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OSAH
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Kevin Kim, Legal Assistant

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

SAVANNAH COURT OF LAKE OCONEE, **Petitioner,** **v.** **DCH, HEALTHCARE FACILITY REGULATION,** **Respondent.**	**Docket No.: 2328768** **2328768-OSAH-DCH-HFR-PCH-66-Beaudrot** **Agency Reference No.: 2328768**

INITIAL DECISION

I. Introduction

The matter is a consolidated administrative appeal of multiple adverse actions in which the Department of Community Health, through the Healthcare Facility Regulation Division (the "Department" or "Respondent"), seeks to impose fines against and revoke the permit of Petitioner Savannah Court of Lake Oconee ("Petitioner" or "Savannah Court") to operate a personal care home. Savannah Court timely appealed each of the Department's proposed enforcement actions.

The hearing in this matter was conducted before the undersigned Administrative Law Judge on January 3, January 30, and February 1, 2024. Savannah Court was represented in the hearing by Chesley S. McLeod, Esq. and Kara G. Silverman, Esq. of Arnall Golden Gregory LLP. The Department was represented by Jason P. Reeves, Esq.

Pursuant to the Order issued in this matter dated February 5, 2024, the record was held open until 4:00 p.m. on Friday, April 5, 2024, for post hearing submissions.

The parties in this matter have had a long and difficult relationship. Incidents and disputes go back over a period of years. One of the most challenging issues in this case has been determining which of the alleged violations that the Department is relying upon as the basis for its proposed sanctions.

Based on and limited to the evidence presented in this matter as to the specific infractions identified by the Department, after a thorough review of the record and the consideration of the analysis and arguments of the parties, the Court finds that the Department can impose fines against Savannah Court with respect to certain of the rule infractions identified by the Department. The

Department has not, however, shown by a preponderance of the evidence that its proposed revocation of Savannah Court's permit to operate is justified. This matter is therefore **AFFIRMED in part**, **REVERSED in part and REMANDED** for further proceedings consistent with this decision.

II. Findings of Fact

The Parties.

1. Savannah Court is the licensed operator of a senior living community in Greensboro, Georgia. The community offers independent living, memory care, and personal care home services. Savannah Court is licensed for 72 beds and is located at 1061 Willow River Run Road, Greensboro, Georgia 30642. (P-2 at p. 2.)

2. The Department is the agency of the State of Georgia that is responsible for health care planning, licensing, certification, and oversight of various health care facilities and services in Georgia, including personal care homes. (*Id.* at p. 2.) The Department is authorized to regulate personal care homes within the State of Georgia and 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 (the "PCH Rules"). The Department enforces the PCH Rules 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 (the "Enforcement Rules").

The Department's Enforcement Matrix and the Standards Applicable to Substantiate a Category I Violation.

3. The Department has created an enforcement matrix to determine the severity and associated fines and other enforcement actions associated with an alleged rule violation. (Jan. 30, 2024 Hr'g Tr., 58:8-24.) A Category I violation can be issued one of three types of tags: J, K, or L. (*Id.*, 59:4-12; Feb. 1, 2024 Hr'g Tr., 50:8-21.) A Category II violation is issued either a G, H, or I tag. (Jan. 30, 2024 Hr'g Tr., 59:13-60:2.) A Category III violation is issued either a D, E, or F tag. (*Id.*, 60:3-8.)

4. Pursuant to Rule 111-8-25-.05(1)(e)1.(i), a Category I violation is defined as "[a] violation or combination of violations of licensing requirements which has caused death or serious physical or emotional harm to a person or persons in care or poses an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in care." Thus, a Category I violation may properly be issued by the Department for an alleged (or actual) rule violation only if it meets the requirements of Rule 111-8-25-.05(1)(e)1.(i). (Jan. 30, 2024 Hr'g Tr., 64:23-65:19.)

The March 6, 2023 Survey (and the December 29, 2022 Elopement).

5. On March 6, 2023, staff from the Department completed an investigation of Savannah Court. Based upon this investigation, the Department cited Savannah Court with three violations pursuant to O.C.G.A. § 31-2-8 and the PCH Rules, Chapter 111-8-62, as well as the Enforcement Rules, Chapter 111-8-25. (R-5.) Each alleged rule violation in the March 6, 2023 survey for which the Department sought to impose a monetary fine related to the same set of events (the "Elopement Incident") relating to a resident that occurred on December 29, 2022. (*Id.*)

6. The first alleged rule violation identified in the March 6, 2023 survey is based on Rule 111-8-62-.18(1)(b), which provides that "[a] home which serves residents with cognitive deficits which place the residents at risk of eloping, i.e. engaging in unsafe wandering activities outside the home must do the following … (b) [u]tilize appropriate effective safety devices, which do not impede the residents' rights to mobility and activity choice or violate fire safety standards, to protect the residents who are at risk of eloping from the premises." (*Id.* at p. 1; *see also* Rule 111-8-62-.18(1)(b).)

7. The Department contends that this Rule was not met for one of four residents sampled (Resident #1). (R-5 at p. 1.) According to the March 6, 2023 survey, Resident #1 exited the back door of the facility's dining room at approximately 6:00 a.m. on December 29, 2022, lost his balance, and fell in the facility's parking lot, which resulted in injuries to Resident #1's leg and hip. (*Id.* at pp. 2-3.)

8. The March 6, 2023 survey indicates that, prior to his fall, Resident #1 attempted unsuccessfully to leave the facility approximately ten times in the early morning hours of December 29, 2022. (*Id.* at pp. 2, 4-5.) Due to this activity, Savannah Court staff placed Resident #1 in the dining room (a common area) "so they could monitor him/her better." (*Id.* at p. 2.)

9. The March 6, 2023 survey further provides: "Staff E stated while he/she was passing medications around 6:00 a.m., and Staff C was assisting another resident, they heard the door alarm go off again. Staff E stated that he/she and Staff C met each other up front about the same time and was told by Resident #3 that Resident #1 went out the back door of the dining room. Staff E stated that the dining room door had a manual lock that could be unlocked from the inside." (*Id.* at pp. 2-3.)

10. The Department recognizes that audible door alarms, like those utilized by Savannah Court, are an appropriate safety device to help limit the risk of elopements. (Jan. 3, 2024 Hr'g Tr., 47:7-10.) The Department surveyor who prepared the March 6, 2023 survey confirmed at the hearing that she has no information to indicate that the door alarms at the Savannah Court facility were not functioning properly on the date of the alleged elopement. (*Id.*, 46:17-47:6.) The

March 6, 2023 survey includes statements from Savannah Court staff that the staff heard the door alarm go off upon Resident #1's exit from the dining room to the parking lot. (R-5 at pp. 2-3.)

11. The Department's surveyor also testified at the hearing that door locks which cannot be manually opened from the inside could present a safety risk, including a fire safety risk. (Jan. 3, 2024 Hr'g Tr., 47:11-24.) The Department's surveyor further confirmed that the governing rules and regulations prohibit staff from (i) physically restraining residents and/or (ii) locking residents in their rooms, and that taking either of these actions to prevent an elopement would be a violation of Rule 111-8-62-.18(1)(b). (*Id.*, 54:18-55:9.) The Department's March 6, 2023 survey does not identify any additional safety devices that Savannah Court should have utilized to comply with Rule 111-8-62-.18(1)(b), (R-5), and the Department's witnesses at the hearing did not identify any such additional safety devices that Savannah Court should have utilized at the facility to prevent an elopement.

12. The second alleged rule violation in the March 6, 2023 survey is based on Rule 111-8-62-.25(1)(a), which provides that "[e]ach resident must receive care and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations." (*Id.* at p. 3; *see also* Rule 111-8-62-.25(1)(a).)

13. The Department's surveyor confirmed at the hearing that Resident #1 never left Savannah Court's property. (Jan. 3, 2024 Hr'g Tr., 45:23-46:16.) The surveyor further confirmed that Petitioner's staff did not need to conduct on off-site search for Resident #1 because staff "went shortly after him." (*Id.*, 46:12-13.) The survey and hearing testimony indicate that Resident #1 was in the back parking lot for no more than fifteen minutes, and potentially for a shorter period of time, prior to Savannah Court's staff's arrival. (*Id.*, 48:17-21; *see also* R-5 at pp. 5).[1]

14. The record further indicates that Savannah Court staff were present with Resident #1 within five minutes of his fall. (Jan. 3, 2024 Hr'g Tr., 52:3-7; *see also* R-8 at p. 2 ("PT. STATED HE HAD ONLY BEEN ON THE GROUND FOR APPROX 5 MINUTES WHEN HE WAS FOUND BY FACILITY STAFF.").) The record also indicates that Savannah Court staff were present with Resident #1 when EMS personnel arrived. (R-8 at p. 2.)

15. The EMS report documented that Resident #1 had "no obvious life threats[,]" and the Department's surveyor testified at the hearing that she had no reason to dispute EMS's finding that Resident #1 had no obvious life threats. (*Id.* at p. 2; *see also* Jan. 3, 2024 Hr'g Tr., 52:8-53:1.)

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[1] The March 6, 2023 survey provides: "DD stated that the facility had a security camera in the room of Resident #1. The security camera footage captured Resident #1 leaving his/her room at 5:45 a.m. DD stated that he/she was notified by the staff regarding the incident at that morning around 6:00 a.m." (R-5 at p. 5.)

16. The Department's survey also documented that "[a] review of a weather website (wunderground.com) showed that on 12/29/22 at 6:00 a.m., the temperature was between 29 and 30 degrees Fahrenheit." (R-5 at p. 4.) At the hearing Savannah Court established that the weather report on which the Department based its findings reflected temperatures only for Augusta, Georgia and includes no temperatures for Greensboro, Georgia where the Savannah Court facility is located. (Feb. 1, 2024 Hr'g Tr., 39:2-41:23.)[2]

17. The third alleged rule violation identified in the March 6, 2023 survey is based on Rule 111-8-62-.30(2)(b), which provides: "[t]he serious incidents that must be reported to the Department include the following: … (b) [a]ny serious injury to a resident that requires medical treatment." (R-5 at p. 6; *see also* Rule 111-8-62-.30(2)(b).) The Department contends that this Rule was not met for two of an unspecified number of residents sampled (Residents #1 and #4). (R-5 at p. 6.)[3]

18. It appears that this alleged rule violation does not serve as a basis for the Department's imposition of a fine, as there is no asterisk set beside the alleged rule violation. (R-5 at p. 6; *see also* Department's May 10, 2023 cover letter (included as part of R-5), notifying Savannah Court that "[t]he violations for which the Department is imposing a fine is attached hereto and marked with asterisks on Exhibit 'A'.") The Department assigned only a Category III, D-tag for this alleged rule violation. (R-5 at p. 6.) According to its Enforcement Matrix, the Department historically has required providers who are assigned a D-tag to complete a plan of correction to address the alleged deficiency. (P-16 at p. 19.)

The March 23, 2023 Settlement Agreement.

19. On March 23, 2023, the parties entered into a settlement agreement (the "Settlement Agreement") to resolve three then pending cases between the parties before the Office of State Administrative Hearings, OSAH Docket Numbers 2228686, 2307107 and 2309543 (R-2). The Settlement Agreement resolved disputes between the parties relating to certain surveys conducted by the Department between May 13, 2019, and October 6, 2022. (R-2, including attached Ex. A.) By its terms, the Settlement Agreement did not address issues identified in the March 6, 2023

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[2] Specifically, Mr. Sammy Foster, the Department's Regional Director for Personal Care Home Program, Healthcare Facility Regulation Division, testified as follows: "Q: So this report actually doesn't include any temperatures at all for Greensboro, but instead of Augusta, right? A: It says that, yes. Q: And that's more than an hour and fifteen minutes away from – Augusta is an hour and fifteen minutes away from Greensboro, right? A: I want to say it definitely would be at least that much, that much of a distance." (Feb. 1, 2024 Hr'g Tr., 41:15-23.)

[3] The record reflects that Savannah Court personnel called both EMS and Resident #1's daughter(s) in the 6 a.m. hour of December 29, 2022, to notify each of Resident #1's fall.

Survey, including the incident of elopement and resident injury that occurred on December 29, 2022, documented in the March 6, 2023 Survey.

20. Pursuant to the Settlement Agreement, Savannah Court agreed to conduct comprehensive quarterly audits for one year utilizing an independent consultant to assist Savannah Court in complying with the rules and regulations governing personal care homes. (*Id.* at ¶ 2(a).)

21. Section 2(b) of the Settlement Agreement provides:

> The Independent Consultant shall:
>
> I. Have no past or present employment relationship with [Savannah Court].
>
> II. Be a licensed healthcare professional with at least the credentialing of a registered professional nurse (RN/RPN).
>
> III. Demonstrate that she or he has the necessary qualifications and experience to serve as [Savannah Court's] Independent Consultant.
>
> IV. Have been selected by the Facility and scheduled to begin the consult and audit within two (2) weeks of the signing of this agreement.
>
> V. Audit, assess, evaluate, and make recommendations to [Savannah Court] that promote [Savannah Court's] full compliance with all applicable State and Federal laws and regulations.
>
> VI. Perform the initial audit within 30 days of the signing of this agreement.
>
> VII. Monitor [Savannah Court] for at least a year.
>
> VIII. Make a written report on a quarterly basis. The report is to be retained by [Savannah Court] and is to be made available at the request of the Department."

(*Id.* at ¶ 2(b).)

22. Paragraph 2(c) of the Settlement Agreement contains additional measures that the Independent Consultant "may" undertake, but was not required to undertake, on behalf of Savannah Court. (*Id.* at ¶ 2(c).)

23. Paragraph 2(g) of the Settlement Agreement provides: "If [Savannah Court] fails to substantially comply with the terms of the Agreement or fails to comply with the Rules and Regulations for Personal Care Homes, Chapter 111-8-62, as well as the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, Chapter 111-8-25, [the Department] will take any and all regulatory action it deems appropriate against [Savannah Court], including the intent to revoke the Permit." (*Id.* at ¶ 2(g).)

24. The Settlement Agreement contains applicable mutual releases. (*Id.* at ¶ 5.) It also provides: "[t]his Agreement shall resolve all issues in, or arising out of, the above-captioned contested case and other issues involving [Savannah] that have occurred on or before October 6, 2022." (*Id.* at ¶ 6.)

The May 10, 2023 Notice of Intent to Impose Fines Based upon the March 6, 2023 Survey

25. On May 10, 2023, the Department issued a notice of intent to impose two fines totaling $3,600 for alleged rule violations cited in the March 6 Survey of Savannah Court that the Department completed on March 6, 2023. (P-5; *see also* R-6.)[4] The March 6, 2023 survey cited Savannah Court for three alleged rule violations. (P-5; *see also* R-5.) The Department seeks to impose fines for alleged violations of Rule 111-8-62-.18(1)(b) (Precautions for Residents at Risk of Elopement) and Rule 111-8-62-.25(1)(a) (Supporting Residents' Rights). (R-5, identifying rules for which the Department seeks to impose fines for this survey with asterisks at pp. 1 and 3.) These two fines are both attributable to the Elopement Incident. In the May 10 notice of intent to impose fines, the Department does not seek to impose a fine for the alleged violation of Rule 111-8-62-.30(2)(b) (Reporting), as there are no asterisks listed beside this alleged rule violation in the March 6, 2023 survey. (*Id.* at p. 6.)

