Medical documentation

revealed that staff administered medication to consumers despite not being retrained. App. 748, 947-61, 1544. The medical director, Staff L, confirmed that there was no documentation that the AMAP staff member had been retrained. App. 749, 1545, 1835.

74. By letter dated March 17, 2022, OHFLAC denied Serenity Hills a BHC license renewal. App. 3-4, Exh. D-6. OHFLAC found that Serenity Hills' conduct jeopardized the health, safety, welfare, and clinical treatment of consumers; violated consumer rights; and failed or refused to make records available to OHFLAC. *Id.* OHFLAC Program Director James Patterson testified that he supported the decision to not issue a renewal license due to the cumulative nature of the violations.

75. The March 17, 2022, letter also assessed Serenity Hills a $10,000 CMP based upon violations that jeopardized the health, safety, welfare, and clinical treatment of consumers. App. 3-4, Exh. D-6. Program Director Patterson testified that he supported OHFLAC's decision to issue a CMP due to the nature of the violations which jeopardized the health and safety of consumers. App. 1890

76. Under W. Va. Code. St. R. § 64-11-1 *et seq.*, a facility can submit a new BHC application to OHFLAC for licensure consideration.

SUMMARY OF THE ARGUMENT

Due to the serious nature and number of deficiencies, OHFLAC properly denied Serenity Hills a renewal license and properly assessed a CMP. The statement of deficiencies properly determined that Serenity Hills violated numerous provisions of the BHC licensure legislative rule. These deficiencies included violating consumer's civil rights and the right to humane treatment. Serenity Hills also failed to investigate and report three incidents to OHFLAC or other regulatory agencies. Therefore, the evidence shows that the Serenity Hills engaged in conduct that jeopardized the health, safety, welfare, and clinical treatment of consumers, violated

consumer rights, and failed or refused to make records available to OHFLAC. As such, the Board of Review's decision requiring OHFLAC to issue a renewal license and reverse assessment of a CMP is in violation of law, clearly wrong, arbitrary and capricious, and an abuse of discretion and/or a clearly unwarranted exercise of discretion.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

The Petitioner requests oral argument pursuant to the criteria found under Rule 18(a). The Petitioner requests Rule 19 argument as the assignments of error illustrates that the lower level decision went against the weight of the evidence. The Petitioner believes that a memorandum decision reversing the Board of Review is appropriate.

ARGUMENT

I. Standard of Review: The procedure governing appeals from a decision of an administrative law judge in a hearing before the Board of Review is set forth in *West Virginia Code* § 29A-5-4. The statute provides grounds for appeal when such a decision is:

1) In violation of constitutional or statutory provisions;
2) In excess of statutory authority or jurisdiction of the agency;
3) Made upon unlawful procedure;
4) Affected by other error of law;
5) Clearly wrong in view of the reliable, probative, and substantial evidence on the whole record; or
6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

The standard of review varies based on whether the issues on appeal stem from the ALJ's factual findings or legal determinations. Courts generally give deference to an administrative agency's factual findings and review an agency's legal determinations *de novo*. Most West

Virginia cases involving judicial review of administrative agency decisions hold that the agency's factual findings should be reversed if they are clearly wrong or are not supported by substantial evidence. Where there are mixed questions of law and fact, such as a misapplication of law to the facts, the agency's decision should be reviewed de novo. See *Healy v. West Virginia Board of Medicine*, 203 W. Va. 52, 506 S.E.2d 89 (1998) (Per Curiam).

II. The ALJ was clearly wrong to require OHFLAC to issue a renewal behavioral health license to Serenity Hills.

Due to the serious nature and number of deficiencies, OHFLAC properly denied Serenity Hills a renewal license and properly assessed a CMP. The statement of deficiencies properly determined that Serenity Hills violated numerous provisions of the BHC licensure legislative rule. These deficiencies included violating consumer's civil rights and right to humane treatment. Personnel records revealed that staff were missing annual evaluations and evidence of required training in AMAP, CPR, and first aid. Serenity Hills also violated consumers' rights by limiting telephone and mail communications. Consumers were also prohibited from speaking to other consumers in common areas. Consumers were written up for small infractions, such as speaking to other consumers, sticking their head outside of the doorway of their bedrooms, or keeping sugar packets in their rooms. These are extreme limitations. Serenity Hills' staff testified that if a consumer incurred three write-ups, then the consumer could be sent back to jail and lose the right to see their children.

