

Mailing Address  
P.O. Box 6133  
Williamsburg VA 23188



Office Location  
325 McLaws Cr. Suite 2  
Williamsburg VA 23185

Courtesy of:  
Peter Mellette, Esq.  
peter@mellettepc.com

## **Client Advisory**

### **VOPA DOPE: Responding to an Investigation by the Virginia Office for Protection and Advocacy**

The Virginia Office for Protection and Advocacy (VOPA) has state and federal mandates to investigate allegations of resident abuse and neglect that go beyond the familiar investigative powers of the Virginia Department of Social Services' Adult Protective Services Unit. VOPA may become involved with a nursing facility or assisted living provider when informing individual residents or their legal representatives of their rights, when investigating allegations of abuse or neglect, or while pursuing legal remedies on behalf of residents. In each of these instances, VOPA may request access to facilities, individuals (residents, representatives, and staff), and documents (medical records, facility reports). The following analysis will offer some suggested responses when VOPA knocks at your door. The following offers general legal information that may or may not apply to the specific facts faced by a particular facility. It should not be relied upon as legal advice, and in any instance of doubt or confrontation with VOPA, a provider should contact its attorney.

- **Authority**

VOPA's mission to serve the disabled is quite far-reaching. VOPA is funded by the Virginians with Disabilities Act Program. VOPA also receives funding from several federal programs: the Developmental Disabilities Program, Protection and Advocacy for Individuals with Mental Illness Program, Client Assistance Program, Assistive Technology Program, Protection and Advocacy of Individual Rights Program, Protection and Advocacy for Beneficiaries of Social Security Program, Traumatic Brain Injury Program, and Help America Vote Program.

VOPA asserts an interest on behalf of most institutionalized individuals as well as disabled individuals residing in rehabilitation centers or in the community. VOPA's advocacy focuses on human rights such as dignity, individual autonomy, and quality of life, as well as disability accommodations under the Americans with Disabilities Act (ADA). VOPA also seeks to win or enforce existing patient bills of rights addressing appropriate treatment, accessibility, and anti-discrimination. VOPA does not advocate on behalf of the disabled in such matters as criminal law or immigration. VOPA is charged with investigating violations of state and federal law which gives it authority over public and private entities, including facilities, providers, and programs.

- **Posting and Monitoring**

Virginia law requires that mental retardation, substance abuse, rehabilitation,

assisted living, long-term care, and juvenile residential facilities post a conspicuous description of VOPA's services and its contact information. Residents must be able to freely contact VOPA and both invite and receive VOPA staff at the facility. VOPA may also arrange to visit institutions to spread awareness of its services and educate residents on their rights. In addition to resident or representative initiated contact, the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services must provide the VOPA Director with copies of Critical Incident Reports (CIR) within fifteen days of critical incidents or deaths at residential facilities. VOPA can also receive referrals from ombudsmen and state agencies including the Departments of Aging, Deaf and Hard-of-Hearing, Education, Health, Housing and Community Development, Mental Health, Mental Retardation and Substance Abuse Services, Rehabilitation Services, Social Services, and the Blind and Vision Impaired.

- **Investigation**

VOPA's monitoring and intake functions may trigger its investigatory function and review of records. In addition to relying upon the written consent of the resident his legal representative, VOPA may access facility records where: (1) a resident "by reason of his mental or physical condition" is unable to grant consent, (2) a resident does not have a guardian or the state or its agent serves as guardian, and (3) VOPA has received a complaint concerning the resident or "there is probable cause to believe that such person has been subjected to abuse or neglect." VOPA must generally seek consent from patients or representatives to investigate and will seek representatives' contact information from facilities. With a finding of probable cause, VOPA may disregard a representative's failure to respond or refusal to grant consent.

VOPA is the sole arbiter of probable cause necessary to trigger an investigation. This is a low threshold which is discretionary and which VOPA takes the position is largely unreviewable. Initial investigation of a single incident or individual may also indicate probable cause to allege and investigate systematic or widespread abuse and neglect of residents of a facility at large or a certain class of individuals. Additionally, a decision by a sister state agency such as the Department of Health to cease an investigation of a suspicious incident or death does not automatically curtail VOPA's independent determination of probable cause or its right of access.

After making a probable cause determination, VOPA may seek access to residents, guardian contact information, staff, records, and perhaps even peer review reports. A facility may request that VOPA document the source of its authority to investigate and state its finding of probable cause, but with few exceptions a facility must permit access. The scope of investigation is broad but not unlimited. VOPA is not barred from access by privacy laws because it maintains confidentiality, but a demand for access to a list of all residents and all guardian contact information may be unreasonable given the scope of a particular investigation. Rather than challenging VOPA based on privacy concerns, a facility may have a better, but still unlikely, chance of demonstrating potential harm to residents because of disruption. Some reasonable, time, place, and manner restrictions to access are permissible in an ongoing, operating facility.

