BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

PEACHTREE ESTATES ASSISTED LIVING FACILITY, Petitioner,	)	Docket No.: OSAH-DCH-HFR-PCH-1233167-158-Brown
v.	)	
DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATION DIVISION, Respondent.	)	

INITIAL DECISION

I. INTRODUCTION

Petitioner Peachtree Estates Assisted Living Facility (also referred to as "Petitioner," "Petitioner facility," and "facility") appealed the Department of Community Health, Healthcare Facility Regulation Division's (also referred to as" Respondent") Notice of Intent to Revoke Permit. The Hearing was held at the Office of State Administrative Hearings on July 24, 2012 (Day 1), July 31, 2012 (Day 2), August 27, 2012 (Day 3), August 28, 2012 (Day 4), November 13, 2012 (Day 5), November 27, 2012 (Day 6), December 10, 2012 (Day 7), December 11, 2012 (Day 8), and December 12, 2012 (Day 9).[1] Peachtree Estates Assisted Living Facility was represented by Robert C. Threlkeld, Esq. and Seslee Mattson, Esq. The Respondent, Department of Community Health, was represented by Stacey Hillock, Esq., Vikram Mohan, Esq., and Shariyf Muhammad, Esq.

[1] The record was held open until February 1, 2013, to allow the parties to submit proposed findings of fact and conclusions of law. An Order allowing the ALJ an additional 45 days to issue the Initial Decision was issued March 6, 2013.

Ms. Teresa Coder was the Resident Director at Peachtree Estates Assisted Living Facility during the time of the February 17, 2012 Survey. She is referred to as "Ms. Coder," or as the "Resident Director."

The Respondent's Surveyor was Ms. Catherine Mullican, who made the monitoring visits, conducted the inspection and investigation, as well as prepared the Survey Report that became the basis for the Respondent's decision to issue a Notice of Intent to Revoke. She is hereinafter referred to as "Ms. Mullican," or the "Surveyor."[2]

II. FINDINGS OF FACT

1.

Peachtree Estates (Petitioner) is a licensed personal care home located in Dalton, Georgia, with a capacity to provide for 75 residents. Its parent corporation is Assisted Living Concepts, Inc. (ALC). (Taylor, Day 6 Tr. 143.) Petitioner is the largest personal care home based on total capacity in Whitfield County. (Taylor, Day 6 Tr. 144.) At the time of the February 17, 2012 survey (hereinafter referred to as the "Survey"), Petitioner facility housed 48 residents, but by the time of the hearing, Petitioner facility housed only 25 residents. (Cook, Day 8 Tr. 127.)

2.

The Respondent establishes the rules and regulations that govern licensed facilities, such as personal care homes, in order to ensure the health and safety of the residents. Typically, personal care homes serve an elderly population, who may be frail, in failing health, or have dementia or other cognitive diseases or illnesses. (Mullican, Day 1 Tr. 35 and Wright, Day 8 Tr. 119.) As part of its responsibility, Respondent conducts surveys, and/or inspections, based on complaints or

[2] Transcript cites are designated as follows: name of witness, Day number, and Transcript (Tr.) page number.

annual reviews, to determine whether facilities are complying with the Respondent's rules and regulations. (Mullican, Day 1 Tr. 34.)

3.

Prior to the subject Survey, on December 20, 2011, Surveyor Catherine Mullican completed a follow-up and complaint investigation survey at Petitioner facility, and cited no rule violations as a result. (Mullican, Day 6 Tr. 10; Petitioner's Ex. 32.) Thereafter, on January 24, 2012, Respondent initiated an investigation of complaints and a facility-reported fall incident at the Petitioner facility. The Surveyor, Catherine Mullican, made five visits on January 25, January 31, February 2, February 8, and February 9, 2012, and completed the survey report on February 17, 2012. (Respondent's Ex. C.)

4.

The complaints involved such issues as failure to provide protective care and watchful oversight, the cleanliness of the facility, meals, menus, inadequate staffing, resident falls, absence of activities for some residents, as well as concerns regarding furniture and fixtures. Based on her observations, review of facility records, and interviews with residents, residents' family members, and staff, Ms. Mullican concluded that Petitioner had violated twenty (20) Rules and Regulations for Personal Care Homes (Ga. Comp. R. & Reg. 111-8-62-01, et seq.(2010)), and one of the Rules and Regulations for Enforcement (Ga. Comp. R. & Reg. 111-8-25.01(2010)). (Respondent's Ex. C.) [3]

[3] The Rules and Regulations for Personal Care Homes and the Rules and Regulations for Enforcement will hereinafter individually and/or collectively be referred to as the "Rules." The ALJ notes that the Rules for Personal Care Homes were revised effective January 8, 2013. For purposes of this Initial Decision, all citations and references to the Personal Care Home Rules are to the Rules as effective March, 2010.

5.

The specific Rules' violations cited by Ms. Mullican, the Surveyor, in the February 17, 2012 Survey are as follows:

1. Rule 111-8-62-.09(3) Administration – requires that a personal care home assign duties to personnel consistent with their position, training, experience and section .10 of the Rules.
2. Rule 111-8-62-.09(4) Administration – requires that a personal care home create and rehearse a disaster preparedness plan.
3. Rule 111-8-62-.11(1)(a) Staffing – requires that the personal care home have as many employees on duty at all times to properly safeguard the health, safety, and welfare of the residents, with minimum ratios of one staff person to fifteen residents during waking hours and one staff person to twenty-five residents during non-waking hours.
4. Rule 111-8-62-.11(2)(f) Staffing – requires that the personal care home ensure sufficient staffing to give prompt, unhurried assistance to residents who require help eating.
5. Rule 111-8-62-.11(2)(g) Staffing – requires that the personal care home ensure sufficient staffing to give assistance, if needed, with daily hygiene, including baths and oral care.
6. Rule 111-8-62-.14(l) Physical Plant Health and Safety Standards – requires that each home complies with fire and safety rules for personal care homes promulgated by the Office of the Safety Fire Commissioner.
7. Rule 111-8-62-.15(1) Furnishings and Fixtures – requires that a personal care home maintain its furnishings in good condition, intact and functional.
8. Rule 111-8-62-.15(2) Furnishings and Fixtures – requires that a home's furnishings and housekeeping standards present a clean and orderly appearance.
9. Rule 111-8-62-.15(3)(c) Furnishings and Fixtures – requires that resident bedroom furnishings include a bureau, dresser, or equivalent, and one chair with arms.
10. Rule 111-8-62-.15(3)(e) Furnishings and Fixtures – requires that resident bedroom furnishings include a bed at least 3 feet wide and 6 feet long with comfortable springs and mattress.
11. Rule 111-8-62-.15(3)(f) Furnishings and Fixtures – requires that personal care homes maintain a linen supply for not less than twice its bed capacity.

12. Rule 111-8-62-.16(1)(e) Admission. Amended – prohibits personal care homes from providing nursing services to its residents.
13. Rule 111-8-62-.16(2) Admission. Amended – requires that a personal care home not admit or retain residents who need care beyond which the facility is permitted to provide.
14. Rule 111-8-62-.16(3)(d) Admission. Amended – requires, prior to admitting a resident, proof such resident has received screening for tuberculosis within twelve months of admission.
15. Rule 111-8-62-.18(1) Services – requires that each personal care home provide individual residents protective care and watchful oversight.
16. Rule 111-8-62-.18(3) Services – requires that each personal care home provide sufficient activities to promote the physical, mental and social well-being of the resident.
17. Rule 111-8-62-.22(8) Nutrition – requires that a personal care home write and post menus 24 hours prior to serving meals and note any changes or substitutions to the menu.
18. Rule 111-8-62-.22(9) Nutrition – requires that a personal care home maintain records of all menus as served for 30 days.
19. Rule 111-8-62-.24(2) Nutrition – requires that a personal care home ensure soap at sinks and toilet tissue at commodes provided for use by the residents.
20. Rule 111-8-62-.27(2) Procedures for Change in Resident Condition – requires the administrator or on-site manager of a personal care home to initiate an investigation of the cause of an accident or injury involving a resident and to report to the resident's representative or legal surrogate the accident or injury and to maintain a copy of the personal care home's report in the resident's file and central file of the personal care home.
21. Rule 111-8-25-.06(3) Investigations and Inspections – requires that facilities cooperate with any inspection or investigation conducted by the Department and provide, without unreasonable delay, any documents to which the Department is entitled under Rule 111-8-.25.

(Respondent's Ex. C.)

6.

Based on these alleged violations, Respondent issued to Petitioner a notice of intent to revoke its permit on March 30, 2012. The Notice of Intent to Revoke outlined the Petitioner's violations of the Rules relating to Administration, Staffing, Physical Plant conditions, Health and Safety Standards, Furnishings and Fixtures, Admission, Services, Nutrition, Supplies, Procedures for Change in Resident Conditions, and Investigations and Inspections. (Respondent's Ex. A.)

7.

While Respondent is authorized to act on an emergency basis when it determines there is imminent harm to the residents, in this case, the Respondent did not employ any of the extraordinary sanctions available in situations involving imminent danger. [4] Not being restricted, a number of residents have been admitted to Petitioner facility since the Survey and the Notice to Revoke, despite the Respondent's position that based on the Survey: "conditions in the facility pose an imminent and serious threat to physical and emotional health and safety to persons in care." (Respondent's Ex. A.)

8.

On March 23, 2012, Petitioner submitted an Immediate Plan of Correction (IPC), at Respondent's request. (Petitioner's Ex. 1.) The IPC was submitted prior to Petitioner's receipt of the written Survey that addressed the staffing issues and investigation of falls. Respondent accepted

[4] The Respondent's Director, E.Wright, distinguished, in her view, imminent danger warranting immediate relocation of residents, such as physical issues (loss of power, no food or medications) from the alleged imminent danger at Petitioner facility, described as "the possibility of something really bad going on with the number of falls, due to lack of staffing." (Wright, Day 7 Tr. 178.) Ms. Wright contends that an emergency relocation could be more detrimental to the residents than remaining at the facility, which seems to oppose the Respondent's position that revocation is the only option for this facility, due to a concern for residents' safety.

Petitioner's March 23, 2012 IPC, which it did not have to accept, especially in light of the subsequent Notice of Intent to Revoke. (Petitioner's Ex. 25.) (Mullican, Day 2 Tr. 84.)

9.

On March 28, 2012, Respondent mailed the Survey to Petitioner (Petitioner's Ex. 23), with a cover letter that did not reference the Respondent's decision to revoke the facility's license. [5] The March 28 cover letter instead instructed the Petitioner to submit a full plan of correction to the Respondent within ten (10) days of receipt of the letter, stating further, that "[f]ailure to correct violations or failure to maintain compliance once corrections are made may result in further sanctions, including revocation of your permit." (Petitioner's Ex. 23.) However, Elaine Wright, Respondent's Director of Personal Care Homes, indicated that the Respondent gives facilities thirty (30) days from receipt of a survey to come into compliance. (Wright, Day 7 Tr. 147.)

10.

On April 12, 2012, Petitioner submitted a comprehensive Plan of Correction and Statement of Disagreement to Respondent (POC). (Petitioner's Ex. 2.) Respondent accepted Petitioner's POC, in which the Petitioner detailed its plan to rectify the deficiencies identified in the Survey. (Wright, Day 8 Tr. 24.)

11.

Prior to receiving Petitioner's April 12 POC, Respondent issued its Notice of Intent to Revoke the personal care home permit. (Wright, Day 7 Tr. 146, in which she indicated that Respondent had decided to revoke Petitioner's permit before sending the March 28 letter.) (See, Petitioner's Ex.

[5] Per the March 28 letter, the February 17 Survey was also subject to revision by Ms. Mullican's supervisors. (See, Petitioner's Ex. 23 (noting that, as survey was subject to supervisory review, "violations may be deleted, corrected and/or additional violations cited based on that review.")

24.) The Notice of Intent to Revoke, dated March 30, 2012, indicated that the decision to revoke was based on the Survey.[6] Despite the declaration in the March 30 cover letter, the Respondent's decision to revoke the personal care home permit was premised not only upon the findings in the Survey, but also on the Respondent's citation history for the facility. (Wright, Day 7 Tr. 183.)

12.

On April 2, 2012, Respondent's Surveyor returned to the facility to investigate a complaint, and monitor ongoing compliance. No further rule violations were cited as a result of that visit. (Petitioner's Ex. 3.) The Respondent did not receive the Notice of Intent to Revoke until April 3, 2012.

Violation of Rule 111-8-62-.09(3) Administration (Category D)

13.

After a review of Petitioner facility records, the Surveyor concluded that Petitioner violated Rule 111-8-62-.09(3) by (1) not completing dementia training for all direct caregivers; and (2) not conducting the initial training and/or annual reassessments for its medical technicians ("med techs") and personal service attendants ("PSAs") as required under the Personal Care Home Rules. (Mullican, Day 1 Tr. 44.)

14.

