BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:	)	
	)	
CHRISTINA ULOFOSHIO	)	OAH No. 10-0274-ALH
d/b/a Graceful Living ALH I, II & III	)	OAH No. 10-0322-ALH
	)	

DECISION

I. INTRODUCTION

Christina Ulofoshio operated three assisted living homes, referred to collectively as Graceful Living. The Division of Public Health, Certification and Licensing (Division) initiated an enforcement action in October of 2009. The parties engaged in mediation and entered into a Memorandum of Agreement in March of 2010. On May 21, 2010, Graceful Living, through its attorney, filed an emergency motion to enforce that agreement. This motion was referred to the Office of Administrative Hearings and assigned OAH Case No. 10-0274-ALH.[1]

Beginning in April of 2010, the Office of Long Term Care Ombudsman (OLTCO) and the Division conducted a joint investigation of Graceful Living Home I. The OLTCO issued a Report of Investigation, and Graceful Living appealed the findings in that report. That appeal was assigned case number 10-0275-ALH. The Division also issued a Report of Investigation and notified Graceful Living that it intended to revoke the license of Home I, deny the renewal of licenses for Homes II and III, and seek the permanent closure of Homes I, II, and III. Graceful Living requested a hearing on that enforcement action, and that case was assigned OAH Case No. 10-0322-ALH.

These three cases were consolidated for hearing, and a hearing was held over a two-week period in November of 2010. There are two agency records in this proceeding: One from the Division, with Bate Stamp numbers 1 through 2859, and a second from OTLCO, Bate Stamped LTCO 1 through LTCO 318. Division exhibits are identified by number, and respondent's exhibits are identified with letters. OLTCO did not have its own exhibits other than the agency record.

This decision addresses OAH Case No. 10-0274-ALH and 10-0322-ALH. There is a separate proposed decision related to the OLTCO complaint. The Division has proven by a preponderance of the evidence that Graceful Living denied a resident access to appropriate and

[1] The Memorandum of Agreement, paragraph 4(e), provides for this referral.

adequate health care. The other allegations have not been proven by a preponderance of the evidence.[2] Sanctions, but not revocation, should be imposed.

II. FACTS

Graceful Living Home I is a licensed Assisted Living Home. R.B. was a 66 year old resident of the home with multiple medical problems. On February 24, 2010, R.B. was seen by a physician, Dr. Michael Mraz, at the Anchorage Neighborhood Health Clinic.[3] The primary reason for that visit was to seek treatment for a decubitus ulcer[4] in the sacral area.[5] Dr. Mraz prescribed an antibiotic and an antibacterial cream. He also prescribed visits from Providence Home Health, a home health care agency, to provide wound care.[6]

Providence Health Care did not provide the prescribed care. Providence Health Care contacted Graceful Living to say they had too many clients and could not treat R.B.[7] On March 3, 2010, Dr. Mraz sent a referral to a different home health agency, Amedisys.[8]

Amedisys opened its file on this referral the next morning, March 4, 2010.[9] According to her own testimony, Sarah Sudtell tried to contact Graceful Living on March 5,[10] two days after Amedisys received the referral. She testified that she was told R.B. had a guardian but Graceful Living would not provide her with the name or contact number for the guardian. This information was needed because Amedisys needed a written release before it could provide treatment. She referred this problem to Amedisys' director, Kali Stern, to obtain that information. According to Ms. Stern, Amedisys contacted the home again on March 8 and did obtain the name and fax number for R.B.'s guardian, though she said she had to place several phone calls to obtain the information.[11]

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2 All of the evidence presented during the consolidated hearing was considered in reaching this decision.

3 Exhibit C.

4 Various witnesses defined decubitus ulcers as 'pressure sores" or "bed sores" that can be caused by lying in one position for extended periods of time. Most witnesses testified that decubitus ulcers were a common problem among elderly residents of assisted living homes and that these sores can be serious and even life-threatening. Physician Assistant Janice Nance testified that developing a decubitus ulcer is not an indication of bad care.

5 The sacrum is a bone at the base of the spine.

6 Exhibit C at 3.

7 Testimony of Christina Ulofoshio; *see also*, Exhibit H.

8 Record at 2372.

9 Division's Record at 2370.

10 March 5, 2010 was a Friday.

11 Mrs. Ulofoshio testified that when Graceful Living was first called, she gave Amedisys the number for the Office of Public Advocacy, which was where his guardian worked. She also said that when Amedisys called back two days later, Thomas Ulofoshio gave them the guardian's phone number.

On March 8, 2010, Amedisys sent a fax to R.B.'s guardian, D J, requesting permission to start treatment.[12] The first attempt at 3:54 p.m. was not successful.[13] A second fax was attempted at 4:26 p.m., but this time the wrong number was dialed and the fax was again unsuccessful.[14] Amedisys conducted internet searches and other research to find Ms. J's correct phone number. On March 19, Amedisys again faxed the consent form to Ms. J at the same number as had been used for the first attempt, but this time Amedisys dialed the area code as well. That transmission was successful,[15] and Ms. J consented to treatment on behalf of R.B.[16]

Amedisys began treatment on March 20, 2010.[17] By this time, the wound that had previously been described as a superficial ulcer,[18] had progressed to a more serious Stage III wound.[19]

R.B. is incontinent, and because of the location of the ulcer the dressing was at risk of being soiled. Graceful Living was instructed to change dressing as needed between visits from Amedisys.[20] Amedisys nurse Sarah Sudtell testified, however, that the type of dressing was designed to resist urine and feces and therefore could be wiped clean rather than changed as long as R.B.'s diaper was changed frequently. According to Ms. Sudtell, this type of dressing should stay on for at least several days and for as long as one week to promote proper healing.

