BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

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| In the Matter of:<br><br>CLAIMANT,<br><br>and<br><br>SAN DIEGO REGIONAL CENTER,<br><br>Service Agency. | OAH No. 2016030611 |

# DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on May 23, 2016.

Wendy Dumlao, Attorney at Law, represented claimant, who was not present at the hearing.

Ronald House, Attorney at Law, represented San Diego Regional Center (SDRC).

The parties asked to submit written closing arguments and to keep the record open until June 6, 2016. Their request was granted and the parties submitted their respective briefs by June 6, 2016. On June 6, 2016, the record was closed and the matter submitted.

## ISSUES

1. Can SDRC withhold supportive living services (SLS) due to its belief that there are inadequate nursing support services for claimant?

2. If SDRC cannot withhold SLS services, should SDRC fund interim services, otherwise known as gap funding, until Licensed Vocational Nursing, Registered Nursing, or Certified Nursing Assistant nursing services are found?

## FACTUAL FINDINGS

### JURISDICTION AND CLAIMANT'S FAIR HEARING REQUEST

1. On February 29, 2016, claimant, through her attorney, requested a fair hearing seeking payment of Supportive Living Services (SLS) and Independent Living Services (ILS) hours. As stated in the fair hearing request, claimant asked that SDRC fund SLS and ILS until SDRC obtains a Health and Safety waiver to cover the gap in hours. In the alternative, claimant asked that SDRC vendorize "SLS agencies nurse [sic] and fund those hours until [Medi-Cal] finds nurses to cover the shifts."[1] In her fair hearing request, claimant also requested aid paid pending, but the parties resolved this issue prior to the hearing and it is not addressed in this decision.

### CLAIMANT'S MEDICAL HISTORY AND SERVICES AND SUPPORTS RECEIVED

2. Claimant is a 38-year-old, non-ambulatory, verbal female. Her diagnoses include mild intellectual disability, cerebral palsy, chronic respiratory failure, unspecified anemia, history of seizures, congenital malformation of skull and face bones, Pfeiffer syndrome, alpha one anti-tryptan deficiency, scoliosis, paraplegia, profound hearing loss, vision impairment, tracheostomy, chronic obstructive pulmonary disease and

[1] SDRC, in a letter dated February 24, 2016, to the provider of claimant's SLS services stated that SDRC "will not approve a supportive living plan that lacks components believed by the SDRC to be integral to [claimant's] health and safety needs. . ."

hydrocephalus with a VP shunt.[2] Claimant uses an electric wheelchair that she maneuvers herself.

Claimant has had over forty surgeries since she was three weeks old. She has had a tracheostomy since birth. She has a history of pneumonia and was hospitalized for one year in 2013 for pneumonia. During this hospitalization, she developed MRSA and decubitus ulcers, or bed sores. Claimant was transferred to Jacobs Healthcare where an attempt was made to insert a smaller tracheostomy tube, she suffered a cardiopulmonary arrest, and was resuscitated. As a result she developed scar tissue that makes it difficult to undergo a tracheostomy change for claimant's health. She was eventually transferred to Carmel Mountain Rehabilitation Center in October of 2013, where she remained until February 22, 2016, when she moved into her own residence under the Medi-Cal Nursing Facility (NF) Waiver Program.

Claimant receives Supplemental Security Income and In Home Supportive Services (IHSS), and she participates in the Medi-Cal NF Waiver Program.[3] Claimant requires 24 hour/seven day a week care. She presently receives 187 hours of IHSS services and participates, once a week for four or five hours a day, in a day program. Her supportive living services provider, Networx, has asked SDRC to fund the following hours: 100 hours of Independent Living Training; 195 hours of personal assistance services; and 248 hours of

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[2] A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is usually placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. https://www.nlm.nih.gov/medlineplus/ency/article/002955.htm

[3] The waiver serves Medi-Cal beneficiaries who, in the absence of this waiver, and as a matter of medical necessity, would require care in an inpatient nursing facility (NF). http://www.dhcs.ca.gov/services/ltc/Documents/Participant_Requirements.pdf.

personal support.

TESTIMONY OF LINDA LIVINGSTON AND CLAIMANT'S IPP

3. Linda Livingston is Resource Coordinator at SDRC where she has worked for the last 26 years. Ms. Livingston described SLS as an array of supports and services that allow a consumer to live in his or her own home. These supports and services are developed through a consumer's planning team who must consider generic supports and the client's needs.

