BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

WALNUT CREEK MANOR, Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-DCH-HFR-PCH-1332781-75-Walker
DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATION DIVISION, Respondent.	:	

INITIAL DECISION

Petitioner, Walnut Creek Manor, appeals a determination by Respondent, the Department of Community Health, Healthcare Facility Regulation Division, (hereinafter the "Department"), to revoke the licensee's permit to operate a personal care home. An administrative hearing was held on April 23, 2013, and the record closed on April 26, 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. In response to a complaint, Department staff conducted inspections of Walnut Creek Manor (or "the facility"), located at 1033 Highway 155 North, McDonough, Georgia, on May 1, 2012, May 15, 2012, May 23, 2012, and July 12, 2012. On August 23, 2012, Department staff completed a Summary Statement of Deficiencies ("the inspection report"), and completed a final inspection of the facility. *Testimony of Deborah Colvin; Exhibit R-1.*

2.

The inspection report identified seven 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, and that the facility had maintained falsified records, the Department sought revocation of the licensee's permit to operate a personal care home. In response to the Department's proposed action, the facility asked for an administrative hearing. *Testimony of Elaine Wright; Exhibit R-1.*

3.

Rule 111-8-62-.13(12)(f) of the Rules and Regulations of the State of Georgia provides that bathroom facilities shall, minimally, have "[a]ll plumbing and bathroom fixtures . . . maintained in good working order at all times; and shall present a clean and sanitary appearance."

4.

Based on its inspection, the Department determined that the facility failed to maintain all plumbing and bathroom fixtures in good working order, as mandated by Rule 111-8-62-.13(12)(f). One of two toilets in a bathroom located at the facility was not working, and in another bathroom, a toilet was unsecured to the floor. Additionally, a bathtub faucet was inoperable. The inspection report stated that these violations were noted on May 15, 2012, and as of August 23, 2012 had not been repaired. *Testimony of Deborah Colvin; Testimony of Debra Smith; Exhibit R-1.*

5.

Rule 111-8-62-.14(6) of the Rules and Regulations of the State of Georgia provides in relevant part:

> Floors, walls and ceilings [of a facility] shall be kept clean and in good repair.

6.

As to the second violation, the inspection report notes that on May 15, 2012, a tile was missing from the floor of a bathroom at the facility, causing a tripping hazard. Inspectors also observed

peeling sheetrock on another bathroom's wall behind a toilet. *Testimony of Deborah Colvin; Exhibit R-1.*

7.

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.

The Rules and Regulations of Georgia also provide that each resident file must include, among other things, "health information including all health appraisals, diagnoses, prescribed diets, medications, and physician's instructions." Ga. Comp. R. & Regs. r. 111-8-62-.25(2)(i).

8.

Based on its inspection, the Department determined that the facility failed to provide protective care and watchful oversight regarding medications for three of twelve residents and failed to maintain appropriate health information. A number of incidents reflect the facility's failures in this regard.

9.

First, a review of the Medication Administration Record for Resident #1 demonstrates that this resident was prescribed Oxycodone 15 mg for pain, to be administered twice per day, but that

Walnut Creek Manor staff could not locate Resident #1's prescribed Oxycodone for a period of time. In substitution for the Oxycodone, the facility's administrator, Madeline Laruy, offered Resident #1 Methadone, a medication that was not currently prescribed to him. Resident #1 declined to take the Methadone, noting that it had made him ill in the past. Ms. Laruy then offered Resident #1 Hydrocodone, another medication that was not currently prescribed to him. The missing Oxycodone was found on-site after Ms. Laruy's attempts to offer Resident #1 alternative medications. Ms. Laruy acknowledged that the prescribed medication had been "missing," and that she had offered Resident #1 Methadone in lieu of the prescribed medication. *Testimony of Deborah Colvin; Testimony of Brandy Carlisle; Testimony of Madeline Laruy; Exhibits R-1; R-3.*

10.

Second, during the inspection, Department staff reviewed the facility's admission agreement which indicates that the facility was responsible for the initial acquisition and refills of prescribed medications. A review of the Medication Administration Record in April 2012 demonstrated that Resident #5 was without Hydrocodone, a pain medication, for a number of days because the prescription was not timely ordered by Ms. Laruy. Ms. Laruy told the inspectors that Resident #5 was only missing his Hydrocodone for a few days, and that she administered over-the-counter Tylenol to Resident #5 during this time. Resident #5 did not have a prescription for over-the-counter Tylenol. In March 2012, the Medication Administration Record reflects that he was given three other over-the-counter medications without a prescription or a physician's orders. Ms. Laruy admitted that she was not aware that even over-the-counter medications must have a doctor's prescription to ensure that such medications do not interfere with prescribed medications. *Testimony of Deborah Colvin; Testimony of Brandy Carlisle; Testimony of Madeline Laruy; Exhibit R-1.*

11.

Third, Brandy Carlisle is a former facility employee. In a confidential interview given to Department inspectors, Ms. Carlisle stated that Ms. Laruy had instructed her to give Resident #2, an individual who was subject to violent outbursts, Tizanidine to calm him down. However, the Tizanidine listed a former Resident's name, Resident #14, on the packaging. Resident #14 had

passed away in hospice care. Ms. Carlisle refused to administer the medication to Resident #2. *Testimony of Deborah Colvin; Testimony of Brandy Carlisle; Exhibit R-1.*

12.

