BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

DOWNING CLARK CENTER INC,	:	
	:	
Petitioner,	:	
	:	Docket No.: OSAH-DHS-CCI-1022119-64-Teate
v.	:	
	:	
DEPARTMENT OF HUMAN SERVICES,	:	
	:	
Respondent.	:	

INITIAL DECISION

I. Introduction

In response to Respondent's Notice of Intent to Revoke License issued on February 4, 2010, Petitioner requested a hearing that was held on August 10, 11, 19, 20, and 25.[1] Hereinafter, Petitioner is referred to as "DCC," the Office of Residential Child Care is referred to as "ORCC," and the Department of Family and Children Services is referred to as "DFCS."

Attached to ORCC's notice of intent to revoke license was a survey dated 1/21/2010 that has not been previously litigated as well as prior surveys therein referenced that indicate agency findings that were resolved either by prior settlement agreement or DCC's payment of fine assessed.[2]

For reasons indicated, ORCC's revocation action is **REVERSED**.[3]

The issue of appropriate sanction in light of prior violations was reserved pending a determination of the deficiencies alleged in the 1/21/2010 survey. Inasmuch as two Category III violations of Ga. Comp. R. & Regs. r. 290-2-5-.08 (2) have been determined, this matter is remanded to ORCC to allow DCC to submit a plan of correction and to allow ORCC to calculate the appropriate fine to be imposed for those two violations in light of prior violations of the same rule in a manner consistent with Ga. Comp. R.& Regs. r. 290-1-6-.06. Upon notification of the amount of the fine, ORCC may either pay the fine or request a new hearing solely on the basis of

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[1] The hearing on August 25, 2010 consisted of the completion of ORCC's cross-examination, DCC's re-direct and ORCC's re-cross of Douglas Laipple, M.D. It was conducted by telephone upon agreement of the parties. The record remained open until September 7, 2010, to allow submission of written closing statements and proposed findings of fact and conclusions of law.

[2] DCC's motion in limine to exclude litigation of matters in prior surveys that were resolved either by settlement agreement of by payment of the penalty assessed was granted with the proviso that such surveys referenced in the 1/21/2010 survey could later be reviewed for appropriateness of sanction to the extent that ORCC's allegations in the 1/21/2010 survey were substantiated.

[3] ORCC's motion to strike DCC's written closing argument inasmuch as it was untimely filed is denied. The closing argument is not substantive and presents no legal argument not previously presented.

the amount of the fine calculated. Any such referral should clearly note that the sole issue is the appropriateness of the calculation of the fine that ORCC determines for the two Category III violations of Ga. Comp. R. & Regs. r. 290-2-5-.08 (2).

II. Findings of Fact

Overview of adverse action taken

1. DCC has been duly licensed to operate a child caring institution since March 19, 2006 and ORCC has placed no current restrictions on that license.[4] (Testimony of Keith Bostick, ORCC Director; Petitioner's Exhibit 1).

2. On January 5, 2010, ORCC received a complaint concerning a major disturbance on January 4, 2010 at DCC's facility. The complaint was investigated by Nikiya Howard, an ORCC specialist surveyor.[5] After interviews with various residents, staff, and police officers, consultation with DFCS investigators, a review of DCC records, including medication administration reports (MAR's), and a review of DCC surveillance footage,[6] Ms. Howard documented her conclusions in the January 21, 2010 survey that reported nine deficiencies. (Testimony of Nikiya Howard, R-1A).

3. After Ms. Howard completed the January 21, 2010 survey, Lamara Ivory, her immediate supervisor reviewed it for accuracy.[7] That review included going to DCC's facility and looking at approximately two unspecified hours of surveillance tapes. Finding nothing inconsistent, she approved Ms. Howard's findings and made no changes to the report or any findings of her own. (Testimony of Lamara Ivory, ORCC Deputy Director).

4. Subsequent to Ms. Ivory's review, Keith Bostick, ORCC's Director, reviewed the January 21, 2010 survey. Based on communications with other ORCC staff relating to the complaint survey, the findings contained in that survey and considering past disciplinary actions taken against DCC, Mr. Bostick elected to issue a notice of intent to revoke DCC's license on February

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[4] Current restrictions, if any, are imposed by an order issued by Judge Gatto to whom this matter was previously assigned. The record indicates no motion to vacate that order prior to the decision here issued.

[5] Ms. Howard's educational background includes an undergraduate degree in social work and a masters degree in healthcare administration. Her work experience includes four years of work with DFCS as a Medicaid Specialist She has conducted approximately 14 investigations for ORCC. However, she was not qualified as an expert in any capacity. (Testimony of Nykia Howard).

[6] Although investigatory conclusions were based in part on video surveillance obtained from DCC during the investigation, video surveillance relied upon in reaching those conclusions was neither submitted demonstratively during the hearing or as an exhibit. Further, upon the review of the video surveillance footage presented by DCC in its rebuttal, no witnesses or document or tape was presented to rebut statements made by Byron Munford or Cindy Downing, two of DCC's witnesses who commented on portions of the video surveillance that DCC tendered as an exhibit.

[7] LaMarva Ivory serves in the capacity of deputy director for ORCC. Prior to Ms. Ivory's appointment as deputy director in July 2010, she served in the capacity of regional program director of ORCC for approximately four years. Her duties as regional program director entailed the direct supervision of field staff conducting complaint and monitoring investigations of licensed child welfare facilities, including child caring institutions. *(Testimony of LaMarva Ivory)*

4, 2010. Prior to making his determination, he read a DFCS report prepared by Carla Sims dated January 5, 2010; however, he did not recall whether he reviewed an annual inspection that was conducted by ORCC on January 12, 2010.[8] (Testimony of Keith Bostick, ORCC Director).

5. In the notice of intent to revoke license issued on February 4, 2010, ORCC informed DCC that "violations that form the basis of the revocation are identified with asterisks [****] on Exhibit A, the January 21, 2010 survey attached. Accordingly, only Prefix Tag Numbers R 801, R 840, R 905, R 1219, R 1222, and R 1224 on the January 21, 2010 survey are identified by ORCC as a basis of the revocation whereas Prefix Tag Numbers R 709, R 1827, and R 1829 are not so identified. (Respondent Exhibits 1 and 1A).

6. The notice of intent to revoke also alleges that the January 21, 2010 survey shows continued noncompliance in the area of supervision and failure to follow policies and procedures and that such a failure has a direct adverse effect on the health and safety of children in care as evidenced by prior disciplinary actions. (Respondent Exhibits 1, 1B, 1C, 1D, 1E, 1F, 1G, 1H, 1I, 1J, 19, 20, 21, 22, 23, 24, 25, 26 and 35).

7. Mr. Bostick concluded that revocation of DCC's license was appropriate in light of the January 21, 2010 survey deficiencies and DCC's prior repeat non-compliance with rules and regulations.[9] His action is consistent with a meeting that occurred with DCC's owners in December 2009 at which time he informed DCC that if subsequent issues developed, ORCC would seek further enforcement actions including license revocation. (Testimony of Keith Bostick).

