IN THE INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

Docket No. 22-ICA-277

West Virginia Department of Health
and Human Resources/Office of Health Facility
Licensure and Certification,
Petitioner,

v.

Heart 2 Heart Volunteers, Inc.
dba Serenity Hills Life Center,
Respondent.

RESPONDENT'S BRIEF

Robert L. Coffield (WVSB #6297)
Shereen C. McDaniel (WVSB #12282)
L. Elizabeth King (WVSB #14268)
Flaherty Sensabaugh Bonasso PLLC
200 Capitol Street
P. O. Box 3843
Charleston, West Virginia 25338-3843
Telephone: (304) 345-0200
rcoffield@flahertylegal.com
smcdaniel@flahertylegal.com
eking@flahertylegal.com

Frank X. Duff (WVSB #6297)
Schrader, Companion, Duff & Law, PLLC
401 Main Street
Wheeling, West Virginia 26003
Telephone: (304) 233-3390
fxd@schraderlaw.com

Counsel for Respondent, Heart 2 Heart Volunteers, Inc. dba Serenity Hills Life Center

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II. INTRODUCTION

COMES NOW Respondent, Heart 2 Heart Volunteers, Inc. dba Serenity Hills Life Center ("Serenity Hills"), by counsel, and submits its brief, in response and opposition to Petitioner, West Virginia Department of Health and Human Resources ("Department") / Office of Health Facility Licensure and Certification's ("OHFLAC") administrative appeal. This Court should dismiss Petitioner's administrative appeal because the Department does not have standing to seek judicial review of the Decision entered by the Board of Review, the Department's quasi-judicial tribunal. Alternatively, even if the Department has standing, the Board of Review's Decision should be affirmed because it is not clearly wrong in view of the reliable, probative, and substantial evidence in the record and is not arbitrary, capricious, or characterized by an abuse of discretion.

II. STATEMENT OF THE CASE

A. Parties and Nature of Administrative Action

Serenity Hills is a behavioral health center located in Wheeling, West Virginia that provides inpatient and outpatient drug and alcohol rehabilitation services to women suffering from substance abuse disorders. The Department, through OHFLAC, licenses behavioral health facilities. W. Va. Code § 27-9-1 (2020); *see also* W. Va. Code R. § 64-11-1, *et seq.* (2021).[1]

On April 9, 2019, OHFLAC completed its initial licensure survey of Serenity Hills. App. at 692, 1916. Thereafter, Serenity Hills was granted a preliminary behavioral health license and was licensed for seventy-two inpatient beds. *Id.* at 689-90, 2122. Subsequently, OHFLAC completed a re-licensure survey and granted Serenity Hills a regular license on December 4, 2019. *Id.* at 692.[2] On September 30, 2021, Serenity Hills submitted a license renewal application. *Id.* at

[1] West Virginia Code of State Rules Section 64-11-1, *et seq.* is the rule which "establishes general standards and procedures for the licensure of behavioral health services." W. Va. Code R. § 64-11-1.1 (2021).
[2] Importantly, during this process and consistent with its ordinary survey practices, OHFLAC would have confirmed that Serenity Hills had implemented appropriate policies, practices and procedures for a

1371. On February 22, 2022, OHFLAC began a renewal licensure survey at Serenity Hills and on February 28, 2022, also began a complaint survey. Sandra Poling and Claudia Pingley were the OHFLAC surveyors assigned to Serenity Hills. The surveyors exited the facility on March 4, 2022, and the survey was officially completed on March 14, 2022. *See* App. at 1661-62.

Following completion of the survey, on March 17, 2022, OHFLAC provided Serenity Hills with a licensure statement of deficiencies (the "Statement of Deficiencies"). *Id.* at 709-63. The same day, OHFLAC advised Serenity Hills's Chief Executive Officer, Sharon Travis ("CEO Travis") that the renewal licensure application was denied. *Id.* at 1371-72. OHFLAC further advised that Bill J. Crouch, the Department's Cabinet Secretary (the "Secretary"), was imposing a Ten Thousand Dollar ($10,000.00) civil money penalty pursuant to W. Va. Code R. § 64-11-13.3.3. *Id.* OHFLAC's non-renewal of Serenity Hills's behavioral health license and its imposition of the civil money penalty were actions taken without first providing Serenity Hills with an opportunity to submit a plan of correction to address and remedy OHFLAC's concerns. *See* W. Va. Code R. § 64-11-4.6.10. OHFLAC's decision to not renew Serenity Hills's behavioral health license forced it to discharge its residents, causing these residents to be displaced.[3]

B. <u>The Contested Case before the Department's Board of Review</u>

From August 16 through August 19, 2022, Serenity Hills and the Department/OHFLAC appeared before the Board of Review for an administrative hearing, with Administrative Law Judge David A. Bishop ("Judge Bishop"), a member of the Board of Review, presiding.[4] This

behavioral health center specializing in rehabilitation services.

[3] On March 22, 2022, Serenity Hills, by counsel, timely submitted its request for an informal meeting and an administrative hearing, pursuant to W. Va. Code R. § 64-11-13.6.2. On May 4, 2022, an informal meeting was held between the parties' representatives; however, OHFLAC refused to reverse its decision or provide Serenity Hills with the opportunity to address any alleged deficiencies.

[4] *See* W. Va. Dep't of Health & Human Res., Office of Inspector Gen., Bd. of Review Brochure (identifying Judge Bishop as a Board of Review member), *available at https://www.wvdhhr.org/oig/pdf/BOR/BOR%20Brochure.pdf*.

administrative hearing was held in accordance with W. Va. Code § 29A-5-1, *et seq*. (1964) and W. Va. Code R. § 69-1-1, *et seq*. (2015). *Id.* During the hearing, the Department/OHFLAC had the burden of proving that the non-renewal of Serenity Hills's behavioral health center license and the issuance of a civil money penalty were proper. Both parties presented testimony from witnesses, and dozens of exhibits were introduced.

1. Hearing Evidence

During the Board of Review hearing, the Department/OHFLAC called the surveyors who conducted Serenity Hills's survey, Sandra Poling and Claudia Pingley, to testify, along with James Patterson, OHFLAC Behavioral Health Program Manager. The Department also called the following former employees of Serenity Hills to testify: Elizabeth Ellsworth, Stacy Boston, Stacey DeGarmo, and Cristyn Davis.

During its case-in-chief, Serenity Hills called the following former residents to testify: Daphne Chapman, Melissa Meinweiser, Jocelyn Jones, Chelsea Glennon, Jenna Wilson, and Brittany Corkran. Serenity Hills also presented testimony from Erica Biggers, a former resident who went on to become an employee. Additionally, Serenity Hills presented testimony from Jacquetta Harrison, a former employee; Dr. Robert Phares, a physician who provided services to Serenity Hills; Dixie Myers, a new hire at the time of Serenity Hills's closing; and CEO Travis.

During the hearing, through its exhibits and witnesses, and cross-examination of adverse witnesses, Serenity Hills presented substantial, credible, and convincing evidence that the most severe allegations contained in OHFLAC's Statement of Deficiencies, and the allegations upon which OHFLAC justified the licensure nonrenewal and civil money penalty, were unfounded.

i. Serenity Hills's residents had the right to treatment in "the least restrictive, most appropriate, and potentially most effective setting."

During the hearing, the Department claimed that Serenity Hills was a "lockdown" facility

and residents did not have access to treatment in the least restrictive manner because a keycard was allegedly needed in order to exit the facility. However, substantial evidence was presented that green exit buttons are located at Serenity Hills's main doors. App. at 563-571 (photos of the exit buttons). If the exit button is pushed, a localized alarm sounds at the location of the door and the door unlocks. *See* App. at 1709 (E. Ellsworth, an adverse witness, testified that the green exit button allowed residents to leave the facility); *id.* at 1805 (S. DeGarmo, an adverse witness, testified that if "you wanted to exit and didn't have the key fob, you would push the green button and the alarm would go off"); *id.* at 1817 (S. DeGarmo further testified that the door alarm only sounded at the location of the door).

ii. Serenity Hills provided residents with humane treatment.

Petitioner alleges that residents were denied humane treatment because of two isolated incidents and because residents were required to follow "strict" rules. Pet. Br. at 3. However, a closer look at these issues demonstrates that this allegation is false.

a. <u>Incident No. 1: Consumer #11 and Erica (Trusty) Biggers</u>

Notably, Consumer #11 was <u>not</u> called to testify on behalf of the Department, but Ms. Biggers did provide testimony. This situation occurred in the kitchen at Serenity Hills. During this time, both Consumer #11 and Ms. Biggers were working in the kitchen, as employees of Serenity Hills. App. at 2031-32, 2040-41, 2044-45. Consumer #11 was continuing to receive outpatient services from Serenity Hills and was living in a sober living house not under the jurisdiction of OHFLAC. Ms. Biggers was also in recovery and was a former Serenity Hills resident. *Id.* Ms. Biggers testified that because they were both in recovery, she considered Consumer #11 a "peer." App. at 2045. She further testified that although they took their job seriously, the kitchen environment was lighthearted and some "roughhousing" occurred: "Like [Consumer #11] would

kick me, like side kick me, because she's way taller than me. I'm short and the running joke would be like that I couldn't do it back because my foot couldn't reach her butt." *Id.*

With respect to the alleged incident, Ms. Biggers testified that it started because Consumer #11 had shaved the back of her neck and it was winter (early January 2022). *Id.* at 2046-47. She testified that she "just swiped [Consumer #11] on the back of the neck and told her that's like what the wind's going to do to you, like its freezing outside and you have no hair." *Id.* She characterized the contact as more of a "tap" than a smack, and she had no reason to believe that she hurt Consumer #11. *Id.* In fact, Consumer #11 laughed at the joke. *Id.* at 2047-48.

