STATE OF NORTH CAROLINA

COUNTY OF ROBESON

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
12DHR07215/07216/07217

FUTURE INNOVATIONS, LLC AND DAVID F. CURTIS, Petitioners, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE DIVISION OF HEALTH SERVICE REGULATION, MENTAL HEALTH LICENSURE SECTION Respondents.	**FINAL DECISION**

THIS MATTER came on for hearing before the undersigned, Beecher R. Gray, Administrative Law Judge, on March 25 and 26, 2013 in Raleigh, North Carolina. Petitioner, having obtained and incorporated certain comments from Respondent, filed a Proposed Decision on April 8, 2013.

APPEARANCES

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For Respondent Joseph Elder
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APPLICABLE LAW

The statutory law applicable to this contested case is N.C. Gen. Stat. Chapter 150B, Article 3, the North Carolina Administrative Procedure Act and N.C. Gen. Stat. Chapter 122C, Articles 1, 2, and 3, the North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. The administrative regulations applicable to this contested case are 10A NCAC 27 D and 10A NCAC 27G.

BURDEN OF PROOF

As Petitioner, Future Innovations, Inc. has the burden of proof by the preponderance of the evidence. *See* N.C. Gen. Stat. § 150B-34(a); *see also Overcash v. N.C. Dep't of Env't & Natural Res*., 179 N.C. App. 697, 704, 635 S.E.2d 442, 447-48 (2006).

ISSUES

Whether Respondent acted in violation of N.C. Gen. Stat. § 150B-23 when it issued a Type A1 Penalty of $6,000.00 to Future Innovations, suspended new admissions to the facility, and issued a Notice of Intent to Revoke Future Innovation's License.

EXHIBITS

P. Ex.s ("P. Exs.") A through N and P through Z were admitted into evidence. These exhibits are:

A. Type A1 Administrative Penalty Letter – July 31, 2012
B. Suspension of Admissions Letter – July 31, 2012
C. Complaint and Follow-up Survey – July 31, 2012
D. Intent to Revoke License Letter – July 31, 2012
E. Resident K.K. Person Centered Profile
F. Clinical Impression and Court Summary for Recipient K.K.
G. Roberson County Sheriff's Incidents Investigation Reports – August 2, 2012
H. Roberson County Department of Social Services Letter - August 9, 2012
I. Incident Statements
J. Department Client Identification Form
K. Resident D.B. August 2, 2012 Follow-up Incident Statement
L. Resident M.B. August 2, 2012 Follow-up Incident Statement
M. Resident J.E. August 2, 2012 Follow-up Incident Statement
N. Academic School Records and Activity Records through July 2012
P. Future Innovations July 10, 2012 Plumbing Receipt
Q. Water Temperature Logs – July 2012
R. Future Innovations Group Therapy Notes
S. K.K. Aggressive Behavior Report
T. D.B. Therapy Notes
U. Medication Record
V. July 12, 2009 Investigation Interview Report – Irish Smith
W. Plan of Correction/Protection and Supporting Documents submitted to Agency by Future Innovations.
X. North Carolina Provider Penalty Tracking Form for Future Innovations
Y. Resident C.N. Therapy Notes
Z. N.C. Gen. Stat. § 131, Article 6.

Respondents' Exhibits ("R. Exs") 5 through 14 were admitted into evidence. These exhibits are:

5. License for Future Innovations
6. Person Centered Profile for Client 3
7. Person Centered Profile for Client 5
8. Person Centered Profile for Client 7
9. Person Centered Profile for Client 8
10. Medication Review Sheet for Client 3
11. Medication Review Sheet for Client 5
12. Medication Review Sheet for Client 8
13. Incident Report dated 7/11/12
14. Statements from facility investigation of 7/9/12 incident

WITNESSES

At the hearing the following witness testimony was received:

For Petitioner:

1. David Curtis – Owner and Operator
2. Lee Cooper – Facility Manager
3. Marcus Gales – Assistant Facility Manager
4. Octavia George – Facility Qualified Professional
5. Quamil Frazier - Resident
6. Keyshawn Marrow - Resident

For Respondent:

1. Emily Stanley - Surveyor
2. Wendy Boone – Team Leader
3. Michiele Eliot – Branch Manager
4. Stephanie Alexander - Section Chief

FINDINGS OF FACT

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents and exhibits received and admitted into evidence, 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 creditable evidence in the case.