Based on the testimony of Christine Ulofoshio and Thomas Ulofoshio, it is more likely true than not true that they did not fully understand that the instruction to change the dressing as needed did not mean that it should be changed each time it was soiled on the outside. Ms. Ulofoshio testified that they needed to change the dressing frequently because it became wet. They also said they were trying to follow Dr. Mraz' original February 24th instructions to keep the wound clean and dry, while Ms. Sudtell was trying to keep the wound moist and covered with a protective dressing.[21]

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12 Exhibit G.
13 Exhibit G, page 3.
14 Exhibit G, page 2.
15 Exhibit I, page 3.
16 Record at 2374 – 2379.
17 Record at 2444.
18 Exhibit C, page 3.
19 Record at 2482. A different nurse evaluated the stage of the wound as Stage II on March 26, 2010. Record at 2504. The wound may have healed somewhat by then, or the difference may reflect a difference in judgment as to how the wound should be classified.
20 Record at 2483.
21 As noted above, Dr. Mraz had seen a Stage I ulcer while Ms. Sudtell was treating a more serious Stage III ulcer.

Ms. Sudtell's nursing notes reflect her increasing frustration with the Ulofoshios' misunderstanding. On March 30th, Ms. Sudtell noted that while she had previously left enough supplies to last two weeks, the supplies were not available in the patient's room. She also observed that the wound was covered with dry gauze.[22] Her notes state that she instructed the caregiver to call Amedisys for all wound dressing changes.[23] On April 6, Ms. Sudtell's notes state that the wound was "open to air" when she arrived, and the wound bed was dry.[24] The caregiver was again instructed to call Amedisys for issues with the wound dressing.[25] Ms. Sudtell also noted "CG [care giver] has been observed with inconsistent learning and follow through since start of care and requires considerable instruction."[26]

On April 13, Ms. Sudtell noted that the wound had been healing with use of duoderm[27] but duoderm had been removed by caregiver and replaced with dry non-sterile gauze.[28] On April 14, the wound was again covered with non-sterile gauze instead of the prescribed dressing.[29] Ms. Sudtell noted:

> Instructed CG that if ALF staff is not competent to perform wound care, they need to call Amedisys to come out and change dressings. CG remains questionable for compliance.[30]

On the other hand, Ms. Sudtell appears to be the only nurse who noted questions about wound care. Melissa Dawley changed R.B.'s dressing on March 26 and April 2 and did not note a problem with Graceful Living's wound care.[31] Jocelyn Kitchen changed his dressing on April 7 and April 15, and did not note any problems with wound care.[32]

Based on the evidence presented, it is more likely true than not true that Graceful Living was not consistently following the prescribed wound care protocol. Because other nurses did not observe this problem, it is more likely true than not true that the proper protocol was followed at least some of the time and that Graceful Living was not intentionally failing to follow instructions. The instructions were not always complied with, however, and this failure contributed to the lack of healing.

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22 Record at 2517.
23 *Id.*
24 Record at 2559.
25 *Id.*
26 *Id.*
27 Duoderm is the name of the type of dressing used.
28 Record at 2588.
29 Record at 2601.
30 Record at 2602.
31 Record at 2505 and 2542.
32 Record at 2572 and 2618.

On April 16, Jocelyn Kitchen was scheduled to visit R.B. and change the dressing on his wound. When she arrived after lunch, she observed R.B. sitting in his wheel chair. He was leaning to one side, unable to lift his head, and was drooling.[33] The caregiver told her that R.B. had been lethargic all morning and that he had similar episodes in the past, from which he would recover. His pulse was 98 and his blood pressure 100/70. Two minutes later his blood pressure was 112/90 and his pulse was 101. Two minutes after that, his pulse was 141. Ms. Kitchen had seen R.B. the day before, and felt that his condition was a significant change. She urged Ms. Ulofoshio to call 911 because R.B. was exhibiting symptoms of a stroke. Ms. Ulofoshio refused, stating that these were not abnormal symptoms for R.B. Ultimately, Ms. Kitchen placed the 911 call, and R.B. was transported to the emergency room.[34]

R.B. was not having a stroke, but he was hospitalized for several weeks and then transferred to Providence Extended Care, which is a nursing home facility. While his wound has improved, his quality of life is considered poor. He has chronic emaciation and temporal wasting. He has advanced schizophrenia and is bed bound. On May 18, 2010, his doctor determined that in the event of a life-threatening disease, he should be allowed to pass away. His doctor entered a do not resuscitate/do not intubate order.[35]

III. DISCUSSION

A. Limitations on Allegations Considered

This case is governed by the Administrative Procedure Act (APA).[36] Under the APA, an accusation must provide written notice to the party of the specific acts or omissions the party is being charged with:

> A hearing to determine whether a right, authority, license, or privilege should be revoked, suspended, limited, or conditioned is initiated by filing an accusation. The accusation must
>
> (1) be a written statement of charges setting out in ordinary and concise language the acts or omissions with which the respondent is charged, so that the respondent is able to prepare a defense;
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> (2) specify the statute or regulation that the respondent is alleged to have violated, but may not consist merely of charges phrased in the language of the statute and regulation.[37]

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33 Ms. Kitchen had seen R.B. the day before and noted that he was disoriented. Record at 2618.
34 *See also* Record at 2628.
35 Exhibit 5, page 30.
36 *See* AS 47.32.150(a).
37 AS 44.62.360.

The Notice of Violation incorporates the Report of Investigation for the specific allegations.[38] That report lists the specific statutes Graceful Living is alleged to have violated, along with the acts or omissions Graceful Living is alleged to have committed.

To the extent that Graceful Living was on notice of the acts or omissions the Division believes were violations, those acts or omissions are considered. In some instances, however, the evidence presented went beyond what was alleged in the Report of Investigation. That information cannot be used to expand the scope of the initial charges. The Division did not amend its accusation.[39] Thus, the charges are limited to what was originally provided to Graceful Living in the Notice of Violation and Report of Investigation.