Ms. Biggers testified the morning after this incident, Consumer #11 came to her office and said that she was uncomfortable with what had occurred the prior day. *Id.* at 2048. Ms. Biggers apologized, said it would never happen again, and assured her that the kitchen would be a more professional environment in the future. *Id.* Thereafter, Ms. Biggers was written up, placed on probation, and required to complete courses in professionalism and boundaries. *Id.* at 2048. That said, Ms. Biggers shared a backstory that likely caused Consumer #11 to be upset with her, and may have influenced Consumer #11's unexpected reaction to the incident. Specifically, Ms. Biggers had recently reported that Consumer #11 was requesting a home visit to a potentially unsafe environment. *Id.* at 2049. As a mandatory reporter, Ms. Biggers reported this to the sober living coordinator and Consumer #11's home visit was denied. *Id.* at 2049-2051.

b. <u>Incident No. 2: Consumer #8 and Sharon Travis, CEO</u>

Petitioner further alleges that Consumer #8 was "physically abused by the CEO during a Valentine's Day party." Pet. Br. at 3. Notably, Consumer #8 was not called to testify at the hearing. Nonetheless, copious evidence was presented, demonstrating that Consumer #8 was not abused under either Serenity Hills's policies or the behavioral health licensure rules. Specifically, Judge

Bishop considered multiple exhibits related to this issue, including Serenity Hills's Board of Directors internal investigation documents; testimony from witnesses; and video surveillance of the actual incident. *See* App. at 1184-1186 (Board of Director's Report), 1180-1182 (Board's Addendum), Exhibit D-4 (video of the incident).

The substantial and overwhelming evidence demonstrated that during a Valentine's Day party on February 11, 2022, residents were required to wear masks due to recent COVID-19 outbreaks in the facility. *See* App. at 2144. During this event, Consumer #8 pulled her mask down and was talking with a group of other residents, in close proximity to one another. *Id.* at 2149. In order to prevent the spread of COVID-19, CEO Travis pulled Consumer #8 by the arm and moved her away from the group of residents. *Id.*[5] Then, Consumer #8, somewhat dramatically, spun around to face CEO Travis. *Id.*, *see also id.* at 2188 (CEO Travis testified "[f]rom the video I've seen, I pulled her around and she kept going. I think she lost her balance, and I did not shove her."). Notably, Consumer #8 was not "shoved" by CEO Travis as alleged in OHFLAC's Statement of Deficiencies, nor did she fall or spill the cup of water she was holding during the incident. *Id.* at 2149, 2264-65. Importantly, CEO Travis testified that she had no intention of causing any physical or emotional distress to Consumer #8, nor did she intend to intimidate her. *Id.* at 2150-51. In fact, CEO Travis denied shoving, pushing, shaking, or violently pulling Consumer #8. *Id.* at 2151.

Similarly, Sandra Poling, an OHFLAC surveyor, acknowledged that CEO Travis did not shove, shake, or violently grab Consumer #8. *Id.* at 1557, 1560. Moreover, Stacy Boston, an adverse witness who was not present when the incident occurred, agreed that this issue was an isolated incident and "not a systemic" problem. *Id.* at 1769. Overall, substantial evidence was presented, demonstrating that Consumer #8 was not abused by CEO Travis.

[5] CEO Travis acknowledged that in hindsight, she should have handled the situation differently, but her judgment was clouded by the fear of COVID recirculating among the facility. *Id.* at 2150.

c. Serenity Hills's Resident Rules

Petitioner claims that Serenity Hills violated consumers' civil rules by having "strict rules" in place that "prohibited consumer interactions." Pet. Br. at 3. However, the substantial evidence demonstrates that Serenity Hills provided residents with a structured environment, opportunities for fellowship, and reasonable rules, in order to encourage recovery from drug abuse.

More specifically, Serenity Hills's residents were required to follow certain rules and abide by a code of conduct. *See, e.g.*, App. at 629-650 (Resident Rules enumerated at App. at 644-645). Stacy Boston, a former case manager, testified that residents who violated rules or otherwise demonstrated poor behavior were given "write-ups." App. at 1757 (explaining the rationale for write-ups, as "if somebody's having a lot of behavior issues, you wouldn't want to . . . just push them through the program"). For example, residents were not allowed to go into each other's rooms. *Id.* However, Ms. Boston agreed that this rule was in place to ensure residents were not using drugs or engaging in other harmful behaviors. *Id.* at 1769. She further agreed that romantic and/or sexual relationships among residents were discouraged because these types of relationships can be detrimental to a resident's sobriety. *Id.* at 1768-69, *see also id.* at 644 (emphasis added) (Serenity Hills's Resident Rules included: "No fraternization – relationships that **go beyond the normal scope of peer interactions. No romantic or sexual involvement**.").

Furthermore, substantial testimony was presented establishing that Serenity Hills's rules were consistent with those of other residential treatment facilities. Indeed, Ms. Boston acknowledged that rules prohibiting residents from going into each other's rooms is common in these types of facilities. *Id.* at 1769 ("[T]hat's something I've seen at other facilities. It's not something abnormal. Not be allowed to go into other's room."). Additionally, Erica Biggers, who had been a resident at Miracles Blossom, another facility, before Serenity Hills, testified that the

Serenity Hills's rules were similar but "more humane":

> Q. Are you familiar with the resident rules at Serenity Hills?
> A. Yes, ma'am.
> Q. Could you explain to us how those rules compare to the rules at Miracles Blossoms?
> A. They both were strict, but I guess Serenity Hills had a more humane and understanding of like our situations when dealing with us with the rules.
> . . .
> A. Okay. Are you familiar with the rules, resident rules, at any other inpatient treatment facilities?
> Q. Miracles Blossoms and I work a lot with other rehabs when trying to get clients into the rehabs.[6]
> A. Okay. How do the rules of Serenity Hills compare to the rules as to those other facilities? Are they similar? Do they differ in any ways?
> Q. Oh, very much so. It's pretty-- certain rules are across the board for all inpatient.

Id. at 2034.

Lastly, evidence established that Serenity Hills's residents were provided with many opportunities to socialize and the facility was the complete opposite of a "prison," as alleged in OHFLAC's Statement of Deficiencies. *See, e.g.*, App. at 536-62 (photographs of activities), App. at 572-77 (photographs of Valentine's Day 2022 events), App. at 499-525 (schedules),[7] 457-98 (satisfaction surveys). Overall, substantial, credible evidence was presented that residents' civil rights were not violated with "strict rules" prohibiting interactions with other residents.[8]

iii. Serenity Hills provided Consumer #8 with a resident advocate.

Pursuant to Serenity Hills's policies, residents were provided with a "resident advocate,"

[6] Ms. Biggers now works as a "peer," which involves helping clients get into detox and treatment, so she is familiar with various treatment facilities. App. at 2032.

[7] As noted on the schedules, residents were eating meals in their room due to COVID precautions and Department guidance to "suspend communal dining unless physical distancing is possible . . . serve residents individual meals in their rooms if this is not feasible." App. at 438; *see also* App. at 2163-65 (testimony by CEO Travis).

[8] OHFLAC's Statement of Deficiencies claimed that Serenity Hills's residents were discriminated against due to sexual orientation and religion. Petitioner's Brief does not mention this allegation; therefore, Serenity Hills presumes that the Department does not contest the Board of Review's findings that no discrimination occurred. *See* App. at 1448, 1463-64.

who was responsible for assisting "residents with the grievance process and provid[ing] them with instruction on filing a formal written grievance." *See* Resident Grievance Guidelines, App. at 349; *Id.* at 2174. The evidence established that on February 18, 2022, **seven days after the alleged "abuse" incident**,[9] Consumer #8 filled out a grievance form; on February 21, 2022, Consumer #8 met with Michelle Forshey (Staff I), the resident advocate, and she explained the process; Consumer #8 then submitted the completed grievance form to Ms. Forshey; and an internal investigation began. *See* Grievance Form (Feb. 18, 2022, 4:00 p.m.), App. at 1192-93; Statement of Crystal Bauer, RN/DON (Feb. 21, 2022),[10] App. at 1200 (Consumer #8 "accompanied by Michelle Forshey was assessed via questions for injury and a report of being grabbed." No bruising, red marks or scratches were reported and she denied needing medical attention).

Notably, Ms. Boston testified that she accompanied Consumer #8 to Ms. Forshey's office to file the grievance. App. at 1774-75. However, before doing so, she had a separate conversation with Ms. Forshey, wherein she informed Ms. Forshey that Consumer #8 had been "manipulative" in the past and advised her that "recently [Consumer #8 had] been in trouble and this could possibly be like a plea to . . . get out of the facility sooner." *Id.* at 1775. Importantly, neither Consumer #8 nor Ms. Forshey were called to testify. Nonetheless, regardless of any statements purportedly made by Ms. Forshey regarding the grievance impacting OHFLAC's survey, as alleged by Petitioner,

[9] Notably, Stacy Boston, case manager, testified as to Consumer #8's disciplinary record. Specifically, on November 26, 2021, she was written-up for speaking to her children in violation of a court order. App. at 1777; *see also id.* at 419. On February 9, two days before the incident, she was written-up for manipulative behavior. *Id.* at 1777-78; *see also id.* at 418. Then, on February 18, 2022 at 11:15 a.m., seven days after the incident and four hours before she completed the grievance form, she was written-up for manipulation and disrespect of staff. *Id.* at 1779; *see also id.* at 417. Following this third write-up, Consumer #8 was placed on probation and was moved up to a higher level of care, which could have potentially resulted in her admission being extended. *Id.* at 1782-85.

[10] Ms. Boston also testified that she was advised during the evening of Friday, February 18, 2022 that Consumer #8 wanted to speak with her first thing on Monday morning. App. at 1737. On Monday morning, Consumer #8 provided her with the completed grievance form, dated February 18, 2022. Therefore, the grievance process began on Monday, February 21, 2022. *Id.*

the undisputed facts are that Ms. Forshey provided Consumer #8 with information on the grievance process and accepted her completed grievance form for processing. *Id.* at 1737.

iv. *No residents of Serenity Hills were "abused."*

Petitioner cites to the allegation that CEO Travis "abused" Consumer #8 as the basis for claiming that Serenity Hills's residents were exposed to "physical abuse." *See* Pet. Br. 4-5. As discussed previously, Consumer #8 was not abused during the Valentine's Day party on February 11, 2022, and Judge Bishop properly reached this conclusion after considering the evidence. *See* App. at 1448-49, 1464-65. Moreover, contrary to the Department's assertion, this incident was reported to both OHFLAC and Adult Protective Services. ("APS") *See* App. 776-77 (unsigned complaint form submitted to OHFLAC), 406-08 (APS screened out this incident, finding it did "not meet APS criteria). Furthermore, Sandra Poling acknowledged that OHFLAC received a complaint regarding Consumer #8, but she received it from OHFLAC after the survey process began. App. at 1526. It is pertinent to note that Consumer #8's grievance was officially submitted on February 21, 2022, and the very next day, Ms. Poling arrived at Serenity Hills to begin the survey, which ultimately included an investigation into the incident. *Id.* at 1954. Thus, regardless of when or how the incident was reported to OHFLAC, its surveyors had knowledge of it during the survey process and an opportunity to investigate.

