



**STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
OFFICE OF INSPECTOR GENERAL**

**Bill J. Crouch**  
Cabinet Secretary

**Board of Review  
416 Adams Street Suite 307  
Fairmont, WV 26554  
304-368-4420 ext. 79326**

**M. Katherine Lawson**  
Inspector General

August 21, 2018

[REDACTED]

RE: [REDACTED] v. WVDHHR  
ACTION NO.: 18-BOR-1860

Dear Ms. [REDACTED]

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the Board of Review is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

You will find attached an explanation of possible actions that may be taken if you disagree with the decision reached in this matter.

Sincerely,

Tara B. Thompson  
State Hearing Officer  
State Board of Review

Enclosure: Appellant's Recourse  
Form IG-BR-29

cc: Tamra Grueser, Bureau of Senior Services

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
BOARD OF REVIEW**

██████████,

**Appellant,**

v.

**ACTION NO.: 18-BOR-1860**

**WEST VIRGINIA DEPARTMENT OF  
HEALTH AND HUMAN RESOURCES,**

**Respondent.**

**DECISION OF STATE HEARING OFFICER**

**INTRODUCTION**

This is the decision of the State Hearing Officer resulting from a fair hearing for ██████████. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' (DHHR) Common Chapters Manual. This fair hearing was convened on August 2, 2018, on an appeal filed June 22, 2018.

The matter before the Hearing Officer arises from the May 17, 2018 determination by the Respondent to terminate the Appellant's Medicaid Aged and Disabled Waiver (ADW) program services.

At the hearing, the Respondent appeared by Tamra Grueser, RN for Bureau of Senior Services (BOSS). Appearing as witness on behalf of the Respondent was ██████████, RN Case Manager (CM) for ██████████. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

**Department's Exhibits:**

- D-1 Bureau for Medical Services (BMS) Manual §501.28 through §501.30 and §501.33 through §501.34
- D-2 ADW Request for Discontinuation of Service, signed April 27, 2018; Facsimile report, dated May 22, 2018; BOSS Notice, dated May 17, 2018
- D-3 West Virginia Incident Management System (WV IMS) ADW Incident reports, dated February 13, March 22, and April 19, 2012
- D-4 ADW Request for Discontinuation of Service, signed April 27, 2018; ██████████ (██████████) Recording Log, dated March 26, 2012; Written Statements, various dates ranging from March 2, 2012 through October 19, 2016; ADW RN Member Contact Form, dated January 26, 2012; Nursing Notes, dated January 26, 2012 and September 9, 2016; DHHR Adult Protective Services (APS) Reporting forms, dated January 26, 2012 and September 9, 2016; ADW Log Notes, various dates ranging from December 10, 2015 through April 27, 2018; Title XIX Medicaid Waiver Program Recording Log, dated September 9, 2016; ██████████ Nurse Progress Notes, dated March 2 and October 20, 2016; ██████████ Miscellaneous Notes, various dates

ranging from March 30, 2017 through April 26, 2018; ADW CM Monthly Contact, dated February 13, 2018

**Appellant's Exhibits:**

None

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the following Findings of Fact are set forth.

**FINDINGS OF FACT**

- 1) The Appellant was a participant of the ADW program and received Personal Attendant (PA) services through the [REDACTED] agency. (Exhibits D-2 through D-4)
- 2) The Respondent's witness, [REDACTED], was the Appellant's RN Case Manager (CM) through [REDACTED]. (Exhibit D-4)
- 3) On April 27, 2018, [REDACTED] RN, [REDACTED], and [REDACTED] completed requests for discontinuation of ADW services due to the Appellant's non-compliance with the program. (Exhibits D-2 and D-4)
- 4) On May 17, 2018, the Respondent issued a notice advising the Appellant that her ADW services were discontinued due to non-compliance with member responsibilities and unsafe environment. (Exhibit D-2)
- 5) On January 26, 2012, [REDACTED] completed an Adult Protective Services (APS) Reporting Form due to possible self-neglect, difficulty getting up to receive services, a bruise on the Appellant's arm, and "don't know what is happening to medications." (Exhibit D-4)
- 6) On February 13, 2012, a West Virginia Incident Management Systems (WV IMS) report was completed citing possible self-neglect related to the Appellant having difficulty getting up to receive services and missing medications. (Exhibit D-3)
- 7) On March 22 and April 19, 2012, WV IMS reports were completed due to the Appellant experiencing falls. (Exhibit D-3)
- 8) On December 10, 2015, [REDACTED] staff, [REDACTED], completed a written statement reporting that the Appellant's sister made her uncomfortable and that the smoke in the home caused her eyes to burn. (Exhibit D-4)
- 9) On September 9, 2016, [REDACTED] staff, [REDACTED], completed an APS Mandatory Reporting Form alleging that the Appellant had been sleeping, was hard to awaken, and was taking medications inappropriately. (Exhibit D-4)
- 10) On October 19, 2016, [REDACTED] staff, [REDACTED], completed a written statement reporting the Appellant was "very verbal," refused to wear her seat belt, and "was throwing lighters in the car." (Exhibit D-4)

