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OFFICE OF ADMINISTRATIVE HEARINGS
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STATE OF NORTH CAROLINA

COUNTY OF CUMBERLAND

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
19 DHR 03768

Arimeta Portee (Sunrise Residential Care) Petitioner, v. NC Department of Health Service Regulation Respondent.	**FINAL DECISION**

THIS MATTER came for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on March 6, 2020, in the Old Cumberland County Courthouse in Fayetteville, North Carolina.

APPEARANCES

For Petitioner: Arimeta Portee
Sunrise Residential Care
5227 Old Railroad Way
Hope Mills, NC 28348

For Respondent: Candace Hoffman
Assistant Attorney General
North Carolina Department of Justice
Post Office Box 629
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ISSUE

Whether the Agency ordered Petitioner to pay a fine or civil penalty and failed to use proper procedure when it, by letter dated May 31, 2019, notified Petitioner that Respondent was imposing a Revocation of License.

APPLICABLE LAW

N.C. Gen. Stat. § 122C, Art. 1, 2, 3 & 3A
10A NCAC 27C, 27D, 27E & 27G

EXHIBITS ADMITTED INTO EVIDENCE

Respondent's Exhibits 1-6 were admitted into the record.

WITNESSES

For Petitioner:	Arimeta Portee Zennetta Portee
For Respondent:	Arimeta Portee Michiele Elliott Claudony Joseph Keith Hines Lisa Carpenter Emily Jones

BASED UPON careful consideration of the sworn testimony of witnesses presented at the hearing, documents received and admitted into evidence, and the entire record in this proceeding, the Undersigned makes the following 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 interest, bias, or prejudice the witness may have; the opportunity of the witness to see, hear, know, and remember the facts or occurrences about which the witness testified; whether the testimony of the witness is reasonable; and whether such testimony is consistent with all other believable evidence in the case.

FINDINGS OF FACT

Parties/Witnesses

1. The Mental Health Licensure and Certification Section of the Division of Health Service Regulation ("Respondent") inspects and licenses mental health facilities in North Carolina. Respondent conducts annual surveys of mental health facilities and conducts complaint investigations and follow-up surveys at mental health facilities as needed.

2. At all times relevant to this matter, Petitioner Arimeta Portee was the owner of a mental health facility known as Sunrise Residential Care. According to Ms. Portee, prior to opening this facility, she had been providing foster care for children for thirty-five years, primarily in New York. (T. p. 13)

3. Michiele Elliott is the Acting Chief of the Mental Health Licensure and Certification Section of the Division of Health Service Regulation. Ms. Elliott has been a registered nurse since 1989 and has worked at the Division of Health Services since 2000. As Acting Chief, Ms. Elliott is responsible for the operations of the section on a day-to-day basis. (T. p 52)

4. Sergeant Claudony Joseph is a sergeant over the patrol division of the Hope Mills Police Department. As a sergeant, he directs patrol officers and gives them assistance when they require it. He is familiar with Sunrise Residential and with Ms. Portee. (T. p. 68-69)

5. Keith Hines was the Qualified Professional at Sunrise Residential. He worked at Sunrise Residential for approximately six months. As part of his duties, he wrote notes on the consumers in the facility and made sure the facility ran on a daily basis. (T. pp. 77-78)

6. Lisa Carpenter was the House Manager at Sunrise Residential. She worked at the facility for only approximately one month. The duties of a house manager include scheduling appointments for clients, taking clients to those appointments, ensuring there was food in the house, and making sure the house was clean. (T. pp. 88-89)

7. Emily Jones is a facility compliance consultant with the Mental Health Licensure and Certification Section of the Division of Health Service Regulation. She has been with the Agency since 2007. She was known as Emily Stanley at the time of the survey. (T. p. 95)

8. As part of her duties as a facility compliance consultant, Mr. Jones surveys mental health facilities in the South Coastal Region of North Carolina. When conducting a survey, Ms. Jones will observe, conduct record reviews, and conduct interviews. (T. p. 96)

9. Zennetta Portee is the daughter of Ms. Portee. She operates an unlicensed boarding home about thirty minutes away from Sunrise Residential. (T. p. 199)

Background

10. At all times relevant to this matter, Respondent licensed Sunrise Residential Care, LLC to operate a mental health facility known as Sunrise Residential Care ("the Facility"), license number MHL 026-939, located at 5227 Old Railroad Way, Hope Mills, North Carolina.

