IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	Civil Action No. 3:12CV59-JAG
	)	
v.	)	Motion
	)	
COMMONWEALTH OF VIRGINIA,	)	
	)	
Defendant,	)	
	)	
PEGGY WOOD, et al.,	)	
	)	
Intervenors	)	

INTERVENORS'
MOTION
FOR
INJUNCTIVE RELIEF

The Intervenors respectfully request that this Honorable Court grant immediate injunctive relief to protect the former residents of the nursing/skilled nursing facility (hereinafter referred to as the "NF") at Central Virginia Training Center ("hereinafter referred to as "CVTC") from imminent serious harm and death, to remedy the illegal discharges and transfers from Training Centers, and to prevent further illegal discharges and transfers from Training Centers, and aver the following:

Factual Background

1. The Intervenors have never voluntarily consented to a move from Training Centers to any other placements. In fact, many of the Inervenors have signed a Statement of

Residential Decision which states that they are "firmly and unalterably opposed to transitioning...from CVTC to the community."

2. Those Intervenors who signed Statements of Residential Decision specified that their decision would "remain in effect until such time as I (or my successor as Authorized Representative) provide a written revocation of this notice."

3. The Intervenors who executed Statements of Residential Decision requested that these documents be placed in their records.

4. None of the Intervenors or their authorized representatives had voluntarily consented to discharge from the Training Centers. Several of the Intervenors were forced out of Training Centers by the Defendants by coercion, deception, or misinformation. Notification that Hiram Davis "qualifies as a Training Center" according to Commonwealth representatives and DBHDS officials was first given to authorized representatives after the forced discharge of several CVTC residents and their subsequent transfer to Hiram Davis Medical Center (hereinafter referred to as HDMC), a hospital and nursing facility associated with Central State Hospital in Petersburg. Hiram Davis is not a Training Center. The selection of the six (6) most ill patients to be evicted from CVTC was made by the same nurse manager responsible for the investigated and documented hostile work environment at CVTC's NF , and not by a physician as required by Federal ICF/IID regulations.

5. Until January 2017, Central Virginia Training Center (CVTC) had both ICF/IID and nursing and skilled nursing CMS-certified beds. CVTC's Building 31 housed the NF, and all remaining CVTC residential buildings were certified ICF/IID. All of the nursing facility beds were dual certified NF/SNF (nursing facility/skilled nursing facility), to be used for either long term or short term stays as needed.

6. As a part of CVTC, the nursing facility funding was always included in the overall CVTC appropriation by the General Assembly. On its website, DBHDS describes CVTC as

follows: "CVTC provides a full range of supports and services for persons with intellectual disabilities including Intermediate Care and Skilled Nursing living areas, an extensive array of day and evening activity programs, various clinical professional therapies as well as medical and dental services for the persons who live at CVTC."

7. The Building 31 NF was surveyed annually by the Health Department, on behalf of CMS, and for many years it has received a superior overall rating of five stars, with five star ratings in all of the three subcategories: health inspections, quality measures and staffing. The facility had a capacity of 88, with a census in the forties at the time of its most recent inspection in August 2016.

8. For the first time in many years, the CVTC NF staffing rating decreased from its usual superior five (5) stars to an above average rating of four (4) stars at the August 2016 survey, with August 2016 also being the month that decertification of the NF was announced and the 24-hour physician on campus was discontinued by DBHDS. DBHDS claimed that nurse departures had increased due to the planned closure of CVTC in 2020 and that the planned closure impeded hiring replacement nursing staff.

9. The Commonwealth claimed, in a letter to all of the authorized representatives of the nursing facility residents, that an anticipated future shortage of nursing staff necessitated the conversion of the SNF beds to ICF/IID beds, for the safety of the residents. This was despite a simultaneous high CMS rating for staffing. The announcement letter did not notify the authorized representatives of their federal right to appeal this decision and the procedure for so doing, nor did it include a list of advocacy agencies and their contact information as required by federal regulations.

10. Beyond requiring that an RN is onsite every shift, CMS NF regulations do not specify a nurse to patient ratio, nor do they require a specific number of nurses on staff, but instead they require that facilities maintain sufficient nursing staff to meet the needs of

patients. CVTC was in no danger of losing its certification, with its 4-star staff rating. As the census was reduced after the decision to decertify the NF beds was made and most of the NF residents were moved to the ICF portion of CVTC's campus, nurse staffing levels at the NF were surely sufficient to give proper care to the much smaller number of individuals who remained, regardless of how their beds are certified with CMS.

11. The decline in nursing staff at CVTC's NF, and the conversion of the NF beds to ICF/IID certification, appears to have been for the sole purpose of facilitating the ultimate closure of CVTC, based upon political decisions and ideology. Had the Commonwealth genuinely wished to increase the nursing staff at CVTC's NF, it could have addressed the hostile work environment at the NF, created by the facility's head nurse (and documented by a DBHDS investigators' report to the state Inspector General, prompted by an OSIG hotline complaint), by recruiting agency or contract nurses, or by removing the NF from the closure list, thereby preventing further staff departures. If the Commonwealth had prevented these departures, there would have been no excuse for evicting the most seriously ill residents.

12. The Commonwealth, through Interim Commissioner Barber, has recently and for the first time stated publicly that it was always the plan to close the nursing facility at CVTC. Consistent with that announced intention, the Commonwealth alleged a nursing shortage which it or allowed or perhaps even promoted. The hostile work environment was tolerated or even supported by senior DBHDS leadership. In fact, the CVTC Director responsible for supervising the nurse who created the hostile work environment was subsequently rewarded and promoted by DBHDS for her actions. However, to the end, the nurse to patient ratio was always better at CVTC's NF than at Hiram Davis Medical Center (hereinafter referred to as "Hiram Davis").