Prefix Tag R 801: Administration and Organization

Failure to comply with written procedures and policies

8. The first deficiency indicated as a basis for revocation was cited as a violation of Ga. Comp. R. & Regs. r. 290-2-5-.08 (2).[10] Ms. Howard concluded that DCC failed to comply with DCC's written policies and procedures in eleven of eleven files that she reviewed.[11] In support of this conclusion, she cited nine findings; however, Respondent submitted no testimony or other admissible evidence regarding the basis for findings (7) and (8). (Testimony of Nikiya Howard; Respondent Exhibits 1 and 1A).

9. DCC's policy for Medication Administration Procedures consists of three categories: (I) Policy, (II) Definitions, and (III) Procedures. Per that policy: (1) medications are administered according to pharmaceutical instructions; (2) the Nurse Manager and/or other designated

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[8] Mr. Bostick is a licensed clinical social worker with a master's degree in social work and a bachelor's degree in child psychology. (Testimony of Keith Bostick).

[9] ORCC utilizes a matrix in making such a determination. (Testimony of Ms. Ivory; Respondent Exhibit 2).

[10] For purpose of sanction consideration, the rule was previously cited on August 12, 2009, July 31, 2009, and July 28, 2009. (Respondent Exhibits 1D, 1E and 1F).

[11] The purpose of this rule is for facilities to develop their own written policies and procedures that describe specific areas of organizational management, provide clients information about their rights as well as provide the public with information about services provided by the program. (Testimony of Nikiya Howard).

categories of staff trained in medication dispersion, shall ensure that all doses of medications, both prescription and over-the-counter, are accounted for and documented in each youth's health record. Under definitions, a medication discrepancy denotes: (1) an inappropriate or incorrect medication prescribed for, dispensed for, or given to a youth, or (2) an omission of vital medication due to a prescribing, dispensing, or administration error. The procedure section consists of 28 procedures. (Respondent Exhibit 6).

10. DCC's policy for Medications indicates one policy statement that "all direct care staff shall receive orientation for the use and management of types of medications." There are 7 statements elaborating on the policy, one of which is #5 that indicates a record of all medications handed out and taken by youth shall include: (1) the name of the youth taking medication; (2) the name of the prescribing physician and date of the prescription if the medication is prescription or psychotropic, and (3) the required dosage, date and time taken, dosage taken, and name and signature of the staff member that handed out and supervised the taking of the medications. This policy does not define medication procedures, only the orientation that direct care staff must receive regarding medications. (Respondent Exhibit 7).

11. The first two findings identify DCC policies with which DCC is required to comply under Ga. Comp. R. & Regs. r. 290-2-5-.08 (2). In Finding (1) Ms. Howard indicated that she reviewed DCC's Medication Administration Procedure on January 20, 2010. Although she did not specify the section number of the procedures indicated, Finding 1 generally identifies Procedures 1, 5, 20, and 24. In Finding (2), she generally identifies statement 5 relating to direct care staff orientation on the policies and procedures. (Respondent Exhibit 1A).

Physician notification of dosage errors and/or medication discrepancies

12. In Finding (3), based on a review of medication logs for December 2009 and January 2010, Ms. Howard concluded that from December 28, 2009 to December 31, 2009 and from January 1, 2010 to January 4, 2010, DCC failed to record documentation on the medication logs and/or in the files for Residents #1, #3, #4, #5, #6, #9 and #11 indicating that the resident's prescribing doctors were notified of dosage errors and/or medication discrepancies as a result of an omission of a vital medication due to a dispensing error. In the absence of such notation, Ms. Howard presumed a deviation in the administration of these medications and a corresponding failure to notify a physician of the presumed discrepancy. (Testimony of Nikiya Howard; Respondent Exhibits 4, 8, 10, 11, 12, 15, 16 and 18).

13. During his approximate eighteen months of employment with DCC, Daniel Lockaby, a certified nursing assistant, was appropriately trained and was responsible for monitoring and oversight of on-site medications. In that capacity, Mr. Lockaby routinely filled out medication administration reports (MAR's) properly. He developed and routinely utilized a short form with all of the resident's names on it that he initialed as he gave the medication to each resident. This form expedited the cumbersome task of initially making notations on the MAR's. Subsequently, he would then promptly record the appropriate notation on the MAR's. The necessity of the short form was to insure that medications to the residents could be appropriately administered to the residents within the requisite time frame. (Testimony of Daniel Lockaby).

14. Contrary to his usual routine of promptly notating the MAR's from the information on his short form, Mr. Lockaby failed to so note the MAR's for December 28, 2009 through January 1, 2010. This occurred due to staffing shortage that occurred in late December 2009 and early January 2010, when another nurse employed by DCC quit her job. During this time, Mr. Lockaby was required to train Tammy Hudgins, another certified nursing assistant, for that position. Even though he only recorded the information on his short form and did not record it on the MAR's, he administered all medications to the residents from December 28 through 31, 2009 and did so in accordance with the prescriptions written. Accordingly, there were no dosage errors and/or medication discrepancies to report.[12] Mr. Lockaby stored his short forms with the MAR's pending recording and they were produced at the hearing for examination. He also trained Ms. Hudgins on the use of his short form prior to recording the notation on MARS. Although Mr. Lockaby fully intended to transfer the information to the MAR's, he simply forgot to do so during the hectic holiday season. (Testimony of Daniel Lockaby; Respondent Exhibits 8, 10, 11, 12, 15, 16 and 18).

15. Due to extenuating circumstances unrelated to his job duties or performance, Mr. Lockaby himself resigned on January 1, 2010 after passing out morning and lunch medications. (Testimony of Mr. Lockaby).

16. Tammy Hudgins administered medications on January 2 and January 3, 2010. She utilized Mr. Lockaby's short form making sure that all medications were properly administered. There were no discrepancies to report. The short form documentation that she utilized and stored with the MAR's was produced. It indicated the children's names and her initials when medication was given to a resident. When she understood all of the correct procedures, she properly documented the MAR's. (Testimony of Tammy Hudgins; Respondent Exhibits 8, 10, 11, 12, 15, 16 and 18).

17. Ms. Hudgins also worked on December 28 and 29 as well as January 2 and she administered the medication to the girls and was intending to transfer that information into the medication record. Further, both Mr. Lockaby and Ms. Hudgins established that at least four of the eleven girls in question were on a "leave of absence" from Downing Clark Center, Inc. between December 28, 2009 and January 3, 2010 due to the holidays. (Testimony of Tammy Hudgins; Testimony of Daniel Lockaby).

18. Alexis Pullen, DCC's Human Resources manager, she worked on January 1 through January 4 and watched the administration of medications by Ms. Hudgins and was aware that all of the girls under her watch properly received their medications. (Testimony of Alexis Pullen).

