BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, and SAN DIEGO REGIONAL CENTER, Service Agency.	OAH No. 2017030241

DECISION

Theresa M. Brehl, Administrative Law Judge, Office of Administrative Hearings, State of California (OAH), heard this matter in San Diego, California, on May 22, 2017.

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

Wendy Dumlao, Attorney at Law, represented claimant.

The matter was submitted on June 2, 2017.[1]

ISSUES

Should SDRC fund non-nursing level respite care?

[1] The record was held open to allow the parties to simultaneously submit written closing arguments on June 2, 2017.Claimant's Closing Argument Brief was marked as Exhibit Q for identification, and SDRC's closing argument brief was marked as Exhibit 7 for identification.

FACTUAL FINDINGS

CLAIMANT'S FAIR HEARING REQUEST

1. Claimant's mother submitted a Fair Hearing Request on February 10, 2017. Her request stated the following under the heading "Reason(s) for requesting a fair hearing":

> On 12/14/16, after SD County reduced [claimant's] IHSS hours I requested assistance from SDRC. This request was provided to my SC. She has ignored my request.

The request described what was needed to resolve the complaint as:

> Authorization of some personal attendant hours for [claimant]. She has a major gap in care hours, because of a reduction in IHSS and lack of nurses.

CLAIMANT'S MEDICAL CONDITION AND CARE NEEDS

2. Claimant is an 11-year-old girl. She is eligible for regional center services based on her diagnoses of cerebral palsy and unspecified intellectual disability. Claimant is non-verbal, non-ambulatory, and medically fragile. She is unable to move any of her limbs. Her medical diagnoses include Spinal Muscular Atrophy Type I (SMA I), Chronic Respiratory Failure with Tracheostomy and Ventilator Dependence, GJ Tube Feeding Dependence, Gastroesophageal Reflux Disease (GERD), and Bilateral Hip Subluxation. She had scoliosis surgery in October 2016. She requires 24-hour care, and she relies on others to meet all her daily needs. Claimant has been dependent on a ventilator, a tracheostomy that requires suctioning, and a JG-tube for medications and feeding since she was an infant.

3. Claimant resided at Rady Children's Bernardy Center until 2010. Since 2010, Claimant has lived with her parents, younger sister, and teenage brother. Her sister also receives regional center services. Claimant's in home medical equipment includes a wheel chair, hospital bed, Hoyer lift, oxygen, nebulizer, LTV 950 ventilator, suction machine, humidifier, trach, Enteralite Infinity feeding pump and feeding pole, GI Mickey Double Button for medications and feedings, and J-tube for formula feedings.

4. According to a January 23, 2015, Nurse Assessment Report, claimant's health had "been stable over the past year with only one hospitalization at Rady Children's on 8/18/14 for routine ventilator titration." The report also noted her medical treatments included:

> Vest treatments: 3 times per day to help maintain lung function
>
> Oral suctioning: 30 times per 8 hours to control oral secretions with breakdown facial skin
>
> Trach suctioning: 2-3 times per 8 hour shift

5. Claimant is authorized to receive 22 hours per day of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) nursing level care through Medi-Cal. Claimant was previously authorized to receive 230 hours per month of In-Home Supportive Services (IHSS) through the county. However, the county terminated her IHSS services, and after an administrative hearing before the California Department of Health Care Services, she was awarded a maximum of eight hours of IHSS care per week. SDRC authorized funding 90 hours per quarter (30 hours per month) of in-home licensed vocational nursing (LVN) respite care services.

6. Finding nurses to staff her care has been difficult. Despite the nursing level care hours Medi-Cal and SDRC authorized, claimant has been recently receiving only approximately 24 hours of nursing care per week. Claimant's parents provide her care when nursing staff is not available.

7. SDRC has assisted claimant's mother in her attempts to find nurses to staff claimant's care, including calling several nursing agencies, Medi-Cal EPSDT workers, and regional center vendors.