The Parties

1. Petitioner Future Innovations, Inc., ("Future Innovations" or "Petitioner") provides Level IV Intensive Residential Mental Health Services to children and adolescent males at its facility (the "Facility") located in Fairmont, Robeson County, North Carolina. Future Innovations is licensed under the authority of N.C. Gen. Stat. § 122C and has been in operations for over five years.

2. Respondent, the North Carolina Department of Health and Human Services, Division of Health Service Regulations, Mental Health Licensure Section (the "Licensure Section" or "Respondent") is an administrative agency operating under the laws of North Carolina and oversees the licensing of residential mental health facilities under the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, N.C. Gen. Stat. § 122C.

3. The parties received notice of hearing by certified mail more than 15 days prior to the hearing, and each stipulated on the record that notice was proper.

Contested Action

4. On July 10 and 11, 2012, a Licensure Section survey team consisting of Emily Stanley and Keith Hughes conducted an unannounced complaint and follow-up survey of the Future Innovations facility.

5. On July 31, 2012, the Licensure Section provided Future Innovations with its survey findings. (P. Ex. C)

6. The Licensure Section Survey contained several allegations that Future Innovations had violated statutory and regulatory requirements for residential mental health faculties. (*See generally* P. Ex. C)

7. As a result of the survey findings, on July 31, 2012, the Licensure Section provided notice to Future Innovations that it was: (1) issuing the Facility a Type A1 monetary penalty of $6,000.00; (2) suspending new admissions to the Facility; and (3) provided notice that it intended to revoke Future Innovations License. (P. Exs. A, B, and D)

Assessment and Treatment Plan Allegations

8. The survey findings allege that Future Innovations failed to comply with 10A NCAC 27G .0205 by failing to provide substance abuse therapy for two of the six individuals reviewed. (P. Ex. C, pp. 1-4)

9. 10A NCAC 27G .0205 states that a provider must assess and create a treatment plan for its clients.

10. The Licensure Section witness testified that the basis for finding Future Innovations out of compliance with 10A NCAC 27G .0205 was that substance abuse treatment was not provided to two residents.

11. For one of the residents, substance abuse specific treatment was provided through at least February 12, 2012. Individual therapy continued for this resident for the entirety of the resident's stay at the facility.

12. For the other resident, individual therapy was provided for the entirety of the resident's stay at the facility.

13. The topics of discussion and coping skills developed during individual therapy sessions assist residents with dealing with the underlying issues and problems that give rise to substance abuse problems.

14. The Licensure Section failed to review any of the individual therapy notes for these two residents cited in this alleged survey findings and failed to consider whether the individual therapy treatment provided to the residents met the residents' needs.

15. Providing individual therapy can meet the needs of individuals, and 10A NCAC 27G .0205 does not require Future Innovations to provide substance abuse specific therapy.

16. Future Innovations created a treatment plan in accordance with 10A NCAC 27G .0205 for each of these residents and provided individual therapy to the residents to address the needs in the plan.

Client Services Allegations

17. The survey findings allege that Future Innovations failed to comply with 10A NCAC 27G .0208 by failing to assure that activities provided to the residents were suitable for the residents' interests and treatment needs. (*Id*. at p. 5)

18. The Licensure Section's alleged findings were based on its observation that the residents were watching television for several hours during the two days the survey team was at the facility. The allegation also was based on interviews with a limited number of residents who stated that residents watched a lot of television and the facility was boring and that school had not been provided for at least a month. (*Id*. at pp. 5-7)

19. During the survey, Future Innovations' staff was required to spend time assisting with the survey and participating in interviews with the survey team. Additionally, many of the residents were also asked to participate in interviews with the survey team.

20. In addition to the survey process, Future Innovations' staff was also investigating an abuse complaint that was made against a staff member.

21. The survey team requested dedicated space to conduct its survey and was placed in the resident activity room where most of the resident activities occur during the day.

22. The facility decided to cancel resident activities during the survey and have the residents remain in the television room because the survey team was working in the activity room, and the staff was required to assist the survey team and conduct its own independent investigation of the July 10, 2012, abuse complaint.