Ms. Livingston explained that the disagreement in claimant's case concerns whether claimant needs Licensed Vocational Nursing (LVN) services to live in her home. SDRC believes that LVN care is necessary to ensure that claimant is safe in her home, and claimant does not believe LVN services are necessary to meet her needs. Ms. Livingstone noted that claimant wanted to live in her own home, and the planning team met to facilitate this, as documented in claimant's June 25, 2015, Individual Program Plan. At the time, claimant was residing at Carmel Mountain Rehabilitation Center, a residential care facility. Towards this goal, the planning team agreed to help claimant select an "appropriate living arrangement" in the community on or by June 2018. The planning team included claimant; claimant's conservators; claimant's subacute care coordinator at Carmel Mountain Rehabilitation Center; claimant's respiratory therapist from this facility; individuals from Networx Supportive Living; and representatives from SDRC, including Kathy Karins, RN.

As part of the process to help claimant move into her own home, SDRC contracted for two assessments: One from a provider selected by claimant's family and one by a nursing coordinator. Based on these assessments, it was determined that claimant required licensed vocational nursing care 24/7. Ms. Livingston stated that the present appeal in this matter interrupted the planning process and a standardized assessment questionnaire, as required under Welfare and Institutions Code section 4689, subdivision

(p)(1), was not completed.

Ms. Livingston acknowledged that SDRC has the responsibility to "gap fund" services that aren't funded by generic resources or provided by a consumer's natural supports. She explained that in claimant's case, the contracted rate that SDRC is allowed to pay for nursing services is not adequate to meet her needs because SDRC cannot find nursing services that accept this contracted rate. SDRC has not applied for a Health and Safety Waiver in order to obtain the ability to pay a higher rate. Ms. Livingston noted that SDRC pays Networxs a flat rate of $5,300 monthly and Networxs arranges the SLS services. SDRC, she said, would fund 8 hours per day of SLS services while Medi-Cal would fund the remaining 16 hours. Ms. Livingston also noted that she has worked with Networxs for the last 15 years and has confidence in the organization's ability to arrange and provide services to consumers.

TESTIMONY OF KATHY KARINS, RN

4. Kathy Karins, RN, testified on behalf of the regional center. Ms. Karins has worked at SDRC for the last 18 years and is Director of Clinical Services at SDRC. Previously, Ms. Karins was SDRC's Supervisor of Nursing Services. Ms. Karins has worked as a registered nurse since 1984 in a number of different areas including home health care and personal assistance. Ms. Karins has known claimant for the last eight years since she (claimaint) became an SDRC client and is familiar with her medical conditions. She testified that she has seen claimant at her apartment and she looked happy and well, and staff were informed about her needs.

Ms. Karins was concerned that there was no nursing oversight of claimant's care, limited training of staff caring for claimant, and the training that existed consisted of staff training other staff. The lack of oversight and training represented "a huge safety issue" because of claimant's tracheostomy. To cover the 16 hours a day to care for claimant or provide oversight and training to staff, Ms. Karins contacted numerous nursing staffing

agencies and vendors; however, she was unable to find nurses to care for claimant.

Ms. Karins was specifically concerned that staff did not have the knowledge necessary to monitor and assess issues regarding her tracheostomy tube and stoma to ensure the airway was clear and clean. She described the tasks of examining the stoma: Suctioning the trach tube; untying the trach tubes; and assessing the secretions, as complex tasks.

To highlight her concern, Ms. Karins cited a note from claimant's January 28, 2016 Nursing Health Assessment from Maria R. Vella, RN. Ms. Vella talked to claimant's pulmonologist, Dr. Kalafer, who told her that claimant is not able to suction herself or put her trach back in if it comes out. He stated that if the trach comes out and is not put back in she could suffocate and possibly die. He recommended that she only leave the hospital if she has twenty-four hour caregivers. He stated that her caregivers had to be trained in all aspects of her trach, suctioning and trach care.

Ms. Karins stressed that, in her opinion, claimant requires skilled nurses to perform tasks relating to the tracheostomy pursuant to Board of Registered Nursing (BRN) and American Nursing Association guidelines. She said that SDRC's procedures, memorialized in a document titled "SDRC Procedure Regarding Clients receiving SDRC Funded Supportive Living Services Who also have Restricted Health Care Conditions" incorporates these guidelines in order to identify regional center clients who need skilled nursing care.