SDRC'S ASSESSMENT AND ATTEMPTS TO ASSIST CLAIMANT WITH NURSING CARE NEEDS

8. Norma Flores and Eleanor Bautista testified regarding SDRC's assessment of the level of services SDRC may fund and SDRC's efforts to help claimant's mother find nursing staff.

9. Ms. Flores is a Social Work Counselor at SDRC, where she has worked for 21 years. She holds an Associate's Degree in Psychology, a Bachelor's Degree in Behavioral Sciences, and a Master's Degree in Counseling and Psychology. She has been claimant's regional center service coordinator for the past three years.

Ms. Flores prepared claimant's January 4, 2017, SDRC Individual Program Plan (IPP). The IPP stated claimant had "maintained stable health," and there had "been a challenge in locating nursing to cover all the hours of care" claimant needs. The IPP also stated claimant was authorized to receive 16 hours[2] per day of EPSDT nursing services funded by Medi-Cal, and 30 hours per month of in-home licensed vocational nurse (LVN) respite care services funded by SDRC.

According to Ms. Flores, claimant's mother has experienced difficulty finding nurses to staff claimant's Medi-Cal and SDRC funded nursing and respite care due to a

[2] The witnesses testified Medi-Cal authorized 22 hours per day of nursing care.

nursing shortage. In addition to the nursing shortage, Ms. Flores learned claimant's mother has some criteria that limit who may provide nursing services, including wanting the nurses to be female, speak Spanish, and have experience. Claimant's mother has been willing to accept Filipino nurses who speak some Spanish. It has also been difficult to find nurses willing to work in claimant's neighborhood, which is not safe during the afternoon. One nurse was assaulted, and therefore, it has been hard to find nurses willing to work in that area at night or in the evening. Additionally, two of SDRC's vendor nurses, who had been caring for claimant, decided during 2016 that they no longer wanted to work with the family.

Ms. Flores has made multiple attempts to assist claimant's mother find nurses, including trying to locate nurses to cover the Medi-Cal funded hours. Ms. Flores documented her efforts to help claimant's mother in SDRC's consumer (Title 19) notes.

According to the Title 19 notes, in January 2016, Ms. Flores gave claimant's mother the names of Spanish speaking nurses. Also in January 2016, SDRC agreed to fund an additional 15 hours per month of LVN level respite care for six months. During a February 2016 conversation, Ms. Flores told claimant's mother that Ms. Flores had called three agencies, Premier Nursing, ACCESS, and Dependable Nursing Care, none of which had nurses available to cover the hours claimant needed. During that conversation, claimant's mother told Ms. Flores that another agency, Maxim, had nurses available to provide LVN care. In March 2016, one of SDRC's vendor LVNs, Eunice, complained that claimant's mother was rude to her, and in April 2016, that LVN decided she would not return to work for the family. In April 2016, Premier Nursing notified Ms. Flores that it had begun covering 56 hours of nursing care per week, including two night shifts. In July 2016, Premier Nursing told Ms. Flores that it was then supplying 72 hours of nursing care per month to the family. During July 2016, SDRC agreed to fund an additional 15 hours per month of respite care for three months.

In December 2016, Ms. Flores learned that claimant's afternoon nurse would no longer be able to cover those hours, and Ms. Flores then sent LVN level nurse information to claimant's mother. In December 2016, SDRC again agreed to fund an additional 15 hours for December 19 to 31, 2016. In January 2017, SDRC again agreed to fund additional LVN hours, and Ms. Flores provided claimant's mother a nurse list. In March 2017, an SDRC vendor LVN, Evelia, complained to Ms. Flores that claimant's mother had made rude comments to her, which led the LVN to believe claimant's mother did not want her to work with claimant anymore. That LVN decided later in March 2017 that she no longer wanted to work with the family. In March 2017, one of the LVNs who provided nursing care through Premier Nursing advised Ms. Flores she could provide SDRC funded respite services.

