**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**

**Jolynn Marra**
**Interim Inspector General**

October 3, 2019

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 19-BOR-1928

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**

[redacted],

**Appellant,**

**v.** **ACTION NO.: 19-BOR-1928**

**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 [redacted]. 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 20, 2019, on an appeal filed July 10, 2019.

The matter before the Hearing Officer arises from the June 11, 2019 determination by the Respondent to terminate the appellant's Medicaid Aged and Disabled Waiver Program (ADW) services due to unsafe environment.

At the hearing, the Respondent appeared by Tamra Grueser, RN, Bureau of Senior Services (BOSS). Appearing as witnesses on behalf of the Respondent were [redacted], Case Management Supervisor, [redacted]; [redacted] (Ms. [redacted]), [redacted] Case Manager; and [redacted] (Ms. [redacted]), [redacted] Homemaker RN. The Appellant appeared and was represented by her son [redacted] (Mr. [redacted]). Appearing as witnesses on behalf of the Appellant were [redacted], the Appellant's son, and [redacted], the Appellant's granddaughter. All witnesses were sworn and the following documents were admitted into evidence.

**Department's Exhibits**:

D-1 Bureau for Medical Services (BMS) Manual §§ 501.27-501.33
D-2 ADW Request for Discontinuation of Service, signed, June 6, 2019, and BOSS Notice, dated June 11, 2019.
D-3 Personal Care Service Agreement, unsigned

D-4 Incident Report: INC-15500-T4H7, dated June 7, 2019; Adult Protective Services Mandatory Reporting Form, dated June 7, 2019; Incident Report: INC-14631-M7Q8, dated May 16, 2019

D-5 [redacted] Administrative Recording Logs dated February 6, 2019 through May

D-6 Aged and Disabled Waiver Case Management Monthly Contacts, signed March 22 and April 23, 2019; Case Management Progress Notes, dated March 21, March 22, March 25, and May 18, 2019

D-7 DHHR Correspondence dated January 18, May 9, May 13, May 15, May 24, June 10, 2019

D-8 [redacted] Case Management Progress Notes, dated November 19, December 7, and December 19, 2018, and January 31, May 8, and June 11, 2019.

D-9 [redacted] Agency and Employee Incident Report, dated February 19, 2019

**Appellant's Exhibits:**

A-1 Personal Attendant Logs, dated February and May 2019; Facsimile Reports, dated February 22, 2019

A-2 Personal Attendant Logs, dated July 2017 and November 2018; Facsimile Reports, dated October 22, November 2, November 12, and November 16 2018

A-3 Letter, from [redacted]; DHHR Adult Protective Services Findings Letter, dated June 18, 2019; Letter, from [redacted]

A-4 Personal Attendant Log, dated June 2017

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) On May 3, 2017, the Appellant began receiving ADW services through [redacted] and [redacted] (Exhibit D-2).

2) Between May 3, 2017 and June 11, 2019 the Appellant was assigned thirteen personal attendants.

3) Service agencies experienced barriers staffing the Appellant's case due to staff unavailability or refusal to provide services in the Appellant's home (Exhibit D-4).

4) On June 6, 2019, [redacted] requested that the Appellant's ADW services be terminated due to an unsafe environment (Exhibit D-2).

5) On June 11, 2019, the Respondent issued a notice to the Appellant advising her ADW services would be discontinued due to an unsafe environment pursuant to BMS Manual § 501.34.B. (Exhibit D-2).

6) The Respondent relied upon information documented in the [redacted] Administrative Recording Logs when making the determination to terminate the Appellant's ADW services (Exhibit D-5).

7) On February 6, 2019, the Respondent's record reflected that direct care worker, [redacted] reported to "[redacted] [illegible]" that Mr. [redacted] was "mean- yelling about washing silverware together with his" and "would not let her turn on any lights in house and ate member's lunch from meals on wheels" (Exhibit D-5).

8) On February 19, 2019, Ms. [redacted] completed an Agency and Employee Incident Report regarding agency staff, [redacted], being frightened and not able to exit the garage due to Mr. [redacted] blocking the entrance (Exhibit D-9).

9) The February 19, 2019 report reflected that the Appellant's services would be placed on hold until "BOSS [illegible] service agreement signed"(Exhibit D-9).