The Surveyor listed the following deficiencies for this Rule in the Survey concerning the med techs and PSAs:

February 2, 2012 Med Tech Training Review:

[6] Respondent issued the Notice of Intent to Revoke prior to several changes being made to the February 17 Survey during the administrative review process. (See Respondent's Exs. B, C)

(i) Staff C (Taylor M.) hired 1/1/08 – training in 2006, no reassessment;
(ii) Staff U (Renee G.), hired 4/29/09 – no date on training, no reassessment;
(iii) Staff V (Shana H.) hired 1/1/08 – training in 2007, no reassess;
(iv) Staff W (Ashley M.), hired 3/4/11 – initial training January 2012, p. 2 of Medication Competency Checklist not completed;
(v) Staff Y (Amanda S.), hired 11/3/11 – no training;
(vi) Staff Z (Winfred H.), hired 11/13/09 – no date on training, no reassessment.

15.

The Survey indicates that L.W., a registered nurse who was serving as the Wellness Director, confirmed the lack of training, but it was also noted that she had been employed at the Petitioner facility less than a year, and was not sure when the training had been done. However, the Respondent noted the lack of documentation of the training for certain staff. (Respondent's Ex. C.)

16.

Also according to the facility's records, med techs were required to score at least 80% on an initial examination before advancing to hands-on training assisting residents with medications. Admittedly, Petitioner did allow certain staff to work with residents before the required training had been completed. (Coder, Day 3 Tr. 119; Petitioner's Ex. 16.)

17.

However, there was clearly a lack of documentation of training of staff. Ms. Coder testified that the med techs/PSAs she worked with were all knowledgeable and caring and trained personnel, but that the training information was not documented. (Coder, Day 3 Tr. 120-129.) Specifically, she testified as follows:

Q: How would the State investigators know whether training had been conducted?

A: They wouldn't know it. (Coder, Day 3 Tr. 122.) I know there was a lot of training done; I think there was a lack of documentation of it. (Coder, Day 3, Tr. 129.)

18.

Additionally, the facility did not document that its employees received the required 16 hours of continuing education each year in certain courses, including working with residents with Alzheimer's diseases and other forms of dementia. (Mullican, Day 1 Tr. 49; Coder, Day 3 Tr. 130.) The Surveyor did not, however, interview the individual staff members referenced in this citation regarding the training each employee received, and whether or not the lack of documentation meant they had never received training in the areas of recognizing dementia. (Mullican, Day 2 Tr. 107.) The facility's Resident Director admitted that certain staff lacked this training, and what documentation the Petitioner facility did have concerning dementia training was dated after the Respondent had cited the facility for this Rule violation. (Coder, Day 3 Tr. 130.)

19.

At the hearing, Ms. Coder described the scope of training given to the med techs and PSAs, and, as it regarded dementia training, Ms. Coder explained that PSAs and med techs have three (3) days of initial training, and are re-assessed annually at the facility. (Coder, Day 4 Tr. 85, 95.) Further, according to the POC, the med techs were reassessed in February and May, 2012. (Coder, Day 4 Tr. 101.) Also at the hearing, Ms. Coder testified that she believed the Surveyor was requesting documentation of the "specialized" training required for a facility with a "specialized" memory-care unit (Rule 111-8-62-.20), as opposed to evidence that staff had received training in recognizing dementia, and she indicated that the facility did not have those records, because Petitioner is not a "dementia-specific" building. (Coder, Day 4 Tr. 93.)

20.

Petitioner has an in-service calendar for dementia training, which was conducted by the Wellness Director, Terri Ward, in February 2012 with a follow-up training in July 2012. (Coder, Day 4 Tr. 92.) (See also Petitioner's Exs. 34, 35 and 36).

21.

At the hearing, two family members of former facility residents described the med techs as experienced, competent, and caring of residents. (Fry, Day 6 Tr. 68, and Perkins, Day 6 Tr. 121.) Another resident's family member, however, stated that certain staff members, especially if they were new, "...admitted that they had no idea what they were dealing with..." when it came to dementia. The resident's family member explained: "My husband would say he wanted sugar with his coffee. He was diabetic. And I had to explain so frequently to new people coming in there that he meant he should have a Splenda packet or whatever was available, which they always had available, but when he said, "sugar," these young people would obediently give him sugar." (V.M., Day 5, Tr. 187.)

Violation of Rule 111-8-62-.09(4) Administration (Category E)

22.

Respondent also cited Petitioner for violating the personal care home rules for failing to have a disaster plan that met all the requirements of the Rule. The Petitioner had a disaster preparedness plan, but there was no written provision in the disaster preparedness plan for an alternative means of transportation when the facility's van was not available. (Mullican, Day 1 Tr. 52, Day 2 Tr. 116.)

23.

The Resident Director testified at the hearing that the Petitioner has an agreement with a nearby church to use its van to evacuate residents in the event of an emergency. Additionally, Ms. Coder testified that Petitioner may also utilize the Whitfield County transport bus to transport residents in the event of an emergency. (Coder, Day 4 Tr. 104.)

Violation of Rule 111-8-62-.11(1)(a) Staffing (Category J)

24.

In determining the appropriate number of staff to properly safeguard the health, safety and welfare of the residents, the Rules require that personal care homes adjust the number of staff to the appropriate number needed to properly care for the needs of the residents. (Coder, Day 3 Tr. 136.) Staffing was a major complaint in the Survey, and is a major concern to Respondent when any investigation is conducted. (Wright, Day 7 Tr. 170.)

25.

Petitioner had not been cited for inadequate staffing in the two years prior to the Survey. (Taylor, Day 6 Tr. 147.) Nevertheless, the Surveyor concluded, based on her observations, interviews, review of the facility's work schedule, and review of the facility's incident reports from November 2011 – January 24, 2012, that Petitioner was understaffed the week of January 19 – 25, 2012, during waking hours. (Respondent's Ex. C; Respondent's Ex. O.)

26.

A review of the facility resident roster indicated that there were forty-eight (48) residents in the facility at the time of the Respondent's investigation. During that time, there were typically only

three (3) employees working on each shift to care for all forty-eight (48) residents. (Coder, Day 3 Tr. 138; Respondent's Ex. O.)

27.

According to the testimony of the Surveyor, Ms. C. Mullican, there were only two (2) direct caregivers in the secured unit working during the waking hours of 7:00 AM to 8:00 PM on January 20, 2012. There was only one (1) staff person involved in direct resident care on January 21, 2012 from 7:00 AM to 3:00 PM, and only three (3) involved directly in resident care from 3:00 PM to 8:00 PM on January 21, 2012. (Mullican, Day 1 Tr. 63.)[7]

28.

The Surveyor did not review Petitioner's daily time-punch records, or its payroll records, which are an accurate method of determining the staffing levels on any given day. (Mullican, Day 3 Tr. 118; Cook, Day 8 Tr. 125; and Cheren, Day 9 Tr. 45.) In April, 2012, the Surveyor returned for a monitoring visit, and did request time-punch reports.

29.

At the hearing, the Surveyor conceded the staffing schedule was, to some extent, inaccurate, as it referred to PSAs no longer employed at the facility. (Mullican, Day 3 Tr. 122.)

[7] Per the Respondent's regulations, "waking hours" are defined, at a minimum, as 7:00 AM to 8:00 PM, but may vary according to the needs of a specific resident population. (See Petitioner's Ex. 15 at 90 (Interpretative Guidelines for Rule 111-8-62-.23)91)); (Mullican, Day 1 Tr. 59.) The minimum staffing ratios for personal care homes are 1 caregiver per 15 residents during waking hours, and 1 caregiver per 25 residents during non-waking hours. Rule 111-8-62-.11(1)(a))

30.

Petitioner's expert witness in surveying, inspection compliance, and sanctions of long-term care facilities, Connie Cheren, compared the staffing levels for January 19 – 25, 2012, to the actual punch reports for the same time period as cited in the Survey. She concluded that the Petitioner was noncompliant with respect to three shifts only. (Cheren, Day 9 Tr. 47.)

31.

Petitioner facility contains a secured unit, which is a separate unit for residents with cognitive issues, including residents suffering from dementia or who may be at risk for elopement. (Mullican, Day 4 Tr. 82; Cheren, Day 9 Tr. 32.) "These residents need more care, generally. A lot of them need assistance going to the bathroom. They need assistance dressing. They need assistance while they're eating. They need a lot more hands-on than what the general population needs." (Coder, Day 3 Tr. 140.)

32.

At the time of the Survey, there were twelve (12) residents in the secured unit, all of whom had some form of dementia or other cognitive impairment. (Mulligan, Day 1 Tr. 68.) According to the Surveyor, on at least one day, if not others, there was only one staff person assigned to assist the residents with eating. (Mullican, Day 1 Tr. 72; Corbin, Day 5 Tr. 139; V.M. Day 5 Tr. 188). Family members often helped residents with meals due to a lack of available staff. (Mullican, Day 1 Tr. 72; C. Corbin, Day 5 Tr. 140; V.M., Day 5 Tr. 188; Fry, Day 6 Tr. 24.)

33.

According to the Resident Director, in instances where there was an emergency and/or the facility was understaffed, she and other non-PSA/med tech staff members provided resident assistance as needed. (Corbin, Day 5 Tr. 155,156; Fry, Day 6 Tr. 64; Cheren, Day 9 Tr. 50).

34.

There were several complaints from resident family members about the lack of staffing. (Coder, Day 3 Tr. 141.) Ms. Coder testified that she was allowed three (3) staff per shift, according to the parent corporation, ALC. She asked for more staff, knowing they could better provide for the residents if they had additional staff. ALC advised the Resident Director that in order to increase the number of staff members, the residents would have to be reassessed to raise their levels of care. (Coder, Day 3 Tr. 139.)

35.

After the Respondent began the investigation of the facility, the staffing levels increased, and presently, Petitioner is properly staffed based on the facility's occupancy and needs of its residents. At the time of this Initial Decision, with a census of 25 residents, Petitioner staffs four caregivers on the first and second shifts, and staffs three caregivers on the third shift. (Cook, Day 8 Tr. 127; Cheren, Day 9 Tr. 56, and Kennedy, Day 8 Tr. 61.) [8]

36.

There were a large number of falls noted on the Survey, which Respondent attributed to the lack of proper staffing. This led Respondent to believe that the facility could not provide adequate

[8] There are three shifts every day at Peachtree Estates. The first shift is from 7:00 AM to 3:00 PM. The second shift is from 3:00 PM to 11:00 PM. The third shift is from 11:00 PM to 7:00 AM. (Testimony of Coder.)

protective care and watchful oversight for the residents. The Surveyor reviewed twenty-seven (27) resident-involved incidents that occurred in November 2011 alone. Of those, there were sixteen (16) instances where residents were found on the floor by staff. (Mullican, Day 1 Tr. 75; Respondent's Ex. H.) Nine (9) of sixteen (16) incidents resulted in minor injuries and four (4) resulted in hospital visits. There were seventeen (17) incidents in December 2011. Of these seventeen (17), twelve (12) were instances where residents were found on the floor. Six (6) of these residents were treated for minor injuries, and one (1) required a hospital visit. Between January 1 and January 25, 2012, there were thirty-two (32) incidents of resident falls. Of those, fourteen (14) residents were found on the floor. Seventeen (17) of these residents sustained minor injuries and three (3) residents were sent to the hospital for medical attention. (Respondent's Ex. H.)

37.

Although there was a great deal of testimony concerning resident falls, according to the Survey, during the January 19 – 25, 2012 time period in which the Surveyor found deficient staffing levels, the Surveyor did not observe any resident falls. (Cheren, Day 9 Tr. 52). In fact, when the incident reports (for falls) were compared alongside the facility's employee punch reports, the falls often occurred on dates where the facility was staffed properly. There were no falls on the dates when the facility was, according to the Surveyor, "understaffed." (See Respondent's Ex. H at January 10, 2012, falls involving Resident #15 (N.R.); and Resident #16 (M. M.); December 21, 2011 fall involving Resident #24 (M.H.); cf. Petitioner's Ex. 5 (4 caregivers staffed on December 10, 2011, 3rd shift; census of 53 residents; and 4 caregivers on December 21, 2011, 2nd shift; census of 51 residents))

38.

The Surveyor reviewed Petitioner's IPC requested by Respondent, and determined that, in accordance with its POC, Petitioner staffed as it stated it would, with four (4) caregivers on the first and second shifts and three (3) caregivers on the third shift. (See, Petitioner's Ex. 25.) After reviewing the punch records for this time period, the Surveyor confirmed that Petitioner was adhering to the regulatory required staffing levels for March 23 – 26, 2012. (Mullican, Day 2 Tr. 84.)

39.

Several residents in the secured unit had hospice services for various reasons, and various services were performed by hospice for those residents. Many times, the hospice services were provided as it related to the resident's illness; meaning, oftentimes the resident's physician had requested or prescribed hospice services. The hospice workers often bathed residents or performed certain tasks for them, possibly concerning therapy, for instance. Respondent attributed the need for hospice services to a lack of staffing, especially in the secured unit. (Mullican, Day 1 Tr. 83.)

Violation of Rule 111-8-62-.11(2)(f) Staffing (Category J)

40.