As a result of the difficulty finding nurses to cover the Medi-Cal and SDRC authorized hours, claimant has not had full-time nursing care. Claimant has nevertheless maintained her health.

10. Ms. Bautista has worked for SDRC for four years, and has been the Nurse Supervisor for the past year. She has an Associate's Degree in Nursing, and she obtained her Registered Nurse license in 2012. She has been working on her Bachelor's Degree in Nursing. Ms. Bautista has experience working with clients in an in-home setting.

Ms. Bautista conducted a nursing assessment in May 2017 to evaluate the level of care necessary for claimant's SDRC funded respite care, and she prepared a Nursing Health Assessment, dated May 19, 2017. Ms. Bautista determined that claimant would need nursing level care, that a lay person could not provide, and the care provider should be certified. Ms. Bautista explained that there were two types of licensure, an LVN or a registered nurse (RN). She determined claimant required at least an LVN level of care for the following reasons: Claimant's medical needs are complex, claimant is ventilator and tracheostomy dependent, claimant requires nebulizer treatment, claimant

requires GJ-tube feedings and medication administration, and claimant requires oxygen administration.

Under the "Recommendations & Plans" heading in Ms. Bautista's Nursing Health Assessment, she wrote:

1. [Claimant] is a medically fragile girl with the following skilled nursing care needs: ventilator dependence; oral and tracheostomy suctioning; tracheostomy care; scheduled and "as needed" nebulizer treatments; oxygen saturation monitoring; oxygen titrated to keep oygen [sic] saturation greater than 92%; GJ tube feedings and administration of complex medication regimen.
2. Due to above skilled nursing needs as well as need for constant monitoring and assessment, the recommended level of care is LVN.
3. This nurse is available to assist per request of Service Coordinator.

On cross-examination, Ms. Bautista acknowledged that claimant had not been receiving full-time nursing care, but she stated that claimant was "not necessarily stable." She noted that claimant's oxygen levels dropped and her trach needed to be suctioned. She also explained that although IHSS providers usually provide personal care, they may also perform paramedical services if it is "signed off by a doctor" and the provider received training to give such care.

CLAIMANT'S MOTHER'S TESTIMONY

11. Claimant's mother wants her daughter to live with her at home, where she believes her daughter receives better and more care, as well as the love and attention no one else can provide. She does not want her daughter to live in a convalescent home. She was in a convalescent home in the past, where they had some good and some bad experiences. They moved her home in 2010. They took claimant to the emergency room during the first and second year she was home due to respiratory

problems and problems with her feeding tube. After they found solutions to those problems, there were no more emergencies. When claimant was at the convalescent home, she was in the emergency room "all the time."

Although claimant needs 24-hour care, they only have nurses three days a week, for eight hours a day. They have always had trouble finding nurses. Claimant's mother would like the nurses to be women and Spanish speaking. She has had problems with nurses in the past, including nurses who "feel they can do whatever they want," such as missing work whenever they want, sometimes at the last minute, and sometimes without even bothering to call. She has had to accommodate the nurses' schedules.

Claimant's mother talked to Ms. Flores multiple times regarding the problems she experienced finding nurses. When claimant's mother asked if they could use non-nurses, Ms. Flores told her there was no program where they could. Ms. Flores also told her that because there were no nurses available, they could put claimant in a convalescent home.

When there are no nurses, claimant's parents rotate the care, but "it is heavy." Claimant's father helps at night and sleeps during the day. He works approximately four days a week. Claimant's mother does not work outside the home. When they received 230 hours through IHSS, claimant's mother taught the IHSS care givers how to use the G-tube and how to suction claimant's mouth.

Although claimant's mother used to be worried about unlicensed staff, she needs someone to help because her other children need her. Due to all the time claimant's parents spend caring for claimant, they have less time to spend with their other two children. Their son has been having some serious issues, including that he does not have any friends and he does not want to go to school.

