The Department has learned today from news articles that, in fulfillment of a court order, a celebrity undergo 90 days of treatment for alcoholism or drug abuse at a residential facility, the celebrity was expected to admit herself to a Morningside Recovery Services facility.

Under California law, the Department of Alcohol and Drug programs has sole authority to license adult alcoholism or drug abuse treatment facilities. Alcoholism or drug abuse treatment facilities means any place that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol or drug abuse and who need alcohol or drug recovery, treatment, or detoxification services.

Until September 2012, Morningside Recovery Services was licensed to operate three alcoholism or drug abuse treatment facilities. The addresses were:

- 1777 Orange Avenue, Costa Mesa
- 1769 Anaheim Avenue, Unit A, Costa Mesa
- 1769 Anaheim Avenue, Unit B, Costa Mesa

In September 2012, after a hearing before an administrative law judge, all three licenses were revoked. Copies of the Accusation and the final Decision are attached.

No residential alcoholism or drug abuse treatment facility may be operated in the state without a current, valid license issued by the Department. At this time, Morningside is not licensed to operate a residential alcoholism or drug abuse treatment facility at any location in California.

The Department is currently in litigation with Morningside regarding their continued operation of residential alcoholism or drug abuse facilities without a license. The trial on those issues is scheduled for December 2, 2013 in the Orange County Superior Court.

The Department also issues program certifications to outpatient programs and licensed residential facilities. Certification is voluntary and not required to operate. Certification or lack thereof does not convey any approval or disapproval by the department, but is for informational purposes only. See Health and Safety Code section 11831.5 (attached). Morningside currently holds a program certification for its outpatient services.

BEFORE THE
DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
STATE OF CALIFORNIA

| In the Matter of: | Case No.: 11-186 |
|---|---|
| MORNINGSIDE RECOVERY, LLC, | OAH No.: 2011120118 |
| Respondent. | |

## DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Department of Alcohol and Drug Programs as its Decision in the above-entitled matter.

This Decision shall become effective 9/20/2012.

IT IS SO ORDERED 9/20/2012.

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
STATE OF CALIFORNIA

By

ref

**BEFORE THE**
**DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS**
**STATE OF CALIFORNIA**

| In the Matter of the First Amended Accusation Against:<br><br>MORNINGSIDE RECOVERY, LLC,<br><br>Respondent. | Case No. 11-186<br><br>OAH No. 2011120118 |
|---|---|

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge of the Office of Administrative Hearings, heard this matter in Los Angeles on May 21, 22, and 23, 2012.

Kevin Mora, Staff Counsel, and Karen T. Fruchtenicht, Senior Staff Counsel, appeared on behalf of complainant Millicent Gomes, Acting Deputy Directory of the Department of Alcohol and Drug Programs (Department), State of California.

Scott D. Hughes, Attorney at Law, and Ronald Talmo, Attorney at Law, represented respondent. Respondent's Chief Executive Officer, Mary Helen Beatificato, was present.

Oral and documentary evidence was received. The record was held open to allow complainant to file a closing brief by June 15, 2012, respondent to file a closing brief by June 29, 2012, and complainant to file a reply brief by July 6, 2012. Complainant timely filed a closing brief and a reply brief; the briefs were marked as Exhibits 14 and 15, respectively. Respondent timely filed a closing brief; the brief was marked as Exhibit Q.

The record was closed and the matter was submitted for decision on July 6, 2012.

FACTUAL FINDINGS

*Jurisdiction and Parties*

1. Complainant filed the First Amended Accusation in her official capacity. Respondent timely filed a Notice of Defense.

2. The Department issued licenses to respondent to provide nonmedical, residential services to adults who need alcohol or drug recovery treatment or detoxification

services at three different 24-hour residential facilities. The Department issued License No. 300168BP for the facility at 1769(A) Anaheim Avenue, Costa Mesa, on January 1, 2010; the license expired on December 31, 2011. The Department issued License No. 300168CP for the facility at 1769(B) Anaheim Avenue, Costa Mesa, on January 1, 2010; the license expired on December 31, 2011. The Department issued License No. 300168HP for the facility at 1777 Orange Avenue, Costa Mesa, on June 27, 2011; the license is scheduled to expire on May 31, 2013. The Department retains jurisdiction to discipline a license after the license has expired. (Health & Saf. Code, § 11834.39, subd. (b).)

3. Respondent's three licenses are subject to a First Amended Temporary Suspension Order (TSO) that the Department issued on April 26, 2012, which amended a prior temporary suspension order that the Department issued on November 1, 2011.

4. In addition to its licensed facilities, respondent operates seven facilities that are not required to be licensed. These facilities provide a sober living environment (SLE) for residents, at 1775 Orange Avenue and 2558 Orange Avenue in Costa Mesa, and at 4821 River Avenue, 29 Ima Loa Court, 102 Via Antibes, 208 Via Lido Soud, and 533 Via Lido Soud in Newport Beach. SLEs are not permitted to provide residential alcoholism or drug abuse recovery or treatment services. (CCR, tit. 9, § 10542, subd. (a).)

5. Respondent also operates an Alcohol and Drug Programs Certified Day Treatment and Outpatient Clinic (Outpatient Clinic), at 1545 Newport Boulevard in Costa Mesa. The Outpatient Clinic is not required to be licensed by the Department. The Department has certified that the Outpatient Clinic meets the Department's standards. The Outpatient Clinic provides outpatient drug and alcohol counseling and medical services to some of the residents of respondent's unlicensed facilities, and to non-residents as well. Respondent provides transportation to the Outpatient Clinic for those of its residents who choose to receive services there.

*Notices of Deficiencies*

6. In two Program Investigative Reports dated August 11, 2011, the Department provided respondent notice of two Class A deficiencies for not properly storing and destroying medications.[1] On August 16, 2011, the Department assessed a civil penalty for the deficiencies.

7. In a Program Investigative Report signed by Complaint Analyst Sunny Langley and dated September 19, 2011, the Department provided notice of 13 deficiencies—11 A deficiencies and two C deficiencies—specifying that respondent did not conduct detoxification observations and assessments in accordance with policy; did not ensure that clients received medications as prescribed and at proper times; had staff administer medications; did not destroy or control medications as required; did not report an unusual

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[1] There are three classes of deficiencies—A, B, and C—with A being the most serious.

incident to the Department; was dishonest to Department inspectors concerning storage, dispensing, and destruction of medications; did not cooperate with Department inspectors; did not ensure that clients are tested for tuberculosis; advertised services for which it is not licensed; and did not ensure complete, accurate, and thorough records. (Ex. 1.) Janelle Ito-Orille, a Department staff service manager who supervised Langley, also signed the report; she testified that she concurred with the classes of citation specified by Langley.

8. In a Program Investigative Report signed by Langley and Ito-Orille and dated September 21, 2011, the Department provided notice of another deficiency, specifying that respondent did not maintain client confidentiality.