13. In November 2016, a member of CVTC's staff informed an officer of CVTC Families and Friends, in strict confidence for fear of jeopardizing his job, that he had learned

from a contact at DBHDS Central Office that DBHDS upper management planned an intentional and steady reduction and erosion of CVTC medical and support services to the extent that the facility would lose its CMS certification, to force discharges from the facility.

14. Also, an October 2016 joint DBHDS and OSIG internal investigation of the NF Nurse Manager by DBHDS, in response to an OSIG "hotline" complaint, revealed that the Nurse Manager was habitually abusive to the degree that some staff refused to be alone in a room with her, and her behavior caused nurses to leave. Staff understood her to be protected by the CVTC Director, and complaints were considered by staff to be intentionally buried. DBHDS did not remove the hostile Nurse Manager, and instead rewarded her for her actions and promoted her as Director of Clinical Services at CVTC. These facts are consistent with the confidential statement to a CVTC parent by a member of the CVTC staff that the Commonwealth planned to deliberately erode services at CVTC to facilitate closure of the Training Center.

15. The Commonwealth decided to retain and promote a head nurse at the NF who was known to be abusive and a cause of nurse departures. The DBHDS plan to close CVTC in 2020 could have been changed and the abusive nurse manager could have been removed, to relieve the anticipated future staffing problems, but DBHDS leadership made the decision to tolerate the hostile work environment, which supports the alleged plan to reduce services.

16. On August 26, 2016, DBHDS Interim Commissioner Jack Barber sent a letter to families of the nursing facility residents informing them that he intended to convert the NF beds to ICF/IID beds at the end of the year, and that all but six (6) patients would be transferred to the ICF portion of the CVTC campus, and Building 31 would be closed as soon as all moves could be arranged. The letter further stated that the remaining six patients (the most seriously ill) would have to leave CVTC, for their own safety, as he anticipated that the

nursing staff would decline in the future sufficiently to jeopardize their well-being. This was simultaneous to the CMS four-star rating for staffing.

17. Barber did not offer the CVTC NF patients any avenue of appeal, despite Medicaid law requiring that they be informed of the appeal process and be given the contact information of advocacy organizations. The failure of the Commonwealth to provide a statement of appeal rights and contact information as to where to file an appeal, along with contact information for the required advocacy groups, violated the rights of these individuals to appeal their discharge and impeded their due process rights. *See* 42 CFR §483.12.

18. The families of three (3) of the six (6) who were given notice of eviction were independently and autonomously aware of the DMAS appeal process and were able to appeal the Department's decision to DMAS, the state's Medicaid agency, but the rest, who were not appropriately informed, were denied an opportunity to appeal. All NF patients, including the three (3) who knew beforehand about the appeal process, were denied information as to their federal right to due process and the procedure for so doing, as affirmed in DMAS documents for the very few who did appeal without receiving the required notification by DBHDS of their right to do so. Despite the findings of the hearing officer, Robert Kerr, that the Commonwealth had violated federal due process procedures, these individuals were still forced to move, because the DMAS appeal process coincided with the exact timing of the conversion of their NF beds to ICF/IID beds (the 30-day post-DMAS appeal date was "coincidentally" January 31, the same date as conversion, and one day after a January 30 discharge date for the last CVTC patient going to Hiram Davis. The DMAS hearing officer refused to recognize federal and state laws that were cited by Intervenors' families as part of the appeal process.

19. Despite previous PASRR II evaluations and years of physician assessments that found all of the individuals residing at CVTC's NF in continuing need of nursing facility

placement, the Commonwealth has now arbitrarily decided that many of these individuals, whose conditions are essentially unchanged, no longer require such a level of placement, based on the Commonwealth's anticipated staffing problems that are caused by its own arbitrary administrative decisions and tolerance of the hostile work environment, and not by medical necessity.

20. The residents of the NF were judged to require nursing facility level of care at their PASRRII examinations in 2016, and Medicaid had for many years paid for all of their services at the higher NF rate. The patients at the nursing facility were not assessed to have recovered, nor were their physical conditions changed in any regard, yet the DBHDS Interim Commissioner insisted that they be transferred to the ICF portion of CVTC or to other facilities, due to his administrative problem with nurse staffing rather than any medical justification, claiming that he essentially had no choice but to do so because CVTC could no longer provide them with 24-hour nursing care. Although the Commonwealth has billed the federal government a higher rate for nursing or skilled nursing services for these individuals, the Commonwealth now claims that 36 of the same individuals, whose conditions are unchanged, do not require such services, for administrative convenience rather than medical reasons.

21. The Commonwealth planned and implemented the movement of 36 of the 42 NF residents to the larger Intermediate Care Facility ("ICF") portion of CVTC or to community-based facilities, after first changing the CMS certification of Building 31 from NF to ICF/IID and then later closing the building.

22. The Commonwealth identified the remaining six (6) individuals as too medically needy to remain at CVTC, due to an anticipated future nursing staff shortage. Five (5) of the six (6) were evicted, including three (3) whose guardians objected strenuously, and sent to Hiram Davis Medical Center (HDMC) in Petersburg, a state-operated nursing facility

associated with Central State Hospital, a mental health facility located across the street from HDMC. The sixth has been given notice of eviction but has been given a temporary reprieve to seek an alternative local placement.

23. DBHDS operates Hiram Davis Medical Center (HDMC), next to the campus of the former Southside Virginia Training Center (SVTC), across the street from Central State Hospital. SVTC was closed in 2014. On state budget documents, HDMC is listed as a distinct non-Training Center facility with its own separate appropriation, separate from the former SVTC, even though it is located next to the former SVTC campus.

24. HDMC primarily receives patients from Central State Hospital (CSH), and DBHDS documents indicate that it is associated with CSH, as does CSH signage. HDMC forms also indicate that the facility is associated with CSH, since the words "Central State Hospital" appear on HDMC admission forms.