Additionally, contrary to the Department's assertions, the video of the incident did <u>not</u> demonstrate that CEO Travis "violently" pulled or "shoved" Consumer #8. *See* Pet. Br. 5; App. at 1557, 1560 (Ms. Poling acknowledged that CEO Travis did not shove, shake, or violently grab. Consumer #8); *see also* 666 (Ms. Poling's contemporaneous investigation notes, noting that CEO Travis did not "violently" grab Consumer #8 or shake her for not wearing her mask properly); App. at D-4 (video surveillance). In fact, Consumer #8 did not even drop or spill a cup of water

she was holding during the incident. Petitioner also fails to mention CEO Travis's hearing testimony, affirming that she did not "scream" at Consumer #8, nor did she tell OHFLAC she "screamed" at Consumer #8. *Id.* at 2194; *see also* App. at 651-54.

Moreover, the evidence demonstrates that Consumer #8's demeanor was normal on February 11 *after* the incident occurred. In fact, video evidence depicts Consumer #8 dancing to the Electric Slide, approximately forty minutes after the incident occurred. *Id.* at 2151-53. The video shows Consumer #8 having "a fun time." *Id.* at 2153. Additional video evidence was presented, showing Consumer #8 and CEO Travis speaking, in a non-confrontational, friendly, manner shortly after the incident. *Id.* at 2152.

Petitioner also mischaracterizes an interaction that occurred in Stacey DeGarmo's office. *See* Pet. Br. 5. During the hearing, a video was introduced and testimony was presented regarding a situation in Ms. DeGarmo's office on February 22, 2022—ten days after the Valentine's Day party. App. at 2188-2189; *see also id.* at D-4. CEO Travis testified that she walked into Ms. DeGarmo's office, and then saw Consumer #8 sitting in the office. *Id.* at 2190 (CEO Travis testifying that Consumer #8 was "sitting back, so I didn't know she was in there"). When CEO Travis realized, she put her hands on her hips and/or lower back, which she "always" does, and took a step back. *Id.* at 2190; *see also* 1826. CEO Travis asked if she was interrupting, Ms. DeGarmo said "no" and they were finishing up, and CEO Travis waited for Consumer #8 to leave the office. *Id.* That was the extent of the interaction, as captured on video surveillance, and no "intimidation" occurred. *Id.* In fact, CEO Travis did not even speak to Consumer #8, other than to generally ask if she was interrupting and if she was alright. *Id.* at 2191-92.

Overall, substantial evidence was presented, demonstrating that Consumer #8 was not "abused" by CEO Travis, was not "traumatized" by the interaction, and was not subjected to

ongoing "intimidation" by CEO Travis.

v. Serenity Hills's residents were provided basic rights, and rules regarding telephone and mail communications were reasonable.

Serenity Hills's Resident Handbook contains certain rules regarding telephone and mail usage, including a mail screening process to ensure contraband is not smuggled into the facility. App. at 634-35.[11] The undisputed evidence is that because of these rules, Serenity Hills never had any illegal or harmful substances smuggled into the facility, and never had any overdoses occur at the facility. *Id* at 1768, 2022, 2035-36, 2130. Moreover, the evidence established that Serenity Hills's rules are consistent with similarly situated facilities. *Id.* at 1815-16 (Stacey DeGarmo testified that other facilities she has worked at have rules regarding telephone calls), 2034-35 (Erica Biggers testified that most inpatient facilities have rules regarding the use of the telephone and the receipt of mail); *but see id.* at 1638 (Claudia Pingley testified that the OHFLAC surveyors did not consider comparing Serenity Hills's rules to the rules of other facilities).

With respect to telephone calls, Serenity Hills's residents were permitted two telephone call slots per week and were permitted to speak with individuals on their contact list while monitored by staff. *Id.* at 635, 1751, 1766-67 (Stacy Boston testified that Serenity Hills had reasonable measures in place to ensure that residents did not communicate with individuals in jail or active addiction, or individuals they were prohibited from speaking with per court order).[12]

Mail received by residents was screened by the resident's case manager, in the presence of the resident, and a copy was made and provided to the resident, and the original was kept by the

[11] Importantly, these rules were in place when OHFLAC first issued Serenity Hills's behavioral health license.

[12] Ms. Boston further testified that 99% of Serenity Hills's residents "were involved in the criminal justice system," and many were ordered by CPS and/or the court system to be there. *Id.* at 1752. As such, residents were not permitted to receive mail from the prison system, but exceptions were made when the individual in jail was not detrimental to the resident's recovery (i.e., a child or a supportive spouse). *Id.* at 1754-55.

case manager and returned to the resident at discharge. *Id.* at 634, 1752, 1754. This process ensured that mailed documents were not laced with drugs or harmful substances. *Id.* at 1754 ("They weren't allowed to have the originals. And the reasoning behind that was because, a lot of time, especially in the criminal justice system, people will take medications and like melt them down and paint the paper with 'em, and so, they can actually get a medication on a piece of paper and then lick it, put it in their mouth, let it dissolve and they can get high from that.").

Furthermore, as previously discussed, the Department failed to prove that residents were prohibited from interacting with one another during their free time. *See* App. at 499-525, 536-62, 572-77, 457-98, 2011-12, 2065-66, 2160-63. The Department claims that residents could be written-up for "sticking their head out of the doorway." Pet. Br. at 8. However, no evidence was presented establishing that any residents had substantiated write-ups for *only* sticking their head out of the door. CEO Travis testified that if this was occurring, she was not aware. *Id.* at 2197. That said, she recognized that staff had implemented some procedures in the living quarters for COVID precautions and this practice was likely in place to prevent residents from crowding the hallways and spreading illness. *See id.* Yet, the overwhelming evidence presented, including the testimony of several former residents, demonstrates that Serenity Hills's residents had various opportunities to communicate, interact, and socialize with other residents.

vi. Serenity Hills properly investigated two allegations of "abuse."

With respect to the incident between CEO Travis and Consumer #8, the undisputed evidence is that on Friday, February 25, 2022, only four days after Consumer #8's grievance was submitted, Serenity Hills's Board of Directors convened and investigated. App. at 1184-86. The Board reviewed witness statements, watched video surveillance and interviewed witnesses, and then voted unanimously that abuse did not occur. *Id.* However, on Monday, February 28, 2022,

OHFLAC's surveyors advised Board members that there was an additional video available and they reopened their investigation. *See id.* at 1180-82. The Board then reconvened, conducted additional interviews, and reviewed additional video surveillance. *Id.* The Board concluded that CEO Travis's conduct demonstrated "a very poor lack of judgment," but was not "abuse." *Id.* at 1181. The Board noted that CEO Travis received the following sanctions: she was off work and out of the facility from February 25 through March 3, 2022; she was written-up; she was on probation for 90 days beginning March 7, 2022; a Board member was to make biweekly visits to the facility; and CEO Travis was instructed to take classes on boundaries, communication and conflict management, and the role of agency leadership. *Id.* at 1182. Thus, the evidence establishes that Serenity Hills did investigate this allegation of abuse. *Id.* at 1654 (OHFLAC acknowledged an investigation was done, but disagreed with the Board's conclusion), 1965-66.

With respect to the incident between Erica Biggers and Consumer #11, when the situation occurred, both individuals were employed by Serenity Hills and were "peers" within the recovery community. Therefore, the situation was treated as an employee misconduct issue and investigated by Human Resources. Ms. Biggers testified that as a result of this investigation, she was written-up, put on probation, and required to take courses in boundaries and professionalism. App. at 2048. The Department did not offer any evidence that contradicted this testimony.

vii. Serenity Hills's policies, which were approved by OHFLAC, do not require a staff member to be removed from work during investigation. Nonetheless, Serenity Hills complied with an Immediate Plan of Correction, approved by OHFLAC on February 24, 2022.

Pursuant to Serenity Hills's Incident Investigation Guidelines, in the event of alleged abuse or neglect, "[s]teps shall be taken to protect the immediate safety of the resident or residents in question by removing the alleged offender from contact with residents, removing the alleged offender from contact with the resident in question, increasing immediate supervision *or removing*

the alleged offender from shift altogether. The action taken shall be commensurate with the severity of the allegation." App. at 229 (emphasis added). Here, CEO Travis was not clinical staff and had sparse one-on-one interaction with Consumer #8. Further, a plain reading of the policy demonstrates that an accused staff member is not required to leave the facility during an investigation. Nonetheless, as the Board of Director's first investigative report notes, CEO Travis had "already took her three days off while things were being investigated." *Id.* at 1186.

However, on February 24, 2022, OHFLAC requested an "Immediate Plan of Correction" from Serenity Hills, apparently because CEO Travis had returned to the facility. *See id.* at 694. According to this document, which was submitted without CEO Travis's knowledge or approval, a staff member that is under investigation cannot return to the facility until the investigation is complete. *Id.* The substantial evidence establishes that CEO Travis complied with this Immediate Plan of Correction and did not return to the facility until March 4, 2022, with the Board's approval. The Board then completed its second investigation, acquitting her of the abuse allegation. *Id.* at 2226, 2264, 1546, 1568-69 (Sandra Poling agreed that CEO Travis was out of the facility from February 25 through March 3, 2022), 1651. Importantly, when CEO Travis returned to the facility, Consumer #8 was no longer a resident. *Id.* at 1570.