The July 31, 2023 Survey.

26. The Department's July 31, 2023 survey cites Savannah Court for four alleged rule violations. (R-13.)

27. *The Department increases the level of violations post survey visit.* After the survey was completed by the surveyor on July 31, 2023, the Department's management increased each of the four alleged rule violations from lower-level tags to Category I, J-tags on or around August 15, 2023. (*Id.*, at unnumbered p. 3 (Personal Care Home Program Control Sheet); *see also* Jan. 30, 2024 Hr'g Tr., 77:5-16; 79:19-80:8; Feb. 1, 2024 Hr'g Tr., 43:8-25.)[5] These changes were made:

[4] The March 6, 2023 survey and other surveys referred to in this Decision are sometimes referred to in the record individually as an "inspection report." (R-6.)

[5] The Department increased the scope of severity for each alleged rule violation in both the July 31, 2023 and August 1, 2023 surveys after each survey was completed. (Feb. 1, 2024 Hr'g Tr., 46:4-12 (in relation

(i) without corresponding edits to the actual findings or in reliance on new or additional information; (ii) without consulting the surveyor who conducted the on-site visits at Savannah Court; and (iii) despite that Department management never physically visited Savannah Court's facility in relation to the July 31, 2023 survey. (Jan. 30, 2024 Hr'g Tr., 78:18-23; 81:13-24.)

28. On cross-examination, the Department's Regional Director acknowledged that the Department's practice is to require a J (or higher-level) tag to justify the revocation of a licensee's permit. (Feb. 1, 2024 Hr'g Tr., 44:1-10 ("Q: Okay. In order for the department to revoke a license, is it the department's policy that the citation – that the citation would actually have to rise to a J tag or higher to support a revocation? A: Well, in the process of doing that, it is – it is in a practice if, indeed, there is going to be revocation – and this is done through our enforcement department – that they would apply Js to that because it would lay – lies in between what they call a pose or threat are imminent for emotional physical."); *id.*, 44:19-45:1 ("Q: Okay. And if the department makes a decision that it wants to revoke a license, it needs to issue a J tag to the rule citation, right? A: That uses the process of putting J tags on the particular findings in reference to that. That is a practice of the department and a subjective practice that we put in place. So that is what you see when you see those particular reports.").)

29. *The "ambulatory resident" rule.* The first alleged rule violation in the July 31, 2023 survey is based on Rule 111-8-62-.15(1)(b), which provides: "[e]xcept for aging in place exceptions, the home is permitted to admit and retain only ambulatory residents who are capable of self-preservation with minimal assistance, i.e. staff may assist the resident in transferring from a sitting or reclining position and provide verbal directions to residents who are able to self-propel to the nearest exit." (R-13 at p. 1; *see also* Rule 111-8-62-.15(1)(b).)

30. The Department contends that this Rule was not met for three of seven residents sampled (Resident #2, #5, and #6). (R-13 at p. 1.) According to the survey, during a tour of Savannah Court on July 27, 2023, Resident #2, Resident #5, and Resident #6 were observed lying in hospital beds. (*Id.*) The record does not reflect whether these individuals were ambulatory when admitted to the facility. The Department presented no evidence that any of these residents experienced any harm, either physical or emotional, as a result of their admissions to Savannah Court. The July 31, 2023 survey includes no findings that any of these residents suffered any serious physical or emotional harm, or were at imminent risk for such harm as a result of their admission to or retention at Savannah Court. (R-13.)

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to the notes reflected on the Department's PCH Program Control Sheet set forth in R-13: Q: "PEA recommended revocation with combined visits on 7/31/23 and 8/1/23. All citations were changed to J levels. See fine letter on the 8/1/23 shell. CC. Do you understand that to mean that every citation issued in both surveys w[as] changed? A: Each one of those particular citation was changed from whatever the previous scoping was, and they was all identified as Js, based on the revocation process.").)

31. *The "aging in place" exception to the ambulatory patient rule and the adequacy of fire drills at Savannah Court.* The second alleged rule violation in the July 31, 2023 survey is based on Rule 111-8-62-.15(1)(c), which provides that personal care homes may allow up to three non-ambulatory residents to remain in the home to support an aging in place strategy that is in the best interests of the resident(s), subject to eight specified requirements. (*Id.* at p. 3; *see also* Rule 111-8-62-.15(1)(c).)

32. The Department contends that Savannah Court failed to satisfy three of the eight specified requirements for two of seven residents sampled (Resident #4 and Resident #7). (R-13 at p. 4.) Specifically, the Department contends that Savannah Court "failed to meet the following criteria for aging in place for non-ambulatory residents, (iv) the facility monitors its performance of fire drills to ensure that it can safely evacuate all the residents at any time in 13 minutes or less; (v) the facility increases the number of documented fire drills to a minimum of one fire drill per month, covering all shifts, as long as one or more residents in the facility are non-ambulatory; [(vii)] the facility ensures sufficient staff on all shifts to support the safe and timely evacuation of all residents in the event of an emergency." (*Id.*)

33. The Department's July 31, 2023 survey documented that both Resident #4 and Resident #7 were ambulatory as of the dates of their respective admissions to the Savannah Court facility (*id.* at pp. 4-5), but as of late July 2023, each was bedbound. (*Id.* at p. 5.)

34. The Department's July 31, 2023 survey further notes: "[a] review of facility fire drills showed one fire drill dated 6/15/23 at 6:30 p.m. with an end time of 6:54 p.m. (24 minutes). There were a total of eight (8) employees listed who assisted with the fire drill to include the director and maintenance." (*Id.* at p. 5.)

35. With respect to the thirteen-minute evacuation requirement, the Department surveyor testified. that Savannah Court's fire drill documentation reflected the start and end times of the fire drill. (Jan. 3, 2024 Hr'g Tr., 93:10-16; 94:2-11; 94:23-95:9.) Other than the start and end times, the Department surveyor was unable to recall "exactly what the document said." (*Id.*, 95:6-9.) The July 31, 2023 survey does not include the words "evacuate" or "evacuation," and the Department surveyor confirmed at the hearing that she does not know whether Savannah Court was able to evacuate all of the residents within thirteen minutes during the June 15, 2023 fire drill. (*Id.*, 95:10-96:19.)[6]

[6] *See also* Jan. 30, 2024 Hr'g Tr., 94:7-18 ("Q: I don't see anything in [the July 31, 2023 survey] that says that the evacuation took 24 minutes. Do you? A: They document the time that they start and end. And it said 24 minutes on the fire drill. That's what that is right there. Q: Right. And the fact that a drill was documented as lasting 24 minutes doesn't necessarily mean that it took more than 13 minutes to get all of the residents out of the building during this particular drill, right? A: I can't speak for – I can only go with what the facility documented."); and *id.*, 95:10-21 ("Q: Because, in fact, it would be common practice for a fire drill for the leaders of the drill to evacuate the occupants, get them outside, and someone is tasked

36. Turning to the next two prongs necessary to meet the aging in place exception, the Department surveyor testified that, in her opinion, "because you have three shifts, there should be three fire drills within the month, covering each shift. So one fire drill covering each shift." (Jan. 3, 2024 Hr'g Tr., 98:7-10.) The Department surveyor also took issue with the fact that eight Savannah Court staff members took part in the June 15, 2023, fire drill. (*Id.*, 98:12-20 ("And having eight employees listed at 6:30 p.m., I don't know how accurate that would be in a normal situation when the administrator and maintenance usually would leave at 4 or 5:00. But also night shift is usually a lot less people than that. So you would want the fire drills to reflect the amount of people that are actually going to be on shift if something were to happen.").)

37. The Department did not introduce evidence to confirm whether the eight staff members who took part in the June 15, 2023 fire drill included staff members who typically work different shifts, such that, collectively, the eight staff members may have covered all three shifts. The Department also did not introduce any evidence regarding whether Savannah Court had insufficient staff on each shift necessary to safely evacuate residents during a fire drill. In fact, the Department surveyor curiously suggested that Savannah Court had too many staff members participating in the June 15, 2023 fire drill. (*Id.*)

38. The Department issued a Category I, J-tag for this alleged rule violation based on its finding that the alleged rule violation posed an imminent and serious threat to the physical or emotional health and safety of one or more persons at Savannah Court. (*Id.*, 97:6-13; R-13 at p. 3.)[7] However, at the hearing, the Department surveyor acknowledged that the alleged rule violation did not result in any actual injury or death. (Jan. 30, 2024 Hr'g Tr., 97:18-20 ("Q: It didn't result in actual injury or death to anyone, right? A: No.").) The Department surveyor also acknowledged at the hearing that the alleged rule violation did not pose an imminent threat to anyone at Savannah Court. (*Id.*, 98:19-22 ("Q: Did you identify an imminent threat in relation to this citation? A: On this date an imminent threat, no, I did not.").)

39. *Written care plan rule.* The third alleged rule violation in the July 31, 2023 survey is based on Rule 111-8-62-.17(9), which provides: "Written Care Plan. Utilizing the information acquired during the admission process and the move-in adjustment period, a home which provides

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with going through the building to make certain that everyone, in fact, actually is out. And the drill is not completed until that individual comes back out of the building to make that confirmation, right? A: Again I don't know. I'm only going based off of what the facility documented. So, no, I was not there for their fire drill, so I cannot answer that.").

[7] On direct examination, the Department surveyor further testified as follows: "Q: The category I violation is in – is which – is in which where the facts has caused death or serious physical or emotional harm; is that correct? A: Right. Q: Or it could pose an immediate and serious threat to the physical and safety of one or more persons; is that correct? So it's either/or? [] A: Yes." (Jan. 30, 2024 Hr'g Tr., 107:11-20.)

proxy caregivers or memory care must develop the resident's individual written care plan within 14 days of admission and require staff to use the care plan as a guide for the delivery of care and services to the resident." (R-13 at p. 5; *see also* Rule 111-8-62-.17(9).) The Department contends that this rule was not met for two of seven residents sampled (Residents #1 and #7). (R-13 at p. 6.)

40. The Department's July 31, 2023 survey provides that Residents # 1 and #7 were memory care residents and a review of their respective files during a visit on July 27, 2023 "showed no written care plan" for either resident. (*Id.* at p. 6.) The Department issued a Category I, J-tag for this alleged rule violation.

41. At the hearing, the Department's Regional Director confirmed that neither Resident #1 nor Resident #7 was documented as suffering any harm as a result of their respective files containing no written care plans on the day of the site visit. (Feb. 1, 2024 Hr'g Tr., 47:12-49:10.) Likewise, the July 31, 2023 does not document any imminent and serious threat or hazard to the physical or emotional health and safety of Resident #1 or Resident #2 as a result of their respective files containing no written care plans on the day of the site visit. (R-13.)

42. *Timely prescription refills.* The fourth alleged rule violation in the July 31, 2023 survey is based on Rule 111-8-62-.20(8)(e), which provides: "[r]efills of prescribed medications must be obtained timely so that there is no interruption in the routine dosing. Where the home is provided with a new medication for the resident, the MAR [medication administration record] must be modified to reflect the addition of the new medication within 48 hours or sooner if the prescribing physician, advance practice registered nurse or physician assistant indicates that the medication change must be made immediately. In homes where unit or multi-dose packaging is not available for immediate changes in medications, unit or multi-dose packaging of the medication must be obtained when the prescription is refilled." (R-13 at pp. 6-7; *see also* Rule 111-8-62-.20(8)(e).)

43. The Department contends that this Rule was not met for four of seven residents sampled (Residents #1, #2, #3, and #4). (R-13 at pp. 7-10.) The Department issued a Category I, J-tag for this alleged rule violation. (*Id.* at p. 6.)

44. With respect to Resident #4, the July 31, 2023 survey provides: "A review of the July 2023 MAR showed Lorazepam .5 mg, take one by mouth twice daily, and was documented with circled staff initials, needs refill, on 7/14/23 at 8:00 a.m. and 8:00 p.m." (R-13 at p. 10.) At the hearing, it was established that the MAR for Resident #4, produced by the Department for purposes of substantiating its findings as reflected in the survey, contains no reference to needing a refill of the Lorazepam prescription. (Jan. 30, 2024 Hr'g Tr., 82:9-83:24.)

45. At the hearing, the Department surveyor acknowledged that: (i) Resident #4 did not die as a result of allegedly missing two doses of Lorazepam; (ii) that the July 31, 2023 survey does not indicate that Resident #4 suffered any serious physical or emotional injury as a result of allegedly missing two doses of Lorazepam; and (iii) that she did not consult any medical experts to determine whether missing any doses of Lorazepam would pose an imminent and serious threat or hazard to Resident #4's physical or emotional health or safety. (*Id.*, 85:3-86:3.) Additionally, the survey contains no findings that allegedly missing two doses of Lorazepam posed an imminent and/or serious threat or hazard to Resident #4's physical or emotional health or safety. (R-13.)

46. With respect to Resident #3, the July 31, 2023 survey provides: "A review of the July 2023 MAR for Resident #3 showed Baclofen 5 mg, take one by mouth twice daily, 8:00 a.m. and 8:00 p.m. The MAR was documented with circled staff initials, need refill, for both 8:00 a.m. and 8:00 p.m. doses from 7/3/23 to 7/7/23, 7/8/23 (8:00 a.m.), 7/25/23 (8:00 p.m.), and 7/26/23 (8:00 a.m., 8:00 p.m.), and 7/27/23 (8:00 a.m.)." (R-13 at p. 10.) At the hearing, it was established that the MAR for Resident #3, produced by the Department for purposes of substantiating its findings as reflected in the survey, contains no staff initials or circles as documented in the survey. (Jan. 30, 2024 Hr'g Tr., 87:12-15; *see also* R-18.) Furthermore, the MAR for Resident #3 does not reflect that any refills were needed for Resident #3 after July 5, 2023. (R-18; *see also* Jan. 30, 2024 Hr'g Tr., 86:23-87:13.) Additionally, the documentation upon which the Department relied for this alleged rule violation does not identify when Resident #3 was first prescribed Baclofen (Jan. 30, 2024 Hr'g Tr., 87:16-88:25), or whether Resident #3's physician had even issued an order to refill the prescription for Baclofen. (R-13; R-18.)[8]

47. The Department surveyor acknowledged at the hearing that Baclofen is a muscle relaxer that is commonly used to treat cramping and stiffness. (Jan. 30, 2024 Hr'g Tr., 89:1-4.) The Department surveyor admitted that Resident #3 did not: (i) die as a result of allegedly missing any doses of Baclofen (*id.*, 89:5-9); and/or (ii) suffer any serious physical or emotional injury as a result of allegedly missing any doses of Baclofen. (*Id.*, 89:10-13.) The Department surveyor also confirmed that the July 31, 2023 survey does not document any basis that would support a finding that missing any doses of a muscle relaxer like Baclofen posed an imminent or serious threat to Resident #3's physical or emotional health and safety. (*Id.*, 89:14-19.)