- 11) On March 30, 2017, [REDACTED] staff, [REDACTED], completed a [REDACTED] Miscellaneous Note documenting that the Appellant told [REDACTED] to kiss her ass when [REDACTED] asked her to refrain from speaking ill of the maintenance man, [REDACTED]. (Exhibit D-4)
- 12) On May 23, 2017, [REDACTED] staff, [REDACTED], completed a [REDACTED] Miscellaneous Note documenting that while [REDACTED] was on the porch using the telephone, the Appellant “was screaming fuck you, fuck you [illegible] just cussing and screaming.” (Exhibit D-4)
- 13) On January 31, 2018, [REDACTED] staff, [REDACTED], completed a [REDACTED] Miscellaneous Note documenting that the Appellant told [REDACTED] that her “belly stuck out too far,” and her “hair was sticking up.” (Exhibit D-4)
- 14) On February 9, 2018, [REDACTED] staff, [REDACTED], completed a [REDACTED] Miscellaneous Note documenting that the Appellant was “using vulgar language” when [REDACTED] advised her that it was not a scheduled day to go to the store. (Exhibit D-4)
- 15) On February 13, 2018, an unknown person completed an ADW CM Monthly Contact form reflecting that [REDACTED] staff had reported the Appellant was being verbally abusive to staff, that the Appellant denied being verbally abusive, and that [REDACTED] staff refused to return to the Appellant’s home. (Exhibit D-4)
- 16) On April 2, 2018, [REDACTED] staff, [REDACTED], completed an ADW Log reflecting that she advised the Appellant by phone that workers were refusing to work for the Appellant because of repeated reports of the Appellant yelling, cussing, and being disrespectful toward staff. The note reflected that the Appellant denied the allegations. (Exhibit D-4)
- 17) On April 2, 2018, [REDACTED] staff, [REDACTED], completed an ADW Log reflecting that the Appellant did not want her new worker to come back because of concerns about the worker’s hygiene, religion, and having nothing in common with the worker. (Exhibit D-4)
- 18) On April 2 and April 25, 2018, [REDACTED] completed ADW Log notes documenting home visits with the Appellant. (Exhibit D-4)
- 19) On April 25, 2018, [REDACTED] completed a home visit with the Appellant to review a contract. (Exhibit D-4)
- 20) On April 26, 2018, [REDACTED] staff, [REDACTED], completed a [REDACTED] Miscellaneous Note documenting that the Appellant was “rude,” “called me an idiot,” and “told me to leave and not come back.” (Exhibit D-4)

**Bureau for Medical Services (BMS) Manual §501.4 Incident Management provided in part:**

ADW providers shall investigate all incidents involving the risk or potential risk to the health and safety of the people they serve [emphasis added] ....

All incident details must be objectively and factually documented (what, when, where, how). [emphasis added] All inconsistencies must be explored. The provider must ensure the safety of all involved (the person receiving ADW services and/or the staff) during the investigation. All required entities must be notified as applicable ....

The provider is responsible for taking appropriate action to identify potential harms, or to prevent further harm, to the health and safety of all people involved. [emphasis added] ...

Critical Incidents are occurrences with a high likelihood of producing real or potential harm to the health and welfare of the person receiving ADW services or incidents which have caused harm or injury. [emphasis added] It could also include any type of suspected criminal activity .... These incidents may include but are limited to, the following...

- G. Unsafe physical environment which the Personal Attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy [emphasis added] ....
- I. Medication errors by a person or his/her family caregiver that comprises the health or safety of the person, such as medication taken that was not prescribed or ordered for the person, and failure to follow directions for prescribed medications, including inappropriate dosages, missed doses, or doses administered at the wrong time. [emphasis added]
- J. Disruption of planned services for any reason that compromises the health or safety of the person receiving ADW services, including failure of the person's emergency back-up plan. [emphasis added]

**BMS Manual §501.4.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures provides in part:**

Any incidents involving a person receiving ADW services must be entered into the West Virginia Incident Management System (WV IMS) within one business day of learning of the incident... All Critical Incidents must be investigated [emphasis added] ....

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WV IMS within 14 calendar days of learning of the incident.