9. In a Program Investigative Report signed by Langley and Ito-Orille and dated September 26, 2011, the Department provided notice of three additional deficiencies—two A deficiencies and one B deficiency—specifying that respondent was operating beyond the conditions and limitations of its licensure, did not refer a client for appropriate health services, and was advertising services for which it is not licensed.

10. In a Program Investigative Report dated March 20, 2012, signed by an investigator and by Ito-Orille, the Department provided notice of operation in violation of law, specifying that respondent was advertising and providing residential drug abuse recovery or treatment services without a license.

11. In a Death Investigative Report signed by Langley and Ito-Orille and dated April 23, 2012, the Department provided notice of six additional deficiencies—four A deficiencies and two C deficiencies—specifying that respondent was operating beyond the conditions and limitations of its licensure; did not ensure a client received necessary referral to medical services; provided residential treatment services to a client at an unlicensed facility; did not conduct detoxification observations according to policy; and did not submit a telephonic and a written report of the death of a client.

*Integrated Facility*

12. The Department contends that respondent operated its licensed and unlicensed facilities as an "integral facility" in violation of California Code of Regulations (CCR), title 9, section 10508, and thereby exceeded the scope of its licenses.

13. Respondent uses a single client census for all of its clients, whether housed at licensed or unlicensed facilities, and the census states that the clients are receiving "treatment." This in itself is not a violation; the census identifies whether each client resides at a licensed or unlicensed facility. Natalie Whitlock, respondent's Quality Improvement Director, testified at hearing, confirming a written statement that she had provided to the Department on August 11, 2011, to the effect that clients living in respondent's SLEs were receiving services and that respondent at that time wished to obtain licenses for all of its houses. (Ex. 1 at p. 710.) She did not, however, identify what services were provided to the SLE residents, or whether those services were licensed services.

14. Since August 12, 2011, all client medications are kept in the clients' respective homes. But until August 11, 2012, respondent stored medications for all of its clients at one location, in Unit 1 of 1775 Orange. And medications were moved back and forth between the licensed 1777 Orange Avenue facility and the adjacent unlicensed 1775 Orange Avenue facility, which share a lot and are bordered by a single fence.

15. A nurse practitioner had an office in Unit 1 of 1775 Orange prior to September 2011, where clients from both the 1775 and 1777 Orange facilities saw her for first aid, and where clients at 1777 would come for detoxification services. Respondent no longer employs nurse practitioners or other medical professionals.

16. Since the Outpatient Clinic opened on September 23, 2011, all treatment, medical and otherwise, for the residents of respondent's unlicensed facilities has been provided at the Outpatient Clinic. The Outpatient Clinic provides services to people who do not reside at any of respondent's facilities, in addition to residents of respondent's facilities, and not all residents of respondent's facilities obtain treatment at the Outpatient Clinic.

17. The Department also contends that respondent's policies and procedures do not distinguish between licensed and unlicensed facilities, but the only evidence submitted was a medications administration policy, which does not establish a violation, as the policy could reasonably be applied to both types of facilities. (Ex. K.)

18. Mary Beatificato, respondent's CEO, testified that respondent would survive economically without the Outpatient Clinic and might even be more profitable; the rents paid by residents at the SLEs generate sufficient revenue, and overhead at the Outpatient Clinic is high. She also testified that the Outpatient Clinic would survive economically without the patronage of residents of respondent's SLEs. There was no evidence to the contrary introduced by the Department. Beatificato became Acting CEO on September 1, 2011, replacing the then-CEO; her title changed to CEO in March or April, 2012. Before becoming Acting CEO, Beatificato had been providing respondent with legal representation, but after the August 11, 2011, inspection, Jeff Yates, respondent's President, asked her to help run the company. Beatificato testified that Yates had overridden the decisions of prior CEOs, but that her agreement with respondent gives her control of respondent's operations and that Yates has diminished influence.[2] She testified that she has acted diligently to bring respondent into compliance with the TSO. No one now resides at 1777 Orange.[3] She also testified that respondent has no current plans to provide detoxification services again. Respondent intends to focus on providing sober living residences, referring people to other providers for detoxification services, and operating the Outpatient Clinic.

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[2] She also testified that Yates, while having an 84% ownership interest in respondent, owns no voting interest.

[3] Its kitchen has been used, temporarily, to provide meals for clients who reside at 1775 Orange, but stoves and refrigerators are being installed in each unit at 1775 Orange.

*Provision of Medical Services*

19. The Department contends that, in addition to nonmedical alcohol and drug recovery treatment and detoxification services, respondent was providing medical services at its licensed facilities. A Department bulletin requires facilities to ensure that residents receive necessary first aid and information regarding medical and dental service referrals. (Ex. 9.) The Department contends that any healthcare service that exceeds the services delineated in the bulletin constitutes a medical service, which cannot be provided in a licensed facility.

20. Respondent did have licensed medical practitioners on its staff, including a doctor, a psychiatrist, and a nurse practitioner, but, as the Department concedes, "the mere presence or employment of nurses does not amount to medical services being provided." (Complainant's Reply Brief at p. 4.) Respondent's website at the time, however, stated that respondent's clinical staff medically assesses clients prior to detoxification and that respondent provides medical supervision during detoxification, identifying a doctor and a nurse as comprising the "Morningside Recovery Team." Respondent's Informed Consent for Treatment form states that clients are seen by medical staff and receive a nursing intake to recommend individualized treatment plans and medical protocols. Respondent received payment for services provided by its nurse practitioner and medical doctor. Respondent collected fees for pharmaceutical services, indicating that respondent provided prescription medications to its residents.

21. CEO Beatificato testified that respondent no longer employs pharmacists, physicians, nurses, nurse practitioners, or psychiatrists.

22. At the time of the Department's 2011 inspections, respondent's medical staff administered and dispensed medication, using pillboxes for that purpose. CEO Beatificato testified that, since November 16, 2011, respondent no longer dispenses medications to clients. House managers at respondent's SLEs have keys to the clients' medication lockers, and open those lockers only in the presence of the clients; the clients self-administer the medications. And respondent's program description (Ex. 8 at p. 1187), submitted to the Department in September 2007, states that nursing staff would ensure that "medications are dispensed exactly as prescribed by physicians," and the Department did not disapprove.

*Operating Beyond Scope of License*

23. The Department contends that respondent operated outside the scope of its licenses by providing treatment services to more people than permitted by its licenses and by admitting and treating Client #7.

24. Respondent used a single client census, showing approximately 70 clients, though it was licensed to treat five clients at the one licensed facility in operation. This alone does not establish, however, that 70 clients were receiving alcohol or drug recovery treatment or detoxification services. Natalie Whitlock, respondent's Quality Improvement Director, testified that clients living in sober living homes were receiving services and that respondent wished to have all the homes licensed. Whitlock did not identify the services that

the SLE clients were receiving, and there was a lack of admissible evidence to show that alcohol or drug recovery treatment or detoxification services were provided at the SLEs, though there was evidence that clients of all facilities received medications and nurse practitioner services at one of the SLEs. This is insufficient to show that respondent provided residential alcoholism or drug abuse recovery or treatment services to more clients than were authorized by respondent's licenses.

