



BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS  
STATE OF GEORGIA

FILED  
OSAH

MAY 1 2014

WILLOW GARDENS, :  
Petitioner, :  
v. :  
DEPARTMENT OF COMMUNITY :  
HEALTH, :  
Respondent. :

Docket No.:  
OSAH-DCH-HFR-PCH-1433318-127-Miller

*K. Westray*  
Kevin Westray, Legal Assistant

INITIAL DECISION

I. Introduction

The Petitioner, Willow Gardens, seeks review of two related determinations by the Respondent, the Department of Community Health ("Department"). First, Willow Gardens appeals the Department's imposition of a \$25,000.00 fine based on an alleged violation of the regulations governing personal care homes. Second, Willow Gardens appeals the Department's denial of its application to increase its bed capacity. These two matters were consolidated for hearing by Order dated March 18, 2014. The evidentiary hearing took place on March 31, 2014, before the undersigned administrative law judge. After considering all of the admissible evidence, the Department's actions are **AFFIRMED**.

II. Findings of Fact

1.

The Petitioner, Willow Gardens, is a personal care home located in Toccoa, Georgia. The facility provides personal services to adult residents who require assistance with activities of daily living. Gwen Woods is Willow Gardens' owner and director. (Testimony of Elaine Wright, Dianne Brookins, and Gwen Woods; Exhibit R-1.)

2.

When Willow Gardens originally obtained a personal care home permit, in 2007, its licensed capacity was six residents. At the facility's request, the Department increased its licensed capacity to fourteen residents as of March 26, 2009. (Testimony of Ms. Wright, Kris Adams, and Debra Smith; Exhibit R-4.)

3.

In May 2012, Willow Gardens began construction on a project to add approximately 1,500 square feet to its facility. Subsequently, in September 2012, Willow Gardens applied to the Department for a capacity increase to twenty-two residents. However, the application was incomplete because the

State Fire Marshal had not issued a certificate of occupancy for the new addition. (Testimony of Ms. Smith, Ms. Adams, and Ms. Woods; Exhibit R-6.)

4.

Construction on the new addition was completed in October 2012. At that time, although Willow Gardens still had not obtained a certificate of occupancy and the Department had not acted on its request for a capacity increase, Ms. Woods admitted new residents to the facility. On December 6, 2012, the Department notified the facility that its request for an increase in capacity could not be granted because its application remained incomplete. (Testimony of Ms. Smith and Ms. Woods; Exhibit R-13.)

5.

On January 8, 2013, Debra Smith, a surveyor for the Department's personal care home program, visited Willow Gardens to conduct an inspection of the premises. During her inspection, she observed that the facility had twenty residents, or six residents in excess of its licensed capacity. (Testimony of Ms. Smith and Ms. Woods; Exhibit R-13.)

6.

On April 10, 2013, Ms. Smith returned to Willow Gardens for another inspection and observed that the facility had nineteen residents, or five residents in excess of its licensed capacity. She further noted that two residents, identified as Resident #1 and Resident #10, had extensive problems with mobility and required care beyond that which the facility was authorized to provide.<sup>1</sup> More specifically, Resident #1 was able to self-propel, using a wheelchair, a distance of only three feet. Resident #10 was bedbound and dependent on staff for all activities of daily living.<sup>2</sup> (Testimony of Ms. Smith and Ms. Woods; Exhibit R-10.)

7.

On July 3, 2013, Ms. Woods submitted a plan of correction to the Department. Regarding the capacity violation, the plan of correction stated, in part:

A delay in completing the permit for increased capacity was encountered by the owner in regards to Fire Marshal[] requirements. First and most time[-]consuming issue was a scaled drawing of the facility pre[-] and post[-]renovation. Fire Marshal[] has since [ac]cepted drawings from owner, and inspected facility. . . .

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<sup>1</sup> Ms. Smith also documented seven other deficiencies in her report. However, the Department has not sought to sanction the facility for these alleged violations. (Testimony of Ms. Wright and Ms. Smith; Exhibits R-1, R-10.)

<sup>2</sup> During a post-inspection interview with Ms. Smith, Ms. Woods stated that she had previously obtained a waiver for Resident #10 which allowed the facility to continue to provide care. She was unaware that the waiver had expired more than four months earlier. (Testimony of Ms. Smith and Ms. Woods; Exhibit R-10.)

Regarding the level of care violations, the plan of correction stated that Willow Gardens had applied for a waiver that would allow Resident #10 to remain at the facility. The plan of correction did not address Resident #1. (Testimony of Ms. Smith and Ms. Woods; Exhibits R-10, R-11.)

8.

On July 12, 2013, Ms. Smith returned to Willow Gardens for a third inspection and observed that the facility had twenty residents, or six residents in excess of its licensed capacity. She further noted that four residents, identified as Resident #1, Resident #10,<sup>3</sup> Resident #12, and Resident #13, required care beyond that which the facility was authorized to provide.<sup>4</sup> On the date of the inspection, Resident #1 was unable to self-propel a wheelchair and was able to ambulate only six feet with the total assistance of two staff members. Resident #10, Resident #12, and Resident #13 were bedbound and receiving treatment for pressure sores. (Testimony of Ms. Smith and Ms. Woods; Exhibit R-2.)