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[12] When Dr. Laipple wrote a prescription for medication, said prescription went to Lacy's Pharmacy to be filled. Lacy's then sent the medication to DCC in four color-coded boxes signifying medications to be given in the morning, noon, night and "prn" (as needed). On a monthly basis, DCC received a computer generated medication record from Lacy's Pharmacy that established the beginning and end date for the prescriptions and the dosages to be administered. Respondent's Exhibits 8 through 18 are records so submitted by Lacy's. This is called the OPUS system which is essentially a fail-safe procedure, In the interim, between the newest computer generated report and the prior one, the prior one is annotated with medication changes but does not reflect the complete prescription number or order date until the newer report is generated. Mr. Lockaby demonstrated in great detail how the process of administration of medications insured that there were no errors to report. (Testimony of Mr. Lockaby).

19. Malinda Broughton, a direct care supervisor, watched medication administration on December 28 and December 29, 2009 and on January 3, 2010. Ms. Broughton was also aware that all girls under her watch received their medications. (Testimony of Malinda Broughton).

20. With respect to the contention of dosage errors of medications given to the residents, the undisputed testimony from Mr. Lockaby, Ms. Broughton, Ms. Pullen and Ms. Hudgins is that all children received the proper dosage of medication and that there were no dosage errors. Hence, there was no reason to contact Dr. Laipple or other physician.[13] There was no evidence presented to the contrary. (Testimony of Daniel Lockaby; Testimony of Malinda Broughton; Testimony of Alexis Pullen; and Testimony of Tammy Hudgins).

Documentation of the date of the prescription

21. For Finding (4), Ms. Howard reviewed MAR's on January 26, 2010, for December 2009 and January 10 2010. She determined that DCC failed to document prescription dates for Residents #1, #3, #4, #5, #6, and #11 on medications there indicated. (Testimony of Nikiya Howard; Respondent Exhibits 4, 8, 10, 12, and 18).

22. The MAR's entitled "Medication Record" are computer generated medication record forms from Lacy's Pharmacy. Respondent Exhibits 8 through 18 are such forms. A new report is received on a monthly basis and is utilized as the medication record until a new report is received the following month. Only the hand-written notations are at issue in the interim period between the last received medication record and the subsequent one a month later. On most of the interim hand-written entries, the prescription date is not indicated. (Testimony of Mr. Lockaby).

23. DCC's medication administration procedure requires that the date of the prescription be documented on a MAR; however, it does not specify a time when such information should be documented. (Respondent Exhibit 6).

Use of check marks rather than initials

24. For Finding #5, Ms. Howard's review of MAR's on January 26, 2010 for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9 and #11 revealed that from January 1, 2010 to January 4, 2010, check marks were used for the dates of prescription administration in lieu of a name or signature of the staff member that handed-out and supervised the taking of the medication as required by DCC policies. (Testimony of Nikiya Howard, Respondent Exhibits 4, 6, 8, 9, 10, 11, 12, 13, 14,15, 16, and18).

25. Respondent does not dispute that DCC policy requires first and last initials and signature of the staff member administering the medication. On January 2, 3, and 4, Ms. Hudgins used check marks rather than initials on the MAR's of ten out of the forty-three girls that were present at DCC. These check marks occurred during Ms. Hudgins' training. When detected by other DCC

[13] Dr. Liapple reasonably disregarded a report to him by one or two of the residents that her medication had not been given between the periods of December 28-31, 2009 and January 1-4, 2010 since he reviewed the allegations with a nurse who indicated that the medications had been given. Dr. Liapple further testified that it is "impossible to know who is telling the truth, but tends to believe the staff." (Testimony of Dr. Liapple)

staff members, she no longer utilized check marks and began using her initials. While the use of the check marks was inconsistent with DCC policy, the use of check marks for this purpose is allowed in other facilities where Ms. Hudgins' has worked. (Testimony of Tammy Hudgins; Respondent Exhibit 6).

Failure to address resident's psychotropic medications

26. For Finding #6, Ms. Howard reviewed MAR's and service, room board and watchful oversight (SRBWO) plans on January 26, 2010 and concluded that: (1) DCC failed to ensure that psychotropic medications for Residents 5, 6, 7, 8, 9, 10, and 11 were being dispensed in accordance with goals and objectives of their service, room, board, and watchful oversight (SRBWO) plans and (2) DCC was not dispensing psychotropic medications in accordance with the resident's SRBWO plan. (Testimony of Nikiya Howard; Respondent Exhibits 1A, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 27, 28, 29, 30, 31, 32, 33 and 34).

27. Ms. Howard identified the room, board, and watchful oversight service plans (SRBWO) for various residents of Downing Clark Center, Inc. Ms. Howard then presented the medication records for December, 2009 and January, 2010. Ms. Howard then testified that the SRBWO's for various residents failed to meet the resident's goals and objectives with respect to the administration of psychotropic medications. However, under cross examination, Ms. Howard admitted that she had no medical training and that her understanding of the definition of psychotropic medications is a layman's opinion as is her opinion regarding whether the SRBWO properly address the goals and objectives with respect to the administration of psychotropic medications.[14] (Testimony of Nikiya Howard: Respondent Exhibits 8 through 18 and 26 through 34).

28. The only medical testimony presented was that of Dr. Laipple, the physician who described the medications for the residents of Downing Clark Center, Inc. He first established that Adderall, Clonidine and Trazadone were not psychotropic medications.[15] Further, when shown the SRBWO's (Respondent Exhibits 26 through 34) and the medication records (Respondent Exhibits 8 through 18), Dr. Laipple testified that it was impossible to determine whether the agency was properly addressing the resident's psychotropic medications from those documents. He testified that to determine whether psychotropic medications were dispensed properly for the dates of 6/15/09 (resident 5), 8/25/09 (resident 7), 7/2/09 (resident 8), 5/28/09 (resident 9), the medication records on those dates would have to be examined. No such medication records were provided by ORCC. With respect to the SRBWO for resident 5 dated 12/4/09, resident 8 dated 12/4/09, resident 10 dated 12/11/09, and resident 11 dated 12/11/09, Dr. Laipple examined the medication records and the SRBWO's for each one of those residents and testified in his medical opinion Downing Clark Center, Inc. properly addressed the resident's psychotropic medication needs and that dispensing of the psychotropic medications were in accordance with the goals

[14] The opinions of Ms. Ivory and Mr. Bostick who reviewed Ms. Howard's findings are also non-medical lay opinions. (Testimony of Ms. Ivory; Testimony of Mr. Bostick).

[15] While Dr. Liapple acknowledged that medical professionals sometimes differ regarding the definition of psychotropic medications, ORCC presented no medical evidence contradicting his designation of drugs that were not considered psychotropic.

and objectives of the residents' SRBWO plan. No evidence to the contrary was presented by ORCC. (Testimony of Dr. Laipple).

