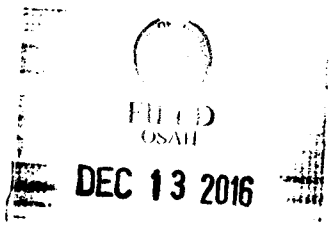
BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

SEYMOUR SOUTHERN COMFORTS, **Petitioner,**	:	
	:	**Docket No.:**
v.	:	**OSAH-DCH-HFR-PCH-1707847-135-Brown**
DCH, HEALTHCARE FACILITY REGULATION DIVISION, **Respondent.**	:	



INITIAL DECISION

I. INTRODUCTION

Petitioner Seymour Southern Comforts (hereinafter "SSC") appeals the decision of Respondent the Department of Community Health ("DCH") 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 October 25, 2016 before the undersigned Administrative Law Judge of the Office of State Administrative Hearings. Dante Ferrigno, administrator of SSC, participated in the hearing on the facility's behalf. Stacey Hillock, Esq., represented DCH.

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

II. FINDINGS OF FACT

1. SSC 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 Dante Ferrigno; Exhibits R-1, R-2.*

2. During the period relevant to this Decision, SSC provided care to eleven residents. One of the residents in the facility's care was "Resident 1,"who was admitted to the facility in June 2010. Resident 1's diagnoses included Alzheimer's disease, acute bronchitis, status-post

transient ischemic attacks, hypertension, allergic rhinitis, and scrotal hernia. *Testimony of Nancy Brown; Exhibit R-9.*

3. At the time of his admission to SSC, and for the duration of his residence at the facility, Resident 1 had a durable power of attorney for health care. This durable power of attorney was executed by Resident 1 on April 20, 2005, and was at that time governed by the ""Durable Power of Attorney for Health Care Act" (O.C.G.A. §§ 31-36-6, -9, -10). Per the durable power of attorney, Resident 1 appointed his son "C.T." as his Attorney-in-Fact, and authorized him "to make any and all decisions for [him] concerning [his] personal care, medical treatment, hospitalization, and healthcare . . . . The durable power of attorney included the following provision, which was initialed by Resident 1:

> I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

According to "L.T.", Resident 1's daughter-in-law, SSC was provided with a copy of the durable power of attorney at the time of Resident 1's admission to the facility or shortly thereafter. According to C.T., Resident 1 was "ready to die," and had no desire to be resuscitated if he suffered a potentially life-ending event. *Testimony of L.T.; Testimony of C.T.; Exhibit R-10.*

4. On March 11, 2016, at approximately 9:40 p.m., staff members of SSC discovered Resident 1 unresponsive and lying partially in bed, with his upper body "hanging" off the bed and his head was very close to the floor. Staff members did not initiate CPR, but instead alerted emergency services at approximately 9:59 p.m. Staff members also notified L.T. and C.T. In his testimony, C.T. recalled that a staff member from SSC called his home after emergency services had been alerted. According to an incident report form completed by Cynthia Lewis, a

staff member of SSC, she contacted L.T. at 9:45 p.m. Ms. Lewis also falsely indicated on this document that staff members initiated CPR upon discovering Resident 1. *Testimony of Nancy Brown; Testimony of Dante Ferrigno; Testimony of C.T.; Exhibit R-2, R-7, R-9.*

5. When emergency services personnel arrived at approximately 10:07 p.m., they found the resident in the same position in which he was discovered. Resident 1 was "cyanotic[1] in the face," "pulseless," "apnic,"[2] and his skin was "cool to the touch." He was pronounced "Dead at [the] scene." *Testimony of Nancy Brown; Testimony of Dante Ferrigno; Exhibits R-2, R-7, R-9.*

6. DCH commenced an investigation after it was notified of the above-described incident, and dispatched Nancy Brown, Compliance Auditor, to conduct a site visit at SSC. During this site visit, Ms. Brown interviewed staff members of SSC, including Mr. Ferrigno. The staff members acknowledged that they did not perform CPR upon discovering Resident 1 at 9:40 p.m. on March 11, 2016, though they could not explain why. Upon reviewing the records the facility maintained for Resident 1, Ms. Brown determined that there was no advance directive or "Do Not Resuscitate" (DNR) order in the resident's file. Based on the findings of her investigation, Ms. Brown determined that SSC violated PCH Rule 111-8-62-.26(2)(d), which requires facility staff members to initiate CPR when a resident experiences cardiac or respiratory arrest unless the resident has a DNR or advance directive. *Testimony of Nancy Brown; Exhibits R-1, R-2, R-3.*

