BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

TRACEY MOORE, Petitioner, v. DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATIONS DIVISION, Respondent.	: : : : : : : : :	Docket No.: OSAH-DCH-HFR-PCH-1545013-55-Woodard

INITIAL DECISION

I. INTRODUCTION

Petitioner Tracey Moore appeals Respondent the Department of Community Health's (hereinafter "the Department") assessment of a civil penalty against her for allegedly operating an unlicensed personal care home, or "PCH." An evidentiary hearing was held on April 8, 2015 before the undersigned Administrative Law Judge at the Gilmer County Courthouse in Ellijay, Georgia. Ms. Moore represented herself at the hearing and Ms. Stacey Hillock, Esq., represented the Department. For the reasons indicated below, the Department's action is **AFFIRMED**. However, inasmuch as there is insufficient evidence to support the Department's calculation of the amount of the civil penalty, it is **MODIFIED** as described *infra*.

II. FINDINGS OF FACT

1.

Ms. Moore does not, and did not at any time relevant to this Decision, hold a license from the Department to operate a personal care home. *Testimony of Tracey Moore.*

2.

Ms. Moore operates a boarding house out of a three-story, eleven bedroom, four bathroom home located at 81 Moore's Road in Mineral Bluff, Georgia (hereinafter "the Moore's Road location"). During the period relevant to this Decision, the boarding house was home to eight boarders. As the operator of the boarding house, Ms. Moore provides the boarders with transportation services in addition to room and board. *Exhibit R-6; Testimony of Tracey Moore.*

3.

Two of the boarder's at Ms. Moore's boarding house were "LF" and "SS", both of whom had been referred to the boarding house by the Adult Protective Services Unit of the local Department of Family and Children Services (DFCS). LF and SS were independent with their activities of daily living and capable of making decisions regarding their care. Both took prescription medications. *Exhibit R-6; Testimony of Tracey Moore.*

4.

The Department commenced an investigation into Ms. Moore's boarding house based upon an anonymous complaint that she had been operating it as an unlicensed personal care home. On September 8, 2014, the Department dispatched Ms. Debra Smith, a surveyor, to the Moore's road location to conduct a site visit. *Exhibits R-1, R-2; Testimony of Debra Smith.*

5.

After arriving at the Moore's road location, Ms. Smith made contact with Ms. Moore and toured the boarding house. Ms. Moore indicated to Ms. Smith during an interview that the residents' medications were kept in individual lockers located in the dining room. Ms. Smith observed that the keys for the residents' lockers were kept on hooks in the kitchen. Each key was labeled with a resident's name. *Exhibit R-2; Testimony of Debra Smith.*

6.

Ms. Smith observed that LF's medications had been placed into a weekly organizer. LF told Ms. Smith that Ms. Moore had placed his medications into the weekly organizer. *Exhibit R-2; Testimony of Debra Smith.*

7.

Ms. Smith observed that SS's morning and evening medications had been placed into plastic bags marked with the handwritten notations "A.M." and "P.M." SS told Ms. Smith that Ms. Moore had placed his morning and evening medications into the bags "so he would not get confused." *Exhibit R-2*; *Testimony of Debra Smith.*

8.

Ms. Moore maintained records of each boarder's health information, and provided these documents to Ms. Smith at her request. The documents consisted of standardized forms, some of which bore the heading "Physician Office Visit Report." The forms were populated with each boarder's name, date of birth, allergies, and a list of the boarder's current medications. Ms. Moore testified at the hearing on this matter that the boarders provided her with the information

included on the form, and that she merely typed the information onto the standardized form and maintained it for the boarder. *Exhibit R-6; Testimony of Tracey Moore.*

9.

Based upon the foregoing facts, Ms. Smith concluded that Ms. Moore was operating a personal care home without having obtained a license from the Department. She met with Ms. Moore at the conclusion of the site visit to discuss her findings and informed Ms. Moore that the assistance she provided to her boarders—specifically, keeping their medications in lockers in the home's dining room and placing LF's medications into a weekly organizer and SS's into separate, marked bags—were "personal services" under the Department's rules for personal care homes and required a PCH licensure. Ms. Moore assured Ms. Smith that she would purchase medication boxes for the residents to keep in their rooms, that she would ensure that LF had his medications bubble packed, and that she would have the residents' case managers or family members monitor their medications as needed. Ms. Smith then concluded her investigation and submitted a written report of her findings to the Department. *Exhibit R-2; Testimony of Debra Smith.*

10.

The Department sent Ms. Moore a letter dated September 29, 2014 informing her of its determination that she had been operating an unlicensed personal care home at the Moore's Road location, demanding that she cease and desist operations, and notifying her of its intent to impose a fine in the amount of $100.00 per bed, per day for each day she operated as an unlicensed personal care home. *Exhibit R-1.*

11.