23. The documentary evidence and testimony of Future Innovations' staff demonstrates that Future Innovations provides school and educational activities, group therapy activities, individual therapy, group discussions, and outside recreational activities at the facility. (P. Exs. N, Q, and W)

24. Future Innovations had conducted school and educational activities during the first week of July which resulted in the residents receiving grades for the activities completed. (P. Ex. N)

25. Quamil Frazier and Keyshawn Marrow, both residents at the facility, testified that they participated in school and educational activities, group therapy activities, individual therapy, group discussions, and outside recreational activities at the facility.

26. The Licensure Section never has cited Future Innovations for failing to provide appropriate client services in the past. The Licensure Section conducted an on-site survey of the facility as recently as March 2012 and found no issues relating to the appropriateness of the activities and client services provided by Future Innovations.

Medication Administration Allegations

27. The survey findings allege that Future Innovations failed to comply with 10A NCAC 27G .0209 by failing to administer medication according to the written order of a physician, failing to keep its Medication Administration Record ("MAR") current, and failing to ensure that staff demonstrated competency in medication administration. (P. Ex. C, pp. 7-13)

28. For one resident, the survey alleged that the facility failed to provide one prescribed medication for several days. (*Id.*, pp. 8-9)

29. In that instance, the physician who prescribed the medication for the resident had not determined prior to the order whether the medication was authorized for payment by Medicaid.

30. The facility was not able to obtain release of the medication from the pharmacy until the authorization for payment was approved. (*see also* P. Ex. C, p. 9)

31. The MAR record for this recipient documents that the facility was awaiting authorization for the medication during the time the medication was not provided. (P. Ex. U)

32. There were no adverse effects on the patient for not receiving the medication.

33. The survey findings also allege that the facility failed to provide two medications to a new resident of the facility for the first six days of his treatment at the facility. (P. Ex. C, pp. 12-13)

34. These medications were not related to the patient's mental health diagnosis.

35. The resident in question had been admitted on an emergency basis. As a result, the resident did not have his prescription or his medication with him upon admission to the facility.

36. It took the facility several days to learn of the existence of the prescription and have the prescription filled.

37. There was no adverse effect on the patient for not receiving the medication.

38. It is reasonable that a facility may not be aware of all of the medications that an adolescent resident previously may have been prescribed prior to admission to the facility, especially upon an emergency admission, and that the facility may not be aware of or able to provide such medications upon admission.

39. The survey findings also allege that staff failed to document providing certain medication on the MAR system to one resident. (P. Ex. C, p. 11)

40. The survey includes a statement from the resident that he had not missed his medication and a statement from staff that its documentation error was an oversight. (*Id*.)

Reporting of Abuse Allegation

41. The survey alleges that Future Innovations failed to follow the requirements of N.C. Gen. Stat. § 131E-256 when it failed to notify the Department within 24 hours of an allegation of abuse made against one of its staff members. This finding was based on an allegation by a resident that a staff member at the facility choked and hit him and was allegedly supported by the statements of a limited number of the residents at the facility. (*Id.* at pp. 13-16)

42. N.C. Gen. Stat. § 131E-256 contains no provision which requires the reporting of an incident within a 24 hour time period.

43. The Licensure Section erred in finding that Future Innovations was in violation of N.C. Gen. Stat. § 131E-256.

44. The survey also alleged that Future Innovations violated 10A NCAC 27D .0101(b)(1) by failing to report an allegation of abuse to the Robeson County Department of Social Services. (*Id*. at pp. 16-21)

45. Licensure Section witnesses testified that a policy or regulation required reporting allegations of abuse within 24 hours, although these witnesses could not recall the specific policy or regulation and did not cite any policy or regulation in its survey findings.

46. Even to the extent that the Future Innovations had a duty to report the incident within 24 hours, Future Innovations met this burden.

47. The Future Innovation Witnesses all testified that they learned of the alleged incident of abuse on the morning of July 10, 2010, and immediately started an investigation of the abuse allegation. The Licensure Section's witness, Emily Stanley, testified that she was told by facility staff that the facility was investigating the incident.