48. With respect to Resident #2, the July 31, 2023, survey provides: "A review of the July 2023 MAR for Resident #2 showed Zolpidem 10 mg, take one (1) by mouth at bedtime (8:00

[8] Rule 111-8-62-.20(8)(e) provides: "Refills of prescribed medications must be obtained timely so that there is no interruption in the routine dosing. Where the home is provided with a new medication for the resident, the MAR must be modified to reflect the addition of the new medication within 48 hours or sooner if the prescribing physician, advance practice registered nurse or physician assistant indicates that the medication change must be made immediately. In homes, where unit or multi-dose packaging is not available for immediate changes in medications, unit or multi-dose packaging of the medication must be obtained when the prescription is refilled." (R-13 at pp. 6-7.)

p.m.) for sleep. The MAR was documented with circled staff initials, need refill, from 7/8/23 to 7/11/23, and then again on 7/13/23 and 7/14/23. During an interview on 7/27/23 at 3:50 p.m., Resident #2 stated that he/she felt like there were times when he/she didn't get his/her medications. Resident #2 stated that sometimes he/she can't sleep when he/she doesn't get it." (R-13 at p. 9.)

49. The Department surveyor confirmed at the hearing that Zolpidem is a sleeping pill. (Jan. 30, 2024 Hr'g Tr., 90:20-21.) The Department surveyor admitted at the hearing that: (i) Resident #2 did not die as a result of missing any doses of Zolpidem (*id.*, 90:22-25); (ii) the July 31, 2023 survey does not document any serious physical or emotional injury to Resident #2 as a result of missing any sleep medication (*id.*, 91:1-4); and (iii) the survey does not document any basis to support a finding that missing doses of a sleeping pill posed an imminent and serious threat to Resident #2's physical or emotional health and safety. (*Id.*, 91:5-9.)

50. With respect to Resident #1, the July 31, 2023 survey identifies numerous medications prescribed to Resident #1, and the survey identifies certain medications that allegedly were not timely dispensed to and/or refilled for Resident #1. (R-13 at pp. 7-9.) The Department did not introduce any of the underlying documentation that allegedly supports its findings relative to Resident #1 in the July 31, 2023 survey, including the MARs for Resident #1.

51. The Department surveyor acknowledged at the hearing that: (i) Resident #1 did not die as a result of allegedly missing any doses of prescribed medications (Jan. 30, 2024 Hr'g Tr., 91:10-16); (ii) the July 31, 2023 survey does not document any serious physical or emotional injury to Resident #1 as a result of missing any medications (*id.*, 91:17-20); and (iii) the survey does not document any bases to support a finding that Resident #1 experienced an imminent and serious threat to his or her physical or emotional health or safety. (*Id.*, 91:21-25.)

52. Savannah Court first received a copy of the July 31, 2023 survey on August 15, 2023. This is two days before the Department issued its August 17, 2023 notices of revocation to Savannah Court. (Feb. 1, 2024 Hr'g Tr., 108:2-7; *see also* P-14.) Based on the PCH Program Control Sheet, the Department made the decision to issue a notice of intent to revoke Savannah Court's personal care home permit no later than August 15, 2023 (R-13). This means that the Department did not give Savannah Court an opportunity to submit a plan of correction to address the alleged rule violations prior to making the decision to pursue revocation. Savannah Court submitted its plan of correction in relation to the July 31, 2023 survey on August 17, 2023. (P-14; *see also* Feb. 1, 2024 Hr'g Tr., 108:2-14.)

53. Savannah Court's plan of correction included measures to address each of the four alleged rule violations. (P-14; Feb. 1, 2024 Hr'g Tr., 108:15-23.) Savannah Court's Regional Director of Operations also testified at the hearing that Savannah Court has implemented all of the corrective measures outlined in the plan of correction. (Feb. 1, 2024 Hr'g Tr., 108:24-110:22.)

The August 1, 2023 Survey.

54. The Department's August 1, 2023 survey cites Savannah Court for three alleged rule violations. (R-20.)

55. After the survey was completed by the surveyor on August 1, 2023, the Department's management again increased each of the three alleged rule violations from lower-level tags to Category I, J-tags on or around August 15, 2023. (R-13 at p. 3 (Personal Care Home Program Control Sheet); *see also* Jan. 30, 2024 Hr'g Tr., 77:5-16; 79:19-80:8; Feb. 1, 2024 Hr'g Tr., 43:8-25, 46:4-12.) These changes were made: (i) without corresponding edits to the actual findings or in reliance on new or additional information; (ii) without consulting the surveyor who conducted the on-site visits to the Savannah Court facility; and (iii) despite that Department management never physically visited the Savannah Court facility in relation to the August 1, 2023 survey. (Jan. 30, 2024 Hr'g Tr., 78:18-23; 81:13-24.)

56. *Proper supervision-response to call pendant alerts.* The first alleged rule violation in the August 1, 2023 survey is based on Rule 111-8-62-.10(1)(c), which provides that "[r]esidents must be supervised consistent with their needs." (R-20 at p. 1; *see also* Rule 111-8-62-.10(1)(c).) The Department contends that this Rule was not met for four of eight residents sampled (Residents #1, #4, #5, and #7). (R-20 at p. 1.) Specifically, the Department contends that, based on a review of various call pendant alert reports, Savannah Court personnel failed to respond to these four residents in a timely manner. (*Id.* at pp. 1-5.)

57. The call pendant reports on which the Department relied do not consistently match the survey findings. (*Compare* R-20 with R-25 through R-31.) For example, the August 1, 2023 survey references call pendant alerts that Savannah Court staff purportedly either did not respond to at all or did not respond to in a timely manner, but the call pendant reports admitted into evidence at the hearing (and on which the Department indicated it relied for purposes of making its findings) often do not reflect that a call alert was even initiated on the alleged dates and times referenced in the survey. (*Id.*; *see also* Jan. 3, 2024 Hr'g Tr., 121:22-123:2; 126:18-128:16; 136:25-137:9.)[9]

58. The August 1, 2023 survey identifies an instance where Savannah Court staff purportedly did not respond to a call pendant alert that was initiated at 5:26 p.m. on June 29, 2023. (R-20 at p. 4.) A review of the applicable call pendant report indicates that Savannah Court staff already was in the room (still responding to a prior call pendant alert initiated by the same resident

[9] The January 3, 2024 hearing transcript contains a scrivener's error at 137:8-9. The Department surveyor answered as follows: "I do *not* see it on these – on these documents that I have here." (*See also* R-25 through R-31, reflecting that no call alert at 5:22 a.m. on July 12, 2023 is reflected on the Department's call pendant alert exhibits.)

at 5:21 p.m. and *first* responded to by Savannah Court staff only one minute earlier at 5:25 p.m.) when the second pendant alert went off. (R-27; *see also* Jan. 3, 2024 Hr'g Tr., 134:8-136:10.)

59. The August 1, 2023 survey does not document the many instances in which Savannah staff responded promptly to call pendant alerts. (Jan. 3, 2024 Hr'g Tr., 118:6-19 (noting a response time of three minutes that the surveyor omitted from the survey); *id.*, at 123:3-124:4 (noting four additional responses on the same day for a single resident all within six minutes or less that were not documented in the survey); *id.*, at 130:15-19 (noting a response time of three minutes that was omitted from the survey); *id.* at 133:7-23 (noting a response time of three minutes that was omitted from the survey.)

60. The Department surveyor testified at the hearing that, in her opinion, a response time greater than five minutes is too long and constitutes a violation of Rule 111-8-62-.10(1)(c). (Jan. 3, 2024 Hr'g Tr., 114:18-20; 126:5-7.) However, the Department surveyor also acknowledged that the Rule contains no requirement to respond within a certain time interval, including a requirement to respond in less than five minutes. (*Id.*, 114:21-115:14; 126: 8-18.)[10] The Department surveyor further admitted that the rules and regulations governing personal care homes do not mandate that personal care homes utilize call pendant alert systems. (*Id.*, 115:15-21.)

61. *Adequate staffing.* The second alleged rule violation in the August 1, 2023 survey is based on Rule 111-8-62-.19(5)(b). (R-20 at p. 5.) In relevant part, the Rule provides: "[a]t a minimum, the home must provide the following staffing: (b) One registered professional nurse, licensed practical nurse, or certified medication aide on-site at all times." (*Id.*; *see also* Rule 111-8-62-.19(5)(b).) Although the August 1, 2023 survey initially quotes the rule correctly, the survey's findings section alters the rule's language as follows: "Based on observation and interview the facility failed to ensure that there was a professional nurse, licensed practical nurse, or a certified medication aide onsite at all times *in the memory care unit.*" (R-20 at p. 5) (alterations reflected with *italics*.) The Department surveyor testified at the hearing that she added the phrase "in the memory care unit" and that the phrase does not appear in Rule 111-8-62-.19(5)(b). (Jan. 3, 2024 Hr'g Tr., 139:11-141:10.)

62. The Department surveyor acknowledged that the Rule is satisfied where only one certified medication aide ("CMA") is on-site at any given time (*id.*, 142:6-14). The August 1, 2023 survey reflects that at least one CMA was present at Savannah Court during the site visit. (R-20 at p. 5.) The Department, however, contends that this Rule was not met because the surveyor observed the CMA in an area other than "in [Savannah Court's] memory care unit" during the surveyor's tour of the Savannah Court facility on July 13, 2023 at 2:00 p.m. (R-20 at p. 5.)

[10] "Q: [] Is there a rule that supports your opinion that a response time should be five minutes or less? A: No." (Jan. 3, 2024 Hr'g Tr., 126:14-17.)

63. The August 1, 2023 survey further provides that "[d]uring an interview on 7/13/23, Staff B stated that several staff were out sick with COVID right now, including the nurse." (*Id.* at p. 6.)

64. The August 1, 2023 survey does not identify any actual or potential serious harm to the physical or emotional health or safety of any Savannah Court resident as a result of this alleged rule violation (R-20). The Department did not offer any evidence of such actual or potential harm at the hearing.

65. *The wound-vacuum incident.* The third alleged rule violation in the August 1, 2023 survey is based on Rule 111-8-62-.25(1)(a), which provides that "[e]ach resident must receive care, and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations." (R-20 at p. 6; *see also* Rule 111-8-62-.25(1)(a).)

66. The Department contends that this Rule was not met for one of eight residents sampled (Resident #3). (R-20 at p. 6.) Specifically, the Department contends that Savannah Court failed to satisfy this Rule due to the alleged failure to provide wound care treatment or services to Resident #3.

67. On or around May 28, 2023, Resident #3 was sent out from the Savannah Court facility to a local hospital for care and treatment of her right leg. (R-20 at p. 8.) During this first hospital admission, which lasted a period of weeks, Resident #3 began receiving wound care treatments, including treatment using a piece of equipment known as a "wound vac." (*Id.*)

68. Efforts were made by both Resident #3's family and the hospital social worker to locate a rehabilitation facility that would accept Resident #3 while she continued to receive wound care treatments following her discharge from the hospital, but those efforts were unsuccessful. (R-20 at p. 8; *see also* Jan. 30, 2024 Hr'g Tr., 13:2-21.)[11] Accordingly, Resident #3 returned to the Savannah Court facility on or around June 12, 2023. (R-20 at p. 9; *see also* Jan. 30, 2024 Hr'g Tr., 17:1-20:15.)[12]

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[11] The record reflects that the unsuccessful efforts to identify a rehabilitation facility that would accept Resident #3 was due to "insurance issues." (R-23 at p. 2; Jan. 30, 2024 Hr'g Tr., 48:10-50:3.)

[12] The record contains conflicting information regarding Resident #3's exact return date to the Savannah Court facility. Some portions of the record, including the August 1, 2023 survey, indicate a return date of June 14th and others indicate a return date of June 12th. (Jan. 30, 2024 Hr'g Tr., 17:1-20:15.) The exact return date is not critical to resolution of this dispute.

69. According to an interview of Resident #3's daughter, "the plan was for [home health] services to provide the wound care [upon Resident #3's return to Savannah Court], but [home health] was unable to provide the level of care that was expected with the wound vac." (R-20 at p. 9; *see also* Jan. 30, 2024 Hr'g Tr., 22:10-22.)[13]

70. The August 1, 2023 survey also notes that Savannah Court notified Resident #3's daughter that it was not permitted to provide wound care treatments. (R-20 at p. 9.) At the hearing, the Department surveyor also confirmed that Savannah Court was not permitted to provide wound care services pursuant to the rules and regulations governing personal care homes. (Jan. 30, 2024 Hr'g Tr., 24:15-18; 26:4-29:25.) The Department surveyor also agreed at the hearing that it would have been a violation of the governing rules and regulations if Savannah Court had provided wound care services to Resident #3. (*Id.*, 30:1-5 ("Q: And, in fact, if the community did provide wound care services, that would be a violation of the governing personal care home rules, right? A: Correct. In this situation, yes, with the wound vac. Yes.").)

71. Following her initial discharge from the hospital, Resident #3 returned to the Savannah Court facility for approximately two to four days before she was sent back to the hospital on June 16, 2023. (*Id.*, 30:6-31:3.) During this two-to-four-day period, the wound vac was not plugged in or otherwise utilized. (*Id.*; *see also* R-20 at pp. 7 and 9.)[14] The August 1, 2023 survey also notes that Resident #3's daughter continued to call representatives of both the hospital and the home health provider during this period, but does not indicate that she ever sought wound care treatment services for her mother from Savannah Court. (R-20 at p. 9 ("[Resident #3's daughter] stated that he/she found out from the facility that they were not allowed to provide this type of wound care so he/she was on the phone back and forth with the hospital and HH all week."); *see also* Jan. 30, 2024 Hr'g Tr., 51:8-52:9.)[15]

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[13] At the hearing, the Department surveyor acknowledged that she did not know where Resident #3 would have gone upon discharge from the hospital if Savannah Court had rejected her. (Jan. 30, 2024 Hr'g Tr., 22:3-9 ("Q: So if the community would've rejected Resident Number 3 upon her discharge from the hospital, where would Resident 3 have gone? A: I don't know. Q: Did you ask [Resident #3's daughter] where Resident 3 would've gone? A: No.").)