9.

By letter dated September 18, 2013, the Department notified Willow Gardens that it intended to impose a fine of \$25,000.00, based on its determination that over a period of ninety-three days, the facility had committed six repeat Category III violations of the rules governing personal care homes. More specifically, the Department proposed to fine Willow Gardens \$300 per day for each of six residents it had retained in excess of its licensed capacity between April 10, 2013, and July 12, 2013.<sup>5</sup> The total fine resulting from this calculation, \$167,400.00, was then reduced to the statutory maximum of \$25,000.00. (Testimony of Ms. Wright; Exhibit R-1.)

10.

On September 24, 2013, Ms. Woods submitted a second plan of correction. This time, the plan of correction indicated that the facility had obtained a certificate of occupancy from the State Fire Marshal's office and had submitted a second request for the Department to conduct a capacity increase inspection. As to the level of care violations, the plan of correction stated that Resident #1 and Resident #12 had been discharged, while the facility had applied for waivers for Resident #10 and Resident #13.<sup>6</sup> (Testimony of Ms. Smith and Ms. Woods; Exhibits R-2, R-5, R-12, R-17, R-18, R-19, R-20.)

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<sup>3</sup> Resident #1 and Resident #10 are the same individuals identified as Resident #1 and Resident #10 in the April 2013 inspection report. (Exhibits R-5, R-22.)

<sup>4</sup> Although Ms. Smith documented four other deficiencies in her report, the Department has not sought to sanction the facility for these alleged violations. (Testimony of Ms. Wright and Ms. Smith; Exhibits R-1, R-2.)

<sup>5</sup> This finding was incorrect, as Willow Gardens was exceeding its licensed capacity by five residents, rather than six, as of April 10, 2013. (Testimony of Ms. Smith; Exhibit R-10.)

<sup>6</sup> The Department subsequently denied both waiver applications. (Testimony of Ms. Adams.)

11.

By letter dated December 2, 2013, the Department notified Willow Gardens that it had denied the facility's application for a capacity increase. The denial was based on the Department's determination that the facility had violated its licensing requirements and the rules governing personal care homes by exceeding its licensed capacity and retaining residents who required care beyond that which the facility was authorized to provide. (Testimony of Ms. Wright and Ms. Adams; Exhibit R-7.)

12.

On February 5, 2014, Ms. Woods submitted a third plan of correction. On this occasion, the plan of correction stated that the facility had appealed the Department's denial of its capacity increase application and that "[o]wner has not discharged any residents as she hopes that a resolution will be obtained and the families will be able to keep their homes." (Testimony of Ms. Smith and Ms. Woods; Exhibit R-14.)

13.

Willow Gardens timely appealed both the denial of its application for an increase in capacity and the imposition of the \$25,000.00 fine. At the hearing, Ms. Woods expressed regret for her failure to ensure that Willow Gardens had complied with the Department's licensing requirements and the rules governing personal care homes. She explained that the State Fire Marshal would not issue a certificate of occupancy until it received scaled architectural drawings of the facility, both before and after the addition, and that it had taken her several months to obtain these drawings. Ms. Woods further explained that during the period in question, she had become overwhelmed by personal problems, financial pressures, and the responsibilities associated with owning and operating a personal care home. As a result, she failed to fulfill all of her administrative duties. (Testimony of Ms. Woods.)

14.

Willow Gardens currently has nineteen residents, and Ms. Woods hopes to obtain a capacity increase that would allow all nineteen residents to remain at the facility. She further seeks a reduction of the proposed fine. However, she has not taken any action to come into compliance with the Department's regulations. At present, Willow Gardens continues to exceed its current licensed capacity by five residents and continues to retain one of the four patients identified as requiring care beyond that which a personal care home is authorized to provide.<sup>7</sup> The Court further notes that Willow Gardens has a history of noncompliance with its capacity limit,<sup>8</sup> and that Ms. Woods has

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<sup>7</sup> Ms. Woods has hesitated to discharge this resident because the resident is married to another resident of the facility. (Testimony of Ms. Woods.)

<sup>8</sup> In addition to the violations that are the subject of the present proceeding, inspections of the facility in July 2008, September 2008, November 2008, and January 2009 noted that Willow Gardens was exceeding its licensed capacity by at least three residents. (Testimony of Ms. Smith.)

demonstrated a consistent inability or unwillingness to address known problems in a timely manner.<sup>9</sup> Under these circumstances, Ms. Woods' assurances that the facility will comply with regulatory requirements going forward are lacking in credibility. (Testimony of Ms. Woods.)

### III. Conclusions of Law

1.

In this case, the Department bears the burden of proof as to the alleged rules violation, while Willow Gardens bears the burden as to its application for an increase in its bed capacity. Ga. Comp. R. & Regs. 616-1-2-.7(1). The burden of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4). The Department met its burden, whereas Willow Gardens did not.

#### A. Rules Violation

2.