Another violation of the Rules for personal care homes concerned the allegation that the facility did not have sufficient staff available in the secured unit to give prompt, unhurried assistance to nine (9) residents who required help eating. (Respondent Ex. C.) The Surveyor observed one meal

where there was no staff available to provide assistance to residents. She witnessed one resident attempting to provide assistance to another resident. (Mullican, Day 1 Tr. 88.)

41.

Family members of residents in the secured unit testified that family members were "forced" to provide assistance to residents at mealtimes, due to lack of proper staffing in the dining area. (Corbin, Day 5 Tr. 139,140; V.M., Day 5 Tr. 187-190; Fry, Day 6 Tr. 24; Perkins, Day 6 Tr. 85.) According to the Surveyor, dementia residents in the secured unit would be served a meal, but would often sit and look at the plate, then get up and wander away unattended, as no staff was available to redirect them to the table to eat. (Mullican, Day 1 Tr. 88; V.M., Day 5 Tr. 188.)

42.

One resident in the secured unit, H.F. (Resident # 22), lost a total of twenty-four (24) pounds in four (4) months, while living at the Petitioner facility. (Respondent's Ex. J1.) Respondent concluded that this weight loss was attributable to poor staffing, meaning there was not enough staff to ensure that the resident ate, and also due to staff lacking dementia training, and not realizing that a dementia-resident must be redirected to eat if that resident becomes distracted. (Mullican, Day 1 Tr. 91.)

43.

Concerning Resident #22, H.F., however, the evidence was that staffing levels had no correlation with his weight loss. H.F. was a 93-year old resident at the facility, who had worked as a chemist until he was 90 years old. About 18 months after retiring, H.F. underwent a medical procedure that required general anesthesia. Following this procedure, H.F. began exhibiting cognitive deficiencies, including dementia and psychotic behavior, and spent some time in the Floyd County

Behavioral Center and a nursing home. (Fry, Day 6, Tr. 26, 40, 42.) H.F. entered Petitioner facility in June, 2011. At the time of his admission he weighed 176 pounds. (Petitioner's Ex. 30.)

44.

Almost immediately, it was apparent that H.F. wished to return to his personal residence. He was uncooperative and combative with caregivers (Mullican, Day 3 Tr.16.) His wife, K.F., testified that H.F. was never happy at the facility, which he referred to as the "hospital." During his time there, his wife visited him 1 – 3 times a day, often at mealtimes. (Fry, Day 6 Tr. 55.) H.F. returned to his personal residence in March 2012, and, according to his wife, he put weight back on immediately. (Fry, Day 6 Tr. 55, 71.)

45.

Petitioner's POC stated that in March 2012, the facility's residents were comprehensively reassessed. One of the areas reviewed was the amount and type of assistance needed by residents during mealtimes. Petitioner adjusted the staffing levels accordingly to ensure appropriate assistance was available and provided, if needed, to its residents. (Petitioner's Ex. 2.)

46.

There was no evidence in the record to support the conclusion that understaffing during mealtimes in the secured unit caused any resident physical harm or weight loss. The remainder of the secured unit residents remained at stable weights. (Coder, Day 3 Tr. 150; Petitioner's Ex. 44.)

Violation of Rule 111-8-62-.11(2)(g) Staffing

47.

A review of the admission agreements for residents in the secured unit revealed that ten (10) of the twelve (12) residents required some assistance with daily hygiene. (Respondent's Ex. I), and Respondent charged Petitioner with a violation of Rule 111-8-62-.11(2)(g) with failing to provide sufficient staff to ensure that each resident is given assistance with daily hygiene, including baths and oral care.[9]

48.

Respondent concluded that family members had to provide services such as bathing and oral hygiene or that residents had to pay for private entities to provide these services, due to lack of staff at the facility. (Corbin, Day 5 Tr. 145, 167-168; Fry, Day 6 Tr. 23.) The Surveyor based this citation on interviews with three (3) family members of residents out of ten (10) subject residents noted in the Survey, but testified that she did not personally observe any resident who was not clean or who exhibited signs of poor oral hygiene. (Mullican, Day 2 Tr. 140). There was certainly no testimony or admitted medical records of residents who experienced any negative effects related to purported insufficient bathing or oral care.

49.

The Resident Director testified that the Petitioner facility adheres to a schedule of bathing and provision of oral hygiene assistance for each resident. (Coder, Day 4 Tr. 112.) She also indicated that the use of such outside providers, often covered by Medicare, was discussed with each incoming resident, the resident's family, and the third-party provider, as utilizing home health or

[9] The ten (10) residents identified in the citation in the Survey were the residents the Surveyor identified as requiring assistance with activities of daily living, including baths and oral care. (Respondent's Ex. C.)

Medicare-provided services could act to reduce a resident's monthly fees charged by Petitioner. (Coder, Day 4 Tr. 113.)

Violation of Rule 111-8-62-.14(1) Physical Plant Health and Safety Standards (Category K)

50.

Respondent alleged that Petitioner violated Rule 111-8-62-.14(1) by not conducting fire drills at those times when evacuation of the facility would be most difficult. The fire drill code states that the evacuation capability of residents in all cases is based on the time of day and night when evacuation of the facility would be most difficult. One of the fire drills was conducted on December 8, 2011, at 5:45 AM (Respondent's Ex. K.) and with three (3) staff present, the evacuation of all residents took longer than thirteen minutes. According to Respondent, this was an inappropriate fire drill, as it should have been conducted when there were less than three staff working the third shift. (Mullican, Day 2 Tr. 59; Respondent's Ex. K.)

51.

The Interpretative Guidelines for the Personal Care Home Rules concerning Physical Plant Health and Safety Standards provide that a Surveyor should refer any potential fire safety problems "to the appropriate fire safety authority for evaluation. " (Petitioner's Ex. 15.) The Surveyor did not contact either the state or local fire safety authority concerning Petitioner's alleged violation of the applicable fire safety code. (Mullican, Day 2 Tr. 166.) The Surveyor testified that she had in the past referred other homes for evaluation by a fire department when she was concerned about the home's fire safety preparedness. (Mullican, Day 2 Tr. 168.)

52.

Although Respondent did not refer Petitioner to the local fire safety authority for evaluation, the Dalton Fire Department (Dalton F.D.) conducted a contemporaneous fire safety inspection of the facility on February 10, 2012, at the request of Petitioner, and the report from Dalton F.D. indicated that the facility passed the fire safety inspection. (Petitioner's Ex. 28.)

Violation of Rule 111-8-62-.15(1) Furnishings and Fixtures (Category D)

53.

The Survey contained an allegation that the Petitioner failed to maintain dining room furniture in good condition. (Respondent's Ex. C.) The Respondent's citation was based upon the Surveyor's observation, on January 25, 2012, of the upholstered back of a chair that was pulled out from the frame, exposing points of staples. (Mullican, Day 1 Tr. 104; Coder, Day 4 Tr. 122.) The arms of one (1) chair came loose when the Surveyor attempted to move it at her visit on February 8, 2012. (Mullican, Day 1 Tr. 104.) And, on another occasion, one resident had been sitting in a dining room chair when an arm fell off the chair in which the resident was sitting. (Stamey, Day 7 Tr. 100.)

54.

The Resident Director testified that, at the time of the Surveyor's inspection, the two (2) dining room chairs in disrepair were no longer utilized by the facility or residents in the dining room. (Coder, Day 4 Tr. 123.) After the Surveyor's inspection, the Petitioner discarded the subject dining room chairs. (Coder, Day 4 Tr. 123.) And, the resident who was in a chair when than arm fell off was not injured or harmed. However, there are/were a sufficient number of dining room

chairs available in the dining room for all residents to sit around the table(s) and sit safely. (Coder, Day 4 Tr. 123.)

55.

According to the Petitioner's POC, the facility's maintenance technician regularly checks the condition of the facility furniture during walk-throughs. (Petitioner's Ex. 3.) Furniture is repaired, if possible, but if not, the facility contacts its Divisional Vice-President of Operations to obtain replacement furniture. (Coder, Day 4 Tr. 124.)

Violation of Rule 111-8-62-.15(2) Furnishings and Fixtures (Category D)

56.

The Survey states that the facility failed to ensure that housekeeping standards were such that the facility presents a clean and orderly appearance. The basis for this citation was the Surveyor's interviews of resident family members, a written statement from a resident's family member, and an inspection of three rooms in the secured unit on February 2, 2012. (Respondent's Ex. C.)

57.

The Surveyor, as indicated in the Survey, saw a soiled Depends under a bed. She observed food particles on the floor of a resident's apartment, and items stored under a bed in another resident's apartment that were covered in dust. In other rooms, there were little throw rugs which were covered in dust and food particles. (Mullican, Day 1 Tr. 104). There was testimony that a resident's family member had to clean the room to ensure it was sanitary. (Perkins, Day 6 Tr. 90.)

58.

The housekeeper who worked at the facility only worked for a few hours per week and cleaned, for the most part, in the non-secured area of the facility. (Coder, Day 3 Tr. 172.) The staff person in the secured unit was a direct caregiver who was responsible for housekeeping. (Mullican, Day 1 Tr. 105.) Even at the hearing, the Resident Director, Ms. Coder, testified that Petitioner's PSAs and med techs are charged with conducting light housekeeping in each resident's room at least once a week if a housekeeper is not present. (Coder, Day 4 Tr. 125.) While residents may contract for additional housekeeping services during the week, that service will amend the resident's service plan. (Coder, Day 4 Tr. 126.)

59.

Although the Resident Director admitted that the cleaning standards were not up to her standards (Coder, Day 4 Tr. 127.), the Surveyor testified that the facility was "generally clean." (Mullican, Day 2 Tr. 170; Petitioner's Ex. 27.)

60.

The Petitioner's POC states that a new housekeeper was hired to supplement the PSA/med tech cleaning efforts. The POC also states that the facility's Resident Director would conduct regular walk-throughs of the building and confirm housekeeping tasks were being completed, particularly in the secured unit. (Petitioner's Ex. 2.)

Violation of Rule 111-8-62-.15(3)(c), 3(e), and 3(f) (Category D)

61.

The Survey alleged that Petitioner failed to ensure that all residents' apartments were furnished in accordance with the Rules, to include a bureau, a dresser, a chair, a bed, mattress, linen, clean towels and washcloths. These citations were based upon: (i) the Surveyor's observations of unoccupied rooms not furnished; (ii) family member interviews, in which the family members stated that the facility "required" residents' families to provide bedroom furnishings; and (iii) the Surveyor's February 8, 2012 interview with Rachel Davis, a former Regional Wellness Director for ALC. (Respondent's Ex. C.)[10]

62.

According to certain residents' family members, resident families were not informed that they had a choice of whether to bring in their own furniture or have the facility provide furniture for the rooms. (Fry, Day 6 Tr. 27; Corbin, Day 5 Tr. 147; A. Perkins, Day 6 Tr. 91) The facility did provide furniture and furnishings for respite care residents who were there only sometimes during the day or for a very short stay. (Mullican, Day 1 Tr. 106)

63.

According to the record testimony, families were not informed that the facility would provide linens, towels, washcloths, bedspreads, etc. for resident use if the family chose not to bring these items. (Mullican, Day 1 Tr. 107; Fry, Day 6 Tr. 28.)

[10] According to the Surveyor's notes, Rachel Davis informed Ms. Mullican that Petitioner's Residency Agreement states that a resident is to provide his own bed. The ALJ's review of Respondent's Ex. M, the facility's residency agreement, did not contain any provision stating residents were required to furnish their own rooms.

64.

The Resident Director conceded that the facility does not maintain a supply of linens for twice the bed capacity, as required by the Rules. (Coder, Day 4 Tr. 12.) In the only two instances where a resident has requested furnishings, such were provided. (Coder, Day 4 Tr. 10.)

65.

Petitioner submitted a Statement of Disagreement as to each of the citations respecting the provision of furnishings and linens. (Petitioner's Ex. 2.) The facility is a community that provides residents with a home-like setting as apartments are provided to the residents to furnish as they wish. In its effort to assist residents when they move into their apartments, and to ease the transition from their own home to a personal care home, Petitioner encourages resident families to furnish the resident's rooms with furniture with which the resident is familiar. (Coder, Day 4 Tr. 7.) Petitioner's approach regarding resident furnishings is reasonable under the Rules.[11]

Violation of Rule 111-8-62-.16(1)(e) Admission. Amended (Category D)

66.

The violation of Rule 111-8-62-.16(1)(e) came about as a result of the Surveyor's observation that "nursing services" were being provided to G.P., a resident in the secured unit (Resident 21). Personal care homes may not provide medical, nursing, health, or supportive services to residents, and the Surveyor concluded that Rule 111-8-62-.16(1)(c) was violated by the facility based on her observation of "nursing services" being provided. (Respondent's Ex. C.)

[11] Rule 111-8-62-.15(4) states: "[p]rovision shall be made for assisting a resident to personalize the bedroom by allowing the use of his or her own furniture if so desired and mounting or hanging pictures on bedroom walls."

67.

Because personal care homes are not nursing facilities and do not have nurses on staff to provide said services, personal care homes or the resident's family may contract with home health, hospice or an outside agency to provide short term nursing health care if needed. (Mullican, Day 1 Tr. 108, 109, 110.)