B. Office of Long Term Care Ombudsman Complaints

OAH Case No. 10-0275 is an appeal of a Report of Investigation by the OLTCO, and the findings in that report. The OLTCO is empowered to "investigate and resolve" complaints involving the action or failure to act by a long term care provider that may adversely affect the health and safety of an older Alaskan.[40] An older Alaskan is any resident who is 60 years old or older.[41] A long term care facility includes an assisted living home.[42] In conducting an investigation, the OLTCO may subpoena witnesses[43] and access the long term care facility.[44] It is a misdemeanor to intentionally interfere with an investigation or retaliate against a person who files a complaint with the OLTCO.[45]

The OLTCO did investigate Graceful Living and the care provided to R.B. It issued a Report of Investigation dated May 14, 2010.[46] This report substantiated two findings of neglect. The first was a finding of

> Intentional failure by caregiver to provide essential care or services to resident R.B. to prevent skin breakdown, a urinary tract infection, dehydration and malnourishment.[47]

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[38] The Notice of Violation and Report of Investigation serve as the functional equivalent of an Accusation under AS 44.62.360 or a Statement of Issues under AS 44.62.370. AS 47.32.140 requires the Division to issue a Notice of Violation and to serve a copy of the Report of Investigation with that notice. An entity receiving a Notice of Violation has an opportunity to correct any violations. AS 44.32.140(b). This can only be done if the Notice or Report describes the violations with sufficient clarity as required by AS 44.62.360(1).

[39] AS 44.62.400 provides for an amended or supplemental accusation.

[40] AS 47.62.015(a).

[41] AS 47.62.090(4).

[42] AS 47.62.090(2).

[43] AS 47.62.015(c).

[44] AS 47.62.025.

[45] AS 47.62.040.

[46] OLTCO Record at 0014 – 0017.

[47] OLTCO Record at 0014.

The second substantiated finding of neglect is "Caregiver failed to provide emergency care that a reasonably prudent person would provide under the circumstances."[48]

The proposed decision related to the OLTCO findings has been sent to the Mental Health Trust Authority for final decision.[49]

C. Violation of AS 47.33.300(a)(12)

1. Introduction

A resident in an assisted living home has the statutory right to:

> have access to adequate and appropriate health care and health care providers of the resident's own choosing, consistent with established and recognized standards within the community.[50]

The Division alleged that Graceful Living violated this provision "as evidenced by the Department's investigation."[51]

The Report of Investigation describes three areas in which a failure to provide adequate or appropriate health care is alleged: 1) the delay in obtaining the prescribed wound care treatment from Amedisys; 2) the failure to follow the wound care protocol; and 3) the failure to call 911 on April 16, 2010.

2. Delay in Treatment

On February 24, Dr. Mraz prescribed visits from Providence Home Health to treat R.B.'s decubitus ulcer.[52] Dr. Mraz did not sign the referral until March 1, 2010.[53] According to the \ Ulofoshios, they were notified by Providence Home Health that Providence could not provide this service. It is not clear from the testimony when this occurred, but it must have been fairly soon as Dr. Mraz signed a new referral to Amedisys on March 3, 2010.[54] The fax header on the bottom of this page shows that it was sent by Anchorage Neighborhood Health Center on March 3, 2010 at 2:23 p.m.[55] This referral indicated that treatment should start "ASAP."[56]

There was a 24 day delay between the visit to Dr. Mraz on February 24 and the first day of treatment on March 20, 2010. Graceful Living is not responsible, however, for Amedisys' decision to wait from March 3 until March 5 to request this information. Nor is Graceful Living

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48 OLTCO Record at 0016.
49 AS 44.64.060(e).
50 AS 47.33.300(a)(12)
51 Division's Report of Investigation, page 9.
52 Exhibit C.
53 Exhibit C, page 3.
54 Division's Record at 2372.
55 *Id.*
56 *Id.*

responsible for the delay between February 24 and March 3. Most importantly, Graceful Living is not responsible for Amedisys' failure to dial the area code when attempting to fax the release to the guardian.[57]

Dr. Mraz requested home health wound care ASAP on March 3. Although Ms. Sudtell acknowledged in her testimony that decubitus ulcers can progress from Stage I to Stage III very quickly, there is no indication in the record that Amedisys saw any urgency in starting treatment. For example, there was no evidence that Amedisys called Graceful Living after March 8, when it erroneously believed it had been given the wrong fax number. Even without calling Graceful Living, it would not take 11 days of effort to find this phone number if that task was viewed as time sensitive.

Graceful Living is not without blame, however. Graceful Living knew that R.B. needed additional wound care as prescribed by Dr. Mraz. Graceful Living also knew that no one was showing up to perform that care. Graceful Living should have been calling Amedisys between March 8 and March 19, asking why they were not coming. Assisted living home residents rely on their caregivers to follow up after treatment has been prescribed, and Graceful Living should have taken a more proactive stance. Its failure to be proactive contributed to the delay in treatment. Accordingly, the Division met its burden of proving Graceful Living denied R.B. access to adequate or appropriate healthcare in violation of AS 47.33.300(a)(12) by allowing this 11 day delay before Amedisys started its home health care treatment.

3. Failure to Follow Wound Care Protocol

The next alleged violation has to do with the wound care provided by Graceful Living between visits by Amedisys. The Division has shown through the testimony of Sarah Sudtell and her nursing notes that Graceful Living was not following the wound care protocol. The initial instructions from Dr. Mraz were to keep the wound dry, which the Ulofoshios did. Amedisys changed the wound care instructions after it developed into a Stage III ulcer. The Ulofoshios did not consistently follow these new instructions. In part, this may be because the new instructions were not in writing. The fact remains, however, that they were instructed on the proper protocol and did not consistently follow it.

[57] Whether Graceful Living refused to provide the phone number for R.B's guardian on March 5 was a disputed question. Ultimately, the Division did not meet its burden of proving by a preponderance of the evidence that Graceful Living refused to provide this information.

The Division met its burden of proving Graceful Living denied R.B. access to adequate and appropriate healthcare in violation of AS 47.33.300(a)(12) by not following the proper wound care protocol.

4. Failure to Call 911

Dr. Mraz' testimony was particularly helpful on this issue. He testified that it was entirely appropriate for Ms. Kitchen to exercise her professional judgment and contact 911 to have R.B. transported immediately to the emergency room. He also testified, however, that a different person who had more familiarity with R.B.'s baseline condition could reach a different conclusion. Dr. Mraz testified that, in his opinion, a nurse could conclude that R.B. should see a doctor, but that it was not of such urgency that calling 911 was required.