25. Respondent admitted Client #7 to one of its sober living homes. Respondent knew Client #7 was suffering from an eating disorder. Although Client #7 had not been diagnosed with an eating disorder, his diagnosis at his prior treatment center, from which he had transferred to respondent's facility, included "rule out eating disorder" or "rule out bulimia," which put respondent on notice that Client #7 might have and should be assessed for an eating disorder. Moreover, after his admission, Client #7's eating behavior proved difficult for respondent to monitor. Eating disorders cannot be treated on an inpatient basis except in a state-licensed hospital, under Health and Safety Code section 1254.5.[4] No evidence was introduced to show that respondent did, in fact, provide inpatient treatment for Client #7's possible eating disorder.

*Failure to Ensure Client's Rights*

26. Respondent failed to conduct scheduled detoxification assessments in accordance with respondent's policy, conducting only two to four assessments per day instead of the required six assessments per day.

27. Respondent failed to conduct scheduled opiate withdrawal assessments in accordance with respondent's policy, conducting only two to three assessments per day instead of the required four assessments per day.

28. Regular assessments are required to determine whether clients are safe or should be referred to a higher level of care.

*Failure to Provide Safe Environment*

29. Respondent created an unsafe environment by improperly handling prescription medication, moving it back and forth between unlicensed and licensed facilities. Respondent failed to properly label or secure medication, putting medications in unlabeled pill boxes.

30. Respondent conceded that it used to store medications for all of its clients at one, unlicensed, facility, in Unit 1 of 1775 Orange, and that the medications were moved to 1777 Orange before the Department inspection on August 11, 2011, but were returned to Unit 1 soon thereafter. Respondent also admitted that, prior to receiving the August 11, 2011,

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[4] All statutory references are to the Health and Safety Code, unless otherwise specified.

Program Investigative Report, it had a policy of using pillboxes to store residents' medications. But within two days of the inspection, respondent moved all medications to the residents' respective homes. And respondent no longer uses pillboxes to dispense medications.

*Failure to Protect Client #7's Rights*

31. The Department contends that Client #7 was not "accorded safe, healthful and comfortable accommodations," as required by CCR, title 9, section 10569, subdivision (a)(3).

32. The progress notes for Client #7, who possibly suffered from an eating disorder, possibly bulimia, state that he spent a good deal of time in the shower though he was not showering, and that his eating was difficult to monitor even though the food cabinets and refrigerator were locked. Respondent, however, did not refer Client #7 to a facility that could provide a higher level of care; instead, respondent transferred Client #7 to First House, a residential treatment facility that was not licensed to provide a higher level of care than respondent.

*Failure to Destroy Unused Prescription Medications*

33. Respondent failed to destroy prescription medications not removed by residents when they left respondent's facilities. The Department's Complaint Analyst Langley and Program Compliance Branch Supervisor Harvinder Baraich discovered large amounts of former clients' medications during the August 11, 2011, inspection of respondent's licensed facilities at 1769A and 1769B Anaheim Avenue, Costa Mesa, neither of which had any resident clients at the time.

34. Respondent admitted that it had failed to destroy medications left at the 1769(A) and 1769(B) Anaheim Avenue facilities. The medications were found in a filing cabinet, locked in an office in the garage of one of the facilities. No residents had access to the medications. Within 24 hours of discovering these medications, respondent destroyed the medications and provided proof of their destruction to the Department.

*Failure to Control Medications*

35. Medications for clients of the licensed facility at 1777 Orange were stored at the unlicensed facility at 1775 Orange, and large amounts of those medications were moved back and forth between the licensed and unlicensed facilities. Respondent stored unknown prescription medications in unlabeled pill boxes. A pill was found on the floor of the garage office at 1769A and 1769B Anaheim Avenue; in a file cabinet in the same office, inspectors found large quantities of former clients' medications that had not been destroyed.

36. Although, prior to August 12, 2011, residents of 1775 Orange received their medications in Unit 1 of 1775 Orange, an unlicensed facility, the nurse who handled and dispensed the medication kept a medications logbook, and there is not sufficient evidence to

demonstrate that residents did not receive their medications, or that residents were given the wrong medications, or that no residents were denied access to their medications. Respondent conceded that the medications were moved to 1777 Orange before the Department inspection on August 11, 2011, and that they were returned to Unit 1 soon thereafter. Respondent also admitted that, prior to receiving the August 11, 2011, Program Investigative Report, it had a policy of using pillboxes to store residents' medications, and that it had been keeping medications for all clients at one facility. But after August 12, 2011, within one or two days of receiving the citations, respondent moved all medications to the residents' respective homes, and stopped using pillboxes to dispense medications.

*Failure to Protect Client Confidentiality*

37. Several former clients of respondent posted complaints about respondent on the Better Business Bureau (BBB) website. Respondent posted replies to the complaints on the same website, and in doing so provided identifying information, such as names and dates of service, about the former clients.

38. Respondent asked the BBB to remove the responses with the identifying information, but was told that once a response was posted it could not be removed.

39. Respondent's attempts to have the information removed from the BBB website were insufficient. Respondent did not explain to the BBB that the posting contained client identifiers in violation of patient privacy, and there was no evidence presented that respondent ever attempted to notify those former clients that identifying information had been posted on the website.

*Continuing to Advertise and Provide Services While TSO in Effect*

40. The TSO temporarily suspended respondent's licenses to operate its licensed facilities. Respondent was not permitted to advertise that it operated a licensed facility while the TSO was in effect.

41. Respondent continued to advertise licensed treatment services on its website after the TSO issued. Adrianna Alatorre, a Complaint Analyst for the Department, reviewed the website and noted in her Program Investigative Report dated March 26, 2012, that the website had not been cleaned of all references to licensed services, such as residential treatment, detoxification services, and supervised housing with recovery activities. (Ex. 4, pp. 1046-1053.) Alatorre also telephoned respondent on February 24, 2012, posing as a member of the public desiring to know what services were provided. Brandon Hilger, respondent's Director of Marketing and Admissions, told Alatorre that "we" offer detoxification services, and that licensed staff monitors clients' progress; Hilger did not say that respondent contracted for a third party to provide the service.

42. The website pages to which Alatorre referred strongly imply that respondent provides detoxification and other licensed services. There are footnotes on various website pages, in print smaller than the rest of the text, stating that detoxification and other services

are not provided at respondent's facilities, and there are some references to "partnered facilities." But the main text of the website, in discussing detoxification, describes in some detail the activities of "Morningside's clinical staff," and refers to "the detox center" and to "detoxification and therapeutic teams." (Ex. 4, pp. 1046-1053 and 987-1024.)

