STATE OF NORTH CAROLINA COUNTY OF GUILFORD	IN THE OFFICE OF ADMINISTRATIVE HEARINGS 12 DHR 01346
ANTHONY MOORE d/b/a HEARTS OF GOLD II Petitioner v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION ADULT CARE LICENSURE SECTION, Respondent.	**FINAL DECISION**

THIS MATTER came on for hearing before the undersigned The Honorable Selina M. Brooks, Administrative Law Judge, on January 16, 2013 in High Point, North Carolina.

APPEARANCES

For Petitioner: Kenneth M. Johnson, Esq.
PO Box 21247
Greensboro, NC 27420

For Respondent: Joseph E. Elder
Assistant Attorney General
North Carolina Department of Justice
P. O. Box 629
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ISSUE

Whether Respondent deprived Petitioner of property, otherwise substantially prejudiced Petitioner's rights, exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously or failed to act as required by law or rule when Respondent assessed an administrative penalty in the amount of Eight Thousand Five Hundred Dollars ($8,500.00) for a Type A rule violation against Hearts of Gold II.

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. § 131D, Article 2
10A N.C.A.C. 13G.0901

RESPONDENT'S WITNESSES

1. Robert Cauthren, Adult Home Specialist with the Alamance County Department of Social Services.

2. Marie Rodgers, Branch Manager with the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Adult Care Licensure Section.

3. Barbara Ryan, Chief of the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Adult Care Licensure Section.

PETITIONER'S WITNESSES

1. Anthony Moore, owner and administrator of Hearts of Gold I and Hearts of Gold II family care homes.

2. Denise Moore, supervisor in charge of Hearts of Gold I.

EXHIBITS

The Parties stipulated to the authenticity and admission of the following Exhibits which were accepted into evidence in this matter.

Exhibit 1 - February 14, 2012 Penalty Letter
Exhibit 2 – Penalty Packet
Exhibit 3 – Accident/Incident Report dated 2/28/11
Exhibit 4 - Accident/Incident Report dated 12/21/10
Exhibit 5 – Death Certificate
Exhibit 6 – Statement of Susie Moore
Exhibit 7 – Statement of Denise Moore
Exhibit 8 – Statement of Nikill Fuller
Exhibit 9 – Statement of Henry Vines
Exhibit 10 – Statement of Janet Woody
Exhibit 11 – Statement of Tinsey Rone
Exhibit 12 – 911 Transcript
Exhibit 13 – Death Report
Exhibit 14 – Alamance Regional Medical Records for Resident #3

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, the Undersigned makes the following findings of fact. In making the findings of fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including but not limited to the demeanor of the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other believable evidence in the case. From the sworn testimony of witnesses, the undersigned makes the following:

FINDINGS OF FACT

1. The Adult Care Licensure Section of the Division of Health Service Regulation ("Agency" or "DHSR") inspects and licenses adult care facilities including family care homes licensed to house 6 or fewer residents and all other adult care homes in North Carolina.

2. The Agency conducts surveys of all adult care homes annually, and conducts complaint investigations, follow-up surveys, and death investigations at adult care homes as needed.

3. Routine monitoring, surveys and complaint investigations are done in conjunction with county departments of social services, and DHSR has oversight of county monitoring. The Alamance County Department of Social Services, through its adult home specialists, conducts oversight activity of adult care homes located in Alamance County.

4. At all times relevant to this matter, Respondent licensed Anthony Moore to operate a family care home known as Hearts of Gold II, license number FCL-001-124, located at 207 Friendly Rd., Burlington, North Carolina. Mr. Moore was the administrator of Hearts of Gold II.