[14] An EMS responder that was called to the Savannah Court facility to transport Resident #3 to the hospital on June 16, 2023 made a complaint on behalf of Resident #3 to the Department. (R-23.) According to the Department's intake report of that complaint, a member of Resident #3's family informed the EMS responder that "a [home health services] nurse visit[s] [Resident #3] to check the wound and wound vac. The facility stated the [home health services] nurse visited the facility but did not check [Resident #3's] wound vac." (*Id.* at p. 1; *see also* Jan. 30, 2024 Hr'g Tr., 47:3-48:9.) This portion of the Department's intake report was not included in the August 1, 2023 survey. (R-20.)

[15] Although the August 1, 2023 survey included a finding that "[Resident 3's daughter] stated that the [hospital] social worker told him/her that he/she had spoken with someone at [Savannah Court] and agreed that staff could provide care to resident with a wound vac[,]" (R-20 at pp. 8-9), the Department surveyor testified at the hearing that she did not confirm that this alleged statement was ever made, including who

72. Resident #3 then spent approximately two days at the hospital on June 16 and 17, 2023, and then returned to Savannah Court. (Jan. 30, 2024 Hr'g Tr., 31:4-10.) Upon this second discharge from the hospital, the hospital sent Resident #3 back to Savannah Court without the wound vac. (*Id.*, 31:11-16.) The Department surveyor testified that she understood that the hospital intentionally did not send the wound vac back with Resident #3 upon the second discharge. (*Id.*, 32:18-33:14.)

73. Following the second discharge from the hospital, Resident #3 spent approximately one day back at Savannah Court's facility before being transferred back to the hospital a third time once a swing bed became available at the hospital on Monday, June 18, 2023. (*Id.*, 32:24-33:4; *see also* R-20 at pp. 9-10 ("CC stated that Resident #3 stayed overnight or possibly two nights at the hospital and was sent back to the facility, without the wound vac. CC stated that on that Monday, he/she got a call from the social worker at the local hospital who told him/her that they wanted to have Resident #3 come back in to assess Resident #3's wound and that they thought they could get him/her into a swing bed. CC stated that Resident #3 went back to the hospital that Monday and went back on the wound vac. CC stated that he/she stayed in the swing bed at the hospital for about another month or so and received treatment for the wound.").)

74. Following the third hospital stay, Resident #3 returned again to Savannah Court, where home health and/or hospice providers began monitoring the wound without the assistance of the wound vac. (R-23 at p. 4; *see also* Jan. 30, 2024 Hr'g Tr., 35:4-36:23.) The Department surveyor confirmed at the hearing that it was appropriate and consistent with the Department's governing rules and regulations for hospice and home health providers to manage Resident #3's wounds within a personal care home setting like that operated by Savannah Court. (Jan. 30, 2024 Hr'g Tr., 54:16-55:16.)

75. An EMS responder that was called to Savannah Court to transport Resident #3 to the hospital on June 16, 2023, made a complaint on behalf of Resident #3 to the Department. (R-23.) According to the Department's investigative report that was created based on the EMS responder's complaint, the EMS responder alleged five separate categories of allegations that, if substantiated by the Department, could have given rise to at least five violations of the rules and regulations governing personal care homes. (*Id.*; *see also* Jan. 30, 2024 Hr'g Tr., 44:1-12.) Ultimately, however, the Department determined that the EMS responder's allegations were "unsubstantiated" for four of the five categories of allegations. (*Id.*, 44:13-18, 52:10-56:22; *see also* R-23 at pp. 3-5.)

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the social worker allegedly spoke with at Savannah Court. (Jan. 30, 2024 Hr'g Tr., 50:4-22.) The Department's internal investigation report also noted that "[Resident #3's daughter] stated that he/she was unsure who [the hospital social worker] spoke with." (R-23; *see also* Jan. 30, 2024 Hr'g Tr., 50:19-22.) This also was not contained in the August 1, 2023 survey.

76. At the hearing, the Department surveyor was unable to identify any serious physical or emotional harm allegedly suffered by Resident #3 as a result of the wound vac not being utilized during the June 12 to June 16, 2023 time period. (Jan. 30, 2024 Hr'g Tr., 65:20-67:19.)

77. The June 16, 2023 EMS report indicates that Resident #3 experienced no serious physical or emotional harm as a result of the non-use of the wound vac. (R-37.) Despite the fact that the EMS report generally was referenced in the Department's August 1, 2023 survey, the Department surveyor admitted at the hearing that the Department did not consider favorable portions of the EMS report in relation to its decision to issue a Category I, J-tag for this alleged rule violation. (Jan. 30, 2024 Hr'g Tr., 69:13-16 ("Q: My question is did DCH consider this portion of the EMS report when it determined that this alleged rule violation warranted a J tag? A: No. That was not included in the report."); *id.*, 70:12-15 ("Q: Did DCH consider this portion of the EMS report when it determined that this alleged rule violation warranted a J tag? A: I did not include this in the report. No."); *id.*, 71:10-14 ("Q: Okay. Did DCH consider this portion of the EMS report when it determined that this alleged rule violation warranted a J tag? A: No. I – I did not include that in my report. Q: Okay. And you're not aware that the department considered any of these portions of the report when it issued a J tag for this alleged rule violation, right? A: I'm – I'm not sure if they did or not.").)

78. Savannah Court first received a copy of the August 1, 2023 survey on August 15, 2023, two days before the Department issued its August 17, 2023 notices of revocation to Savannah Court. (P-15.) Based on the PCH Program Control Sheet, the Department made the decision to issue a notice of intent to revoke Savannah Court's personal care home permit no later than August 15, 2023. (R-13.) This means that the Department did not give Savannah Court an opportunity to submit a plan of correction to address the alleged rule violations before making the decision to pursue revocation. Indeed, the Department issued the notices of intent to revoke Savannah Court's permit before Savannah Court submitted its plan of correction on August 24, 2023. (P-14; *see also* Feb. 1, 2024 Hr'g Tr., 110:23-113:22.)

79. Savannah Court's plan of correction included measures to address each of the three alleged rule violations. (P-15; Feb. 1, 2024 Hr'g Tr., 113:23-118:11.) Savannah Court's Regional Director of Operations testified at the hearing that Savannah Court has implemented all of the corrective measures outlined in the plan of correction and/or otherwise implemented additional measures to address each of the alleged rule violations cited in the August 1, 2023 survey. (Feb. 1, 2024 Hr'g Tr., 108:24-110:22.)

August 17, 2023 notifications of intent to revoke Savannah Court's permit.

80. On August 17, 2023, the Department issued two letters to Savannah Court. (P-1; P-6.) Each notified Savannah Court of the Department's intent to revoke Savannah Court's permit to operate a personal care home. (P-1; P-6.)

81. With the first letter, the Department enclosed copies of the July 31 and August 1, 2023 surveys. (P-1.) The same letter also states: "[v]iolations that form the basis of the revocation are identified with asterisks [****] on Exhibits 'A' and 'B' that are attached and incorporated by reference in this notice." (P-1 at p. 1.)[16] The July 31, 2023 and August 1, 2023 surveys contain four and three alleged rule violations, respectively. (P-1 at 1; *see also* R-13; R-20.) All seven alleged rule violations are identified with asterisks, (R-13 at pp. 1, 4, 6-7; R-20 at pp. 1, 5-6). Therefore, the Department's revocation action is based on all seven alleged rule violations identified in the July 31, 2023 and August 1, 2023 surveys.

82. With the second letter, signed by Sophia Clark-Leslie, the Department identified an additional basis for the revocation action—Savannah Court's alleged breach of the March 23, 2023 Settlement Agreement. (P-6.)[17] Specifically, the Department contends that Savannah Court breached paragraphs 2(b), 2(c), and 2(g) of the Settlement Agreement. (*Id.* at p. 1 ("This letter is to serve as termination of the Settlement Agreement and notice of intent to revoke permit. This is based on paragraph 2(b) and 2(c) of the settlement agreement [sic] 'The independent consultant', the Department finds that the independent consultant's report was insufficient.").)

83. Ms. Clark-Leslie's August 17, 2023 letter further provides: "Also, paragraph 2(g): If the Facility fails to substantially comply with the terms of the Agreement or fails to comply with the Rules and Regulations for Personal Care Homes, Chapter 111-8-62, as well as the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, Chapter 111-8-25, Respondent will take any and all regulatory action it deems appropriate against the Facility, including re-issuance of the intent to revoke the Permit."[18]

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[16] The Department previously had sent a copy of the July 31, 2023 survey to Savannah Court by letter dated August 15, 2023. The August 15, 2023 letter, despite containing citations for the same alleged rule violations, includes no statement that the Department planned to revoke Savannah Court's permit in relation to the July 31, 2023 survey. (R-13.)

[17] Sophia Clark-Leslie is identified as "Attorney, Director of Legal Services, Georgia Department of Community Health, HFRD Legal Unit" in the August 17, 2023 letter. (P-6 at p. 2.)

[18] A review of the actual Settlement Agreement reveals that Ms. Clark-Leslie's letter misquotes the language of paragraph 2(g), as paragraph 2(g) does not include the phrase "re-issuance of." (*See* R-2 at p. 7.) As confirmed at the hearing and by a review of the Settlement Agreement itself, there is no indication in the record that the Department previously sought to revoke Savannah Court's personal care home permit. (Feb. 1, 2024 Hr'g Tr., 101:4-102:3.)

84. Neither of the August 17, 2023 letters indicates that the Department's intent to revoke Savannah Court's permit to operate a personal care home is based on alleged rule violations cited in the March 6, 2023 or October 31, 2023 surveys. (P-1; P-6.)

85. Prior to the hearing, the Department did not provide any explanation for its unilateral contention that the independent consultant's report was insufficient. (Feb. 1, 2024 Hr'g Tr., 100:17-101:3; *see also* Jan. 3, 2024 Hr'g Tr., 82:5-83:2.)

86. At the hearing, the Mr. Anthony Moss testified regarding the Department's position that Savannah Court breached the Settlement Agreement.[19] Mr. Moss testified that he has "dealt with" "one or two" nurse consultant reports in his professional capacity. (Jan. 3, 2024 Hr'g Tr., 63:12-17.) With respect to the sufficiency of the nurse consultant's report, Mr. Moss testified that: (i) he would have expected the nurse consultant's report to contain "measurable goals" relating to how a facility planned to achieve compliance with the applicable rules and regulations governing personal care homes, as well as various but unspecified compliance metrics, percentages, and medical outcomes based upon the goals to be achieved; and (ii) in his opinion, the nurse consultant's report prepared for Savannah Court did not adequately reflect such measurable goals, compliance metrics, percentages, and medical outcomes data. (*Id.*, 63:18-65:3; 76:8-16.)

87. The Settlement Agreement does not contain specific criteria that the nurse consultant's report is required to include. (R-4.) Instead, the Settlement Agreement provides: "The Independent Consultant shall: VIII. Make a written report on a quarterly basis. The report is to be retained by the facility and is to be made available at the request of the Department." (*Id.*, Para. 2(b)(VIII).) On cross-examination, Mr. Moss testified that Paragraph 2(b)(VIII) does not require the nurse consultant's report to contain measurable goals, logs, or any information about outcomes. (Jan. 3, 2024 Hr'g Tr., 75:8-25.)[20]

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[19] Mr. Moss serves as Deputy Director/GEMA Liaison for the Healthcare Facility Regulation Division. (Jan. 3, 2024 Hr'g Tr., 61:20-25; *see also* Respondent's Witness List.) Mr. Moss testified that he was not involved in the negotiation or drafting of the settlement agreement. (*Id.* 68:20-25.) Mr. Moss testified that he did not serve in the position of Deputy Director at the time the nurse consultant's report was submitted to the Department. (*Id.*, 81:6-11.) Mr. Moss further testified that he believes he first reviewed the Settlement Agreement "as we got close to [. . .] September[,]" which was after the Department issued its notice of termination and intent to revoke Savannah Court's permit on August 17, 2023. (*Id.*, 69:1-6.) Mr. Moss further testified that he was not involved in the Department's unilateral determination that the Settlement Agreement had been breached. (*Id.*, 69:11-17.)

[20] The January 3, 2024 hearing transcript indicates that Mr. Moss's answer to the question, "Does paragraph 2(b)(VIII) require that the report contain measurable goals" was "indiscernible." (*Id.*, 75:13-15.) Mr. Moss's answer at the hearing was "No."

88. Mr. Moss also confirmed that the Settlement Agreement contains no provisions authorizing the Department to determine or otherwise make a judgment call as to the sufficiency of the contents of the nurse consultant's written report. (*Id.*, 85:19-24 ("Q: Mr. Moss, can you identify a single provision in the settlement agreement that even gives the department the authority to make an assessment of whether the nurse's first report was sufficient or insufficient? A: No.").)[21]

89. With respect to the issue of compliance with Paragraph 2(c) of the Settlement Agreement, Mr. Moss testified (i) that he was unfamiliar with the Ultipro system referenced in the nurse consultant's report (*id.*, 65:23-66:4; 66:16-67:16), and (ii) that he did not "see where [the nurse consultant's report recommended] mandatory on-site training" for Savannah Court staff. (*Id.*, 65:23-66:14.)[22]

90. On cross-examination, Mr. Moss acknowledged that Paragraph 2(c)(V) of the Settlement Agreement does not require the nurse consultant to recommend only on-site, in-person training. (*Id.*, 71:17-19 ("Q: So in fact there was no requirement by the independent consultant to recommend on-site training. A: It was not a requirement, no.").)

91. Savannah Court timely retained Tina Hicks-Greenway to serve as Savannah Court's independent nurse consultant consistent with the requirements of Paragraph 2(b) of the Settlement Agreement. (Feb. 1, 2023 Hr'g Tr., 92:20-93:5; 93:10-15.) Savannah Court initially retained Ms. Hicks-Greenway to serve in this capacity for at least one year. (*Id.*, 93:24-94:2.)

92. Ms. Hicks-Greenway holds bachelor's and master's degrees in nursing. (P-9; *see also* Feb. 1, 2024 Hr'g Tr., 95:13-24.) Ms. Hicks-Greenway also has experience working with hospice and physician practices. (P-9; *see also* Feb. 1, 2024 Hr'g Tr., 95:25-96:7.)

93. Ms. Hicks-Greenway had no past or present employment relationship with Savannah Court prior to being retained as an independent consultant. (*Id.*, 93:6-9.) Ms. Hicks-Greenway audited, assessed, evaluated, and made recommendations to Savannah Court for the purpose of promoting Savannah Court's compliance with applicable state and federal laws and

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[21] Mr. Moss also testified that the Department is not in the role of serving as a consultant to providers. (Jan. 3, 2024 Hr'g Tr., 76:17-19 ("Q: And is it the state's or the department's role to be a consultant for the facility? A: No.").)