48. After concluding its initial investigation, Future Innovations filed an Incident Report with the Department and Robeson County Department of Social Services on July 11, 2012. (R. Ex. 12) A copy of the Incident Report was provided to the Licensure Section survey team before they completed their survey.

49. Based on the Incident Report, Robeson County Department of Social Services conducted an independent investigation of the alleged incident and determined that the allegation could not be substantiated. (P. Ex. H)

Staff Abuse Allegation

50. The survey alleges that Future Innovations violated 10A NCAC 27D .0304 by failing to protect residents from harm, abuse, or neglect. This finding was based on: (1) the allegation of physical abuse of a resident by a staff member and (2) the Licensure Section's findings of alleged violations of 10A NCAC 27 D. 101, 10A NCAC 27G .0205, .0208, and .0209, and .0303. (*Id*. at pp. 21-32) The Agency testified that it determined that the violations of 10A NCAC 27 D. 101, 10A NCAC 27G .0205, .0208, and .0209, and .0303. constituted neglect.

51. The allegation of abuse of a resident by a staff member involved a resident's allegation (the "accusing resident") that a male staff member ("accused staff member") had choked and hit him in the face during a dispute over whether the resident could retrieve deodorant from his room.

52. The accusing resident made the allegation more than 24 hours after the alleged event to a contract therapist that is not employed by Future Innovations.

53. The alleged abuse took place sometime between 6 a.m. and 7 a.m. on Sunday, July 8, 2010.

54. Based on the accusing resident's written statement and interview, the accusing resident became verbally aggressive with the accused staff member after he was told he could not go to his room to retrieve his deodorant. The accusing resident stated that in response to his aggressive behavior, the accused staff member choked the accusing resident, told the

accusing resident that he would kill him, asked the other residents to leave the room, and then hit the accusing resident repeatedly in the face. (P. Ex. C, p. 26)

55. The accusing resident's statement varies on the number of times he was hit in the face. In his initial report made to his therapist, he alleged that the staff member hit him three times in the face. (R. Ex. 13) In a later interview with the Licensure Section, the accusing resident stated he was hit five times in the face. (P. Ex. C, p. 26) The accusing resident also told at least one resident that he was hit in the face only twice. (*Id*. at p. 23)

56. Written statements and interviews of several of the residents at the facility purportedly supported the allegation that a staff member had choked and hit the resident. (*Id*.)

57. The written statements and interviews supporting the allegations of the accusing residents included several important variations. For example, one resident testified that the staff member held the resident down in a chair as he choked him. (P. Ex. C, p. 23) Another resident stated that the resident and the staff were "swinging all over the floor." (*Id*., p. 25) One resident claimed he saw the staff member push the accusing resident into the corner and hit him." (*Id*., p. 24)

58. Other residents' written statements contradicted the allegations. For example, one resident wrote that he only saw the staff member restrain the accusing resident with no mention of choking or hitting. (P. Ex. I, Statement of Resident D.B.)

59. The written statements and interviews of staff members who were present at the time of the alleged incident support that the resident became aggressive with the accused staff member. (P. Ex. I, Statement of Staff J.P. and I.S.) However the written statement and interviews with staff do not support the allegation that the accused staff member choked or hit the accusing resident. (*Id*; see also P. Ex. C, pp. 28-30)

60. A physical examination of the accusing resident by facility staff and by the Licensure Section Survey team revealed that the accusing resident had no swelling, bruising, or marks on his face or neck. A physical examination of the resident by the Robeson County Department of Social Services also revealed that the accusing resident had no marks or bruising. (P. Ex. H)

61. Subsequent to the investigation, several of the residents voluntarily informed the facility that the accusing resident had asked them to lie for him and support his story that he was choked and hit by the accused staff member. The accusing resident told these individuals that he could get the facility closed down if they supported his story. (P. Exs. K-M)

62. Quamil Frazier and Keyshawn Marrow, residents at the facility who were present during the incident, testified that the accusing resident had asked them to go along with his story so that they all could be discharged from the facility.

63. Quamil Frazier testified that while he was not afraid of the accusing resident, he agreed to go along with the accusing resident's story because he wanted to go home.

64. Both Quamil Frazier and Keyshawn Marrow testified that they did not see a staff member choke or hit the accusing resident.