Prefix Tag R 840: Staffing

29. The second deficiency indicated as a basis for revocation was cited as a violation of Ga. Comp. R. & Regs. r. 290-2-5-.08 (6).[16] Ms. Howard concluded that DCC failed to ensure that there was a sufficient number of qualified and trained staff to provide for the needs, care, protection and supervision of children. In support of this conclusion, she cited eight findings, five of which fell within a failure to have sufficient number of staff to provide for the supervision of children and three of which fell within a failure to supervise residents to protect the health, safety, and well-being of children in care. (Testimony of Nikiya Howard; Respondent Exhibit 1A).

Failure to have sufficient number of staff to provide for the supervision of children

30. Finding # 1 indicates a review of an intake report dated January 5, 2010 that reveals a major disturbance at DCC on January 4, 2010 that led to the arrest of approximately 20 children in state custody for a variety of charges including rioting, criminal damage to property, and assaulting officers. (Testimony of Nikiya Howard; Respondent Exhibits 1, 1A and 36).

31. Finding #2 is based on interviews on January 21, 2010 with officers of the Gordon County Sherriff's Office indicating observations upon their arrival at DCC on January 4, 2010.[17] Within the context of those interviews, Ms. Howard made the following conclusions:

a. The scene was chaotic;
b. There were residents found outside the facility trying to leave the grounds;
c. The facility was in dishevel (food, trash, blankets observed in the hallway);
d. Several steel doors were observed to have been breached;
e. There was no order;
f. The staff was unable to manage the behaviors of residents;
g. The scene was assessed and it was clear that there was inadequate supervision;
h. They did not observe enough staff to provide for the care of the residents;
i. Several residents were detained after causing property damage and/or attacking the officers.

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[16] For purpose of sanction to be imposed, if any, this rule was previously cited on 12/17/09, 11/20/09, 8/12/09, 7/28/09, 4/17/09 and 10/13/08. (Respondent Exhibits 1B, 1C, 1D, 1F, 1G, and 1H).

[17] ORCC elected not to call Detective Bedford in light of representations that were made by Detective Bedford regarding production of Forsyth County Sherriff records that were required to be produced at the hearing. The Sherriff's office did not honor the subpoena that was duly issued and did not file a motion to quash in refusing to do so as required. The testimony of officers subpoened by ORCC other than Deputy Josh Vinall was stricken in light of violations of the rule of sequestration that had been imposed when the officers dined with Deputy Vinall at a lunch break following his testimony. Deputy Vinall openly discussed the case including DCC's attorney's questions with them at that time. (Testimony of Jamie Davis; Testimony of Ginger Daffron; Detective Stephanie Sanford). While Deputy Vinall's testimony was not stricken, proferred testimony was allowed that could support DCC's motion to strike his testimony that was denied pursuant to Ga. Comp. R. & Regs. r. 616-1-2-.18 (6).

32. In response to a call reporting a fight that was apparently initiated by a DCC consumer, police responded on January 4, 2010. Police began to arrive at approximately 10:34 p.m. and continued to do so until approximately 29 police officers were present at the dormitory. Deputy Vinall was the first officer to arrive. He was met at the door from the facility to the dayroom by Byron Munford, a direct staff supervisor for all four dormitory units. (Testimony of J. J. Vinall, Deputy; Respondent Exhibit 36; Petitioner's Exhibit VIDEO).

33. A video of the incident simultaneously displays all of the four dormitories when Deputy Vinall arrived. The video reveals that virtually all of the DCC residents were either in their rooms or were casually in the hallway. Nothing was on the floors; there was no indication that any of the girls were causing a disturbance; and the video revealed exactly what Mr. Munford and Ms. Downing had stated - Downing Clark Center, Inc. was calm and completely under control and properly staffed. The video showed a time period of 10:34 p.m. on January 4, 2010 and ended at 1:35 a.m. on January 5, 2010 when the police are seen leaving the premises. Even at the end of the video and after observing the arrest of numerous residents, nothing was on the floors and there was no evidence of destruction in Downing Clark Center, Inc. Both Mr. Munford and Ms. Downing testified and it is uncontroverted that after the arrest of the various residents, they toured the facility and observed absolutely no damage. (Petitioner's Exhibit VIDEO; Testimony of Bryan Munford; Testimony of Cindy Downing).

34. Most residents at DCC were mental health consumers with varying diagnosis, medication and counseling needs which could not be managed in a foster care setting or by their families or relatives. Some of the patients had significant trust issues related to sexual or physical abuse and some had prior negative experience with police as a result of prior behaviors. Consumers at DCC reside in a two level dormitory that is divided into four units designated as Clark North, Clark South, Downing North and Downing South. There are security cameras that constantly record hall activity in each of those units. In addition, there are security cameras in areas such as a day room where guests are received and at the security gate. By regulation, cameras are not allowed in individual, non-public rooms. Routinely, there are 45 girls in the dormitory with 11 to 12 girls in each unit with a maximum of 15 per unit. Per Carla Sims, a DFCS investigator, there were 43 residents at the time of the incident. (Testimony of Byron Munford, direct staff supervisor; Testimony of Cindy Downing; Testimony of Carla Sims).

35. DCC staff was well trained in crisis prevention, a training that was reinforced in accordance with a training schedule on an ongoing basis. Alexis Pullen, the human resource director, is also qualified as a Crisis Prevention Instructor. (Testimony of Cindy Downing; Testimony of Alexis Pullen).

36. Deputy Vinall could not recall any crisis intervention training with children or adolescents. While he testified and/or indicated in his police report that he observed "total chaos" upon arrival with several security doors breached and food, bed linens, and clothing throughout the hallways, and the sound of someone screaming inside the facility, the testimony describing his observations is not credible in light of the videos that were recording while he was there, the failure to mention the "scream" in his police report, and credible testimony from Bryon Munford. (Testimony of Deputy Josh Vinal; Testimony of Bryon Munford; Testimony of Cindy Downing).

37. As the police arrived, residents could hear them downstairs and began to leave their rooms and move into the hallway. Many were agitated or frightened and required staff intervention that appears to have been provided. (Testimony of Bryon Munford; Testimony of Cindy Downing; Testimony of Joseph Daugherty; Testimony of Alexis Pullen; Petitioner's Exhibit VIDEO).

38. Mr. Munford or other staff present alerted Ms. Downing and other key staff members including Joseph Daugherty and Alexis Pullen. Ms. Downing arrived shortly after Deputy Vinal. She pleaded for additional time to work to calm the residents. Deputy Vinal indicated that she could have 10 minutes to attempt to do so. After that time Deputy Vinal and other police officers took control and would not allow the staff to continue with interventions consistent with their training. (Testimony of Bryon Munford; Testimony of Cindy Downing; Petitioner's Exhibit VIDEO).

39. Once the police assumed control and precluded further intervention customary for dealing with mental health consumers, "chaos" occurred. At that time, there were several confrontations between some of the residents and the approximately 29 police that entered the residential halls. Despite pleas for police restraint, the police continued and ultimately arrested and removed 20 residents for criminal charges including rioting, criminal damage to property, and assaulting officers, an event that prompted media coverage. (Testimony of Bryon Munford; Testimony of Cindy Downing; Respondent Exhibit 36).