43. Hilger testified that, on the day respondent received the TSO, CEO Beatificato instructed him to clarify or remove any advertisements or articles referencing respondent's providing licensed services, and that he spent that day and the next morning doing so. He also testified that three weeks later he re-posted the sections and articles he had removed, inserting footnotes with a disclaimer stating that respondent does not provide those services but outsources licensed services to its "partners," other detoxification facilities in the Newport Beach area. The evidence was unclear as to why the deleted sections and articles were reposted, and as to whether CEO Beatificato directed Hilger to repost them.

44. Respondent's revised financial agreement form for use with new clients states that detoxification services are no longer provided. It also states, however, that clients will pay respondent a daily fee for detoxification services in the event of a relapse.

*Admitting Patient #6*

45. The Department contends that respondent operated outside the scope of its licenses by admitting Client #6 solely for mental health treatment, not for alcohol or other drug abuse issues. Although Client #6 was housed at an unlicensed facility, the Department contends that respondent operated all its facilities as an integrated facility, and that Client #6's file included an initial assessment, a discharge summary, an intake drug history, and a drug screening report, thereby indicating that Client #6 received alcohol and drug treatment from respondent.

46. Client #6 was admitted to a sober living home and received mental health treatment at the Outpatient Clinic. Although respondent did not explain the presence in the file of documents pertaining to drug history and screening, no evidence was presented that demonstrates that Client #6 actually received licensed services from respondent, or resided at a licensed facility, or that the unlicensed facility was an integral part of respondent's licensed facilities.

*Failure to Refer Patients #6 and #7 for Medical Services*

47. The Department contends that respondent should have referred Client #6 for medical services to address mental health issues, but failed to do so. There is evidence that Client #6 did not receive the therapy that she sought when she became a resident at one of respondent's unlicensed facilities.

48. Respondent should have referred Client #7 for medical services to address a suspected eating disorder, but failed to do so. Client #7, who was known to respondent to have, or possibly have, an eating disorder, was admitted to one of respondent's licensed facilities to receive substance abuse treatment. Respondent found it difficult to monitor

Client #7's eating behaviors and physically transferred Client #7 to First House, another residential treatment facility that was not operated by respondent and that was not licensed to provide a higher level of care than respondent. Despite this transfer, Client #7 remained a client of respondent's. Although Client #7 had been moved to First House, respondent's staff continued to review Client #7's lab reports and, on a Friday, decided to consider additional treatment options for Client #7, including possible transfer to a hospital for eating disorder treatment, the following Monday. Client #7 died over the weekend, while respondent's medical records software continued to show that Client #7 was receiving services from respondent. The electronic record has not been modified since then, as CEO Beatificato desired to preserve the evidence.

*Failure to Report Incidents Involving Client #3 and Client #7*

49. Client #3 was hospitalized for three days after receiving medication from respondent and having a seizure. Respondent is required to report to licensing staff any "facility-related injury." (CCR, tit. 9, § 10561, subd. (b).) While that term is not defined, it may be reasonably construed to encompass a reaction to facility-administered medication in the form of seizures requiring hospitalization. Thus, respondent should have reported to the Department that Client #3 had suffered a "facility-related injury" and was transported to a hospital to receive medical treatment, but failed to do so.

50. Client #7 was still receiving services from respondent despite his physical removal to another facility, and was never discharged by respondent. Respondent was required to report that Client #7 had died, but failed to do so.

*Attempt to Deceive Department Staff During Investigation*

51. Respondent moved medications from Unit 1 of the unlicensed facility at 1775 Orange to the licensed facility at 1777 Orange prior to the August 11, 2011, Department inspection and then moved the medications back to the unlicensed facility after the inspection, all with the intent to deceive Department staff. Department staff learned of the deception when they returned unannounced to speak to residents the following day. Department staff attempted to access Unit 1 of the unlicensed facility; Natalie Whitlock, who was present for the inspection, falsely told the inspectors that she was unable to access the unit. Whitlock testified at hearing that she could have let the Department inspectors into the unit but was under instructions from Yates, respondent's president, not to allow them access. After learning that the Department had found a means to enter the unit, Whitlock recanted and allowed Department staff to enter. Whitlock also told the inspectors that the medications had been moved from 1775 Orange to 1777 Orange, and back again; Whitlock believed that the Department inspectors would have discovered this fact anyway by interviewing clients.

52. Since the August 2011 incident, CEO Beatificato has instituted policies to bring respondent into compliance with the Department's requirements and to ensure cooperation with Department inspectors investigating its licensed facilities. There were, however, later findings of deficiencies. (See, e.g., Factual Findings 7-11.)

53. Respondent contends that the Department lacks the authority to inspect respondent's unlicensed sober living homes and failed to provide written notice of alleged deficiencies, and that therefore the Department has no authority to revoke respondent's license. Respondent's contentions are not supported by applicable law or by the evidence.

## LEGAL CONCLUSIONS

1. No one may operate an alcoholism or drug abuse recovery or treatment facility to provide recovery, treatment, or detoxification services in California without first obtaining a license from the Department. (§ 11834.30; CCR, tit. 9, § 10505.) The Department may suspend or revoke a license to operate an alcoholism or drug abuse recovery or treatment facility on any of the grounds set forth in section 11834.36, subdivision (a). Those grounds include:

a. Violation, repeated violation, or aiding, abetting, or permitting the violation or repeated violation by the licensee of the statutes and regulations governing the Department's licensees (§ 11834.36, subd. (a)(1)-(3));

b. Conduct inimical "to the health, morals, welfare or safety of either an individual in, or receiving services from, the facility or to the people of the State of California." (§ 11834.36, subd. (a)(4)); and

c. Misrepresentation of a material fact in obtaining a license. (11834.36, subd. (a)(5).)

2. The Department may seek suspension or revocation of a license in an administrative hearing when:

> (1) The licensee is issued a notice of deficiency for any action which has resulted in death, serious physical harm, or imminent danger to a resident of the facility; or
>
> (2) The licensee fails to correct any Class A deficiency by the date specified in the notice of deficiency; or
>
> (3) The licensee repeatedly fails to correct Class B deficiencies; or
>
> (4) The licensee has failed to pay civil penalties . . . .

(CCR, tit. 9, § 10548, subd. (a).) To proceed with an administrative hearing, the Department must deliver to the licensee an accusation and notice of suspension or revocation, explaining, among other things, the reasons for the action and ordering the licensee to suspend operation of the facility. (CCR, tit. 9, § 10548, subd. (b).) The Department did so in this case. (Factual Findings 3, 6-11.)

3. The Department bears the burden of proof in this matter, as it seeks to discipline respondent's license. (*Bley v. Board of Dental Examiners* (1932) 120 Cal.App. 426, 430-431.) The standard of proof to establish the charging allegations in this case is a preponderance of the evidence. (§ 11834.37, subd. (b).)

4. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for operating beyond the scope of its licenses by acting as an integrated facility in violation of CCR, title 9, section 10508, by reason of Factual Findings 1-18. To be considered an integral facility under CCR, title 9, section 10508, a sober living home must not only be under the same management and control but must be an "integral component" of a licensed facility. At the time the citations were issued, respondent had chosen to operate its SLE facilities as if they were integral components of the licensed facilities. There was a good deal of porosity in the boundary between respondent's licensed facilities and SLEs, including the transfer to and from a licensed facility of medications stored at an SLE, the dispensing of medications to residents of licensed facilities at one of the SLEs, and the provision of nurse practitioner services and other services, possibly including detoxification services, at one of the SLEs to residents of other facilities. In mitigation of respondent's violation, those practices have ceased—the evidence of respondent's current operations does not demonstrate that respondent's licensed and unlicensed facilities are integral components of the same facility, or that respondent's operation of the Outpatient Clinic is integral to the operation of the SLEs. The Department's interpretation of CCR, title 9, section 10508 is entitled to great weight (see *Mason v. Retirement Board of the City of San Francisco* (2003) 111 Cal.App.4th 1221, 1228), and that interpretation is found to be applicable as of the time that the citations issued. But the Department has not provided any testimony or other evidence that would warrant deviation from the plain meaning of "integral" with respect to respondent's current operations.

5. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for operating beyond the scope of its licenses by providing medical services in violation of sections 11834.02, subdivision (a), 11834.10, and 11834.26, by reason of Factual Findings 1-11 and 19-22.

6. Cause does not exist to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for operating beyond the scope of its licenses by providing services to more clients than allowed by its licenses and for treating a client with an eating disorder, in violation of section 11834.10, and CCR, title 9, section 10513, by reason of Factual Findings 1-11 and 23-25.

7. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to ensure each client's personal rights by failing to conduct scheduled assessment checks and opiate withdrawal assessments, in violation of CCR, title 9, section 10569, by reason of Factual Findings 1-11 and 26-28.

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8. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to ensure each client's personal rights by improperly handling and documenting administration of medication in violation of CCR, title 9, section 10569, subdivision (a)(3), by reason of Factual Findings 1-11, 29, and 30.

9. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to ensure each client's personal rights when a client died while receiving services from respondent in violation of CCR, title 9, section 10569, subdivision (a)(3), by reason of Factual Findings 1-11, 31, and 32. There was insufficient evidence to establish that the cause of the client's death was related to treatment provided by respondent. There was, however, sufficient evidence to establish that respondent was on notice that the client may have required treatment that he was not receiving under respondent's care.

10. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to destroy prescription medications not removed by residents upon the termination of services in violation of CCR, title 9, section 10572, subdivision (g), by reason of Factual Findings 1-11, 33, and 34.

11. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to control prescription medications in violation of CCR, title 9, section 10572, subdivision (f), by reason of Factual Findings 1-11, 35, and 36.

12. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to keep information regarding its clients confidential in violation of CCR, title 9, sections 10568 and 10569, subdivision (a)(1), by reason of Factual Findings 1-11 and 37-39.

13. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for providing licensed services while its licenses were subject to a TSO, in violation of CCR, title 9, section 10505, subdivision (a), by reason of Factual Findings 1-11 and 40-44.

14. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for advertising licensed services while its licenses were subject to a TSO, in violation of CCR, title 9, section 10505, subdivision (a), by reason of Factual Findings 1-11 and 40-44.

15. Cause does not exist to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for operating beyond the scope of its licenses by admitting a client for mental health services, in violation of CCR, title 9, sections 10501, subdivision (a)(6), and 10513, by reason of Factual Findings 1-11, 45, and 46.

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16. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failing to refer two clients to mental health professionals in violation of CCR, title 9, section 10572, subdivision (a), by reason of Factual Findings 1-11, 47, and 48.

17. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(1)-(3), for failure to report a facility-related injury requiring hospitalization and a client's death in violation of CCR, title 9, section 10561, subdivision (b), by reason of Factual Findings 1-11, 49, and 50.

18. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(4), for engaging in conduct inimical to the health, morals, welfare, and safety of clients or the people of the State of California, by deceiving Department staff regarding the location of medications and regarding access to a facility, by reason of Factual Findings 1-11, 51-53.

19. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(4), for engaging in conduct inimical to the health, morals, welfare, and safety of clients or the people of the State of California, by repeatedly violating applicable laws and regulations, by reason of Factual Findings 1-11, 19-22, 26-44, and 47-53.

20. Cause exists to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(4), for engaging in conduct inimical to the health, morals, welfare, and safety of clients or the people of the State of California, by engaging in a pattern and practice of violations, by reason of Factual Findings 1-11, 19-22, 26-44, and 47-53.

21. Cause does not exist to suspend or revoke respondent's licenses under section 11834.36, subdivision (a)(5), as no evidence was presented that respondent misrepresented a material fact in obtaining its licenses.

22. Respondent has corrected, in whole or in part, several violations, and has taken significant steps under its current CEO toward compliance with Department requirements. Respondent has not, however, corrected all violations, even some that could be corrected. In view of that, and in view of the numerosity and seriousness of respondent's violations, license revocation is warranted. Respondent does not currently plan to provide licensed services in the foreseeable future. Respondent may apply for reinstatement of its licenses any time after 12 months from the effective date of this Order. (Gov. Code, § 11522.)

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## ORDER

The First Amended Temporary Suspension Order, dated April 26, 2012, is hereby vacated.

License numbers 300168BP, 300168CP, and 300168HP, issued to respondent Morningside Recovery, LLC, are revoked.

DATED: August 17, 2012

HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearings

D. Janine LaMar, SBN 196397
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Attorneys for the State
Department of Alcohol & Drug Programs

BEFORE THE

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

| IN THE MATTER OF:<br><br>MORNINGSIDE RECOVERY, LLC<br>3421 Via Oporto, Suite 200<br>Newport Beach, CA 92663<br><br>Respondent. | DADP No. 11-186<br><br>OAH No. 2011120118<br><br>**FIRST AMENDED ACCUSATION FOR REVOCATION OF LICENSE**<br><br>[Gov. Code § 11503] |
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**JURISDICTION**

1. This matter arises under Health and Safety Code section 11834.01 *et seq.,* which governs licensed adult alcoholism, drug abuse recovery, and treatment facilities.

2. The regulations governing adult alcoholism, drug abuse recovery, and treatment facilities are contained in California Code of Regulations Title 9, section 10500 *et seq.*

3. The California Department of Alcohol and Drug Programs (Department) is the agency of the State of California with primary responsibility for the licensing and

inspection of adult alcoholism, drug abuse recovery, and treatment facilities.