68.

The Respondent's bases for the alleged violation of Rule 111-8-62-.16(1)(e) arose from the Surveyor's staff interview with former Wellness Director Leisha Wade and former Regional Wellness Director Rachel Davis, as well as a review of the Petitioner's admission agreement. However, while conducting the investigation, the Surveyor witnessed facility staff crush medication for resident G.P., mix it in yogurt, and feed it to her on February 9, 2012. Residents in personal care homes should be able to assist with taking their own medications, while staff are there only to assist. (Mullican, Day 1 Tr. 108; Respondent's Ex. C.)

69.

The Survey indicates that on February 8, 2012, the Surveyor requested that a staff member produce a physician order to crush medications for G.P. The staff member was unable to produce such an order. However, on January 10, 2012, the facility had received a physician's order to crust G.P.'s medications. (Petitioner's Ex. 20.) While the January 10, 2012 crush order gave the authority to crush (meds), it is silent regarding placing such medications in G.P.'s food.

70.

At the hearing, Petitioner was able to produce another crush order from G.P.'s physician, allowing the facility to not only crush medications for G.P., but to place the medication in her food as well. (Petitioner's Ex. 42.) The "updated" order was needed as G.P. would spit out her medications, so the revised order was necessary to assist G.P. with taking her medications. (Respondent's Ex. C.)

71.

The Surveyor testified that crushing resident's medication and placing the medication into food is permissible under the Rules, so long as the resident knows that he/she is taking a medication. (Mullican, Day 1 Tr. 113; Cheren, Day 9 Tr. 77.) The Surveyor's testimony is in accordance with Rule 111-8-62-.21(3) that allows a personal care home to assist residents with pouring or taking medications. (Petitioner's Ex. 15.)

72.

The Resident Director testified that G.P. had difficulty swallowing pills. However, she was able to take her medications without assistance when placed in her food. (Coder, Day 4 Tr. 133.) According to Ms. Coder, "G.P. knew exactly what meds she was taking." She asked for her medications by name on any given occasion. (Coder, Day 4 Tr. 131.)

Violation of Rule 111-8-62-.16(2) Admission. Amended (Category E)

73.

The Survey cited Petitioner for failing to ensure that no residents were retained who needed care beyond which the facility is permitted to provide in the cases of three (3) of twelve (12) residents

in the secured unit, those residents being M.H. (Resident #7), M.M. (Resident #16), and G.P. (Resident #21).

74.

According to the Respondent, the Surveyor observed that these particular residents had needs beyond that which a personal care home is permitted to provide. (Mullican, Day 1 Tr. 111.) Staff is allowed to assist with eating, dressing, grooming, ambulation and transfers, but assist only. These three (3) residents were non-ambulatory and required total care, with the exception of M.H., who could feed herself. (Mullican, Day 1 Tr. 111 – 113.)

75.

The following testimony was obtained from the Resident Director at the hearing:

1. M. H. - At the time of M.H.'s admission to the facility in January 2011, she could propel herself in her wheelchair. At some point, M.H.'s health declined, and her ability to ambulate declined, as well. (Coder, Day 4 Tr. 137). While physical therapy temporarily improved M.H.'s condition, when physical therapy ended, her condition declined again. The family and those certain staff in the facility were able to acquire a smaller wheelchair for her, and in fact, it improved M.H.'s ability to propel herself. Over time, however, it was apparent that she could not sufficiently ambulate, and she could no longer remain as a resident at Petitioner facility. (Coder, Day 4, Tr. 138.) M.H. was discharged from the facility on August 6, 2012. (Coder, Day 4 Tr. 139.)
2. M.M. – When admitted in February 2011, M.M. could ambulate, but her physical condition declined over time and she could no longer ambulate. (Coder, Day 4 Tr. 19, 139 and 140.) M.M. was married to A.M., who also lived at the facility, but in the assisted living unit, not the secured unit. The couple had married late in life and had adult children from their prior marriages. (Coder, Day 4 Tr. 140.) A.M. wanted his wife to remain at the facility with him, but in the spring of 2012, A.M. was diagnosed with leukemia. The dynamics were difficult for the facility, having to handle both families. Subsequently, however, A.M.'s daughters,

who both live in Ohio, decided to move him back to Ohio. Thereafter, M.M. was transitioned to a nursing home in Georgia. (Coder, Day 4 Tr. 142.)

3. G. P. – When she was admitted to the facility in December 2011, she could propel herself in her Hoveround Jazzy electric wheelchair. (Coder, Day 4 Tr. 20.) Although she was a stroke victim, G.P. could feed herself, get into bed by herself, and speak, albeit in a slurred voice. (Coder, Day 4 Tr. 132.) Shortly after she was admitted, G.P.'s health declined, and her family contracted for hospice care. Her family wished for G.P. to remain at the facility until her death, fearing that another move would hasten her death. (Coder, Day 4 Tr. 134.) However, once it was apparent that G.P. was no longer an appropriate resident for the facility, she was transitioned to another facility. On March 23, 2012, Petitioner issued a Notice of Intent to Discharge (Petitioner's Ex. 43.), and she was discharged on April 19, 2012. (Petitioner's Ex. 7.)

76.

After the Surveyor's inspection that ended in February, 2012, the Resident Director requested from ALC permission to obtain waivers to retain G.P., M.H., and M.M. (Coder, Day 4 Tr. 25). ALC, having re-evaluated these three (3) residents and determined that they no longer were appropriate residents for the facility, however, denied Ms. Coder's request, and issued notices of discharge shortly thereafter. (Coder, Day 4 Tr. 25.)

Violation of Rule 111-8-62-.16(3)(d) Admission (Category D)

77.

Respondent cited Petitioner for a violation of Rule 111-8-62-.16(3)(d) for failing to produce a tuberculosis ("TB") screening for one (1) resident at the facility. (See, Respondent's Ex. C.) On her February 8, 2012 visit to the facility, the Surveyor reviewed the current file of respite resident, D.S. The file the Surveyor reviewed did not include a TB screening. The facility did not produce a TB screening on February 8, 2012. (Mullican, Day 1 Tr. 115, 116.)

78.

At the time of the Survey, Resident D.S. was in the midst of a four-day respite stay at the facility. (Petitioner's Ex. 17.) A chest x-ray report in the facility records from a previous visit from D.S. confirmed that D.S. had received a TB screening within 12 months of her respite stay in February 2012. (Petitioner's Ex. 19.)

Violation of Rule 111-8-62-.18(1) Services (Category L)

79.

In this allegation, Respondent alleged that Petitioner failed to provide 28 of 48 residents with protective care and watchful oversight, including the 24-hour responsibility for the well-being of residents and residents' whereabouts. (Mullican, Day 2 Tr. 8; Respondent's Ex. C.)

80.

This citation is primarily based on the Surveyor's review of incident reports provided by the Petitioner, that documents residents' occurrences of falls at the facility between November 1, 2011 and February 17, 2012. (Respondent's Ex. C at 22-35.) This citation also references incidents involving inappropriate behavior of former resident L.C. (Resident #41) toward female residents. Lastly, this alleged Rule violation concerns weight loss in three (3) residents, M.S. (Resident #31), P.B. (Resident #38) and H.F. (Resident #22), without documentation of measures to prevent further weight loss for two (2) of these residents, M.S. (Resident #31), and P.B (Resident #38).

81.

This citation also contains a list of resident falls between November 2011 and February 17, 2012. According to the documentation, seventy-six (76) of the seventy-eight (78) falls referenced in the Survey were unwitnessed falls. (See Respondent's Ex. C.)

82.

R.J. (Resident #4) had four (4) incidents in which he fell, each of which led to some sort of injury. (Mullican, Day 2 Tr. 8 – 12.) R.J. is in his early 60's, and suffers from a closed brain injury suffered during a motorcycle accident. He is impulsive and independent. (Coder, Day 4 Tr. 151.) He refuses to ask for assistance for most ADLs, including using the restroom. (Coder, Day 4, Tr. 153.) Most of R.J.'s falls are unwitnessed, and are at night in his apartment. (Coder, Day 4 Tr. 154, Cheren, Day 9 Tr. 87; Respondent's Ex. H.) Although his physician has recommended that R.J. be accompanied at all times, that is not R.J.'s wish, so he refuses to ask for help/assistance. (Mullican, Day 2 Tr. 9; Coder, Day 4 Tr. 152.) He continues to remain an appropriate resident for the facility.

83.

On two (2) separate occasions, Petitioner has failed to provide protective care and watchful oversight for resident W.M. (Resident #8). On May 20, 2011, W.M. fell outside in the backyard of the facility during the evening and was left outside the facility overnight. Although the facility's policy provides for a bed check every two (2) hours, W.M. was missing from the facility from 8:00 or 9:00 PM in the evening until the Petitioner's staff discovered him outside the following morning around 4:00 AM. Resident W.M. had to be transported to the hospital due to injuries sustained during the fall and being left outside overnight. (Meek, Day 5 Tr. 183.)

84.

On another occasion, W.M. eloped from the facility and traveled across four (4) lanes of traffic to get to the other side of the street. (Meek, Day 5 Tr. 184.)

85.

Respondent cites falls of V.L. (Resident #6) who had multiple falls, resulting in several injuries, such as a nasal fracture, fracture to the facial bone, a fractured rib, and contusion to the rib. (Mullican, Day 2 Tr. 14.) However, according to Petitioner, V.L. is a very active resident in the secured unit, and appeared to fall as a side-effect of the anti-psychotic Ativan she was prescribed. Due to the facility's intervention, this resident's physician changed the Ativan prescription to "PRN." There was a reduction in the number of falls after that time. (Coder, Day 4 Tr. 155 – 158.)

86.

The Respondent's Surveyor observed that the individual incident reports failed to list any steps that the facility took to prevent the incidents from recurring. The Universal Incident/Occurrence Report is an ALC form used by the Petitioner facility to document resident incidents or occurrences. Very few, if any, of the seventy-eight (78) forms submitted were completed in their entirety. In other words, on each form there is a section that reads: STEPS TAKEN TO PREVENT RECURRENCE, and check boxes are provided for the staff to complete. However, this particular section is not completed on most, if not all, of the incident reports that were provided to the Surveyor by the Petitioner facility. (Mullican, Day 2 Tr. 14-26; See Respondent's Ex. H.)

87.

Although weight loss was again addressed as an issue in the citation concerning protective care and watchful oversight, the record shows that the facility did attempt to intervene and provide other nutrition sources when a resident's weight loss was noted. (Coder, Day 4 Tr. 177 – 191.)

88.

Review of Petitioner facility records for L.C. (Resident #41) documented that this resident had a history of inappropriate behaviors toward other female residents who were cognitively impaired. The records show that L.C. was "very flirty" and "overly helpful" with female residents. (Coder, Day 4 Tr. 172.) Some of the incidents were terribly degrading towards women of all ages, meaning, he also was inappropriate towards residents' family members. Initially, staff sought to re-direct L.C. from this type of inappropriate behavior. When the inappropriate behavior continued, and "re-directing" did not work, L.C.'s wife was notified, who suggested that he be restricted to his room, but that was an unacceptable solution. (Coder, Day 4 Tr. 173.) Next, the facility contacted the State Ombudsman, Jeffrey Taylor, to discuss what type of appropriate action could be taken concerning the situation with L.C. (Taylor, Day 6 Tr. 174.)

89.

After discussing the situation with his wife, on January 21, 2012, L.C. was sent to Hamilton Medical Center for a psychiatric evaluation to determine if he met criteria for admission to the Westcott psychiatric ward. When it was determined that L.C. did not meet the admission criteria, he was refused re-entry to Petitioner facility due to his current mental state, and was effectively discharged prior to the Survey date of February 17, 2012. (Coder, Day 4 Tr. 174.)

90.

Although the Respondent indicated that L.C. was retained as a resident at the time of the Survey (Mullican, Day 2 Tr. 40), the letter from the facility concerning his "immediate discharge" is dated January 23, 2012. (Petitioner's Ex. 33.)

Violation of Rule 111-8-62-.18(3) Services (Category D)

91.

Respondent cited Petitioner for a violation of Rule 111-8-62-.18(3) in failing to provide sufficient activities to promote the physical, mental, and social wellbeing of each resident. The Residency Agreement states that the facility provides a program of planned activities as well as opportunities for all residents to participate. (Respondent's Ex. M.)

92.

During the Surveyor's visits to the facility, she observed one activity being conducted in the non-secured unit. There were no regularly-scheduled events taking place on the secured unit. (Mullican, Day 2 Tr. 48.)

93.

Additionally, the Residency Agreement contains a provision that the facility staff will work with the residents to identify programs that are consistent with the resident's cognitive, recreational and social needs. The transportation section of the Residency Agreement states that the residence provides or arranges for transportation; however, during the time of the inspection, the Surveyor did not observe any "outings," as such, due to the van that was not currently in service. (Respondent's Ex. M.)

94.