Under SDRC's procedure, the SLS agency's consulting registered nurse develops an Individual Health Care Support Plan. This plan documents training provided to staff by licensed healthcare practitioners prior to care being provided. The plan also includes documentation from a consumer's primary doctor concerning the consumer's medical condition; the identification of a licensed professional who will perform procedures if the client needs medical assistance; identification of persons who will performed medical assistance that does not require a licensed professional; names of all physicians involved in

the consumer's care; identification of the consumer's adaptive equipment and name of the medical supply company; a date the primary care doctor or designee will review the plan; a signed statement from the primary doctor that the plan meets the scope of the practice; and a signed statement from the SDRC representative that SDRC has reviewed and approved the plan and will be responsible for monitoring the plan.

SDRC's procedure document noted the following:

> (IHSS) funded staff, or family members may be trained to support these [restricted health care conditions], but the Supportive Living Agency coordinating services must ensure that any unlicensed assistive personnel has received training by a licensed healthcare practitioner for the support they provide. . . .

Ms. Karins recognized that nurses trained some staff, and the guidelines she cited permitted family members to do the tasks associated with claimant's tracheostomy. On cross examination, Ms. Karins was asked whether having a tracheostomy requires a nurse to provide care and monitor claimant's tracheostomy. Ms. Karins respondent, "it depends."

5. The BRN guidelines Ms. Karins relied on in her testimony do not bar unlicensed support staff from providing tracheostomy care for claimant. In fact, the guidelines give the suctioning of chronic tracheotomies as an example of a task that a nurse may assign.

As stated in the BRN guidelines, registered nurses "can use" the guidelines "when called upon to make decisions about assigning to and supervising of unlicensed assistive personnel. Unlicensed care givers should be utilized only to be assistive to licensed nursing personnel." A registered nurse may assign tasks that do not require the professional judgment of a registered nurse. The tasks must (a) be considered routine care for the patient; (b) pose little potential hazard for the patient; (c) involve little or no

modification from one client-care situation to another; (d) be performed with a predictable outcome; and (e) not inherently involve ongoing assessments, interpretations, or decision-making which could not be logically separated from the procedure itself. All of these criteria appear to be present with regards to claimant's tracheostomy care.[4]

TESTIMONY OF CLAIMANT'S SISTER

6. Claimant's sister, who is claimant's co-conservator, testified at the hearing. As conservator, with her brother, claimant's sister has the power to make medical decisions on claimant's behalf and choose where claimant lives. Claimant's sister sees claimant daily; monitors the in home care she receives; and is in daily close contact with her healthcare providers. Claimant has had a trach tube all her life; claimant's sister took care of claimant throughout her life and performed the suctioning of the tube without problems. She described claimant as able to express her needs clearly, and she said claimant can do most of the suctioning of the trach tube herself.

7. Claimant's sister said that claimant wanted to be independent and live in the community, and she is now very happy now and doing well. Claimant's sister explained that on February 22, 2016, claimant moved into her apartment because she was about to lose her Medi-Cal NF Waiver funding that gave claimant the ability to move into her apartment. SDRC wanted her to remain at Carmel Mountain Rehabilitation Center.

[4] The record is unclear whether a nurse formally assigned tracheostomy care to claimant's non-nursing providers. But, even if this was not the case, as discussed below, a nurse provided training to claimant's providers with the understanding that they would provide tracheostomy care, and Drs. Kalafer and Freeman stated that non-medical staff can provide this care with training. Regardless, the BRN guidelines recognize that it is not contrary to a patient's health and safety for non-nursing staff to provide tracheostomy care.

Claimant's sister said claimant wasn't doing well at Carmel Mountain; she was isolating herself; and was very depressed. Claimant's sister was concerned that claimant would lose her will to live if she stayed at Carmel Mountain.

8. Claimant's sister said that claimant's family does not oppose nurses caring for claimant, but they have not been able to find nurses that comply with the NF Waiver. She said Dr. Kalafer told Ms. Vella that claimant requires in home care consisting of 24 hour support staff who are trained in airway management but who do not necessarily need to be licensed nurses. Martin Freeman, M.D., claimant's primary care doctor, agreed with Dr. Kalafer, and stated in a declaration that "(n)on-medical personnel can provide [paramedical services] with physician oversight and nursing services as ordered by a physician as required." Claimant's sister commented that claimant never needed nursing services while she was living with her family.

9. Claimant's sister has confidence in the staff that monitors and cares for claimant. She stressed that a registered nurse trains claimant's staff and the RN is in constant communication with staff. She said that claimant's family recognized the risks involved due to nonmedical staff caring for claimant due to her medical fragility.