65. The Licensure Section was provided copies of the residents' written statements which raised serious doubts about the information the survey team had collected during its July 10 and 11 survey. No one at the Licensure Section performed any follow-up investigation or questioning of any of the residents after the Licensure Section received this information. (P. Ex. W)

66. Octavia George, Future Innovations' Qualified Professional, testified that she did not believe that the residents were being honest with her during her initial investigation.

67. The accusing resident's clinical record demonstrates that the accusing resident had a history of violence, lying, failing to take responsibility for his actions, and had once attempted to convince the residents of a youth detention facility that they could "join together and bust out of the facility." (P. Exs. E-F)

68. Approximately one week prior to the alleged incident, the accusing resident made an allegation against a staff member. The accusing resident alleged that the staff member had cursed at another staff member for waking up a resident for breakfast. Both staff members denied that the incident had occurred. (P. Ex. S)

69. On the evening of July 9, 2010, a staff member reported that the accusing resident stated to her that the accused staff member was going to be fired. When asked why he believed the accused staff member would be fired, the accusing resident stated that: "he wanted to kill the man for making him sit down and getting loud with him in front of his peers." The accusing resident made no allegation at that time that the accused staff member had physically abused him. (P. Ex. S)

70. On August 3, 2012, the accusing resident communicated to Qualified Professional Octavia George that he was planning on contacting the Robeson County Department of Social Services and doing everything in his power to shut the facility down. This threat made Octavia George uncomfortable, and a police report was filed with the Robeson County Sherriff's Department. (P. Ex. G)

71. The Robeson County Department of Social Services conducted its own independent investigation of the incident and determined that the allegation of abuse could not be substantiated. (P. Ex. H)

72. The Licensure Section was aware of the Department of Social Services' investigation but did not consult with the Social Services investigators in conducting its investigation and did not consider that the Department of Social Services had determined that the allegation could not be substantiated.

73. Based on the above Findings of Fact, the preponderance of the evidence does not support a finding that Future Innovations or its staff physically harmed or abused the accusing resident.

74. Based on the above Findings of Fact, the preponderance of the evidence does not support a finding that the Licensure Section's allegations relating to 10A NCAC 27 D .0101, 10A NCAC 27G .0205, .0208, .0209, and .0303 constitute neglect of any of the residents of the facility.

75. The Agency erred in finding that Future Innovations was in violation of 10A NCAC 27D .0304.

Clean and Safe Facility Allegations

76. The survey findings also allege that the facility violated 10A NCAC 27G .0303 by failing to maintain the facility in a clean, safe, attractive, and orderly manner. The Licensure Section based this allegation on issues related to two sinks in the facility not being in working and serviceable order on the first day of its survey, a fan blade being missing from a non-operational fan, a hole that was punched in a resident's room wall, peeling paint in one of the day rooms, a wall plate missing from the wall, and a light bulb missing from a resident's overhead light socket. (P. Ex. C, pp. 32-33)

77. The testimony of Lee Cooper and Marcus Gales demonstrates that the facility was aware of the issues relating to the two sinks and had contacted a plumber to service the sinks prior to the unannounced arrival of the survey team on July 10, 2012.

78. Chavis Plumbing arrived at the facility just prior to or shortly after the survey team arrived at the facility for its unannounced visit.

79. Chavis Plumbing completed work on two lavatories, including two sinks on July 10, 2012, at total cost of repair of $250.00. (P. Ex. P)

80. In regard to the missing overhead light cover and bulb in one of the resident rooms, Future Innovations witnesses testified that it often removes these items from resident rooms if the resident attempts to break the lights because the broken glass could cause harm to the resident.

81. Given the height of the facility ceiling, the empty socket posed no risk to the residents.

82. In regard to the missing overhead fan blade, the fan blade has been missing since Future Innovations took possession of the building. The Licensure Section and the Construction Section never has cited the facility for this issue. The missing fan blade posed no risk to the residents.

83. In regard to the peeling paint in the facility sitting room, Future Innovations witnesses testified that it made every effort to re-paint these rooms when paint began to peel and that residents often peel paint from the walls.

84. As to the punched hole that was observed in the resident's room, many of the facility's residents suffer from behavioral and anger management issues, and it is not unusual for a frustrated and angry resident to punch a hole in a wall.