Petitioner noted that the Surveyor made this allegation of a Rule violation based on her observation on two dates, January 25, 2012 (11:00 AM – 1:30 PM) and February 8, 2012 (11:45 AM – 2:40 PM), during or directly after lunchtime. (Mullican, Day 3 Tr. 50; Respondent's Ex. C). On those dates, the Surveyor observed that residents were sitting in the secured unit dining room without any activities to attend. Even the Survey notes, though, that Patti Cole, a "meaningful pursuits" coordinator, indicated to the Surveyor that she was in the process of developing an activity calendar for the secured unit, at that time. While the Survey does not mention it, card-making was offered and taking place in the secured unit on February 8, 2012. (Cheren, Day 9 Tr. 111.)

95.

In addition, community activities are offered to all residents. Participation is voluntary, but a popular monthly activity for all residents and their family members are dance parties. (Coder, Day 4 Tr. 192.) Dance parties were held from July – December, 2011, and were well-attended by residents from the secured unit and their family members. (Coder, Day 4 Tr. 192.)(See Petitioner's Ex. 38 (photographs of secured unit residents participating in September 2011 dance party). (See also Petitioner's Ex. 39 (photographs of Halloween 2011 party, that was well-attended by secured unit residents.)

96.

At the hearing, the facility Resident Director described, at length, daily and/or weekly activities available to all residents of the Petitioner facility:

Q: What other activities are offered? Let's focus on the January/February 2012 time frame. What other activities were made available to the entire community, to all residents?

A: They like their Bingo three times a week, which I've tried to touch and you cannot touch it. It's Monday, Wednesday and Friday, at 2:00, and you don't deviate from it, or, you know, I could be probably pierced with something. But you don't mess with Bingo at all. There are church services you don't mess with. We have exercise in the morning. And, a lot of the residents from the gardens will come up for the exercise, whether they can actually do it in the rhythm doesn't seem to matter, as long as, you know, they just like to move their arms and get that going. There's bowling. We have bowling pins that we put down on the floor and then roll a softball into them. We do a ball toss and we do that both in the front and in the back. We go for walks around the courtyard in the back. I've taken them out front and walked around and sat down on the front porch with them. And our building is actually directly across the street from the Dalton High School, so we can watch the football games. We can't see the track very well. But the band, which is right now—there's a lot of band going on. So they'll sit out front and watch the bands play. Soccer games they like to watch. Sometimes I'm not so sure if they understand what's going on over there, but it seems to make them happy. (Coder, Day 4 Tr. 199; see, also, Coder, Day 4 Tr. 38. ["Peachtree Estates] did not discriminate between the front and back. Just because [secured unit residents were] cognitively impaired does not mean they cannot dance, or go to church service, or play Bingo, or anything else.")

97.

The Petitioner's Ombudsman testified that he has observed more activities in the secured unit during his recent visits to the facility (Taylor, Day 6 Tr. 136, 140.)

Violation of Rule 111-8-62-.22(8) (Category E) and Rule 111-8-62-.22(9) Nutrition (Category D)

98.

These Rule violations are related to alleged failure of the facility 1) to post menus, including changes to the menu once printed, and 2) to maintain all menus served for the previous 30 days.

The citation was based on the Surveyor's observations of the menus on file and the menu being served on February 2, 2012, and a February 2 interview with then-kitchen manager T. Allen. (Respondent's Ex. C.) The Surveyor indicated in the Survey that the facility did not post a menu 24 hours prior to each meal and failed to note menu changes or substitutions as required by the Rules. (Mullican, Day 2 Tr. 50.)

99.

The Surveyor testified that when she requested a record of all menus served for the past 30 days, the facility staff presented to her the four (4) weekly menus which had been previously presented as the current menus, and indicated to her that the menus rotated weekly. (Mullican, Day 2 Tr. 50.) As there were no notes on the menus indicating substitutions or changes to the menu that may have occurred, there was no way to indicate if the menus presented to the Surveyor were the menus served for the last 30 days. There were no dates on the menus. (Respondent's Ex. Q.)

100.

Prior to the Survey, Petitioner placed dated menus on tables in the dining rooms, but did not post them on the walls. Instead of a daily menu, the facility maintained weekly menus for 30 days. However, based on its POC the facility is posting daily menus, and maintaining daily menus for 30 days as required. (Coder, Day 5 Tr. 116; Petitioner's Ex. 2.)

Violation of Rule 111-8-62-.24(2) Nutrition (Category D)

101.

According to the Survey, Petitioner violated Rule 111-8-62-.24(2) by failing to ensure that soap was at sinks and toilet tissue was placed at all commodes for the residents' use. This citation was

based on Ms. Mullican's interviews with family members of residents and the former Regional Wellness Director, Rachel Davis. (Respondent's Ex. C.)

102.

Petitioner informed residents that they may bring their own personal hygiene items to the facility, including toilet paper and soap, if they so choose. (Petitioner's Ex. 2.) Most residents choose to bring their own personal toilet paper and soap.

Violation of Rule 111-8-62-.27(2) Procedures for Change in Resident Condition (Category L)

103.

The allegation of the violation of this Rule was that the Petitioner failed to investigate seventy-six (76) of seventy-eight (78) incidents reported by the facility between November 2011 and January 2012. (Respondent's Ex. C.)

104.

The incident reports were completed by the facility's caregivers, and provided to the Surveyor during her inspection on January 25, 2012. The Surveyor testified during the hearing that the incident reports were insufficient because the portion of the then-standard incident report form entitled "Steps to Prevent Recurrence" was generally not completed by the staff. (Mullican, Day 2 Tr. 55.) The Surveyor testified that if the facility was not investigating the cause of resident falls or injuries, the facility would not implement measures to minimize the number of resident falls or injuries. (Mullican, Day 2 Tr. 55).

105.

There was testimony concerning a resident who had nail marks across the resident's upper arm. That same resident was observed by the staff to have sustained a bruise in the middle of the resident's chest extending over the left breast and down the arm. However, the Surveyor could not locate any documentation of steps taken to prevent recurrence on the incident form. (Mullican, Day 2, Tr. 56.) The Resident Director testified that "there was a lack of documentation on the incident report log where it has a spot that says what are you going to do." (Coder, Day 4 Tr. 46.)

106.

The question posed by the Respondent was:

Q: So, there was no way for the State to verify the investigation because there was no documentation?

A: Not according to that incident report, no. (Coder, Day 4 Tr. 46.)

107.

According to the testimony at the hearing, however, the Petitioner did investigate the incidents of falls or any other injury to a resident, and those incidents were reported to the resident's representative (Coder, Day 4 Tr. 144, 149), but the facility was not using the incident report form to record intervention plans. (Cheren, Day 9 Tr. 93.)

108.

As support for the interventions taken by Petitioner subsequent to a resident fall, the Resident Director outlined the different types of interventions the Petitioner took depending on the circumstances surrounding the fall, including, for example, the specific actions taken in each specific resident's case. (Coder, Day 4 Tr.149; Coder, Day 5 Tr. 75.)

109.

In addition, the testimony was that at each daily staff meeting, any and all incident reports from the previous day are discussed. Specifically, the cause of the incident, involved resident(s), and the potential interventions concerning each resident, are discussed by the staff and Resident Director. (Coder, Day 4 Tr. 145.)

110.

Petitioner recently developed a new incident form that contains a separate investigative report, to record its investigations and interventions in response to any incident, including resident falls. The separate investigative form is attached to a revised version of the incident report form referenced in the Survey. (Coder, Day 5 Tr. 70.)

Violation of Rule 111-8-25-.06(3) Investigations and Inspections (Category D)

111.

The Respondent cited Petitioner for violating this Rule when the facility failed to cooperate with the Respondent's Surveyor when the facility's shift communication notebook was not provided to her. According to the Survey, the Petitioner's Wellness Director at the time, Rachel Davis, refused the request to review said notebook upon the advice of legal counsel. (Respondent's Ex. C.)

112.

The shift communication notebook is an internal document the Petitioner utilizes to allow PSAs on different shifts to communicate to one another. (Coder, Day 4 Tr. 59). All information contained in the notebook should also be in the Resident Service Notes maintained at the facility. (Coder, Day 4 Tr. 201). In this instance, however, there was testimony that, as of January –

February, 2012, Petitioner's shift communication notebook contained detailed notes that should have been in the Resident Service Notes. (Davis, Day 7 Tr. 56.) The Resident Director testified that she had never allowed a state entity to review a shift communication notebook in her 30 years in the elder care industry. (Coder, Day 4 Tr. 47).

113.

However, the evidence was that the Surveyor did review the shift communication notebook, and was only denied the ability to copy certain pages of it. (Mullican, Day 2 Tr. 58).

Survey Aftermath

114.

On April 2, 2012, Petitioner submitted a POC that was reviewed and approved by the Respondent. As of April 17, 2012, no further Rule violations were found as a result of that inspection. (Petitioner's Ex. 3.) Additionally, no action to impose interim sanctions to protect the residents was taken by Respondent at that time. Ombudsman Jeff Taylor testified that Petitioner has resolved most of the concerns brought to his attention by residents and family members. (Taylor, Day 6 Tr. 188). Connie Cheren, the personal care home expert, testified that, based upon her personal observations of the facility, conversations with residents and their families, and a review of the medical records, in her opinion, the facility is in compliance with the State's Regulations regarding personal care homes. (Cheren, Day 9 Tr. 56).

III. CONCLUSIONS OF LAW

A. Standard of Review and Burden of Proof

1.

Chapter 13 of Title 50 of the Georgia Administrative Procedure Act governs the standards for a hearing in this matter. O.C.G.A. § 50-13-41 sets forth the powers available to an Administrative Law Judge (ALJ) in considering the actions of an agency. In pertinent part, the ALJ "shall have all the powers of the referring agency with respect to a contested case." O.C.G.A. § 50-13-41(b).[12]

2.

A review of an agency decision by an ALJ is a "de novo" hearing. Rule 616-1-2-.21(3). The ALJ is "not to be limited to the evidence presented to or considered by the Referring Agency prior to its decision." Rule 616-1-2-.21(3) As the Respondent seeks to sanction Petitioner, it bears the burden of proof. Rule 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Rule 616-1-2-.21(4).

B. Applicable Law and Regulations

3.

The governing regulations the Respondent has promulgated for personal care homes in Georgia are set forth at Rule 111-8-62-.01, *et seq.* The Respondent also publishes written guidelines that set forth the Respondent's interpretation of the Personal Care Home Rules. (Petitioner's Ex. 15, Interpretive Guidelines for Personal Care Homes ("Interpretive Guidelines")).

[12] A "contested case" means "a proceeding, including, but not restricted to, rate making, price fixing, and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing." O.C.G.A. § 50-13-2(2). This matter regarding the Respondent's action to revoke Petitioner's personal care home permit is required by law to be determined by the Respondent after an opportunity for hearing, and as such is a "contested case."

4.

A personal care home is defined by Georgia Statute as "any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage." O.C.G.A. § 31-7-12(a)(1). A personal care home does not provide 24 hour nursing services as would a skilled nursing facility, and by definition provides a less acute level of care than an assisted living community would provide.[13]

5.

Chapter 7 of Title 31 of the Official Code of Georgia Annotated gives the Respondent the authority to enforce the Personal Care Home Rules and provides the Respondent with tools with which to sanction facilities in the event the well-being and safety of residents are threatened. Pursuant to O.C.G.A. § 31-7-2.2(a)(1), the Respondent's Commissioner may order the emergency relocation of residents in a personal care home "when the commissioner has determined that the "residents are subject to an imminent and substantial danger.'" The Respondent also may order the emergency placement of a monitor in a personal care home when "[t]he health, safety, security, rights or welfare of the patients or residents cannot be adequately assumed by the institution."

[13] An "assisted living community" is a personal care home which is then separately licensed as an "assisted living community," having a minimum of 25 beds and providing "assisted living care," which may include the administration of medications by a medication aide or the provision of assisted self-preservation. O.C.G.A. § 31-7-12.2. A "skilled nursing facility," on the other hand, provides 24 hours of nursing supervision. A nursing home by definition provides continuous medical supervision. "A 'Nursing Home' is a facility which admits patients on medical referral only and for whom arrangements have been made for continuous medical supervision." Rule 290-5-8-.01(a); O.C.G.A. § 31-6-2(34).

O.C.G.A. § 31-7-2.2(b)(1)(D). In addition, the Respondent has the authority to "order the emergency prohibition of admissions" to a personal care home where the personal care home "has failed to correct the violation of departmental rules and regulations within a reasonable period of time, as specified in the department's corrective order, and the violation:

> (A) could jeopardize the health and safety of the residents or patients in the institution....if allowed to remain uncorrected; or (B) Is a repeat violation over a 12 month period, which is intentional or due to gross negligence.
>
> (2) Admission to an institution...may be suspended until the violation has been corrected or until the department has determined that the institution....has undertaken the action necessary to effect correction of the violation." O.C.G.A. § 31-7-2.2 (c)(1)(2); Rule 111-8-25-.05(3)(d)&(e).

6.