5. By letter dated February 14, 2012, Respondent assessed an administrative penalty against Petitioner for a Type A violation of 10A N.C.A.C. 13G.0901 for failing to provide supervision adequate to meet the needs of a resident based on the resident's condition and symptoms. The assessed amount was Eight Thousand Five Hundred Dollars ($8,500.00). Included with the penalty assessment was a penalty recommendation sheet and penalty matrix completed by Ms. Rodgers. Resp. Ex. 1

6. The assessed penalty was based on a penalty proposal prepared by Mr. Cauthren, including the investigative findings he prepared in a Corrective Action Report ("CAR"). This CAR and the penalty proposal were provided to Mr. Moore prior to the penalty being assessed. Resp. Ex. 2

7. At all times relevant to this case, Mr. Cauthren was an adult home specialist with the Alamance County Department of Social Services. Mr. Cauthren has been an adult home specialist in Alamance County for over fourteen years.

8. As part of his duties as an adult home specialist, Mr. Cauthren conducts monitoring of adult care homes to ensure a home's compliance with licensure rules and when necessary conducts complaint and death investigations.

9. Complaint investigations are conducted when a complaint is received from community members, DHSR, or as a result of information provided by staff or residents of a monitored home.

10. During a complaint investigation, Mr. Cauthren gathers information to determine if a home is in compliance with applicable rules. If the home is not in compliance, he documents the noncompliance in a Corrective Action Report ("CAR"). The CAR is a formatted report listing the administrative rule cited for violation, and the findings supporting the rule violation cited.

11. After he completes a CAR, Mr. Cauthren forwards the report to DHSR for review by the Quality Improvement Committee ("QIC"). The QIC committee may edit the CAR or make recommendation for changes if necessary. After edits, the CAR is returned to the adult home specialist with any comments, edits or recommendations.

12. At all times relevant to this case, Marie Rodgers was a Branch Manager with the Department of Health and Human Services, Division of Health Service Regulation, Adult Care Licensure Section. Ms. Rodgers has served as Branch Manager since 2008 and prior to that worked as a surveyor conducting investigations and inspections of adult care homes.

13. As Branch Manager, Ms. Rodgers oversees surveyors who conduct annual surveys and various kinds of investigations for DHSR. She also participates in the QIC review process and prepares penalty recommendations for consideration by the Penalty Review Committee. Her penalty recommendations are based on penalty proposals received from county Departments of Social Services as well as DHSR staff, including information submitted by a provider against whom a penalty is being considered. Ms. Rodgers considers specific criteria in determining a recommended monetary penalty amount based on her review.

14. At all times relevant to this matter, Barbara Ryan was the chief of the Adult Care Licensure Section of the Division of Health Service Regulation. Ms. Ryan has served as chief for eight years.

15. As chief, Ms. Ryan manages and oversees the Adult Care Licensure Section operations and enforces the law and rules applicable to adult care homes in North Carolina. Ms. Ryan is responsible for taking any necessary administrative actions that are permitted by law and supported by information gathered from facility surveys and investigations. Ms. Ryan is

responsible for assessing administrative penalties based on information provided through the penalty process.

16. At all times relevant to this case, Mr. Cauthren was assigned to monitor Hearts of Gold II. He had been assigned to monitor this home since 2008. Anthony Moore was the home administrator.

17. Mr. Cauthren also monitored a facility known as Hearts of Gold I which at all times relevant to this matter was located across the street from Hearts of Gold II. Mr. Moore had been the administrator of Hearts of Gold I for three or four years.

18. While conducting a complaint investigation on February 28, 2011 at Hearts of Gold II, Mr. Cauthren inquired about resident J.H. whom Mr. Cauthren had previously seen in the home. Mr. Cauthren was informed by Mr. Moore that J.H. had passed away. Upon inquiry, Mr. Moore provided the circumstances surrounding J.H.'s death including that J.H. had choked. Mr. Cauthren advised Mr. Moore to file a death report with DHHS. The death report was submitted on or about March 16, 2011.

19. During his investigation, Mr. Cauthren learned of another choking incident involving J.H. which occurred on December 2010.

20. On December 21, 2010, J.H. was eating lunch and choked on a cookie. The Heimlich maneuver was performed on J.H. and the food was dislodged. When EMS responded J.H. was sitting up and talking.

