BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

MOUNTAIN VIEW PERSONAL CARE HOME, Petitioner,	:	Docket No.: OSAH-DCH-HFR-PCH-1332780-44-Walker
v.	:	
DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATION DIVISION, Respondent.	:	

INITIAL DECISION

Petitioner, Mountain View Personal Care Home, appeals a determination by Respondent, the Department of Community Health, Healthcare Facility Regulation Division, (hereinafter the "Department"), to impose a fine of $600.00 for two repeat category III violations. An administrative hearing was held on May 10, 2013. For the reasons given below, the action of the Department is **AFFIRMED**.

I. FINDINGS OF FACT

1.

The Department conducts annual inspections of state-licensed Personal Care Homes and also responds to complaints made about Personal Care Homes. On September 14, 2012, staff from the Department completed a follow-up inspection and Summary Statement of Deficiencies ("the inspection report") at Mountain View Personal Care Home located at 3675 Kensington Road, Decatur, Georgia. *Testimony of Elaine Wright; Exhibit R-1.*

2.

Mountain View Personal Care Home ("Mountain View" or "the facility") was established in 1882 and is a not-for-profit organization. The Department's inspection report identified several

violations of the Rules and Regulations for Personal Care Homes, Ga. Comp. R. & Regs. r. 111-8-62. Finding that the facility was not in substantial compliance with the Rules and Regulations, the Department sought to impose a fine on the facility for violations that had been cited on at least three occasions in the past twenty four months. In response to the Department's proposed action, the facility requested an administrative hearing. *Testimony of Elaine Wright; Testimony of Barbara Hamler; Exhibit R-1.*

3.

Georgia Rule 111-8-62-.18(1) provides in relevant part:

> Each personal care home shall provide room, meals and personal services to the residents of the home which are 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 the 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. Personal services shall be provided by the administrator or on-site manager or by appropriately qualified staff designated by the administrator or on-site manager.

Ga. Comp. R. & Regs. r. 111-8-62-.18(1).

4.

Based on its inspection, the Department determined that the facility failed to provide protective care and watchful oversight regarding the area of supervision of medications and blood sugar monitoring for two residents of the facility, Resident #13, and Resident #9. A violation of this rule had also been cited by the Department on two prior occasions, 4/8/11 and 3/6/12. *Testimony of Elaine Wright; Exhibit R-1.*

5.

As to the first incident cited, a review of the Medication Administration Record for Resident #13 reflects that this resident received no medication from 8/23/12 through 8/28/12. However, the evidence also demonstrated that prior to arriving at the facility, Resident #13 was in the care of

the Veteran's Administration Hospital. When Resident #13 was transferred to the facility, his physician at the Veteran's Administration Hospital failed to issue any orders regarding medication. The facility timely contacted the hospital regarding such orders, but only was able to dispense medication after the orders arrived. *Testimony of Shakema Allen; Exhibit R-1.*

6.

As to the second incident, the evidence demonstrated that medical orders for Resident #9 prescribed that Lantus insulin should not be administered if his blood sugar was less than 100. Nonetheless, the facility failed to test Resident #9's blood sugar on numerous occasions because it did not have the necessary testing strips. *Testimony of Debra Smith; Exhibits R-1; R-8; R-10.*

7.

Georgia Rule 111-8-62-.21(6) provides in relevant part:

> Medications shall be properly labeled and handled in accordance with current applicable laws and regulations.

Ga. Comp. R. & Regs. r. 111-8-62-.21(6).

8.

The evidence presented at the hearing demonstrates that the facility failed to properly handle medications on several occasions. On August 28, 2012, the inspection report detailed that the facility was storing, as opposed to disposing of, medications that had expired on 5/2/10, 4/19/12, and 4/8/12. This same rule was previously cited on 3/6/12 and 5/3/12. *Testimony of Debra Smith; Exhibits R-1; R-7.*

9.

Barbara Hamler, who chairs the Mountain View board of directors, testified on behalf of the facility. She did not deny the allegations in the inspection report; however, she explained that the facility's former director had resigned on June 30, 2012. The facility has hired a new director, Shakema Allen, who is working very hard to improve facility management. She notes

that the Department did not find any repeat violations in the January 2013 audit. *Testimony of Barbara Hamler.*

II. CONCLUSIONS OF LAW

1.

The Department bears the burden of proof to show that its proposed imposition of sanctions is appropriate. The standard of proof is preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.07, -.21(4).

2.

In the instant case, the Department notified Petitioner that it intended to impose a $600.00 fine for several violations of the Rules and Regulations for Personal Care Homes, Chapter 111-8-62.[1] Ga. Comp. R. & Regs. r. 111-8-25-.05 (giving Department authority to impose civil penalty fine.). Petitioner contests this proposed action. The administrative hearing is *de novo* and the undersigned must make an independent determination on the basis of the evidence presented at the hearing. Ga. Comp. R. & Regs. r. 616-1-2-.21(1), (3).

3.

Pursuant to Georgia Code Section 31-2-8(b), the Department may sanction a licensee who has violated Department rules, regulations, or formal orders related to the continued licensing of the facility. O.C.G.A. § 31-2-8(b); Ga. Comp. R. & Regs. r. 111-8-25-.04.

4.

The Department may sanction a licensee by administering a public reprimand, suspending any license for a definite or indefinite period, revoking a license, or imposing a fine of up to $25,000 as a sanction against a licensee. Ga. Comp. R. & Regs. r. 111-8-25-.05. The statute provides that in taking any of these actions, "the [D]epartment shall consider the seriousness of the

[1] The purpose of the personal care home rules is "to establish the minimum standards for the operation of personal care homes which provide residential and personal services to adults who require varying degrees of supervision and care and to assure safe, humane and comfortable, supportive residential settings." Ga. Comp. R. & Regs. r. 111-8-62.-.02.

violation, including the circumstances, extent, and gravity of the prohibited acts, and the hazard or potential hazard created to the health or safety of the public." O.C.G.A. § 31-2-8(c); Ga. Comp. R. & Regs. r. 111-8-25-.05(4).

5.

The Department categorized the incidents cited as Category III violations. A Category III violation is a violation or combination of violations of licensing requirements which indirectly, or over a period of time, has or is likely to have adverse effect on the physical or emotional health and safety of a person or persons in care, or a violation or violations of administrative, reporting or notice requirements. Ga. Comp. R. & Regs. r. 111-8-25-.05(1)(e)(iii).

6.

Although the inspection report detailed multiple violations, the Department only imposed a fine as to the two violations that had been cited on at least three occasions in the past twenty four months. In the instant case, the Department has proven the violations and a $600.00 fine is appropriate. Although Mountain View presented credible evidence that it was not at fault regarding the failure to administer medication to Resident #13, there was an additional violation, the failure to test Resident #9's blood sugar, that supported the imposition of a fine for a violation of Rule 111-8-62-.18(1). The Department also proved that the continued storage of expired medications violated Rule 111-8-62-.21(6).

7.

Mountain View also presented testimony that the facility's new director had substantially improved the facility's management, and thus the fine should be waived. Ga. Comp. R. & Regs. r. 111-8-25-.05(4) allows a facility to claim financial hardship if the fine would "cause significant financial hardship that would compromise its ability to provide care or services in compliance with licensing requirements." In this case the facility did not present evidence of significant financial hardship, and thus the imposition of a $600.00 fine is appropriate.

III. DECISION

IT IS HEREBY ORDERED THAT the Department's proposed action is **AFFIRMED.**

SO ORDERED, this 22nd day of May 2013.

RONIT WALKER, ALJ