BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

TOTAL CARE COMMUNITY LIVING III, Petitioner, v. DCH, HEALTHCARE FACILITY REGULATION DIVISION Respondent.	* * * * * * * * *	Docket No.: OSAH-DCH-HFR-CLA-1420851-158-Malihi

FILED
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JAN 17 2014

Kevin Westray, Legal Assistant

Ms. Pamela Reaves
For Petitioner

Ms. Stacey Hillock, Esq.
For Respondent

INITIAL DECISION

I. Introduction

Petitioner, Total Care Community Living III, appeals a determination by Respondent, the Department of Community Health, Healthcare Facility Regulation Division (hereinafter "Respondent"), to impose a fine for a violation of the rules governing Community Living Arrangements. The hearing was held on January 10, 2014.

II. Findings of Fact

1.

Petitioner is licensed to operate a Community Living Arrangement (hereinafter "CLA").[1]

[1] A Community Living Arrangement is defined as

> any residence, whether operated for profit or not, that undertakes through its ownership or management to provide or arrange for the provision of daily personal services, supports, care, or treatment exclusively for two or more adults who are not related to the owner or administrator by blood or marriage and whose residential services are financially supported, in whole or in part, by funds designated through the Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases.

GA. COMP. R. & REGS. 290-9-37-.05(g).

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Petitioner owns and operates a CLA in Gordon, Georgia (hereinafter "TCCL III"). Ms. Pamela Reaves serves as TCCL III's administrator. *Testimony of Pamela Reaves.*

2.

One of the individuals who resided at TCCL III was "RC", a 52-year-old female with a primary diagnosis of severe mental retardation. RC also suffers from osteoporosis, hypertension, anxiety, and depression. RC came to be under the care of TCCL III after her discharge from Central State Hospital. At the time of the incident giving rise to the sanction imposed against Petitioner, RC had resided at TCCL III for approximately two years. *Exhibit R-9.*

3.

RC has an "extensive history" of displaying aggressive, unpredictable, and self-injurious behavior. Staff members who provide care to RC must strictly abide by a Behavioral Support Program. RC's Behavioral Support Program, which was last updated in March 6, 2013, specifies that she requires one-to-one supervision from personnel who are "trained in the intervention components of the Behavioral Support Program." These intervention components emphasize that RC's care requires primarily verbal prompts, with physical interaction resorted to only in rare instances. Her Behavioral Support Program further specifies that staff must be monitored monthly to ensure that they are competent to provide her with care. *Exhibit R-9.*

4.

On March 9, 2013, RC was injured while under Petitioner's care at TCCL III. RC sustained a fracture to her left arm during the incident and had to be taken to the hospital for treatment. Ms. Reaves reported the incident to Respondent later that same day. *Exhibits R-1A, R-6.*

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5.

After receiving a complaint that Petitioner had falsified an incident report, Ms. LaTonda Oladapo, a Compliance Auditor with Respondent, conducted an annual inspection and complaint investigation at TCCL III on March 29, 2013. During her investigation, Ms. Oladapo discovered that RC had not been properly supervised by trained personnel at the time of the March 9, 2013 incident. *Testimony of Elaine Wright; Testimony of LaTonda Oladapo.*

6.

Ms. Oladapo's review of the facility's records revealed that three staff members were on duty at the time RC sustained her injury: staff members E, G, and J. Staff Member G had been assigned to provide RC with one-to-one care at the time of the incident. Personnel records indicated that, at the same time she was assigned to care for RC, Staff Member G was undergoing training. Petitioner proved unable to provide Ms. Oladapo with documentation that Staff Member G had received training of any kind. Indeed, Petitioner did not even have a file for Staff Member G. Another staff member on duty at the time, Staff Member E, admitted to Ms. Oladapo in an interview that he had last undergone training in the techniques necessary to care for a resident like RC in 2011. Ms. Oladapo also learned in an interview with another staff member that Staff Member G had only started work with Petitioner two days prior to the March 9 incident. *Exhibit R-1A; Testimony of LaTonda Oladapo.*

7.

After interviewing staff members and reviewing Petitioner's records, Ms. Oladapo determined that neither Ms. Crockett, nor any of TCCL III's staff had complied with RC's Behavioral Support Program during the incident, further indicating to her that Petitioner's staff had not received adequate training. Rather than comply with the intervention components of

RC's Behavioral Support Program, staff members at TCCL III had immediately resorted to physical restraint. Ms. Oladapo concluded that this failure on the part of Petitioner's staff members to adhere to the Behavioral Support Program had contributed to RC's injury. *Testimony of LaTonda Oladapo.*

8.

Petitioner was required to submit a Plan of Correction to Respondent as a result of the rule violations discovered during the course of Ms. Oladapo's investigation. Petitioner submitted this Plan of Correction to Respondent on or about June 11, 2013. In its Plan of Correction, Petitioner wrote that it had been unsuccessful in obtaining a complete file on Staff Member G, but that it had discharged her after the incident. Petitioner further indicated in the Plan of Correction that it would provide appropriate training to its staff and that "no more staff will be assigned untrained to any residents in the facility effective immediately." Petitioner assured Respondent in the Plan of Correction that staff that insufficiently trained staff members had been taken off the schedule or no longer worked at the facility. *Exhibit R-12; Testimony of Elaine Wright.*

9.