The Department's rules governing personal care homes require that "[a] licensed personal care home must not serve more residents than its approved licensed capacity." Ga. Comp. R. & Regs. 111-8-62-.06(3). Nothing in the rule suggests that a licensee may admit or retain new residents while an application for an increase in capacity is pending or on appeal. Therefore, the Court concludes that Willow Gardens violated Ga. Comp. R. & Regs. 111-8-62-.06(3) by admitting and retaining residents in excess of its licensed capacity, as detailed in the Findings of Fact, above.

3.

Pursuant to O.C.G.A. § 31-2-8(b) and (c), the Department is authorized to enforce its rules, subject to notice and opportunity for a hearing, through an array of sanctions, including fines. See also Ga. Comp. R. & Regs. 111-8-62-.33, 111-8-25-.04. When the Department decides to impose a fine, it applies an enforcement matrix based on the severity and frequency of the rule violation. Ga. Comp. R. & Regs. 111-8-25-.05(1)(e); see Exhibit R-3. The most serious violations are designated "Category I," while the least serious violations are designated "Category III." Ga. Comp. R. & Regs. 111-8-25-.05(1)(e)(1).

4.

A Category III violation is defined as "[a] violation or combination of violations of licensing requirements 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, or a violation or violations of administrative, reporting, or notice requirements." Ga. Comp. R. & Regs. 111-8-25-.05(1)(e)(1)(iii). In this case, Willow Gardens committed a Category III violation by failing to comply with its bed capacity limit. This violation was likely, indirectly and over a period of time, to

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<sup>9</sup> For example, Ms. Woods provided no satisfactory explanation for the nearly one-year delay in obtaining a certificate of occupancy. The Court is unconvinced that this length of time was required to produce scaled drawings of the facility or was caused by the State Fire Marshal. (Testimony of Ms. Woods.)

adversely affect the physical health and safety of the facility's residents, especially because the State Fire Marshal had not granted the facility a certificate of occupancy for its new addition. Ga. Comp. R. & Regs. 111-8-62-.06(3), 111-8-25-.05(1)(e)(1)(iii).

5.

The Department is authorized to impose a fine ranging from \$50.00 to \$300.00 for each Category III violation, depending on whether the violation is an "initial," "subsequent," or "repeat" violation. Id.; Ga. Comp. R. & Regs. 111-8-25-.05(1)(e)(2.). A violation is considered a repeat violation "[i]f the present violation or a substantially similar violation also had been found and cited any two (2) other times during the past twenty-four (24) months . . . ." Ga. Comp. R. & Regs. 111-8-25-.05(1)(e)(2.)(iii). Furthermore, "[t]he fine amount for repeat violations shall be the top figure in the category." Id.

6.

As detailed in the Findings of Fact, above, the Department correctly determined that Willow Gardens has committed a repeat Category III violation with a maximum fine of \$300.00. The evidence showed that as of April 10, 2013, there were nineteen residents in the facility, or five more than its licensed capacity, for which a fine of \$1,500.00 per day (\$300.00 per day, per resident) should be imposed.<sup>10</sup> Over a period of ninety-three days, from April 10, 2013, to July 12, 2013, Willow Gardens accrued fines totaling \$139,500.00. However, the Department correctly reduced the amount to the statutory maximum fine of \$25,000.00. O.C.G.A. § 31-2-8(c)(6).

B. Application to Increase Bed Capacity

7.

The Department is authorized to deny an application for an increase in capacity where a licensee has "failed to comply with the licensing requirements of this state." O.C.G.A. § 31-2-8(b)(3); see also Ga. Comp. R. & Regs. 111-8-25-.04(c), -.05(2)(a).

8.

Here, the Department properly denied Willow Gardens' application to increase its licensed capacity based on its violations of the rules regarding bed capacity and level of care. As noted above, Willow Gardens has admitted and retained residents in excess of its licensed capacity for well over a year, in violation of Ga. Comp. R. & Regs. 111-8-62-.06(3).

9.

The Department's rules further provide that a personal care home "is permitted to admit and retain only ambulatory residents who are capable of self-preservation with minimal assistance, i.e.[,] staff

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<sup>10</sup> The Department erroneously determined that the facility was six residents over its licensed capacity during the relevant time period, which caused it to calculate the fine at \$1,800.00 per day.

may assist the resident in transferring from a sitting or reclining position and provide verbal directions to residents who are able to self-propel to the nearest exit.” Ga. Comp. R. & Regs. 111-8-62-.15(1)(b). A personal care home may not “admit or retain a resident who needs care beyond [that] which the home is permitted to provide.” Ga. Comp. R. & Regs. 111-8-62-.15(2). In this case, the evidence showed that for an extended period of time, Willow Gardens retained four residents who were non-ambulatory and required care beyond that which the facility was permitted to provide, in violation of Ga. Comp. R. & Regs. 111-8-62-.15(1)(b) and (2).

#### IV. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, the Department’s decisions to impose a \$25,000.00 fine against Willow Gardens and to deny its application for an increase in its licensed capacity are hereby **AFFIRMED**.

SO ORDERED, this 1<sup>st</sup> day of May, 2014.



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**KRISTIN L. MILLER**  
**Administrative Law Judge**