Documents received from hospice care indicate that patients transferred from Walnut Creek Manor were transferred without their prescribed medications. In some cases, hospice employees traveled to the facility to obtain the medications. Some prescriptions were never located. *Testimony of Deborah Colvin; Exhibits R-1; R-7.*

13.

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).

14.

The evidence presented at the hearing demonstrates that the facility failed to properly handle discontinued medications and the medications of discharged residents. As noted, Resident #1's Oxycodone was missing from the facility for a number of days, and Ms. Laruy offered him medications that were not currently prescribed. Ms. Laruy directed a staff member to administer Tizanidine to Resident #2, a medication that was not prescribed to this Resident and, in fact, belonged to a deceased resident. Further, patients transferred to hospice care arrived without their prescribed medications. *Testimony of Deborah Colvin; Testimony of Brandy Carlisle; Testimony of Madeline Laruy; Exhibits R-1; R-7.*

15.

Georgia Rule 111-8-62-.22(5) provides in relevant part:

> A home shall have a properly equipped kitchen to prepare regularly scheduled, well-balanced meals unless it arranges for meals with a permitted food service establishment.

Ga. Comp. R. & Regs. r. 111-8-62-.22(5).

16.

The evidence presented at the hearing demonstrates that the facility failed to maintain a properly equipped kitchen, because the door of the refrigerator, which was for resident use, had a handle that was broken in two places, the top and bottom. *Testimony of Deborah Colvin; Testimony of Debra Smith; Exhibit R-1.*

17.

Georgia Rule 111-8-25-.04(a) gives the Department the authority to impose sanctions where an applicant or licensee has:

> Knowingly made any verbal or written false statement of material fact either in connection with the application for a license; or on documents submitted to the department as part of any inspection or investigation; or in the falsification or alteration of facility records made or maintained by the facility . . . .

Ga. Comp. R. & Regs. r. 111-8-25-.04(a).

18.

On May 15, 2012, Ms. Laruy presented her file to two department representatives for review. The file contained a copy of Ms. Laruy's purported nursing license issued by the Georgia Board of Nursing. The document purported to show Ms. Laruy's license number, listed with Ms. Laruy's name and address. The purported license reflected an expiration date of January 31, 2012. When questioned about the license, Ms. Laruy stated that she had allowed the license to expire. *Testimony of Debra Smith.*

19.

At the hearing, the Department presented a number of documents reflecting communications from Ms. Laruy to medical doctors and/or state agencies, including the Department. When signing these communications, Ms. Laruy often followed her signature with the initials "RN," representing herself as a registered nurse. She also told staff and residents at the facility that she was a registered nurse. *Testimony of Deborah Colvin; Testimony of Brandy Carlisle; Testimony of Debra Smith; Testimony of Madeline Laruy; Exhibits R-1; R-7; R-8; R-9; R-10.*

20.

On June 14, 2012, a search of the Secretary of State's website revealed that the purported license number registered to Ms. Laruy was in fact registered to another individual. Ms. Laruy acknowledged that she had never held a nursing license and that the license was a forgery. However, at the hearing she maintained that no resident suffered because of her misrepresentation because she had the work experience and education to be a registered nurse, and that, in any event, Walnut Creek Manor always had a registered nurse on staff. *Testimony of Debra Smith; Testimony of Madeline Laruy; Exhibits R-1; R-11.*

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.

On October 1, 2012, the Department notified Petitioner that it intended to revoke Petitioner's permit to operate a personal care home for seven violations of the Rules and Regulations for Personal Care Homes, Chapter 111-8-62.[1] Petitioner contests this proposed action. 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.

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 upon a finding that the licensee has "[k]nowingly made any false statement of material information in connection with the application for a license, or in statements made or on documents submitted to the department as part of an inspection, survey, or investigation, or in the alteration or falsification of records maintained by the . . . facility." Moreover, 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(c); Ga. Comp. R. & Regs. r. 111-8-25-.04.

4.

Pursuant to Georgia Code Section 31-2-8(c), the Department may administer a public reprimand, suspend any license for a definite or indefinite period, revoke a license or impose a fine 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 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's presentation in this case details a number of serious violations, making clear that Ms. Laruy is unfit to administer the facility. Ms. Laruy deprived facility residents of necessary medications by failing to order them from the pharmacy, "losing" these medications within the facility, and failing to send medications with residents transferred to hospice care. She attempted to administer medications, and told her employees to administer medications, that were not prescribed to facility residents. Not only were such actions prohibited by statute, and Department rules and regulations, they created substantial risk to the health and safety of facility residents. Moreover, at the hearing, Ms. Laruy demonstrated a notable lack of remorse regarding

her falsification of a nursing license, maintaining that in her estimation, she had the necessary experience and education to qualify for this designation. Coupled with her failure to maintain the facility in good working order, Ms. Laruy's actions mandate that revocation is the only appropriate sanction in this case.

III. DECISION

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

SO ORDERED, this 15th day of May 2013.

RONIT WALKER
Administrative Law Judge