40. With the exception of Byron Munford's testimony, Finding #3 is based on interviews with staff that were not present as witnesses and is not supported by videotape. Mr. Munford's testimony does not support the finding and there is no indication in the record of any admission against interest that might be asserted regarding statements that he made during Ms. Howard's investigation. (Testimony of Bryon Munford; Testimony of Nikiya Howard).

41. The video footage used to support Ms. Howard's finding in Finding #4 was not tendered as a document in this matter. Further, no eye-witnesses supporting ORCC's allegations of occurrences during the 7:55 p.m. to 10:20 p.m. referenced video footage gave testimony. (Record as a whole).

42. Finding 5 references a shift report dated 1/4/10 for the 7 p.m. to 7 a.m. shift that ORCC did not tender as an exhibit. Further, no witness that observed the facts alleged in Ms. Howard's review was presented. (Record as a whole).

43. Even though ORCC has no specific staffing ratio requirements, DCC's license authorizes DCC to operate a child caring institution for up to 72 consumers between the ages of 6 and 17 with no waivers or variances granted on the license. DCC has not exceeded its ORCC licensed residential capacity of 72 consumers at any time at issue. (Testimony of Cindy Downing, DCC CEO; Petitioner's Exhibit 1).

44. Although ORCC has no specific staffing requirements, DFCS required DCC to have a staff to children ration of one to seven for children in DFCS custody placed at DCC. DFCS routinely placed children with DCC until shortly before the incident on January 4, 2010 that prompted investigation by ORCC, DFCS and other regulatory agencies. (Testimony of Cindy Downing).

45. Carla Sims, a DFCS project director became DFCS's lead investigator following the January 4, 2010 incident. At the time of the incident, Ms. Sims determined that there were 43 residents, 26 of whom needed maximum oversight and 17 of whom required additional oversight. Without referencing any residents upon which she based her conclusions, Ms. Sims opined that 26 of those residents required a maximum oversight ratio of 1 staff member to 5 patients and that 17 of them required additional oversight with a ratio of 1 staff member to 8 patients. Although Ms Sims determined that DCC failed to provide maximum watchful oversight, she did not refute that DCC's time sheets reflected appropriate staff ratio per contract with DFCS. (Testimony of Carla Sims).

46. With regard to inadequate supervision, Ms. Sims indicated that it was not so much related to ratio numbers as to the ability to protect residents due to violence or other criteria. However, Ms. Sims did not identify any residents upon which either of her conclusions is based. Although Ms. Sims is an experienced investigator, she was not qualified as an expert on staffing requirements. Further, she cited no regulations or other admissible evidence and no objective criteria upon which such conclusions were based. (Testimony of Carla Sims).

Failure to supervise residents to protect the health, safety, and well-being of children in care

47. Finding 6 references a record that ORCC did not tender as an Exhibit. No actual witness to the matters asserted was presented. (Record as a whole).

48. Finding 7 alleges matters that are not established by witnesses who observed the occurrences or by other documentation that might support such assertions. (Record as a whole).

49. Finding 8 references a record that ORCC did not tender as an Exhibit. No actual witness to the matters asserted was presented. (Record as a whole).

Prefix Tag R 905 Referral and Admission

50. The third deficiency indicated as a basis for revocation was cited as a violation of Ga. Comp. R. & Regs. r. 290-2-5-.09 (2). Ms. Howard concluded that DCC failed to admit children whose known needs could be met by DCC. To support this conclusion, she made three findings based on record reviews and three staff interviews. (Testimony of Nikiya Howard; Respondent Exhibit 1A).

51. Finding #1 is based on Ms. Howard's interview on January 22, 2010, with Joseph Daugherty, one of the three staff members that she interviewed. Mr. Daugherty opined that he "did not feel the girls were safe, and at times they were not physically safe, due to inadequate training" and that Residents 8, 10, 11 and 12 were admitted to the facility despite the fact DCC "did not have the staff to manage the aggressive action behaviors exhibited." (Testimony of Joseph Daugherty; Respondent Exhibit 1A).

52. During three months in which he was employed as a program director, Joseph Daugherty disagreed with some of the placements that DFCS requested and DCC ultimately approved.

While working as program director, he was part of a team of three individuals who conducted such pre-placement assessments of residents to determine whether DCC could meet the resident's needs for room, board and watchful oversight. Mr. Daugherty could not recall specifically any of the residents identified in Ms. Howard's finding. (Testimony of Joseph Daugherty; Respondent Exhibit 1A).

53. Ms. Blanchard, a DFCS employee, initially screened residents before referring them to DCC. Upon receipt of a packet of information from Ms. Blanchard, Ms. Downing reviewed it and then had Dr. Laipple review it and then a nurse or another third party such as Mr. Daugherty review it. If any two of the three individuals voted to reject the resident, DCC rejected Ms. Blanchard's referral and did not admit the proposed resident. If one of the three members rejected Ms. Blanchard's recommendations, the three individuals would confer to reach a conclusion. Through this process, only children whose known needs could be met by DCC based upon pre-placement assessment, planning enrollment, board and watchful oversight capacity were admitted to DCC. (Testimony of Cindy Downing).

54. ORCC presented no further evidence that would support a conclusion that any resident had been admitted whose needs could not be met by DCC.

55. Findings #2 and #3 are based on the statements of witnesses that were not present at the hearing.

Prefix Tags R 1219, R 1222 and R 1224: Health Services

Failure to administer psychotropic medications in accordance with goals and objectives

56. Prefix Tag R 1219, the fourth deficiency indicated as a basis for revocation, was cited as a violation of Ga. Comp. R. & Regs. r. 290-2-5-.12 (3) (d) (3). Ms. Howard concluded that DCC failed to administer residents' psychotropic medications in accordance with the goals and objectives on the resident's service plan in seven of seven resident files that she reviewed. She included two findings to support her conclusion. (Testimony of Ms. Howard; Respondent Exhibit 1A).

57. Finding #1 is essentially the same as Finding #6 under Prefix Tag R 801 addressed in Findings of Fact 26-28 above. Finding #2 indicates only that Cindy Downing acknowledged the findings, not that she agreed with them.

Failure to document that the residents' prescribing physicians were notified of dosage errors

58. Prefix Tag R 1222, the fifth deficiency indicated as a basis for revocation on the January 21, 2010 survey, was cited as a violation of Ga. Comp. R. & Regs. r. 290-2-5-.12 (3) (d) (3) (iii). Ms. Howard concluded that DCC failed to document that the residents' prescribing physicians were notified in cases of dosage errors in eleven of eleven files reviewed. She included five findings to support her conclusion. (Testimony of Ms. Howard; Respondent Exhibit 1A).

59. Findings #1 and #2 are essentially the same as Findings #1 and #2 under Prefix Tag R 801 addressed in findings of fact relating to Prefix Tag R801 above. (Respondent Exhibit 1A).