10) On March 14, 2019, the Respondent's record reflected that [redacted] reported to "[redacted] [illegible]" that Mr. [redacted] was "yelling and screaming about how she backed out of driveway and hit a tire he had laying around a property marker" and that she "has heard of son's rants and does not feel the money is worth the headache" (Exhibit D-5).

11) On March 22 and April 23, 2019, the Respondent's record reflected that Ms. [redacted] was advised that Mr. [redacted] must sign a service agreement stating that he won't be at the home when agency staff is scheduled to work (Exhibit D-6).

12) On March 22 and April 23, 2019, Ms. [redacted] met with Mr. [redacted] and discussed staffing barriers unrelated to environmental safety (Exhibit D-6).

13) On June 7, 2019, "[illegible] [redacted]" signed that a report had been received from direct care worker, [redacted], on May 10, 2019 stating that "she worked one day and never returned to work … she stated that she no longer wished to do work" (Exhibit D-5).

14) On "[illegible] 19, 2019" the Respondent's record reflected that [redacted] reported to [redacted] that "she did not feel safe" and "son [redacted] trapped her in garage that was dark, demands she hang up broom," and "had to push past him to get out" (Exhibit D-5).

15) In May 8, 2019, [redacted] required the Appellant's son, [redacted] (Mr. [redacted]), to sign a Personal Care Service (PCS) Agreement (Exhibit D-3).

16) The PCS agreement advised that as a family member of an ADW participant, Mr. [redacted] had "certain responsibilities to maintain my Aged and Disabled Services" (Exhibit D-3).

17) The PCS agreement advised that Mr. [redacted] could not be present in the home while services were provided to the Appellant by [redacted] (Exhibit D-3).

18) The PCS agreement advised that Mr. [redacted] "failure to comply with the above agreement may result in termination of my personal care services through [redacted]" and that if he did not follow the contract that "this letter may also be forwarded to [BOSS] who have the authority to force closure of my mother's services" (Exhibit D-3).

19) On May 16, 2019, Ms. [redacted] completed an West Virginia Incident Management System (WV IMS) incident report indicating that on unreported dates, Mr. [redacted] yelled at and berated agency staff, barred the doorway to prevent agency staff from exiting, and refused to allow staff to turn on lights when completing tasks he demanded staff complete (Exhibit D-4).

20) On June 7, 2019, Ms. [redacted] completed a WV IMS incident report and Adult Protective Services Mandatory Reporting Form which indicated that the Appellant's ADW services were being terminated due to noncompliance and unsafe environment (Exhibit D-4).

21) The Appellant's siblings were not prohibited from visiting the Appellant due to Mr. [redacted] presence in the home (Exhibit A-3).

## APPLICABLE POLICY

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

> ADW providers shall review, investigate, and track all incidents involving risk or potential risk to the health and safety of the people they serve …. All incident details must be objectively and factually documented (what, when, where, how). All inconsistencies must be explored. The provider must ensure the safety of the participant and the agency staff during the investigation.
>
> Critical incidents including unsafe physical environment in which the agency staff are threatened or abused, and the staff's welfare is in jeopardy and disruption in the delivery of ADW services due to persons residing in the home compromising health and safety.

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

> Any incidents involving a person receiving ADW services must be entered into the WV IMS within ONE business day of learning of the incident. All critical incidents must be investigated. An Incident Report documenting the outcomes of the investigation must be completed and entered into WV IMS within 14 calendar days of learning of the incident. An agency is responsible to investigate all incidents. 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, type of incident, initial determination of the incident, and verification that an approved professional conducted the investigations.
- All parties were interviewed, and incident facts were evaluated.
- Person was interviewed.
- Determination of the cause of the incident.
- Identification of preventative measures.
- Documentation of any action taken as the result of the incident.
- Changes in needs were addressed on the Service Plan.

**BMS Manual § 501.29 Rights and Responsibilities:**

The agency has a responsibility to provide the participant or their legal representative with notice of their requirement to comply with the Person-Centered Service Plan, cooperate with scheduled home visits, maintain a safe home environment for all service providers, and not ask personal attendants to provide services that are excluded by policy or not on their Service Plan.

