BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

MONA PEARSON, Petitioner,	:	Docket No.: OSAH-DCH-HFR-PCH-1537427-76-Woodard
v.	:	
DEPARTMENT OF COMMUNITY HEALTH, HEALTHCARE FACILITY REGULATIONS DIVISION, Respondent.	:	

FILED
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JUL 6 2015
Kevin Westray, Legal Assistant

INITIAL DECISION

I. INTRODUCTION

Petitioner Mona Pearson appeals Respondent Department of Community Health's issuance of a "Notice to Cease and Desist and Intent to Impose Fine" dated August 27, 2014. An evidentiary hearing was held on April 15, 2015 before the undersigned Administrative Law Judge at Houston County State Court, Warner Robins, Georgia. Petitioner was represented by Greg Holt, Attorney at Law, Warner Robins. Respondent (hereafter "the Department" or "DCH") was represented by Shariyf Muhammad, Attorney at Law, Atlanta.

For the reasons indicated below, the Department's action is **REVERSED**. Petitioner is not required to cease operations, nor is a fine or civil monetary penalty authorized.

II. FINDINGS OF FACT

1.

Ms. Pearson 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 Mona Pearson; testimony of Irene Hubbard.*

2.

Ms. Pearson is a Christian minister, and licensed as a prison Chaplain by the Georgia Department of Corrections. Ms. Pearson often preaches at State-run institutions, including Johnson State Prison, local Youth Detention Centers (YDCs) and other similar facilities, and over many years has developed working relationships with prison counselors and other officials. One of Ms. Pearson's goals is to provide a place to live and an opportunity for gainful employment for inmates who do not have a home to return to after their release from prison. *Testimony of Mona Pearson.*

3.

Ms. Pearson and her husband reside on rural property located at 112 Cardinal Avenue in Perry, Georgia. The property contains two mobile homes and a smaller trailer that can be used as residences, and

a screened-in building. At the request of local law enforcement and prison officials, Ms. Pearson and her husband have made their property available as an informal "halfway house" for recently released prison inmates. Most of these individuals are released into the community without a home to return to or a source of income. Through her many contacts in the community, Ms. Pearson helps these individuals obtain jobs, although some residents cannot work due to physical or mental disability or age. Those who cannot find employment are often eligible for Federal disability benefits, and Ms. Pearson assists them in obtaining Social Security or Veterans Administration payments. Those with incomes are required to pay $100 per week (or $400 per month) in rent. Others residents are not employable or eligible for Federal assistance. Those individuals stay at the Pearsons' property for free, although they must do chores around the property that are commensurate with their physical ability. *Testimony of Mona Pearson; testimony of residents Paul Rue, Arthur Stapp, Keith Springer; Ricardo Roman.*

4.

The Department received an anonymous complaint that Ms. Pearson was operating an unlicensed personal care home, or "PCH." This complaint was assigned for investigation to Irene Hubbard, RN, a nurse surveyor employed by the Department. On April 10, 2014, Ms. Hubbard travelled to the Pearson property to conduct a site survey. Ms. Hubbard was given permission to inspect the property and its buildings, and to speak with residents. Ms. Hubbard found "fourteen or fifteen" men living on the property, many of whom were previously incarcerated. Ms. Pearson and several of the residents explained that her intent was to "help people get back into society," and to provide a place to live for those with nowhere to go after prison. Ms. Pearson admitted to Ms. Hubbard that she stored prescription medications for six residents in a vault in her personal bedroom, "because of the type of individuals she had" on the property. Ms. Pearson stated that she held a medication call twice a day. The residents were free to take the medication or to refuse it. The medications were then returned to the locked vault. One resident told Ms. Hubbard that Ms. Pearson "assisted him...with medications and doctor appointments." Ms. Pearson also told Ms. Hubbard that "someone at the State" had told her that she did not need to have a license to operate her facility, apparently as she was not a personal care home. *Testimony of Irene Hubbard; Respondent Exhibit 3.*

5.