11. The Facility was licensed to provide Supervised Living for Persons with Mental Illness pursuant to 10A NCAC 27G .5600A. A ".5600A" facility is a home-like setting for up to six people to provide structure and support to people who have mental illness, substance abuse issues, or a combination thereof, that impact their ability to negotiate their lives effectively. The facility is supposed to provide supervision twenty-four hours a day seven days a week. (T. pp. 52-53)

12. Petitioner acknowledged that it is her responsibility to be knowledgeable and comply with all the mental health statutes and rules. (T. p. 14)

13. On April 18, 2019, Ms. Jones conducted an annual, complaint, and follow-up survey at the Facility. During the survey, Ms. Jones interviewed staff, residents, and officers from

the local police department, as well as reviewed records including client records, facility records, staff notes, a staff communication log, and police records. (R. Ex. 3)

14. Based on record reviews and interviews, Ms. Jones concluded that the facility failed to develop and implement strategies based on assessment affecting two of ten clients and failed to develop a treatment plan for three of ten clients. (R. Ex. 3 p. 2)

15. Clients that live in a .5600A facility should have a treatment plan completed within thirty days after admission and updated annually. These treatment plans will usually list goals and strategies for the staff of certain particular behaviors of the client. (T. p. 99)

16. Ms. Jones found that the treatment plan had expired for Client #1 and there were no treatment plans for Clients #3 and #7. (T. pp. 99-100; R. Ex. 3 p. 2)

17. Ms. Jones found that the treatment plans for Client #6 and Client #8 did not address the eloping behaviors of those particular clients. Without specifically addressing those issues in the treatment plans, staff would not know how to address this particular behavior and how to implement strategies to help these particular clients with this behavior. (T. p. 100; R. Ex. 3 p. 3)

18. Petitioner informed Ms. Jones that the Department of Social Services was the one that completed the treatment plans for those particular clients. (T. p. 101; R. Ex. 3 p. 3) In Ms. Jones' experience she had never heard of the Department of Social Services completing treatment plans.

19. To work with clients in a group home, one needs to be trained on the client's individual treatment plans to know how best to serve them. Petitioner never provided any client-specific training to Mr. Hines or Ms. Carpenter. (T. pp. 85, 89)

20. Mr. Hines, the QP, was never asked to update treatment plans to address new behavior for clients, such as eloping. (T. p. 79) When interviewed, he stated that the Petitioner handled the treatment plans for the clients and that was not part of his job duties. (R. Ex. 3 p. 3)

21. The Facility never had a treatment team meeting during the time Mr. Hines worked there. Petitioner offered no evidence that there had ever been treatment team meetings. (T. p. 82)

22. This deficiency has been cited four times since July 8, 2016. (R. Ex. 3 p. 4)

23. Based on record review and interviews, the facility failed to ensure client records were maintained for two of ten clients. (R. Ex. 3 p. 5)

24. During the survey, Ms. Jones asked Petitioner several times for client records for Client #9 and Client #10. These records were not provided. (T. p. 102)

25. Petitioner claimed she told Ms. Jones that she had a key to unlock a cabinet with the client records, but that Ms. Jones denied her a chance to get the key. (T. p. 32) According to

Ms. Jones, Petitioner did not ask her for the opportunity to get the key, and, if she had, she would have allowed Petitioner to get the client records for her. (T. p. 102)