85. Marcus Gale, the Assistant Facility Manger, testified that he personally repairs the walls as soon as practical after such incidents occur. Marcus Gales described the technique he used to repair the walls and testified that he keeps his tools for making such repairs in his vehicle because of the frequency of these events.

86. The Licensure Section conducted an on-site survey of the facility in March 2012 and had not cited the facility for any of the issues cited in the July 2012 survey.

87. Given the short period of time between the March 2012 on-site survey and the July 2012 survey, it is not reasonable to conclude that the facility is not maintained in a clean and safe manner.

Hot Water Allegation

88. Finally, the survey alleged that Future Innovations violated 10A NCAC 27G .304 because the hot water temperature at the time of testing by the survey team was 80 degrees. (P. Ex. C, pp. 33-34). Several residents testified that the water at the facility was either "always cold" or cold after a several showers had been taken. (*Id*.).

89. Facility staff checks the water temperature at the facility several times per shift, and the hot water temperature had always been between 100 and 116 degrees. Future Innovations keeps a log of the water temperatures. The log indicates that the temperature of the water at the facility on July 10, 2012, varied between 101 and 109 degrees. (P. Ex. Q)

90. Future Innovations witnesses testified that staff had not received complaints from residents about the water temperature. David Curtis testified that based upon the size of the hot water heater, it was possible that, in the course of providing twelve showers, the water temperature may decrease as the hot water heater is emptied.

91. The survey team checked the water temperature on July 10, 2012, which is the same day that a plumber was working on the sinks and water system.

92. The Licensure Section was not aware if the plumber was working in the facility at the time it checked the hot water temperature and did not know if the plumber had turned off the hot water heater in order to complete the necessary repairs.

Type A1 Penalty

93. N.C. Gen. Stat. § 122C-24.1(1) states that the Department shall impose an administrative penalty for Type A1 violations when a violation of the regulations, standards, and requirements "result in a death or serious physical harm, abuse, neglect, or exploitation."

The monetary penalty for a Type A1 penalty can be no less than $1,000.00 and no more than $20,000.00.

94. As a result of the survey findings, the Licensure Section issued a Type A1 Penalty in the amount of $6,000.00 to Future Innovations on July 31, 2012. (P. Ex. A) The July 31, 2012 Notice stated that the basis for the Type A1 penalty was the alleged finding that Future Innovations violated 10A NCAC 27D .0304 – Clients Rights – Protection from Harm, Abuse, Neglect, and Exploitation. (*Id*.)

95. The Type A1 penalty was based on the alleged finding of serious physical harm that allegedly occurred when a staff member choked and hit a resident on July 9, 2012. The Type A1 penalty also was based on the Licensure Section's finding that the alleged violations of 10A NCAC 27G .0205 (substance abuse treatment), 27G .0208 (client services), 27G .0209 (medication requirements), 10A NCAC 27 D .0101 (failure to report to DSS), and 10A NCAC 27G .303 (location and exterior requirements) constituted serious negligence.

96. 10A NCAC 27C .0102(b)(1) defines abuse to mean the infliction of mental or physical harm or injury by other than accidental means.

97. 10A NCAC 27C .0102(b)(17) defines neglect to mean the failure to provide care or services necessary to maintain the mental or physical health and well-being of the client.

98. The $6,000.00 penalty issued by the Licensure Section was based on the Penalty Matrix completed by the Department. (R. Ex. 5) The matrix completed by the Department resulted in a total score of 19.

99. Based on the above Findings of Fact, the Penalty Matrix should have reflected a score of 5 in the first column, a score of 1 in the second column, a score of 2 in the third column, a score of 0 in the fourth column, and a score of 1 in the last column for a total of 9.

100. Based on this score, the monetary penalty should not exceed $1,000.00.

101. Based on the above Findings of Fact, the incidents and violations alleged by the Agency did not cause death or serious physical harm, abuse, neglect, or exploitation to any of the residents of the facility.

102. Based on the above Findings of Fact, a penalty in the amount of $1,000.00 is appropriate for the survey findings related to Medication Administration only.