Based on her observations on April 10, 2014, Ms. Hubbard prepared a report with her findings that Ms. Pearson provided housing, food, and one or more personal services to one or more non-relative adults. Ms. Hubbard concluded, therefore, that Ms. Pearson was operating an unlicensed personal care home in violation of Ga. Comp. R. & Regs. 111-8-62-.06(1). *Respondent Exhibit 3.*

6.

Ms. Hubbard returned to the property to conduct a follow-up investigation on June 9, 2014. Ms. Hubbard found that sixteen men now lived on the property. Nine of the men received prescription medications, which were stored in the vault in Ms. Pearson's bedroom. Ms. Hubbard observed Ms. Pearson removing medications from the vault for six residents. There is no evidence that Ms. Hubbard saw Ms. Pearson actively assist any resident with their medications, such as removing the medication for its original packaging or urging the resident to take their dosage. Ms. Hubbard prepared a second report based on her inspection of June 9, in which she again concluded that Ms. Pearson was operating an unlicensed personal care home. *Testimony of Irene Hubbard; Respondent Exhibit 4.*

7.

Ms. Hubbard traveled to the Pearson property on July 22, 2014 to conduct an unannounced follow-up investigation. She found that ten men resided on the property. Two residents and Ms. Pearson verified that she still kept their prescription medications in the locked vault. Ms. Hubbard prepared a third report based on the July 22 inspection, and again concluded that Ms. Pearson was operating an unlicensed personal care home. *Testimony of Irene Hubbard; Respondent Exhibit 5.*

8.

Ms. Hubbard made a fourth, and final, trip to the Pearson property on September 10, 2014. Although the Pearsons had cooperated with Ms. Hubbard during her previous inspections, this time Ms. Pearson's husband refused to allow Ms. Hubbard access to the property. Ms. Hubbard called the local police, who escorted her onto the property despite the Pearsons' continued opposition, and their request that Ms. Hubbard be arrested as a trespasser. Ms. Hubbard found that the residents now kept their own medications in a locked box in their personal bedrooms. Ms. Hubbard's found no violations of PCH rules during this visit, *Testimony of Irene Hubbard; Respondent Exhibit 6.*

9.

On August 27, 2014, the Department issued a "Notice to Cease and Desist and Intent to Impose Fine." This notice stated that Ms. Pearson was operating an unlicensed personal care home. Ms. Pearson was ordered to cease operations immediately, to "close your personal care home and assist residents who are currently living there to relocate to a suitable residence." The Notice stated that "Operating a personal care home without a license is a criminal offense [and t]his matter is being referred to local law enforcement for possible criminal prosecution." Finally, the Notice stated that "DCH will impose a civil penalty in the amount of $100.00 per bed, per day for each day you operated the unlicensed personal care home," to be doubled to $200.00 per day if she continued to operate the facility after receipt of the notice.

10.

Ms. Pearson has appealed the Department's intended closure of her facility, and the imposition of a fine. This matter was referred by the Department to the Office of State Administrative Hearings, which scheduled and held an evidentiary hearing. At that hearing, the Department asserted that Ms. Pearson should be assessed a fine for each day she provided personal services to the residents from Ms. Hubbard's first inspection on April 10, 2014, through the third inspection on July 22, 2014, a period of 104 days. The number of "beds" used to calculate the fine equals the number of residents housed by the facility. The Department based the bed count on the lowest occupancy rate of the three inspections, which was ten residents on site on July 22, 2014. Therefore, the total fine sought by the Department was 104 days (x) 10 beds (x) $100.00 per violation, for a total of $104,000.00.[1] *Testimony of Shirley Rodriquez, Regional Director, PCH Program, Department of Community Health.*

11.

Ms. Pearson testified that she was asked to keep her residents' medications in a safe and secure location by the mother of "C.J.," a resident with a drug abuse problem who was one of the rare individuals placed at Ms. Pearson's facility even though he was not a convicted felon. C.J. was likely to steal medications from other residents when the opportunity arose, and Ms. Pearson purchased a large vault, which she had installed in her private bedroom where no resident had access. Ms. Pearson implemented a schedule where she would remove the medications (still in their original containers) twice per day, then give the unopened containers to the resident named on the packaging. At no time did Ms. Pearson actively assist the resident with his medications, and each resident had the freedom to either take or not take his medications.