The criteria utilized for a thorough investigation include:

- Report was fully documented to include the date of the incident, date the agency learned of the incident, facts of the incident [emphasis added], type of incident, initial determination of the incident, and verification that an approved professional conducted the investigation ....
- Determination of the cause of the incident [emphasis added]

**BMS Manual §501.16.3 Case Management Responsibilities provides in part:**

The CM is responsible for follow-up with the person receiving ADW services to ensure that services are being provided as described in the Service Plan. [emphasis added] ... At a minimum, a monthly telephone contact and a home visit every six months must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the person in the comment section. [emphasis added] ...

Specific activities to assure that needs are being met also include ...

- O. Ensure services were provided in accordance to the Service Plan ...
- P. Evaluate social, environmental, service, risks and support needs of the individual [emphasis added] ...

- S. Proactively identify problems and coordinate services that provide appropriate high-quality care to meet the individualized and often complex needs of the person [emphasis added]
- W. Follows up on all service delivery concerns within two business days and documents in the WV IMS [emphasis added]

**BMS Manual §501.17.2 Personal Attendant Responsibilities provides in part:**

All services provided must appear on the Service Plan and must be fully documented on required forms and comply with BMS documentation standards, including form instructions. The Personal Attendant must inform the RN of any changes in the person's health, safety, or welfare and document the person's wellness response on the ADW Wellness Scale. [emphasis added]

**BMS Manual §501.34 Discontinuation of Services provides in part:**

The following require a Request for Discontinuation of Services Form: ...

- B. Unsafe Environment – an unsafe environment is one which the Personal Attendant and/or other agency staff are threatened or abused and [emphasis added] the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
  - a. The person receiving ADW services or other household members repeatedly [emphasis added] ... display verbally and/or physically abusive behavior ...
  - b. The person or other household members display an abusive use of alcohol and/or drugs and/or illegal activities in the home.
- C. The person is persistently [emphasis added] non-compliant with the Service plan [emphasis added]

**BMS Manual Chapter 200- Definitions provides in part:**

**Abuse** – The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

**DISCUSSION**

The Appellant was a recipient of ADW program services. On May 17, 2018, the Respondent issued a notice advising the Appellant that her ADW services were discontinued due to non-compliance with member responsibilities and unsafe environment. The Appellant contested the discontinuation of ADW services due to non-compliance and unsafe environment.

Evidence that contained allegations made by the Appellant toward agency staff were irrelevant to the issues of non-compliance and unsafe environment and were given little weight in the decision of this Hearing Officer. Authors of illegible handwritten documents were not available for cross-examination during the hearing; therefore, the information contained in the illegible handwritten documents could not be verified. Statements made by authors who reported that they were told information by another party are considered hearsay. As the authors of hearsay statements were not available for cross-examination during the hearing, this Hearing Officer was unable to ascertain the truth of the statements and the validity of the documentation could not be affirmed. Evidence documents that reflected an absent author, illegible author, illegible handwriting, or hearsay was given little weight in the decision of this Hearing Officer.

*Non-Compliance:*

The Respondent had to prove that the Appellant was persistently non-compliant with the service plan. The Respondent testified that since the Appellant's onset of services in 2011, the Appellant demonstrated persistent non-compliance by sleeping through PA services, refusing PA services, and mismanaging her medications. The Respondent testified that documents entered into evidence would justify the closure of the Appellant's ADW services.

The Appellant testified that she occasionally slept late but denied that she was persistently non-compliant with her Service Plan. No evidence was entered to refute the Appellant's denial of allegations of non-compliance with the Service Plan. Without reviewing the Appellant's Service Plan, this Hearing Officer is unable to determine whether the Respondent's evidence corroborates that the Appellant was persistently non-compliant with her Service Plan.

*Unsafe Environment:*

The Respondent had to prove that the Appellant repeatedly threatened or displayed verbal abuse by willfully inflicting injury, intimidation, or punishment resulting in physical harm, pain, or mental anguish to agency staff. The Respondent had to prove that the Appellant or other household members displayed an abusive use of alcohol or drugs in the home. Further, the Respondent had to prove that the agency staff's welfare was in jeopardy because of an unsafe environment caused by the Appellant's drug abuse in the home and verbal abuse toward staff.

Drug Abuse:

The Respondent testified that from 2011 through 2018, the Appellant had multiple instances of missing medication. The Appellant denied that she ever abused her medications. Two APS Reporting Forms and one WV IMS report were submitted as evidence reflecting that on January 26, 2012, February 13, 2012, and September 9, 2016, the Appellant had difficulty getting up to receive services, had a bruise on her arm, and that prescribed medication could not be accounted for. No evidence was entered to establish that the Appellant intentionally took more medications than prescribed. On at least one occasion, the evidence reflected that the Appellant believed her medications to have been stolen by another party.