Suspension of Admissions

103. N.C. Gen. Stat. § 122C-23(g) allows for the suspension of admission to a facility where the conditions of the facility are detrimental to the health or safety of the clients.

104. The Licensure Section determined that based on the survey findings, it was suspending new admissions to the facility (P. Ex. B)

105. Based on all on the above Findings of Fact, the conditions at Future Innovations were not detrimental to the health or safety of its clients.

Intent to Revoke Future Innovations License

106. N.C. Gen. Stat. § 122C-24(c) allows the revocation of a provider's license in any case in which there has been a substantial failure to comply with any provision the statute or regulations that govern the facility.

107. On July 31, 2012, the Licensure Section issued a Notice of Intent to Revoke Future Innovations License based on the same facts and circumstances set forth in its Notice of Suspension of Admissions. (P. Ex. D)

108. The Notice of Intent to Revoke was sent to all of the Local Management Entities ("LMEs") for which Future Innovations serves patients. (*Id*.)

109. Since the filing of its appeal, the Licensure Section has informed Future Innovations that its decision to revoke Future Innovations' license has been affirmed.

To the extent that certain portions of the foregoing Findings of Fact constitute mixed issues of law and fact, such Findings of Fact shall be deemed incorporated herein as Conclusions of Law. Based upon the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter under chapters 122C and 150B of the North Carolina General Statutes.

2. All parties correctly have been designated, and there is no question as to misjoinder or nonjoinder.

3. An ALJ need not make findings as to every fact which arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel*, 110 N.C. App. 438, 440, 429 S.E.2d 611, 612 (1993).

4. N.C. Gen. Stat. § 122C-24.1(1) states that the Department shall impose an administrative penalty for Type A1 violations when a violation of the regulations, standards, and requirements "result in a death or serious physical harm, abuse, neglect, or exploitation." The monetary penalty for a Type A1 penalty can be no less than $1,000.00 and no more than $20,000.00.

5. Future Innovations complied with the requirements of 10A NCAC 27G .0205 because it had assessed and created a treatment plan for the two residents who allegedly were found not to be in compliance with this regulation.

6. Based on the above Findings of Facts, the Agency erred in finding that Future Innovations violated 10A NCAC 27G. 0205.

7. Given the recent history of observed compliance with the client services requirement, the extenuating circumstances of the survey and internal investigation process, and the testimony and documentary evidence regarding client services provided at the facility, the preponderance of the evidence supports a finding that Future Innovations provides adequate client services in compliance with 10A NCAC 27G .0208.

8. Based on the above Findings of Fact, the undersigned finds that the Agency erred in finding Future Innovations in violation of 10A NCAC 27G. 0208.

9. Based on the above Findings of Facts, the Agency did not err in its finding that Future Innovations was in violation of 10A NCAC 27G. 0208 by failing to document on its MAR that it had provided medication to one resident. However, the resident statement indicates that the resident received the medication and that the facility's error was a documentation oversight.

10. The documentation error does not rise to the level of a Type A1 penalty, and it does not justify suspending the facility's admissions or the issuance of an Intent to Revoke the facility's license.

11. Although no harm or death resulted from the facility's failure to document providing medication, based on the testimony of the Licensure Section witnesses, the undersigned has determined that a Type A2 penalty would be appropriate for this finding because there is a risk that physical harm could occur if medication administration is not documented appropriately.

12. Based on the above Findings of Fact, the Agency erred in finding that Future Innovations violated N.C. Gen. Stat. § 131E-256 and 10A NCAC 27D .0101(b)(1).

13. Based on the above Findings of Facts, the undersigned finds that the Agency erred in finding that Future Innovations was in violation of 10A NCAC 27G .0303.

14. Based on the above Findings of Fact, the Licensure Section did not err by finding that Future Innovations was in violation of 10A NCAC 27G .304 based on the survey team's temperature measurements. However, the preponderance of the evidence supports a finding that the water temperature during the period preceding and after the survey complied with the regulation. Furthermore, there is no evidence that the water temperature could have caused any harm to the residents.

15. This finding does not rise to the level of a Type A1 penalty, does not justify suspending the facility's admissions or the issuance of an Intent to Revoke the facility's license.