26. Petitioner instead gave Ms. Jones a typed statement regarding Client #9 and Client #10, which Petitioner contends is a discharge record. This statement was not sufficient as a discharge record as it did not explain the purpose or reasoning of the discharge. (T. p. 102)

27. Petitioner informed Ms. Jones that Client #9 and Client #10 had been discharged from the facility a year before Ms. Jones arrived. Through her investigation, Ms. Jones found this not to be true. (T. p. 103)

28. This deficiency constitutes a re-cited deficiency. (R. Ex. 3 p. 7)

29. Based on record review and interviews, Ms. Jones concluded that the facility failed to have fire and disaster drills held at least quarterly and repeated on every shift. (R. Ex. 3 p. 8)

30. Ms. Jones asked for documentation of these drills being completed but did not receive sufficient documentation. There were several shifts where there was no documentation of these drills being completed. (T. p. 104)

31. Ms. Carpenter did not see or witness any fire or disaster drills taking place while she worked at the Facility. (T. p. 90)

32. Based on record reviews and interviews, Ms. Jones concluded that the facility failed to provide supervision to ensure the safety and welfare of six of ten clients. (R. Ex. 3 p. 10)

33. Petitioner testified that she is at the Facility all the time with the staff. (T. p. 24) Petitioner was not present at the Facility during Mr. Hines' shift, and she was not at the Facility at all times. (T. p. 78)

34. During her job interview, Ms. Carpenter was asked by Petitioner to stay at the Facility and supervise the clients while Petitioner left the Facility. Ms. Carpenter had received no training from Petitioner before being asked to care for the clients. (T. p. 88)

35. Ms. Jones found there was not adequate supervision for the behaviors of Client #6 and Client #8 who had eloping behaviors, aggressive behaviors and showed no progress towards completing their goals according to notes from the Qualified Professional. (T. p. 105)

36. Petitioner testified that every time one of the residents eloped that a staff member would go after them. (T. p. 24)

37. Neither Mr. Hines nor Ms. Carpenter saw Petitioner put any measures in place to prevent the clients from eloping from the Facility. (T. p. 80, 90)

38. Ms. Jones received several police reports from the Hope Mills Police Department that showed approximately thirty-nine calls to the police from April 2018 until the time of the survey. (T. p. 105) (R. Ex. 2)

39. Petitioner would at times call Officer Joseph and report that her residents had run away and within the community. (T. p. 69)

40. When the residents were found outside of the Facility by police officers, the officers would often bring them back to the facility and call Petitioner to meet them. (T. p. 73)

41. Officer Joseph witnessed residents out in the community without staff present, "too many times to count." Of all those times, Officer Joseph only witnessed Facility staff following a resident who had eloped twice, and on one of those occasions the staff member simply stopped following the eloped resident. (T. pp. 71-72)

42. Officer Joseph was familiar with one of the residents in particular because the station would receive calls about a suspicious person walking around. This resident would walk through yards, walk up to garages, and knock on doors. One time, this resident was almost shot by an off-duty police officer. (T. p. 72)

43. One of Officer Joseph's fellow officers documented a report of another resident who was found in the roadway with a head injury and heat exhaustion. (T. p. 74; R. Ex. 2 p. 22) Neither Petitioner nor any Facility staff were present at the time. (T. p. 75)

44. The Hope Mills Police Department compiled several Incident Investigation reports on the Facility. Twelve investigative reports from various officer concerning interactions between the residents and the community are included in Respondent's Exhibit 2. (T. p. 71; R. , Ex. 2)

45. Petitioner disagreed with the testimony of Officer Joseph. Petitioner initially told Ms. Jones that no staff from the facility had called the police, but instead it was neighbors calling the police. Ms. Jones did not find that to be true, and it is not in accord with the official police reports. (T. p. 106)