The regulations found in Rules 111-8-25-.01, *et seq.* further detail enforcement options available to the Respondent under appropriate circumstances. Rules 111-8-25-.04 and .05, specifically, set forth the Respondent's enforcement options and the range of sanctions the Respondent may seek to impose upon a licensee, such as administering a public reprimand, Rule 111-8-25-.05(1)(a); suspending its license, Rule 111-8-25-.05(1)(b); prohibiting certain persons in management or control from exercising further management or control, Rule 111-8-25-.05(1)(c); revoking the license, Rule 111-8-25-.05(1)(d); imposing a civil penalty fine, Rule 111-8-25-.05(1)(e); or limiting or restricting its license, Rule 111-8-25-.05(1)(f).

7.

If the Respondent believes that there is imminent or substantial danger to a personal care home's residents, the Respondent may take immediate action to protect those residents. Such action can include: relocating on an emergency basis a facility's residents, Rule 111-8-25-.05(3)(b); placing a

monitor in the facility where the health and safety of the residents cannot be adequately assured, Rule 111-8-25-.05(3)(c); and suspending or prohibiting admissions of new residents to the facility, Rule 111-8-25-.05(3)(d) and (e).

8.

Before any sanctions are imposed, the Respondent is required by its own Rules to consider the seriousness of the violation under Rule 111-8-25-.05(4). This Rule requires that the Respondent consider the harm or potential harm that a violation causes to a personal care home's permit.

9.

In addition, the Respondent has the authority to impose civil penalty fines on a graduated basis depending on the degree of seriousness of the conduct from the least serious conduct, Category III, to the most serious conduct, Category I. Rule 111-8-25-.05(1)(e)(1)(i) – (iii). A Category III violation encompasses conduct which "indirectly or over a period of time has or is likely to have an adverse effect on the physical or emotional health and safety of a person or persons in care," while a Category I violation occurs when a violation "has caused death or serious physical or emotional harm to a person or persons in care or poses an imminent and serious threat to the physical or emotional health and safety." By contrast, the revocation regulation does not specify when revocation is warranted, stating: "The department may revoke any license." Rule 111-8-25-.05(1)(d).

10.

Rule 111-8-25-.05(1)(e)(2) governs the Respondent's authority to impose fines based on the facility's citation history. Rule 111-8-25-.05(1)(e)(2) provides that the specific amount of any fine shall be based upon "whether and when the particular or similar rule, law, or order, or the act,

omission, incident, circumstance, or conduct giving rise to the violation of the same regulatory requirement, or one substantially similar thereto, has been cited by the Department previously. Under this Rule, if the same or a substantially similar violation has not been cited by the Respondent within the past twenty-four (24) months against the facility, it shall be considered to be an "initial violation." Rule 111-8-25-.05(1)(e)(2)(i). The fine amount for initial violations shall be in the bottom figure of the appropriate category (i.e., Category I, II or III). Rule 111-8-25-.05(1)(e)(2)(i).

11.

When the same or substantially similar violation has been found and cited by the Respondent once within the past twenty-four (24) months, the present violation shall be considered as a "subsequent violation." Rule 111-8-25-.05(1)(e) (2)(ii). Fines for subsequent violations must fall between the top and bottom figures of the appropriate category. Rule 111-8-25-.05(1)(e)(2)(ii). Respondent must consider other factors, such as the existence of mitigating or aggravating circumstances, in connection with determining a fine amount in this range. Rule 111-8-25-.05(1)(e)(2)(ii). When the same or substantially similar violation has been found and cited by the Respondent twice within the past twenty-four (24) months, the present violation shall be considered as a "repeat violation." Rule 111-8-25-.05(1)(e)(2)(iii). The fine amount for repeat violations shall be the top figure in the category. Rule 111-8-25-.05(1)(e)(2)(iii).

12.

The plain language of Rule 111-8-25-.05(1)(e)(2) also limits the Respondent's ability to impose any sanction upon a facility for a "subsequent" or "repeat" violation if a facility submits and adheres to a plan of correction:

"In no case, however, shall a facility be sanctioned for a violation characterized as a subsequent or repeat violation unless the time frame identified in the acceptable plan of correction has passed and the facility nonetheless has failed to attain or maintain correction."

The Petitioner submitted a Plan of Correction on that was accepted by Respondent.

13.

The Respondent has promulgated a written policy, referred to as the State Enforcement Matrix, based on the Rules. The State Enforcement Matrix provides that the highest level of fine, a sanction of a lesser degree than revocation, may be imposed if residents have suffered death, serious physical or emotional harm or are in "imminent danger." (Petitioner's Ex. 47; Rule 111-8-25-.05(3)). The State Enforcement Matrix categorizes Rule violations by scope (i.e., substantial compliance, Category I, II, or III) and severity (i.e., initial, subsequent, or repeat). Each combination of scope and severity is assigned a letter (and sanctions appropriate for a citation of each respective scope and severity.) Violations for which no follow-up is required are categorized as A (initial), B (subsequent), and C (repeat) violations. Category III violations are categorized as D (initial), E (subsequent) and F (repeat) violations. Category II violations are categorized as G (initial), H (subsequent), and I (repeat) violations. Category I violations, which are properly cited only in instances of death, serious harm, or an imminent threat of serious harm, are categorized as J (initial), K (subsequent), and L (repeat).

C. Alleged Violations of the Rules

14.

Rule 111-8-62-.09(3) Administration

This Rule requires that personal care home staff "be assigned duties consistent with their position, training, experience, and the requirements of Rule 111-8-62-.10." Rule 111-8-62-.10 requires in

pertinent part that the administrator or on-site manager be responsible for ensuring that work-related training within an employee's first sixty (60) days of employment include training on: (d) the medical and social needs of the resident population. Work-related training must also include sixteen hours of continuous training each year.

Although there was clearly a lack of documentation of the required training for six employees, there was also no evidence that the six employees were interviewed or questioned by the Surveyor as to whether or not they had received said training required by the Rules. According to the Interpretive Guidelines for Rule 111-8-62-.10(2), "Documentation of ....training may be kept in the employee's personnel file or a separate training file."

Since there is no requirement that the documentation of training be kept in the personnel file, the Petitioner did not violate this Rule for failure to provide documentation of training for staff.

15.

Rule 111-8-62-.09(4) Administration

This Rule requires that each personal care home have a "written and regularly rehearsed disaster preparedness plan, approved by the Department, in compliance with O.C.G.A. 31-7-3(c)." O.C.G.A. § 31-7-3(c) provides that a disaster preparedness plan (DPP) include "written procedures for personnel to follow in an emergency including care of the resident; notification of attending physician and other persons responsible for the resident; and arrangements for transportation, for hospitalization, for alternate living arrangements, for emergency energy sources, or for other appropriate services."

Although there was no doubt the facility had, and still has, a disaster preparedness plan to transport residents in the event of an emergency, the one provided to the Surveyor at the time of the investigation was unacceptable to Respondent as it failed to include alternative transportation arrangements while the facility van was out of service.

At the time of the Surveyor's visits, the facility van was out of service, and had been since December of 2011. However, while there are no written descriptions in the plan for alternative transportation arrangements, there is no requirement that the DPP include a "back-up transportation plan," in the event the mode of transportation is out of service. The Resident Director testified that there is a "backup" plan for the residents to be transported, and that a church bus, as well as a Whitfield County bus, is available to them; however, that information was not written down in the DPP.

While this is not a violation of Rule 111-8-62-.09(4), Petitioner is well-served by updating and/or revising its DPP to include what the provisions are for transportation if the facility van/bus is out of service.

16.

Rule 111-8-62-.11(1)(a) Staffing

This Rule requires that the personal care home shall have as many employees on duty at all times as may be needed to properly safeguard the health, safety and welfare of the residents. The on-site staff to resident ratio of 1:15 during waking hours and 1:25 during non-waking hours, is discussed in the Interpretative Guidelines: "[s]taffing as outlined in the [Rule] is a minimum. Minimum staffing refers to staff who are directly involved in the provision of direct care to residents." (Petitioner's Ex. 15.) Respondent cited Petitioner for insufficient staffing levels during the week of

January 19 – 25, 2012, specifically in the secured unit, where a single caregiver was assigned to assist all twelve residents.[14]

The Rules and interpretative Guidelines are unclear regarding the minimum staffing requirements in instances where the number of residents are slightly above multiples of 15 or 25. Regulatory compliance expert Connie Cheren testified that minimum staff ratios should be interpreted on an hours per patient basis. (Cheren, Day 9 Tr. 44.) Director of Personal Care Homes for the Respondent, Elaine Wright. testified that considering the ratios on this basis would not be incorrect. (Wright, Day 8 Tr. 24.)

In its determination that Petitioner was understaffed, the Surveyor did not consider or take into account the fact that the Resident Director, med techs and other professional staff would assist residents when needed or if understaffed for any reason.

And, while the Respondent did not prove that the Petitioner was understaffed the entire week of January 19 – 25, 2012, the evidence shows that Petitioner was understaffed on three shifts during that time period; therefore, Petitioner violated Rule 111-8-62-.11(1)(a).

Although a violation, the Respondent's determination that this is a Category I violation is misplaced. The evidence documents residents' falls, but the Respondent did not show any correlation between these falls and staffing levels. The Respondent determined that residents' falls were attributable to low staffing levels, but did not consider any other time periods during the five (5) visits made to the facility, to determine whether or not the greater number of falls occurred

[14] At the hearing, there was testimony concerning inadequate staffing in November and December, 2011. The Survey references a review of staffing levels between January 19 – 25, 2012, so the ALJ's determination is limited to those dates. However, Respondent confirmed that Petitioner had adequate staffing as of the December 2011 survey. (Wright, Day 7 Tr. 177.)

during the times when the facility was understaffed. Under its POC, the Petitioner is appropriately staffed, and in compliance with the Rule.

17.

Rule 111-8-62-.111(2)(f) Staffing

Rule 111-8-62-.11(2)(f) provides "[s]ufficient staff time shall be available to insure that each resident ....(f) is given prompt, unhurried assistance if she or he requires help with eating. " While the Surveyor (who reviewed the assessment forms for the secured unit residents) testified that nine (9) of the twelve (12) residents in the secured unit needed assistance with eating, a review of the assessment forms in the Respondent's file indicates that only three (3) of the twelve (12) residents required assistance with eating. (Respondent's Ex. I.)

Among the twelve (12) residents in the secured unit, Respondent identified weight loss in several residents and reported in the Survey that the weight loss was due to lack of proper staff. The evidence from the hearing showed that there were other clinical and/or medical reasons several of the secured unit's residents did not eat well, that were totally unrelated to whether or not the secured unit was properly staffed.

Although the undersigned disagrees that this is a Category I violation, as the Respondent did not show harm or an imminent threat of serious harm to the residents regarding this deficiency, the Petitioner admitted to understaffing on three shifts during the week of January 19 – 25, 2012, and, consequently, there was a shortage of staff to assist the residents with eating in the secured unit. Petitioner violated this Rule as stated in the Survey, but not to the severity so stated. Again, however, Petitioner is currently appropriately staffed according to its POC.

18.

Rule 111-8-62-.11(2)(g) Staffing

Rule 111-8-62-.11(2)(g) requires that sufficient staff time shall be available to insure that each resident is given assistance, if needed, with daily hygiene including baths and oral care. The Rule only requires that staff time should be available to assist residents "if needed." Assistance from third-party agencies or family members may preclude the need for the facility to assist residents with daily hygiene.

Upon review of the evidence, the Respondent has not met its burden of proof as to this Rule, and the Petitioner did not violate it. This citation was based on information from three (3) family members of residents that proved to be somewhat unreliable at the hearing. During the January – February 2012 period in question, the evidence showed that the referenced three (3) residents often received baths from home health or hospice, did not contract with Petitioner to receive baths, or declined baths due to personal preference. In addition, the Respondent presented no evidence concerning a lack of cleanliness or hygiene for any resident during the time period in question.

19.

Rule 111-8-62-.14(1) Physical Plant Health and Safety Standards

Pursuant to Rule 111-8-62-.14(1), "[e]ach home shall be in compliance with fire and safety rules promulgated by the Office of the Safety Fire Commissioner for personal care homes." The fire and safety rules are contained in specified editions of the International Fire Code (IFC) and the National Fire Codes (NFC) published by the National Fire Protection Association (NFPA), as modified by the Safety Fire Commissioner. Ga. Comp. R. & Regs. 120-3-3-.04 (2010).

The Respondent asserts that Petitioner's failure to conduct fire drills when evacuation would be most difficult violates the fire and safety rules. Rule 120-3-3-.04(70)(b)(1) – (3) provide descriptive terms for a facility's evacuation capability. Rule 120-3-3-.04(70)(b)(1) describes a facility's evacuation capability as "impractical" if "[t]otal evacuation of all residents from the building or structure cannot be achieved in less than thirteen minutes whether day or night." A facility's evacuation capability is based on the time of day or night when evacuation of the facility would be the most difficult. (e.g., sleeping residents and/or fewest staff present). Ga. Comp. R. & Regs. 120-3-3-.04 (2010). Although the fire and safety rules do not require that personal care homes conduct its drills when evacuation capability is most difficult, the Surveyor noted that the facility's evacuation capability was "impractical" on December 16, 2011, when the fire drill took more than 24 minutes to complete. Consequently, there has been a violation of this Rule by the Petitioner.

20.