The Division attempted to prove that Graceful Living had no intention of seeking any medical care for R.B. that day and that the refusal to call 911 was because it was inconvenient. According to Ms. Kitchen, the Ulofoshios told her that Thomas Ulofoshio had a personal appointment that afternoon and that Christine Ulofoshio needed to remain in the home to care for the other residents. Accordingly, they could not call 911 because that would leave the home unstaffed.

The Ulofoshios disputed this. They testified that there was another staff person present if the Ulofoshios had to go the hospital with R.B. and also that the "appointment" Thomas had referred to was an appointment to bring R.B. to the emergency room later in the afternoon. They said that R.B's condition was variable and that it was not unusual for him to look and act as he did when Ms. Kitchen observed him on the 16th. Since his condition was not so different from his baseline condition,[58] they felt it was sufficient to take him to the emergency room later.

While it is true that people don't make typically appointments to go to the emergency room, English is not the first language for either of the Ulofoshios. While they speak English well, and appear to understand English, their word choice is not always the same as a native speaker. Based on their testimony during the hearing, it would not be surprising for either of them to say "I have an appointment later" to indicate a plan to take R.B. to the emergency room later.

The Division also argues that the Ulofoshios' testimony was not credible because if they truly believed R.B.'s symptoms were consistent with his typical condition, there would be no

[58] Other witnesses who have known R.B. longer than Ms. Kitchen also testified that R.B.'s condition was variable and that he would frequently be uncommunicative with people he did not know.

reason to take him to see a doctor at all. The Division argues that their claim that they were planning to take him to the emergency room later was an after the fact justification for not calling 911 at the time.

Finally, the Division argues that Ms. Ulofoshio actually believed that R.B. was having a stroke but refused to call 911. As evidence of this, the Division cites to an e-mail written by Thomas Ulofoshio in which he states "Christiana thought he was having a stroke."[59] Ms. Ulofoshio testified that this e-mail was incorrect because she did not believe R.B. was having a stroke. Ms. Kitchen did think R.B. was having a stroke based on his symptoms. According to Ms. Kitchen's testimony, Ms. Ulofoshio resisted calling 911 because she thought his symptoms were not that unusual for R.B. This observation by a third party suggests that Ms. Ulofoshio did not believe at the time that R.B. was having a stroke. The e-mail written by Mr. Ulofoshio is not sufficient to support a finding that Ms. Ulofoshio thought otherwise.[60]

While there is a dispute as to whether it was necessary to call 911, there is no dispute that R.B. should have been seen by a doctor on April 16. If, as argued by the Division, Graceful Living had no intention of bringing him to the emergency room later that day, and if Ms. Kitchen had not insisted on calling 911 herself, there would have been a denial of access to appropriate health care. That did not actually occur, however, because Ms. Kitchen did call 911.

While there are indications in the evidence that Graceful Living would not have sought medical attention later in the day, there was also evidence that supported Ms. Ulofoshio's testimony that they did intend to take him to the emergency room. The Ulofoshios voluntarily sought medical attention for R.B. in February when his ulcer was still superficial. They also brought him back to the Anchorage Neighborhood Health Center in April when they had concerns about the wound care treatment he was receiving. Testimony from other witnesses was that the Ulofoshios were attentive to their residents and usually provided good care. The Division has not proven that it is more likely true than not true that R.B. would not have been taken to the emergency room later in the day if 911 had not been called.

Based on Dr. Mraz' testimony, it would have been reasonable to seek medical attention later, rather than through an immediate call to 911. Accordingly, the Division has not met its burden of proving Graceful Living denied R.B. access to adequate and appropriate healthcare in violation of AS 47.33.300(a)(12) by not calling 911.

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[59] Division's Record at 1830.

[60] Pursuant to AS 44.62.460(d), hearsay such as this e-mail may be used to supplement or explain evidence, but is not sufficient by itself to support a finding.

C. Violation of AS 47.33.300(a)(1)

Assisted living home residents have the right to live in a safe and sanitary environment.[61] The Division alleged that Graceful Living did not provide a safe and sanitary environment to R.B. "as evidenced by the Department's investigation."[62]

The Notice of Violation sent to Graceful Living incorporates the Report of Investigation for the specific allegations. That report does not state in "ordinary and concise language" the manner in which Graceful Living Home I was unsafe or unsanitary. Accordingly, Graceful Living was not given proper notice of this charge. Graceful Living would have no way of knowing from reading the Report of Investigation what changes were needed in order to become safe and sanitary. Because it was not given notice, a finding against Graceful Living on this issue would be improper.

Even if this charge were considered, the Division has not met its burden of proving Graceful Living failed to provide a safe and sanitary environment to R.B. There was evidence that Home I, where R.B. resided, was not safe and sanitary. Sarah Sudtell testified that the home smelled and was dirty. She said it was the worst assisted living home she had ever seen. According to her, the floors and walls were dirty. She also noticed an open closet door and it appeared that there were medical supplies or cleaning supplies in the closet that residents could access.

Francis Seater is a Licensed Speech Language Pathologist employed by Amedisys. She said that Home I was the singularly dirtiest assisted living home she had ever visited. Graceful Living Home III was actually closed due to unsanitary conditions in 2009.[63]

On the other hand, there was also abundant evidence that Home I was safe and sanitary.

Meg Smith is a care coordinator for the Alzheimer's Resource Agency. She has placed clients in numerous assisted living homes, including one client at Graceful Living Home I. She visits her clients every month for an hour or more each time. She testified that Graceful Living was up to standards in terms of safety and cleanliness. She rated it a 5 on a 1 – 5 scale.

R.B.'s guardian, D J visited him at Home I six or seven times. She had no concerns about cleanliness. S.R. testified that her husband was a resident of Graceful Living from 2002 through 2010. He started at a different home, but then was moved to Home I. She testified that

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[61] AS 47.33.300(a)(1).

[62] Division's Report of Investigation, page 9.