Policy identifies medication errors including the Appellant's failure to follow directions for prescribed medications, inappropriate dosages, missed doses, or doses administered at the wrong time qualify as a Critical Incident. The agency is required by policy to conduct investigations and record factual documentation of Critical Incidents. Policy requires that Critical Incidents involving a person receiving ADW services must be entered in the WV IMS within one business day of learning of the incident. Pursuant to policy, a determination of the cause of the incident must be documented through the course of investigation. Although this documentation is required, only one WV IMS report, dated February 13, 2012, was submitted as evidence and the information contained in the report did not confirm a determination of the cause of the Appellant's medication mismanagement.

The evidence submitted regarding the Appellant's medication mismanagement does not support the Respondent's assertion of unsafe environment due to drug abuse in her home.

### Verbal Abuse:

The Appellant's CM had the responsibility to document monthly telephone contact evaluating potential Appellant service issues, to follow up on service delivery concerns within two business days, and to document follow up in the WV IMS. Evidence contained only one Case Management Monthly Contact log, dated February 13, 2018, that reflected the Appellant's denial of agency reports of the Appellant's verbal abuse toward [REDACTED] staff. Policy provides that an unsafe physical environment in which the welfare of agency staff is in jeopardy due to abuse to agency staff is considered a Critical Incident. The Respondent argued that the duration of time that the Appellant displayed verbal aggression verified an unsafe environment to agency staff; however, no WV IMS documentation was submitted to demonstrate any Critical Incidents of unsafe physical environment had occurred during the duration of the Appellant's receipt of ADW services. The Appellant denied that she had ever cursed or verbally abused staff.

On April 2 and April 25, 2018, the CM completed a note documenting the CM's home visits with the Appellant. During the hearing, the CM testified that on April 25, 2018, she reviewed a behavior contract regarding verbal abuse by the Appellant and that the Appellant signed it. The CM testified that during the meeting the Appellant was "extremely verbally aggressive"; however, the CM's documentation of the meeting did not reflect any verbal aggression by the Appellant. The Appellant initially testified that she did not remember the April 25, 2018 meeting but later agreed that she remembered her CM visiting and testified that she had signed a document although she denied any verbal aggression toward staff. A copy of the behavior contract was not submitted as evidence; therefore, the type of behavior the Appellant agreed to refrain from could not be verified.

The evidence contained notes describing the Appellant as "very verbal," "speaking ill," "cussing and screaming," "using vulgar language," "rude", and calling staff "idiot". The authors of the notes were not available during the hearing to provide clarification of their statements. No evidence was entered to demonstrate that the Appellant's comments willfully inflicted injury, intimidation, pain, or mental anguish toward agency staff or that the staff's welfare was in jeopardy because of the Appellant's comments. The Respondent's evidence does not corroborate that the Appellant's verbal comments to staff met the thresholds of abuse and frequency required to discontinue ADW services.

The Respondent failed to prove by a preponderance of evidence that the Appellant was persistently non-compliant with the Service Plan. No credible evidence was entered to refute the Appellant's argument that she was compliant with her Service Plan and provided a safe environment. The Respondent's evidence failed to prove that the Appellant repeatedly threatened or displayed verbal abuse by willfully inflicting injury, intimidation, or punishment resulting in physical harm, pain, or mental anguish to agency staff. The Respondent failed to prove that the agency staff's welfare was in jeopardy because of an unsafe environment caused by a display of an abusive use of alcohol or drugs by the Appellant or other household members.

### CONCLUSIONS OF LAW

- 1) A Request for discontinuation of ADW services may be completed when the person is persistently non-compliant with the Service Plan.
- 2) The Appellant's Service Plan was not submitted as evidence.
- 3) The Respondent failed to prove that the Appellant was persistently non-compliant with her Service Plan.



- 4) A Request for discontinuation of ADW services may be completed when agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- 5) The Respondent failed to prove that the Appellant repeatedly threatened or displayed verbal abuse by willfully inflicting injury, intimidation, or punishment resulting in physical harm, pain, or mental anguish to the agency staff.
- 6) The Appellant's verbal comments to staff did not meet the threshold of abuse or frequency required to discontinue ADW services.
- 7) Evidence did not verify that the Appellant or other household members displayed an abusive use of alcohol or drugs in the home that placed the staff's welfare in jeopardy.
- 8) The Respondent incorrectly terminated the Appellant's ADW services due to non-compliance and unsafe environment.

### **DECISION**

It is the decision of the State Hearing Officer to **REVERSE** the Department's decision to terminate the Appellant's participation in the Aged and Disabled Waiver program due to non-compliance and unsafe environment.

ENTERED this 21st day of August 2018.

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**Tara B. Thompson**  
State Hearing Officer