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

In the Matter of	)	
	)	OAH No. 15-0637-ALH
THE JAGNE'S ALH III	)	Agency No. 100821
	)	

DECISION

I. Introduction

The Division of Health Care Services (Division) investigated The Jagne's ALH III (Jagne's ALH), and substantiated ten different violations. The Division suspended the home's license, and proposed a license revocation and permanent closure of the home. Jagne's ALH appealed that decision.

A hearing was held on July 13 and 14, 2015. Jagne's ALH was represented by its owner and administrator, Pa M. Jagne. The Division was represented by Assistant Attorney General, Kimberly Allen. The evidence in the record establishes eight separate violations. Based on those violations, the Division's proposed remedies are affirmed.

II. Facts

Pa M. Jagne is the owner and administrator of The Jagne's ALH III, which was licensed to provide care for up to five residents with mental or developmental disabilities.[1] Samba Jeng was the primary live-in caretaker for Jagne's ALH.[2] Because Jagne's ALH was having financial difficulties, Mr. Jeng was not receiving his full wages, although he was being paid a portion of his wages.[3] Mr. Jeng told Mr. Jagne that he didn't want to leave, but he needed money to support his family. Mr. Jagne asked Mr. Jeng to give him time to find a replacement if he decided to quit.[4] Mr. Jagne also began to look for someone to replace Mr. Jeng.[5]

On May 21, 2015, Mr. Jagne received a text message from Mr. Jeng telling Mr. Jagne that he had quit on the 15th, but had stayed longer to help him out.[6] Mr. Jeng followed up with a

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1 Jagne Testimony; Agency Record (Record) at 2 – 3.
2 Jagne Testimony.
3 *Id.*
4 *Id.*
5 *Id.*
6 Record at 80.

text saying he was leaving at 11:00 the next day.[7] At 11:49 on May 22, Mr. Jeng sent a text saying: "If u ar Nt hea by 12 noon, ur home will b left with out a staff as I told u earlier."[8]

Mr. Jagne arrived at Jagne's ALH at about 8:00 in the evening.[9] He found one of the residents standing outside. The resident told him that he had been knocking on the door but no one was answering. They went inside, and Mr. Jagne learned that Mr. Jeng was not in the house.[10] At that time, Mr. Jagne learned that resident M.S. was missing.[11] He texted Mr. Jeng at 8:20 asking if he knew where M.S. was.[12] Mr. Jeng did not know where she was, and would not respond to Mr. Jagne's questions asking what time Mr. Jeng had left the house.[13]

Although she had never wandered away from Jagne's ALH before, Mr. Jagne was aware that M.S. should not be left alone for any period of time.[14] According to her legal guardian, T F, M.S. suffers from multiple personalities and is primarily non-verbal.[15] She cannot tell anyone who she is, or where she lives.[16] According to Ms. F, leaving M.S. alone would be like leaving a small child alone, and she should not be left alone for even five minutes.[17]

At 2:00 am, Ms. F was called by Providence Hospital and was told that M.S. had been brought there by the police. She called Mr. Jagne and arranged to have him pick up M.S. from the hospital.[18] Ms. F believed that M.S. had been receiving good care and was happy at Jagne's ALH. However, Ms. F was planning to move M.S. because of the home's financial problems.[19]

Because Mr. Jeng had left, Mr. Jagne arranged for Mr. Abdoulaye Diop to take care of the home's residents. Mr. Diop and Mr. Jagne did not know each other, but they had a mutual acquaintance, Ousaino Jallow.[20] Mr. Diop had been in this country for two years, but was not allowed to be employed here.[21] However, he was willing to help Mr. Jagne without pay.[22]

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7 Record at 81. Mr. Jagne responded by saying he needed to have a voluntary termination of employment notice from Mr. Jeng.
8 Record at 83.
9 Jagne testimony.
10 *Id.*
11 *Id.*
12 Record at 83; Jagne testimony.
13 Record at 83 – 85; Jagne testimony
14 Record at 137; Jagne testimony.
15 F testimony.
16 *Id.*
17 *Id.*
18 F testimony; Record at 202.
19 F testimony.
20 Diop testimony; Jagne Testimony; Exhibit 3 (recorded interview of Mr. Jagne).
21 Diop testimony.
22 *Id.*

Mr. Jagne met Mr. Diop at the house and asked him to stay with the residents and cook their meals.[23] Mr. Diop came on Tuesday at 4:00 and left around 4:00 the next day.[24] Other than the residents, no one else was at the home until later on Wednesday, when Mr. Diop's wife, Sharon Jay came over.[25]