[63] Graceful Living disputed that Home III was unsanitary on that date, but the evidence of that inspection and closure is admissible evidence to show that Graceful Living homes were not always clean and safe.

Home I was clean, there were no bad odors, and the food looked good. Her husband was well cared for. He had been in the hospital at one point, and was returned to the home with hospice care. Her husband was not expected to live, but he recovered and lived for another four or five years under the care of Graceful Living.

M.G. testified about the care given to her daughter, S.T., a young woman who suffered a traumatic brain injury. S.T. was living in a different Graceful Living home for about one year.[64] M.G. felt that the home was clean and safe, and that the residents were treated well. S.T. had been in three other homes first, and the Graceful Living home was the best of all of them. The food tasted good, and the home was very clean. Graceful Living was the only home that treated S.T. "like a human being."

S.T. also testified that Graceful Living provided excellent care and was clean. She did not live at Home I, but has visited it since she moved out. Unlike other homes she lived in previously, Graceful Living staff treated residents with respect. S.T.'s fiancé, D.S., testified that Home II was clean and the residents were treated like family. He has also visited Home I, which he described as immaculate.

Megan Wilts is a care coordinator for Medicaid Waiver Services. She has to see each client face to face at least once each month, often in the Assisted Living Home. Three of her clients have been in Home I, one of whom is there now. She has visited 15 to 20 times in the past year, and the home is always clean. She says she is particular about cleanliness, and Graceful Living rates in the top ten of the over 100 homes she has seen.

D.D. testified about his brother-in-law, L.W., who has lived at Graceful Living for about three years. He has been looking after L.W. for 20 years, and has known him for 50. He testified that the staff treat L.W. well and the home is clean.

The only people who testified that Home I was not safe or sanitary were Amedisys employees. Even though there was concern that R.B.'s wound could become infected, neither of these employees noted any concern about the cleanliness of the home in their contemporaneous notes. It may be that these witnesses exaggerated their concerns (consciously or unconsciously) after the fact because they were trying to shift the focus away from Amedisys' delay in contacting R.B.'s guardian and starting treatment for his wound. It is possible for the home to have been immaculate on some days and the dirtiest home ever seen on other days, but this is not likely. While some of the witnesses favorable to Graceful Living might also have been biased,

[64] She moved out to live with her fiancé.

the Division has the burden of proving charges by a preponderance of the evidence. It did not meet that burden.

D. Violation of 7 AAC 75.020(d)(2)

An assisted living home serving three or more residents must be licensed by the state.[65] There are two types of licenses an ALH may have: probationary or standard.[66] These two types are further divided into three categories based on the residents served:

> A license shall be issued to a home providing care
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> (1) primarily to persons with a mental or developmental disability;
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> (2) primarily to persons who have a physical disability, who are elderly, or who suffer from dementia, but who are not diagnosed as chronically mentally ill; and
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> (3) to approximately equal numbers of persons described in both (1) and (2) of this subsection.[67]

The Division asserted that Graceful Living Home I was operating beyond the scope of its license because R.B. is diagnosed with schizophrenia and another resident, L.W., has Down 's syndrome, which is a developmental disability.[68] It is the Division's position that a home licensed under 7 AAC 75.020(d)(2) may not have a single resident who has a chronic mental illness or who has a developmental disability. According to the Division, this is because it is dangerous to have mentally ill residents in the same home as elderly residents who are often frail.[69]

The physical license issued to Graceful Living states that the ALH is licensed for "Five (5) adults, age 18 and older who have physical disability, are elderly or suffer from dementia but who are not chronically mentally ill."[70] This license is issued pursuant to a regulation that uses different language, and the difference is significant. It is the regulation that controls.

7 AAC 75.020(d) divides homes into three classes. Under the Division's interpretation, homes licensed under subparagraph 020(d)(1) may serve people with mental or developmental disabilities; homes licensed under subparagraph 020(d)(2) may serve people who have a physical disability, are elderly, or who have dementia as long as none of them are also chronically

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65 AS 47.33.1010(a); AS 47.32.900(2).

66 7 AAC 75.020(a).

67 7 AAC 75.020(d).

68 Division's Report of Investigation, page 6.

69 Mental illness takes many forms. Some mentally ill individuals are violent just as some individuals with dementia are violent, but most mentally ill people are not a danger to themselves or others. The legislature has attempted to eradicate stereotypes concerning mental disabilities including mental illness and developmental disabilities. *See* AS 18.80.200 & 230.

70 Division Record at 0004.

mentally ill or have a developmental disability;[71] and homes licensed under subparagraph 020(d)(3) may serve approximately equal numbers of residents under both of the other categories.

The Division's interpretation ignores the word "primarily" in subparagraphs 020(d)(1) and (d)(2). The plain meaning of this regulation is that a home such as Graceful Living Home I, which is licensed for five adults, is not outside the scope of its license by having one resident who has a chronic mental illness as long as most of its residents do not.[72] The Division's interpretation also ignores the wide range of disorders that might result in someone being classified as mentally ill. These include depression, anxiety, and somatoform disorders.[73] While a person such as R.B. who is diagnosed with paranoid schizophrenia will likely have delusions or auditory hallucinations, only some schizophrenics are predisposed to violence.[74]

A harder question, especially for smaller homes, is: how many mentally ill residents may a home have before needing a license under subparagraph 020(d)(3)? Could a home licensed under subparagraph 020(d)(2) have five elderly residents if two of them were diagnosed with chronic depression? Would one of those two residents be forced to move to home licensed for chronically mentally ill residents? These questions need not be resolved at this time because there was no evidence at the hearing that Home I had more than one resident who was diagnosed with a chronic mental illness.[75] Home I was primarily serving residents with physical disabilities, who were elderly, or who had dementia but who were not diagnosed with a chronic mental illness.