25. HDMC is not a Training Center, nor is it part of a Training Center.[1] Hiram Davis is a separate nursing facility, with its own distinct budgetary appropriation, not formally part of any other state facility, but associated with Central State Hospital in Commonwealth documents and in Central State Hospital signage.[2] DBHDS claimed in a DMAS hearing in December of 2016 that Hiram Davis "qualifies as a Training Center."

26. Hiram Davis Medical Center (hereinafter referred to as "Hiram Davis") is the only nursing home alternative that was offered to the residents of the NF at CVTC, except for inappropriate NF's that were geriatric and had no oxygen system or wall suction. Some suggested NF placement alternatives refused to accept the evicted residents because of their

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[1] The Commonwealth claims that Hiram Davis "qualifies" as a training center, but that does not make it a Training Center under the applicable laws. This claim by the Commonwealth is only a manipulation of terms to avoid the intent of the state statute that prohibits the discharge of those individuals who choose to remain in a Training Center. Section 37.2-837(A)(3) of the Virginia Code.

[2] The Commonwealth claims that Hiram Davis provides services that qualifies it as a training center, but that is just an excuse to avoid the statutory requirements. Hiram Davis Medical Center is not and never has been a training center whether it "qualifies" as one or not.

complex needs, because they were not in the age range of 55 to 65, because they had long-term needs, or because the NF did not have any expertise in intellectual disabilities.

27. HDMC is a greatly inferior nursing facility as compared to the NF at CVTC. In fact, HDMC is not even ADA compliant, thereby creating risks and barriers for the intellectually disabled individuals who are placed there.

28. Hiram Davis was penalized by CMS for numerous safety violations in 2015 through 2017, while CVTC was not. HDMC is surveyed annually by the Health Department on behalf of CMS, and it was given a below average rating of two (2) stars at the time of the CVTC forced transfers, with a subcategory breakdown of one (1) star for Health Inspections, two (2) stars for quality measures, and five (5) stars for staffing. In accordance with the requirements of the Affordable Care Act, HDMC was penalized 1% of its federal payments each year by CMS due to its poor safety record, from 2015 to the present year.

29. Hiram Davis has been cited for deficiencies such as uninvestigated and unexplained injuries/bruises, failure to follow physician-ordered diabetes management, medication errors, unsanitary food preparation, unclean linens with an infection risk, failure to keep accurate and complete medical records, failure to give residents proper treatment to prevent bedsores, failure to treat reduced range of motion, and failure to have a full-time Director of Nursing.

30. The NF at CVTC had only one (1) deficiency in its most recent CMS survey, an administrative record-keeping deficiency, whereas Hiram Davis had 46 deficiencies, a significant number of which were related to safety risks including improper infection control and unsanitary practices.

31. The ratio of nurses to patients at CVTC compared favorably to the ratio at Hiram Davis, even immediately prior to the January evictions. All NF's are required by federal law to post their staff-to-patient ratios for each shift. The staffing at CVTC's NF consistently

compared favorably with HDMC, even for the months immediately prior to the evictions from CVTC. The ratio of RN's to patients was markedly higher at CVTC then at HDMC, based upon a FOIA review of institution daily census versus daily nursing staff numbers, distinctly listing staff by certifications and degrees.

32. Hiram Davis primarily cares for mentally ill patients at Central State Hospital, who pose a risk to the highly vulnerable and fragile individuals transferred there from the NF at CVTC. Patients with intellectual disabilities are inappropriately intermingled with patients who have mental illness.

33. At the time of Peggy Wood's admission to Hiram Davis, there were several residents intermittently heard to scream on the second floor and one of them was just across the hall from her, and this environment is highly detrimental to such a medically compromised and fragile individual as Peggy Wood.

34. There are other environmental deficiencies at Hiram Davis that place individuals from the NF at CVTC at greater risk, such as shared bathrooms and sinks, and documented infection control deficiencies, and one shared shower-trolley bath per 18 patients. Sinks are also shared among multiple rooms, in noncompliance with CDC and Joint Commission guidelines.

35. While CVTC's NF is dual-certified by CMS for nursing and skilled nursing, it is and always has been a part of Central Virginia Training Center, funded by the General Assembly through the CVTC budgetary appropriation, and indicated as such in Commonwealth documents.

36. The residents at the NF at CVTC were the most severely disabled and most extremely fragile of all of the intellectually disabled persons being served in Training Centers in Virginia, and the six (6) compelled to move to outside facilities are or were the most severely disabled and fragile of all, as determined by a nurse.

37. The most severely medically disabled NF residents at CVTC were subjected to eviction, and placed at risk. Subsequently several have died and most, if not all, have been hospitalized repeatedly.

38. Of the six (6) CVTC NF patients who were evicted from CVTC in January 2017, three (3) were sent to HDMC without the consent of their Authorized Representatives (AR's). The families of those three (3) refused discharge from CVTC and chose continuing Training Center placement, in accordance with state and federal law, and the Ruling of this Court.

39. Of those three (3) forcibly transferred from CVTC to HDMC, one (1) died six (6) weeks later after repeated emergency hospitalizations and weeks in the ICU's of two (2) hospitals, having declined dramatically after spending just a few days at HDMC. One (1) nearly died and would have done so without the emergency intervention of his mother, an RN. Another of the six (6), an elderly patient whose family acceded to the Department's demands to move her to HDMC, died six (6) weeks later, after having lived safely and comfortably at CVTC for many decades. All three (3) of the evicted individuals have repeatedly been hospitalized or otherwise treated for infections contracted at HDMC.