Additionally, the Department erroneously asserts that CEO Travis should have left the facility on March 11, 2022. *See* Pet. Br. at 10. Indeed, at that point, there was no reason for CEO Travis to leave the facility, as she had already been cleared by the Board of Directors. Moreover, the environment at Serenity Hills on March 11 was actually fueled by OHFLAC's comments to staff that Serenity Hills was "not licensable." App. at 1833. Further, Petitioner fails to mention that there was an investigation by APS on March 11, 2022, and the APS worker found CEO Travis to be "calm and cooperative," and noted that Consumer #8 was no longer in the facility. App. at 405.

The APS worker also noted "no concerns for anyone's immediate safety." *Id.* Similarly, the Ohio County Sheriff's Office responded to the facility and the responding officer noted that he had received a "false report" and the allegations were unfounded. *Id.* at 413-14.

viii. An isolated, medication storage issue did not jeopardize Serenity Hills's residents' safety.

On February 4, 2022, a snowstorm caused a power outage at Serenity Hills. App. at 1664, 1866-67, 2198-99. During the outage, a nurse (Lisa) placed two refrigerated medications, Vivitrol and Victoza, outside to keep the medications cold. *Id.* at 1868-69 (Cristyn Davis, RN, Medical Director, noted that she has no reason to believe the medications froze while outside). The medications were then brought inside and administered to the appropriate resident. The evidence demonstrates that no residents were harmed by the storage of these medications outside for a limited period of time. *Id.* at 1664, 2214. Furthermore, CEO Travis and Ms. Davis did not even know about this incident until OHFLAC's survey; therefore, Serenity Hills's administration had no ability to report the incident to OHFLAC. *Id.* at 1868-69, 2198. Nonetheless, there is no evidence to suggest that medication storage issues were a systematic problem at Serenity Hills. Rather, the substantial evidence demonstrates this was an isolated incident and although a nurse may have made a poor judgment call, no residents were harmed.

ix. No requested information or interviews were withheld from OHFLAC.

During OHFLAC's investigation of Serenity Hills, its surveyors met with multiple residents and employees. App. at 1662. There is no evidence that any individual requested to be interviewed by OHFLAC refused. *Id.* at 1662. Nor is there any evidence that any employees were terminated for cooperating with OHFLAC. *Id.* Further, the surveyors' files together contain over 500 pages, including copious documents from Serenity Hills. *Id.* at 764-1280.

Notwithstanding this evidence, the Department claims that OHFLAC's investigation was

somehow impeded because during a confrontational exchange with staff, CEO Travis stated that staff was being insubordinate by speaking with the State. *Id.* at 1284. Notably, this conversation occurred on March 9, 2022—after OHFLAC's investigation had already been ongoing for weeks—and was secretly recorded by Ms. Davis. *Id.* at 1281-93, 1858. When the context of this conversation is taken as a whole, it is clear that it was a heated discussion and CEO Travis was baited into making this comment. *See generally, id.* at 1281-93. Nonetheless, no employee was actually disciplined or fired for cooperating with OHFLAC.

With all that being said, regardless of the statement by CEO Travis, which was taken completely out of context, the Department presented no evidence to establish that Serenity Hills did not cooperate with OHFLAC's investigation. Rather, the evidence shows that although Serenity Hills cooperated, OHFLAC acted egregiously and disregarded its own procedures.

x. The Department/OHFLAC failed to provide Serenity Hills with an opportunity to submit a Plan of Correction for alleged violations that did not jeopardize resident safety.

The Department failed to prove that the following deficiencies caused harm to any residents: 1) The development of policies and procedures for managing finances that follow generally accepted accounting principles (GAAP) (App. at 2205,[13] 415-16); 2) the timely completion of job performance evaluations (*id.* at 2209); 3) the timely training of staff members in CPR and first aid (*id.* at 2209-10, 452-55[14]); 4) obtaining written informed consent for medication administration (*id.* at 2210, 1542-43); and 5) the retraining of Approved Medication Administrative Personnel (AMAP) (*id.* at 2211-12, 1543-45). Before deciding to not renew Serenity Hills's license, OHFLAC failed to provide Serenity Hills with the opportunity to submit

[13] CEO Travis testified that Serenity Hills had an accountant and an Independent Accountant's Report was completed in January 2021. App. at 415-16.

[14] Evidence shows that Serenity Hills had previously reported to OHFLAC that it was having issues locating CPR instructors for its employees. App. at 452-55.

a Plan of Correction, which could have addressed these relatively minor alleged deficiencies.[15]

xi. OHFLAC did not follow its Survey Protocol.

OHFLAC surveys are to be completed pursuant to the *Survey Protocol for Licensure of Behavioral Health Centers* (the "Survey Protocol"). App. at 400-404. On March 14, 2022, OHFLAC concluded its survey and conducted an exit conference. Pursuant to the Survey Protocol, the facility administrator is to decide who attends the exit conference. *Id.* at 403. CEO Travis, the facility administrator, was not notified of the exit conference or given an opportunity to decide who attended. *Id.* at 1924. Instead, an exit conference call was held between James Patterson, OHFLAC Program Manager, and Ms. Davis. *Id.* at 1922-24. No one else was on the call. *Id.*

The Survey Protocol also states that "the surveyor(s) should always provide the center with the opportunity to provide additional information after the findings/concerns are presented and prior to leaving the center." *Id.* at 403. It further states: "All citable issues must be presented at the exit so that the center may comment, question, and/or provide additional information." *Id.* at 403. CEO Travis was not made aware of the survey findings, or provided an opportunity to comment, question, or present additional information prior to OHFLAC exiting the facility. *Id.* at 2239-40.

2. Board of Review's Final Administrative Decision

Following the hearing, on November 4, 2022, Judge Bishop entered the final administrative decision, reversing OHFLAC's prior actions. App. at 1440-73. In pertinent part, the Board of Review found the allegation that Serenity Hills did not cooperate with OHFLAC's investigation to be erroneous and not supported by the evidence: "There is **no persuasive evidence** presented

[15] OHFLAC's Statement of Deficiencies also raised issue with CEO Travis, an individual in recovery, for facilitating two classes at Serenity Hills, which were akin to an Alcoholics Anonymous or Narcotics Anonymous meeting, and were non-billable. Petitioner's Brief does not mention this allegation, so Serenity Hills presumes that the Department defers to Judge Bishop's findings that CEO Travis was permitted to facilitate these peer groups. App. at 1452, 1467.

by the Respondent which indicates that Serenity Hills failed to provide any documents, records, or record access requested by OHFLAC surveyors." App. at 1461 (emphasis added). The Board of Review further found that

> [t]he [Department/OHFLAC] did not prove by a preponderance of evidence that [Serenity Hills] jeopardized the health, safety, welfare, or clinical treatment of their consumers, and therefore renewal licensure denial is not supported under W. Va. C.S.R. § 64-11-13.1.4.
>
> **A majority of the OHFLAC findings in the statement of deficiencies, including the most significant violations of consumer jeopardy and violations of consumer rights, were not supported by the reliable evidence presented.** Findings of a locked facility, inhumane treatment, a biased advocate, discrimination, abuse, violations of communication rights, failure to investigate, impeding regulatory compliance, uncertified staff, and a violation of the immediate plan of correction **were not accurately determined.**
>
> The [Department/OHFLAC] did not prove by a preponderance of evidence that [Serenity Hills] jeopardized the health, safety, welfare, or clinical treatment of their consumers clearly giving rise to imminent danger of serious harm or the immediate risk of imminent danger of serious harm, and therefore the civil money penalty is not supported under W. Va. C.S.R. § 64-11-13.3.3.

Id. at 1471-72 (emphasis added).

C. Department Action Following the Administrative Hearing

On November 21, 2022, the Department/OHFLAC renewed Serenity Hills's license for a two-year period from November 4, 2022, through October 31, 2024. Then, on December 1, 2022, Petitioner submitted its Notice of Appeal and Petition for Appeal, requesting this Court to reverse the decision of the Board of Review, the Department's own administrative tribunal, which was properly entered by Judge Bishop, the Department's designated hearing officer.[16]

[16] Petitioner's Brief seems to suggest that Serenity Hills should reapply for a new behavioral health license. *See* Pet. Br. at 14. However, Serenity Hills should not be required to take this action, considering the Board of Review already directed OHFLAC to renew the licensure and OHFLAC has in fact renewed the license. Furthermore, if Serenity Hills reapplies and that application is denied, Serenity Hills would have to once again invoke its due process rights and proceed with a costly and time-consuming administrative process. Obviously, this would result in substantial prejudice to Serenity Hills.

III. SUMMARY OF ARGUMENT

The Department's Board of Review is the administrative, quasi-judicial tribunal within the Department that is authorized to provide fair and impartial hearings to providers who have been aggrieved by the Department's actions. Based upon the evidence presented during the four-day administrative hearing, Judge Bishop, a member of the Board of Review, properly concluded that the Department failed to prove that Serenity Hills's practices jeopardize the health, safety, welfare, and clinical treatment of consumers, and failed to prove that Serenity Hills failed or refused to make requested records available to OHFLAC during its survey and investigation. Therefore, Judge Bishop appropriately reversed the Department's decision to not renew Serenity Hills's behavioral health license and its issuance of a civil money penalty against Serenity Hills.

The legislative rules providing an aggrieved behavioral health center with due process to contest Department action are found within the West Virginia Code of State Rules at Section 64, Article 11. In the event the Board of Review upholds the Department's action, the owner of a behavioral health center has the right to seek judicial review from this Court. *See* W. Va. Code R. § 64-11-13.8.1 (2021). Conversely, the Department has no authority to appeal a final administrative decision of the Board of Review. Simply put, the Board of Review is the Department's quasi-judicial tribunal with authority, as delegated by the Department's Secretary, to apply the Department's policies in contested cases and ensure the integrity of the Department's programs. Thus, the Board of Review's Decision cannot be contested by the Department. As such, the Petitioner lacks standing and its administrative appeal should be dismissed.

Moreover, even if the Department has standing, the Board of Review's Decision should be affirmed because it is not clearly wrong in view of the reliable, probative, and substantial evidence in the record and it is not arbitrary, capricious, or characterized by an abuse of discretion. More

specifically, during the administrative process, Petitioner failed to prove that Serenity Hills engaged in conduct that jeopardized the health, safety, welfare, and clinical treatment of consumers, and failed to prove that Serenity Hills did not make requested records available to OHFLAC. Therefore, by reversing the non-renewal of Serenity Hills's behavioral health license and the imposition of the civil money penalty, the Board of Review reached the correct conclusion and its Decision should be affirmed.