12.

Five current or former residents testified regarding their knowledge of Ms. Pearson's facility. Each individual testified that Ms. Pearson kept prescription medications for a number of residents in a locked vault in her personal bedroom. Several residents stated that they always stored their medications in their own bedrooms, even though the locked vault was available as a security measure to prevent theft and drug abuse. None of these current or past residents ever saw Ms. Pearson assisting a resident in any way with their medications, even in a very limited capacity such as encouraging a resident to take his medicine. *Testimony of Paul Rue, Ricardo Roman, Arthur Stapp, Keith Springer, and Lester Vanzant.*

[1] Respondent countered that if the fine was upheld, it should be based on a maximum of 8 beds, and not 10 beds. This would reduce the fine from a maximum of $104,000 to $83,400.

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.

Operation of an unlicensed personal care home may also subject its owners or operators to additional civil sanctions, and potential criminal prosecution. "It is declared that the owning or operating of an unlicensed personal care home in this state constitutes a nuisance danger to the public health, safety, and welfare. The commissioner [of DCH] or the district attorney of the judicial circuit in which such unlicensed personal care home is located may file a petition to abate such nuisance as provided in Chapter 2 of Title 41." O.C.G.A. § 31-7-12.1(f). "Any person who owns or operates a personal care home in violation of Code Section 31-7-12 shall be guilty of a misdemeanor for a first violation, unless such violation is in conjunction with abuse, neglect, or exploitation as defined in Code Section 30-5-3, in which case such person shall be guilty of a felony and, upon conviction, shall be punished by imprisonment for not less than one nor more than five years. Upon conviction for a second or subsequent such violation, such personal shall be guilty of a felony and, upon conviction, shall be punished by imprisonment for not less than one nor more than ten years." O.C.G.A. § 31-7-12.1(g).

4.

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).

5.

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).

6.

In the present case, the Department alleges that Ms. Pearson provided personal services to residents by assisting them with their medications, specifically, by storing medications in a locked vault in her personal bedroom and taking them out of the vault twice a day for residents to self-administer. There is no credible evidence that Ms. Pearson took any additional steps to assist residents with their medications, which could include placing the medications in a separate container such as a bubble pack; labeling the medications to assist the resident with proper timing and dosage amounts; or placing the medications into a weekly or monthly organizer. Thus, Ms. Pearson took no active role in assisting any boarder with their medications. This distinguishes the facts in the present case from those in *Tracey Moore v. Department of Community Health, OSAH Docket No.: DCH-HFR-PCH-1545013-55-Woodard (5/2015).* In *Moore v DCH,* the undersigned found that Petitioner, the owner of an unlicensed boarding house, had separated one resident's medications into AM and PM bags for his convenience, and had placed another resident's medications into a bubble-wrapped package so he would not spill any pills. The undersigned affirmed a portion of the civil penalty against Petitioner because she took an active role in the administration of the two resident's medications. The undersigned rejected the Department's argument that Petitioner should be sanctioned for merely storing residents' medications in a locked box, as that did not constitute "assistance with or supervision of self-administered medication" under O.C.G.A. § 37-7-12(a)(2).

7.

In conclusion, the undersigned determines that Ms. Pearson has not operated a personal care home as defined by O.C.G.A. 31-7-12(a)(1), and is not currently required to obtain such licensure from the Department. As she does not operate a personal care home, she is not subject to the Department's proposed closure of her facility, nor is she subject to a fine. However, the administrative law judge notes that the Department is entrusted by the Georgia General Assembly with the task of regulating all health care facilities in this State, including personal care homes. In order to fulfill this obligation, the Department may investigate a complaint that the Petitioner is providing the personal services that can be lawfully provided only by a licensed personal care home operator. If the Department receives such a report in the future about Ms. Pearson's facility, she is cautioned to allow the Department's inspector access to her property and its residents.

IV. DECISION

IT IS HEREBY ORDERED that the Department's decision to impose a civil penalty and a cease and desist order against Petitioner Mona Pearson is **REVERSED.**

SO ORDERED, this 8th day of July 2015.

M. PATRICK WOODARD
Administrative Law Judge