40. For example, the elderly roommate of Peggy Wood passed away a mere three (3) weeks after being evicted from CVTC and transferred to the inferior HDMC. DBHDS Acting Commissioner Jack Barber was forewarned by Peggy Wood's physician brother on October 27, 2016 that death would result for that patient within weeks of transfer. Tyler Bryant's long-established regimen of drugs was not continued at HDMC, where his new doctor claimed not to believe in western medicine and said "the body should heal itself," and Tyler Bryant passed away after suffering terribly for weeks in the Intensive Care units of two (2) hospitals, where he acquired pressure sores and infections. These two (2) individuals were denied the superior quality of medical care that had been provided to them at CVTC and at Lynchburg hospitals that were familiar with their needs for many years. Taylor Bryant,

Tyler's twin brother who was also evicted from CVTC, nearly died at Hiram Davis while Tyler was hospitalized, and was saved only by his RN mother's emergency intervention. To this day Taylor's doctor incorrectly claims that Taylor does not have seizures – even when the doctor and several witnesses were in Taylor's room when he had a seizure. Seizures often go on documented in the medical record, despite being witnessed by HDMC staff.

41. Similarly, other individuals moved out of CVTC have not fared well at all. In fact, four (4) of the nine (9) individuals moved out of CVTC since last summer have died. This is a nearly 50% mortality on a short timeframe, with several deaths within weeks of transfer.

42. The reduction in the former CVTC NF residents' quality of care and safety has resulted or will likely result in harmful or disastrous outcomes for these severely medically disabled residents.

43. The Defendants have failed to replicate in other settings the high level and quality of specialized medical/nursing care that is required to keep CVTC's NF residents safe and healthy.

44. Many of the patients being served at the Training Centers are twisted and contorted, and cannot even straighten out their limbs. Many of them have osteoporosis and are so fragile that they break bones very easily. The very few fractures at the Training Centers demonstrate how much expertise exists at the true Training Centers.

45. The best facilities with the best healthcare staff to care for many severely disabled individuals are the Training Centers. The highest level of medical care provided at any Training Center is at CVTC, which is necessary to meet the serious medical needs of those who reside or previously resided at CVTC.[3]

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[3] The unique high quality and extensive medical care provided at CVTC is evidenced by the opinions of the local physicians who provide care to the residents of CVTC. Eighty-seven (87) Lynchburg-area physicians have signed a "physicians' petition" to save CVTC, stating that the closing of the facility will endanger its residents.

46. Taylor and Tyler Bryant were transported from the NF at CVTC to Hiram Davis Medical Center in January of 2017.

47. Taylor and Tyler Bryant suffered from numerous disabling conditions in addition to profound intellectual disability, and they could neither speak nor walk. They required assistance to even roll over in bed.

48. They lived with tracheostomies and oxygen, among other necessary medical devices, and they required constant monitoring as they frequently needed airway suction treatments. Taylor and Tyler Bryant were offered only inappropriate or unattainable nursing facility placement alternatives with no oxygen or deep suction treatments, or offering only geriatric intermediate level of care.

49. Their susceptibility to threatening allergic reactions necessitated limited contact with others. Their CVTC attending physician had ordered that they never be left unattended throughout the day.

50. Taylor and Tyler Bryant were placed at substantial risk of harm by being transferred to HDMC.

51. HDMC has refused to continue the use of Zelmac with the Bryant brothers, a drug that has been used with CVTC physician-ordered “special IDE access” for approximately ten (10) years with significant success. The Bryants had an FDA special access protocol for Zelmac, which drug was not available at other pharmacies or facilities. Tyler Bryant was abruptly withdrawn from Zelmac on January 27, 2017.

52. The primary care physician at CVTC has determined that the benefits of Zelmac outweigh any risks, but Hiram Davis discontinued its use despite the probable negative consequences. Taylor and Tyler Bryant had been prescribed Zelmac by the primary care physician at CVTC and had used it successfully for years.

53. HDMC has stopped or discussed stopping other drugs that are being used by the Bryant sons which will or would have put them at significant additional risk. Multiple drugs were terminated or reduced by 50 to 75% with adverse effects of poor allergen control, increased respiratory secretions, and even a visit to the emergency room by Taylor Bryant. Taylor Bryant also mistakenly received inappropriate sedating drugs for cerebral palsy spasticity at HDMC.

54. Taylor and Tyler Bryant needed to start all over with new specialists at HDMC who were not familiar with the complex needs of these individuals, thereby placing them at great risk of harm.

55. Their complex treatment protocols were devised by teams of highly qualified specialists years ago, and altering their treatments has been or will be disastrous.

56. In January 2017, Taylor Bryant had CVTC physician-ordered activity restrictions due to acute Mononucleosis, but he was moved during his period of recovery upon order of Jack Barber, which placed him at great risk. The transfer order was halted once by the CVTC physician, but subsequently, the hostile nurse manager wrote into Taylor's record, "transfer not to be stopped by anyone other than Jack Barber, M.D." Jack Barber is a psychiatrist without certification in internal medicine, which internal medicine expertise is a requisite to making decisions of high complexity such as those related to these patients. Taylor has hydrocephalus, epilepsy and a history of status seizures among his many disabling conditions.

57. Tyler Bryant was extremely fragile with respiratory problems, severe asthma and multiple chemical allergies, and he should not have be moved to a new facility with a high risk of aggravating these problems.

58. Both Taylor and Tyler Bryant were on contact isolation, and should be not have been moved to a new environment where they were subjected to exposure to others. Peggy Wood was known to have Clostridium Difficile bacteria in her stool, and was on C Diff

contact precautions upon admission to other hospitals because of this, but was admitted Hiram Davis without contact precautions, despite this blatant risk to others. Had this bacteria in stool been addressed at the time of transfer, Peggy Wood may not have contracted toxic megacolon and pseudomembranous colitis in April 2016 while at Hiram Davis.