21. As a result of the December 21, 2010 incident involving J.H., changes were made as to how staff would supervise him while he ate. Staff identified that J.H. would eat too fast or overstuff his mouth if not monitored. Supervision changes included monitoring J.H. while he ate, instructing him to slow down if he was eating too fast, sitting with him or staying close beside him to instruct him to slow down or to move his plate while he finished what was in his mouth.

22. On February 26, 2011, J.H. was eating lunch with other residents. J.H. was seated at the end of the table with his back toward the opening between the living room and the dining room. J.H. began to choke and another resident alerted Mr. Moore.

23. Mr. Moore was in the living room and facing into the living room tending to another resident with his back to J.H. He heard other residents say that J.H. was choking. Mr. Moore called 911 and Cardiopulmonary Resuscitation ("CPR") was performed on J.H. until emergency responders arrived.

24. Ms. Denise Moore came over to Hearts of Gold II from the Hearts of Gold I facility across the street to assist Mr. Moore. She relieved Mr. Moore of performing CPR and took over for him while he remained on the line with the emergency dispatcher. According to

the transcript of the 911 call Mr. Moore made, he was pulling bologna and cookies out of J.H. mouth and made remarks about removing a lot of food from J.H.'s mouth. Resp. Ex. 12

25. J.H. was transported to Alamance Regional Medical Center where he was pronounced dead. The cause of death was listed as "Respiratory Failure." Resp. Ex. 13

26. Mr. Cauthren consulted with Marie Rodgers of DHSR about his findings and determination that Hearts of Gold II had committed a Type A violation for failing to provide appropriate supervision to J.H. while he ate according to his current symptoms and based on the requirements the facility had identified for monitoring J.H. during meals.

27. Ms. Rodgers confirmed that the findings supported a Type A level violation.

28. Mr. Cauthren submitted his CAR to the DHSR Quality Improvement Committee ("QIC") for review. Other than minor changes, the Type A violation in the CAR was found to be supported. Resp. Ex. 2

29. Mr. Cauthren informed Mr. Moore that he could submit additional information for consideration, including any comments about information he believed to be inaccurate in the CAR. Mr. Moore submitted information, including statements from family members of other residents of Hearts of Gold II. Resp. Exs. 8 7 9

30. These statements revealed that staff members of both Hearts of Gold homes were aware of J.H.'s needs and would pull up a chair and sit beside him and give J.H. one piece of food at a time to eat. According to the statements, J.H. would not take time to chew his food and would stuff his mouth unless staff sat with him and helped feed him. J.H. was repeatedly told to not put too much in his mouth and was constantly monitored so he would not overfill his mouth.

31. The additional information provided by Mr. Moore was submitted in the penalty proposal to DHSR.

32. Ms. Rodgers reviewed the penalty proposal sent by Mr. Cauthren, including the information provided by Mr. Moore. She applied the statutory factors applicable to determining the amount of an administrative penalty for a Type A rule violation. The determinations made by Ms. Rodgers in applying each factor were included in a penalty recommendation sheet and a penalty matrix which she prepared. The penalty recommendation and penalty matrix were based on her review of the findings in the penalty proposal.

33. Prior to assessment of the penalty, the penalty proposal and recommendation were forwarded for consideration by the Penalty Review Committee (the "PRC"). The PRC is an advisory body appointed by the Secretary of the Department of Health and Human Services which reviews proposed penalties and makes a recommendation as to whether a penalty should be assessed and in what amount. The PRC does not have any binding authority over whether the Adult Care Licensure Section assesses a penalty.

34. Mr. Moore attended and participated in the PRC meeting held on February 9, 2012. The PRC recommended no penalty be assessed.

35. The PRC recommendation was not accepted by Ms. Ryan and she decided, based on the findings from the investigation and the information in the penalty proposal and penalty recommendation, that a Type A violation of 10A N.C.A.C. 13G.0901 was supported. Ms. Ryan assessed an administrative penalty in the amount of Eight Thousand Five Hundred Dollars ($8,500.00). Resp. Ex. 1

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the undersigned Administrative Law Judge makes the following Conclusions of Law:

1. The North Carolina Office of Administrative Hearings has jurisdiction over the parties and subject matter of this contested case under N.C. Gen. Stat. 150B-23. There is no question as to misjoinder or nonjoinder. The parties received proper notice of the hearing in this matter.