4. The Department may revoke the license of an alcoholism or drug abuse recovery or treatment facility based upon the violation of one or more of the subsections of Health and Safety Code section 11834.36(a)(1)–(6) and California Code of Regulations, title 9, section 10548.

5. In accordance with Health and Safety Code section 11834.37, administrative proceedings for the suspension, revocation, or denial of a license shall be conducted in accordance with the provisions of Government Code section 11500 *et. seq.*

6. The standard of proof to be applied in administrative proceedings shall be the preponderance of evidence. (Health & Saf. Code §11834.37(b).)

**THE PARTIES**

7. Millicent Gomes (Complainant) is the Department's Acting Deputy Director, Licensing and Certification Division, and is an authorized representative of the Director of the Department pursuant to a delegation of authority attached hereto as Exhibit A.

8. Respondent MORNINGSIDE RECOVERY, LLC, (Respondent) is licensed by the Department to operate three residential alcohol and drug abuse recovery and treatment facilities doing business as Morningside Recovery located at 1777 Orange Avenue, Costa Mesa, California (1777 Orange); 1769 Anaheim Avenue, Unit A, Costa Mesa, California (1769A Anaheim); and 1769 Anaheim Avenue, Unit B, Costa Mesa, California (1769B Anaheim), collectively referred to herein as the "Licensed Facilities." 1777 Orange was licensed on May 23, 2011. 1769A Anaheim and 1769 B Anaheim were each licensed on January 4, 2010. A copy of Respondent's most recent licenses (300168HP, 300168BP, and 300168CP) setting forth the capacity, limitations, and effective dates accompany this Accusation as Exhibit B, and are hereby incorporated by reference.

9. Respondent, by virtue of licensure, must operate in accordance with the statutes and regulations governing the licensing and operation of residential alcoholism and drug recovery or treatment facilities contained in Health and Safety Code section 11834.01 *et. seq.* and California Code of Regulations, title 9, section 10502 *et. seq.*

10. Respondent also operates eight facilities that it purports to be sober living environments. Sober living environments are unlicensed cooperative living arrangements for people recovering from substance abuse. They serve as an interim environment between treatment facilities, such as the Licensed Facilities, and clients' homes. Treatment services may not be provided at a sober living environment. Respondent's facilities are located at 1775 Orange Avenue, Units 1 – 6, Costa Mesa, California (1775 Orange), 2558 Orange Avenue, Units A – F, Costa Mesa, California (2558 Orange), 4821 River Avenue, Newport Beach, California (4821 River), 29 Ima Loa Court, Newport Beach, California (29 Ima Loa), 100 Via Antibes, Newport Beach, California (100 Ima Loa), 102 Via Antibes, Newport Beach, California (102 Via Antibes), 208 Via Lido Soud, Newport Beach, California (208 Via Lido), and 533 Via Lido Soud, Newport Beach, California (533 Via Lido), collectively referred to herein as the "Unlicensed Facilities."

11. The applicable statutes, regulations, and certification standards are attached hereto as Exhibit C, and are incorporated by reference.

## FACTUAL ALLEGATIONS

SUBJECT MATTER: CONDITIONS OF LICENSURE; ACCOUNTABILITY; HEALTH-RELATED SERVICES

APPLICABLE LAW: Health and Safety Code sections 11834.02 and 11834.30; 9 CCR sections 10505(a)

ALLEGATIONS:

12. Respondent's Licensed Facilities are licensed to provide nonmedical services to adults who need alcohol, drug, or alcohol and drug recovery treatment or

detoxification services. (Health & Saf. Code § 11834.02(a)) Respondent's Unlicensed Facilities are prohibited from providing residential, alcoholism or drug abuse recovery or treatment services without first obtaining a current, valid license from the Department. (Health & Saf. Code § 11834.30; 9 CCR § 10505(a)) Respondent is operating its Licensed Facilities beyond the scope of its licenses by using its Unlicensed Facilities in conjunction with its Licensed Facilities as an integrated facility in violation of California Code of Regulations Title 9, section 10508.

13. The Licensed and Unlicensed Facilities are owned and operated by Morningside Recovery, LLC. Respondent operates all the facilities under the same policies and procedures. Respondent's client documents do not differentiate between the types of services or where they are provided.

14. On at least one occasion, Respondent admitted a client for treatment at a licensed facility and then immediately housed the client at an unlicensed facility where the client received treatment.

15. On at least two separate occasions, clients underwent detoxification treatment and received their medication at 1775 Orange, an unlicensed facility.

16. Respondent maintains a single roster of clients, a "Client Census," for the care and supervision of clients residing in both Licensed and Unlicensed Facilities. The roster does not differentiate between clients in licensed or unlicensed facilities.

17. On or about August 11, 2011, and for a prior and continuing period of time unknown to Complainant, 1777 Orange was the only licensed facility being used by Respondent. 1769A and 1769B Orange were both vacant. While 1777 Orange is only licensed to treat five clients, Respondent had approximately seventy clients housed in the Unlicensed Facilities that were receiving treatment.

18. Respondent's management staff provides management and oversight for both the Licensed and Unlicensed Facilities.

19. Respondent has engaged in practices that resulted in confusion by both

clients and staff as to what type of facility the clients are housed in.

SUBJECT MATTER: PROVIDING MEDICAL SERVICES

APPLICABLE LAW: Health and Safety Code sections 11834.02, 11834.10, and 11834.36

ALLEGATIONS:

20. Respondent may provide "nonmedical services" to adults who are "recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. (Health & Saf. Code § 11834.02(a)) Respondent is prohibited from operating its facility beyond the conditions and limitations specified on its license. (Health & Saf. Code § 11834.10) Violation of the applicable statutes and regulations can result in the suspension or revocation of Respondent's license. (Health & Saf. Code § 11834.36)

21. On or about August 11, 2011, and for a prior and continuing time unknown to Complainant, Respondent operated beyond the limitations of its license by providing medical services to clients.

22. Respondent's staff includes licensed medical practitioners who provide care to clients as part of the services provided by Respondent.

23. Respondent's medical staff provides prescription medication as part of the services to clients.

24. Respondent's medical staff administers and dispenses medication.

SUBJECT MATTER: OPERATING BEYOND SCOPE OF LICENSE

APPLICABLE LAW: Health and Safety Code section 11834.10; 9 CCR section 10513

ALLEGATIONS:

25. Respondent must not operate a facility beyond the conditions and limitations specified on its license. (Health & Saf. Code § 11834.10; 9 CCR § 10513.

26. On or about August 11, 2011, and for a prior and continuing period of time unknown to Complainant, Respondent had in operation one facility licensed to house five clients. Respondent at the time had approximately seventy clients receiving treatment that were housed in the Unlicensed Facilities.

27. Respondent was providing services for Client #7[1], who was admitted, in part, because of an eating disorder. The inpatient treatment of eating disorders shall be provided only in state licensed hospitals. (Health & Saf. Code § 1254.5) Respondent is not a state licensed hospital.