TESTIMONY OF DEBORAH CALLAHAN

10. Deborah Callahan is the Director of Networxs. Ms. Callahan has spent the last 28 years working with persons with developmental disabilities and their special healthcare needs.

11. Ms. Callahan has been involved with providing supportive living services for claimant for the last year. In August 2015, she submitted to SDRC a detailed Individual Supportive Living Plan for claimant. This plan was revised on December 15, 17, 2015, and February 17, February 18 and February 24, 2016. Under a budget she prepared dated March 25, 2016 and revised May 17, 2016, Networxs is seeking 187 hours in In Home Support Services; 100 hours for Independent Living Training; 195 hours for Personal

Assistance Services; and 248 hours for Personal Support. Ms. Callahan noted that even with IHSS and Medi-Cal to fill the gap in support hours, additional funding is required. Ms. Callahan noted that Med-Cal pays for a nurse who spends two to three hours a week at claimant's home, and she noted that claimant receives nursing services at the day program she attends.

12. Ms. Callahan does not believe that claimant needs skilled nursing services; she believes that trained non-nursing staff can adequately support claimant 24/7, although she would accept nurses if nurses could be found. She testified that she contacted 20 to 30 nursing staffing agencies, including SDRC vendors, and was unable to find nurses who could provide supportive living services for claimant. Ms. Callahan stressed that Dr. Freeman, claimant's doctor, does not believe that nursing services are required. She cited his declaration dated April 19, 2016, in which he stated, "[claimant] requires paramedical services as well as assistance in all daily living skills. Non-medical personnel can provide these services with physician oversight and nursing services as ordered by a physician when required." Ms. Callahan added that IHSS does not require licensed nursing services and claimant's family does not believe licensed nursing services are necessary.

13. With SDRC's agreement Ms. Callahan arranged for a nurse to provide training to Networx staff in tracheostomy care and suctioning, administration of enemas, and monitoring for seizures. The nurse who provided this staff training prepared a detailed twenty-two page curriculum for staff, which was made part of the record. Staff signed verifications that they received the training and both the training curriculum and verifications were provided to SDRC. Ms. Callahan observed staff after they were trained to ensure that they followed the nurse's instructions.

TESTIMONY OF REBECCA AHZOCAR

14. Rebecca Ahzocar is claimant's coordinator of services at Networxs; she coordinates claimant's medical care and outings. Ms. Ahzocar has worked for the last 15

years with persons with developmental disabilities.

Ms. Ahzocar testified that she and all staff received the training provided by the nurse; staff do not work with claimant until they are trained, and she has observed them work with claimant. She stated that claimant requires suctioning three to eight times a day and more often at night. Ms. Ahzocar stated that claimant can suction herself, and she can express how she feels to staff. At night claimant uses oxygen, and Ms. Ahzocar uses an oximeter to measure claimant's oxygen levels as directed by claimant's doctor. Ms. Ahzocar does not believe that claimant's health is at risk right now; she believes that Networx staff can meet claimant's needs.

THE PARTIES' ARGUMENTS

15. SDRC in its post hearing submission described the issue as whether SDRC should be compelled to pay for a supportive living plan SDRC believes is unsafe. SDRC highlighted one part of the BRN guidelines that states, "Unlicensed assistive personnel may not reassign an assigned [nursing] task." At the same time, SDRC acknowledged that claimant is well cared for and happy in her placement.

Claimant in her post hearing brief argued that she has the right to live in her own home in the community, and she can live safely without nursing services with the SLS services Networxs has in place. She cited Welfare and Institutions Code section 4689. Under this section a consumer is entitled to supportive living arrangements typical for persons without disabilities and the services or supports offered must be flexible and tailored to the consumer's needs and preferences. Claimant also cited California Code of Regulation, title 17, section 58632, which requires that a service design for SLS services requires only that the "[r]isks of endangerment to health, safety, and well-being are minimized" not removed entirely. Claimant added, in response to Ms. Livingston's testimony regarding claimant's failure to complete the standardized questionnaire, that Welfare and Institutions Code section 4689, subdivision (p)(1), does not mandate the

denial of SLS services if claimant failed to complete the standardized assessment questionnaire. Claimant noted that this questionnaire was not completed at the time of claimant's IPP as required under Section 4689, subdivision (p)(1), and this failure was not claimant' s fault.