59. Taylor and Tyler had their own room with a sink and their own private bath at the NF at CVTC, but at HDMC they had to share living accomodations which placed them at great risk. For example, at HDMC there is no sink or bathroom in the room where they were forced to reside.[4] Instead they had to use the facilities in the room across the hall from their designated room, a large room for seventeen, with several shared sinks and a shared bathroom, with a shower trolley bath shared among 18 patients. Using such a facility did and will put these vulnerable individuals at immediate and regular risk of infections.

60. When Taylor or Tyler Bryant are infected, they must be hospitalized, which greatly increases their risk of further infection. In fact, this type of nosocomial infection and hospitalization actually occurred to Tyler Bryant.

61. Shortly after his move to Hiram Davis, Tyler Bryant became seriously infected and required the administration of antibiotics. Tyler Bryant experienced many avoidable complications such as wound infection, pressure ulcers, urinary tract infections, inadequate pain care, pneumonia, asthma, allergic reactions, and verbal abuse. He suffered two large skin breakdowns on his right hip. He was in critical condition for many days and was receiving oxygen. He remained in intensive care for weeks at Southside Regional Medical Center, where Tyler's mother was told by a nurse that the care he received "would not be what he had

[4] ADA regulations require such amenities in each room to prevent the spread of infection. Unfortunately for the residents being transferred there who need this greater level of protection, Hiram Davis has avoided these requirements by being grandfathered in. As a result, Hiram Davis is not compliant with the regulations, but the NF at CVTC was fully compliant with all ADA regulations.

before." Tyler was also treated in the Intensive Care Unit at Chippenham Hospital, and was notified of his eviction from HDMC during his stay at Chippenham Hospital.[5]

62. Moving Taylor and Tyler Bryant to Hiram Davis has resulted in harm to Taylor and in death to Tyler, with Taylor remaining in peril of further decline or death as long as he remains at Hiram Davis.

63. At least one medical doctor, who provides treatment at CVTC, has opined that this death was predictable when you "take them out of a place where they've been stable and monitored and well cared for." Peggy Wood's physician brother also forewarned DBHDS and the General Assembly Joint Committee of the deaths due to the decisions by DBHDS leadership at an October 2016 General Assembly subcommittee meeting at SWVTC.

64. Taylor Bryant has recently been given antipsychotic medication in error. He has also recently been transferred to a hospital for acute respiratory failure. He had received inappropriate doses of Ativan and Diastat which greatly increased his risk of respiratory depression. Taylor has contracted pneumonia while at Hiram Davis. Taylor has had seven (7) of his drugs reduced at Hiram Davis and is in decline. He has had multiple episodes of abdominal distention that requires enemas and rectal tubes, which problems are due to the decision of Hiram Davis staff to withhold his long-established prescription drug Zelmac that prevented these conditions. Taylor was recently denied a request for a neurology consult by his new primary care physician. Taylor was abruptly stopped from being seen by MCV

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[5] Tyler Bryant was forced from his home in a Training Center, and was transferred to Hiram Davis, which is not a Training Center. Because Hiram Davis later refused to allow his return, he essentially had nowhere to go. Tyler was threatened with discharge with no place to go. In fact, nursing facilities suggested by DBHDS to care for him have declined to admit him, so he was forced to spend his last days at the ICU at Chippenham Hospital. The NF at CVTC was the only adequate treatment environment that was suitable and available for Tyler Bryant. Similar actions are being taken regarding other individuals and there will be no safety net at all for persons being transferred from the Training Centers. With the Disability Law Center of Virginia recently advocating for a woman who was evicted from SEVTC due to her challenging behaviors, the Commonwealth has also planned to remove the only safety net facility in the state for those with such behaviors by its choice of SEVTC as the only Training Center to remain open. CVTC is the last remaining Training Center to accept all such medically or behaviorally complex individuals for regular admission, and regular admissions do continue for complex cases.

neurology in March 2015 by the directive of the hostile CVTC nurse manager who did not allow out-of-town consults. Taylor has had multiple medication reductions without any input from neurology consultants. The new physician for Taylor stated that she does not have a DEA license to give certain medications. Taylor's CVTC doctor ordered that he be continually kept within "line of sight" by nurses because of the potential for sudden and rapid decline due to his severe disabilities.

65. Unfortunately and sadly, the fate of Taylor Bryant may soon be the same as that of his brother, Tyler, because Taylor's former high quality of medical care has been seriously reduced at HDMC.

66. The medical records of Peggy Wood were erroneous, altered, or falsified in 2015-2016 to reduce documentation of the number of medical events requiring medical interventions, which made her more attractive on paper for lesser care nursing homes. The discharge documents for Peggy Wood contained errors and were the subject of OSIG, DOJ, and DBHDS investigations, which resulted in some complete changes in practice.

67. Peggy is unable to speak or walk, and is unable to even roll over in bed, has frequent aspirations, bronchiectasis, COPD, constipation, osteoporosis, seizures, stomach tube, brocontractures, neurogenic bladder, C diff colitis, and pilonidal duct with tendency to skin breakdown. Multiple illness exacerbations and several hospitalizations have occurred since January 30, 2017: two for pneumonia, one for suspected perforated bowel, two for depression of blood platelets and drop in oxygen levels, and a few treatments for continuing urinary tract infections.

68. She is dependent upon close monitoring, feeding, and frequent repositioning in upright position to avoid reflux aspiration by nurses because she is extremely prone to aspiration, distention, pressure sores, and contracting infections. Such infections result in hospitalizations, putting her at risk for further infections.

69. Peggy Wood was transferred in January of 2017 against her family's will, and over the objections of her authorized representative, from the NF at CVTC to HDMC.

70. Peggy Wood was transferred despite an inadequate Notice of Discharge, without proper orientation of her Authorized Representative to her discharge and transfer, without proper direction by her physician, upon the order of a psychiatrist not certified in internal medicine, and without appropriate due process.