60. Findings #3 and #4 are based on interviews with individuals who were not present to give testimony. (Respondent Exhibit 1A).

61. There is no Finding #5 and the last Finding is designated #6. (Respondent Exhibit 1A) Per Ms. Pullen, DCC policy does not require a designated staff to be a certified nurse. (Respondent Exhibits 6 and 7; Testimony of Alexis Pullen).

Failure to maintain a complete record of all medications handed out

62. Prefix Tag R 1224, the sixth and last deficiency indicated as a basis for revocation on the January 21, 2010 survey, was cited as a violation of Ga. Comp. R. & Regs. r. 290-2-5-.12 (3) (d) (5). Ms. Howard concluded that DCC failed to maintain a complete record of all medications handed out by authorized staff and taken by the children in eleven of eleven files reviewed. She included three findings to support her conclusion. (Testimony of Ms. Howard; Respondent Exhibit 1A).

63. Findings #1 and #2 are essentially the same as Findings #1 and #2 under Prefix Tag R 801 addressed in findings of fact relating to Prefix Tag R 801 above. (Respondent Exhibit 1A).

64. Finding #3 is based on an interview with Ms. Pullen and is identical to Finding #3 in R 1222 as addressed above.

Prefix Tag R 709; Inspections and Investigations

65. The first of three deficiencies not indicated to be a violation upon which revocation was based was Prefix Tag R 709, an allegation that DCC violated Rule 290-2-5-.07(d). Ms. Howard determined that DCC failed to allow access to its books, records, papers, or other information related to conducting an investigation. In support of her conclusion, she made two findings. (Testimony of Ms. Howard; Respondent Exhibit 1A).

66. The first finding is related to general allegations over the course of Ms. Howard's investigation. Ms. Howard notified DCC via telephone on January 21, 2010 at 11:46 a.m. that she would need specific documents including the medication logs for eleven residents for the month of January. Ms. Howard then arrived at DCC at 2:30 p.m.; however, the documents were not made available until 5:00 p.m. Ms. Howard testified that per her training and office policy, it is standard procedure to allow a facility no more than thirty (30) minutes to produce the requested documentation. Ms. Howard indicated that the policy is in place to prevent facilities from falsifying documentation. (Testimony of Nikiya Howard; Respondent Exhibit 1A).

67. Prior to the onsite visit on January 21, 2010, Ms. Howard notified DCC via email on January 15, 2010 to provide her by close of business on January 18, 2010, the names and contact information of staff working the night of the January 4, 2010 incident. Ms. Howard received the

requested information at 5:15 p.m. on January 19, 2010. (Testimony of Nikiya Howard, Exhibit R-1A).

68. Subsequently, Ms. Howard notified the facility on January 20, 2010 via email of her inability to contact staff members that DCC indicated were working on January 4, 2010 and requested alternate telephone numbers. Ms. Howard indicated that on January 22 and 25, 2010, DCC was notified via telephone and email of her inability to contact staff and once again requested alternate contact numbers. Ms. Howard requested that she be contacted by staff by January 25, 2010. Ms. Howard further stated that contact was made with staff on January 27, 2010 when Ms. Howard contacted the staff at the facility. (Testimony of Nikiya Howard, Exhibit R-1A).

69. Upon Ms. Howard's arrival on January 21, 2010, there were investigators from at least four other County and State agencies who already had possession of the documents requested by Ms. Howard. Those agencies were unwilling to release them for Ms. Howard's review until they had completed their review. Once the other agencies completed their review of the records in question, DCC immediately turned them over to Ms. Howard for inspection. (Testimony of Cindy Downing).

70. With respect to the telephone numbers requested, it is undisputed that the phone numbers possessed by Downing Clark Center, Inc. were turned over to Ms. Howard in a timely fashion and there is no evidence that the telephone numbers supplied were misleading in any fashion. (Testimony of Cindy Downing).

Prefix Tags R 1827 and 1829: Physical Plant and Safety

71. The second and third deficiencies not indicated to be a violation upon which revocation was based was Prefix Tag R 1827, are allegations that DCC violated Rule 290-2-5-.18(7) by failing to maintain the walls in good repair and Rule 290-2-5-.18(9) by failing to keep its facility free of hazards and safety citing two broken wooden benches. ORCC presented no evidence regarding this allegation. (Record as a whole).

III. Conclusions of Law

1. The Rules and Regulations for Child Caring Institutions, Chapter 290-2-5, in general, define a child caring institution as any facility providing full-time care for children through 18 years of age outside of their homes. A licensed child caring institution is responsible for providing the degree of supervision indicated by a child's age, developmental level, physical, emotional and social needs. Full-time care is referred to as room, board, and watchful oversight. Ga. Comp. R. & Regs. r. 290-2-5-.03(e).

2. Prefix Tag R 801, the first deficiency supporting revocation alleged in the January 21, 2010 survey, was alleged as a violation of Ga. R. & Regs. r. 290-2-5-.08 (2) Administration and Organization.

> "Program Description and Implementation. In accordance with these rules and regulations, a licensed child caring institution shall develop, implement and

> comply with written policies and procedures that describe the range of services including room, board and watchful oversight and the manner in which such services will be provided by the facility. Such policies and procedures shall describe how identified services will be provided, the specific emergency safety intervention plan, including the emergency safety interventions, that will be used, and how such services will be assessed and evaluated. A program description must show what services are provided directly by the facility and how it will coordinate its services with those provided by any Medicaid rehabilitation option provider or other available community or contract resources."

Ga. Comp. R. & Regs., r. 290-2-5-.08 (2) (2010).

ORCC's conclusion that DCC failed to comply with DCC's written policies and procedures in eleven files that Ms. Howard reviewed is based on nine factual allegations, the first two of which identify DCC's own procedures that it has purportedly violated.

The third finding is supported by a record review that noted a failure to record documentation on medical logs and/or in the files for residents identified. In the absence of such documentation, there is a reasonable presumption that the medication was not administered and thus that the physician was not notified of dosage errors and/or medication discrepancies. However, it only raises a presumption. DCC presented credible testimony rebutting that presumption and ORCC failed to present persuasive evidence to the contrary. Accordingly, while DCC's action constituted an administrative failure to record documentation as required by its policies, it did not constitute a failure to notify a physician of dosage errors and/or medication discrepancies as alleged. This violation constitutes a Category III violation within the context of ORCC's enforcement matrix (See Exhibit 2).

The failure to document prescription dates for identified residents identified as Finding 4 is not established as a violation. While DCC policy requires that the prescription be recorded, it does not specify a time when such documentation must occur. Inasmuch as DCC's policy of utilizing medical log records provided by its pharmacy on a monthly basis is reasonable in the absence of medical evidence to the contrary, this finding does not support a violation.

Utilization of check marks rather than initials asserted in Finding #5 is a technical violation of ORCC's procedures. While reasonably explained to indicate that no harm occurred, it constitutes a Category III violation as an administrative rule violation.