## LEGAL CONCLUSIONS

### BURDEN AND STANDARD OF PROOF

1. "Burden of proof" means the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court; except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evid. Code, § 115.) In this matter, claimant has the burden of establishing that SDRC is required to fund the requested non-nursing supportive living services.

2. A preponderance of the evidence means that the evidence on one side outweighs the evidence on the other side, not necessarily in number of witnesses or quantity, but in its effect on those to whom it is addressed. In other words, the term refers to evidence that has more convincing force than that opposed to it. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.) In order to prevail, the party with the burden of proof is only required to provide evidence that is more persuasive for his position than the evidence against.

3. "'Preponderance of the evidence means evidence that has more convincing force than that opposed to it.' [Citations.] . . . . The sole focus of the legal definition of 'preponderance' in the phrase 'preponderance of the evidence' is on the *quality* of the evidence. The *quantity* of the evidence presented by each side is irrelevant." (*Glage v. Hawes Firearms Company* (1990) 226 Cal.App.3d 314, 324-325.) "If the evidence is so evenly balanced that you are unable to say that the evidence on either side of an issue

preponderates, your finding on that issue must be against the party who had the burden of proving it [citation]." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 663.)

THE LANTERMAN ACT

4. Pursuant to the Lanterman Developmental Disabilities Services Act, the State of California accepts responsibility for persons with developmental disabilities. (Welf. & Inst. Code, § 4500, et seq.) The purpose of the Act is to rectify the problem of inadequate treatment and services for the developmentally disabled and to enable developmentally disabled individuals to lead independent and productive lives in the least restrictive setting possible. (Welf. & Inst. Code, §§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Act is a remedial statute; as such it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

5. When an individual is found to have a developmental disability under the Lanterman Act, the State of California, through a regional center, accepts responsibility for providing services to that person to support his or her integration into the mainstream life in the community. (Welf. & Inst. *Code*, § 4501.) The Lanterman Act acknowledges the "complexities" of providing services and supports to people with developmental disabilities "to ensure that no gaps occur in . . . [the] provision of services and supports." (Welf. & Inst. Code, § 4501.)

6. Welfare and Institutions Code section 4512, subdivision (b), defines "services and supports":

> "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or

> toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, and normal lives. . . . Services and supports listed in the individual program plan may include, but are not limited to, . . . personal care, day care, special living arrangements, . . .protective and other social and sociolegal services, information and referral services, . . . [and] supported living arrangements . . . .
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> services,. . . [and] supported living arrangements.

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LAWS RELATING TO REGIONAL CENTER'S PURCHASE OF SERVICES AND "GAP" FUNDING

7. Regional centers shall ensure adherence with federal and state law and regulations, and when purchasing services and supports shall ensure all of the following: (1) Conformance with the regional center's approved purchase of service policies, (2) Utilization of generic services and supports when appropriate; (3) Utilization of other services and sources of funding under Section 4659. . . . (Welf. & Inst. Code, § 4646.4, subd. (a).)

8. Regional center funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving public funds. (Welf. & Inst. Code, § 4646, subd. (a)(8).) Regional centers shall identify and pursue all possible sources of funding for consumers receiving regional center services. (Welf. & Inst. Code, § 4659, subd. (a).) Effective July 1, 2009, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services,

California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. (Welf. & Inst. Code, § 4659, subd. (c).)

9. A regional center must secure services and supports that meet the needs of a consumer, as determined by the consumer's IPP, and "within the context of the (IPP)." (Welf. & Inst. Code, § 4648, subd. (a)(1).) If a service specified in a client's IPP is not provided by a generic agency, the regional center must fill the gap, or fund the service, in order to meet the goals set forth in the IPP (*Id.*; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 390).)

LAWS AND REGULATIONS RELATING TO SUPPORTIVE LIVING SERVICES

10. The Lanterman Act also places a "high priority" on providing opportunities for adults with developmental disabilities, regardless of the degree of disability, to live "in their own homes" with "support available as often and for as long as it is needed." (Welf. & Inst. Code, § 4689.) Towards this goal, regional centers shall ensure that supportive living arrangements are "flexible and tailored to a consumer's needs and preferences" and that consumers are not excluded from supportive living arrangements based "solely on the nature and severity of their disabilities." Personal assistance is a service and support option that may be provided where it would "result in greater self-sufficiency for the consumer and cost-effectiveness to the state." (Welf. & Inst. Code, § 4648, subd. (a)(11).) The range of supported living services and supports is identified, non-exclusively, under Welfare and Institutions Code section 4689, subdivision (c), and California Code of Regulations, title 17, section 58614, subdivision (b)(1)-(16).