Mr. Diop had not had a background check, and did not have CPR training.[26] Mr. Jagne told Mr. Diop that if someone came to the door, he should say he was Ousainou Jallow.[27] As it turned out, a licensing specialist did come to the door to investigate the home, and Mr. Diop told him his name was Ousainou Jallow.[28]

Ms. Jay drove Mr. Diop to Jagne's ALH, and then left him there and went back home.[29] She came the next day to spend time with her husband, and spent Wednesday night at the home. Mr. Jagne told her not to open the door if anyone came to the home.[30]

The Division received a report that the home may have been left unattended on May 22, 2015, and began an investigation.[31] Upon confirming the report, the Division immediately suspended the home's license pursuant to AS 47.32.130(a), which allows for immediate suspensions when there is an immediate danger to the health, safety, or welfare of a resident.[32] The Division continued its investigation, and concluded that Jagne's ALH had committed several violations.[33] Based on that conclusion, the Division informed Jagne's ALH that it intended to continue the suspension of the license and seek license revocation and permanent closure of the home.[34]

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23 *Id.*
24 *Id.*
25 *Id.*
26 *Id.*
27 Diop testimony; Jagne testimony.
28 Diop testimony; Brazington testimony (Mr. Brazington is a licensing specialist who was conducting an investigation after the Division learned that the home may have been left unattended the evening M.S. wandered from the home).
29 Jay testimony.
30 *Id.*
31 Record at 3 – 4.
32 Record at 6; Record at 15.
33 Brazington testimony.
34 Record at 10.

III. Discussion

A. Governing Law

Assisted living homes must be licensed by the state.[35] They are governed under AS 47.33.005 – 990, and 7 AAC 75.010 – 990. The Division is authorized to conduct investigations of possible violations.[36] If it determines that a violation occurred, the division has a variety of enforcement actions it may take against the home, including revocation of its license and ordering that the home be permanently closed.[37] The assisted living home may request a hearing to contest both the finding of violations and any sanction imposed for a violation.[38] Each of the violations found by the Division in this investigation is discussed below.

B. Failure to Employ Sufficient Staff

The first violation alleged by the Division was that Jagne's ALH failed to employ sufficient staff to supervise the residents.[39] Assisted living homes are required to employ sufficient care providers and other staff to meet the needs of the residents.[40] It is undisputed that Jagne's ALH was left without any staff from the time Mr. Jeng left on May 22 until around 8:00 in the evening when Mr. Jagne arrived. Mr. Jagne also conceded that M.S. should not have been left alone.

M.S. had wandered from her prior home, but had not done so while in his care.[41] M.S. was well cared for, and happy at Jagne's ALH.[42] Mr. Jagne argued that Mr. Jeng did not give him sufficient notice that he was leaving. Regardless of how much notice Mr. Jeng gave, however, Mr. Jagne still violated 7 AAC 75.210 because the home was unattended–no care provider was present. This is a serious violation. Moreover, Mr. Jagne was told the evening before, and again shortly before noon, that the care provider was leaving, and did not take any action to see if a provider was present until eight hours later.

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35 AS 47.32.020.
36 AS 47.32.090.
37 AS 47.32.140.
38 AS 47.32.150.
39 Record at 6.
40 7 AAC 75.210(c).
41 Jagne testimony.
42 F testimony.

C. Cardiopulmonary Resuscitation (CPR)

Assisted living homes are required to have at least one care provider or employee with CPR training on duty at all times.[43] The Division alleged that Jagne's ALH violated this requirement. Mr. Diop did not have CPR training when he was the only care provider in the home.[44] The Division has proven this violation.

D. First Aid Training

An assisted living home is also required to have at least one care provider or employee on duty with first aid training.[45] Mr. Diop did not have the required training when he was the only care provider on duty.[46] The Division has proven this violation.

E. Tuberculosis

Any person who will be in direct contact with residents must be free from active pulmonary tuberculosis. Proof must be provided annually, and must be available for review by the Division.[47] Jagne's ALH III was unable to provide proof that Mr. Diop was free from active tuberculosis.[48] The Division has proven this violation.

