BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS

STATE OF GEORGIA

SHALOM PERSONAL CARE HOME Petitioner,	:	Docket No.: OSAH-DCH-HFR-PCH-1333619-67-Baxter
v.	:	
DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATION DIVISION, Respondent.	:	

INITIAL DECISION

Petitioner, Shalom Personal Care Home, appeals a decision by the Department of Community Health, Healthcare Facility Regulation Division ("Department"), to impose a fine of $601.00 for one Initial Category I violation. An administrative hearing was held on May 13, 2013. For the reasons set forth below, the action of the Department is **AFFIRMED**.

I. FINDINGS OF FACT

1.

Dr. Patricia Williams owns Shalom Personal Care Home. Personal care homes provide residents, who are typically mentally or developmentally disabled, with services such as assistance with activities of daily living and medication supervision. One of Petitioner's residents, S.A., suffers from schizophrenia, has a history of wandering, and is under the guardianship of Adult Protective Services ("APS"). When Dr. Williams accepted S.A. as a resident in June 2012, she was not informed of his habitual elopement history. Had she known, Dr. Williams would not have accepted S.A. as a resident. *Testimony of Mullican, Williams & Wright; Exhibit A.*

2.

On June 28, 2012, Department staff conducted an on-site visit to Shalom Personal Care Home ("Shalom" or "Facility") to investigate a complaint and a Facility-reported incident. The investigation revealed that S.A. was able to elope from the Facility on four separate occasions. Shalom's records indicate that on June 3, 2012 (days after his initial arrival), S.A. went missing

from the Facility and was subsequently located by the police at a Rite Aid on Sugarloaf Parkway, a busy four-lane highway. Two days later, on June 5, 2012, S.A. eloped again and was returned to the Facility after the police found him in a parking lot near Sugarloaf Parkway and Lawrenceville Highway. On June 7, 2012, S.A. eloped for the third time and was missing for two weeks before Shalom discovered that he had been admitted to the hospital. Since the Department's on-site visit to Shalom, S.A. eloped again on July 22, 2012, while attending church. The Facility took no measures after each elopement to prevent S.A. from eloping and did not seek to discharge S.A. from the Facility since it could not adequately supervise him. *Testimony of Mullican & Williams; Exhibits 1, 4.*

3.

Shalom notified APS whenever S.A. eloped but, with the exception of the fourth elopement, failed to notify the Department as required by the personal care home rules. Dr. Williams explained that she was not aware she needed to notify the Department since she was already notifying another state agency, APS. *Testimony of Mullican & Williams; Exhibit 1.*

4.

The Facility has a door alarm to alert staff whenever someone enters or leaves the Facility. The alarm was not armed on June 3, 2012, when S.A. first eloped, and was not working during S.A.'s third elopement. Though the alarm has since been repaired, Department staff observed that it was not armed during the June 28, 2012 site visit even though S.A. was present in the Facility. Moreover, Facility staff failed to activate the alarm during the day, though S.A. was not always in line of sight, because staff did not want the alarm to constantly sound as people came and went. *Testimony of C. Mullican; Exhibit 1.*

5.

In addition to the elopements, the Department's investigation found that on June 26 and June 27, 2012, Shalom provided S.A. with medications that were not prescribed per his Patient Discharge Medication Instructions, following his June 8, 2012 hospital admission. Though Dr. Williams explained that S.A. was discharged from the hospital without medications, S.A.'s Patient Discharge Medication Instructions indicates otherwise. *Testimony of Mullican & Williams; Exhibits 5, 6.*

II. CONCLUSIONS OF LAW

1.

Under Ga. Comp. R. & Regs. r. 616-1-2-.07, the Department bears the burden of proof in this matter. The standard of proof is by a preponderance of the credible evidence. OSAH Rule 616-1-2-.21(4).

2.

As a result of the Department's investigation, Shalom was found to be in violation of two of the Rules and Regulations for Personal Care Homes, Ga. Comp. R. & Regs. r. 111-8-62[1]. The Department, however, proposed a fine for only one rule violation, Ga. Comp. R. & Regs. r. 111-8-62-.18(1).

3.

Ga. Comp. R. & Regs. r. 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 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.

4.

Pursuant to Ga. Comp. R. & Regs. r. 111-8-62-.34(5) and Ga. Comp. R. & Regs. r. 111-8-25-.05, the Department is authorized to enforce its rules, subject to notice and opportunity for a hearing, by imposing an array of sanctions, including fines.

5.

Fine amounts are based on the severity and frequency of the rule violation. A "Category I" violation is the most severe, a "Category II" violation is less severe and a "Category III" is the least severe. Ga. Comp. R. & Regs. r. 111-8-25-.05. A "Category I" violation is defined as "a

[1] The Rules & Regulations for Personal Care Homes were amended effective January 8, 2013. The personal care home rules cited in this Decision refer to the rules in effect as of October 2, 2012, the date of issuance of the Department's Notice of Intent to Impose Fine.

violation or combination of violations of licensing requirements which has caused death or serious physical or emotional harm to a person or persons in care or poses an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in care." Ga. Comp. R. & Regs. r. 111-8-25-.05(1)(e)(1)(i). Further, a "Category I" violation allows for the imposition of a fine ranging from $601.00 to $1000.00 per violation, per day. *Id.* The exact amount of the fine within that range depends on whether the violation is an "Initial," "Subsequent" or "Repeat" violation. Ga. Comp. R. & Regs. r. 111-8-25-.05(1)(e)(2). An "Initial" violation means "the same or a substantially similar violation has not been cited previously by the department within the past twenty-four (24) months against the facility." *Id.*

6.

Petitioner's failure to provide proper supervision and oversight of S.A. led to his four elopements from the Facility. Petitioner failed to activate its door alarm to alert it of S.A.'s possible elopement and also failed to discharge S.A. when it became evident Petitioner was unable to keep him from eloping. This lack of oversight posed an imminent and serious threat or hazard to S.A.'s physical or emotional health and safety as evidenced by the fact that on at least two occasions, S.A. was found near busy traffic intersections. The potential for harm to S.A. is also apparent from the fact that Petitioner failed to provide medications to S.A. consistent with his hospital discharge orders.

III. DECISION

The Department's decision to impose a $601.00 fine against Petitioner for an Initial Category I violation of Ga. Comp. R. & Regs. r. 111-8-62-.18(1) is **AFFIRMED**.

SO ORDERED, this 4th day of June, 2013.

AMANDA C. BAXTER
Administrative Law Judge