Even when claimant has nurses, her mother has caught them falling asleep. There are various people who would like to help. Some have experience with tube feeding, but

claimant's mother does not know the experience they have. She plans to train them, she would always be in the apartment, and they could call her for anything.

UNLICENSED PERSONS WILLING TO PROVIDE THE RESPITE CARE REQUESTED

12. Two witnesses, Marciela Olaguas and Adriana Escorza, testified that they are willing to be claimant's care givers. Neither of them is licensed to work as a nurse, either as an RN or LVN, in California. Claimant's mother also identified a third unlicensed person willing to provide the care, but that person was not available to testify at the hearing.

13. Ms. Olaguas has agreed to be a respite care giver for claimant. She currently works in a respite program, and she has worked for IHSS. Ms. Olaguas previously worked as a nurse in Mexico. She received three years of basic training, which included two years at a school in Sonora, Mexico and one year at the University of Sonora. Ms. Olaguas then worked at a hospital in Mexico for 11 years. While working at the hospital, she cared for patients that were babies up through adults, and she worked with ventilators, feeding tubes, and tracheostomies. While working for IHSS, she also worked with ventilators, feeding tubes, and tracheostomies. Ms. Olaguas noted that she received a diploma in psychology in Mexico. She does not hold a California nursing license.

Mr. Olaguas would feel comfortable caring for claimant with more training using the monitors. She would help while the parents are in the home. She is ready to start training immediately.

14. Ms. Escorza has a daughter who is a regional center client. Her daughter needed a tracheostomy for four to six months. Ms. Escorza then learned how to suction her daughter's trach, and she has experience with a compression vest to remove phlegm. Her daughter also has a G-Tube. She does not have any experience monitoring

a ventilator, but she has observed. If someone teaches her, Ms. Escorza would be willing to help. She is not a nurse.

IHSS Program's Coverage of Paramedical Services

15. Claimant submitted publications regarding the provision of paramedical services by IHSS care givers. Those publications cited Welfare and Institutions Code section 12300.1[3] and gave examples of paramedical services, including administering medications or injections, blood/urine testing, wound care, tube feeding, and suctioning. They also noted that such services require authorization and training by a licensed health care professional before they may be provided through IHSS.

Registered Nursing Publication Regarding Unlicensed Assistive Personnel

16. Claimant submitted a 1994 document from the Board of Registered Nursing titled "Unlicensed Assistive Personnel." That document stated that its purpose was "to establish guidelines registered nurses (RNs) can use when called upon to make

[3] Welfare and Institutions Code section 12300.1, which concerns IHSS services, provides that '"supportive services' include those necessary paramedical services that are ordered by a licensed health care professional who is lawfully authorized to do so, which persons could provide for themselves but for their functional limitations. Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional. These necessary services shall be rendered by a provider under the direction of a licensed health care professional, subject to the informed consent of the recipient obtained as a part of the order for service."

decisions about assigning to and supervision of unlicensed assistive personnel. Unlicensed health care givers should be utilized only to be assistive to licensed nursing personnel." Under the heading "Clients/Patients For Whom Tasks May and May Not be Assigned," it stated (bold emphasis in original):

> Tasks may be assigned to unlicensed assistive personnel if the client/patient is not medically fragile and performance of the task does not pose potential harm to the patient. This would include clients/patients with chronic problems who are in stable conditions. Tasks may **not** be assigned when the patient is **medically fragile**. Medically fragile is defined as a patient whose condition can no longer be classified as chronic or stable and for whom performance of the assigned task could not be termed routine. Medically fragile includes those patients who are experiencing an acute phase of illness or are in an unstable state that would require ongoing assessment by an RN. When clients/patients with a chronic problem experience an acute illness [sic] routine tasks associated with on-going chronic problems may be assigned to unlicensed assistive personnel, if the task does not pose potential harm to the patient. In this situation, tasks associated with the acute illness may not be assigned to unlicensed assistive personnel.