IV. STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Oral argument is unnecessary because the facts and legal arguments are adequately presented in the briefs and record on appeal, and the Court's decision process would not be significantly aided by oral argument. *See* W. Va. R. App. P. 18(a)(4). If the Court determines that this matter is appropriate for oral argument, then Rule 19 of the *West Virginia Rules of Appellate Procedure* should apply because this case involves assignments of error in the application of settled law (i.e., the standing of an agency to appeal the decision of its internal tribunal, and the application of behavioral health regulations). *See* W. Va. R. App. P. 19(a)(1).

V. STANDARD OF REVIEW

The Supreme Court of Appeals of West Virginia (the "Supreme Court") has held that "[t]he question of standing is a legal issue which this Court reviews *de novo.*" *Tabata v. Charleston Area Med. Ctr., Inc.*, 233 W. Va. 512, 516, 759 S.E.2d 459, 463 (2014) (citing *Zikos v. Clark*, 214 W.Va. 235, 237, 588 S.E.2d 400, 402 (2003)). Should this Court determine that Petitioner has standing in this administrative appeal, the Court may only reverse, vacate, or modify the Board of Review's final administrative decision if it finds that it is

(1) In violation of constitutional or statutory provisions;
(2) In excess of the statutory authority or jurisdiction of the agency;
(3) Made upon unlawful procedures;
(4) Affected by other error of law;

(5) <u>Clearly wrong</u> 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.

W. Va. Code § 29A-5-4(g) (2021) (emphasis added).[17]

VI. ARGUMENT

The Supreme Court has recognized that "[g]enerally speaking, '[s]tanding is an element of jurisdiction over the subject matter.'" *State ex rel. Paul B. v. Hill*, 201 W.Va. 248, 256, 496 S.E.2d 198, 206 (1997) (citation omitted)); *see State ex rel. Healthport Techs., LLC v. Stucky*, 239 W. Va. 239, 242-43, 800 S.E.2d 506, 509-10 (2017). Here, Petitioner lacks standing; accordingly, this administrative appeal should be dismissed. In the alternative, if this Court finds that Petitioner does have standing, the Board of Review's Decision should be affirmed because it is not clearly wrong, arbitrary, capricious, or characterized by an abuse of discretion.

A. <u>The Department does not have Standing to Appeal a Final Administrative Decision Entered by the Board of Review.</u>

Pursuant to West Virginia Code § 9-2-6(a)(7), the Secretary "is vested with the power to create the Office of the 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**." W. Va. Code § 9-2-6(a)(7) (2022) (emphasis added). Furthermore, the OIG "shall be headed by the Inspector General who shall report directly to the

[17] *See* W. Va. Code § 9-2-13(j) (2018), *repealed by* H.B. 2006, effective May 23, 2023; *see also* Syl. Pt. 2, *W. Va. Dep't of Health & Human Resources v. C.P.*, 245 W. Va. 130, 857 S.E.2d 622 (2021) (citation omitted) ("On appeal of an administrative order from a circuit court, this Court is bound by the statutory standards contained in W. Va. Code § 29A-5-4(a) and reviews questions of law presented *de novo*; findings of fact by the administrative officer are accorded deference unless the reviewing court believes the findings to be clearly wrong."); Syl. Pt. 3, *In re Queen*, 196 W. Va. 442, 473 S.E.2d 483 (1996) ("The 'clearly wrong' and the 'arbitrary and capricious' standards of review are deferential ones which presume an agency's actions are valid as long as the decision is supported by substantial evidence or by a rational basis.").

secretary." *Id.* The Board of Review is a statutorily created tribunal, operating under the authority of the Department and within the OIG.[18] *Id.* § 9-2-6(a)(13)[19]; *see W. Va. Dep't Health & Human Resources v. C.P.*, 245 W. Va. 130, 136, 857 S.E.2d 622, 628 (2021). Accordingly, the Board of Review is a division of the OIG, which in turn, is an office that directly reports to the Secretary.

Board of Review proceedings are governed by the Department's regulations, along with the contested case provisions of the State Administrative Procedures Act. W. Va. Code § 29A-5-1 (1964), *et seq* [hereinafter "APA"]; W. Va. Code R. § 69-1-3.1 (2015) (the general procedural rules for administrative hearings conducted by the Department)[20]; W. Va. Code R. § 64-11-13 (2021) (providing the specific due process afforded to behavioral health providers).[21] Following the proceeding, a decision is issued by the hearing officer on behalf of the Board of Review. W. Va. Code R. § 69-1-9 (2015). More specifically, if "the secretary or member of the Board of Review served as the hearing officer, the secretary or member of the Board of Review shall issue a decision following his or her review of the proposed find[ings] of fact, conclusions of law, and legal briefs or memoranda." *Id.* § 69-1-9.2. In other words, if the Secretary or a member of the Board of Review (e.g., Judge Bishop) serves as the hearing officer, then he/she has authority to

[18] *See* W. Va. Dep't of Health & Human Resources (DHHR) Organization Assessment & Strategic Plan (June-Oct. 2022) at 7, figure 4, *available at* https://governor.wv.gov/Documents/DHHR%20REport.pdf (providing the Department's current organizational chart).

[19] Specifically, the Secretary may "[o]rganize within the department a board of review, consisting of a chairman appointed by the secretary and as many assistants or employees of the department as may be determined by the secretary and as may be required by federal laws and rules respecting state assistance, federal-state assistance, and federal assistance, **the board of review to have such powers of a review nature and such additional powers as may be granted to it by the secretary** and as may be required by federal laws and rules respecting federal-state assistance and federal assistance." W. Va. Code § 9-2-6(a)(13) (emphasis added).

[20] The regulations promulgated by West Virginia Code of State Rules § 69-1-1, *et seq.* set forth the general rules governing Board of Review hearings, including that parties may present evidence and argument, cross examine witnesses, and submit rebuttal evidence. *Id.* §§ 69-1-4.1,4.7.

[21] *W. Va. Dep't Health & Human Resources v. C.P.*, 245 W. Va. 130, 137, 857 S.E.2d 622, 629 (2021) (citation omitted) ("Proceedings before DHHR's Board of Review are governed by both the Administrative Procedures Act, West Virginia Code §§ 29A-5-1 to -5, and regulations promulgated by DHHR.").

enter the final administrative decision. Notably, this is contrary to the situation where the secretary or a member of the Board of Review does not serve as the hearing officer. In that circumstance, the hearing officer's proposed decision is submitted to the Secretary, who may accept, reject, or modify the recommended decision. *Id.* § 69-1-9.2.[22]

1. There is no express or implied authority that permits the Department to appeal a Final Administrative Decision entered by the Board of Review.

Here, this matter arose from the Department/OHFLAC's refusal to renew Serenity Hills's behavioral health license. The Department's authority to issue such a license is codified at W. Va. Code § 27-9-1 (2020), which provides that "[n]o behavioral health center shall provide behavioral health services unless a license is first obtained from the Secretary." This code section further permits the Secretary to implement rules in regard to the operation of behavioral health centers. *Id.* Moreover, the Secretary is authorized to "impose a civil money penalty, suspend, or revoke the license of any center for good cause after reasonable notice," **including due process rights as provided in legislative rules**." *Id.* (emphasis added).

The corresponding legislative rules are found at W. Va. Code R. § 64-11-1, *et seq.* (2021).[23] Importantly, these rules provide behavioral health centers with due process in the event a license is limited, denied, suspended, or revoked, or a civil money penalty is assessed. W. Va. Code R. § 64-11-13.6. More specifically, the behavioral health center is provided with notice of adverse action, given an opportunity to request an administrative hearing and/or an informal meeting, and if requested, provided with an administrative hearing before the Board of Review. *See generally, id.* In the event the behavioral health center receives an adverse ruling from the Board of Review,

[22] The regulations further provide that "[a]ll appeals from the final order or decision of the secretary shall be taken pursuant to West Virginia Code § 29A-5-4." W. Va. Code R. § 69-1-9.4.

[23] *See* W. Va. Code R. § 64-11-1.1, 1.6 ("This rule establishes general standards and procedures for the licensure of behavioral health services. . . . These standards are the basis for the licensing and approval of behavioral health centers providing services and supports [sic] in the state of West Virginia.").

it may file an administrative appeal: "Any owner of a behavioral health center who disagrees with the final administrative decision as a result of the hearing may, within 30 days after receiving notice of the decision, appeal the decision . . . ." *Id.* § 64-11-13.8.1.

In the context of contested behavioral health licensure matters, the APA applies by virtue of the rules and because those rules specifically provide an aggrieved behavioral health center with due process rights. *Id.* § 13.6.4 (noting that W. Va. Code § 29-4-1, et seq. [sic] and W. Va. Code R. § 69-1-1, et seq. apply). In other words, the APA only applies because a contested case process is outlined in the rules. Certainly, no provision of the behavioral health licensure rules provides the Department with the right to appeal a final administrative decision of the Board of Review, the Department's internal, administrative tribunal. Indeed, these rules only provide an aggrieved "**owner of a behavioral health center**" with the right to appeal following entry of the final administrative decision. *See* W. Va. Code R. § 64-11-13.8.1 (emphasis added).[24] Clearly, this procedure was established so that providers who are aggrieved by the Department's action, and have the action upheld by the Board of Review, have due process to seek judicial review. And clearly, this procedure was not established for the purpose of allowing the Department to appeal its own final administrative decision.

Additionally, while the APA provides that "[a]ny party adversely affected by a final order or decision in a contested case is entitled to judicial review," the Department is not an adversely affected party with a right to appeal a Board of Review decision. *See* W. Va. Code § 29A-5-4(a)

[24] West Virginia Code § 9-2-13(c) (2015) also provides that "[a]ny party adversely affected or aggrieved by a final decision or order of the agency [i.e., the Board of Review] may seek judicial review of that decision." Nothing in this statutory section contemplates the Department appealing a decision of the Board of Review. Indeed, when taking Section 9-2-13 as a whole, it is clear that its references to the "appellant" in an administrative appeal, refer to an individual or provider who received an adverse ruling from the Board of Review—not the Department itself.