Serenity Hills' staff stated to surveyors that they operated as a "lockdown" facility for all consumers. Consumers were not allowed to exit their bedroom. The locked doors of the facility prohibited consumers from gaining access to outside areas as an alarm would sound if the door was opened. This type of lockdown facility is in contradiction to the BHC rules which allow for consumers to have basic civil rights and freedom of movement. Indeed, during the final night

that Serenity Hills was open, two consumers allegedly jumped from their windows to leave the facility further indicating that consumers were not free to exit the facility through the doors. App. 2230.

Equally troubling, Serenity Hills also failed to investigate and report three incidents to OHFLAC or other regulatory agencies. The evidence shows that Consumer #11 was smacked while working in the kitchen. This allegation was never reported even though the consumer was still receiving counseling services from Serenity Hills. When therapist Staff X inquired about the incident to HR/consumer advocate, she was told she was "instigating" and essentially causing trouble. App. 1702. Serenity Hills also failed to report and investigate an incident involving medication left outside during a power outage. Nursing staff told surveyors that the incident was not reported because she "didn't know I was supposed to." App. 752, 912, 1249. Serenity Hills CEO testified that she was not aware of this incident at the time. App. 2198.

Serenity Hills also failed to report an incident where the CEO grabbed a consumer during a party. The consumer advocate dissuaded the consumer from filing a grievance and told her that the CEO would be required to leave the facility during the OHFLAC survey. When Consumer #8 decided to file the complaint anyway, Serenity Hills failed to report the incident or investigate the allegation. Medical director Staff L provided audio recordings and testified regarding the CEO instructing her not to speak to OHFLAC or she would be guilty of "insubordination." App. 1842

Therefore, the evidence shows that the Serenity Hills engaged in conduct that jeopardized the health, safety, welfare, and clinical treatment of consumers, violated consumer rights, and failed to make records available to OHFLAC. As such, the ALJ was clearly wrong when he ordered OHFLAC to issue Serenity Hills a renewal behavioral health center license.

In his Discussion section, the ALJ erroneously found that Serenity Hills did not violate any provisions of the behavioral health licensure legislative rule when its CEO threated employees with "insubordination" if they spoke to OHFLAC surveyors. (Decision p. 22.) The ALJ reasoned that there was no evidence that any employee was disciplined or otherwise failed to provide documentation to OHFLAC. This is in error as an employee of a behavioral health center should be free to provide documents or information to OHFLAC without threat of insubordination. This instruction to multiple staff members precluded OHFLAC from being able to conduct a more thorough investigation as staff was forbidden from speaking to OHFLAC surveyors. Indeed, documents cannot be requested by OHFLAC if conversations with staff are not allowed to take place. This is the type of behavior and non-cooperative conduct that W.Va. Code St. R. § 64-11-13.1.5. prohibits.

The ALJ also erroneously found that consumers were free to leave the facility, despite uncontroverted evidence that an alarm sounded if the door was opened. (Decision p. 23.) The ALJ also incorrectly concluded that consumers were not subjected to inhumane treatment despite evidence that they could be written up, and potentially returned to jail, if they interacted with other consumers, stuck their heads out of the doorway of their rooms, and left sugar packets in their rooms. (Decision p. 23-24.)

The ALJ also erroneously concluded that Serenity Hills provided an unbiased consumer advocate. Staff A testified that she personally witnessed the advocate attempt to dissuade Consumer #8 from filing a grievance regarding the Valentine's Day party incident. Staff X also testified that she was told she was "instigating" when she asked the consumer advocate about the status of the kitchen neck slap incident. App. 1702. Furthermore, OHFLAC surveyors reported that that the consumer advocate "confirmed her own prejudice" by telling surveyors that

Consumer #8 only filed a complaint against the CEO due to being set back a level in her treatment status.