The document included "suction of chronic tracheotomies" and "gastrostomy feedings in established, wound-healed gastrostomies" as examples of tasks which may be assigned. The document also stated:

> To reiterate, it is the direct care RN who ultimately decides the appropriateness of assignment of tasks. The registered nurse must be knowledgeable regarding the unlicensed assistive personnel's education and training, and must have opportunity to periodically verify the individual's ability to perform the specific tasks.

OTHER OAH DECISIONS CLAIMANT CITED

17. In support of claimant's argument that SDRC should fund the requested non-nursing respite care, claimant supplied a 2016 OAH decision that concerned supportive living services under Welfare and Institutions Code section 4689.[4] In that case, the dispute revolved around whether SDRC should fund non-nursing care as part of a supportive living plan where the parties could not find licensed vocational nurses willing to accept SDRC's contracted rate. That claimant's care provider developed a plan to train and supervise non-nursing staff to monitor claimant's airway and provide tracheostomy care.

The claimant in that case was a 38-year-old woman, who suffered from cerebral palsy and chronic respiratory failure, was tracheostomy dependent, and needed 24-hour care. Unlike the claimant here, the claimant in that case suffered from mild intellectual disability, was able to maneuver an electric wheelchair herself, was able to perform trach suctioning herself, and was able to verbally communicate. That claimant had moved into her own residence under the Medi-Cal Nursing Facility (NF) Waiver Program. SDRC believed LVN level care was needed, but that claimant was unable to find nursing services that would accept SDRC's contract rate. The claimant's provider had contacted 20 to 30 nursing staffing agencies, including SDRC vendors, and was unable to find

[4] Official notice was taken of the decision.

nurses to provide supportive living services. The claimant's provider submitted an assistive living plan to SDRC and arranged for a nurse to train non-licensed staff and visit claimant weekly. Two of that claimant's doctors opined that non-medical staff could provide the care with training.

In that case, the administrative law judge concluded:

> 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.

18. Claimant's brief referenced another OAH decision.[5] That case concerned whether a regional center was required to fund respite services, as the payer of last resort, after IHSS reduced the services it provided due to budgetary issues. It did not concern the funding of nursing level care, which is at issue here.

Even if the prior OAH decisions had precedential value, as is discussed further below, the facts and circumstances of the present matter are distinguishable from the prior OAH decisions claimant cited.[6]

LEGAL CONCLUSIONS

BURDEN OF PROOF

1. The burden of proof is on the claimant to establish SDRC is required to fund the requested non-nursing level respite care. (Evid. Code, § 115.) The standard is a preponderance of the evidence. (Evid. Code, § 500.)

---

[5] Claimant did not supply a copy of that second OAH decision or request official notice of it.

[6] Claimant did not present any authority that the prior OAH decisions may be afforded precedential value.

2. "'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.)

STATUTORY AUTHORITY

3. The Lanterman Developmental Services Act (Lanterman Act), Welfare and Institutions Code section 4500 et seq., governs the state's responsibilities to persons with developmental disabilities.

4. Welfare and Institutions Code section 4501 states:

> The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors, and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance.
>
> The complexities of providing services and supports to persons with developmental disabilities requires the coordination of services of many state departments and

> community agencies to ensure that no gaps occur in communication or provision of services and supports. A consumer of services and supports, and where appropriate, his or her parents, legal guardian, or conservator, shall have a leadership role in service design.
>
> An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities. . . .

5. Regional centers "shall identify and pursue all possible sources of funding for consumers receiving regional center services." (Welf. & Inst. Code, § 4659, subd. (a).) 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 family meets the criteria of such coverage but chooses not to pursue that coverage." (Welf. & Inst. Code, § 4659, subd. (c).)

