**BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS**
**STATE OF GEORGIA**

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| **MAGNOLIA PLACE OF CAIRO,**<br>**Petitioner,** | **Docket No.: 1834337**<br>**1834337-OSAH-DCH-HFR-PCH-65-Brown** |
| **v.** | |
| **DCH, HEALTHCARE FACILITY REGULATION,**<br>**Respondent.** | **Agency Reference No.: 1834337** |



# FINAL DECISION

## I. INTRODUCTION

This matter concerns the proposed decision of the Department of Community Health ("DCH") to impose a civil penalty of $601 against Petitioner, Magnolia Place of Cairo, for an alleged violation of the Rules and Regulations for Personal Care Homes (Ga Comp. R. & Regs. 111-8-62-.01 to -.34). An evidentiary hearing was conducted via telephone conference on August 7, 2018. Thomas Lehman, Esq. represented Petitioner in this matter. Crandall Heard, Esq., represented DCH.

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

## II. FINDINGS OF FACT

1. Magnolia Place of Cairo (hereinafter "Magnolia Place") is a personal care home licensed by DCH. The facility is owned by Jerry McDaniel and administered by Brandi Strickland, R.N. (Testimony of Jerry McDaniel; Testimony of Brandi Strickland).

2. During the period relevant to this decision, Magnolia Place served between twenty-three and thirty-five residents, some of whom required hospice care. One such resident was "W.G.", a 93-year-old male diagnosed with late-stage Alzheimer's disease, hypertension, hyperlipidemia, and coronary artery disease. (Testimony of Brandi Strickland; Exhibit R-4).

3. While he resided at Magnolia Place, W.G. received hospice services from Bethany Hospice. Jane Toles, R.N., a nurse with Bethany Hospice, visited W.G. at Magnolia Place twice per week, and was also available for consultation by telephone. Ms. Toles worked under the supervision of Dr. Patrick Fenlon, Bethany Hospice's medical director, who prescribed medications for W.G. and developed his plan of care in consultation with Dr. Ashley Register, W.G.'s primary care physician. As W.G. was under hospice care, the focus of the care he received at Magnolia Place was comfort, rather than cure. (Testimony of Jane Toles; Testimony of Dr. Ashley Register).

4. W.G.'s medications included Risperdal, for behavior; Tamulosin HCL and Oxybutin, for urinary problems; aspirin; and Carvedilol, for hypertension. According to W.G.'s Medication Assistance Record, which was retained in his file at Magnolia Place, staff members were required to administer two doses of Risperdal, one dose of Tamulosin, one dose of aspirin, one dose of Oxybutin, and one dose of Carvedilol to W.G. every day. (Testimony of Leisha Lavender, Compliance Auditor, DCH; Exhibit R-4).

5. Ms. Toles sometimes communicated changes to W.G.'s medication regimen, as authorized by Dr. Fenlon, to Magnolia Place staff members. These communications were often oral, and thus not documented in W.G.'s file. (Testimony of Jane Toles; Testimony of Brandi Register).

6. On June 13, 2017, Leisha Lavender, a Compliance Auditor with DCH's Healthcare Facility Regulations Division, visited Magnolia Place to conduct an annual inspection and complaint investigation.[1] The on-site inspection included a review of records maintained by Magnolia Place. (Testimony of Leisha Lavender; Exhibit P-1; Exhibit R-4).

[1] The nature of this complaint was not described at the evidentiary hearing.

7. During her review of the facility's records, Ms. Lavender noted that W.G.'s Medication Assistance Record included several entries in which a staff member included his or her circled initials under a given date and next to a time written in by staff members. When Ms. Lavender asked staff members what the circled initials meant, the staff members indicated that they signified that the medication was not administered at the corresponding date and time. The staff members further explained that they sometimes did not administer W.G.'s medications as prescribed because hospice personnel had directed them to "use their discretion" in determining whether they needed to be administered. Ms. Lavender found no written documentation authorizing staff members to deviate from W.G.'s prescriptions as they described. (Testimony of Leisha Lavender; Exhibit R-7).

8. Based on her observations during the on-site inspection, Ms. Lavender determined the facility to be in violation of Ga. Comp. R. & Regs. 111-8-62-.25(1)(a), which provides: "Each resident must receive care, and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations."[2] Ms. Lavender advised Ms. Strickland—who had not been present at the facility during the on-site inspection—of her findings in a telephone conversation on June 14, 2017. DCH provided Magnolia Place with a written report of Ms. Lavender's findings on or about August 30, 2017. (Testimony of Leisha Lavender; Testimony of Brandi Strickland; Exhibit R-4).

9. Immediately following the on-site inspection, Ms. Strickland obtained written orders from W.G.'s physician authorizing the facility to administer Risperdal and Cogentin "as needed" and to withhold his blood pressure medication if his blood pressure fell below certain levels. She also developed a plan of correction in response to Ms. Lavender's findings, which she submitted to DCH in September 2017. (Testimony of Brandi Strickland; Exhibit P-1; Exhibit R-6).