(2021). For example, in a recent Memorandum Decision, the Supreme Court found that patients who submit complaints to the West Virginia Board of Medicine ("WVBOM") do not have the right to file an administrative appeal following dismissal of the complaint by the WVBOM because the authorizing statute only provides the right to judicial review to medical professionals 'against whom disciplinary action is taken.'" *J.H. v. W. Va. Bd. of Med.*, 2022 WL 10076874, at *2 (W. Va. Oct. 17, 2022). Notably, the Supreme Court reached this conclusion even though the APA applies to contested cases before the WVBOM. *See id.* at *2 n. 4. The Supreme Court also emphasized that "'[w]here the language of a statute is free from ambiguity, its plain meaning is to be accepted and applied without resort to interpretation.'" *Id.* (citation omitted). As such, the Supreme Court found that because the controlling statute did not provide a complainant with the right to judicial review, the patient lacked standing to appeal. *Id.*

Here, this Court should apply the same rationale. More specifically, the behavioral health licensure rules are unambiguous and only provide an aggrieved behavioral health center owner with the right to judicial review of a final administrative decision. In this context, the behavioral health center owner is the "affected party" under the APA. Accordingly, here, the Department lacks standing to appeal the Board of Review's Decision.

Furthermore, the Department seems to argue that it has implied authority to seek judicial review based upon the final page of Judge Bishop's Decision. However, the Department has mischaracterized Judge Bishop's guidance. The final page of the Decision is titled "Appellant's Recourse to Administrative Hearing Decision" and is a standard notification provided by the Board of Review. *See* App. 1474. In fact, throughout the course of the contested case process, Serenity Hills was referred to as the "Appellant." *See id.* 1440, 1475. As such, Judge Bishop's guidance was a standard notification to Serenity Hills <u>not</u> the Department that it has certain appeal rights,

should it choose to invoke them. This is further clarified in Judge Bishop's letter to Serenity Hills's counsel, enclosing the Decision, stating: "You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter." *Id.* 1439 (this letter is not directed to the Department's counsel, who is copied on the letter). For these reasons, the Department does not have the right to appeal the Board of Review Decision and, therefore, lacks standing in the present appeal.

2. The Department does not have the right to appeal the Board of Review's Decision, pursuant to long-standing administrative law principles.

It is well-established that a state agency does not have the right to appeal a final decision entered by that agency's own administrative tribunal, particularly when there is no specific statutory authority to permit the agency to appeal. *See Mason Cnty. Bd. of Educ. v. State Superintendent of Schs.*, 160 W. Va. 348, 349 234 S.E.2d 321, 322 (1977) [hereinafter "Mason"] (citations omitted).[25] In *Mason*, the Supreme Court examined whether a county board of education had standing to seek judicial review of an adverse decision of the State Superintendent of Schools. *Id.* The court also specifically discussed whether an agency is entitled to judicial review of an adverse decision made within the quasi-judicial process of that agency. *Id.* As the Department's Petition notes, the APA did not apply in *Mason*, as the State Board of Education is specifically exempt from the statute, and county boards of education are not state agencies. *Id.* at 349, 322.

[25] *See also Hadley v. Bd. of Trs. of the Firemen's Pension Fund of the City of Batavia*, 447 N.E.2d 958, 962 (Ill. App. Ct. 1983) ("The prevailing view under state administrative procedure acts is that dissenting members of an agency which is quasi-judicial in nature have no standing to challenge in court the final decisions of the agency."); *State ex rel. Broadway Petroleum Corp. v. City of Elyria*, 247 N.E.2d 471, 475 (Ohio 1969) (citations omitted) ("The weight of authority negatives [sic] the right of an administrative officer of a governmental entity, or even the governmental entity or any representative thereof, to attack or avoid the decision of an agency of such governmental entity, which is authorized to review and reverse the determination of such administrative officer and does review and reverse that determination, except to the extent that legislation gives such administrative officer, the governmental entity or its representative the right to do so.").

Nonetheless, *Mason* provides the following, on-point guidance regarding an agency's standing to appeal its own quasi-judicial tribunal's decision: "[T]he general rule that in the absence of statutory authority, an administrative officer or agency is not entitled to judicial review of an adverse ruling made within the administrative appellate process of the agency." *Id.* (citations omitted). The Supreme Court went on to find that

> There is a quality of reasonableness in this general rule, since we can assume that **the final decision of an administrative tribunal reflects that particular agency's policy**. To permit it to be attacked in the courts by its own personnel, in the absence of an express legislative authorization, would open the door to competing and antagonistic policies.

Id. at 322, 350 (emphasis added).

Unlike in this matter, upon reviewing the specific issue before it, the Supreme Court found that a county school board may appeal the decision of the State Superintendent of Schools because the two entities were not within the same agency such that there was "administrative autonomy." *Id.* at 323, 352. Indeed, county school boards operated "virtually independent" of the State Superintendent. *Id.* Notably, in reaching this decision, the Supreme Court recognized that school boards do not act as normal state agencies:

> The procedural matters involving suspension or dismissal of a teacher **are not analogous to the normal administrative proceeding, <u>where there is a gradatory procedure within an autonomous and integrated agency</u>**. In the normal administrative procedure, the process moves vertically within the agency and decisions are made by persons employed by such agency. In this context, one may presume a fair measure of control over the decision-making process by the agency itself, **and it should not be expected that the agency or its employees involved in the decision-making process would have a right to appeal an adverse ruling made by its higher level administrators.**

Id. (emphasis added). In other words, pursuant to the court's findings, in the ordinary administrative situation, an agency may <u>not</u> appeal a decision made internally within that agency's

gradatory process, without express legislative authorization. *Id.*

Here, the Department/OHFLAC's relationship with the Board of Review is distinguishable from the relationship between a county school board and the State Superintendent. More specifically, there is a gradatory procedure within the Department for contested cases to be heard by the Board of Review and a defined, intra-agency appeals process. Clearly, the Board of Review has the authority to review action taken by the Department's various offices, such as OHFLAC, and if appropriate, reverse such action.[26] As such, the Department's various offices, along with the Board of Review, operate within one, autonomous and integrated agency (i.e., the Department).

Moreover, contrary to Petitioner's Brief, the Board of Review is not a "quasi-independent agency." Rather, it is organized within the Department and the Secretary maintains a level of control over its operations. In point of fact, the Board of Review is organized within the OIG, which is an office that reports directly to the Secretary. W. Va. Code § 9-2-6(a)(7) (2022). Additionally, the Chairman of the Board of Review is appointed by the Secretary, and the Secretary is charged with determining any other assistants or employees necessary to staff the Board of Review. *See id.* § 9-2-6(a)(13). Although the corresponding legislative rules are somewhat vague regarding the selection of hearing officers, it appears that the Secretary also appoints the hearing officers or administrative law judges who preside over the Board of Review proceedings. *See* W. Va. Code R. § 69-1-8.1 ("Every hearing officer appointed by the secretary to conduct a hearing under this rule . . . ."). Further, the only express statutory authority the Board of Review has is "such powers of a review nature." W. Va. Code § 9-2-6(a)(7). All other authority is "granted to it

[26] Indeed, the Board of Review's Common Chapters Manual even gives the Board of Review authority to reverse and remand, or simply remand, a case to the Department for further action if the "Hearing Officer determines at the hearing that the Department failed to adequately evaluate the matter at hand." *See* Bd. of Review Common Chapters Manual at ¶ 710.21 (2015), *available at* https://www.wvdhhr.org/oig/pdf/BOR/BORCommonChapters.pdf.

by the secretary." *Id.* In turn, the Secretary has delegated to members of the Board of Review, including Judge Bishop, the authority to enter final administrative decisions.[27] Therefore, it cannot be said that the Board of Review operates "virtually independent" of the Department. This is simply not the reality of the Board of Review's operations.[28]

Under these circumstances, it can be presumed that the Department itself exercises a fair measure of control over the decision-making process utilized by its own administrative tribunal. It can likewise be presumed that the Department has a fair measure of control over the decision-making process utilized by Judge Bishop, a designated member of the Board of Review, who is authorized to enter final administrative decisions on behalf of the Secretary. It is therefore reasonable to conclude that Judge Bishop's Decision properly reflects the Department/OHFLAC's policies. Accordingly, Petitioner does not have standing in this administrative appeal, as the Decision was entered by the Department's own quasi-judicial officer, following a quasi-judicial proceeding, in which the Board of Review considered and applied Petitioner's own policies.

3. ***Public policy disfavors allowing the Department's appeal to proceed.***

The Department's attempt to appeal the final administrative decision by the Board of Review is in contravention of public policy and thwarts the mission of the Board of Review "**to preserve the integrity of Department programs** by providing due process to appellants through

[27] *See* W. Va. Code R. § 69-1-8.2 ("All final rulings on substantive matters shall be made by the secretary or as designated by the secretary to the Board of Review.").

[28] Notably, while the Board of Review hears some 2,000 contested cases per year, the Petitioner's Brief failed to reference a single situation where the Department appealed an adverse ruling entered by the Board of Review. For example, in 2018, the Board of Review adjudicated 1,985 cases and reversed the Department's prior action in 118 cases. *See* DHHR/Inspector Board of Review Report by Category and Decision FY 2018, *available at* https://www.wvdhhr.org/oig/pdf/bor/FY%202018%20%20Report%20by%20Category%20and%20Decision.pdf. In 2017, the Board of Review adjudicated 2,168 cases and reversed the Department's prior action in 116 cases. *See* DHHR/Inspector General Board of Review Report by Category and Decision FY 2017, *available at* https://www.wvdhhr.org/oig/pdf/bor/FY%202017%20Report%20by%20Category%20and%20Decision.pdf. Notwithstanding this volume of cases, Petitioner cites no administrative appeal decisions wherein the court found that the Department has standing to appeal a final administrative decision of the Board of Review.

impartial hearings and timely decisions." *See* Office of the Inspector General, Board of Review (BOR) (last visited 4/15/2023), *available at* https://www.wvdhhr.org/oig/bor.html (emphasis added). Indeed, allowing the Department to appeal adverse decisions of the Board of Review would essentially give the Department a "second bite at the apple," undermining the finality of the Board of Review's decisions. Furthermore, allowing the Department to appeal every adverse administrative decision would lead to inefficiencies in the administrative process, leading to significant costs and delays for both the Department and the public. Lastly, and more concerningly, allowing the Department to appeal Board of Review decisions would likely create a chilling effect on the Board of Review's decision-making process. Simply put, by knowing that its decisions can be challenged on appeal by the Department—the very governmental agency it operates under—the Board of Review will likely be hesitant to make adverse rulings against the Department or to exercise its discretion in order to maintain the integrity of the Department's programs (e.g., OHFLAC's licensure of behavioral health centers). Overall, the public policy interest in preserving the certainty of final administrative decisions, coupled with the interest in protecting the impartiality of the Board of Review, favors a ruling from this Court that the Department may not seek judicial relief of a Board of Review decision.