2. Petitioner has the burden of proving that Respondent deprived Petitioner of property, otherwise substantially prejudiced Petitioner's rights, exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously or failed to act as required by law or rule when Respondent assessed an administrative penalty in the amount of Eight Thousand Five Hundred Dollars ($8,500.00) for a Type A rule violation against Hearts of Gold II.

3. N.C. Gen. Stat. § 131D-2 *et seq*. authorizes Respondent to regulate and monitor adult care homes in the State of North Carolina. Pursuant to N.C. Gen. Stat. § 131D-34, Respondent is authorized to assess administrative penalties against adult care homes for violations of relevant federal and State laws, rules, and regulations of adult care homes.

4. At the time the violation at issue in this matter was cited, N.C. Gen. Stat. § 131D-34 defined a Type A level violation as any violation of law or rules applicable to adult care homes that resulted in death or serious physical harm to a resident or a substantial risk that death or serious physical harm would occur.

5. Adult care homes are required by administrative rule to provide adequate supervision to its residents according to the residents assessed needs as set forth in10A N.C.A.C. 13G.0901. This includes providing supervision based on the changing needs of the resident and presenting symptoms.

6. Staff of Hearts of Gold II identified that based on the current symptoms of resident J.H., he required additional supervision while eating, including monitoring him while he

ate, standing or sitting beside him while he ate, cutting his food up into small pieces, instructing him to slow down when starting to eat too fast, and removing his plate from him when eating too fast. This was based on a choking incident involving J.H. that occurred on December 21, 2010 during which staff had to perform the Heimlich maneuver on J.H. to dislodge a cookie he had shoved in his mouth.

7. Hearts of Gold II failed to provide the necessary supervision required to meet the needs of J.H. based on his symptoms related to eating too fast and stuffing his mouth. This failure occurred on February 26, 2011 when Mr. Moore left the dining area while J.H. was eating. Mr. Moore was in the living room with his back to J.H. tending to another resident. J.H. stuffed his mouth and choked resulting in his death. Hearts of Gold II failed to provide adequate supervision of J.H. as previously identified as being necessary based on his eating habits.

8. Hearts of Gold II provided additional information for consideration by Respondent during the penalty process and this information was duly considered.

9. Respondent's citation of a Type A violation of 10A N.C.A.C. 13G.0901 is supported by a preponderance of the evidence. Respondent did not act erroneously, did not fail to act as required by rule or law, did not fail to follow proper procedure, did not act arbitrarily or capriciously when citing the Type A violation.

10. A Type A violation requires the assessment of an administrative penalty. Respondent did not exceed its authority or jurisdiction, did not act erroneously, did not fail to act as required by rule or law, did not fail to follow proper procedure, did not act arbitrarily or capriciously when assessing an administrative penalty against Petitioner in the amount of Eight Thousand Five Hundred Dollars ($8,500.00) and this penalty amount was reasonable.

DECISION

NOW THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, the undersigned Administrative Law Judge determines that Respondent did not exceed its authority or jurisdiction, did not act erroneously, did not fail to act as required by rule or law, did not fail to follow proper procedure, did not act arbitrarily or capriciously when citing the Type A violation and assessing and administrative penalty in the amount of Eight Thousand Five Hundred Dollars ($8,500.00) against Petitioner. The penalty is payable as set forth in N.C. Gen. Stat. § 131D-34.

NOTICE

Under the provisions of North Carolina General Statute 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of Wake County or in the Superior Court of the county in which the party resides. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision.** In conformity

with the Office of Administrative Hearings' rule, 26 N.C.A.C. 03.0102, and the North Carolina Rules of Civil Procedure, **this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on the Certificate of Service attached to this Final Decision.** N.C. Gen. Stat. §150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. §150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

This the 12th day of April, 2013.

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Selina M. Brooks
Administrative Law Judge