71. Peggy Wood aspirated only 23 hours after arriving at Hiram Davis and contracted pneumonia the very first week at Hiram Davis. The second week at Hiram Davis she was sent to the Emergency Room at Southside Virginia Hospital. The third week at Hiram Davis she contracted a urinary tract infection, and has had other incidents of urinary tract infections, pneumonia, aspiration, bowel blockage, toxic megacolon, thrombocytopenic purpura, and early skin breakdown at HDMC since that time.

72. Peggy Wood did not receive a full bath from January 31, 2017, to April 13, 2017. She has received hospitalizations for C Diff colitis and for urinary tract infections while at Hiram Davis.

73. Peggy Wood has deteriorated during her first several months at Hiram Davis since arriving on January 30, 2017. Ms. Wood has seemed at times to be in imminent danger of further harm and death including when hospitalized for suspected perforation of bowel, toxic megacolon, pneumonia, urinary tract infections, thrombocytopenia, early skin breakdown, and an over a month-long prolonged pelvic rash near the area at risk of pressure sores, due to infrequent diaper changes and no shower trolley baths documented for several months at Hiram Davis.

74. There is imminent risk of immediate harm to the Intervenors if an injunction is not granted.

75. One (1) resident who was recently discharged from the NF at CVTC survived only three (3) weeks at Hiram Davis.

76. If the medical condition of this discharged individual had been unstable at the time she was scheduled to move, the move would have been delayed until she had been stabilized, as has long been the practice at CVTC. Transfer order should be made by physicians with expertise and certification in internal medicine, family practice, intensive care specialties, and not psychiatry.

77. If this recently discharged individual had been near death, she would not have been moved at all. This was an individual who needed early morning suction treatments due to airway secretions, and at HDMC such treatments are provided only by a respiratory therapist who comes on duty at 9:00 a.m. on weekdays only. Although a part-time respiratory therapist was hired in April 2017, staff are still being trained in respiratory equipment. The situation is far inferior to the respiratory therapy that was available at CVTC. The individual's demise was utterly predictable under such circumstances.

78. If emergency relief is not granted, the sickest and most fragile patients at CVTC with complex medical needs, along with those who have thus far survived their eviction from CVTC, will suffer irreparable harm, possibly death.

79. The decertification of nursing/skilled nursing beds and canceling of nursing/skilled nursing facility services at CVTC with planned noncompliance with federal ICF/IID regulations that require a continuation of 24 hour nursing care for those who choose to remain at CVTC and require that level of care, will result in irreparable harm and possible or even probable deaths.

80. The transfer of patients from the superior rated 5-star NF at CVTC to the reduced care at 2-star HDMC will result in irreparable harm to the residents, as indeed it already has.

81. Other Intervenors are at risk of forced transfer to HDMC or other state operated facilities which are not training centers, and which offer an inferior level and quality of care which will predictably result in great physical or psychological harm and even death.

82. For example, Southwestern Virginia Training Center (SWVTC) has many intellectually disabled individuals who also have mental illness and/or autism and are behaviorally complex. If the Commonwealth is allowed to continue forced transfers of the intellectually disabled persons from Training Centers to non training center facilities, despite their choice to remain in a Training Center, by merely and inappropriately calling all state facilities "training centers," then all of the residents of SWVTC are at grave risk of transfer and potentially severe harm.

83. The Intervenors have been, are being, or are at further risk of being transferred to facilities that are not Training Centers in defiance of their clearly and repeatedly stated choice to remain in a Training Center.

84. Other Intervenors have been transferred to other Training Centers, nursing facilities or community facilities without honest legal certification that their quality of care and level of services and safety will be comparable to that provided at their former training center, a requirement of Virginia law unless comparability is waived by the AR.

85.The Intervenors have been and are at further risk of being transferred to a different Training Center or to a non training center state facility, without any adequate and accurate certification that the quality of care provided there is comparable to what they received at their former training center.

Coerced Transfer of Residents Out of Training Centers

86. Section 37.2-837(A)(3) of the Virginia Code states:

> Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no individual at a training center who is enrolled in Medicaid shall be discharged if the individual or his

> legally authorized representative on his behalf chooses to continue receiving services in a training center.

87. This Section does not distinguish between individuals generally in a Training Center or individuals in the skilled nursing section of a Training Center, and therefore is applicable to both.

88. The forced transfer of individuals out of the NF at CVTC to Hiram Davis, which is not a training center, violates this Statute.[6]

89. This Court referred to this Section as the "bedrock assurance" that no one will be evicted from a training center. As stated by the Court:

> Nothing in the decree compels Virginia to close any facility. Decisions of that sort lie in the hands of the Virginia General Assembly. If it deems it wise, the General Assembly can appropriate funds to continue to operate some or all of the Training Centers, even while funding the Medicaid waivers. The Court recognizes that the Virginia Department of Behavioral Health and Developmental Services is trying to move away from the care model with Training Centers, but the ultimate decision whether to close any Training Center lies not with the Department but with the legislature. Moreover… Virginia Code Section 37.2-837(A)(3) provides that no one may be forced to leave a Training Center against his/her her will…. The statute serves as bedrock assurance that no one will be evicted from a Training Center.

90. Contrary to this "bedrock assurance," the Commonwealth has apparently taken the position that they are free to move individuals from CVTC or from any Training Center to any DBHDS facility, which they can then call a "training center," by virtue of its now having intellectually disabled occupants.

91. The Defendants have tried to circumvent this Section by misrepresenting information, by harassment, and by coercion.

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[6] The Commonwealth seeks to justify the transfers to Hiram Davis by citing Section 37.2-100 of the Virginia Code. However, that same Section provides definitions of "abuse" and "neglect," which are problematic to the Commonwealth's actions. "Abuse" is defined as "any act by an employee or other person responsible for the care of an individual . . .that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death." "Neglect" is defined as the "failure by an individual or a program or facility . . . responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment." The actions of the Commonwealth in allowing or promoting the decline and death of individuals is abuse and neglect, under the same statute's definition section.