46. According to Petitioner, the Facility had called police, but not thirty-nine times. Petitioner claimed that a neighbor who she believed to be a police man was the one calling the police, despite the fact that Petitioner's name and the name of one of her staff members were listed multiple times on the police call log as the caller. Petitioner does not believe the police call log is correct. (T. pp. 15-18)

47. Petitioner further testified that a police Incident Investigation report that listed herself as the reporting person was incorrect. (T. p. 22)

48. Based on record reviews, observations and interviews, Ms. Jones concluded that the facility failed to ensure that medications for administration at the facility were packaged and labeled as required for Client #7. (R. Ex. 3 p. 25)

49. Petitioner informed Ms. Jones that she did not have a Medication Administration Record ("MAR") for Client #7 because he received his medication from Veterans Affairs (V.A.). She told Ms. Jones that the V.A. sent the medication for two weeks at a time already placed in pill containers. (R. Ex. 3 p. 26)

50. Ms. Jones found that Client #7 did not have a MAR and his pills were in a plastic pill container without any sort of labeling. There was no way for Ms. Jones to be able to tell what pills were in the container. If the pills were to be spilled for any reason, there would be no way to identify each medication. Should another resident take the pills, there could be serious adverse reactions. (T. pp. 107-108)

51. The V.A. generally sends medications in prescription bottles or sometimes in blister packs. It would be a violation of pharmacy law to send medications through the mail in a pill planner. In Ms. Elliot's thirty year of experience, she has never seen the V.A. use plastic pill containers like the ones used by Petitioner. (T. p. 59)

52. Based on record reviews, observation and interviews, Ms. Jones concluded that the facility failed to administer medications on the written order of a physician and failed to keep the MARs current for three of three clients audited. (R. Ex. 3 p. 28)

53. Client #2's MARs were not transcribed with a physician order for Zyprexa that was supposed to be given orally every morning. Ms. Jones was not able to tell if that medication had been administered to Client #2. Client #6's MARs had not been transcribed with an order for Clozapine and Flonase. Ms. Jones also did not observe Clozapine in Client #6's medication box. There was no MAR available for Client #7. (T. p. 109-110)

54. Clint #6 had diagnoses which included severe psychosis, and Clozapine is an anti-psychotic drug. In order for Client #6 to remain stable and have relief from the symptoms of his psychosis he needed to receive this medication. (T. p. 58)

55. Documentation of medication administration is critical because it is the only way for the provider, the licensee, the surveyor, and the physician to know that the medication has been administered as ordered. If the records are not accurate it places the client in extremely dangerous situations. It is especially problematic with someone with serious and persistent mental illness because oftentimes they present at the emergency room or to a doctor with active symptoms. If a treating physician looks at the MAR and sees that the patient is already on Clozapine, then he or she may make the assumption that the medication is not working when actually the client is simply not receiving it. (T. p. 58)

56. Petitioner informed Ms. Jones that she did not have a MAR for Client #7 because he received his medication from Veteran's Affairs (V.A.). (R. Ex. 3 p. 30) The V.A. does not send MARs. That is the responsibility of the licensee or their contracted pharmacist. (T. p. 60)

57. This deficiency had been cited before. (T. p. 111)

58. Based on record reviews and interview, Ms. Jones concluded that the facility failed to obtain a drug regimen review for two of three audited clients who received psychotropic drugs. (R. Ex. 3 p. 31)

59. A drug regimen review for clients who receive psychotropic drugs is important to make sure that there will not be any adverse medications with the psychotropic medications and other medications they may be taking. Client #2 and Client #7 did not have drug regimen reviews. (T. p. 111)

60. Based on observation, record review, and interviews, Ms. Jones concluded that the facility failed to ensure that it would serve no more clients than the number for which it is licensed. (R. Ex. 3 p. 34)

61. The facility was licensed for six clients. (R. Ex. 3 p. 34). When Ms. Jones visited the facility there were approximately ten clients at the facility. There were also ten beds in the facility. This was a re-cited deficiency. (T. p. 112).