The ALJ also erroneously found that the CEO did not abuse Consumer #8 at the Valentine's Day party. (Decision p. 25-26.) The ALJ agreed that the CEO "forcefully pulled Consumer #8 away from the group of women by the arm, but that unwanted touching alone does not satisfy the controlling rule regarding resident abuse." (Decision p. 25.) The ALJ then erroneously found that the Consumer was not physically injured, and, therefore, abuse did not occur. *Id.*

The ALJ finding that Consumer # 8 was not injured is in error. Program coordinator Staff R testified that later that same day, Consumer #8 came to her office and stated that she wanted to leave Serenity Hills because the CEO had placed her hands on her. Consumer #8 stated she did not feel safe. During this conversation, the CEO came into the office and "stared" at Consumer #8. (Exh. D-4.) Staff R testified that she ended the conversation because of Consumer #8's change of body language after the CEO entered the office. (*See also* Exh. D3 p. 18.) Mental abuse is still abuse; a resultant physical injury is not required. Video evidence of this intimidating behavior by the CEO was produced at the administrative hearing. Exh. D-4.

Staff R testified that she later discussed the Valentine's Day party incident with the CEO, who commented that no one would believe Consumer #8. The CEO also commented that she hoped Consumer #8 did not get her children back. Additionally, case manager Staff A testified that she heard the CEO question Consumer #8's credibility during discussions of the incident.

By grievance form dated February 18, 2022, Consumer #8 filed a grievance regarding the incident. App. 720, 1192-93. Consumer #8 reported that the incident "hurt me, publicly in front of everyone...the [CEO] totally broke me inside when she did that. I want transferred to a

different facility. I don't feel this is a safe place anymore." *Id.* Therapist Staff X testified that she was not at the Valentine's Day party, but the incident between Consumer #8 and the CEO was brought to her attention. She testified that she observed Consumer #8 to be withdrawn and quiet following the incident. Staff X testified that it is not appropriate for staff to place their hands on a consumer. Program coordinator Staff R testified that she viewed the Valentine's Day party incident and considered it to be abuse because the CEO made physical contact with the consumer. Mental distress occurred because of this physical contact. Likewise, medical director Staff L testified that she viewed the video and considered the CEO's conduct to be abusive. App. 1839.

Therefore, the ALJ was clearly wrong when he determined that Consumer #8 was not abused merely because there was not a physical injury. The evidence shows that Consumer #8 made statements the same day as the incident expressing that she considered the incident to be abusive. Indeed, Consumer #8 filed a formal grievance regarding the incident on February 18, 2022. The ALJ also incorrectly considered that the incident was not abuse because Consumer "remained at the party" and later participated in "pamper me days" and other events at the facility. (Decision p. 25-26.)

Additionally, the ALJ was incorrect in his determination that Serenity Hills reasonably restricted telephone and mail communications at the facility. Indeed, the evidence showed that consumers were only permitted two, 10 minute phone calls per week that are monitored by staff. App. 725, 1144-47. Staff A reported that the facility restricts consumers' mail. App. 726. Staff A testified that the strict rules delayed mail from being delivered to consumers. Less restrictive methods are available.

Staff A also testified that consumers were only authorized to communicate with "good" people. She explained that staff searched the internet and social media to determine if a person was "healthy" and authorized to communicate with a consumer. App. 1751. Furthermore, Staff A testified that Consumer #8 was written up at Serenity Hills for asking about her mail, which consisted of a winter coat and photographs of her children. App. 1791-1793. Staff A testified that Consumer #8 lacked a winter coat, and to her knowledge, was not able to obtain the coat that was needed due to the cold weather or the photographs of her children. App. 1795. Photographic prints received in the mail were not permitted, even if depicting the residents' children. The pictures were photocopied in black and white ink and provided to the residents. The original prints were provided to the residents upon discharge. App. 1708-09, 1803. Serenity Hills alleged that the original photographs may contain drugs which required this restrictive practice; however, less restrictive measures were available such as making colored copies of the photographs or testing the photographs for drugs. Staff testified that residents were upset when they only received black and white photographs of their children.

Similarly, therapist Staff X testified that consumers often complained about the strict telephone rules. Program coordinator Staff R testified that she received complaints that mail was lost at Serenity Hills. She also explained that Serenity Hills prohibited consumers from receiving any mail from the jail system, even from a spouse. (*See also* Staff A testimony.)