11. When creating a service design for supportive living services, consistent with the principles stated in Welfare and Institutions Code section 4689, subdivision (a)(1) through (a)(8), a competent vendor must provide ongoing monitoring to help confirm, assure, or signal that "supports and services remain responsive to the consumer's needs

and preferences" and "[r]isks of endangerment to health, safety, and well-being are minimized." (Cal. Code Reg., tit., 17 § 58632, subds. (b)(2) and (b)(3).)

12. "Supported Living Arrangement" means the full array of regional center-funded services and supports received by a SLS consumer, including SLS, day program, transportation, and all other regional center services and supports. (Cal. Code Reg., tit., 17 § 58601, subd. (a)(7).)

13. Under Welfare and Institutions Code section 4689, subdivision (p)(1), to ensure that consumers in or entering into supportive living arrangements receive the appropriate amount and type of supports to meet the person's choice of needs as determined by the IPP team, and that generic resources are utilized to the fullest extent possible, the IPP team must complete a standardized assessment questionnaire at the time of development, review, or modification of a consumer's IPP. The questionnaire shall be used during the individual program plan meetings, in additional to the provider's assessment, to assist in determining whether the services provided or recommended are necessary and sufficient and that the most cost effective methods of supported living services are utilized.

EVALUATION AND DISPOSITION

14. The dispute in this case is whether SDRC should be required to fund a supportive living plan it believes is unsafe because it believes only nurses may safely monitor claimant's airway management and provide tracheostomy care. This dispute exists because neither SDRC nor claimant has been able to find nurses who will accept SDRC's contracted rate to provide these services. As a result, claimant's provider has developed a plan that uses non-nursing staff to monitor claimant's airway and provide tracheostomy care.

SDRC's argument that the provider's service plan is unsafe was not convincing. The weight of the evidence showed that the supportive living services plan currently in place

allows for claimant to live safely in her home in the community consistent with the goal of her IPP and section 4512, subdivision (b). Doctor Kalafer stated that non-nursing support staff trained in airway management can safely provide airway management services and tracheostomy care; Dr. Freeman stated that non-nursing staff can safely provide these services; the provider's staff work closely with claimant's family and doctor; a nurse visits claimant weekly; at claimant's day program a nurse monitors her; and claimant appears to be doing well under the service plan and claimant's family has confidence in the plan. The BRN guidelines SDRC cited to support its belief that the service plan is unsafe recognize that a nurse may assign routine tasks, such as tracheostomy care, to non-nursing staff, and in her testimony, Ms. Karins did not state that it is inherently unsafe for non-nursing staff to provide tracheostomy care and airway management.

The parties recognized that nursing staff would, ideally, be available to claimant for tracheostomy care. Until nursing services are found, or SDRC obtains a waiver to obtain the ability to pay a higher contracted rate, SDRC must fill the gap and fund the services presently in place in order to meet the goals in claimant's IPP. [5]

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[5] SDRC stated that the IPP planning process to find an appropriate living arrangement was interrupted when she moved into her apartment in February 2016 and she requested this hearing. SDRC did not, however, assert this interruption as a basis to deny claimant's appeal except as background to claimant's appeal. Regardless, it is noted that claimant's IPP anticipated that claimant would move into the community by June 2018, and claimant needed to move into her apartment, because if she did not, the NF Waiver she obtained would expire. It is further noted that while claimant did not complete the Section 4689 supportive living arrangement questionnaire, the IPP planning team as a whole had the responsibility to make sure this form was completed. SDRC also did not argue that the failure to complete this form means that claimant should not be living in her apartment without some level of 24/7 supportive services. Claimant may complete this

## ORDER

Claimant's appeal is granted. SDRC shall fund the following hours monthly: 100 hours for Independent Living Training; 195 hours for Personal Assistance Services; and 248 hours for Personal Support. SDRC shall fund these hours until Licensed Vocational Nursing, Registered Nursing, or Certified Nursing Assistant nursing services are found to provide the applicable services.

DATED: June 20, 2016

_____/s/_____

ABRAHAM M. LEVY

Administrative Law Judge

Office of Administrative Hearings

## NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within ninety days.

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questionnaire at claimant's next IPP meeting for purposes of changing or modifying any supports and services she receives.