Graceful Living argued that for many years the Division allowed residents in a home licensed under .020(d)(2) as long as their primary diagnosis was not a chronic mental illness. More recently, according to Graceful Living, the Division has adopted a stricter interpretation. The Division now excludes any individual with a chronic mental illness from homes license

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[71] Although the term "developmental disability" is not listed in .020(d)(2), the Report of Investigation, at page 6, states that Graceful Living was operating outside the scope of its license because one resident was diagnosed with Down's Syndrome. The term "developmental disability" covers a very wide range of ability levels.

[72] Nor is it outside the scope of its license because L.W. is diagnosed with a developmental disability. L.W. is elderly and has dementia, and neither the physical license nor the regulation excludes or refers to residents with a developmental disability, so L.W. fits squarely within the class of residents covered by .020(d)(2) even if the word "primarily" is ignored.

[73] *See* Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), published by the American Psychiatric Association.

[74] DSM-IV-TR, page 314.

[75] They could be addressed in a later case that raises them squarely, or they could be addressed in a clarifying regulation.

under subparagraph .020(d)(2) even if the mental illness is not the individual's primary diagnosis.

In response, the Division admits that it has stepped up its enforcement of this regulation. According to Division witnesses, individuals with a chronic mental illness have never been permitted in an assisted living home licensed under this subsection, but the Division previously looked only at each individual's primary diagnosis to determine what type of home was appropriate. It now looks at the complete diagnosis of each resident, and excludes residents with a chronic mental illness regardless of whether that is the primary diagnosis.

Graceful Living's interpretation of 7 AAC 75.020 acknowledges the word "primarily" used in the regulation. It also better accounts for the fact that most individuals with chronic mental illness are not a danger to themselves or others. In addition, it is consistent with how the Division has viewed this regulation in the past; looking only at the primary diagnosis of each resident. It is not the correct interpretation, however. Each home is licensed to serve a population consisting "primarily" of a certain group. Primarily is used as a synonym for "mostly." The regulation does not say that the population served is "only" that group. Nor does it say that the population served may consist entirely of chronically mentally ill individuals as long as they have a different "primary" diagnosis.

The Division has not met its burden of proving that Graceful Living operated outside the scope of its license in violation of 7 AAC 75.020(d)(2).

E. Violation of 7 AAC 75.290(a)(1)

Assisted living homes are required to access emergency services when necessary, and "provide the emergency care that a reasonably prudent person would provide under the circumstances."[76] The Division asserted that Graceful Living acted improperly by not calling 911 on April 16 when R.B. was exhibiting symptoms of a stroke.

As discussed in section III-C-4 above, calling 911 was not the only option available to a reasonably prudent person. The Division has not met its burden of proving that Graceful Living violated 7 AAC 75.290(a)(1).

F. Violation of AS 47.05.310(c)

An entity's license may not be renewed if the individual applying for the license has been found by another agency to have neglected a vulnerable adult.[77] This provision could preclude

[76] 7 AAC 75.290(a)(1).
[77] AS 47.05.310(c)(1).

the license renewal for Homes II and III. This allegation specifically refers to the findings of the OLTCO.[78] A proposed decision related to those findings has been submitted to the Mental Health Trust Authority.[79] If the final decision is that the finding of neglect is substantiated, then the Division will be required to take action pursuant to AS 47.05.310(c) & (f).[80] If the Mental Health Trust Authority does not accept the findings of neglect to be substantiated, then there is no action to take related to this statute.

G. Violation of Settlement Agreement

Both parties have alleged violations of the prior settlement agreement. At the conclusion of mediation, the parties entered into a written settlement agreement.[81] This agreement was re-written and the resulting Memorandum of Agreement was signed by Ms. Ulofoshio and the Commissioner of Health and Social Services.[82]

The Division originally asserted that Graceful Living violated this agreement by providing services to R.B., who has schizophrenia, and to L.W., who has Down's syndrome.[83] The relevant portion of the agreement is paragraph 4(a)(vii):

> The maximum number of residents shall be five residents each for Homes I and II, and three residents for Home III. No residents who are chronically mentally ill, regardless of the level of diagnosis of the mental illness (e.g. primary versus secondary versus tertiary), or who are bed-ridden may be admitted.

There is no allegation that L.W. was bed-ridden or was chronically mentally ill. Thus, having him as a resident could not violate this provision. R.B., on the other hand, is chronically mentally ill. He had been admitted to Home I several years earlier, however, and it is Graceful Living's position that this agreement only prohibited new admissions.

The prior investigation and enforcement action included an allegation that D.N., a mentally ill resident, should not have been a resident of Home III. The Division argued that having him as a resident was outside the scope of Graceful Living's license, while Graceful Living argued that it was permitted to accept mentally ill residents as long as their primary diagnosis was a physical disability or dementia, and not mental illness. The parties attempted to resolve this dispute with paragraph vii of the Memorandum of Agreement. According to the Division, Graceful Living had agreed not to have any residents who were chronically mentally

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78 OLTCO Record at 0021 – 0024.
79 The OLTCO is established within the Mental Health Trust Authority. AS 47.62.010(a).
80 Subsection f of this statute provides for an exemption from the prohibitions in subsection c.
81 Exhibit F.
82 Division Record at 1167 – 1176.
83 Division's Report of Investigation, page 6.

ill. Graceful Living argued that this provision only precluded the admission of new residents who were diagnosed with a chronic mental illness.