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

A Request for Discontinuation of Services Form must be completed when an environment is unsafe or the individual is non-compliant with the Service Plan. An unsafe environment is one in which the personal attendant or other agency staff are threatened or abused, and the staff's welfare is in jeopardy. This may include but is not limited to:

- The person receiving ADW services or other household members repeatedly display sexually inappropriate, verbally or physically abusive behavior, or threaten a personal attendant or other agency staff with weapons or verbal threats to harm.

If it is an unsafe environment, services may be discontinued immediately upon approval of the OA, and all applicable entities are notified, i.e. police, Adult Protective Services.

**WV Common Chapters § 710.22.H – I Cross Examination and Admissability of Evidence provide in part:**

Both parties shall have the right to cross-examine witnesses who testify. The Hearing Officer must consider the factors of relevancy, reliability, and repetitiveness when ruling on the admissibility of evidence. Routine records are admissible without the testimony of the record keeper or other witness, where cross-examination of the witness would not be meaningful.

## DISCUSSION

The Respondent's witness, Ms. [redacted], testified that the June 11, 2019 decision to terminate the Appellant's ADW services was due in part to an incident that had occurred in February 2019, Mr. [redacted] May 8, 2019 refusal to sign a service plan agreement, and due to issues aligning agency staff for the Appellant's home.

## Non-Compliance

The Respondent's testimony, emails, and incident reports reflected that the request for closure was based on an unsafe environment and the Appellant's non-compliance with her plan of care. The Respondent testified that Mr. [redacted] was being non-compliant in providing a safe environment for agency staff by refusing to mail back the direct care worker's log and refusing to sign a service plan agreement. The Appellant's witness, [redacted], testified that Mr. [redacted] faxed the log back to the agency. Mr. [redacted] testified that they talked to him about a service plan agreement but that he had not actually been given one to sign.

The Appellant argued that the plan of care was not admitted into evidence and that it could not be determined that staff were required to conduct activities beyond those listed in the plan of care. Ms. [redacted] testified that the last service plan was completed on May 8, 2019 and mailed to the Appellant on May 9, 2019. The Respondent's representative testified that non-compliance was not the issue of the hearing and therefore a plan of care was not included in the evidence.

The Respondent representative's testimony regarding the issue of non-compliance was conflicting. As the Respondent initially argued that the Appellant's non-compliance with the plan of care was an issue and then denied that non-compliance was an issue, little weight was given to the Respondent's testimony regarding Mr. [redacted] actions being related to the Appellant's non-compliance with her service plan. The service plan was not provided as evidence and non-compliance was not cited on the Respondent's termination notice. The evidence failed to establish that the Appellant was non-compliant with her service plan.

## Unsafe Environment

*Claims of Unsafety*

The Respondent bears the burden of proof. The Respondent had to prove by a preponderance of evidence that Mr. [redacted] threatened or abused agency staff and that staff's welfare was in jeopardy. The Respondent's representative argued that Mr. [redacted] provided house slippers to personal attendants and requested that they drag a mop behind them to prevent tracks on the floors. The Respondent argued that Mr. [redacted] refused to allow staff to turn on lights and required staff to accept or watch religious videos. Although the Respondent's emails and incident reports echo these claims, no evidence was provided to establish a factual basis on which to verify these specific claims by the Respondent.

The Respondent's May 9, 2019 email reflected that the agency had received a complaint in January 2019 alleging he had trapped an agency worker in the garage and prevented her from leaving. During the hearing, Ms. [redacted] testified that she received the call about the incident on February 20, 2019; however, her testimony conflicted with evidence which reflected that Ms.

[redacted] completed an Agency Incident Report on February 19, 2019. On Ms. [redacted] February 19, 2019 Agency and Employee Incident Report, [redacted], agency staff, was reported to have had her exit from the garage blocked by Mr. [redacted] and that the Appellant's services would be placed on hold. Policy provides that this action qualified as a critical incident. Ms. [redacted] testified that the February 2019 complaint of the worker not feeling safe caused the agency to feel unsafe about assigning additional staff to the Appellant. The email reflected that the allegation was not reviewed with Mr. [redacted] or the Appellant until May 2019 and that Mr. [redacted] denied the allegation. During the hearing, Mr. [redacted] and the Appellant testified that he did not place any agency worker in an unsafe situation.

