BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GOLDEN DAYS QUALITY CARE HOME,	:	
Petitioner,	:	
	:	**Docket No.:**
v.	:	**OSAH-DCH-HFR-PCH-1630927-55-Woodard**
	:	
DCH, HEALTHCARE FACILITY REGULATION DIVISION,	:	
Respondent.	:	

INITIAL DECISION

I. INTRODUCTION

Petitioner Golden Days Quality Care Home (hereinafter "Golden Days"), by and through its owner and administrator Della Grant, appeals Respondent the Department of Community Health's (hereinafter "DCH") decision to impose a civil penalty against it for an alleged violation of the rules governing the operation of personal care homes. The evidentiary hearing on this matter was conducted via telephone conference on March 22, 2016 before the undersigned Administrative Law Judge of the Office of State Administrative Hearings. Mrs. Grant participated in the hearing on behalf of Golden Days. Stacey Hillock, Esq., represented DCH.

For the reasons indicated below, DCH's action is **AFFIRMED**.

II. FINDINGS OF FACT

1. Golden Days currently holds a license to operate as a personal care home from DCH and held such license during the period relevant to this Decision. *Testimony of Della Grant; Exhibits R-1, R-2.*

2. During the period relevant to this Decision, Golden Days had five staff members, including Della Grant and her daughter, Brittney Grant. The facility provided care to six residents. *Testimony of Della Grant; Exhibit R-2.*

3. One of the residents in the facility's care was W.G., a seventy-three year old male diagnosed with coronary artery disease, arterial hypertension, alcohol dependence (under control due to environmental constraints), major depressive disorder with psychotic features, and low-grade dementia. W.G.'s medical history included a myocardial infarction—which required that he undergo a graft and stent placement—and one suicide attempt. W.G.'s medications included Zoloft, an anti-depressant; Aricept, which is used to treat dementia; and nitroglycerin, which is prescribed to treat chest pain associated with coronary artery disease. *Testimony of Debra Smith; Exhibits R-9, R-10.*

4. W.G. was discharged to Golden Days on May 15, 2013 from West Central Georgia Regional Hospital, where he was admitted after he was arrested and adjudged "Incompetent to Stand

Trial" in Gordon County, Georgia. According to the Golden Days Admission Agreement signed by W.G., Golden Days agreed to provide W.G. with "protective care" and "watchful oversight" while he was a resident of the facility. *Testimony of Della Grant; Exhibit R-11.*

5. On June 23, 2015, Della Grant took W.G. and three other residents—W.C., a resident diagnosed with schizophrenia; T.V., a resident diagnosed with schizoaffective disorder; and T.S., a resident diagnosed with moderately severe mental retardation and chronic obstructive pulmonary disorder—to go river tubing at "Toccoa River Adventures" (hereinafter "TRA") in McCaysville, Georgia. All four residents had some level of cognitive impairment due to their diagnoses. Della Grant's ten-year-old grandson, T.G., accompanied them. Della Grant did not take other Golden Days staff members with her on the planned outing to TRA; she planned to meet Brittney Grant, who lived near TRA, at "Horseshoe Bend," the starting point for the tubing trip. *Testimony of Della Grant; Exhibits R-12, R-13, R-14, and R-15.*

6. After Della Grant, the four residents, and her grandson were dropped off at Horseshoe Bend by a TRA van, they were met by Brittney Grant, who informed Della Grant that she had been stung by a bee, and that she would have to leave to go to the emergency room because she was allergic to bee stings. Brittney Grant thereupon departed, leaving one Golden Days staff member—Della Grant—to supervise four residents and a small child during the river tubing trip. *Testimony of Della Grant; Exhibit R-2.*

7. Rather than cancel the remainder of the outing due to a lack of sufficient staff on hand to protect and supervise the participants, Della Grant proceeded downriver with the four residents and her grandson. Each member of the party was in his or her own inner tube, and the six of them were connected to one another by a rope. *Testimony of Della Grant; Exhibits R-2, R-6.*

8. Sherri Counts, who was visiting north Georgia from Orlando, Florida, was also tubing on the Toccoa River on June 23, 2015 with her family. At the hearing on this matter, Ms. Counts recalled that the river was three-feet deep and "very cold" at the time. Approximately ten minutes into the Counts' family tubing trip, Ms. Counts heard someone yelling for help, and witnessed Della Grant in the water, struggling with a female resident (later identified as W.C.), who had fallen out of her inner tube. According to Ms. Counts, Della Grant and W.C. repeatedly submerged in the river, and appeared to be drowning. Ms. Counts and her husband assisted Della Grant in getting W.C.—who seemed mentally and emotionally "vacant" and physically lethargic—back into her inner tube, and thereafter proceeded downriver. Ms. Counts stated that even with three adults helping, it was very difficult to get the residents back into their inner tubes. *Testimony of Sherri Counts.*

9. At some point, Della Grant decided to discontinue the tubing trip, whereupon she, her grandson, and three of the residents exited onto the riverbank. However, W.G. adamantly refused to exit the river, and insisted on continuing downriver by himself to the finishing point at TRA. Della Grant decided to stay with the other three residents, and allowed W.G. to continue tubing downriver unsupervised. She and the rest of the party caught the transportation van back to TRA, where she planned to meet W.G. *Testimony of Della Grant; Exhibits R-2; R-6.*

10. While Della Grant and the rest of the party were on the way back to TRA, W.G. was discovered floating face down in the river by an employee of TRA, whereupon emergency medical services (EMS) were alerted. EMS responded to the scene and commenced CPR. EMS responders noted that W.G.'s pupils were pinpoint, and that he was "pulseless," "non-breathing," and "cold to the touch." W.G. was transported by ambulance to Fannin Regional Hospital, and subsequently airlifted to Erlanger Medical Center in Chattanooga, Tennessee, where he died. *Testimony of Deputy Mike Early, McCaysville Police Department; Exhibits R-17, R-18.*