The language used in this paragraph specifically prohibits admissions and does not make any provision for current residents. If the parties had intended this paragraph to apply to current residents as well, it could have said that. In addition, this paragraph appears to be a compromise between the parties' positions. As discussed in section III-D above, Graceful Living had a strong argument that its license permitted it to accept some residents who were mentally ill. The Division gained a significant benefit by having Graceful Living agree not to accept any new mentally ill residents in any of its three homes. The Division has not met its burden of proof that Graceful Living violated this section of the settlement agreement.[84]

The Division also asserted that Graceful Living violated the agreement by having Ms. Ulofoshio act as a caregiver at Home I in addition to her duties as an administrator.[85] Paragraph 4(a)(iv) of the agreement states that Ms. Ulofoshio must spend at least 40 hours per week working as the home's administrator during the hours of 6:00 a.m. to 10:00 p.m.[86] The Division alleged that Ms. Ulofoshio was acting as a caregiver for large portions of the day.[87]

The relevant portion of the settlement agreement states:

> The resident manager for Home II, and Christina and Thomas Ulofoshio, respectively for Homes I and III, must spend at least 40 hours per week working at their respective homes during the waking hours (6:00 a.m. to 10:00 p.m.) and may not function as a caregiver while acting as the administrator.[88]

There are 112 hours each week during the waking hours of 6:00 a.m. to 10:00 p.m. Assuming it takes 40 hours each week to perform the functions of an administrator, there are still 72 hours available each week for Ms. Ulofoshio to also serve as a caregiver. While it is certainly possible that Ms. Ulofoshio's time spent as a caregiver prevented her from spending sufficient time as an Administrator, it is also possible that she did spend 40 hours each week on administrative duties while also spending a significant amount of time as a caregiver. The Division has not met its burden of proving by a preponderance of the evidence that Ms. Ulofoshio violated the settlement agreement by working as a caretaker for large portions of the day.

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84 In its closing argument, the Division changed its position and argued that R.B. and L.W. did not fall within the terms of the settlement agreement because they never should have been admitted to the home in the first place as their primary diagnosis was schizophrenia for R.B. and Down's syndrome for L.W. Closing Brief at 23. As discussed in section III-D above, Graceful Living was not acting outside the scope of its license by serving these two individuals.

85 Division's Report of Investigation, page 5.

86 Division's Record at 1769.

87 Division's Report of Investigation, page 5.

88 Division's Record at 1769.

Finally, the Division argues that Graceful Living has violated paragraph 4(a)(vi) of the settlement agreement[89] which states that Graceful Living must submit updated staffing plans prior to reopening Homes II and III.[90] This is not a provision capable of being violated by Graceful Living. Graceful Living was not obligated to submit staffing plans; it simply would not have its licenses renewed without those plans. The Division has not met its burden of proving that this provision of the settlement agreement has been violated.

Graceful Living also alleged violations of the settlement agreement. It has the burden of proving these allegations by a preponderance of the evidence.[91] Graceful Living asserts that it fulfilled all of its obligations under the settlement agreement but that the Division was refusing to inspect Home II and refusing to renew the license for Home III.[92]

The settlement agreement was finalized on March 24, 2010.[93] While the essential terms of this agreement had been approved by the parties on March 5,[94] that preliminary agreement contemplated final approval by the Commissioner,[95] which did not occur until March 24.

The Division actually began its efforts to comply with the settlement agreement before it received final approval from the Commissioner. On March 8, Leana Christy contacted the Ulofoshios to set up inspections of Homes II and III.[96] Home III was inspected on March 22.[97] There were continuing communications between Ms. Christy and the Ulofoshios from March 22 through April 19, 2010 concerning both parties' attempts to comply with the settlement agreement.[98] On April 20, the Division received an allegation of neglect as of Home I.[99] On April 22, Ms. Christy informed Mr. Ulofoshio that the Division could not issue a license until the Report of Investigation concerning the allegation of neglect at Home I was complete.[100]

Ms. Christy also testified about her efforts to obtain staffing plans and information about the administrator for Home II. The settlement agreement required staffing plans that addressed communications, job descriptions, schedules, caregiver orientation, and an on-going training

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89 Division's Record at 1770.
90 Division's Report of Investigation, page 5.
91 2 AAC 64.290(e).
92 Exhibit 1 to Motion for Emergency Hearing to Enforce Stipulation. This motion was the basis for the opening of OAH No. 10-0274-ALH.
93 Division's Record at 1774.
94 Exhibit F.
95 Exhibit F, page 3, paragraph 6.
96 Division's Record at 1874; Testimony of Leana Christy.
97 *Id.* Division's Record at 1922 – 1934.
98 Division's Record at 1874 – 1875; Testimony of Leana Christy.
99 Division's Record at 1875.
100 Division's Record at 1876; Testimony of Leana Christy.

plan.[101] Arguably, this required more detail than what had been submitted by Graceful Living in the past.[102] Ms. Christy testified that the plans she received from Graceful Living were not complete. She also testified that she was attempting to get additional information about the administrator for Home II.

Implicit in the settlement agreement is an obligation to work together in good faith to complete the necessary steps for renewing the licenses at Homes II and III. Ms. Christy's testimony demonstrates that she was doing that. The Ulofoshios' testimony did not rebut that evidence. While there was testimony from them that they had submitted some information, Graceful Living did not show that all of the necessary information had been received or that the Division was asking for more than what would normally be required in any license renewal process. Graceful Living has not met its burden of proof on this issue.

H. Neglect of R.B.

The final allegation in the Report of Investigation is that Graceful Living neglected R.B. The Division asserts that R.B. received delayed and then improper treatment for his decubitus ulcer, and that Graceful Living failed to call 911 on April 16 when a reasonably prudent person would have done so.

The Division defines neglect as "the intentional failure by a caregiver to provide essential care or services necessary to maintain the physical and mental health of the vulnerable adult."[103] As discussed in section III C 3 above, Graceful Living did fail to promptly obtain wound care services from Amedisys and did fail to follow the proper wound care protocol. The Division has not, however, shown that these were intentional failures.

There was a 24 day delay between the visit to Dr. Mraz on February 24 and the first day of treatment on March 20, 2010. Assuming the accuracy of Ms. Stern's and Ms. Sudtell's testimony, three days of delay occurred because Graceful Living did not give them the guardian's contact information on March 5.[104] Graceful Living is not responsible, however, for Amedisys' decision to wait from March 3 until March 5 to request this information. Nor is Graceful Living responsible for the delay between February 24 and March 3. Most importantly, there was no evidence that Graceful Living was in any way responsible for Amedisys' failure to dial the area code when attempting to fax the release to the guardian.

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101 Division's Record at 1770.

102 *See* Division's Record at 305 – 316.

103 Division's Closing Argument at 3 quoting AS 47.24.900(9).

104 The evidence on this question is conflicting. The Division has not proven that these three days of delay were Graceful Living's fault.