SUBJECT MATTER: ACCOUNTABILITY

APPLICABLE LAW: 9 CCR sections 10563 and 10569

ALLEGATIONS:

28. Respondent is held accountable for the general supervision of its licensed facility and for the establishment of policies concerning its operation. (9 CCR § 10563) Respondent must ensure each client's personal rights including safe accommodations and freedom from physical abuse. (9 CCR § 10569)

29. Respondent failed to conduct scheduled assessment checks as required by Respondent's protocol.

30. On a least two separate occasions, Respondent's staff failed to conduct timely opiate withdrawal assessments as required by Respondent's protocol.

SUBJECT MATTER: CLIENT SAFETY

APPLICABLE LAW: Health and Safety Code section 11834.26; 9 CCR section 10569(a)(3)

ALLEGATIONS:

[1] In accordance with federal law, 42 Code of Federal Regulations, part 2, any information that may identify a person as receiving treatment for drug or alcohol addition is confidential. Such information may only be released by a court order pursuant to 42 CFR 2.68. The client referenced in the Department's September 8, 2011 Program Investigative Report is identified using the number 3. The client referenced in the Department's September 26, 2011 Program Investigative Report is identified using the number 6. The client referenced in the Department's April 17, 2012 Death Investigative Report is identified using the number 7.

31. Respondent's Licensed Facilities are authorized to provide non-medical treatment services. (Health & Saf. Code § 11834.26(a)(1)-(3)) Respondent's clients are afforded certain personal rights, including the right to be accorded safe, healthful, and comfortable accommodations. (9 CCR § 10569(a)(3))

32. On or about August 11, 2011, and for a prior and continuing time unknown to Complainant, Respondent created an unsafe environment by improperly handling prescription medication.

33. Respondent's staff made documentation and/or administrative errors related to the medication of at least three clients.

34. Respondent's staff failed to provide clients timely access to their medication.

<u>SUBJECT MATTER</u>: CLIENT DEATH

<u>APPLICABLE LAW</u>: 9 CCR section 10569(a)(3)

<u>ALLEGATIONS</u>:

35. Respondent's clients are afforded certain personal rights, including the right to be accorded safe, healthful, and comfortable accommodations. (9 CCR § 10569(a)(3))

36. Client # 7 died while receiving services from Respondent.

<u>SUBJECT MATTER</u>: DESTRUCTION OF MEDICATION

<u>APPLICABLE LAW</u>: 9 CCR section 10572(g)

<u>ALLEGATIONS</u>:

37. Respondent must destroy prescription medications not removed by the resident upon termination of services and retain a log of such destruction. (9 CCR § 10572(g).)

38. On or about August 11, 2011, and for a prior and continuing time unknown to Complainant, Respondent's staff failed to destroy unused medication upon the termination of its former clients' services.

SUBJECT MATTER: CONTROL OF MEDICATION

APPLICABLE LAW: 9 CCR section 10572(f)

ALLEGATIONS:

39. Licit medications which are permitted by Respondent shall be controlled as specified by its written goals, objectives and procedures. (9 CCR § 10572(f))

40. On or about August 11, 2011, and for a prior and continuing time unknown to Complainant, Respondent's staff failed to properly control prescription medications.

41. During an inspection of the unlicensed facility located at 1775 Orange, and the licensed facility located at 1777 Orange, medication and medication cabinets were improperly moved back and forth between the two facilities by Respondent's staff.

42. Respondent stored unknown prescription medication in unlabeled containers.

SUBJECT MATTER: CLIENT CONFIDENTIALITY

APPLICABLE LAW: 9 CCR sections 10568 and 10569(a)(1)

ALLEGATIONS:

43. Respondent must keep all information and records obtained from or regarding its clients confidential and maintained in conformity with Title 42, Subchapter A, Part 2 Section 2.1 though 2.67-1, Code of Federal Regulations. (9 CCR § 10568) Further, Respondent's clients have the right to confidentiality. (9 CCR § 10569(a)(1))

44. Respondent identified or confirmed client identities on the Better Business Bureau (BBB) website located at www.la.bbb.org.

SUBJECT MATTER: CONTINUING TO PROVIDE TREATMENT SERVICES

APPLICABLE LAW: 9 CCR section 10505(a)

ALLEGATIONS:

45. Respondent shall not operate, establish, manage, conduct, or maintain a

facility which provides 24-hour non-medical, residential, alcoholism or drug abuse recovery or treatment services to adults without first obtaining a current, valid license from the Department. (9 CCR § 10505(a)).

46. On or about November 2, 2011, the Department issued a Temporary Suspension and Order (TSO) to Respondent. The TSO temporarily suspended Respondent's licenses to operate its Licensed Facilities.

47. On or about February 24, 2012, Department staff was informed by Respondent's staff that Respondent continued to provide detoxification services.

48. On or about March 1, 2012 Respondent's website advertised that Respondent continued to provide residential alcoholism or drug abuse recovery or treatment services.

SUBJECT MATTER: ADVERTISEMENT OF TREATMENT SERVICES

APPLICABLE LAW: 9 CCR section 10505(b)

ALLEGATIONS:

49. Respondent shall not hold out, advertise, or represent by any means that it is operating, establishing, managing, conducting, or maintaining a facility which provides 24-hour nonmedical, residential, alcohlsm or drug abuse recovery or treatment services to adults without first obtaining a current, valid license from the Department. (9 CCR § 10505(b).

50. On or about November 2, 2011, the Department issued a Temporary Suspension and Order (TSO) to Respondent. The TSO temporarily suspended Respondent's licenses to operate its Licensed Facilities.

51. On or about March 1, 2012 Respondent's website advertised that Respondent continued to provide residential alcoholism or drug abuse recovery or treatment services.

SUBJECT MATTER: ADHERENCE TO EXPRESS CONDITIONS OF LICENSURE

APPLICABLE LAW: 9 CCR sections 10513 and 10501(a)(6)

ALLEGATIONS:

52. Respondent is prohibited from operating the Licensed Facilities beyond the conditions and limitations specified in the license. (9 CCR § 10513) Respondent's licenses allowed it to only maintain and operate 24-hour residential nonmedical alcoholism or drug abuse recovery or treatment services. (9 CCR § 10501(a)(6)).

53. Respondent knowingly admitted Client #6 for mental health services and not for alcoholism or drug abuse recovery or treatment services as allowed per the license.

SUBJECT MATTER: FAILED TO PROVIDE MEDICAL SERVICES REFERRAL

APPLICABLE LAW: 9 CCR sections 10572(a)

ALLEGATIONS:

54. Respondent is required to ensure that its clients receive referrals to needed medical services. (9 CCR § 10572(a))

55. Despite knowing that Client #6 was admitted for, and suffering from, mental health problems, Respondent's staff did not refer the client to a mental health professional.