On June 13, 2013, Respondent sent a Notice of Intent to Impose Fine to Petitioner. In this Notice, Respondent informed Petitioner that, based on the findings of its investigation, it would seek to impose a $301.00 fine against Petitioner for its failure "to have enough qualified and trained employees on duty as were needed to safeguard properly the health, safety, and welfare of one resident." *Exhibit R-1.*

10.

Petitioner requested a hearing on July 1, 2013 and the matter was referred to the Office of

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State Administrative Hearings for adjudication.

11.

At the hearing of this matter, Ms. Reaves insisted that Staff Member G was adequately trained to care for RC, though she could provide no documentation to support her assertion. According to Ms. Reaves, Staff Member G was undergoing training with Staff Member E at the time of the incident. Ms. Reaves explained the absence of any records relating to Staff Member G's training by saying that Staff Member G had taken or destroyed her file after she was discharged from TCCL III. *Testimony of Pamela Reaves.*

III. Conclusions of Law

1.

As Respondent seeks to impose a fine against Petitioner, Respondent bears the burden of proof. GA. COMP. R. & REGS. 616-1-2-.07(1). The standard of proof is a preponderance of evidence. GA. COMP. R. & REGS. 616-1-2-.21(4).

2.

Respondent is the state entity responsible for enforcing the Rules and Regulations governing CLAs. O.C.G.A. § 31-2-4(d)(8) (2013); GA. COMP. R. & REGS. 290-9-1 et seq [hereinafter CLA RULES]. Respondent is authorized to impose sanctions as provided in its General Licensing and Enforcement Requirements, which are found in Chapter 111-8-25 of the Official Compilation, Rules and Regulations for the State of Georgia. GA. COMP. R. & REGS. 111-8-25-.01 et seq. [hereinafter ENFORCEMENT RULES].

3.

Section 290-9-37-.14(1) of the CLA Rules provides that:

> the Community Living Arrangement shall have as many qualified and trained employees on duty as shall be needed to safeguard properly the health, safety, and

> welfare of residents and ensure the provision of services the residents require to be delivered in the Community Living Arrangement . . . .

CLA RULES § 290-9-37-.14(1).

4.

When Respondent determines that a CLA has violated any of its 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.

ENFORCEMENT RULES § 111-8-25-.05(1)(a)–(f). In determining the appropriate sanction, "the department shall consider the seriousness of the violation or violations, including the circumstances, extent and gravity of the prohibited act or acts or failure to act, and the hazard or potential hazard created to the physical or emotional health and safety of the public." ENFORCEMENT RULES § 111-8-25-.05(4). Respondent is authorized to impose a fine of between $301.00 and $600.00 for Category II violations, which are those that have a "direct adverse effect on the physical or emotional health and safety of a person or persons in care." ENFORCEMENT RULES § 111-8-25-.05(1)(e)1.(ii).

5.

Respondent met its burden in demonstrating that Petitioner committed a violation of its rules governing the operation of Community Living Arrangements by failing to have qualified and trained staff on duty to provide adequate care to RC. Respondent established that, on March

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9, 2013, Petitioner assigned Staff Member G to provide one-to-one care to RC. Although RC had a well-documented history of displaying aggressive and self-injurious behavior, Petitioner left her in the care of a staff member who had not yet undergone the training necessary to meet RC's Behavioral Support Program. Respondent was justified in concluding that neither Staff Member G, nor any staff member at TCCL III had the requisite qualifications to care for RC based on the absence of any records that the staff members had been trained, Staff Member E's admission that he had not undergone training in intervention techniques in the previous two years, and the facts surrounding RC's injury, in which TCCL III's staff members did not exhibit techniques that would have been acquired in training.

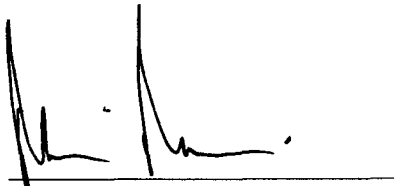
6.

Petitioner's violation had a "direct adverse effect on the physical or emotional health and safety of a person or persons in care." ENFORCEMENT RULES § 111-8-25-.05(1)(e)1.(ii). The failure of Petitioner to assign a staff member with adequate training to provide care to RC resulted in a serious injury. Because staff members had not received adequate training in the intervention techniques described in RC's Behavioral Support Program, RC suffered a fracture of her arm. Accordingly, Respondent was authorized by its Enforcement Rules to impose a fine of $301.00. Id.

IV. Decision

For the foregoing reasons, Respondent's decision to impose an enforcement fine against Petitioner as provided in the notice sent to Petitioner on June 13, 2013 is **AFFIRMED**.

SO ORDERED, this 17th day of January, 2014.



Michael Malihi, Judge

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