Dr. Mraz requested home health wound care ASAP on March 3. Although Ms. Sudtell acknowledged in her testimony that decubitus ulcers can progress from Stage I to Stage III very quickly, there is no indication in the record that Amedisys saw any urgency in starting treatment. For example, there was no evidence that Amedisys called Graceful Living after March 8, when it erroneously believed it had been given the wrong fax number. Even without calling Graceful Living, it would not take 11 days of effort to find this phone number if that task was viewed as time sensitive.

The weight of the evidence at the hearing was that most of the delay was caused by Amedisys' actions and inactions. It was the Division's burden to show that Graceful Living intentionally failed to provide essential care to R.B. While Graceful Living ought to have contacted Amedisys and insisted that it start treatment sooner, the Division has not met its burden of proving that Graceful Living *intentionally* failed to provide essential care to R.B. As discussed in section III C 2, Graceful Living failed to provide R.B. with access to the appropriate health care services, but this failure was not intentional neglect as defined by AS 47.24.900(9).

The same is true with the failure to follow the proper wound care protocol. The weight of the evidence at the hearing was that Graceful Living attempted to provide proper wound care for R.B. The initial instructions from Dr. Mraz were to keep the wound dry, which the Ulofoshios did. Amedisys changed the wound care instructions after it developed into a Stage III ulcer. Mr. and Mrs. Ulofoshio did not fully understand the new instructions given to them – none of which were provided in writing. As discussed in section III C 3, above, this was a failure to provide access to appropriate health care services. It was not intentional neglect as defined by AS 47.24.900(9).

The Division has not met its burden of proving by a preponderance of evidence that Graceful Living *intentionally* failed to provide essential care or services.

I. Penalty

Graceful Living denied R.B. access to adequate and appropriate health care. Graceful Living was not proactive in obtaining the services of a home health provider for R.B.'s wound care. It subsequently failed to follow the prescribed wound care protocol. This was not the first time Graceful Living has had problems in one of its homes. In 2006, Home III was found not to have been providing three balanced meals and one snack each day.[105] In 2007, Home II, was found to have violated applicable statutes and regulations when its utilities were shut off for non-

[105] Division's Record at 867.

payment.[106] More recently, in 2009 Home III, which was being remodeled, was found to be unsafe and uninhabitable, and was immediately closed.[107]

In mitigation, there was evidence from residents, family members of residents, health care personnel, and others that was favorable to Graceful Living. Dr. Mraz testified that he sees many patients from assisted living homes. Most send their residents to see him by bus or taxi. Graceful Living, however, has a caregiver bring the residents to their appointments. This greatly assists him in providing appropriate medical care.

In addition to taking residents to medical appointments, Thomas Ulofoshio would bring residents with him when he ran errands so they would have an outside activity during the day. He would also bring them to restaurants for lunch. Other witnesses talked about Graceful Living treating residents like family. According to her mother, Graceful Living was the only home that treated S.T. like a human being.

While the Graceful Living homes do many things well, the two instances of failure to provide appropriate medical care that have been proven here are serious violations. Based on these violations, there is a wide variety of enforcement action that can be taken. This ranges from a warning notice to revocation of Home I's license.[108] The Department may also impose a civil fine.[109] The enforcement action in this case should be consistent with other actions taken for similar violations. If the enforcement action is different, it is important to explain why a different action is taken.

The parties did not provide any information about enforcement actions taken in similar cases. Nor are there any similar cases published on the Office of Administrative Hearings website.

In this case, revocation is inappropriate because the unintentional violations were not at the most serious level of prohibited actions and because the evidence showed that Home I usually provides an excellent environment, making it an asset to the community. Given all of the circumstances of this case, it is appropriate to attempt to save the home but bring it into compliance by taking the following actions:

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106 Division's Record at 794.

107 Testimony of Barbara Dick. In addition to safety issues related to construction, Ms. Dick noted that the house was extremely unclean and medicine from prior residents was left in the kitchen where they were assessable to current residents.

108 AS 47.32.140(d).

109 AS 47.32.140(f).

1. For a period of six months , Home I should not be permitted to serve any individual not currently receiving services;[110]
2. Home I's license should be converted to a provisional license;[111]
3. Home I should be required to submit a plan of correction that addresses training for caregivers in prevention and treatment of decubitis ulcers. This plan to be submitted within 60 days and the training completed within 120 days;[112]
4. A civil fine in the amount of $1,000 for each violation proven, for a total of $2,000, should be imposed and made payable within 90 days;[113] and
5. Failure to comply with paragraphs 3 or 4 should result in immediate revocation of Home I's license, after adjudication if requested.[114]

These sanctions provide for additional oversight of Home I as Graceful Living will not be able to convert the provisional license to a biennial license without demonstrating compliance with applicable statutes and regulations.[115] The limitations on serving additional residents will give Graceful Living time to prepare and comply with the plan of correction. The civil fine emphasizes the seriousness of the violations. In addition, Graceful Living is still subject to the terms and conditions of the Memorandum of Agreement it entered into previously.

IV. CONCLUSION

The Division alleged a number of serious violations, and has proven by a preponderance of the evidence two instances of failure to provide access to appropriate or adequate medical care. Imposing a significant sanction is appropriate, but Home I's license should not be revoked for those violations. Instead, the sanctions listed in section III (I) above should be imposed.[116]

DATED this 3rd day of January, 2011.

By: *Signed*
Jeffrey A. Friedman
Administrative Law Judge

110 AS 47.32.140(d)(4).
111 AS 47.32.140(d)(2).
112 AS 47.32.140(d)(13).
113 AS 47.32.140(f).
114 AS 47.32.140(d)(6).
115 AS 47.32.050.
116 Graceful Living requested an award of attorney fees for the Division's violation of the settlement agreement and for its deficient investigation. Graceful Living did not cite any authority for awarding attorney fees in this proceeding.

Adoption

The undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 8th day of February, 2011.

By: *Signed*
Signature
William J. Streur
Name
Commissioner
Title

[This document has been modified to conform to the technical standards for publication.]