[22] The nurse consultant's report recommended that Savannah Court staff complete various types of training, including training through Savannah Court's Ultipro system. (R-4.) The report does not describe whether those portions of the recommended training that would utilize the Ultipro system should be completed on-site at the Savannah Court facility or virtually. Mr. Moss testified that he has no way to determine whether the nurse consultant recommended only on-site, in-person training. (*Id.* at p. 1; *see also* Jan. 3, 2024 Hr'g Tr., 74:6-14.)

regulations. (*Id.*, 93:16-20.) Ms. Hicks-Greenway also conducted an initial audit within thirty days of the execution of the settlement agreement on March 23, 2023. (*Id.*, 93:21-23.)

94. Ms. Hicks-Greenway prepared a written report within the first quarter of the Settlement Agreement's execution. (*Id.*, 94:3-6; 99:14-16.)[23] Savannah Court provided a copy of Ms. Hicks-Greenway's written report to the Department upon its request. (*Id.*, 94:22-95:1; 96:8-98:13; P-7.) Specifically, the Department first requested a copy of the written report on July 12, 2023, (*id.*, 97:8-19), and Savannah Court submitted a copy of the written report to the Department on July 24, 2023. (*Id.*, 97:23-98:13; 99:3-13; *see also* P-8.) Ms. Clark-Leslie acknowledged receipt of the written report the same day of July 24, 2023 (within twenty minutes of receiving the report). (P-7 at pp. 5-6.)

95. Ms. Clark-Leslie's email response included no statement or indication that the written report was untimely or insufficient. (*Id.*) The first instance that the Department ever notified Savannah Court of its contention that the written report was insufficient was via Ms. Clark-Leslie's August 17, 2023 letter. (Feb. 1, 2024 Hr'g Tr., 99:20-101:3.) The letter failed to offer any explanation as to why the Department contended that the written report was "insufficient." (Jan. 3, 2024 Hr'g Tr., 82:5-83:2.)

<u>*The October 31, 2023 Survey*</u>.

96. The Department's October 31, 2023 survey cites Savannah Court for two alleged rule violations. (R-33.) Both alleged violations relate to the same underlying events. (*Id.*; *see also* Feb. 1, 2024 Hr'g Tr., 71:1-9.) Specifically, the October 31, 2023 survey documents that on October 12, 2023, Resident #7 entered Resident #1's room and sexually assaulted her. (*Id.*) Savannah Court timely reported the incident to the Department on October 12, 2023. The Department does not contend that Savannah Court failed to timely report the incident. (R-34; *see also* Feb. 1, 2024 Hr'g Tr., 54:10-55:5; 83:17-84:22.)

97. The first alleged rule violation identified in the October 31, 2023 survey is based on Rule 111-8-62-.10(1)(c), which provides that "[r]esidents must be supervised consistent with their needs." (*Id.* at p. 1; *see also* Rule 111-8-62-.10(1)(c).)

98. The Department contends that this Rule was not met for one of nine residents sampled (Resident #7). (R-33 at p. 1.) Specifically, the Department contends that Savannah Court failed to supervise Resident #7 consistent with his needs. (*Id.*) The October 31, 2023 survey states that: "Resident #7 exhibited known hypersexual behavior and did not have proper supervision.

[23] The Settlement Agreement bears an execution date of March 23, 2023 (P-2), and the written report is dated June 7, 2023. (P-8.)

Resident #7 was alleged to have sexually assaulted another resident due to the failure of the facility to provide appropriate supervision." (*Id.*)

99. The Department contends that Savannah Court had prior notice that Resident #7 presented a risk for hypersexual behavior that could manifest in harm to other residents and/or staff prior to the October 12, 2023 sexual assault apparently committed by Resident #7. (Feb. 1, 2024 Hr'g Tr., 65:6-22; 75:8-14.) The Department identifies two bases for this alleged prior notice: (i) a physician evaluation form that was completed in relation to Resident #7 on October 13, 2023, the day after the alleged assault occurred on October 12, 2023; and (ii) a statement that Resident #7 purportedly made to a Savannah Court staff member ("Staff F") on an unspecified date. (R-33. at pp. 1-2; *see also* Feb. 1, 2024 Hr'g Tr., 75:8-14.)[24]

100. The October 13, 2023 physician evaluation form notes that Resident #7 "will need evaluation from PCP for possible hormones to control sexual behaviors." (R-35; *see also* R-33 at p. 2.)[25] The Department surveyor confirmed at the hearing that this physician evaluation form was completed the day after the alleged resident-on-resident incident. (Feb. 1, 2024 Hr'g Tr., 75:15-76:4.) The surveyor further confirmed that the October 13, 2023 physician evaluation form could not have placed Savannah Court on notice of Resident #7's alleged "known hypersexual behavior" prior to the incident's occurrence on October 12, 2023. (Feb. 1, 2024 Hr'g Tr., 76:25-77:6 ("Q: Okay. Let – let me state it this way. So we've established that the physician evaluation form was, in fact, completed the day after the October 12th incident. So we know that can[not] be a basis to indicate the community had prior knowledge of his sexual propensity, right? A: Right.").)[26]

101. Resident #7's medical records include two physician evaluation forms. (R-33 at p. 1; *see also* Feb. 1, 2024 Hr'g Tr., 58:3-59:11.) In addition to the October 13, 2023 evaluation, a separate evaluation was completed for Resident #7 on April 10, 2023 "when he initially was admitted into [Savannah Court]." (Feb. 1, 2024 Hr'g Tr., 58:3-59:11.) The April 10, 2023 physician evaluation contains no information suggesting that Resident #7 presented as a risk to any other residents or staff, or that he otherwise was known to exhibit any "hypersexual behavior(s)." (R-33 at p. 1; Feb. 1, 2024 Hr'g Tr., 59:2-11.)

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[24] The October 31, 2023 survey also provides that "Staff F stated the resident had made flirtatious comments toward staff." (R-33 at p. 3.) The record does not contain additional context or information concerning this statement, including the contents of the alleged flirtatious comments, when they were made, to whom they allegedly were made, or whether anyone understood that such flirtatious comments, to the extent they were made, reasonably could be viewed as threatening or an indicator for future wrongful conduct.

[25] Based on the October 31, 2023 survey, "PCP" means primary care physician. (R-33 at p. 2.)

[26] The February 1, 2024 hearing transcript appears to contain a scrivener's error, i.e., as the question included the term "cannot" as opposed to "can."

102. The Department supervisor acknowledged that the only bases supporting the Department's finding that Savannah Court should have known that it needed to provide additional one-on-one supervision to Resident #7 were unrelated to the October 13, 2023 physician evaluation form. (Feb. 1, 2024 Hr'g Tr., 78:22-79:13.)

103. Respondent points to the October 31, 2023 survey which states: "During staff interviews on 10/27/2023, Staff F stated in August 2023 (staff did not remember the exact date), he/she and another staff were walking on the 300- hallway, and the door of Resident #7 was opened. Staff F stated that Resident #7 told the staff if he/she was younger, the resident would hold staff down. Staff F stated the resident had made flirtatious comments toward staff." (R-33 at p. 3.)

104. The evidence in the record concerning whether Staff F ever reported Resident #7's alleged statement to Savannah Court management is disputed and contradictory. The October 31, 2023 survey contains no reference to Staff F purportedly making the comment known to Savannah Court management. (R-33; *see also* Feb. 1, 2024 Hr'g Tr., 87:4-11.) The Department surveyor testified at the hearing, however, that Staff F claimed to have reported the comment to Savannah Court "upper management." (Feb. 1, 2024 Hr'g Tr., 62:7-22.) The Department surveyor did not identify the individual within "upper management" to whom Staff F allegedly reported. Furthermore, the Department surveyor did not identify any documents that corroborated Staff F's alleged claim that she reported the alleged comment to upper management for Savannah Court. (*Id.*, 62:23-62:2 ("Q: All right. Is there any documentation that those comments were reported to management that you're aware of? A: Not that I was aware of. I could not find any of that.").) Finally, Savannah Court's Director of Operations testified on cross-examination that she had no prior knowledge of Resident #7's alleged comment to Staff F. (*Id.*, 125:25-126:7.)

105. With respect to the alleged comment itself, the October 31, 2023 survey provides: "Staff F stated that Resident #7 told the staff if he/she was younger, the resident would hold staff down." (R-33 at p. 3.) At the hearing, the Department surveyor clarified that the reference to "he/she" means Resident #7. (Feb. 1, 2024 Hr'g Tr., 80:10-16.)

106. The second alleged rule violation in the October 31, 2023 survey is based on Rule 111-8-62-.25(1)(h), which provides: "[e]ach resident has the right to be free from mental, verbal, sexual and physical abuse, neglect and exploitation. Each resident has the right to be free from actual or threatened physical or chemical restraints and the right to be free from isolation, corporal or unusual punishment and interference with the daily functions of living, such as eating or sleeping." (R-33 at pp. 3-4; *see also* Rule 111-8-62-.25(1)(h).)

107. The Department contends that this Rule was not met for one of nine residents sampled (Resident #1). (R-33 at p. 4.) Specifically, the Department contends that this Rule was

not met because "Resident #1 was sexually assaulted by Resident #7 while living at the facility." (*Id.* at pp. 4-7.)

108. The rules and regulations governing personal care homes provide certain specified rights to personal care home residents. Rule 111-8-62-.25(1)(c)(3) provides: "[e]ach resident has a right to interact with members of the community both inside and outside of the home and to participate fully in the life of the community." (*Id.*; *see also* Feb. 1, 2024 Hr'g Tr., 81:24-82:9.) Similarly, Rule 111-8-62-.25(1)(b) provides: "[e]ach resident must have the right to associate and communicate freely and privately with persons, in groups of the resident's choice without being censored by staff." (*Id.*; *see also* Feb. 1, 2024 Hr'g Tr., 82:24-83:5.)

109. The October 31, 2024 survey provides that prior to the October 12, 2023 incident: "Staff M stated Resident #1 told him/her that Resident #7 would often visit him/her in his/her room." (R-33 at p. 6.) The Department surveyor testified that, consistent with the governing rules and regulations, residents have a right to freely visit with one another. (Feb. 1, 2024 Hr'g Tr., 81:19-23 ("Q: Okay. And you would agree that residents have a right to visit freely with other residents, correct? A: Only if that resident – if the other resident agrees to that person visiting him or her.").)

110. The Department surveyor's testimony continued as follows: "Q: So according to these rules, absent a known proclivity for hypersexual behavior or other concerning behavior, the community could not prevent residents from visiting one another, right? A: Right. Unless the resident disagrees with that person visiting him or her. Q: And based on your interview of Resident Number 1, did she tell you that prior to October 12, 2023, that she ever objected to Resident Number 7 visiting her? A: No. No." (*Id.*, 83:6-16.) There is no evidence in the record that Resident #1 ever objected to Resident #7's visits to her room or otherwise notified Savannah Court of any concerns relating to Resident #7 prior to the October 12, 2023 incident.

111. At the hearing, Savannah Court's Regional Director of Operations also testified to the measures Savannah Court immediately implemented to address the resident-on-resident incident. These measures included calling EMS and notifying the police, assisting with the immediate transfer of both residents to a local hospital, providing additional supports to Resident #1 and her family, conducting an internal investigation of the events, and ensuring that the residents would be segregated. (Feb. 1, 2024 Hr'g Tr., 118:19-121:14.) Resident #7 moved out of the Savannah Court facility within days of the incident. (*Id.*, 120:19-121:3.)

<u>*Other Savannah Court Actions to Address Care Issue Concerns.*</u>

112. Savannah Court has implemented measures since mid-August 2023 to address resident care concerns. Between mid-August 2023 and February 1, 2024, the Regional Director

of Operations, who resides in Fort Myers, Florida, traveled to the Savannah Court facility no less than twenty times. (*Id.*, 121:23-122:6.) The Regional Director's site-visits to the facility covered all three shifts at the community. (122:7-123:20.) During her visits, the Regional Director participated in patient rounds with other care staff, reviewed and audited charts and records, and met with Savannah Court's executive director, other care staff, and resident family members. (*Id.*)

113. Savannah Court also hired a new Corporate Wellness Director in July 2023. (*Id.*, 127:16-128:3.) The Corporate Wellness Director made over thirty visits to the Savannah Court facility between mid-August 2023 and February 1, 2024. (*Id.*, 128:24-129:7.) During those visits, the Corporate Wellness Director has conducted numerous training sessions with care staff, including Savannah Court's resident care coordinator and the resident care team. (*Id.*, 129:8-130:20.) The Corporate Wellness Director's visits covered all three shifts and included unannounced "pop-up" visits to the Savannah Court facility. (*Id.*, 131:5-132:8). The Corporate Wellness Director also met with hospice representatives and clinical managers regarding medication management in conjunction with Savannah Court's pharmacy provider, as well as general care planning. (*Id.*, 132:9-19.)

114. Savannah Court has increased its staffing, including in the memory care unit, and has conducted additional training sessions on elopement risks, care planning, and residents' rights. (*Id.*, 134:3-135:14.) With respect to medication administration, Savannah Court has increased the cadence with which it conducts medication cart audits and checks and has also conducted additional training sessions for staff with respect to medication administration. (*Id.*, 135:15-19.) Savannah Court has also hired additional staff, including a licensed practical nurse. (*Id.*, 130:21-131:4.)

III. Conclusions of Law

1. The Department bears the burden of proof to show that its proposed imposition of sanctions is appropriate. Ga. Comp. R. & Regs. r. 616-1-2-.07. The standard of proof is preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21(4).

2. The administrative hearing in this matter is a *de novo* hearing. The Court must make an independent determination on the basis of the competent evidence presented at the hearing. Ga. Comp. R. & Regs. r. 616-1-2-.21(1), (3); *see also Longleaf Energy Assocs., LLC v. Friends of the Chattahoochee, Inc.*, 298 Ga. App. 753, 769 (2009) (the administrative law judge must consider the applicable facts and law anew, without according deference or presumption of correctness to the decision of the agency). In reaching this decision, the Court has "all the powers of the ultimate decision maker in the agency with respect to a contested case." O.C.G.A. § 50-13-41(b); Ga. Comp. R. & Regs. r. 616-1-2-.21(1).

3. The Department "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 …." General Licensing and Enforcement Requirements (hereinafter, the "Enforcement Rules"), Rule 111-8-25-.05(1)(e). The Department 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. *Id.* 111-8-25-.05(1)(e)1.(i)-(iii).

4. 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. These violations subject the violator to a fine of up to $2,000 per violation per day. Enforcement Rules, Rule 111-8-25-.05(1)(e)1.(i). The Department must substantiate that any alleged violation serving as a basis for a proposed revocation rises to the level of a Category I violation, consistent with the standard set forth in Rule 111-8-25-.05(1)(e)1.(i).

5. It is undisputed that Petitioner Savannah Court has an ongoing obligation to comply with the PCH Rules, Chapter 111-8-62, as well as the Enforcement Rules, Chapter 111-8-25. It is undisputed that failure to comply requires the Department to take all regulatory action appropriate against the facility to enforce those rules. It is undisputed that upon an appropriate showing of facts, this action can include revocation of the facility's permit.