92. The Defendants have sought to obtain a waiver of the rights protected by this Section through deception and intimidation.

93. Under Virginia law, "consent" is the "voluntary agreement of an individual or that individual's authorized representative to specific services," and consent "must be given freely and without undue inducement, any element of force, fraud, deceit, or duress, or any form of constraint or coercion." (VAC Section 35 – 105 – 115.) Individuals who have been misled, unduly pressured or coerced have not legally consented to discharge from the Training Centers.

94. The Commonwealth violates its own regulatory definition of consent when it denies training center residents, or their authorized representatives on their behalf, free choice in placement settings, but instead badgers them to choose community settings, even as frequently as several times a day, as has been reported by many training center families. One mother even reported that she had received harassing phone calls by DBHDS community integration managers and social workers as often as ten (10) times in one week. Threats of legal actions, Adult Protective Services involvement, false claims of equality of all services and access to all services in the community compared with those provided at a Training Center, deception, manipulation, coercion and duress, do not comply with the federal and state right to freely choose to continue receiving services at a Training Center.

95. Many Intervenors never consented, as consent is defined by the Commonwealth in regulations, to the move to a "community" setting or to HDMC. The alleged consent of some of the authorized representatives to these moves, including Hiram Davis treatment consent forms that were executed by some of these authorized representatives upon eviction from CVTC, was not a voluntary agreement.

96. The Commonwealth has attempted to accomplish indirectly and deceptively what is prohibited by this Statute.

Failure to Certify Comparable Quality of Services Before Transfer

97. The General Assembly of Virginia has further dictated in Chapter 639 of the 2014 Acts of Assembly:

> That the Department of Behavioral Health and Developmental Services shall, before transferring any training center resident to another training center or to community-based care, provide written certification to such training center resident or his legally authorized representative that (i) the receiving training center or community-based option provides a quality of care that is comparable to that provided in the resident's current training center regarding medical, health, developmental and behavioral care and safety and (ii) all permissible placement options available under the Commonwealth's August 23, 2012, settlement agreement with the U.S. Department of Justice, including the option to remain in a training center, have been disclosed to the training center resident or his legally authorized representative.

98. Such quality of care and safety comparability certifications have not been provided for the residents who were forcibly moved from the Training Centers to HDMC. The name of the receiving facility was left blank in the final certifying sentence of the form that the Commonwealth devised to certify comparability of quality of care and safety, and therefore the "certification" was defective and inadequate. The absence of the name of the receiving facility in the final sentence of these forms has frequently occurred and has continued despite being pointed out to DBHDS staff in January 2017.

99. The residents are entitled to receive comparable quality of care and safety to that provided at the Training Center of origin, regardless of where they are transferred.

100. The decertification of skilled nursing beds at CVTC and the forced transfer of residents out of the NF to HDMC violates this comparability act by the General Assembly. None of the CVTC nursing facility residents were informed by DBHDS of their right to appeal the Department's decision, thus they were denied their federal right to due process, as affirmed by DMAS in the paperwork of the two individuals who were independently aware of this right and applied for an appeal. The DMAS hearing officer did not enforce the Code of

Virginia, the comparability act of 2014, or the Federal Regulations despite being cited to the relevant statutes and regulations in briefs that were filed.

101. Since the quality of care at HDMC is inferior to the quality of care at the NF at CVTC, the Commonwealth is in violation of this act, and the Virginia Code, by conducting coerced transfers to HDMC.

102. HDMC has high staffing turnover rates, incompetent risk management with documented lack of introspection, deaths from avoidable issues, and a lower overall CMS rating of two (2) stars. CVTC had an overall rating of five (5) stars, which it has maintained for many years. Furthermore, the federal government has penalized Hiram Davis each year from 2015 to 2017 for being in the lowest quartile of hospitals nationwide for safety and infection control.

103. By forcing invidividuals to move from the NF at CVTC into other DBHDS facilities without the required certification of comparable quality of care and safety, the Commonwealth has violated Chapter 639 of the 2014 Acts of Assembly.

104. The forcing of residents of any Training Centers to Hiram Davis, or other state psychiatric facility, without the required certification of comparable quality of care and safety, is a violation of this Act.

105. These transfers to other state facilities cannot be legally certified as providing comparable services, because the quality of care is less than comparable.

106. For example, as to transfers that could not be certified as providing comparable services, many individuals have been transferred from CVTC to Southeastern Virginia Training Center (hereinafter referred to as "SEVTC"). SEVTC is the only Training Center that the Commonwealth currently plans to keep open after all other Training Centers are closed. SEVTC has only one (1) physician who works for a few days a week, whereas CVTC had three (3) full-time and three (3) part-time physicians, with an internal medicine physician

physically on-site at all times. CVTC was the only Training Center that provided a certified nursing facility, and its superior quality far exceeded the Department's only other nursing facility, which, unlike the NF at CVTC, is not ADA compliant. Furthermore, CVTC has never evicted anyone for behavioral challenges whereas SEVTC has engaged in such evictions. SEVTC does not provide comparable quality of medical, health, behavioral, and developmental care as exist at CVTC, and therefore transfers to SEVTC from CVTC cannot truthfully be certified as providing comparable quality of care and safety.

107. The Commonwealth seeks to avoid the purpose and intent of the comparability of care act by decertifying skilled nursing beds at the NF at CVTC and then transferring individuals to regular ICF/IID beds at CVTC, thereby achieving the false appearance of comparability of medical care between CVTC and the other Training Centers.