7. In a letter dated June 30, 2016, DCH advised SSC 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. Mr. Ferrigno requested a hearing on or about July 27, 2016. *Exhibits R-1, R-10.*

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[1] Blue coloration of the skin. *Testimony of Nancy Brown.*
[2] Pulseless. *Testimony of Nancy Brown.*

8. At the hearing, Mr. Ferrigno testified that DCH's proposed civil penalty was unwarranted because Resident 1 had a valid durable power of attorney for health care. He further opined that the requirements of the rules governing personal care homes should not supersede the resident's clear wish that he not be resuscitated in the event of a sudden and detrimental change in his condition. *Testimony of Dante Ferrigno.*

III. CONCLUSIONS OF LAW

1. Because DCH seeks to impose a fine against SSC, 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 SSC for violating PCH Rule 111-8-62-.26(2), which provides, in pertinent part, as follows:

> (2) When the sudden change in the resident's condition causes the resident to experience cardiac or respiratory arrest, the home must immediately take one of the following actions:
>
> . . .
>
> (d) If the resident is not enrolled in hospice, and does not have either a

> DNR or an advance directive, then the staff of the home must immediately initiate cardiopulmonary resuscitation where it is not obvious from physical observation of the resident's body (e.g. body is stiff, cool to the touch, blue or grayish in color) that such efforts would be futile and there is not a physician, or authorized registered nurse or physician assistant on site to assess and provide other direction and contact emergency medical services immediately to arrange for emergency transport.

Ga. Comp. R. & Regs. 111-8-62-.26(2).

4. In the present case, it is undisputed that SSC's staff members did not perform CPR on Resident 1. Accordingly, the court must determine whether Resident 1 had "either a DNR or and advance directive" such as would relieve the facility of its obligation to immediately initiate CPR. Ga. Comp. R. & Regs. 111-8-62-.26(2)(d).

5. At the time he was admitted to SSC, and at all times thereafter, Resident 1 had a durable power of attorney for health care. At the time this document was executed, Georgia law did not provide for advance directives. However, the Georgia legislature allowed for advance directives through passage of the Georgia Advance Directive for Health Care Act (hereinafter "the Act") in 2007. Ga. L. 2007, p.133, § 2. The Act included a "savings clause," which provided that it would not "apply to, affect, or invalidate a living will or durable power of attorney for health care executed prior to July 1, 2007 . . . ." O.C.G.A. § 31-32-3.

6. In passing the Act, the legislature recognized that advance directives combine the provisions of a living will and durable power of attorney. Ga. L. 2007, p.133, § 2. They serve the dual functions of allowing the resident (1) to choose someone to make his or her healthcare decisions and (2) to state his or her treatment preferences if he or she has a terminal condition or if he or she is in a state of permanent unconsciousness. O.C.G.A. § 31-32-4. In contrast, a durable power of attorney for health care served only one function: to enable the individual to delegate health care decision-making to an agent. See O.C.G.A. §§ 31-36-1 to -10 (2006).

7. Resident 1 did not have an advance directive or a DNR order. Further, the court finds that, given the additional "treatment preference" function served by the advance directive, a durable power of attorney for health care cannot be considered the functional equivalent of an advance directive. Therefore, the failure of staff members to immediately initiate CPR upon discovering Resident 1 constituted a violation of PCH Rule 111-8-62-.26(2)(d).[3]

8. 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 properly assessed a fine of $601.00 against SSC for an initial Category I rule violation.

IV. DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, DCH's decision to impose a civil penalty against SSC in the amount of $601.00 is **AFFIRMED**.

SO ORDERED, this 8th day of December, 2016.

Barbara A. Brown

BARBARA A. BROWN
Administrative Law Judge

[3] Where a resident has a durable power of attorney for health care, PCH Rules direct the facility to "immediately contact the health care agent for directions regarding the care to be provided" and to initiate CPR and contact emergency services if the health care agent is not immediately available. Ga. Comp. R. & Regs. 111-8-62-.26(2)(c). In this case, it appears that the facility contacted L.T. and C.T. at some point after staff members discovered Resident 1. However, there is no evidence on record that would suggest staff members obtained directions from C.T. regarding the care to be provided to Resident 1. Further, although a staff member indicated on an incident report form that she alerted L.T. at 9:45 p.m., this document reveals nothing about the contents of Ms. Lewis' discussion with L.T. and is unreliable considering that it includes the false attestation that staff members initiated CPR.