16. The preponderance of the evidence does not support a finding that a Future Innovations' staff member choked or hit a resident. Therefore, there is no basis for finding that Future Innovations caused serious physical harm or abuse to any of its residents.

17. There was no evidence presented that the facility failed to maintain the mental or physical health of its residents. There is therefore no basis for finding serious neglect as required for a Type A1 penalty under N.C. Gen. Stat. 122C-24.1(1).

18. Based on all of the above Findings of Fact, Future Innovations has not failed to substantially comply with the provision of the statute and regulations that govern the facility.

19. Based on all of the above Findings of Fact, the Licensure Section has inadequate basis to issue the Intent to Revoke or to affirm its decision to revoke Future Innovations' license.

20. The preponderance of the evidence supports a finding that Future Innovations' residents did not suffer death, substantial physical harm, abuse, neglect, or exploitation.

21. The Agency violated the standards of N.C. Gen. Stat. § 150B-23 by erroneously issuing Future Innovations a Type A1 monetary penalty on the asserted basis that residents at the facility suffered substantial physical harm, abuse, or neglect.

22. The preponderance of the evidence supports a finding that Future Innovations can be subject to a $1,000.00 monetary penalty relating to violations of Medication Administration.

23. The medication administration violation does not support a Type A1 penalty, suspension of admissions, or revocation of Future Innovations license.

24. N.C. Gen. Stat. § 122C-23(g) allows for the suspension of admission to a facility where the conditions of the facility are detrimental to the health or safety of the clients.

25. The preponderance of the evidence supports a finding that the conditions at the Future Innovations facility were not detrimental to the health or safety of its clients.

26. The Agency violated the standards of N.C. Gen. Stat. 150B-23 when it erroneously suspended admissions to the Future Innovations facility.

27. N.C. Gen. Stat. § 122C-24(c) allows the revocation of a provider's license in any case in which there has been a substantial failure to comply with any provision the statute or regulations that govern the facility.

28. Future Innovations has not failed to substantially comply with the provision of the statute and regulations that govern the facility.

29. The Agency violated the standards of N.C. Gen. Stat. 150B-23 by erroneously issuing a Notice of Intent to Revoke Future Innovations License.

30. Because Future Innovations challenged the Licensure Section's Notice of Intent to Revoke its License and the Licensure Section subsequently affirmed that decision, the undersigned accepts the oral request of Petitioner to amend the Contested Case Petition such that the petition now includes the subsequent decision made by the Licensure Section to affirm its decision to revoke Future Innovations' license.

31. Amending the petition to include the Licensure Section's subsequent decision to affirm its July 31, 2012 Notice of Intent to Revoke Future Innovations' license does not prejudice Respondent in any way because the decision to affirm the revocation was based on the reasons for revocation as set forth in the Licensure Section's July 31, 2012 Notice of Intent to Revoke.

32. In the interest of justice, judicial economy and with an eye at protecting the resources of the State there is no basis or justification for requiring Future Innovations to file a separate contested case petition to challenge the subsequent decision to affirm the Licensure Section's Intent to Revoke Future Innovations' license given that the undersigned has found that the findings that led to such decision have insufficient support in the evidence.

33. Because the undersigned has found as a matter of fact and law that the Licensure Section erred in its findings that gave rise to the issuance of the Notice of Intent to Revoke there remains no basis to revoke Future Innovations' license. Any attempt to do so, based on the July 2012 survey and July 31, 2012 Notice of Intent to Revoke, is erroneous, null, and void.

34. The Licensure Section's actions substantially prejudiced Future Innovation's rights by erroneously requesting a monetary penalty, suspending the facility's admissions, issuing an intent to revoke, and subsequently affirming its decision to revoke Future Innovation's License.

FINAL DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, Respondent Licensure Section's decision to issue a Type A1 Administrative Penalty, suspend new admissions to the Future Innovation Facility, and issue an Intent to Revoke Future Innovations' License is erroneous, not supported by the evidence, and is REVERSED. A monetary penalty of $1,000.00 shall be paid by Future Innovations and Future Innovations shall fully and completely abide by the Plan of Correction it submitted to the Department in response to the July 10-11 Survey Findings.

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. Admin. Code 03.012, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **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 16th day of June, 2013.

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Beecher R. Gray
Administrative Law Judge