F. Care Provider Orientation

Before a care provider provides care for a resident, the care provider must receive orientation about the home's policies and procedures. This orientation must include the policies related to fire safety, resident rights, abuse, neglect, exploitation, and mistreatment of residents, infection control, house rules, sanitation, medication management, and the physical layout of the home.[49] Mr. Jagne met with Mr. Diop and Ms. Jay, and provided them with some information about the home, and what was expected of care providers.[50] However, Mr. Diop and Ms. Jay were only provided minimal information. They were told to be there to help the residents, and to cook their meals.[51] They may also have been shown the physical layout of the home.[52] Mr. Diop and Ms. Jay were not provided information about infection control, resident rights, or how

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43 7 AAC 75.210(d)(1)(A).
44 Diop testimony.
45 7 AAC 75.210(d)(1)(B).
46 Diop testimony.
47 7 AAC 75.220(c).
48 Record at 4.
49 7 AAC 75.240(b).
50 Diop testimony.
51 *Id.*
52 Jagne testimony.

to recognize abuse, neglect, exploitation, or mistreatment of residents. The Division has proven that Jagne's ALH failed to properly orient Mr. Diop and Ms. Jay before they cared for residents.

G. Emergency Situations

When a resident is absent from the home without prior notice and could be at risk of harm, the assisted living home must access emergency services, if needed, and provide notice to the resident's representative.[53] M.S. was absent from the home without prior notice when Mr. Jagne arrived at around 8:00 p.m. He did not know how long she had been absent, but it could have been as long as eight hours. He knew that M.S. should not be unsupervised, and he knew that she had difficulty communicating with others. Despite this knowledge, Mr. Jagne did not contact the police until after 11:00 p.m.[54] He only spoke with Ms. F after 2:00 a.m., when she called him.

Mr. Jagne believed he needed to wait 24 hours, and also believed he needed more information from Mr. Jeng, before he could report that M.S. was missing.[55] As the administrator of an assisted living home caring for someone who should not be left alone, Mr. Jagne should have recognized the importance of reporting her absence immediately. There is no requirement to wait 24 hours before reporting anyone missing, and while more information from Mr. Jeng might have been helpful, that information could have been added after reporting M.S.'s absence. The Division has proven this violation.

H. Criminal History Check (Background Check)

Before an individual may be associated with an assisted living home as a service provider, employee, or volunteer, the home must request and obtain an approved criminal history check.[56] It is undisputed that Jagne's ALH did not request a criminal history check for Mr. Diop or Ms. Jay. Mr. Diop had not had a criminal history check.[57] Ms. Jay had been working for another care providing entity, and had passed a background check.[58] She was prepared to provide proof to Mr. Jagne, but he did not request it. It is the home's obligation to request a

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53 7 AAC 75.290.

54 Record at 73. This document reflects contact with the police at 11:20 p.m. related to Mr. Jeng's attempt to re-enter the home to get his belongings. Mr. Jagne attempted to inform the police officers that M.S. was missing, but they told him he would have to call back to initiate another contact when they were finished with this first incident. Jagne testimony. He did call to report M.S. missing a few minutes after midnight. Record at 75.

55 Jagne testimony.

56 7 AAC 10.900(b); 7 AAC 10.910.

57 Diop testimony.

58 Jay testimony.

background check on each person who will be associated with the home. While there is no reason to believe that Ms. Jay would not have passed a criminal history check, there are times when someone has previously been approved but, because of a recent event, would no longer pass a criminal history check. Accordingly, it is important to request a check for each new employee, care provider, or volunteer. Mr. Jagne did not do this. The Division has proven this violation.

I. Cooperation with Investigation

An assisted living home is required to cooperate with an investigation by the Division.[59] The Division alleged that Jagne's ALH failed to cooperate because Ms. Jay was instructed not to let anyone into the home, and because Mr. Diop was told to give a false name.[60] The Division also alleged that Mr. Jagne lied to its investigator.[61] The instructions to Mr. Diop and Ms. Jay are not considered a failure to cooperate with an investigation, because the investigation did not start until after the instructions were given.[62] One cannot fail to cooperate until after an investigation has begun. However, on the second day of the investigation, Mr. Jagne was asked additional questions about the person who had been the care provider the day before (Mr. Diop). Mr. Jagne continued to assert that Mr. Jallow had been the care provider, when in fact he was not. Only when he was pressed on this issue did he finally admit that Mr. Diop was the volunteer who had been on duty the day before.[63] Providing false information to the Division during an investigation is a failure to cooperate. The Division has proven this violation.

J. Right to a Safe Environment

Assisted living home residents have rights, including the right to live in a safe and sanitary environment.[64] The Division alleged that M.S.'s environment was not safe because the home was not adequately staffed.[65] The general statement of a right to a safe environment is more specifically defined in regulations, including 7 AAC 75.210 which is discussed in section III B, above. This charge is duplicative, and is not considered a separate violation.