6. It is apparent from the record in this case, including the long history of enforcement actions brought by Respondent, that the relationship between Petitioner and Respondent has become strained. Respondent's frustration with Petitioner is palpable and understandable. As the Department notes in its Proposed Findings of Fact and Conclusions of Law, the Department believes that revocation is the only appropriate remedy in this matter. The Department's position is that entering into another settlement agreement or any remedy short of revocation will simply be another instance of "fool me once, shame on you; fool me twice, shame on me." It argues that Savannah Court, after the termination of the settlement agreement and during these proceedings, continues to violate applicable Rules and Regulations. It notes that Savannah Court subsequently was cited by the Department for two (2) violations on November 2, 2023, arising from the October 12, 2023 sexual assault of one of the residents.

7. The Department argues with a broad brush, and at times unburdened by a detailed analysis of the facts, that Savannah Court's "inadequacies" have resulted in an elopement of a resident, inadequate fire drills to ensure resident safety in the event of an emergency, inappropriate response times for individuals whose health and safety is dependent on a timely response to their call for assistance, inadequate dispensation of prescribed medication to ensure the comfort and enjoyment of life, and a sexual assault of one of its residents.

8. The Department's understandable frustration is not a legal basis for revocation, however. Nor is a general assertion of inadequacies that gloms together all of the alleged

infractions helpful. To revoke Savannah Court's permit to operate its personal care facility in Greensboro, Georgia, Respondent must identify to Petitioner and then prove in this hearing by a preponderance of the evidence the specific identified infractions upon which Respondent is relying to justify revocation. For the Court to reach the correct decision in this matter, it is essential that the precise bases for Respondent's proposed revocation be identified and evaluated using the appropriate standards.

9. The record in this case is extensive. It addresses years of dealings between Petitioner and Respondent. It raises important questions regarding patient care in the personal care home operated by Petitioner Savannah Court. But the controlling facts are those that are relevant to the specific grounds identified by the Department as the basis for the revocation of Savannah Court's permit. To be clear, the Department cannot rely upon other alleged infractions as to which it has proposed penalties, but which it has not identified as a basis for revocation, to sustain the proposed revocation. It can only justify revocation by reference to those infractions it has identified as the basis for revocation.

10. This matter is not about whether Savannah Court does a good job, a fair job or a poor job operating its personal care facility in Greensboro. As to the issue of revocation, which is the principal focus of this matter, the question is whether the specific alleged infractions identified by Respondent as the basis for revocation justify revocation of Savannah Court's permit or whether a lesser penalty is appropriate.

11. In this matter, the evidence relates *both* to alleged infractions which the Department asserts justify revocation *and* other infractions where only penalties have been proposed. The following chronological timeline is therefore helpful in following the history of dealings between the parties, identifying the grounds that the Department is relying upon to justify revocation of Petitioner's permit and identifying alleged infractions for which the Department is seeking penalties.

> <u>May 13, 2019 – October 6, 2022.</u> The Department conducts a series of surveys identifying alleged compliance issues that result in three enforcement actions by the Department against Savannah Court. These are appealed by Savannah Court to the Office of State Administrative Hearings (OSAH Docket Numbers 2228686, 2307107 and 2309543). (Exhibit-R-2)
>
> <u>December 29, 2022.</u> The Elopement Incident occurs at the Savannah Court facility when a resident exits the facility, falls and injures himself.
>
> <u>March 6, 2023</u>. The Department's March 6 survey identifies three alleged rule violations and proposes three fines, all of which relate to the Elopement Incident.

March 23, 2023. The parties enter into the Settlement Agreement which resolves issues identified in the surveys from the May 13, 2019 -- October 6, 2022 and OSAH Docket Numbers 2228686, 2307107 and 2309543. It does not address the Elopement Incident.

May 10, 2023. The Department issues a Notice of Intent to Impose Fines based upon results of March 6 survey relating to the Elopement Incident. The May 10, 2023 notice does not propose revocation of Savannah Court's permit to operate.

July 31, 2023. The Department's July 31, 2023 survey cites Savannah Court for 4 alleged rule violations relating to (i) non-ambulatory admissions, (ii) failure to satisfy "aging in place" requirements, (iii) absence of written care plans and (iv) failure to fulfill prescription refills timely.

August 1, 2023. The Department's August 31, 2023 survey cites Savannah Court for 3 alleged rule violations relating to (i) failure to supervise properly based upon call pendant record examination, (ii) inadequate staffing and (iii) issues arising from wound care and use of a wound vac.

August 15, 2023. The Department modifies the survey results for the July 31, 2023 and August 1, 2023 surveys to increase all of the identified infractions to the most severe Category 1, J-tag level.

August 17, 2023. The Department issues two letters to Savannah Court. Each letter notifies Savannah Court of the Department's intent to revoke Savannah Court's permit to operate a personal care home. The first letter identifies the basis for revocation as the seven infractions identified in the July 31, 2023 and August 2023 surveys. The second letter adds as an additional basis for revocation of the permit as alleged breach of the Settlement Agreement. The second letter is the first notification that Savannah Court receives of an alleged breach of the Settlement Agreement.

September 9, 2023. On motion by the Department, the undersigned enters an order in this matter reopening matters which were the subject of the Settlement Agreement and consolidating all pending matters into this matter.

October 12, 2023. A resident at the Savannah Court facility is sexually assaulted by another resident (the "Sexual Assault").

October 31, 2023. An October 31, 2023 survey conducted by Respondent cites Savannah Court for two alleged rule violations arising from the Sexual Assault incident. The October 31, 2023 survey proposes fines, but does not indicate that these two infractions are the basis for revocation of Savannah Court's permit.

12. Neither of the August 17, 2023 letters indicates that the Department's intent to revoke Savannah Court's permit to operate a personal care home is based on alleged rule violations cited in either the March 6, 2023 or October 31, 2023 surveys. Accordingly, while the March 6, 2023 and October 31, 2023 surveys are relevant for whether penalties may be assessed against Petitioner for alleged infractions identified in those surveys, the alleged infractions and incidents which are identified in those surveys do not serve as the basis for revocation of Savannah Court's permit. The Department can only sustain its proposed revocation of Savannah Court's permit if a preponderance of the evidence proves the seven alleged rule infractions identified in the two August 17, 2023 letters and alleged breach by Savannah Court of the Settlement Agreement identified in the second of the two letters. This decision will therefore first address the eight grounds for revocation identified in the two August 17, 2023 letters, beginning with the purported revocation of the Settlement Agreement, and then turn to the seven enumerated alleged infractions identified in the August 17, 2023 letters.

Analysis of Alleged Grounds for Revocation of Permit.

13. *The Settlement Agreement.* As noted, the Department contends that Savannah Court breached Paragraphs 2(b), 2(c), and 2(g) of the parties' Settlement Agreement and these breaches justify the Department's revocation of the Settlement Agreement. The Department argues that these breaches of the Settlement Agreement are one of the grounds for revocation of Savannah Court's permit. The Court finds that the Department failed to establish by a preponderance of the evidence that Savannah Court breached the referenced provisions of the Settlement Agreement and failed to show that revocation of the Settlement Agreement can serve as a basis for revocation of Savannah Court's permit.

14. Paragraph 2(b) of the Settlement Agreement identifies eight mandatory requirements. (P-2.) The preponderance of the evidence shows that Savannah Court complied with each of these requirements. The Department's revocation of the Settlement Agreement is therefore not justified and cannot serve as the basis for revocation of Savannah Court's permit.

15. Specifically, the evidence shows that:

(i) Savannah Court timely retained an independent consultant to perform the tasks outlined in Paragraph 2(b), (Feb. 1, 2024 Hr'g Tr., 92:20-93:5; 93:10-15). This satisfied the requirements of section 2(b)(IV).

(ii) The independent consultant had no past or present employment relationship with Savannah Court prior to being retained as an independent consultant, (*id.*, 93:6-9). This satisfied the requirements of section 2(b)(I).

(iii) The independent consultant is a licensed healthcare professional with at least the credentialing of a registered professional nurse, (*id.*, 95:13-24; *see also* P-9). This satisfied the requirements of section 2(b)(II).

(iv) In addition to holding bachelor's and master's degrees in nursing, the independent consultant has experience working with hospice and physician practices, (Feb. 1, 2024 Hr'g Tr., 95:25-96:7; *see also* P-9). This satisfied the requirements of section 2(b)(III).

(v) The independent consultant conducted an audit, assessed, evaluated, and made recommendations to Savannah for the purpose of promoting Savannah Court's compliance with applicable state and federal laws and regulations, (P-8; *see also* Feb. 1, 2024 Hr'g Tr., 93:16-20). This satisfied the requirements of section 2(b)(V).

(vi) The independent consultant performed an initial audit within thirty days of the signing of the Settlement Agreement on March 23, 2023, (Feb. 1, 2024 Hr'g Tr., 93:21-23). This satisfied the requirements of section 2(b)(VI).

(vii) Savannah Court retained the services of the independent consultant for at least one year, (*id.*, 93:24-94:2). This satisfied the requirements of section 2(b)(VII).

(viii) Prior to the Department's attempted termination of the Settlement Agreement on August 17, 2023, the independent consultant timely completed the first required quarterly written report on June 7, 2023, (*id.*, 94:3-6; 99:14-16; *see also* P-8). Savannah Court timely provided the written report to the Department upon the Department's request, (Feb. 1, 2024 Hr'g Tr., 94:22-95:1; 96:8-98:13; 99:3-13; *see also* P-7). This satisfied the requirements of section 2(b)(VIII).

16. The Department contends that the independent consultant's written report was insufficient. The Department's August 17, 2023 notice of termination failed to provide any explanation for this contention that the written report was insufficient. (P-6.) At the hearing, the Department's Deputy Director testified that he would have expected the independent consultant's report to have included measurable goals, logs, compliance metrics and percentages, and medical outcomes data. (Jan. 3, 2024 Hr'g Tr., 63:18-65:3; 76:8-16.)[27] The Settlement Agreement does

[27] The Department did not show an objective basis for the Deputy Director's "expectation." The Deputy Director testified that he was not employed by the Department when the Settlement Agreement was

not require the report to include any such information, metrics, or data and is wholly silent as to what the report should contain. (P-2.)

17. The independent consultant's report is indeed cursory and "bare bones." But the fact that the Department believes that the written report could and should have been more robust (or otherwise should have included additional or different data) does not give rise to a breach of the explicit terms and requirements of the Settlement Agreement.

18. The Department also contends that Savannah Court breached Paragraph 2(c) of the Settlement Agreement. The basis for the Department's contention appears to be that the nurse consultant's written report does not expressly recommend that Savannah Court conduct only in-person training. (*See* Jan. 3, 2024 Hr'g Tr., 65:23-67:16.) The language of Paragraph 2(c) of the Settlement Agreement is permissive and is not mandatory. (P-2, Para. 2(c), states that "[i]n assisting the Facility with its compliance and corrective measures, the Independent consultant **may**: [ ] V. [r]ecommend that the training (or portions thereof) be in-person only.") (emphasis supplied.)

19. At the hearing, the Department's Deputy Director (Mr. Moss) acknowledged on cross-examination that Paragraph 2(c)(V) does not require the nurse consultant to recommend only in-person or on-site training. (Jan. 3, 2024 Hr'g Tr., 70:12-71:19.) Moreover, the Department did not offer evidence to substantiate its assertion that the independent consultant did not recommend only in-person training. (*Id.*, 74:6-14.) The Department thus failed to show by a preponderance of the evidence that Savannah Court breached Paragraph 2(c) of the Settlement Agreement.

20. Finally, the Department contends that Savannah Court breached Paragraph 2(g) of the Settlement Agreement. Paragraph 2(g) provides:

> If the Facility fails to substantially comply with the terms of the Agreement or fails to comply with the Rules and Regulations for Personal Care Homes, Chapter 111-8-62, as well as the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, Chapter 111-8-25, Respondent will take any and all regulatory action it deems appropriate against the Facility, including the intent to revoke the Permit.

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executed in March 2023. The Deputy Director further testified that he was not involved in the negotiation or drafting of the Settlement Agreement. He also testified that he has "dealt with" only one or two nurse consultant reports during his professional tenure.

Neither party argues that the applicable provisions of the Settlement Agreement are ambiguous. In the absence of language in the Settlement Agreement, the Department's expectations of what the independent consultant's written report should have contained are insufficient to establish a breach.

(P-2 at p. 7.)

21. The Department did not show by a preponderance of the evidence that Savannah Court failed to substantially comply with the terms of the Settlement Agreement. But even assuming for purposes of argument that Savannah Court had breached the Settlement Agreement in a manner justifying revocation, the quoted language with respect to continuing compliance with the governing rules and regulations for personal care homes, Paragraph 2(g) adds nothing to the Department's argument. By law, Savannah Court is subject to the governing rules and regulations for personal care homes. The Department is authorized and directed by law to institute various enforcement actions for non-compliance. Settlement of the matters identified in the Settlement Agreement does not and could not preclude the Department from pursuing violations which are not subjects of the Settlement Agreement.

22. Nor does Paragraph 2(g) alter the Department's burden to establish that it has satisfied the necessary requirements to impose revocation of a permit. Paragraph 2(g) is in this sense redundant as it simply confirms that the Department may seek to impose all the various enforcement measures outlined in the Enforcement Rules for non-compliance with the terms of the Settlement Agreement or governing rules and regulations which are not the subject of the Settlement Agreement.

23. Again, even assuming for purposes of argument that the Department properly revoked the Settlement Agreement, the Department is still required to show that Savannah Court is not in substantial compliance with the governing rules and regulations, and, with respect to a revocation action, establish that a Category I violation was warranted for any alleged rule violation for which the Department seeks revocation. The Department has failed to meet that burden with respect to its proposed revocation of the Settlement Agreement as a basis to revoke Savannah Court's permit. Therefore, the Department's purported revocation of the Settlement Agreement cannot serve as a basis for revoking Savannah Court's operating permit.

24. It should also be noted that the Department did not address or introduce any evidence as to any of the underlying violations that were the basis for the three pending matters which were resolved as part of the Settlement Agreement. As a consequence, whatever infractions that were resolved in the Settlement Agreement cannot serve as a basis for the proposed revocation of Savannah Court's permit nor can they serve as the basis for imposition of a monetary fine. The Department appears to acknowledge this by its conduct in not presenting any evidence regarding the alleged infractions that gave rise to the Settlement Agreement. Finally, as the evidence shows that the Department's purported revocation of the Settlement Agreement was not justified, the Settlement Agreement continues in effect, and the matters addressed by the Settlement Agreement are hereby disposed of.