108. These individuals are not receiving comparable services when they are transferred to general ICFD/IID living areas at CVTC unless they are then provided 24-hour long term nursing services as required under federal ICF regulations [42 CFR 483.460(a)(1) and (a)(2)]. However, the quality of nursing care at the ICF section of CVTC is still superior to private nursing homes and to HDMC.

109. The Defendants should not be allowed to circumvent the clear meaning and goal of the General Assembly by disingenuously claiming that these individuals no longer need nursing facility level of care.

110. The Commonwealth has offered only alternative placements that will allow them to discontinue the NF section of CVTC, including inappropriate and unavailable placements, without consideration of the real needs of these individuals and without legally certifying a comparable quality of care and safety.

111. The forced discharge letters do not even include Training Center placement as an option.

112. Martha Bryant was harassed with repeated telephone calls at her school workplace to force her to accept a transfer of her twin sons out of CVTC.

113. Wriley Wood was threatened by DBHDS that they would report him to Adult Protective Services in December 2016 at a DPDR meeting in order to force his acceptance of the transfer of his daughter.

114. The Defendants have further tried to avoid this Statute by altering medical records and discharge documents to make it appear that residents are higher functioning than they really are, and to then falsely claim that these residents can be accommodated at locations with inferior nursing, medical, and multidisciplinary services.

115. The Discharge Planning and Discussion Record ("DPDR") for the evicted contains misleading information that falsely implies that individuals need less acuity in care than is actually true.

116. Medical events that demonstrate the significant medical needs of the population at the NF at CVTC are instead obfuscated and euphemistically mislabeled as "facility or institutional incident reports/risk management events/occurrence reporting system events," to minimize or diminish their medical significance.

117. DBHDS "Institutional risk events" include "hospitalizations/ falls/ aspiration events," to lessen their importance, and is the subject of multiple OSIG and DBHDS reports.

118. These mischaracterizations made individuals falsely appear as being in less need of training center intensive nursing care and more suitable for outside nursing home placement, even if no such nursing home capable of managing the medical complexity exists.

119. Even when the Commonwealth has certified that comparable quality of care is available in the community or at another Training Center, that certification is inaccurate and the quality of available medical, health, behavioral and developmental care and safety does not compare favorably to CVTC.

120. Some certifications of comparable quality of care have not even named the facility where the individuals are to be transferred, and therefore cannot be considered proper certifications of comparable quality of care.

121. In some cases, families of the residents at Training Centers who were forcibly transferred to HDMC have been inappropriately told that they are not entitled to a certification of comparable quality of care and safety because they did not choose the placement at HDMC. Clearly, the law does not require that the family choose the placement in order to receive the mandated certification of comparable quality of care and safety.

122. The options offered to the residents of the NF at CVTC did not provide the same level and quality of medical services as were available at the NF at CVTC.

123. All legally permissible placement options have not been disclosed to the residents or their authorized representatives.

Injunctive Relief

124. As evidenced by the statements above, the Intervenors are likely to prevail on the issues. The statutory language is clear and the Commonwealth has undoubtedly not complied with that statutory language.

125. The Intervenors will suffer irreparable harm if they are forcibly and involuntarily moved to inferior settings such as HDMC, or remain at HDMC after forced removal from CVTC, or moved to other training center locations without comparable quality of care and safety, or to forced placements in the "community." This irreparable harm could be more than serious physical injury and extreme psychological damage, as it could also be death, which untimely and unfortunate mortality of members of the Intervenor class has already occurred.

126. Granting emergency relief or a preliminary injunction at this time, will ensure that the endangered individuals will remain in their current Training Center, will be

transferred back the Training Center where they had superior quality of care, or will be transferred from HDMC to an appropriate Training Center setting that reestablishes comparable quality of care and safety to that which existed at the former NF at CVTC or at their original Training Center. The Commonwealth should identify and provide only alternative care settings that comply with the state and federal statutes and regulations. Denying injunctive relief will allow great harm that could result in very serious injury or death to the Intervenors, as has already occurred to some individuals.

Relief

WHEREFORE, the Intervenors request that the Commonealth be found in violation of VAC 35-105-115, and that the Commonwealth be directed to cease badgering the CVTC families and to instead respect their legal choice to continue receiving services in a Training Center by simply inquiring annually if they would like to consider other placements, as required by the Settlement Agreement entered into by the original parties.

WHEREFORE, the Intervenors respectfully request that this Court find the Commonwealth in violation of §37.2-837 of the Code of Virginia, 1950, as amended, and that Commonwealth be enjoined from forcibly transferring any further individuals out of any Training Centers; that this Court find Defendants in violation of Chapter 639 of the 2014 Acts of Assembly, and that they be enjoined from moving any other individuals from any Training Centers until there is accurate certification that comparable quality of care and safety exists at the proposed placement location, unless the AR legally waives such certification, and that all permissible placement options available have been disclosed to the residents being considered for transfer including the choice to remain in a Training Center; and that the Commonwealth be directed to transfer all Intervenors who were forcibly relocated to HDMC to a Training Center that provides comparable quality of care and services to that previously provided by the NF at CVTC; that the Commonwealth be directed

to provide truly comparable quality of care and services at CVTC to those class members previously moved there from the NF at CVTC; that the Commonwealth be directed to return Intervenors who have been moved from one Training Center to another Training Center without truthful and accurate certifications of comparable quality of care and safety and notice of all legally permissible placements; that the Commonwealth be directed to return all Intervenors to their previous Training Centers who were moved under duress or fraud involuntarily to other settings; and that this Court enter an order making the aforementioned injunctive relief permanent; and that this Court grant any other relief as this Court deems just and proper.

Respectfully submitted,

Dated: August 3, 2017

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CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of August, 2017, I forwarded by email a copy of Intervenors' Motion for Injunctive Relief to the following:

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