- **Litigation and Post-Litigation or Settlement Oversight**

If VOPA cannot resolve a complaint within a reasonable amount of time and sees no administrative remedy, it may initiate litigation. Virginia law would suggest that VOPA must exhaust all administrative remedies first, but the exigencies of injunctive relief by a state agency (VOPA) may affect a court's assessment. Possible causes of action include VOPA pursuing its right of access to a facility on its own behalf or VOPA assuming associational standing to pursue injunctive relief for an individual resident or class. VOPA may not, however, bring a class action seeking punitive damages. After the filing of a legal complaint, it appears that VOPA is subject to the same discovery rules afforded any plaintiff as opposed to its broad, statutorily granted, investigatory capacity. A settlement or verdict in VOPA's favor is likely to result in ongoing oversight of a facility and possibly an award of attorney's fees.

The following provides some examples and results of recent legal action by VOPA (further information on VOPA investigations, litigation, and goals can be found at <http://www.vopa.state.va.us/index.htm>. The annual goals may be of special interest to providers because they spell out planned areas, topics, and even types of facilities for future investigation by VOPA.):

- **Settlements and litigation with state agencies concerning accessibility.** VOPA reached a settlement with the Department of Rehabilitative Services to provide transportation to children, regardless of age, from school to extracurricular activities. VOPA also reached similar agreements with the Departments of Education and Blind and Hearing Impaired. VOPA unsuccessfully sought to enforce a settlement agreement with the Richmond City School Board (to retrofit schools constructed before 1992, before the ADA took effect, with handicapped accessibility) by suing the City of Richmond for failure to adequately fund the project. The court of appeals reversed summary judgment in favor of VOPA and granted summary judgment in favor of the city because the city had not denied a benefit or engaged in discrimination.
- **Injunction and settlement gaining access to state agency's records.** VOPA sued the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services for identification and contact information of all individuals deemed "ready for discharge" that had not been discharged within thirty days of such a recommendation by treatment staff. VOPA asserted that receipt of complaints authorized it to investigate discharge plans. VOPA won a preliminary injunction granting access, and the parties subsequently agreed to a consent order resulting in the disclosure of the requested information for a specified time period.
- **Consent agreement with private assisted living facility to address suspicious death and other concerns.** After the Department of Social Services failed to revoke an assisted living facility's licensure following significant allegations of resident neglect, VOPA filed its own complaint seeking preliminary and

permanent injunctive relief on grounds of alleged physical abuse of residents, theft and diversion of medications, and neglect of a patient's post-hospitalization treatment which allegedly resulted in death. VOPA sought implementation of medication recordkeeping and inventory practices as well as dismissal and permanent exclusion from the facility of a specific employee. In lieu of further litigation, the parties reached a consent agreement providing for additional staff training, prescreening of prospective residents, CIR reporting, and unrestricted access of VOPA. The facility was also required to pay for the temporary addition of a registered nurse and pharmacist to oversee and review the dispensing of medication, and a third party healthcare professional was retained to provide oversight of the entire facility.

- **Non-suit against private nursing facility following suspicious death.** After the Centers for Medicare and Medicaid failed to terminate a nursing facility's provider agreement, VOPA filed a complaint seeking preliminary and permanent injunctive relief on grounds of alleged neglect of certain patients' medical treatment, including a patient who died because of alleged improper monitoring of respiratory care. VOPA sought an injunction directing written certification to VOPA of the competency of nursing staff, implementation of facility by an independent third party for three years at defendant's cost. VOPA had sought similar goals in a settlement proposal which the facility rejected as both duplicative of the Virginia Department of Health survey process and costly. VOPA's lawsuit survived a motion to dismiss but VOPA failed in its attempt to compel discovery of the identity of current residents and guardians because it had not received any complaints concerning residents during the current year. VOPA non-suited the case, perhaps because of its inability to demonstrate an ongoing threat of or actual ongoing abuse and neglect.

The moral of the story is clear: VOPA can present an additional source of investigation and oversight of facilities facing allegations of resident abuse and neglect. Nursing facilities should take VOPA investigations seriously and involve facility counsel early on in any response. For more information, please contact Peter Mellette or Harrison Gibbs at (877) MELLETTE – or (877) 635-5388.

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