The ALJ incorrectly found that OHFLAC "waived" requirements that staff be trained in CPR and First Aid. During COVID, OHFLAC did allow the facility to hire employees without first obtaining the required CPR and First Aid training; however, at no time did OHFLAC waive or indicate that employees no longer had to obtain such training.

The ALJ correctly determined that Serenity Hills failed to document that it provided informed consent regarding medication to its consumers (Decision p. 29); failed to have AMAP personnel properly trained, *Id.*; failed to report the Valentine's Day party incident or the neck slap incident to OHFLAC (Decision p. 30); and failed to report the medication being left outside during a snowstorm (Decision p. 31). However, despite these violations, OHFLAC was still required by the ALJ to issue a renewal license to Serenity Hills even though Serenity Hills' staff had discharged all the consumers due to concerns for their safety. Indeed, OHFLAC was aware of the chaotic situation at Serenity hills, including that consumers were being discharged by the medical staff due to safety concerns and that some consumers had left the facility by jumping from their bedroom window. Renewing a license under these circumstances would have been improper.

III. The ALJ was clearly wrong when he vacated the CMP levied against Serenity Hills.

The ALJ was in error in Conclusion of Law 9 that a CMP was not appropriate. Under W. Va. Code. St. R. § 64-11-13.3.3., OHFLAC may impose a $10,000 civil monetary penalty to a BHC if its conduct jeopardizes the health, safety, welfare, or clinical treatment of consumers when such practices clearly give rise to imminent danger of serious harm. Serenity Hills engaged in conduct that jeopardized the health, safety, welfare, and clinical treatment of consumers, violated consumer rights, and failed to make records available to OHFLAC. Due to the nature and seriousness of these violations, OHFLAC was justified in issuing a CMP against Serenity Hills and deny relicensure.

IV. The Department has standing to appeal the Board of Review's final order.

By Order dated February 9, 2023, this Court directed the parties to address standing in this appeal. The administrative hearing in this matter was held before the Department's Board of Review. Hearings conducted before the Board of Review are subject to the requirements of the

Administrative Procedures Act ("APA.") Indeed, under W. Va. Code St. R. § 69-1-3, "[a]ll administrative hearings conducted pursuant to this rule will be held according to West Virginia Code, § 29A-5-1 *et seq.*" Under the APA, "[a]ny party adversely affected by a final order or decision in a contested case is entitled to judicial review thereof under this chapter..." W. Va. Code § 29A-5-4(a). It is critical to note that the Respondent's Motion to Dismiss did not cite, or discuss, Section 29A-5-4(a) language which authorizes that "any party" is entitled to judicial review in a contested case.

Furthermore, the final page of ALJ David A. Bishop's decision acknowledges that proceedings for judicial review "must be instituted by filing an appeal to the Intermediate Court of Appeals as provided in W.Va. Code 29A-5-4, within 30 days after the date upon which such party received notice of the final order or decision of the agency." Therefore, ALJ Bishop's decision acknowledges that the APA applies, and that parties can initiate an appeal to the Intermediate Court of Appeals within 30 days.

Therefore, the Department is a party to the administrative hearing held before the Board of Review. Serenity Hills argues that the Department does not have the right to appeal the Board of Review decisions because the Behavioral Health Licensure Rule states that "any owner of a behavioral health center who disagrees with the final administrative decision as a result of the hearing may...appeal the decision of the Circuit Court of Kanawha County. W. Va. Code St. R. § 64-11-13.8.1. This part of the legislative rule does not specifically prohibit the Department's right to appeal, it merely affirms that the behavioral health center may appeal adverse decisions. Additionally, Section 13.8.1.b., acknowledges that the Department may appeal a circuit court's decision in an administrative matter to the Supreme Court of Appeals. It is illogical that the

Department only has appeal rights to the Supreme Court of Appeals, but not the lower administrative decision. At worst, this only creates an ambiguity in the rule.