Ms. Moore requested a hearing on October 8, 2014. In her written hearing request, Ms. Moore reported that she had corrected all of the deficiencies identified during Ms. Smith's site visit. She attached a copy of Ms. Smith's report from the September 8, 2014 site visit, which included Ms. Moore's handwritten notations to the effect that, as of September 12, 2014 all boarders were provided with personal lockboxes and keys, that LF's and SS's medications were in bubble packs or plastic bags as of September 30, 2014, and, finally, that all boarders handled their medications without her assistance. *Exhibit R-3.*

12.

Ms. Smith conducted a follow-up inspection at the Moore's Road location on October 21, 2014. No rule violations were cited as a result of the inspection. *Exhibit R-7; Testimony of Debra Smith.*

13.

Pursuant to O.C.G.A. § 31-7-12.1(b), the Department assessed a civil penalty against Ms. Moore in the amount of $100.00 per bed, per day, for each day it determined that the facility operated as an unlicensed personal care home. Accordingly, based upon the Department's determination that Ms. Moore had provided unlicensed personal services to two residents (two "beds") for twenty-three days—September 8, 2014 (the date of the site visit) through September 30, 2014 (the date on which Ms. Moore indicated she had ceased providing unlicensed personal services)—it assessed a civil penalty in the amount of $4,600.00. *Testimony of Elaine Wright.*

14.

At the hearing on this matter, Ms. Moore admitted to the rule violations cited by Ms. Smith during the September 8, 2014 site visit. She testified that she had placed LF's medications into the weekly planner only in one instance because LF, who suffered from hand tremors, had scattered his medications on the floor. With regard to SS, Ms. Moore explained that she had not placed his medications into the bags marked "A.M." or "P.M.", but that she had merely labeled the bags and given them to SS. According to Ms. Moore, she provided SS with the bags because he habitually dropped his medication bottles onto the floor in attempting to retrieve them from the locker, causing him confusion as to which bottles contained morning medications and which contained evening medications. *Testimony of Tracey Moore.*

III. CONCLUSIONS OF LAW

1.

As the Department seeks to impose a civil penalty, it bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2.

All persons operating personal care homes in Georgia must be licensed by the Respondent. O.C.G.A. § 31-7-12(b); Ga. Comp. R. & Regs. 111-8-62-.06. Any unlicensed personal care home is subject to a civil penalty in the amount of $100.00 per bed, per day for

each day it is found to have been operating as an unlicensed personal care home. O.C.G.A. § 31-7-12.1(b). "A facility shall be deemed to be an unlicensed personal care home if it is unlicensed and is not exempt from licensure and [it] is providing personal services and operating as a personal care home as those terms are defined in Code Section 37-7-12." O.C.G.A. § 31-7-12.1(a).

3.

Code Section 37-7-12 defines "personal care home" as

> . . . any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage . . . .

O.C.G.A. § 37-7-12(a)(1); *see also* Ga. Comp. R. & Regs. 111-8-62-.03(cc).

4.

According to Code Section 37-7-12, the term "personal services" includes "individual assistance with or supervision of self-administered medication . . . ." O.C.G.A. § 37-7-12(a)(2); *see also* Ga. Comp. R. & Regs. 111-8-62-.03(dd).

5.

In the present case, the Department alleges that Ms. Moore provided personal services to boarders by assisting them with their medications, specifically, by storing boarders' medications in individual lockers in the facility's dining room, placing LF's medications into a weekly organizer, and placing SS's medications into the A.M. and P.M. bags. The Department asserts that Ms. Moore provided such services from September 8, 2014 through September 30, 2014 and thereby operated as an unlicensed personal care home during such time. The Department's determination that the facility operated as an unlicensed personal care home through September 30, 2014 is based on Ms. Moore's admission in her letter that she had provided residents with their own lockers and keys and that LF's and SS's medications had been bubble-packed or placed in a plastic bag as of that date.

6.

The Department established by a preponderance of the evidence that Ms. Moore's facility was operating as an unlicensed personal care home from September 8 through September 12. Ms. Moore averred in her letter that she had provided the residents with their own lockboxes and

keys and thereby ceased assisting them with their medications, which was later verified during the October 21 follow-up visit. However, the Department failed to demonstrate that the facility thereafter provided personal services to two or more boarders. This would require an affirmative showing that Ms. Moore was actively assisting LF and SS with their medications through September 30. Ms. Moore's acknowledgment in her letter that both boarders' medications had been bubble packed as of that date did not amount to an admission that she had been assisting the boarders with their medications until that date. Based on the evidence on record, the civil penalty against Ms. Moore should be calculated at $100.00 per bed for five days, rather than twenty-three. Accordingly, the appropriate amount of the civil penalty is $1,000.00.

IV. DECISION

IT IS HEREBY ORDERED that the Department's decision to impose a civil penalty against Ms. Moore is AFFIRMED. However, the amount of the fine is **MODIFIED** to $1,000.00, the amount commensurate with the number of days for which the Department established that Ms. Moore's facility was operating as an unlicensed personal care home.

SO ORDERED, this 12th day of May, 2015.

M. PATRICK WOODARD
Administrative Law Judge