[2] Ms. Lavender also found the facility to be in violation of the PCH Rule requiring facilities to maintain only ambulatory residents. However, DCH did not seek to impose a fine against Magnolia Place for this violation. (Exhibits R-3, R-4).

10. Ms. Lavender conducted another inspection of Magnolia Place on December 13, 2017. She found no rule violations during this inspection. (Testimony of Brandi Strickland).

11. After conducting an administrative review of Ms. Lavender's findings, Shirley Rodriguez, the director of DCH's PCH program, determined that Magnolia Place's rule violation placed W.G. at risk of significant harm. Accordingly, on January 21, 2018, DCH notified Magnolia Place of its intent to impose a $601 civil penalty on the facility based on its determination that it had committed a "Category I violation." Category I violations are those which have "caused death or serious physical or emotional harm to a person or persons in care or pose[] an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in care." (Testimony of Shirley Rodriguez; Exhibit R-3).

12. At the hearing, Ms. Toles and Dr. Register testified that nothing about Magnolia Place's administration of W.G.'s medications, as documented in the Medication Assistance Record, placed W.G.'s health or safety at risk. Indeed, Dr. Register and Ms. Strickland—who is also a registered nurse—testified that administration of W.G.'s blood pressure medication in strict accordance with the written orders maintained in his file could have caused his blood pressure to "bottom out." Ms. Toles also testified that waking Petitioner to take his medications would "do more harm," as the goal of his caregivers was to ensure his comfort. (Testimony of Jane Toles; Testimony of Dr. Ashley Register; Testimony of Brandi Strickland).

13. Ms. Strickland acknowledged that the facility's failure to obtain physicians' orders in writing violated the rules governing personal care homes. However, she testified that this practice has since been corrected and that the facility's policy is now to obtain written confirmation of any changes in the residents' care. (Testimony of Brandi Strickland).

## III. CONCLUSIONS OF LAW

1. Because DCH seeks to impose a civil penalty against Magnolia Place, 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. DCH is the state entity tasked with the licensure and regulation of healthcare facilities, including personal care homes. O.C.G.A. §§ 31-7-3, -12. Pursuant to this responsibility, it has promulgated rules for the operation of personal care homes, which 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. Pursuant to its Enforcement Rules, DCH "may impose a civil penalty fine . . . for each violation of a law, rule, regulation, or formal order related to the initial or continued licensing of a facility. . . ." Enforcement Rules 111-8-25-.05(1)(e). DCH must assign violations a category based upon the severity of their consequences or the degree to which they place a resident at risk of physical or emotional harm. See Enforcement Rules 111-8-25-.05(1)(e)1.(i)-(iii). The most severe violations, those which "ha[ve] caused death or serious physical or emotional harm to a person or persons in care or pose[] an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in care," are in Category I, and subject the violator to a fine of up to $1,000 per day. Enforcement Rules 111-8-25-.05(1)(e)1.(i).

4. In the present case, DCH assigned the violation observed by Ms. Lavender to Category I based on its determination that W.G. was placed at risk of harm due to the facility's failure to administer his medications as prescribed. However, this determination is not supported by a

preponderance of the evidence. The credible testimony presented at the hearing established that Magnolia Place administered W.G.'s medications in accordance with the orders of his primary care physician and the medical director of his hospice care provider. W.G.'s primary care physician and hospice care nurse testified that nothing about the facility's administration of W.G.'s medications placed the resident at risk of physical or emotional harm. Thus, while Magnolia Place's record-keeping practice violated the PCH Rules,[3] there is no evidence that it warranted the maximum penalty for an initial violation.

5. However, DCH was authorized to impose the minimum civil penalty for Magnolia Place's violation of record-keeping requirements. Enforcement Rules 111-8-25-.05(1)(e)1.(iii), 2.; PCH Rules 111-8-62-.24(2); see also PCH Rules 111-8-62-25(1)(a) ("Each resident must receive care . . . which must be . . . in compliance with applicable federal and state law and regulations."). Therefore, Magnolia Place must pay a fine of $50.00 for its initial violation of administrative requirements.

## IV. DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, DCH's decision to impose a civil penalty against Magnolia Place is **MODIFIED**. DCH is authorized to collect a

[3] See PCH Rules 111-8-62-.24(2) ("Each resident file must include . . . Health information including all health appraisals, diagnoses, prescribed diets, medications, and physician's instructions.").

fine of $50.00 for Magnolia Place's initial violation of the administrative rule governing record-keeping.

**SO ORDERED**, this 28th day of August, 2018.

**Barbara A. Brown**
**Administrative Law Judge**

**From:** Westray, Kevin
**To:** tlehman@syrupcity.net; crandall.heard@dch.ga.gov
**Subject:** Magnolia Place of Cairo v. DCH-HFR 1834337
**Date:** Tuesday, August 28, 2018 2:56:00 PM
**Attachments:** 1834337.PDF

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Good afternoon Attorneys,

Please find attached Judge Brown's decision in the above listed case. Have a good evening.

Best regards,
Kevin

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