B. <u>The Board of Review's Decision was Not Clearly Wrong in Light of the Reliable Evidence.</u>

The Supreme Court has found that significant deference must be afforded to the findings of administrative law judges: "As a general rule, we uphold the factual findings of an ALJ if they are supported by substantial evidence. . . . We cannot overlook the role that credibility places in factual determinations, a matter reserved exclusively for the trier of fact." *Martin v. Randolph Cty.*

Bd. of Educ., 195 W. Va. 297, 306, 465 S.E.2d 399, 408 (1995).[29] Here, Judge Bishop appropriately considered the evidence in the record and the credibility of witnesses, and reversed the denial of Serenity Hills's renewal license and the Department's assessment of a civil money penalty.

1. The Board of Review correctly found that the Department/OHFLAC was required to renew Serenity Hills's behavioral health license.

OHFLAC justified its refusal to renew Serenity Hills's license by claiming that it conducted practices which jeopardize the health, safety, welfare and/or clinical treatment of consumers; and that it failed or refused to make records available to OHFLAC. *See* W. Va. Code R. § 64-11-13. However, after considering the evidence, Judge Bishop correctly found that Petitioner failed to prove Serenity Hills jeopardized the safety of its residents and failed to prove that Serenity Hills refused to make requested records available. *See* App. at 1461-62.

In point of fact, the reliable, probative, and substantial evidence demonstrates that Serenity Hills's residents had the right to treatment in "the least restrictive" setting. *See* App. at 1446-57, 1462. Indeed, various witnesses testified that a green exit button could be used to leave the facility and while a localized alarm sounded, it did not stop residents from using the button.

Notably, Daphne Chapman, a former resident, testified that if a resident decided she wanted to leave the facility, she would simply "[h]it the green button and walk on out. The door opened." *Id.* at 1993. She further testified that this process was common knowledge among the residents. *Id.* Similarly, Erica Biggers testified that as a resident, she knew that she could hit the green exit button and leave, and this was common knowledge among the residents. *Id.* at 2035-36. She testified that there were occasions when residents used this button to leave the facility, sometimes against

See also Bd. of Educ. of the Cnty. of Mercer v. Wirt, 192 W.Va. 568, 579, 453 S.E.2d 402, 413 (1994) ("Indeed, if the lower tribunal's conclusion is plausible when reviewing the evidence in its entirety, the appellate court may not reverse even if it would have weighed the evidence differently if it had been the trier of fact").

medical advice. *Id.* at 2036. Former resident, Jocelyn Jones, also testified that she knew about the green exit buttons and did not feel that she was locked in the facility with no way to leave. *Id.* at 2064-65. Lastly, Brittany Corkran testified that if she wanted to leave the facility before her treatment was complete, she had options:

> Q. [W]hen you were admitted to Serenity Hills, if you wanted to leave-- say you woke up in the middle of the night and just said I don't want to be here anymore-- how would you go about leaving the facility? Do you understand my question?
> A. [W]ell, you have a couple of choices. You could either just get your things, walk to the front door, press the green button, and leave, or you could go to the MHT [mental health tech] desk, ask them to call a ride for you, and they would then call your family or someone and help you pack your things and take you outside to wait for them.

Id. at 2102.

Additionally, the evidence established that Serenity Hills's residents were treated humanely and were not denied civil rights. With respect to resident rules, while Serenity Hills provided a highly structured setting, this environment was necessary in order for its residents to recover from substance abuse. *Id.* at 1447, 1462-63. In point of fact, former residents testified that these rules and the skills they learned at Serenity Hills helped them to achieve and maintain their sobriety. For instance, Daphne Chapman testified that

> Serenity Hills was a very structured program. It was a very strict program, but . . . us girls are coming from a place from prison, jail, the streets, all kinds of different spots in our life, and, you know, we need structure, and it has to be strict. . . . It was a very hard program, but I have learned more in this past year, I'm 45 years old, than I have in my whole entire life. . . . Serenity Hills was amazing.

App. at 1992-93.

Similarly, Chelsea Glennon testified that Serenity Hills was very structured, but the structure helped residents recover from the "chaos of addiction."[30] Moreover, Jocelyn Jones

[30] Unfortunately, the testimony of Chelsea Glennon and Jenna Wilson, was inadvertently not recorded by Judge Bishop during the hearing; however, this testimony is referenced in the Decision.

testified as follows:

> Q. There was a certain level of structure at Serenity Hills. Do you agree with that?
> A. Yes, I would.
> Q. From your perspective as a resident, why was there this level of structure in place?
> A. I believe that the level of structure there was for safety first and foremost. There was a lot of people that were recovering. People were on different levels of the recovery because recovery is individually-based and so some person may have came in there court-ordered that maybe they weren't all the way ready to recover, but their process, you know, they had the ability to take that process and there was some other people that maybe they had hit their rock bottom like I, myself, personally and knew that there was no other way other than to figure it out. . . .
> Q. Without the tools that you learned at Serenity Hills, do you believe that you would have been able to achieve and maintain your sobriety?
> A. No, I do not.

Id. at 2067-68.

Notwithstanding Serenity Hills's structured environment, former residents shared stories of activities and events in which they participated. *See* App. 2011-12 (Melissa Meinweiser testified that she learned how "to have sober fun and stay clean"), App. at 2065-66 (Jocelyn Jones testified they would take walks, go to the gym, watch television together, and play games). CEO Travis discussed various opportunities for socialization, including jewelry making, painting, game night, and even a baby shower for a pregnant resident. *See* App. at 2160-63.

Although Serenity Hills, like many treatment facilities, had necessary restrictions on telephone and mail communications, substantial evidence was presented that residents did have access to telephone and mail communications, and that the restrictions imposed were necessary for resident safety. *Id.* at 1449-50, 1465. Indeed, Stacy Boston testified that telephone calls were monitored because "these women don't always deal with . . . people who are healthy" (e.g., drug dealers, abusers, human traffickers). *Id.* at 1766-67. Similarly, mail is monitored to prevent contraband from coming into the facility. Fortunately, these measures worked and Serenity Hills

never had any overdoses within its facility. Clearly, Serenity Hills had an interest in keeping its residents safe from harmful influences and this interest was served by the implementation of these reasonable rules.

With respect to the allegations regarding Consumer #8, Judge Bishop correctly evaluated the evidence, consisting of video surveillance, exhibits, and sworn testimony, and found that the incident involving CEO Travis and Consumer #8 did not constitute "abuse."[31] *Id.* at 1464-65. In point of fact, while Consumer #8 was not called to testify, Brittany Corkran, a former resident and an eyewitness to the event, testified as follows:

> Q. **Did you witness an incident between Ms. Williams and Ms. Travis?**
> A. **Yeah.** When [Consumer #8] had her mask down, Ms. Sharon reached over and was like, [Consumer #8], put your mask on. I've told you-- I don't know exactly what she said, something to the effect of, you know, I've told you several times today. You have to keep your mask on.
> Q. **When that event-- when that incident occurred, did you find it to be shocking or abnormal or upsetting, anything of that nature?**
> A. **No.** [Consumer #8], like, acted like, when Ms. Sharon touched her arm that it was, like-- I don't know. **She's very, very dramatic.** . . . But I mean, there was music going on, the DJ was there and I mean, it was more-more of a thing where, if you were to be with someone and you're talking to them and something was going on and they can't hear you or they're not paying attention and you would like touch their arm and be like, hey . . . I'm trying to get your attention. It was something like that and I mean, **I feel like [Consumer #8] made it, like, it was like some big thing or something, but it wasn't.** . . .
> Q. **Okay. So, from your perspective as someone that was an eyewitness to this, you felt like [Consumer #8's] physical reaction was sort of dramatic. Is that correct?**
> A. **Yes. [Consumer #8] is very dramatic about everything**.
> Q. Okay. Did it seem to you like Ms. Travis pulled [Consumer #8] very hard?
> A. No.
> Q. **Okay. Do you believe that Ms. Travis hurt [Consumer #8] physically?**
> A. **Absolutely not.**

Id. at 2107-08 (emphasis added).

[31] *See* W. Va. Code R. § 64-11-3.1 (2021) (In pertinent part, abuse is defined as "[t]he willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.").

Moreover, evidence was presented regarding Consumer #8's behavior after the incident, demonstrating that she was not "traumatized" by the situation. In fact, CEO Travis testified that Consumer #8 did not act like she was scared of her at any point on February 11 or February 12, 2022, during a "Pamper Me Day." *Id.* at 2178-90. She also testified that she actually put make-up on Consumer #8 during this event. *Id.* at 2180. Likewise, Ms. Corkran testified that Consumer #8's demeanor was fine after the event, and she did not begin to complain until "a few days later when we were having our staff meetings together and her counselor had felt like she wasn't actually growing there as a resident." *Id.* at 2108-09. Indeed, Ms. Corkran felt that Consumer #8 was using the incident as an excuse to be released from rehabilitation. *Id.* at 2109.