The fifth finding, like the third finding, is based in part on a record review and a reasonable presumption that in the absence of notation in the medical logs and/or the resident's record that the psychotropic drugs were not administered, and that the psychotropic needs of the identified residents were not met. Beyond that presumption, the finding is based on a review of the SRBWO plans for the residents by a non-medically trained reviewer. Dr. Laipple, the only witness qualified as medical expert clearly refuted the reviewer's extrapolation of this conclusion from the SRBWO plans that she reviewed in conjunction with the medical log reviews. The overwhelming weight of testimony presented rebuts the presumption that they were not administered. Accordingly, this finding does not support a rule violation.

While the seventh and eight findings were admissible for establishing the reviewer's course of conduct, they are hearsay and inadmissible for the truth of the matters asserted since the witnesses were not present to give testimony. Even in the absence of objection, hearsay is without probative value to establish any fact. Finch v. Caldwell, 155 Ga. App.813 (1980).

The eighth finding is consistent with DCC policy and alleges no violation.

In conclusion, ORCC's determination that DCC violated Ga. Comp. R. & Regs., r. 290-2-5-.08 (2) supports two Category III administrative rule violations: a failure to document the medical/log and or resident's record and a failure to utilize initials on the records indicated. However, neither of these violations was shown to have a direct adverse effect on the health and safety of children in DCC's care.

3. Prefix Tag R 840, the second deficiency supporting revocation alleged in the January 21, 2010 survey, was alleged as a violation of Ga. R. & Regs. r. 290-2-5-.08 (6) relating to Staffing, also under the category of Administration and Organization.

> "Staffing. The institution shall have sufficient numbers of qualified and trained staff as required by these rules to provide for the needs, care, protection, supervision and room, board and watchful oversight of children. All staff and volunteers shall be supervised to ensure that assigned duties are performed adequately and to protect the health, safety and well-being of the children in care."

Ga. Comp. R. & Regs. r. 290-2-5-.08 (6) (2010)

ORCC concluded that DCC failed to ensure that there was a sufficient number of qualified and trained staff to provide for the needs, care, protection and supervision of children. Eight findings were alleged to support the conclusion, Findings 1 through 5 are presented to support a determination that DCC failed to have sufficient number of staff to provide for the supervision of children and Findings 6 through 8 are presented to support a determination that DCC failed to supervise residents to protect the health, safety, and well-being of children in care.

Finding #1 recites a police report that reveals a major disturbance at DCC on January 4, 2010 that led to the arrest of approximately 20 children entrusted to DCC by DFCS. Charges included rioting, criminal damage to property, and assaulting officers.

Finding #2 is based on interviews with officers who participated in police action on January 4, 2010. Ms. Howard made several conclusions that were not supported by a preponderance of the evidence presented in this matter. All conclusions reached within the finding were rebutted and no other evidence supporting a contrary conclusion was presented. Once the police assumed control, the chaos described erupted and DCC staff could no longer intervene upon police directive despite pleas to do so.

Finding #3 is based on inadmissible hearsay. Finch v. Caldwell, 155 Ga. App.813 (1980).

Finding #4 is based on video footage regarding occurrences from 7:55 p.m. to 10:20 p.m. that was not presented as evidence. That footage is the best evidence of the factual assertion and Ms. Howard's statements have little or no probative value in its absence other than to show her course of conduct.

Finding #5 references a shift report dated 1/4/10 for the 7 p.m. to 7 a.m. shift that ORCC did not tender as an exhibit and no witness who observed the facts alleged therein so confirmed the finding made.

Even though ORCC has no specific staffing requirements, ORCC licensed DCC to care for up to 72 consumers. Further, DFCS, who routinely placed residents with DCC until the incident on January 4, has contractual requirements regarding staffing. At all pertinent times, DCC met these requirements. A preponderance of the evidence does not support a conclusion that DCC failed to have sufficient number of staff to provide for the supervision of the children.

Finding #6 references a record that ORCC did not tender as an exhibit and no witness was presented.

Finding #7 alleges matters that are not established by witnesses who observed the occurrences or by other documentation.

Finding #8 references a record that ORCC did not tender as an exhibit or present any witness to the matters asserted.

In summary, ORCC's determination that DCC violated Ga. Comp. R. & Regs., r. 290-2-5-.08 (6) is not supported.

4. Prefix Tag R 905, the third deficiency supporting revocation alleged in the January 21, 2010 survey, was alleged as a violation of Ga. R. & Regs. r. 290-2-5-.09 (2) relating to Admissions, under the category of Referral and Admissions.

> "Admissions. An institution shall only admit children whose known needs can be met by the institution based on preplacement assessment, planning and room, board and watchful oversight capacity."

Ga. Comp. R. & Regs., r. 290-2-5-.09 (2) (2010).

ORCC concluded that DCC failed to admit children whose known needs could be met by DCC. In support of this conclusion, the reviewer made three findings.

Finding #1 is based on the testimony of Joseph Daugherty, one of three staff members interviewed. While Mr. Daugherty opined that he disagreed with admissions on occasions, the value of his testimony was diminished by his inability to specify residents to whom he referred. Moreover, he acknowledged that he was one of three individuals making admission decisions.

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DCC rebutted his testimony with that of Ms. Downing who described a reasonable and detailed process of admissions designed to meet admission requirements.

Findings #2 and #3 are entirely based on inadmissible hearsay in the absence of testimony from the staff members identified. Finch v. Caldwell, 155 Ga. App.813 (1980).

ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-5-.09 (2) is not supported by a preponderance of the evidence presented.

5. Prefix Tag R 1219, the fourth deficiency supporting revocation alleged in the January 21, 2010 survey, was alleged as a violation of Ga. R. & Regs. r. 290-2-5-.12(3)(d)(3), psychotropic medication under the sub-category of Health Services.

> "Psychotropic medications. No child shall be given psychotropic medications unless use is in accordance with the goals and objectives of the child's service plan developed by an external physician and/or MRO provider."

Ga. Comp. R. & Reg. r. 290-2-5-.12(3)(d)(3)(2010).

ORCC determined that DCC failed to administer resident's psychotropic medications in accordance with goals and objectives on the child's service plan in seven resident files reviewed. Finding 1 relating to prescriptions of psychotropic medications comparing medication logs to SRBWO plans is refuted by the testimony of Dr. Laipple, whose testimony as a medical professional supercedes that of Ms. Howard or her superiors as lay persons in such matters. The admission against interest made by Cindy Downing cited in Finding #2 is credibly refuted by Ms. Downing who admitted acknowledging only that these were the reviewer's findings, not that she agreed with the truth of the matter asserted.

ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-5-.12(3)(d)(3) is not supported by a preponderance of the evidence presented.

6. Prefix Tag R 1222, the fifth deficiency supporting revocation alleged in the January 21, 2010 survey, was alleged as a violation of Ga. R. & Regs. r. 290-2-5-.12(3)(d)(3)(iii) psychotropic medication under the sub-category of Health Services.