25. *The four July 31 survey alleged rule violations.* The July 31, 2023 survey cites Savannah Court for four alleged rule violations. (R-13.) The Department increased the severity tags associated with each alleged rule violation to a Category I, J-tag after the Department surveyor completed the survey. (*Id.*, PCH Program Control Sheet; *see also* Jan. 30, 2024 Hr'g Tr., 77:5-16; 79:19-80:8; Feb. 1, 2024 Hr'g Tr. 43:8-25; 46:4-12.). Although never specifically stated, it appears that the tags were increased to support revocation of Savannah Court's permit.

26. Pursuant to Rule 111-8-25-.05(1)(e)1.(i), a Category I violation is defined as "[a] violation or combination of violations of licensing requirements which has caused death or serious physical or emotional harm to a person or persons in care or poses an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in care." Thus, a Category I violation may properly be issued by the Department for an alleged (or actual) rule violation only if it meets the requirements of Rule 111-8-25-.05(e)(1)(i). (Jan. 30, 2024 Hr'g Tr., 64:23-65:19; *see also* Feb. 1, 2024 Hr'g Tr., 44:1-10; 44:19-45:1.) Furthermore, the Department's Regional Director acknowledged that it is the Department's practice to require a J (or higher-level) tag to support the Department's intent to revoke a provider's license. (Feb. 1, 2024 Hr'g Tr., 44:1-10; 44:19-45:1.)

27. *July 31 Survey Alleged Violation 1: Rule 111-8-62-.15(1)(b), violation under the "ambulatory resident" rule.* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.15(1)(b) for three of seven residents sampled. (R-13 at p. 1.) The Department presented no evidence that any of the three residents experienced any harm, either physical or emotional, as a result of their admissions to the Savannah Court facility. Furthermore, the July 31, 2023 survey includes no findings that any of the residents suffered any actual physical or emotional harm, or were at imminent risk for such harm, as a result of their admission to or retention at Savannah Court. (R-13.) Accordingly, there is insufficient evidence to support a Category I, J-tag for this alleged rule violation. This alleged rule violation is therefore insufficient to support the revocation of Savannah Court's permit to operate a personal care home. The infraction may, however, serve as the basis for imposition of a fine.

28. *July 31 Survey Alleged Violation 2: Rule 111-8-62-.15(1)(c), violation under the "aging in place" exception to the ambulatory patient rule and the adequacy of fire drills at Savannah Court.* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.15(1)(c). Specifically, the Department questioned the adequacy of the fire drills conducted at the facility. The testimony of the Department's witness raised questions as to the adequacy of the fire drills, but the Department did not document the underlying facts of the inadequacy of the fire drills. The Department also failed to present sufficient evidence to meet its burden necessary to issue a Category I, J-tag for this alleged rule violation.

29. The Department did not introduce sufficient evidence to meet its burden and show that this alleged rule violation caused serious emotional harm or posed an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in Savannah Court's care. The Department surveyor again admitted that the alleged rule violation: (i) did not result in any actual injury or death, (Jan. 30, 2024 Hr'g Tr. 97:18-20), and (ii) did not pose an imminent threat to anyone at the Savannah Court facility. (*Id.*, 98:19-22.) For this reason, reliance upon this alleged rule violation is insufficient to support the revocation of Savannah Court's permit to operate a personal care home.

30. Revocation based on this alleged rule violation is also improper for two additional reasons. First, the Department also failed to establish by a preponderance of the evidence that Savannah Court did not properly monitor its fire drills to ensure that it could evacuate residents within thirteen minutes. Although the Department surveyor documented the start and end times of the June 15, 2023 fire drill, the surveyor was unable to confirm the time it took to actually evacuate Savannah Court residents during the drill in question. (Jan. 3, 2024 Hr'g Tr., 93:10-16; 94:2-18; 94:23-96:19.)

31. Second, to meet the aging in place exception under Rule 111-8-62-.15(1)(c), personal care homes must "increase[ ] the number of documented fire drills to a minimum of one fire drill per month, covering all shifts…." *Id.* The Department surveyor construes this language to mean that a personal care home that has one or more non-ambulatory residents must conduct at least three fire drills per month, as opposed to the one fire drill per month specifically referenced in the rule. (Jan. 3, 2024 Hr'g Tr., 98:7-10.) The rule requires personal care homes with non-ambulatory residents to conduct fire drills covering all shifts. Savannah Court has three shifts per day. (Feb. 1, 2024 Hr'g Tr., 122:7-19.)

32. The adequacy of fire drills is a serious matter. The Department's concern as to this issue is more than justified. It appears, however, that Savannah Court is correct and that the rule does not require more than one fire drill per month. The Department did not provide authority to the contrary. The record also reflects that eight Savannah staff members participated in the June 15, 2023 fire drill, (R-13 at p. 5). The Department did not introduce sufficient evidence to support a finding that any of the three shifts were unrepresented by the eight staff members. The Department has not met its burden and shown by a preponderance of the evidence that Savannah Court was non-compliant. Therefore, the Department cannot rely upon this alleged rule violation as the basis for revocation of Savannah Court's permit. Nor can it rely upon this alleged rule violation for the imposition of a fine.

33. *July 31 Alleged Violation 3: Rule 111-8-62-.15(1)(c), violation as to written care plans.* The third alleged rule violation in the July 31, 2023 survey is based on Rule 111-8-62-.17(9). The Department contends that Savannah Court failed to substantially comply with the

requirements of Rule 111-8-62-.15(1)(c). The Department issued a Category I, J-tag for the alleged failure to maintain a written care plan for two of seven residents sampled. (R-13 at p. 6.)

34. At the hearing, the Department's Regional Director for the Personal Care Home Program, Healthcare Facility Regulation Division, confirmed that neither resident was documented as suffering any harm as a result of their respective files containing no written care plans on the day of the site visit. (Feb. 1, 2024 Hr'g Tr., 47:12-49:10.) Nor did the Department offer evidence showing that either resident suffered any actual physical or emotional harm or was at imminent risk for such harm as a result of the alleged lack of a written care plan. (R-13.) There is, therefore, insufficient basis to support a Category I, J-tag for this alleged rule violation. This rule violation therefore cannot support the revocation of Savannah Court's permit to operate a personal care home. This rule violation can, however, serve as the basis for imposition of an appropriate fine by the Department.

35. *July 31 Survey Alleged Violation 4: Rule 111-8-62-.20(8)(e)*, *violation as to timely prescription refills*. The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.20(8)(e) relating to medication administration. (R-13 at pp. 6-7.) The Department issued a Category I, J-tag for this alleged rule violation in relation to four of seven residents sampled. (R-13 at pp. 6-10.)

36. The evidence shows certain variations between the Department's survey findings in relation to this rule violation that do not match up with the underlying documentation on which the findings are based. (*See* Findings of Fact, Paragraphs 42-53.) In other instances, the Department failed to introduce underlying documentation that supports its findings relative to certain residents in the July 31, 2023 survey, including the applicable MARs for Residents #1 and #3. (*See id.*, Paragraphs 50, 46.) On balance, however, the preponderance of the evidence supports the Department's survey and shows deficiencies in the timely refill of prescriptions. This rule violation can serve as the basis for imposition of a fine.

37. What the evidence does not show is that Savannah Court's deficiencies in relation to this rule as identified in the July 31, 2023 survey findings satisfy the required criteria for the issuance of a Category I, J-tag. (*See id.*, Paragraphs 45, 47, 49 and 51) Therefore, this rule violation is insufficient to support the revocation of Savannah Court's permit to operate a personal care home. Again, as explained above, it may serve as the basis for the imposition of an appropriate monetary fine.

38. *The three August 1, 2023 survey alleged rule violations.* The August 1, 2023 survey cites Savannah Court for three alleged rule violations. (R-13.) The Department increased the severity tags associated with each alleged rule violation to a Category I, J-tag after the

Department surveyor completed the survey. (*Id.*, PCH Program Control Sheet; *see also* Jan. 30, 2024 Hr'g Tr., 77:5-16; 79:19-80:8; Feb. 1, 2024 Hr'g Tr. 43:8-25; 46:4-12.)

39. *August 1 Survey Alleged Violation 1: Rule 111-8-62-.10(1)(c)*, *proper supervision/response to call pendant alerts.* The Department contends that Savannah Court personnel failed to substantially comply with the requirements of Rule 111-8-62-.10(1)(c) for four of eight residents sampled. (R-20 at p. 1.) Specifically, the Department contends that, based on a review of various call pendant reports, Savannah Court personnel failed to timely respond to four residents' call pendant alerts. (*Id.* at pp. 1-5.)

40. The Department surveyor testified at the hearing that, in her opinion, a response time greater than five minutes is too long and constitutes a violation of Rule 111-8-62-.10(1)(c). (Jan. 3, 2024 Hr'g Tr., 114:18-20; 126:5-7.) However, the Department surveyor acknowledged that the rules and regulations governing personal care homes, including Rule 111-8-62-.10(1)(c), contain no requirement to respond within a certain time interval, including a requirement to respond within five minutes. (*Id.*, 114:21-115:14; 126:8-18.) The Department surveyor further agreed that the rules and regulations governing personal care homes do not even require personal care homes to utilize call pendant alert systems. (*Id.*, 115:15-21.) Moreover, the call pendant reports on which the Department relied do not consistently match the survey findings. (*Compare* R-20 with R-25 through R-31; *see also* Findings of Fact, Paragraphs 57-59.)

41. The Department thus failed to meet its burden and failed to show by a preponderance of the evidence that Savannah Court failed to comply with Rule 111-8-62-.10(1)(c). This alleged rule violation therefore cannot support revocation of Savannah Courts's permit. Nor has the Department shown by a preponderance of the evidence a violation that can serve as basis for imposition of a penalty for this alleged infraction.

42. *August 1 Survey Alleged Violation 2: Rule 111-8-62-.19(5)(b)*, *adequate staffing.* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.19(5)(b). (R-20 at p. 5.) In relevant part, this Rule provides: "[a]t a minimum, the home must provide the following staffing: (b) One registered professional nurse, licensed practical nurse, or certified medication aide on-site at all times." (*Id.*; *see also* Rule 111-8-62-.19(5)(b).)

43. Although the August 1, 2023 survey initially quotes the rule correctly, the survey's findings section alters the rule's language as follows: "Based on observation and interview the facility failed to ensure that there was a professional nurse, licensed practical nurse, or a certified medication aide onsite at all times *in the memory care unit.*" (R-20 at p. 5 of 10) (alterations reflected with *italics*.) The Department surveyor testified at the hearing that she added the phrase "in the memory care unit" and that the phrase does not appear in Rule 111-8-62-.19(5)(b). (Jan. 3,

2024 Hr'g Tr., 139:11-141:10.) The Department surveyor further acknowledged that the Rule is satisfied where only one CMA is on-site at any given time (*id.*, 142:6-14), and the August 1, 2023 survey reflects that at least one CMA was present at Savannah Court during the site visit. (R-20 at p. 5.) The Department, however, contends that this Rule was not met because the surveyor observed the CMA in an area other than "in [Savannah Court's] memory care unit" during the surveyor's tour of the Savannah Court facility on July 13, 2023 at 2:00 p.m. (R-20 at p. 5 of 10.)

44. On its face, the Rule does not require a CMA to be on-site in the memory care unit. Instead, the Rule is satisfied where at least one professional nurse, licensed practical nurse, or CMA is on-site at all times. (*See* Rule 111-8-62-.19(5)(b).) It is undisputed that Savannah Court had a CMA on-site at the time of the Department surveyor's site visit. (R-20 at p. 5 of 10.) More is not required.

45. Moreover, even if the applicable rule required a CMA to be physically present specifically within the memory care unit at all times, the August 1, 2023 survey identifies no actual or potential imminent harm to the physical or emotional health or safety of any Savannah Court resident as a result of the alleged rule violation. (R-20.) The Department did not offer evidence at the hearing to otherwise satisfy the criteria necessary to support a Category I, J-tag for this alleged rule violation. Therefore, this alleged rule violation is insufficient to support the revocation of Savannah Court's permit to operate a personal care home. Nor has the Department shown by a preponderance of the evidence this is an infraction that can serve as the basis for imposition of a penalty.

46. *August 1 Survey Alleged Violation 3: Rule 111-8-62-.25(1)(a), the wound-vacuum incident.* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.25(1)(a) with respect to one of eight residents sampled. (R-20 at p. 6.) The Rule provides that "[e]ach resident must receive care, and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations." (*Id.*) Specifically, the Department contends that Savannah Court failed to substantially comply with this Rule due to the alleged failure to provide wound care treatment or services to Resident #3 involving utilization of a piece of equipment referred to as a "wound vac" (the "Wound Vac Incident").

47. People reside in personal care homes because they need care and assistance. Residents at personal care homes often experience significant medical events that require medical treatment. Personal care homes are not medical treatment facilities, however, and can provide only limited services to their residents.

48. At the hearing, the Department surveyor confirmed that Savannah Court was not permitted to provide wound care treatment or services pursuant to the rules and regulations

governing personal care homes. (Jan. 30, 2024 Hr'g Tr., 24:15-18; 26:4-29:25.) The Department surveyor also acknowledged that it would have been a violation of the governing rules and regulations had Savannah Court provided wound care services to Resident #3. (*Id.*, 30:1-5 ("Q: And, in fact, if the community did provide wound care services, that would be a violation of the governing personal care home rules, right? A: Correct. In this situation, yes, with the wound vac. Yes.").) Savannah Court had no duty or obligation to provide wound care services. To the contrary, Savannah Court was legally precluded from doing so according to the controlling rules and regulations.

49. The record also reflects that Resident #3's family members did not understand or expect that Savannah Court would be providing wound care treatment or services to Resident #3. (Findings of Fact, Paragraphs 68-70.) That being the case, the Department failed to establish that Savannah Court failed to substantially comply with Rule 111-8-62-.25(1)(a).

50. Moreover, the Department surveyor did not identify any serious physical or emotional harm allegedly suffered by Resident #3 as a result of the wound vac not being utilized during the time frame of June 12 through June 16, 2023. (Jan. 30, 2024 Hr'g Tr., 65:20-67:19; *see also* Findings of Fact, Paragraph 75.) The contents of the EMS report (R-37), coupled with the fact that the hospital discharged Resident #3 back to Savannah Court within a matter of days *without* the wound vac (Findings of Fact, Paragraph 74), suggests that the fact that the wound vac was not used during the period from June 12 through June 16, 2023 did not pose an imminent and serious threat or hazard to Resident #3's physical or emotional health and safety. Thus, even if the Department had established (which it did not) that Savannah Court failed to substantially comply with Rule 111-8-62-.25(1)(a), the Department failed to establish the criteria necessary to warrant a Category I, J-tag for this alleged rule violation. The Department also failed to show that this alleged infraction can serve as the basis for imposition of a penalty.

51. *Summary of conclusions as to grounds for revocation of permit as asserted in the two August 17 letters of intent to revoke.* It bears repeating at this point that this matter is a *de novo* proceeding and the decisions in this matter must be based upon the entire record introduced at the hearing. One of the principal purposes of this hearing is to develop a detailed factual record to determine whether the Department' proposed actions are justified.