The undisputed evidence also established that Consumer #8 waited seven days after this incident to complete a grievance form, which was ultimately submitted to Serenity Hills ten days after the incident. *See id.* at 1464. During this time, Consumer #8 was written-up (i.e., her third write-up) and placed on probation for actions unrelated to CEO Travis. Nonetheless, once she submitted a grievance, she had access to a resident advocate, who handled the intake of the grievance and started the investigation process. *Id.* at 1737 (Ms. Boston testified "Michelle sat and talked to her for a little bit about what the grievance meant"), 1786 (Consumer #8 turned the form into Ms. Forshey), 1523 (OHFLAC surveyor acknowledged Consumer #8 reported the incident), 2177 (CEO Travis testified that Ms. Forshey "did her job").[32] Therefore, the clear evidence demonstrated that Consumer #8 was provided with a resident advocate. Furthermore, during OHFLAC's survey, it was advised of Consumer #8's grievance, a complaint was submitted to OHFLAC regarding the incident, and OHFLAC had an opportunity to investigate.

[32] Melissa Meinwieser also testified regarding a past situation where she was unhappy with her therapist, leading to her filing a grievance with Ms. Forshey. App. at 2010. She testified that Ms. Forshey explained the grievance process and advocated for her. *Id.* at 2010-11.

Petitioner further incorrectly asserts that Stacey DeGarmo alleged Ms. Travis "intimidated" Consumer #8 on February 11, 2022, following the Valentine's Day party. Pet. Br. at 19. First, this alleged situation occurred on February 22, 2022, ten days after the fact. Further, video surveillance, coupled with witness testimony, clearly proved that CEO Travis did not engage in "intimidation." Rather, CEO Travis merely walked in Ms. DeGarmo's office, realized Consumer #8 was there, and then waited as Consumer #8 got up from her chair and left. No intimidation occurred and this is plainly apparent from video surveillance.

In addition, Serenity Hills's Board of Directors conducted a timely investigation and issued its initial report on February 25, 2022, only four days after submission of the grievance. *See id.* at 1466. Thereafter, OHFLAC instructed the Board to reopen their investigation. The Board complied and on March 6, 2022, issued its Addendum, finding CEO Travis's behavior to be a lapse of judgment, but not abuse. After hearing the evidence in its entirety, Judge Bishop agreed with the Board's prior findings. Moreover, with respect to CEO Travis's administrative leave pending investigation, the undisputed evidence is that Serenity Hills's policies did not require CEO Travis to be placed on administrative leave; however, once the Immediate Plan of Correction was submitted on February 24, 2022, she left the facility. She was not at Serenity Hills beginning on February 25 until she returned on March 4, 2022, with the permission of the Board of Directors. At the time of her return, Consumer #8 had already been discharged. Further, the Department failed to present any convincing evidence that CEO Travis was required to leave the facility on March 11, 2022 *after* she had already been cleared of abuse by the Board of Directors and *after* Consumer #8 was no longer a resident.

With respect to Consumer #11 (i.e., the kitchen incident), Judge Bishop found that although this matter was treated as a staff misconduct issue, and therefore not reported to OHFLAC, it was

thoroughly investigated internally and Ms. Biggers was disciplined. *See id.* at 1466, *see also id.* at 2138-39 (CEO Travis confirmed there was an investigation and Ms. Biggers was disciplined)

Additionally, the medication storage issue regarding the snowstorm did not jeopardize patient safety. *Id.* at 1468. Indeed, this was an isolated incident where a nurse made a poor judgment call in the face of a facility-wide power outage. The nurse was clearly trying to keep these medications from spoiling in the refrigerator, but in hindsight, should have used better decision-making. That said, the undisputed evidence is that this was an isolated occurrence and no residents were harmed. It is also undisputed that Serenity Hills's administration was not advised of this incident until the OHFLAC survey and, thus, had no opportunity to report it to OHFLAC.

Further, while Judge Bishop found that some alleged deficiencies were substantiated, these deficiencies did not cause immediate jeopardy to residents and, accordingly, Serenity Hills should have been given an opportunity to submit a Plan of Correction. *Id.* at 1471. For example, Serenity Hills did not dispute that it was behind on annual staff evaluations and AMAP training. However, these are relatively minor infractions that providers are normally given an opportunity to correct before being shut down. Serenity Hills should have also been afforded an opportunity to implement OHFLAC approved financial policies. With respect to CPR and first aid training for staff, Serenity Hills also recognizes that it was behind. However, it had timely reported this issue to OHFLAC and as Judge Bishop found, OHFLAC waived this requirement. *Id.* at 1467.

Lastly, Judge Bishop correctly concluded that Serenity Hills did not fail or refuse to make requested records available to OHFLAC. *Id.* at 1461. In point of fact, the Serenity Hills's policies initially received by OHFLAC were "unsigned" and not official copies. However, Ms. Pingley acknowledged that she never asked CEO Travis for the signed policies. *See* App. at 1655, *id.* at 104-399 (Serenity Hills's approved policies). Further, OHFLAC claimed that Serenity Hills did

not have a "conflict of interest policy"; however, during the hearing, it was established that such a policy is contained within its Bylaws which were contained in the surveyors' files. *Id.*at 1669-71.

Moreover, the Department failed to prove that Serenity Hills did not cooperate with its investigation, simply because of CEO Travis's statement regarding "insubordination." The fact of the matter is that OHFLAC's investigation had been ongoing for weeks before this comment was made, no employees were fired for communicating with OHFLAC, and Serenity Hills had cooperated fully with OHFLAC's survey. Indeed, CEO Travis testified that when the surveyors were at Serenity Hills, she did not prevent them from meeting with any employees or residents. *Id.* 2202. She denied withholding any documents specifically requested from OHFLAC. *Id.* She also explained that during the March 9, 2022 recorded conversation, she "was totally confused on what was going on." *Id.* at 2203. OHFLAC had essentially cut off all communication with her and instead, was disrupting the facility's operations by continuing to contact staff without the knowledge of the CEO. *Id.* Lastly, she explained that she did not intend to imply that Ms. Davis could not talk to OHFLAC, but simply that she wanted to be informed if additional investigation was ongoing. *Id.* at 2204.

Overall, the Department failed to prove by a preponderance of the evidence that Serenity Hills engaged in continuous, systematic practices that jeopardize the health, safety, welfare and/or clinical treatment of residents. *Id.* at 1462-70. Petitioner also failed to present persuasive evidence "which indicates that Serenity Hills failed to provide any documents, records, or record access requested by OHFLAC surveyors." *Id.* at 1461. Accordingly, the Board of Review's Decision, reversing Serenity Hills's licensure nonrenewal is clearly correct and should be affirmed.[33]

[33] As a final point, Petitioner's Brief asserts that OHFLAC could not renew Serenity Hills's license because by March 11, 2022, the facility was a "chaotic situation." Pet. Br. at 22. However, Petitioner fails to recognize that OHFLAC escalated this situation by refusing to communicate with the facility's administrator, telling lower-level staff members that the facility was "not licensable," and essentially

2. The Board of Review correctly vacated the civil money penalty.

For the reasons set forth above, the Board of Review correctly concluded that Serenity Hills did not engage in conduct that jeopardized the health, safety, welfare and/or clinical treatment of its consumers clearly giving rise to imminent danger of serious harm or the immediate risk of imminent danger of serious harm. Therefore, the Board of Review appropriately overturned the Department's decision to impose a civil money penalty. *See* W. Va. Code R. § 64-11-13.3.3 (2021).

VII. CONCLUSION

The Court should dismiss the Department/OHFLAC's Petition because the Department does not have standing to appeal the final administrative decision of the Board of Review, its own administrative tribunal. Nonetheless, even if Petitioner had standing, the Board of Review's Decision should be affirmed because it is not clearly wrong in view of the reliable, probative, and substantial evidence in the record as a whole and because it is not arbitrary, capricious or characterized by an abuse of discretion. Accordingly, the Board of Review's findings and conclusions should be given deference. Here, the Board of Review, when considering the evidence as a whole, correctly determined that Petitioner failed to prove by a preponderance of the evidence that Serenity Hills jeopardized the health, safety, welfare, or clinical treatment of its residents/consumers; and failed to prove that Serenity Hills refused to make requested records available. These findings are clearly established by the substantial evidence in the record.

For these reasons, this Court should enter a Memorandum Decision, dismissing Petitioner's administrative appeal. In the alternative, this Court should enter a Memorandum Decision, affirming the Board of Review's Decision.

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creating turmoil within the facility. The Department/OHFLAC should be admonished for its handling of this situation and its actions, which caused the displacement of thirty inpatient residents, along with twelve women living at the sober living house on Serenity Hills's campus—which was not even under OHFLAC's jurisdiction.

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

By Counsel.

Robert L. Coffield (WVSB #6297)
Shereen C. McDaniel (WVSB #12282)
L. Elizabeth King (WVSB #14268)
Flaherty Sensabaugh Bonasso PLLC
200 Capitol Street
P. O. Box 3843
Charleston, West Virginia 25338-3843
Telephone: (304) 345-0200
rcoffield@flahertylegal.com
smcdaniel@flahertylegal.com
eking@flahertylegal.com

and

Frank X. Duff (WVSB #6297)
Schrader, Companion, Duff & Law, PLLC
401 Main Street
Wheeling, West Virginia 26003
Telephone: (304) 233-3390
fxd@schraderlaw.com
Counsel for Respondent, Heart 2 Heart Volunteers, Inc. dba Serenity Hills Life Center

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, Shereen Compton McDaniel, counsel for Respondent, Heart 2 Heart Volunteers, Inc. dba Serenity Hills Life Center, do hereby certify that on the 20th day of April 2023, the foregoing "**RESPONDENT'S BRIEF**" was served upon the following counsel of record via the e-filing system maintained by the Intermediate Court of Appeals of West Virginia and the Supreme Court of Appeals of West Virginia, via e-mail, and via United States Mail, postage prepaid, addressed as follows:

James "Jake" Wegman
Assistant Attorney General
Health and Human Resources Division
6th Floor, 812 Quarrier Street
Charleston, West Virginia 25301
Jake.W.Wegman@wvago.gov

Copies of the same were also provided to the Board of Review via e-mail and U.S. Mail, as follows:

David Bishop, Hearing Officer
Board of Review
State Capitol Complex
Building 6, Room 817-B
Charleston, West Virginia 25305
David.a.bishop@wv.gov

Shereen Compton McDaniel (WVSB #12282)