> "The external prescribing physician and/or MRO provider shall be notified in cases of dosage errors, drug reactions, or if the psychotropic medication does not appear to be effective."

Ga. Comp. R. & Regs., r. 290-2-5-.12(3)(d)(3)(iii)(2010).

Inasmuch as it has already been established that a preponderance of the evidence demonstrates that there were no dosing errors to report to prescribing physicians, Findings 1 and 2 are effectively refuted.

Findings 3 and 4 are based on inadmissible hearsay in the absence of the residents or staff identified as witnesses at the hearings. Finch v. Caldwell, 155 Ga. App.813 (1980).

ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-5-.12(3)(d)(3)(iii) is not supported by a preponderance of the evidence presented.

7. Prefix Tag R 1224, the sixth deficiency supporting revocation alleged in the January 21, 2010 survey, was alleged as a violation of Ga. R. & Regs. r. 290-2-5-.12(3)(d)(5) a category under Child Care Services rather than under Health Care Services as identified on the survey.

> "An institution shall maintain a record of all medications handed out by authorized staff and taken by children to include: name of child taking medication, name of prescribing physician and date of prescription (if the medication is prescription or psychotropic), required dosage, date and time taken, dosage taken, and name and signature of staff member that handed out and supervised the taking of the medication."

Ga. Comp. R. & Regs., r. 290-2-6-.12(3)(d)(5)(2010).

A preponderance of the evidence supports a conclusion that DCC maintains such a record. Specific administrative violations of DCC policy with regard to how this record is to be maintained, i. e. recording it on the medical log and/or the patient's record, are indicated above in the second Conclusion of Law that determined two Category III violations.

ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-6-12(3)(d)(5)is not supported by a preponderance of the evidence presented.

8. Not cited as a basis for revocation, Prefix Tag R 709 alleges a failure to allow access to the books, records, papers, or other information related to conducting an investigation as a violation of Ga. Comp. R. & Regs., r. 290-2-5-.07 (d) under the general heading of Inspections and Investigations.

> "Failure to Allow Access. Failure to allow access of the department's representative to the institution, its staff, or the children receiving care at the institution or the books, records, papers, or other information related to initial or continued licensing, or failure to cooperate with a departmental inspection or investigation shall constitute good cause for the denial, restriction, revocation or suspension of a license, or other penalty as provided by law."

Ga. Comp. R. & Regs., r. 290-2-5-.07 (d)(2010).

In light of exigent circumstances supporting the reasonableness of the delay indicated in the reviewer's findings, ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-5-.07(d) is not supported by a preponderance of the evidence presented.

9. Also not cited as a basis for revocation, Prefix Tag R 1827 alleges a violation of Ga. Comp. R. & Regs. 290-2-5-.18(7) relating to ceilings and walls within the context of the category of Physical Plant and Safety.

> "Ceilings and Walls. All ceilings shall be at least seven (7) feet in height. Ceiling and walls shall be of good repair."

Ga. Comp. R. & Regs. r 290-2-5-.18 (9) (2010).

The findings reference a single hole of unspecified dimensions observed one day after the conclusion of the police investigation that began on January 4 and ended on January 5. The simple observation of a hole without more is insufficient to conclude that DCC is not compliant with this requirement.

ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-5-.18(7) is not supported by a preponderance of the evidence presented.

10. Prefix Tag R 1827 alleges a violation of Ga. Comp. R. & Regs. 290-2-5-.18(9) relating to physical hazard within the context of the category of Physical Plant and Safety.

> "The institution shall be kept clean and free of hazards to health and safety and of debris and pests."

Ga. Comp. R. & Regs. r 290-2-5-.18 (9) (2010).

The findings reference two broken wooden benches observed on January 6, 2010 that were being removed. The simple observation of two broken benches without more is insufficient to conclude that DCC is not compliant with this requirement.

ORCC's determination that DCC violated Ga. R. & Reg. r. 290-2-5-.18(7) is not supported by a preponderance of the evidence presented.

11. In a license revocation action, the agency has the burden of proof on all matters asserted and the licensee has the burden for any affirmative defenses. Ga. Comp. R. & Regs. r. 616-1-2-.07(1)(a) (2004). The evidentiary standard is a preponderance of the evidence presented. Ga. Comp. R. & Regs. r. 616-1-2-.21(2004). After review of matters alleged by ORCC and defenses asserted by DCC, a preponderance of the evidence presented supports only two Category III violations of Ga. Comp. R. & Regs., r. 290-2-5-.08 (2): two administrative rule violations being (1) a failure to document the medical/log and or resident's record and (2) a failure to utilize initials on the records indicated. With regard to these two violations, the record does not demonstrate a direct adverse effect on the health and safety of children in DCC's care.

12. ORCC is authorized to impose appropriate sanctions against licensees that fail to comply with the requirements set forth in the Rules and Regulations for Child Caring Institutions. O.C.G.A. §49-2-17; Ga. Comp. R.& Regs. r. 290-1-6-.05. These sanctions include imposition of fine, public reprimand, limitation or restriction of a license, suspension of license, prohibition of

persons in control, revocation of license, denial of application or renewal of license, emergency relocation of residents, and placement of a monitor. Ga. Comp. R.& Regs. r. 290-1-6-.06.

13. Category III ($50 to $300 per violation per day) denotes "violations which indirectly or over a period of time has or is likely to have an adverse effect on the physical health of person or persons in care or violation of administrative, reporting, or notice requirements. Ga. Comp. R.& Regs. r. 290-1-6-.06(1)(iii).

14. Multiple violations resulting from the same act, omission, incident, circumstance, or conduct, are not charged per violation but are charged at the highest category for which a violation is cited as a result of that act, omission, incident, circumstance of conduct." Ga. Comp. R.& Regs. r. 290-1-6-.06(2). ORCC utilizes a matrix that for repeat Category III violations indicates a plan of correction, plus a fine at the highest allowable daily rate per violation, and consideration of other sanction options. (See Respondent Exhibit 2).

IV. Decison

ORCC's adverse action to revoke DCC's licensure is **REVERSED**; however, inasmuch as two Category III administrative rule violations of Ga. Comp. R. & Regs. r. 290-2-5-.08 (2) are determined (a failure to document the medical/log and or resident's record and a failure to utilize initials on the records indicated), it is necessary to determine an appropriate monetary fine in light of prior violations of the same rule.

ORCC is directed to calculate an appropriate monetary fine as allowed under it rules and to allow DCC to submit a plan of correction for the two Category III violations determined. Upon notification of the amount of the fine, DCC shall either pay the monetary fine assessed or request a new hearing solely on the basis of the monetary fine that ORCC calculates.

In light of the confidential nature of some of the evidence presented in this matter, the hearing record shall remain sealed.

SO ORDERED, this 23rd day of September 2010.

Steven W. Teate
Administrative Law Judge

OFFICE OF STATE ADMINISTRATIVE HEARINGS

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