62. There were more than six clients living in the facility when Ms. Carpenter worked there. (T. p. 89)

63. Petitioner told Mr. Hines that she had concealed that more than six clients lived at the Facility. (T. p. 79) She told him that during a previous audit, she took the excess clients out of the back of the Facility and took them to either the home of a staff member or to her daughter's unlicensed boarding home. (T. p. 80)

64. Petitioner claimed that two to the clients were living in her daughter's unlicensed boarding home. No discharge paperwork was shown to Ms. Jones. (T. pp. 41, 65)

65. Discharge procedure involves contacting the LME/MCO and working with care coordinators and guardians to assess the client's readiness to move and help them by developing skills to be ready to be independent. (T. p. 65) The Petitioner has a duty to follow clients who are discharged to make sure they are safe, and Petitioner failed to do that.

66. The money for the boarding home goes through Petitioner. Even money for former clients who are living at the boarding house goes through Petitioner. (T. p. 202)

67. Based on record reviews and interviews, Ms. Jones concluded that the facility failed to document their response to Level 1 incidents. (R. Ex. 3 p. 44)

68. Facilities are required to report Level one incidents. They must also complete a quarterly report to their MCO. (T. p. 114; R. Ex. 6) Ms. Jones review of the facility records from August 2018 to the date of the survey revealed no incident report documentation. (R. Ex. 3 p. 44)

69. Based on record reviews and interviews, Ms. Jones concluded that the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. (R. Ex. 3 p.46)

70. Providers must document Level two incidents to the MCO within 72 hours. For Level two, any absence that requires police contact must be reported to the LME. There was no documentation that Level two incidents had been reported for any of the calls to the police station. Ms. Jones was only able to find one incident report. (T. pp. 115, 117; R. Ex. 6)

71. Based on record reviews and interview, Ms. Jones concluded that the facility failed to ensure three of six audited staff received annual training updates in alternatives to restrictive interventions. (R. Ex. 3 p. 51)

72. Staff are required to be trained upon hire and annually to learn how to de-escalate clients. The personnel records provided to Ms. Jones did not have updated trainings in them. Ms. Jones never received documentation from Petitioner that showed the staff had received this training. (T. pp. 118-119)

73. Based on record reviews and interviews, Ms. Jones concluded that the facility failed to ensure three of six audited staff received annual training updates in seclusion, physical restraint, and isolation time-out. (R. Ex. 3 p. 56)

74. Staff are required upon hire to have training in restrictive interventions, as well as annual updates and training in restrictive interventions. From the staff records provided to Ms. Jones, there was no updated trainings for those three staff members. (T. pp. 119-120)

75. According to Mr. Hines, he did not receive any training as part of his job, nor did Petitioner ever ask him for any proof of training. This includes but is not limited to training on alternatives to restrictive interventions and training in seclusion, physical restraints and isolation time-out. (T. p. 78)

76. Based on record review, observation and interviews, Ms. Jones concluded that client bedrooms failed to meet the 160-square foot minimum for double occupancy rooms. (R. Ex. 3 pp. 57-58)

77. A Facility is required to have a certain amount of square feet in a bedroom for more than one individual to live in that bedroom. (T. p. 120) The facility was licensed for a capacity of one client in each upper floor bedroom and two clients in each lower bedroom. Ms. Jones observed two beds in each room on the upper floors, two beds in the master bedroom, and two beds in each of the two rooms in the enclosed garage area. (R. Ex. 3 p. 58) The rooms did not allow sufficient area to serve two clients in each room.