Ms. [redacted] testified that there were no lights on in the living room when she was present in the home but that there was light coming through the window. During the hearing, Ms. [redacted] and Ms. [redacted] testified that they were in the Appellant's home every six months and denied feeling unsafe or intimidated while in the Appellant's home. Ms. [redacted] testified that she had never been in the Appellant's home. The Respondent's witnesses testified that they had never been in the garage of the home. No testimony was provided by any of the witnesses to establish that the witnesses felt unsafe while in the Appellant's home in the presence of Mr. [redacted]

The Respondent's email evidence reflected a statement that the Appellant's other two sons refused to visit the home due to Mr. [redacted] presence in the home and testified that the evidence demonstrated how Mr. [redacted] interfered with the services that the Appellant was scheduled to receive. The Appellant's witness, [redacted], testified that the Respondent's assertion was incorrect. Letters provided by the Appellant and testimony from [redacted] and the Appellant's granddaughter reflected that none of the family members were afraid to visit the Appellant or Mr. [redacted]

During the hearing, Ms. [redacted] testified that nine months was the longest period for one agency member to be staffed in the Appellant's home. Ms. [redacted] testified that when the direct care worker quit, he provided Ms. [redacted] with a box of religious materials and claimed that he could not work in the Appellant's home any longer due to religious materials being given to him by Mr. [redacted] Ms. [redacted] testified that the staff member never made any claim to feeling unsafe or threatened but refused to return on the basis of dissemination of religious material. Mr. [redacted] argued that he was unaware of the contents of the box of which Ms. [redacted] testified to receiving. No evidence was entered to corroborate the Respondent's testimony.

*Agency Incident Documentation*

The Respondent's witnesses were provided with an opportunity during the hearing to review each of their documents and make any notation regarding incidents of unsafe environment. The May 20, 2019 WV IMS Incident Report related to the February 2019 alleged incident reflected that the incident occurred on May 16, 2019, which conflicted with Ms. [redacted] February 19, 2019 Agency Incident Report. Mr. [redacted] argued that he was unaware of agency staff safety complaints until three months after the alleged incident occurred. Policy requires the agency to investigate all incidents and to include in the WV IMS report that all parties were interviewed and incident facts were evaluated. The agency failed to meet this requirement.

Ms. [redacted] notes indicate that on March 22, 2019 she was advised that a service agreement must be signed by Mr. [redacted] stating that Mr. [redacted] must not be in the home when agency staff is present. Ms. [redacted] documentation established that she met with the Appellant multiple times, however, the documentation failed to reflect that any alleged unsafe behaviors by Mr. [redacted] were discussed during the March and April 2019 monthly case management contact.

The evidence reflected that agency staff did not advise Mr. [redacted] of safety concerns or request his signature of a service plan agreement until May 8, 2019. The May 8, 2019 case management progress note and Respondent witness testimony reflected that the Appellant had not received direct care worker services since February 19, 2019 –three months prior—and services were not terminated until issuances of the June 11, 2019 notice. During the hearing, the Respondent testified that the Appellant's last ADW services were provided on February 19, 2019. The Respondent's testimony during the hearing conflicted with the Respondent's reports in Exhibit D-5, which reflected direct care worker contact with administrative staff regarding the Appellant as late as May 10, 2019. Due to the conflicting evidence regarding the dates of agency services provided, the Respondent's evidence was found to be unreliable.

Although Ms. [redacted] completed incident WV IMS reports in May and June 2019 mirroring claims of unsafe environment, the incident reports did not establish specific dates or provide details of incidents or the names of involved direct care staff other than [redacted]. While the incident reports provide documentation of Ms. [redacted] plan to follow up on the allegations, no information was reflected to demonstrate that an investigation into the incident allegations had occurred or what the outcome of the investigation had been. The agency had a responsibility as outlined in policy to report the February 2019 alleged incident into WV IMS within one business day of learning of the incident. Further, policy requires that all critical incidents must be investigated and outcome of the investigation documented within 14 days of learning of the incident. Policy requires that details of the incident and investigation must be reflected on the WV IMS incident report. The agency grossly failed to follow correct procedures for investigating and reporting the alleged February 2019 incident. The WV IMS reports provided as evidence do not establish a factual basis of dates, incidents, and agency staff present during incidents of unsafe environment involving Mr. [redacted]

*Cross-Examination*

The Appellant's representative contended that none of the personal attendants making allegations were present during the hearing, that the documentation contained notes that were unsigned by the individuals making the allegations, and that testimony provided regarding their complaints was hearsay. Ms. [redacted] testified that the agency covers multiple counties and that handwritten statements are not received from the direct care workers. Ms. [redacted] testified that the only agency documentation would be the daily log and plan of care signed by Mr. [redacted] and that Mr. [redacted] had failed to submit the February 2019 direct care worker logs. Even if the evidence had established that Mr. [redacted] faxed the logs back to the Respondent, Ms. [redacted] testified that direct care workers wouldn't have made documentation of safety concerns on the daily log and plan of care because they would know Mr. [redacted] would see the log when he signed it.