11. No criminal charges are currently pending against Della Grant as a result of the June 23, 2015 incident. *Testimony of Deputy Mike Early.*

12. Della Grant documented the above-described incident in a written report dated June 23, 2015, which she submitted to DCH. She also submitted a follow-up report on or about June 24, 2015. *Exhibit R-6.*

13. Based upon the above-described written reports, DCH commenced an investigation into Golden Days. As part of this investigation, Debra Smith, RN, a surveyor with DCH, conducted a site visit to Golden Days, interviewed Mrs. Grant, Ms. Counts, and other witnesses to the June 23, 2015 incident, and reviewed relevant documentation, including the police report and hospital records generated during the June 23, 2015 incident. Based on the findings of her investigation, Ms. Smith determined that Golden Days had violated PCH Rule 111-8-62-.10(1) by failing to ensure that residents were accompanied by an adequate number of facility staff members during the outing to TRA.[1] *Testimony of Debra Smith; Exhibits R-2, R-7, R-17, R-18.*

14. In a letter dated October 19, 2015, DCH advised Golden Days of its intent to impose a fine of $601.00 against it for violation of PCH Rule 111-8-62-.10(1), which it categorized as an "initial Category I violation" in accordance with its Enforcement Rules. Della Grant requested a hearing on or about October 25, 2015. *Exhibits R-1, R-8.*

15. At the hearing on this matter, Della Grant testified that despite his diagnosis of low-grade dementia, W.G. did not have significant cognitive impairment, and that she believed he had the capacity to finish the tubing trip unattended. She asserted that W.G. exercised independent free will when he adamantly refused to leave the river and decided to continue on his own. She further argued that her conduct was not expressly prohibited by the rules and regulations governing the operation of personal care homes, and that Golden Days should therefore not be subject to a fine or any other sanction from DCH. Della Grant also disputed Ms. Counts' testimony that she and the residents were in peril at any time during the trip, or that she required significant help from the Counts family to return the residents to their respective tubes. *Testimony of Della Grant.*

[1] Ms. Smith also cited four other violations of the rules and regulations governing the operation of personal care homes in her report. However, DCH sought to fine Golden Days only for the violation of PCH Rule 111-8-62-.10(1). *Testimony of Debra Smith; Exhibits R-1, R-2.*

III. CONCLUSIONS OF LAW

1. Because DCH seeks to impose a fine against Golden Days, 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 DCH, which is authorized to promulgate rules to protect the health, safety, and welfare of occupants of such facilities. O.C.G.A. §§ 31-7-3, -12. The rules that DCH has promulgated for personal care homes are found in Chapter 111-8-62 of the Official Compilation, Rules and Regulations for the State of Georgia. Ga. Comp. R. & Regs. 111-8-62-.01 et seq. [hereinafter "PCH Rules"]. DCH enforces the rules governing PCHs through 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. In the present case, DCH proposes to fine Golden Days for violating Ga. Comp. R. & Regs. 111-8-62-.10(1), which provides as follows:

> (1) The home must maintain a minimum on-site staff to resident ratio of one awake direct care staff person per 15 residents during waking hours and one awake direct care staff person per 25 residents during non-waking hours where the residents have minimal care needs. *However, the home must staff above these minimum on-site staff ratios to meet the specific residents' ongoing health, safety and care needs.*

Ga. Comp. R. & Regs. 111-8-62.-.10(1). (Emphasis added by the Administrative Law Judge). Further, pursuant to Ga. Comp. R. & Regs. 111-8-62-.10(1)(c), "[r]esidents must be supervised consistent with their needs." Id.

4. Della Grant acknowledges that she took four residents on a river tubing outing, and that she failed to discontinue that outing after it became apparent that she would be the only staff member to supervise all four residents and her young grandson. All four residents had significant cognitive impairments, and lacked the capacity to participate in an outing such as the one at issue without significant assistance from staff members. Further, W.G. suffered from serious heart problems, and it was ill-advised that he participate in such strenuous activity as a river tubing trip. That an insufficient number of staff members were on hand during the outing was demonstrated by the fact that Della Grant had to rely on assistance from bystanders after W.C. fell out of her inner tube. Further, the recklessness of Della Grant's actions in proceeding on the river outing despite the lack of additional staff members is made glaringly apparent by the fact that no staff member was available to accompany W.G. downriver. Della Grant's assertion that W.G. had free will to continue downriver by himself does not absolve her of responsibility for his protection and supervision, especially as he should not have been put in such a perilous situation in the first place. The evidence clearly shows that as a result of Della Grant's failure to ensure that adequate staff members were on hand to assist residents during the outing, one resident died.

5. DCH is authorized pursuant to its Enforcement Rules to impose a fine of between $601 and $1000 per day for Category I violations, or those which have "caused death or serious physical or emotional harm to a person or persons in care." Enforcement Rules § 111-8-25-.05(1)(e)1.(i). According to the Enforcement Rules, the appropriate fine amount for an initial violation is "the bottom figure in the appropriate category." Enforcement Rules § 111-8-25-.05(1)(e)2.(i). Accordingly, DCH lawfully assessed a fine of $601.00 against Golden Days for its initial Category I rule violation.

IV. DECISION

IT IS HEREBY ORDERED that DCH's decision to impose a civil penalty against Golden Days in the amount of $601.00 is **AFFIRMED**.

SO ORDERED, this 20th day of April, 2016.

M. PATRICK WOODARD, JR.
Administrative Law Judge