78. Based on record reviews, interviews and observations, Ms. Jones concluded that the facility failed to meet the scope of the license, and the facility failed to provide supervised living in a 24-hour facility which provides residential services to individuals who have a mental illness and/or other disabilities and who require supervision when in the residence. (R. Ex. 3 p. 37)

79. The systemic failures of the facility included failure of the licensee to operate within the scope of the license by providing housing to more than the licensed capacity, failing to have

updated strategies to address behaviors of clients, failure to have staff supervision to meet the needs of the clients, failure to have trained staff, failure to provide medications as ordered including drug regimen reviews and failure to assess and document incident reporting including failure to determine cause and implement corrective actions. (R. Ex. 3 p. 41)

80. At the end of the survey, Ms. Jones generated a Statement of Deficiencies ("SOD") which outlined the rules of each of the citations and her findings. A Type A-1 rule violation was cited for serious neglect. (T. p. 97; R. Ex. 3 p. 41)

81. Respondent Agency found that the Facility had multiple failures across a wide range of rule areas, and there was a failure to provide the care and services for which the Facility was licensed. (T. p. 57) According to Ms. Elliott, the systemic failures collectively, some being repeat citations, could have resulted in several A-1 penalties, but the decision was made to lump the multiple failures under "scope of license" in the Statement of Deficiencies.

82. Ms. Elliott reviewed the Statement of Deficiencies in this matter and believed that the Statement of Deficiencies was written and composed in a manner consistent with Respondent Agency's process. (T. pp. 53-54)

83. Ms. Jones performed this survey in a manner consistent with her standard process and procedures for surveys. At the end of the survey she informed Petitioner of all of the rule areas that were out of compliance. (T. pp. 122-123)

84. Any time a Type A-1, Type A-2, or Type B Administrative Action is issued on-site, a plan of protection is given to the provider to fill out. The plan of protection is a way for Respondent Agency to know the licensee will put an immediate plan of action in place to ensure the clients are protected. Petitioner provided a plan of protection at the end of the survey. (T. pp. 122-23)

85. Ms. Jones gathered all her evidence from the survey into a Non-Disclosure File. (T. p. 98; R. Ex. 1)

86. At the end of a survey, the quality improvement process team at Respondent Agency reviews the evidence from the survey related to deficiencies that are greater than standard deficiencies. The team goes through the evidence to make sure that it warrants a penalty and that it is consistent with how the Section cites deficient practices. This evidence is also reviewed by management. (T. p. 53)

87. On May 2, 2019, Stephanie Gilliam, then-Chief of the Mental Health Licensure & Certification Section, issued a Suspension of Admissions based on the findings from the April 18, 2019, Survey by Respondent. (R. Ex. 5)

88. A Suspension of Admissions was issued due to the survey findings of extensive failure to meet the minimum standards in medications, treatment planning, supervision, care coordination, and the finding that all of that constituted serious neglect. (T. p. 62)

89. Petitioner had an informal appeal with Respondent Agency in Raleigh, North Carolina where she was told that this was her opportunity to share any information with Respondent Agency that might help them understand the situation in a different manner. At this meeting, Petitioner did not provide any corrective actions that demonstrated an ability to come into compliance. She only brought one record with her to the meeting. (T. pp. 62-63, 186)

90. On May 31, 2019, Ms. Gilliam issued a Notice of Revocation of License based on the findings from the April 18, 2019 Survey by Respondent. (R. Ex. 4)

91. After the Notice of Revocation was issued, Petitioner had a second informal appeal with Respondent Agency. Petitioner was unable to provide any operational details about how she was going to achieve compliance, nor did she bring any records with her to the meeting. (T. pp. 64, 187)

92. At the contested case hearing, Petitioner contended that she was not aware that she should bring any documentation to the informal hearings. Her contentions are not credible. Petitioner was specifically asked if she ever gave the agency the information that had been requested to which she ultimately responded "No." (T. pp. 38-40)

93. Throughout the course of the contested case hearing, when asked for documentation to support her contentions, on the occasions when she wanted to show something, Petitioner was told repeatedly by the court that she must first show the documentation to counsel for Respondent. She consistently failed to do that.