More importantly, under the APA, "any party" may appeal an administrative decision to the Intermediate Court. Indeed, ALJ Bishop's decision specifically cited to the appellate rights found under the APA which indicates either party can appeal. ALJ Bishop's decision does not cite W.Va. Code St. R. § 64-11-13.8.1. or otherwise indicate that the Department is forbidden from appealing. As a statute, the APA, which allows an appeal by "any party" would control over a legislative rule issued by the Department. Syl. Pt. 3, *Rowe v. W.Va. Dep't of Corr.*, 170 W.Va. 230, 292 S.E.2d 650 (1982).

Under the concept of *pari material*, "statutes which relate to the same subject should be read and applied together." *Manchin v. Dunfree*, 174 W.Va. 532, 535-36, 327 S.E.2d 710, 713-14 (1984.) In the present matter, when analyzing both the APA and the Behavioral Health Centers Licensure Rule, the APA's clear and unambiguous language that "any party" may appeal should trump and override any alleged ambiguity in the Behavioral Health Centers Licensure Rule.

The Department has standing to bring an appeal of final orders issued by the Board of Review. Under W.Va. Code § 9-2-6(a)(7), the Department shall establish an Office of Inspector General ("OIG") for the "purpose of conducting and supervising investigations, performing inspections, evaluations, and review, and providing quality control for the programs of the department." The Code further mandates that "neither the secretary nor any employee of the department may prevent, inhibit, or prohibit the Inspector General...from initiating, carrying out, or completing any investigation, inspection, evaluation, review or other activity oversight of

public integrity." *Id.* The Department was mandated to organize a Board of Review which was placed within the Office of Inspector General. *See* W. Va. Code § 9-2-6(a)(13).

Therefore, the OIG is a quasi-independent agency within the Department designed to provide quality control for programs under the Department. This is distinguishable from the cases cited by Serenity Hills for the proposition that the Department cannot appeal Board of Review decisions. Indeed, *Mason County Board of Education v. State Superintendent of Schools ("Mason")* cited by the Petitioner is not applicable because the APA does not apply to Board of Education cases. 160 W.Va. 348, 349; 234 S.E.2d 321, 322 (1977). Also, unlike *Mason*, the OIG is established as a quasi-independent agency. The West Virginia Code prohibits the Secretary or Department employees from interfering with OIG operations. Board of Review decisions are therefore made without interference from the Secretary. As such, when the Board of Review issues a decision in a case, it is an appealable order and not merely a "proper reflection" of Department policies as argued by Serenity Hills.

The Supreme Court of Appeals of West Virginia has held that standing "is an element of jurisdiction over the subject matter." *State ex rel. Paul v. Hill,* 201 W.Va. 248, 256, 496 S.E.2d 198, 206 (1997.) Additionally, a court only has subject matter jurisdiction when there is a case or controversy, which, in part, requires the asserting party to have standing to assert the claim. *See State ex rel. Healthport Techs., LLC v. Stucky,* 239 W.Va. 239, 242-43, 800 S.E.2d 506, 509-10 (2017.)

As previously discussed, the Department avers that it does have standing to appeal the Board of Review's decision in this matter. Specifically, under the APA, any party may file an appeal of final administrative order. Indeed, ALJ Bishop's decision cited to the APA for the proposition that parties can appeal his final order to the Intermediate Court. As previously

discussed, the OIG is a quasi-independent agency within the Department designed to provide quality control for programs under the Department. When the Board of Review issues a decision, it does so without interference from the Secretary, therefore its orders are appealable under the APA. As such, the Department has standing to proceed with this administrative appeal and therefore, this Court has jurisdiction in this matter.

CONCLUSION

THUS, the Decision below contains both legal and factual errors and should be REVERSED.

Respectfully Submitted,

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HEALTH AND HUMAN RESOURCES,
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BEFORE THE WEST VIRGINIA INTERMEDIATE COURT OF APPEALS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES/ OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION,
Petitioner,

v. **DOCKET NO.: 22-ICA-277**

HEART 2 HEART VOLUNTEERS, INC. dba SERENITY HILLS LIFE CENTER,
Respondent.

CERTIFICATE OF SERVICE

I, James "Jake" Wegman, Assistant Attorney General, certify that I have this 6th day of March 2022, served a true copy of the foregoing **PETITIONER'S BRIEF** upon the following individual(s) by depositing the same in the United States Mail properly addressed and/or by email as follows:

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