56. Despite knowing that Client #7 was admitted, in part, for an eating disorder, Respondent's staff did not provide the client with timely referrals to an appropriate medical professional.

SUBJECT MATTER: REPORTING REQUIREMENTS

APPLICABLE LAW: 9 CCR section 10561

ALLEGATIONS:

57. The terms of Respondent's license require that it follow the prescribed procedures of 9 CCR section 10561(b) in the event of an occurrence identified in subsection (b)(1). As such, Respondent must report telephonically to the Department's licensing staff within one working day, and report in writing within seven working days, any facility-related injuries requiring medical treatment or any death of

any resident from any cause.

58. Respondent failed to report an incident in which Client #3 was transported to the hospital to seek medical treatment.

59. Respondent failed to report Client #7's death.

SUBJECT MATTER: CONDUCT INIMICAL

APPLICABLE LAW: Health and Safety Code section 11834.36(a)(4)

ALLEGATIONS:

60. Respondent engaged in conduct that is inimical to the health, morals, welfare, and safety of either an individual in or receiving services from its facility, or to the people of the State of California by acting in a dishonest and misleading manner towards Department staff during their investigation of the Facilities.

61. On or about August 11th and 12th, 2011, Respondent's staff engaged in behavior designed to deceive Department staff regarding the location of medications.

62. Respondent's staff engaged in behavior designed to deceive Department staff regarding access to a facility for an authorized inspection.

SUBJECT MATTER: CONDUCT INIMICAL

APPLICABLE LAW: Health and Safety Code section 11834.36(a) (4)

ALLEGATIONS:

63. Respondent engaged in conduct that is inimical to the health, morals, welfare, and safety of either an individual in or receiving services from its facility, or to the people of the State of California by continually violating applicable laws and regulations during the past several years.

SUBJECT MATTER: CONDUCT INIMICAL

APPLICABLE LAW: Health and Safety Code section 11834.36(a) (4)

ALLEGATIONS:

64. During the period of licensure, the exact dates which are unknown to Complainant, Respondent engaged in conduct that is inimical to the health, morals,

welfare, and safety of either an individual in or receiving services from its facility, or to the people of the State of California in that it engaged in the pattern and practice of violations as alleged above in allegations 12 through 53.

## CAUSE FOR DISCIPLINE

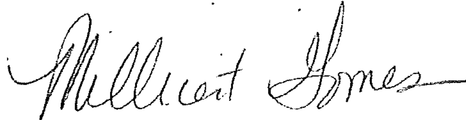
65. The facts alleged in paragraphs 12 through 53 above, individually and jointly, constitute violations of licensing laws. These facts provide cause, pursuant to Health and Safety Code section 11834.36(a)(1)-(5), to revoke Respondent's license to operate the facility.

66. The facts alleged in paragraphs 12 through 63, above, individually and/or jointly, constitute conduct that is inimical to the health, safety, morals, and welfare of clients in care at the facility, and of the people of the State of California. These facts provide cause, pursuant to Health and Safety Code section 11834.36(a)(1-4), to revoke Respondent's license to operate its facilities.

## PETITION FOR DISCIPLINE

WHEREFORE, Complainant requests that Respondent MORNINGSIDE RECOVERY LLC's licenses to operate residential alcohol and drug abuse recovery or treatment facilities be revoked.

DATED: 4/26/12



MILLICENT GOMES
Acting Deputy Director
Licensing and Certification Division
California Department of Alcohol and Drug Programs

Health and Safety Code

11831.5. (a) Certification shall be granted by the department pursuant to this section to any qualified alcoholism or drug abuse recovery or treatment program, regardless of the source of the program's funding, upon approval of a completed application and payment of the required fee. The certification shall be valid for a period of not more than two years. The department may extend the certification period upon receipt of an application for renewal and payment of the required certification fee prior to the expiration date of the certification.

(b) The purposes of certification under this section shall be all of the following:

(1) To identify programs that exceed minimal levels of service quality, are in substantial compliance with the department's standards, and merit the confidence of the public, third-party payers, and county alcohol and drug programs.

(2) To encourage programs to meet their stated goals and objectives.

(3) To encourage programs to strive for increased quality of service through recognition by the state and by peer programs in the alcoholism and drug field.

(4) To assist programs to identify their needs for technical assistance, training, and program improvements.

(c) Certification may be granted under this section on the basis of evidence satisfactory to the department that the requesting alcoholism or drug abuse recovery or treatment program has an accreditation by a statewide or national alcohol or drug program accrediting body. The accrediting body shall provide accreditation that meets or exceeds the department's standards and is recognized by the department.

(d) Certification, or the lack thereof, shall not convey any approval or disapproval by the department, but shall be for information purposes only.

(e) The standards developed pursuant to Section 11830 and the certification under this section shall satisfy the requirements of Section 1463.16 of the Penal Code.

(f) The department and the State Department of Social Services shall enter into a memorandum of understanding to establish a process by which the Department of Alcohol and Drug Programs can certify residential facilities or programs serving primarily adolescents, as defined in paragraph (1) of subdivision (a) of Section 1502, that have programs that primarily serve adolescents and provide alcohol and other drug recovery or treatment services.

(g) Regulations adopted by the department pursuant to this section shall be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and for the purposes of that chapter, including Section 11349.6 of the Government Code, the adoption of these regulations is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, and general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including subdivision (e) of Section 11346.1 of the Government Code, any emergency regulations adopted pursuant to this section shall be filed with, but not be repealed by, the Office of Administrative Law and shall remain in effect until revised by the department. Nothing in this subdivision shall be interpreted to prohibit the department from adopting subsequent amendments on a nonemergency basis or as emergency regulations in accordance with the standards set forth in Section 11346.1 of the Government Code.

Health and Safety Code

11834.01. The department has the sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities.

(a) In administering this chapter, the department shall issue new licenses for a period of two years to those programs that meet the criteria for licensure set forth in Section 11834.03.

(b) Onsite program visits for compliance shall be conducted at least once during the license period.

(c) The department may conduct announced or unannounced site visits to facilities licensed pursuant to this chapter for the purpose of reviewing for compliance with all applicable statutes and regulations.

11834.02. (a) As used in this chapter, "alcoholism or drug abuse recovery or treatment facility" or "facility" means any premises, place, or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.

(b) As used in this chapter, "adults" may include, but is not limited to, all of the following:

(1) Mothers over 18 years of age and their children.

(2) Emancipated minors, which may include, but is not limited to, mothers under 18 years of age and their children.

(c) As used in this chapter, "emancipated minors" means persons under 18 years of age who have acquired emancipation status pursuant to Section 7002 of the Family Code.

(d) Notwithstanding subdivision (a), an alcoholism or drug abuse recovery or treatment facility may serve adolescents upon the issuance of a waiver granted by the department pursuant to regulations adopted under subdivision (c) of Section 11834.50.