94. Despite the fact that Petitioner had never produced the documentation to the agency prior to the hearing, this Tribunal was potentially willing to consider such information, although keenly aware that Respondent had a legitimate objection to any such documentation since it had not previously been produced. Petitioner stated more than once that she had the documentation. (T. p. 9, 35 40, 141, 143, 220) She wanted to give me, the trier of fact, all of the documentation that she had which was considerable and then wanted me to find what I needed in order to refute the contentions of the agency. (T. pp. 220-221).

95. It is not the role of the finder of fact in any trial of any sort to ferret out the information from stacks of documentation in order to prove a litigant's case, even a pro se litigant. To do such is to become that litigant's lawyer, to the detriment of the opposing litigant. This Tribunal tries to help *pro se* litigants to the degree possible, but one has to be careful and not begin representing the *pro se* litigant. A bedrock of our jurisprudence is for both sides in litigation to have an equal and fair opportunity to present their respective cases. The judge must be fair and impartial, not favoring either side. In this contested case, many, many attempts were made to try to direct Petitioner to simply produce any documentation that she desired for me to see and to give it to counsel for agency before I would look at it. Despite the many entreaties, Petitioner did not produce any documentation.

96. Most of Petitioner's contentions that the agency erred and that she disagrees with the allegations and assertions against her and the facility are determined by assessing creditability. Petitioner's testimony and her contentions are not credible.

97. On July 1, 2019, Petitioner timely appealed the Revocation of License by filing a Petition for Contested Case Hearing with the Office of Administrative Hearings.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings (OAH) has jurisdiction over the parties and the subject matter pursuant to Chapters 131D and 150B of the North Carolina General Statutes.

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

3. Petitioner has the burden of proving by a preponderance of the evidence that Respondent has deprived Petitioner of property, ordered her to pay a fine or civil penalty, substantially prejudiced Petitioner's rights and has exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule. N.C. Gen. Stat. § 150B-25.1(a).

4. Respondent has the burden of proving by clear and convincing evidence that the person who was fined actually committed the act for which the fine or penalty was imposed. N.C. Gen. Stat. § 150B-25.1(b).

5. N.C. Gen. Stat. § 122C-1 *et seq*. authorizes Respondent to license, inspect, and regulate mental health facilities in the State of North Carolina.

6. On April 18, 2019, Ms. Jones completed an annual, complaint, and follow-up survey at the Facility. As a result of that survey, Ms. Jones completed a Statement of Deficiencies. (R. Ex. 3)

7. The April 18, 2019, Statement of Deficiencies cited Petitioner for a number of deficiencies which were cross-referenced into one Type A-1 violation of 10A NCAC 27G .5601 Supervised Living – Scope. Petitioner failed to meet the scope of the license for a 24-hour treatment facility which provides residential services to individuals who have a mental illness and/or other disabilities and who require supervision when in the residence. Specifically:

   a. The Facility failed to develop and implement strategies based on assessment affecting Client #6 and Client #8 and failed to develop treatment plans for Client #1, Client #3, and Client #7 as required by 10A NCAC 27G .0205.

   b. The Facility failed to ensure client records were maintained for Client #9 and Client #10 as required by 10A NCAC 27G .0206.

   c. The Facility failed to have fire and disaster drills held at least quarterly and repeated on each shift as required by 10A NCAC 27G .0207.

   d. The Facility failed to provide supervision to ensure the safety and welfare for Client #2, Client #3, Client #4, Client #6, Client #8, Client #10 as required by 10A NCAC 27G .0208.

e. The Facility failed to ensure that medications for administration at the facility were packaged and labeled as required for Client #7's medication as required by 10A NCAC 27G .0209.

f. The Facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting Client #2, Client #6, and Client #7 as required by 10A NCAC 27G .0209.

g. The Facility failed to obtain drug regimen review for Client #2 and Client #7 who received psychotropic drugs as required by 10A NCAC 27G .0209.