52. In the Department's two letters dated August 17, 2023, the Department asserted eight grounds for revocation of Savannah Court's permit. After review of the evidence and for the reasons discussed above, the Court finds that the Department has failed to show by a preponderance of the evidence that any of the eight alleged grounds can serve as basis for revocation of Petitioner's permit. The Department has, however, shown that three of the alleged violations can serve as the basis for imposition of monetary penalties.

Analysis of Alleged Grounds for Imposition of Penalties.

53. Having concluded the analysis of the alleged infractions that the Department urges as the basis for revocation of Savannah Court's permit, the Court now turns to other alleged infractions that the Department has identified as the basis for imposition of penalties, but which were not identified as the basis for revocation of Savannah Court's permit.

The March 6, 2023 Survey

54. *The March 6, 2023 survey and proposed imposition of fines.* The March 6, 2023 survey cites Savannah for three alleged rule violations. (R-5.) Each alleged rule violation in the March 6, 2023 survey for which the Department seeks to impose a monetary fine (Rule 111-8-62-.18(1)(b) and Rule 111-8-62-.25(1)(a)) is based on the same set of events (an elopement) relating to a resident that occurred on December 29, 2022. (*Id.*)

55. *The March 6, 2023 Survey Alleged Violation 1: Rule 111-8-62-.18(1)(b), appropriate safety devices.* The Department contends that Savannah Court failed to substantially comply with Rule 111-8-62-.18(1)(b), which requires Savannah Court to "[u]tilize appropriate effective safety devices, which do not impede the residents' rights to mobility and activity choice or violate fire safety standards, to protect the residents who are at risk of eloping from the premises." (R-5.)

56. Savannah Court had a door alarm system in place on December 29, 2022. (R-5 at pp. 2-3.) The record reflects that at the time of the alleged elopement, Savannah Court's audible door alarm system was functioning, as evidenced by the fact that Savannah Court staff heard the alarm system go off when Resident #1 exited the back door of Savannah Court's dining room. (*Id.*) The Department surveyor testified at the hearing that she has no information to indicate that Savannah Court's door alarms were not functioning properly on the date of the alleged elopement. (Jan. 3, 2024 Hr'g Tr., 46:17-47:6.)

57. The Department recognizes audible door alarms, like those utilized by Savannah Court, as an appropriate safety device to help limit the risk of elopements. (*Id.*, 47:7-10.)

58. The Department surveyor also confirmed that door locks which cannot be manually opened from the inside could present a safety risk, including a fire safety risk. (*Id.*, 47:11-24.) The Department surveyor further acknowledged that the governing rules and regulations prohibit staff from (i) physically restraining residents and/or (ii) locking residents in their rooms, and that taking either of these actions to prevent an elopement would be a violation of Rule 111-8-62-.18(1)(b).

(*Id.*, 54:18-55:9.) The Department's March 6, 2023 survey does not identify any additional safety devices that Savannah Court should have utilized to comply with Rule 111-8-62-.18(1)(a), (R-5). Nor did the Department's witnesses at the hearing identify any such additional safety devices that Savannah Court should have utilized to prevent elopements.

59. In summary, the evidence shows that: (i) Savannah Court utilizes audible door alarms to limit the risk of elopements; (ii) the door alarms were functioning properly on December 29, 2022; (iii) the Department recognizes door alarms as an appropriate safety device to limit the risk of elopements; (iv) Savannah Court is legally prohibited from taking certain additional measures, such as restraining Resident #1 or locking Resident #1 in his room, to prevent an elopement attempt; (v) Savannah Court is legally prohibited from employing certain additional measures that may create a fire or other safety risk (such as doors that cannot be opened from the inside); and (vi) the Department has not identified any additional actions or safety devices that Savannah Court should have implemented to further limit the risk of elopements. For these reasons, the Department has failed to establish that Savannah Court was not in substantial compliance with Rule 111-8-62-.18(1)(a). The imposition of a fine for this alleged infraction is, therefore, not supported by a preponderance of the evidence.

60. *The March 6, 2023 Survey Alleged Violation 2: Rule 111-8-62-.18(1)(b), proper care.* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.18(1)(b), which provides that "[e]ach resident must receive care and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations. (R-5.)

61. The record establishes that Resident #1 suffered a fractured hip/leg in Savannah Court's parking lot within minutes of exiting the back door of the facility's dining room. However, this result does not necessarily mean that Savannah Court failed to provide proper care and services: the fact that the Elopement Incident occurred does not establish by *res ipsa loquitor* that an infraction of the rule occurred.

62. Of particular importance on this issue, the survey documents note that Resident #1 had (unsuccessfully) attempted to leave Savannah Court ten times during the early morning hours of December 29, 2022. (R-5 at p. 2.) In response, Savannah Court staff relocated Resident #1 into a common area for the purpose of increased monitoring. (R-5 at p. 2.) But we know that those increased monitoring efforts were not successful. It is undisputed that staff were aware of Resident #1's behavior and the resulting risk at the time of the incident. It is undisputed that even in the face of that awareness, Resident #1 still got away. Whatever was being done was not adequate to address an identified and known risk.

63. It is true that Resident #1 never left the Savannah Court facility premises. It appears he was in the parking lot for a limited period of time, no more than fifteen minutes. No search was required for Resident #1 as Savannah Court staff "went shortly after him" upon hearing the door alarms. Staff was with Resident #1 within five minutes of his fall and immediately called EMS. (*See* Findings of Fact, paragraphs 18-19, 23-24.) But all of these prompt and appropriate responses to the elopement are instances of locking the barn door after the horse is already out. And whatever the weather conditions were, it was not a balmy summer evening. The elopement was serious, dangerous and resulted in significant injury. While Savannah Court is not an insurer and strictly liable for everything that occurs at its facility, when faced with a known issue it is required to address the risk proactively to prevent adverse consequences. In this instance, it did not do so.

64. For these reasons, the Department has shown by a preponderance of the evidence that Savannah Court was not in substantial compliance with Rule 111-8-62-.25(1)(a). The Department has shown by a preponderance of the evidence the basis to impose a fine for this alleged rule violation.

65. *The March 6, 2023 Survey Alleged Violation 3: Rule 111-8-62-.30(2)(b).* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.30(2)(b). (R-5 at p. 6.) The Department's intent to impose fines in relation to the March 6, 2023 survey apparently does not relate to this particular alleged rule violation, however, and the Department has taken no other enforcement actions relative to this alleged rule violation. Accordingly, it is not necessary to address whether the Department met its burden of proof relative to this alleged rule violation. (*See* Findings of Fact, Paragraph 18.)

The October 31, 2023 Survey

66. *The October 31, 2023 Survey and proposed imposition of fines.* The October 31, 2023 survey cites Savannah Court for two alleged rule violations. (R-33.) Both alleged rule violations relate to the same underlying event – a resident-on-resident sexual assault. (*Id.*; *see also* Feb. 1, 2024 Hr'g Tr., 71:1-9.)

67. *The October 31, 2023 Survey – Violation I: Rule 111-8-62-.10(1)(c).* The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.10(1)(c), which provides that "[r]esidents must be supervised consistent with their needs." (R-33 at p. 1.) Specifically, the Department contends that Savannah Court failed to supervise Resident #7 (the alleged perpetrator) consistent with his needs. (*Id.*) The October 31, 2023 survey states that: "Resident #7 exhibited known hypersexual behavior and did not have proper supervision. Resident #7 was alleged to have sexually assaulted another resident due to the failure of the facility to provide appropriate supervision." (*Id.*)

68. The Department did not show by a preponderance of the evidence that Savannah Court had actual knowledge or had reason to have knowledge of Resident #7's asserted "known hypersexual behavior" prior to the alleged assault on October 12, 2023.

69. The physician evaluation form that references Resident #7's hypersexual behavior was completed the day *after* the incident. The physician evaluation was completed in direct response to the incident. (*See* Findings of Fact, paragraphs 97.) The Department surveyor properly acknowledged at the hearing that the October 13, 2023 physician evaluation form could not have placed Savannah Court on notice of Resident #7's "hypersexual behavior" or that Savannah Court should have known that it needed to provide additional one-on-one supervision to Resident #7. (*Id.*, paragraphs 97, 99.)

70. The statement that Resident #7 purportedly made to a Savannah staff member prior to the incident was insufficient to place Savannah Court on notice that Resident #7 was a risk to other Savannah Court residents or staff. (*Id.*, paragraphs 101-102.) This ambiguous hearsay statement, if it was in fact made, is insufficient standing alone to establish Savannah Court knew or had reason to know that Resident #7 presented a risk.

71. The Department has therefore not met its burden and established that Savannah Court knew or had reason to know that Resident #7 represented a risk at the time of the sexual assault incident. The Department has not shown by a preponderance of the evidence that Savannah Court was not in substantial compliance with Rule 111-8-62-.10(1)(c). In the absence of evidence that Savannah Court knew or had reason to know that Resident #7 represented such a heightened risk, the Department has not met its burden to justify imposition of a fine for this alleged violation.

72. *The October 31, 2023 Survey – Violation II: Rule 111-8-62-.25(1)(h)*. The Department contends that Savannah Court failed to substantially comply with the requirements of Rule 111-8-62-.25(1)(h), which provides: "[e]ach resident has the right to be free from mental, verbal, sexual and physical abuse, neglect and exploitation. Each resident has the right to be free from actual or threatened physical or chemical restraints and the right to be free from isolation, corporal or unusual punishment and interference with the daily functions of living, such as eating or sleeping." (R-33 at pp. 3-4.)

73. The Department contends that this Rule was not met because "Resident #1 was sexually assaulted by Resident #7 while living at the facility." (*Id.* at pp. 4-7.)

74. The rules and regulations governing personal care homes provide certain specified rights to personal care home residents. Rule 111-8-62-.25(1)(c)(3) provides: "[e]ach resident has a right to interact with members of the community both inside and outside of the home and to

participate fully in the life of the community." (*Id.*; *see also* Feb. 1, 2024 Hr'g Tr., 81:24-82:9.) Similarly, Rule 111-8-62-.25(1)(b) provides: "[e]ach resident must have the right to associate and communicate freely and privately with persons, in groups of the resident's choice without being censored by staff." (*Id.*; *see also* Feb. 1, 2024 Hr'g Tr., 82:24-83:5.)

75. The October 31, 2024 survey provides that, prior to the October 12, 2023 incident: "Staff M stated Resident #1 told him/her that Resident #7 would often visit him/her in his/her room." (R-33 at p. 6.) The Department surveyor testified that, consistent with the governing rules and regulations, residents have a right to freely visit one another. (Feb. 1, 2024 Hr'g Tr., 81:19-23 ("Q: Okay. And you would agree that residents have a right to visit freely with other residents, correct? A: Only if that resident – if the other resident agrees to that person visiting him or her.").)

76. The Department surveyor's testimony continued as follows: "Q: So according to these rules, absent a known proclivity for hypersexual behavior or other concerning behavior, the community could not prevent residents from visiting one another, right? A: Right. Unless the resident disagrees with that person visiting him or her. Q: And based on your interview of Resident Number 1, did she tell you that prior to October 12, 2023, that she ever objected to Resident Number 7 visiting her? A: No. No." (*Id.*, 83:6-16.) The record of the hearing fails to show that Resident #1 ever objected to Resident #7's visits to her room or otherwise notified Savannah Court of any concerns relating to Resident #7 prior to October 12, 2023.

77. The assault is serious and troubling. The instinctive and understandable reaction is to assume something was not done correctly that permitted this to occur. As noted above, however, the Department has failed to show by a preponderance of the evidence that Savannah Court knew or should have known that Resident #7 represented a heightened risk that would have justified limiting his legally recognized rights to move about the facility and visit with other residents. In the absence of such evidence, the Department has not met its burden and cannot sustain the imposition of a fine under Rule 111-8-62-.25(1)(h) based upon the limited evidence produced at the hearing.

Concluding Observations.

78. Savannah Court provides needed services in Greensboro and the surrounding community. As the Department's counsel stated at the start of the hearing, "[Savannah Court] provides an invaluable service to the community," and revocation "would create a void in th[e] community" and a gap in services in this rural area of the state. (Jan. 3, 2024 Hr'g Tr., 5:18-20.) Moreover, this Court has received communications from current Savannah Court residents and family members expressing concerns as to the significant adverse consequences any revocation (and resulting closure) would have on residents and their respective families. (Joint Exhibits 1 (Jan. 18, 2024 Smith correspondence) and 2 (Jan. 29, 2024 Rowland correspondence).)

79. The burden is on the Department to show that Savannah Court (i) failed to substantially comply with the governing rules and regulations, *and* (ii) that the severity category assigned to the violations meets the requirements of the Enforcement Rules and the Department's established practices to justify the sanction. The Department has met its burden and has identified several failures to comply with the rules and regulations by Savannah Court that justify the imposition of fines. But the Department has not met its burden and shown that the requisite severity of those violations justifies revocation of Savannah Court's permit to operate.

IV. Decision

1. The Department has failed to show by a preponderance of the evidence that any of the eight alleged infractions identified in the Department's two letters dated August 17, 2023, can serve as basis for revocation of Petitioner's permit. The Department's proposed revocation of Petitioner Savannah Court's permit to operate a personal care home is therefore **REVERSED**.

2. The Department has shown by a preponderance of the evidence that three of the alleged infractions identified in the Department's two letters dated August 17, 2023, can serve as the basis for imposition of fines. These three infractions for which the Department may impose fines are (1) a violation of Rule 111-8-62-.15(1)(b) identified in Conclusions of Law, Paragraph 27, (2) a violation of Rule 111-8-62-.15(1)(c) identified in Conclusions of Law Paragraphs 33-34 and (3) a violation of Rule 111-8-62-.20(8) identified in Conclusions of Law, Paragraphs 35-37. As the Department has not proposed a fine with respect to these three infractions, this matter is **REMANDED** to the Department to calculate and impose appropriate fines with respect to these three infractions.

3. The Department has shown by a preponderance of the evidence that one of the alleged infractions identified in the Department's two surveys dated March 6, 2023 and October 31, 2023 can serve as the basis for impositions of a fine. The infraction for which the Department may impose a fine is a violation of Rule 111-8-62-.18(1)(b) identified in Conclusions of Law Paragraphs 60-64. The Department's proposed imposition of a fine with respect to this infraction is therefore **AFFIRMED.**

4. The Department has failed to show by a preponderance of the evidence that any of the other alleged infractions identified by the Department's two surveys dated March 6, 2023 and October 31, 2023 can serve as the basis for imposition of fines. The Department's proposed imposition of fines with respect to these alleged infractions is therefore **REVERSED**.

SO ORDERED this 26th day of April, 2024.

Charles R. Beaudrot
Administrative Law Judge