6. Welfare and Institutions Code section 4502.1 states:

> The right of individuals with developmental disabilities to make choices in their own lives requires that all public or private agencies receiving state funds for the purpose of serving persons with developmental disabilities, including,

> but not limited to, regional centers, shall respect the choices made by consumers or, where appropriate, their parents, legal guardian, or conservator. Those public or private agencies shall provide consumers with opportunities to exercise decisionmaking skills in any aspect of day-to-day living and shall provide consumers with relevant information in an understandable form to aid the consumer in making his or her choice.

7. The services and supports provided to persons with disabilities are defined by Welfare and Institutions Code section 4512, subdivision (b), and may include day care and/or respite care.

8. Welfare and Institutions Code section 4690.2, subdivision (a), defines "[i]n-home respite services" as:

> [I]ntermittent or regularly scheduled temporary nonmedical care and supervision provided in the client's own home, for a regional center client who resides with a family member. These services are designed to do all of the following:

(1) Assist family members in maintaining the client at home.
(2) Provide appropriate care and supervision to ensure the client's safety in the absence of family members.
(3) Relieve family members from the constantly demanding responsibility of caring for the client.
(4) Attend to the client's basic self-help needs and other activities of daily living including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by the family members.

9. Welfare and Institutions Code section 4686 outlines when a non-licensed respite worker may provide incidental medical care as follows:

(a) Notwithstanding any other provision of law or regulation to the contrary, an in-home respite worker who is not a licensed health care professional but who is trained by a licensed health care professional may perform incidental medical services for consumers of regional centers with stable conditions, after successful completion of training as provided in this section. Incidental medical services provided by trained in-home respite workers shall be limited to the following:

(1) Colostomy and ileostomy: changing bags and cleaning stoma.

(2) Urinary catheter: emptying and changing bags and care of catheter site.

(3) Gastrostomy: feeding, hydration, cleaning stoma, and adding medication per physician's or nurse practitioner's orders for the routine medication of patients with stable conditions.

(b) In order to be eligible to receive training for purposes of this section, an in-home respite worker shall submit to the trainer proof of successful completion of a first aid course and successful completion of a cardiopulmonary resuscitation course within the preceding year.

(c) The training in incidental medical services required under this section shall be provided by physicians or registered nurses. Training in gastrostomy services shall be provided by a physician or registered nurse, or through a gastroenterology or surgical center in an acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, which meets California Children Services' Program standards for centers for children with congenital gastrointestinal disorders, or comparable standards for adults, or

by a physician or registered nurse who has been certified to provide training by the center.

(d) The in-home respite agency providing the training shall develop a training protocol which shall be submitted for approval to the State Department of Developmental Services. The department shall approve those protocols that specifically address both of the following:

(1) A description of the incidental medical services to be provided by trained in-home respite workers.

(2) A description of the protocols by which the training will be provided. Protocols shall include a demonstration of the following skills by the trainee:

(A) Care of the gastrostomy, colostomy, ileostomy, or urinary catheter site.

(B) Performance of gastrostomy tube feeding, changing bags and cleaning stoma of colostomy or ileostomy sites, and emptying and changing urinary catheter bags.

(C) Identification of, and appropriate response to, problems and complications associated with gastrostomy care and feeding, colostomy and ileostomy care, and care of urinary catheter sites.

(D) Continuing education requirements.

(e) Training by the gastroenterology or surgical center, or the certified physician or registered nurse, shall be done in accordance with the approved training protocol. Training of in-home respite workers shall be specific to the individual needs of the regional center consumer receiving the incidental medical service and shall be in accordance with orders from the consumer's treating physician or surgeon.

(f) The treating physician or surgeon shall give assurances to the regional center that the patient's condition is stable prior to the regional center's purchasing

incidental medical services for the consumer through an appropriately trained respite worker.