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59 AS 47.32.100.
60 Record at 9.
61 *Id.*
62 Telling Mr. Diop to lie about his name was a serious error, and is addressed in more detail in section III L. Telling Ms. Jay not to let anyone inside might be appropriate, but only if accompanied by instructions to allow Division personnel to enter and inspect the premises.
63 Brazington testimony.
64 AS 47.33.300(a)(1).
65 Record at 9.

K. Inspection of Financial Records

An applicant for an assisted living home license, or an applicant for a modified license must show it has sufficient financial resources:

> Before the department will approve an application under 7 AAC 75.080, the applicant must demonstrate that the home has sufficient financial resources to operate for a minimum of three months without considering resident income.[66]

If requested, the home must allow an inspection of its records to determine whether the home can meet this requirement.[67]

The Division alleged that Jagne's ALH was in violation of this requirement because he was unable to pay Mr. Jeng, and had received an eviction notice for failing to pay his rent.[68] Mr. Jagne conceded that he was having financial difficulties. However, the regulation cited by the Division only applies to an application for a new or modified license. Jagne's ALH was already licensed, and had not requested a modification.[69] This allegation has not been proven.[70]

L. Appropriate Remedy

The facts of this case are sufficiently severe to warrant revocation of the home's license and permanent closure of the home.[71]

Mr. Jagne was told on May 21st, by text message, that Mr. Jeng would not be available to work the next day. He was told again, on May 22nd, that there would be no staff at the home if no one showed up by noon. While this did not give Mr. Jagne very much warning, and he may have thought Mr. Jeng would in fact stay if a replacement did not show up, Mr. Jagne had to know there would be a serious problem if Mr. Jeng did leave. M.S. could not be left unattended, and Mr. Jagne could not risk having that happen. He should have taken steps to ensure that Mr. Jeng would stay, or he should have gone to the home himself. In the alternative, he could have contacted the Division to let them know of the impending crisis. Instead, Mr. Jagne did nothing for several hours.

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66 7 AAC 75.085.

67 *Id.*

68 Record at 9.

69 The home's license was valid from February 1, 2015 through January 31, 2017. Record at 2.

70 If there is another statute or regulation addressing continued financial stability while licensed, that provision was not cited in the notice of charges sent to Jagne's ALH. *See* 7 AAC 49.070 (requirement to state statute, regulation, or policy relied on).

71 *See* AS 47.32.140(d)(6) & (7).

The failure to take prompt action to ensure the home was staffed might, by itself, justify revocation and permanent closure.[72] The events that occurred afterward, however, make it unnecessary to decide that question. First, Mr. Jagne arrived around 8:00 pm but waited several more hours before reporting M.S. missing. Second, when he arranged for Mr. Diop and Ms. Jay to be care providers, he made no effort to obtain criminal history checks for them. Nor did he verify that they had CPR and first aid training, or that they were free from active tuberculosis. Mr. Jagne was told that Mr. Diop had done similar work before, and was told that Ms. Jay was currently employed at another care providing entity, but he did not even verify those statements. Next, he specifically told Mr. Diop to give a false name if anyone asked who he was. This is an indication that Mr. Jagne knew he should not use Mr. Diop as a care provider. Finally, Mr. Jagne attempted to mislead the Division during its investigation when he initially told them that Mr. Jallow had been the care provider when in fact it was someone else.

The Division cannot inspect every assisted living home every day. It must rely on owners and administrators to follow the rules. Here, Mr. Jagne ignored the rules about background checks and required training, and attempted to hide that fact by asking Mr. Diop to use someone else's name. He also provided false information during an investigation. This all occurred a short time after Mr. Jagne allowed Jagne's ALH to be unstaffed, and the residents unattended, for several hours. Under these circumstances, license revocation and permanent closure of the home is the appropriate remedy.

IV. Conclusion and Order

Jagne's ALH violated eight of the ten regulations and statutes listed in the Division's Report of Investigation & Notice of Violation. Accordingly, IT IS HEREBY ORDERED:

1. The assisted living home license for The Jagne's ALH III is revoked; and
2. The Jagne's ALH III assisted living home is permanently closed.

Dated this 4th day of August, 2015.

Signed
Jeffrey A. Friedman
Administrative Law Judge

[72] This would have been a serious failure even if M.S. had not wandered from the home.

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 16th day of September, 2015.

By: *Signed*
Name: Jared C. Kosin, J.D., M.B.A.
Title: Executive Director
Agency: Office of Rate Review, DHSS

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