Rule 111-8-62-.15(1) Furniture and Furnishings

According to Rule 111-8-62-.15(1) "[f]urnishings of the home in the living room, bedroom, and dining room shall be maintained in good condition, intact, and functional." When the Surveyor was present during the complaint investigation, two of the facility's dining room chairs had loose upholstery in the back, with exposed staples. There was also another chair which was missing an arm. The chairs were not being used by the facility, and there were a sufficient number of chairs in the dining room for all residents to sit in and use safely. There were no reported injuries of residents using any of these chairs in disrepair.

As the out-of- service chairs remained in the facility's dining room at the time of the inspection, Respondent has established that Petitioner technically violated Rule 111-8-62-.15(1). The fact that

it was a Category D violation is appropriate, as there is no evidence of harm occurring from those chairs. Petitioner has implemented in its POC a system to ensure its furnishings remain in good condition.

21.

Rule 111-8-62-.15(2) Furniture and Furnishings

Rule 111-8-62-.15(2) states that "[f]urnishings and housekeeping standards shall be such that a home presents a clean and orderly appearance." There was a violation of this Rule in the secured unit, which resulted from a turnover in the housekeeper position at the facility. The Surveyor observed deficiencies in housekeeping and, upon speaking with the Resident Director, who admitted that the housekeeping was not up to standards, noting that there was at that time a vacancy in the housekeeping position at the facility. The "fill-in-the-gap" measure was to ask other staff members to assist in those duties. However, since the implementation of the POC, there have not been further complaints regarding cleanliness at the facility.

22.

Rule 111-8-62-.15(3)(c); (e), and (f)

Rule 111-8-62 -.15(3) states that "[r]esident bedroom furnishings shall include the following...(c) a bureau or dresser....and at least one chair with arms per resident in each bedroom;...(e) an individual bed that is at least 36 inches wide and 72 inches long with a comfortable springs and mattress, clean and in good condition....(f) bedding for each resident which includes two sheets, a pillow, a pillow case....[a] home shall maintain a linen supply for not less than twice the bed

capacity. A home shall provide each resident clean towels and wash cloths at least twice weekly."[15]

The Respondent's citations for this Rule and its subparts were based on the interviewed family members who were told to bring furniture and furnishings for the resident family member who was moving into the facility. In other words, the families interviewed did not believe they had a choice in the matter, and that all bedroom furniture and linens had to be supplied by the resident. The evidence at the hearing was clear that the facility did not *proactively* offer to furnish residents' rooms upon admission as it had been their experience at the facility that families wished to furnish their family member's room with their own personal belongings that were familiar to them. There was testimony by the Resident Director, however, that the facility was capable of providing the required furniture and linens upon request. (emphasis added)

While the Rule may not indicate that the personal care home *shall* provide furniture and furnishings, the Interpretive Guidelines for this Rule and its subparts specifically states: "A separate bed must be available for and individually assigned to each resident.....Any variation... would require a waiver." This Interpretive Guideline certainly contemplates that the facility will provide the furniture. The facility did not offer furniture and furnishings, at least to the residents' families in the secured unit, who were interviewed at the time of the inspection. (emphasis added)

The ALJ finds that Rules 111-8-62-.15(3)(c) and (e) were violated, and the facility did not provide the residents' rooms with the furniture that each resident room shall contain. However, the Respondent did not find any evidence that an occupied room lacked the required bed and

[15] The Interpretative Guidelines contemplate personal care homes charging residents for the provision of furniture. (Mullican, Day 3 Tr. 25.)

furnishings. The Resident Director testified that the furniture was available, but that the families were encouraged to bring furniture with which the resident was familiar, but if they had refused, the furniture and linens would have been provided.

23.

Rule 111-8-62-.15(3)(f)

This Rule expressly requires facilities to maintain a linen supply for twice a facility's bed capacity. As the Petitioner did not maintain such a supply at the time of the inspection, the facility was in violation of this Rule. The Category D scope of this Rule violation was appropriate under the circumstances.

24.

Rule 111-8-62-.16(1)(e)

This Rule prohibits personal care homes from providing certain services: "(e) medical, nursing, health or supportive services required on a periodic basis, or for short-term illness, shall not be provided as services of the home. When such services are required, they shall be purchased by the resident or the resident's representative or legal surrogate, if any, from appropriately licensed providers managed independently for the home. The home may assist in arrangement for such services, but not provision of those services."

Although the scope of nursing services is not clearly defined under the Rules, it is clear that personal care homes generally should not "administer medications" to residents incapable of self-administration. The limit upon the services a personal care home can provide is gleaned from the

Interpretative Guidelines for Rule 111-8-62-.16(1)(e), which states that only homes with specialized memory-care units can administer medications:

> A personal care home may not provide medical, nursing, or health services to its residents. However, if the home has a specialized memory care unit, a licensed nurse.....may administer medications to residents who are incapable of self-administration.

(Petitioner's Ex. 15.)

Personal care homes staff cannot administer medications, but personal care home staff may assist and supervise residents with the self-administration of medication. Rule 111-8-62-.21(3) provides in pertinent part:

> A resident who is not capable of independent self-administration of medication may be assisted and supervised in self-administration by staff to the following extent: (d) He or she may be physically assisted in pouring or otherwise taking medication.

(Petitioner's Ex. 15.)

The Interpretative Guidelines for Rule 111-8-62-.20(1)(d)(1) defines "incapable of self-administration of medications" as requiring the residents to lack awareness that they are ingesting medications:

> 'Incapable of self-administration of medications means that the resident requires more than assistance with or supervision of medications. As an example, residents would be determined to be incapable of self-administration if they do not participate independently in the administration of the medication as indicated by receiving the medication in their own hands and placing it voluntarily in their own mouths or, if unable to hold the medication properly, being able to acknowledge the need for assistance in getting the medication to their mouths by swallowing it voluntarily.

(Petitioner's Ex. 15.)

The citation was based on the Surveyor's observation of a facility med tech crushing the medication of a resident, G.P. (Resident 21), placing it in yogurt, and feeding the yogurt to the

resident. The Survey indicates that the med tech stated to G.P. that she was feeding her yogurt, but the Surveyor did not investigate further to determine whether G.P. knew she was taking her medication when she was eating the yogurt.

The preponderance of the evidence from the hearing record, however, indicated that G.P. was able to acknowledge the need for assistance in taking her medications, and that G.P. would often request assistance with her medications. The evidence also showed that G.P. was able to swallow voluntarily her medications once they were crushed, pursuant to a physician's order. Because G.P. was able to acknowledge her need for assistance in ingesting her medications, Rule 111-8-62-.16(1)(e) does not prohibit the facility's conduct. As the Respondent did not show that G.P. was unable to acknowledge the need for assistance with her medications at the time of the inspection, there was no evidence that the Petitioner violated this Rule.

25.

Rule 111-8-62-.16(2)

Rule 111-8-62-.16(2) specifically provides: "No home shall admit or retain a resident who needs care beyond which the facility is permitted to provide. Applicants requiring continuous medical or nursing services shall not be admitted or retained." (emphasis added)

The terms "continuous medical or nursing services" is defined in the Interpretative Guidelines for Rule 111-8-62-.16(2):

> 'Continuous medical or nursing care and treatment' means services which are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be medically complex enough to require constant supervision, supervision by licensed nursing

personnel, or other professional personnel for safe and effective performance; and consistent with the nature and severity of the resident's condition.

Rule 111-8-62-.16(1)(c) and its Interpretive Guideline also prohibit the admission or retention of non-ambulatory residents: "Criteria for admission to a home are as follows: ...(b) The home shall admit or retain only ambulatory residents." In turn, Rule 111-8-62-.03(c) defines ambulatory as follows:

> (c)"Ambulatory Resident" means a resident who has the ability to move from place to place by walking, either unaided or aided by prosthesis, brace, cane, crutches, walker or hand rails, or by propelling a wheelchair; who can respond to an emergency condition, whether caused by fire or otherwise, and escape with minimal human assistance such as guiding a resident to an exit, using the normal means of egress.

The Rule violation was based on the Surveyor's observation of three (3) residents in the secured unit. The undersigned ALJ finds that those three (3) former residents, G.P., M.M., and M.H., were ambulatory and did not require continuous medical or nursing services at the time of admission. After these residents' conditions declined such that they required care beyond which the facility was permitted to provide, the facility acted reasonably, and timely, in conjunction with the resident's families, to discharge these residents to an appropriate facility. The facility provided protective care to these residents while they remained at the facility. Consequently, the Petitioner did not violate this Rule.

Further, subsequent to the Survey, Petitioner reassessed all of its residents and discharged any resident no longer appropriate for a personal care home.

26.

Rule 111-8-62-.16(3)(d)

Rule 111-8-62-.16(3)(d) requires that, prior to admission to a personal care home, a prospective resident must produce a statement from a physician stating that the resident "has received screening for tuberculosis within twelve (12) months of admission." At the time of the Survey, the Surveyor did not find evidence of a tuberculosis screening for respite resident D.S. (Resident 10). During the hearing, evidence was presented showing that D.S. had a tuberculosis screen within the past 12 months. Accordingly, Petitioner did not violate this Rule.

27.

Rule 111-8-62-.18(1)

Rule 111-8-62-.18(1) states that each personal care home must provide personal services to residents commensurate with the needs of the individual residents:

> The personal services shall include 24-hour responsibility for the well-being of the residents. Each home shall provide individual residents protective care and watchful oversight including but not necessarily limited to, a daily awareness by the management of resident's functioning, his or her whereabouts, the making and reminding a resident of medical appointments, the ability and readiness to intervene if a crisis arises for a resident, supervision in areas of nutrition, medication and actual provision of supportive medical services.

(Petitioner's Ex. 15.)

The Interpretative Guidelines for Rule 111-8-62-.18(1) provide surveyors and facilities guidance regarding the meaning of "24-hour responsibility" and "protective care and watchful oversight":

> Twenty-four hour responsibility for the well-being of the residents means knowing the whereabouts and condition of the residents. This does not mean 24 hour observation.

> Often a resident may be away from the facility unsupervised by the staff of the home. However, the home must know where the resident is at all times.

(Petitioner's Ex. 15.)

There was evidence of incidents of lack of protective oversight in the cases of several residents. For the most part, the failures to provide protective oversight were due to the limited staff. One resident wandered from the facility and was left outside overnight where he was found in the early morning. The same resident on another occasion eloped from the facility and wandered across four (4) lanes of traffic. One resident had fingernail marks across her upper arm and across her chest. On another occasion, the facility left the door to the secure unit open in order to allow the limited staff to enter and exit easily from the secured unit to the non-secured unit.

Another male resident had a documented history of inappropriate behavior involving female residents. The inappropriate behavior was first noted by the facility in October 2011, but this resident was not discharged until January 2012. There were attempts to redirect him when he displayed inappropriate behavior, but he eventually had to be discharged.

At the hearing, there was a great deal of evidence and testimony heard concerning resident falls and weight loss. The three isolated instances of weight loss referenced in the Survey, however, are better explained by reasons other than understaffing or lack of protective care. For instance, there was evidence of the residents' depression, for such reasons as loss of family members, and a desire to return to their own homes. Once the residents received professional help or were discharged to their homes, they gained weight.

Resident falls are a serious matter. However, the Survey does not necessarily "tie" the listed falls to a lack of staffing on the date/time of the fall, nor is there any indication how increased staff could prevent these falls. Most of the falls occurred in the individual residents' apartments, where

the residents were not *observed* 24 hours per day. (emphasis added) Seventy-six (76) of the seventy-eight (78) falls referenced in the Survey were unwitnessed.

As testified to by several witnesses, falls are common in a geriatric population; however, Respondent seemed to indicate in its Survey that the falls were related to a lack of staff in the secured unit, but it did *not* provide evidence that additional staff would, or could, prevent resident falls. (emphasis added)

However, I do find that Petitioner violated Rule 111-8-62-.18(1) in failing to provide protective care and watchful oversight, but not for 28 of 48 residents, as alleged in the Survey. Certainly, protective care and watchful oversight was not provided to the resident who was left outside overnight and who eloped and crossed four lanes of traffic. Nor were the female residents provided protective care when the resident who had a history of inappropriate behavior could not be re-directed and continued to harass them. While maybe less significant, the female resident with unexplained fingernail marks across her upper arms and chest may also indicate a lack of protective care, as there was no written indication as to how this incident occurred, and what, if any, was the conclusion of the investigation as to her injuries. I would disagree that the Rule violation is a Category L violation, as there was no evidence that behavior of this nature was repeated from prior incidents.

28.

Rule 111-8-62-.18(3)

This Rule requires that "each home...provide sufficient activities to promote the physical, mental and social well-being of each resident." The Interpretive Guidelines for this Rule indicates that a home is not required to create or post a formal monthly activity calendar, but residents and staff

must be made aware of planned activities. The record evidence established that Petitioner organizes and/or hosts several weekly activities for all of the residents, including those in the secured unit. Such activities include church services, dances, holiday parties, wellness exercises, sing-alongs, Bingo, and walks outside the facility.

The ALJ makes no distinction between activities sponsored by third-party agencies and those led by volunteers at the facility, as long as the Petitioner provides for activities for its residents, and the residents are made aware that the activities are being provided for them.