(g) Prior to the purchase of incidental medical services through a trained respite worker, the regional center shall do all of the following:

(1) Ensure that a nursing assessment of the consumer, performed by a registered nurse, is conducted to determine whether an in-home respite worker, licensed vocational nurse, or registered nurse may perform the services.

(2) Ensure that a nursing assessment of the home has been conducted to determine whether incidental medical services can appropriately be provided in that setting.

(h) The agency providing in-home respite services shall do all of the following:

(1) Ensure adequate training of the in-home respite worker.

(2) Ensure that telephone backup and emergency consultation by a registered nurse or physician is available.

(3) Develop a plan for care specific to the incidental medical services provided to be carried out by the respite worker.

(4) Ensure that the in-home respite worker and the incidental medical services provided by the respite worker are adequately supervised by a registered nurse.

[¶] . . . [¶]

(k) For purposes of this section, "in-home respite worker" means an individual employed by an agency which is vendored by a regional center to provide in-home respite services. These agencies include, but are not limited to, in-home respite services agencies, home health agencies, or other agencies providing these services.

EVALUATION

10. SDRC agreed to provide 30 hours per month of respite care to claimant. SDRC conducted a nursing assessment to determine the required level of care, as mandated by Welfare and Institutions Code section 4686, subdivision (g). Based on that assessment, SDRC determined claimant needs at least LVN level care. SDRC has funded additional LVN hours and has helped claimant's mother locate LVNs to provide the care. Unfortunately, it has been difficult to find and maintain coverage of nursing hours for a variety of reasons, including a shortage of nurses, claimant's mother's requirements, neighborhood safety concerns, and problems some LVNs experienced getting along with claimant's family.

11. Claimant failed to meet her burden of proving facts by a preponderance of that evidence that would support the use of non-nursing care in this case under Welfare and Institutions Code section 4686. Although claimant may desire to use the 30 hours per month authorized by SDRC for non-licensed respite care, Welfare and Institutions Code section 4686, subdivision (a), states that the incidental medical care provided by non-licensed respite care givers "shall be limited" to specific enumerated care. Claimant requires ventilator monitoring and tracheostomy care, including suctioning, which categories of incidental medical care are not listed in section 4686, subdivision (a).

12. While claimant may know some non-licensed persons who are willing to assist with claimant's care, the only evidence presented regarding how those providers might be trained was claimant's mother's testimony that she planned to train them. Welfare and Institutions Code sections 4686, subdivisions (b), (c), and (d), require training by physicians or registered nurses and require continuing education. Those subdivisions do not allow for training provided by a non-licensed parent. The fact that claimant's mother may have trained IHSS care givers to perform paramedical services in the past was not persuasive, as the IHSS documents presented by claimant also require

IHSS care givers to receive training from health care professionals before providing such care. Even if a plan were put into place to appropriately train non-licensed individuals to provide claimant incidental medical care, claimant would still need medical care outside the limited types of care outlined in Welfare and Institutions Code section 4686. Additionally, although SDRC's documents contained statements by its service coordinator and/or LVNs that claimant's health was "stable," none of claimant's doctors provided any "assurances to the regional center that the patient's condition is stable," as required by Welfare and Institutions Code section 4686, subdivision (f).

13. The 2016 OAH decision claimant relied upon was distinguishable from the present case. In that case, the claimant was able to communicate her needs and could suction her tracheostomy herself. Her doctors opined that trained non-nursing personnel could adequately provide the necessary care, and her provider developed a training and supervision plan, which included regular visits by a registered nurse. The other decision cited in claimant's brief did not concern nursing level care.

Here, claimant is non-verbal and cannot assist with her own care, claimant's mother wants to train the care givers herself, and none of claimant's doctors advised that it would be safe to allow non-nursing staff to provide the necessary care.

ORDER

Claimant's appeal from San Diego Regional Center's determination that it will only fund LVN level respite care is denied.

DATED: June 16, 2017

_____

THERESA M. BREHL

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.