h. The Facility failed to ensure that it would serve no more clients than the number for which it is licensed as required by 10A NCAC 27G .0404.

i. The Facility failed to document their response to level I incidents as required by 10A NCAC 27G .0603.

j. The Facility failed to ensure critical incident reports were submitted to the Local Management Entity within 72 hours as required by 10A NCAC 27G .0604.

k. The Facility failed to ensure Staff #2, Staff #3, and the Qualified Professional received annual training updates in alternatives to restrictive interventions as required by 10A NCAC 27G .0107.

l. The Facility failed to ensure Staff #2, Staff #3, and the Qualified Professional received annual training updates in seclusion, physical restraint and isolation time-out as required by 10A NCAC 27G .0108.

m. The Facility failed to meet the 160 square foot minimum for double-occupancy rooms as required by 10A NCAC 27G .0304.

8. Respondent may revoke a license to operate a mental health facility where "the Secretary finds that there has been a substantial failure to comply with any provision of this Article or other applicable statutes or any applicable rule adopted pursuant to these statutes." N.C. Gen. Stat. § 122C-24(a). Respondent shall revoke a license to operate a mental health facility where "such failure to comply endangers the health, safety or welfare of the individuals in the facility." 10A NCAC 27G .0405(d)(3).

9. Respondent is required to give written notice to the licensee of the revocation of its license. The licensee shall then have sixty (60) days to appeal the revocation by filing a Petition for Contested Case Hearing with OAH. If the notice of revocation is appealed within that timeframe, the revocation is automatically suspended until a decision on the revocation is made by OAH. 10A NCAC 27G .0405(d).

10. By certified letter dated May 31, 2019, Respondent notified Petitioner that it was revoking its license to operate the Facility. That action was based on Respondent's finding that Petitioner had "failed to comply with the provisions of North Carolina General Statute"

specifically, Articles 2 and 3 of Chapter 122C of the North Carolina General Statutes. (R. Ex. 4) Respondent's decision was based upon the findings from the April 18, 2019 Survey by Respondent.

11. On July 1, 2019, Petitioner filed a Petition for Contested Case Hearing appealing the notice of revocation. This appeal suspended the revocation of Petitioner's license pursuant to 10A NCAC 27G .0405(d).

12. As concluded above, the violations and deficiencies identified in the April 18, 2019, Survey by Respondent are supported by a preponderance of the evidence. Therefore, Respondent correctly determined that Petitioner has substantially failed to comply with the provisions of Articles 2 and 3 of Chapter 122C of the North Carolina General Statutes.

13. Based on the violations and deficiencies identified during the survey, the undersigned concludes that Petitioner's failure to comply with the licensure statutes and rules endangered the health, safety, and welfare of the residents in the Facility.

14. The preponderance of the evidence supports Respondent's decision to revoke Petitioner's license to operate the Facility pursuant to N.C. Gen. Stat. § 122C-24(a) and Petitioner has failed to meet its burden. Therefore, Respondent did not deprive Petitioner of property; otherwise substantially prejudice Petitioner's rights; exceed its authority or jurisdiction; act erroneously; fail to use proper procedure; act arbitrarily or capriciously; or fail to act as required by rule or law by issuing the notice of revocation on May 31, 2019.

Based on the foregoing Findings of Fact and Conclusions of Law, the Undersigned makes the following:

FINAL DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the undersigned hereby determines that Respondent's decision to revoke Petitioner's license to operate the Facility on May 31, 2019, should be **UPHELD**.

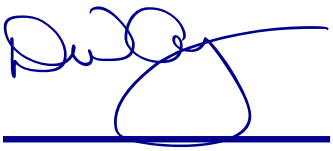
NOTICE OF APPEAL

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

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 the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **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 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties as indicated by 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.

SO ORDERED, this the 13th day of July, 2020.



Donald W Overby
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service:

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Attorney For Respondent

This the 13th day of July, 2020.

Jerrod Godwin
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