Ms. [redacted] testified that direct care workers made contact with the agency by calling the agency and that the contact was documented by administrative staff taking the workers' calls and

then forwarded to Ms. [redacted]. The Appellant argued that because the individuals who made complaints and who received and signed the complaints were not present, that it cannot be determined that the information contained in the documentation is credible. As the Respondent witness's testimony established that the documentation was kept in the regular course of agency business, this Hearing Officer finds that the documents themselves may be considered. However, Common Chapters provides that records are admissible without the testimony of the record keeper or other witnesses where cross-examination of the witness would not be meaningful.

As the documentation provided at one illegibly dated note claiming the direct worker felt unsafe because Mr. [redacted] "trapped her in garage that was dark" and "had to push past him to get out" and provided vague documentation of "yelling about silverware," and "screaming about how she backed out of driveway and hit a tire," this Hearing Officer finds that cross-examination of the witnesses would be meaningful to determining whether the alleged actions by Mr. [redacted] caused the Appellant to fail to meet her responsibility to provide a safe environment for agency staff.

The evidence did not provide clear details regarding incidences of unsafe environment. Conflicting evidence and testimony regarding when direct worker services were last provided to the Appellant decreased the reliability of the Respondent's evidence. Without an opportunity for cross-examination of the witnesses, this Hearing Officer cannot clearly discern that the Appellant threatened or abused agency staff and that the staff's welfare was in jeopardy based on the documentation submitted into evidence.

*Personal Attendant Turnover:*

The Respondent testified that typically when staff call off a replacement is sent but due to the county in which the Appellant lives being a "difficult area" and history of workers being previously in the home, that a replacement could not be aligned. The Respondent's representative argued that the Appellant had 5 personal attendants since the beginning of service because "they all refused to go back and take abuse from the son," however, the evidence demonstrated that the Appellant had 13 personal attendants and no evidence was entered to demonstrate that 13 personal attendants had refused to go back to the Appellant's home due to "abuse from the son."

The Respondent's witness, Ms. [redacted] testified that she was aware of agency difficulty staffing the Appellant due to direct care workers not returning to the home. Ms. [redacted] testified that attendants just didn't get along with Mr. [redacted] personality. Ms. [redacted] testified that agency staff priority was the Appellant's bathing, grooming, and dressing. She testified that agency turnover in the Appellant's home was due to complaints about Mr. [redacted] "OCD behaviors" and staff's inability to tolerate "him being on them about every little thing."

Ms. [redacted] testified that "many" workers refused to go back to the home due to Mr. [redacted] asking them to complete environmental tasks not identified on the plan of care and that as a result, environmental tasks were removed from the Appellant's plan of care due to the agency feeling it was unfair to the worker to have to clean shared areas of the home. No evidence was entered to demonstrate that Mr. [redacted] had threatened or abused agency staff or that agency staff's welfare was in jeopardy due to Mr. [redacted] response to environmental tasks outlined on the plan of care. While the agency had difficulty aligning staff for the Appellant's home, agency staff turnover and

disagreement between the agency staff and the Appellant regarding the plan of care are not –in themselves—evidence of an unsafe environment.

## CONCLUSIONS OF LAW

1) A request for discontinuation of Medicaid ADW services must be completed when agency staff are threatened or abused and the staff's welfare is in jeopardy.

2) The Respondent's evidence failed to verify that agency staff were threatened or abused and staff's welfare was in jeopardy while providing services to the Appellant while Mr. [redacted] was present in the home.

3) The Respondent incorrectly terminated the Appellant's Medicaid ADW services on the basis of unsafe environment.

## DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Medicaid Aged and Disabled Waiver Program benefits due to unsafe environment.

ENTERED this 3rd day of October 2019.

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**Tara B. Thompson**
State Hearing Officer