Based on the evidence presented at the hearing and the interpretation of the Interpretive Guideline for this Rule, the undersigned ALJ finds no violation of Rule 111-8-62-.18(3).

29.

Rules 111-8-62-.22(8) and 111-8-62-.22(9)

Rule 111-8-62-.22(8) states "[m]enus shall be written and posted 24 hours prior to serving of the meal. Any change or substitution shall be noted and considered part of the original menu."

Rule 111-8-62-.22(9) requires that personal care homes "maintain records of all menus as served. Menus shall be kept on file for thirty days for review by the Department."

The Interpretative Guidelines for Rules 111-8-62-.22(8) and 111-8-62-.22(9) provide that a personal care home's daily menu should be posted in an area where residents know the menu can be found. All records of changes and substitutes must also be kept on file for 30 days.

Prior to the inspection, Petitioner placed dated menus on tables in the dining rooms so that residents could select their meals, but did not post the menu on a wall or board. Rule 111-8-62-.22(8) does not require that menus be posted on a facility's wall, and any attempt to cite a facility for failure to post a menu on a wall would be improper. Therefore, the Respondent did not establish a violation of this Rule, and it should not have been cited as a "subsequent" Category II violation.

The facility is currently posting menus outside of the dining rooms on the facility's bulletin boards, according to its POC.

However, with respect to Rule 111-8-62-.22(9), there was a violation of the Respondent's Rules, as the facility maintained a cycle of four weekly menus that were rotated weekly but not identified individually by date. Under the provisions of its POC, Petitioner now maintains copies of its dated menus for 30 days. The Respondent's categorization of this violation as a Category III/D violation appears appropriate, as it is an administrative violation.

30.

Rule 111-8-62-.24(2)

Rule 111-8-62-.24(2) requires that each personal care home "insure that soap at the sinks and toilet tissue at each commode are provided for use by the residents." According to the evidence presented at the hearing, Petitioner violated this Rule by indicating to residents' family members that they were required to bring their own soap and toilet tissue. As there was no reported incident where a resident actually lacked soap at a sink or toilet tissue at a commode, the Respondent's categorization of this citation as a Category III/D violation is appropriate.

Rule 111-8-62-.27(2)

Rule 111-8-62-.27(2) provides that immediate investigation of the cause of an accident or injury shall be initiated and reported by the administrator or on-site manager to the resident's representative or legal surrogate with a copy of the report maintained in the resident's file and in a central file. (Petitioner's Ex. 15.)

This citation was based on a review of incident reports completed and maintained by the Petitioner. In addition, the Surveyor interviewed the Resident Director who seemed to affirm that any investigation of incidents would be documented on the incident reports. There was a lack of *written documentation* on the incident reports; however, the Surveyor did not determine whether or not the facility investigated the cause of the incidents as reported on the incident reports. (emphasis added)

The testimony at the hearing established that the facility did investigate and report the cause of any accident and/or injury to the resident's family or legal representative as required by Rule 111-8-62-.27(2), but failed to complete the incident report in writing as it should on many of the incident reports. Apparently, the facility had been cited for this "failure to document" on August 24, 2010, and February 22, 2011.

While I find that this Rule was *technically violated* for failure to complete documentation on the incident forms, I also find that there was *no evidence* that any resident suffered serious physical or emotional harm, or was in imminent danger of such harm, as a result of the facility's failure to complete the PCH Incident/Accident Form as it should have been completed. (emphasis added) Failure to complete the incident form properly does not prove that the incident or injury was not

investigated. Nor does it prove that the family was not notified of the accident or injury to a resident. However, the Rule and the Interpretative Guidelines about the Rule indicate that the information that is required on the PCH Incident/Accident Form will be completed properly and will be kept in the resident's file and a "central" file. (Respondent's Ex. G.)

In addition, pursuant to its POC, the facility has enhanced its procedures for documenting investigations of incidents and the interventions to be implemented in response to those incidents.

32.

Rule 111-8-25-.06(3)

Rule 111-8-25-.06(3) states as follows:

> Facility staff shall cooperate with any inspection or investigation conducted by the department and shall provide, without unreasonable delay, any documents which the department is entitled hereunder.

(Petitioner's Ex. 14.)

Respondent determined that the facility violated this Rule by failing to make copies of notes concerning residents that were contained in a communication log, stating that said information was in-house documentation and not part of the residents' files.

Rule 111-8-25-.06(2) states:

> Department representatives shall be allowed reasonable and meaningful access to the facility's premises, and information pertinent to licensure including staff and persons in care. The department shall have the authority to require the productions of any documents related to the initial and continued licensing of any facility.

(Petitioner's Ex. 14.)

On the advice of legal counsel, the facility denied the Surveyor permission to make copies of the shift communication notebook. However, the evidence at the hearing was that the Surveyor was provided access to the facility's shift communication notebook. The Surveyor could make notes, but not make copies of the documents, or writings, contained in that notebook. And, the Rule speaks only to production of documents "related to the initial and continued licensing of any facility." Rule 111-8-25-.02(13) defines "licensing requirements" as "any provision of law, rule, regulation, or formal order of the department which apply to facilities with respect to initial or continued authority to operate." Consequently, Respondent is entitled to any documents related to any provision of law, rule, regulation, or formal order of the Department which applies to personal care homes.

The ALJ's review of the Rules and corresponding Interpretative Guidelines indicate that facilities must maintain the following documents: the facilities' policies and procedures (Rule 111-8-62-.09(1)), disaster plans (Rule 111-8-62-.09(4)), employee personnel files (Rule 111-8-62-.10(11)), monthly staff schedules (Rule 111-8-62-.11(1)(c)), records of pet inoculations (Rule 8-62-.14(11)), photographs of residents at risk of eloping (Rule 111-8-62-.19(2), resident files (Rule 111-8-62-.25(1)), and incident reports (Rule 111-8-62-.27(2)). Neither the Rules nor the Enforcement Regulations indicate that the Respondent is entitled to Petitioner's shift communication notebook pursuant to Rule 111-8-25-.06(3). The ALJ concludes that Petitioner did not violate this Rule as the Survey alleges.

D. Sanction

33.

As previously stated, when the Respondent determines that a personal care home has violated any of the Rules, it may impose any one or more of the following sanctions:

(a) Administer a Public Reprimand,
(b) Suspend any License,
(c) Prohibit Persons in Management or Control,
(d) Revoke any License,
(e) Impose a Civil Penalty Fine, or
(f) Limit or Restrict any License.

Ga. Comp. R. & Regs. 111-8-25-.05(1)(a) – (f)(2010).

34.

The undersigned Administrative Law Judge (ALJ) stands in the shoes of the referring agency and "has all the powers of the referring agency with respect to a contested case." Further, the ALJ "shall make an independent determination on the basis of the competent evidence presented at the hearing" and "may make any disposition of the matter available to the Referring Agency." Ga. Comp. R. & Regs. 616-1-1-.21(1)(2010).

35.

Here, the Respondent established that Peachtree Estates Assisted Living Facility failed to have adequate staffing in violation of Rule 111-8-62-.11(1)(a); failed to provide sufficient staff time to certain residents to insure that the resident is given prompt, unhurried assistance with eating, in violation of Rule 111-8-62-.11(2)(f); failed to comply with fire and safety rules for personal care homes promulgated by the Office of the Safety Fire Commissioner, in violation of Rule 111-8-62-.14(1); failed to comply with the requirement that a home maintain its furnishings in good condition, intact, and functional, in violation of Rule 111-8-62-.15(1); failed to maintain certain housekeeping standards to present a clean and orderly appearance, in violation of Rule 111-8-62-.15(2); failed to comply with Rule 111-8-62-.15(3)(e) and (f) as it relates to providing certain bedroom furniture and bedding for residents; failed to provide protective care and watchful oversight for certain residents, in violation of Rule 111-8-62-18(1); failed to maintain records of

all menus as served for 30 days, in violation of Rule 111-8-62-.22(9); failed to insure that soap at the sinks and toilet tissue at the commodes were provided for use by the residents, in violation of Rule 111-8-62-.24(2); and, lastly, failed to maintain appropriate documentation on the incident reports of the investigation of the cause of accident or injury to residents, in violation of Rule 111-8-62-.27(2).

36.

Respondent seeks revocation of Petitioner's license to operate, pursuant to Rule 111-8-25-.05(4). That decision was based on the Survey report, and certain past Rules' violations, according to Ms. Elaine Wright, Director of the Respondent's Personal Care Home Program (Wright, Day 7 Tr. 184.) as well as concerns for residents' safety. There was little evidence concerning the details of prior allegations of Rules violations, (noted as a Citations History) other than a provided list that appeared after several days of testimony and evidence.

37.

Concerning the safety of residents, however, Respondent presented insufficient evidence that the residents were in "imminent" or "substantial" danger, demanding revocation of the facility's permit to operate as a personal care home. The passage of time between the initiation of its investigation on January 24, 2012, and the issuance of its Notice of Intent to Revoke on March 30, 2012, without imposing any interim measures against the facility, is not consistent with the Respondent's contention that residents were in imminent harm. The fact that Respondent did not employ any extraordinary sanctions, which it has a right to do under the statute, as well as the Rules, is a significant fact in this case, as there were several options that Respondent could have chosen, and chose none of them, when confronted with the Petitioner's Rule violations presented in the Survey. O.C.G.A. § 31-7-2.2.

38.

Respondent's own actions following the Survey are inconsistent with the contention that the residents of the facility were at imminent risk of substantial harm. Although Ms. Wright testified that adverse action by Respondent calls for monitoring visits by its surveyors to ensure the residents are not at imminent risk, in the Petitioner's case, monitoring visits were made with no consequences to the facility, even after the Survey had been issued. It was the "possibility that something really bad" could happen due to resident falls, that was the Respondent's issue causing concern for residents at the facility.[16]

39.

The Survey which led to the decision to revoke Petitioner's license was completed on February 17, 2012, and the Notice of Intent to Revoke was dated March 30, 2012. The hearing in this matter began on July 24, 2012, and lasted over several months, the last day of testimony being December 12, 2012. During those ten months, and indeed during the first three months of 2013, Respondent has not prohibited or restricted admission for any new residents. O.C.G.A. § 31-7-2.2(c)(1). A monitor was not placed at the facility; Respondent has not relocated the residents in the facility; nor has the Respondent closed the facility. O.C.G.A. § 31-7-2.2(b)(1)(D).

40.

Lastly, Respondent accepted both the IPC and the Petitioner's POC, the provisions of which were being adhered to by the time of the hearing, based on testimony and documentary evidence showing that the monitoring visits revealed no additional violations. Rule 111-8-25-.05(1)(e)(2)

[16] "The Peachtree Estates issue was the possibility of something really bad going on with the number of falls that were happening with the residents, with the lack of staffing. And an emergency relocation in those kinds of circumstances are often more detrimental to the residents because it's hard to place 50 residents in an emergency relocation." (Wright, Day 7 Tr. 181.)

states that a facility cannot be sanctioned for a violation characterized as a subsequent or repeat violation unless the time frame identified in the acceptable plan of correction has passed and the facility has not corrected the violation. Revocation is too harsh a sanction in the Petitioner's case, and not warranted by the circumstances of this case or by the evidence presented at this hearing. O.C.G.A. § 31-7-4.

41.

Nevertheless, the violations established by the Respondent are serious, and could have created potential hazards to the safety of the facility's residents if not corrected. Accordingly, the undersigned concludes that Peachtree Estates Assisted Living Facility should be sanctioned as follows:

1. Petitioner shall receive a Civil Penalty Fine, with the amount based on the violations the Respondent proved at the hearing, as calculated by the Respondent on remand;

2. Petitioner's license shall be limited as follows:

(i) Petitioner's admissions to the secured unit are hereby restricted to the current residents. Petitioner is prohibited from admitting additional residents into the secured unit until the expiration of one year from the date of this Initial Decision, and the passing of an annual survey by Respondent with no Rule violations.

(ii) Petitioner may admit no more than forty-five (45) residents in the non-secured area of the building. If there are currently more than forty-five (45) residents living at Peachtree Estates Assisted Living Facility in the non-secured area, all present residents may remain at the facility. However, no additional residents may be admitted above the census of forty-five (45) residents. Thereafter, the facility's census may not exceed forty-five (45) residents in the non-secured area until the expiration of one year from the date of this Initial Decision, and the Respondent conducts an annual survey with no Rule violations noted.

Ga. Comp. R. & Regs. 111-8-25-.05(1)(e) and 111-8-25-.05(1)(f)(2010).

IV. Decision

For the foregoing reasons, the Respondent's decision to sanction Peachtree Estates Assisted Living Facility's license is hereby AFFIRMED. However, the proposed sanction of revocation of its permit to operate is hereby REVERSED, and modified as stated herein. This matter is hereby REMANDED to the Respondent to calculate and impose the Civil Penalty Fine, in accordance with Ga. Comp. R. & Regs. 111-8-25-.05(1(e)(2010).

SO ORDERED, this 11th day of April, 2013.

Barbara A. Brown
Administrative Law Judge