STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| AGENCY FOR HEALTH CARE ADMINISTRATION, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 99-2982 |
| BAYTREE LAKESIDE ASSISTED LIVING FACILITY, | ) | |
| Respondent. | ) | |

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Largo, Florida, on October 13, 1999.

APPEARANCES

For Petitioner: Karel L. Baarslag, Senior Attorney
Agency for Health Care Administration
State Regional Service Center
2295 Victoria Avenue, Room 309
Fort Myers, Florida 33901

For Respondent: Alan S. Zimmet
Joseph A. Corsmeier
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STATEMENT OF THE ISSUE

The issue is whether Respondent's assisted living facility is guilty of various Class I and II deficiencies.

## PRELIMINARY STATEMENT

By Petition for Formal Administrative Hearing dated June 30, 1999, Respondent requested a formal hearing on whether it was guilty of various Class I and II deficiencies in the operation of its assisted living facility.

As confirmed at the start of the hearing, Respondent did not raise the affirmative defense of standing. (Transcript, p. 13.) The parties stipulated that Tags A 206 and A 401 are not at issue in this case. The relevant tags are Tags A 503, A 504, A 511, and A 512. All are alleged to be Class II deficiencies, except for Tag A 512, which Petitioner alleges is a Class I deficiency.

At the hearing, Petitioner called one witness and offered into evidence Petitioner Exhibits 1-3. Respondent called six witnesses and offered into evidence Respondent Exhibits 1-15. All exhibits were admitted.

The court reporter filed the Transcript on October 27, 1999.

## FINDINGS OF FACT

1. Respondent owns and operates an assisted living facility in Saint Petersburg. The facility is located on 46th Avenue North, just east of its intersection with 66th Street.

2. The facility is located on a parcel with 160 feet of frontage on 46th Avenue North, which is a major arterial. The parcel runs 636 feet deep.

3. The facility comprises three residential buildings containing 47 residential rooms. The front building contains 31

residential rooms, a kitchen, a dining room, a great room, a lounge, an activity room, and a lobby. The middle building contains 14 residential rooms and two lounges. The rear building contains only two residential rooms.

4. The buildings are located on the front two-thirds of the parcel. The rear third of the parcel is dedicated to a concrete nature walk. A lake adjoins one rear corner of the parcel.

5. The parcel is enclosed on three sides by a four-foot wood fence, which, among other things, separates the nature walk from the lake. However, the front of the parcel is neither fenced nor gated. A circular driveway separates the front of the front building from 46th Avenue North.

6. A small fence on the front of the parcel connects the building to the east fence. However, persons could leave or enter the facility through the lobby or on the west side of the front building.

7. On May 30, 1999, between 3:30 a.m. and 6:00 a.m., Resident 1 left the facility unobserved by staff. She drowned in a canal known as Joe's Creek, which is about .3 miles southwest of one of the front corners of the parcel.

8. Resident 1 had lived at the facility for three years. For most of this time, she had lived in one of the two rooms in the rear building. She had free access in and out of her room and onto the nature path at the rear of the parcel.

9. On May 1, 1999, staff determined that the roommate of Resident 1 needed more care than she could receive in this remote room. The only available room was at the rear of the front building. Not wanting to separate the two roommates, staff decided to relocate Resident 1 and her roommate to the new room and did so sometime during the first week of May.

10. The new room had two doors: one to the interior hallway within the front building and one directly outside. However, Resident 1 had previously had unimpeded access to the outdoors and had never wandered or tried to leave the facility. In fact, Resident 1 never left the facility even on a sign-out basis, such as during one of the many visits she had from her daughter. Staff properly determined that Resident 1 presented an insubstantial risk of wandering.

11. Resident 1, who was 84 years old and weighed 130 pounds, was a high-functioning resident. She suffered from occasional stiffness of the joints, but was fully ambulatory. She required no supervision with her activities of daily living, although she required supervision with her medications.

12. Resident 1 was diagnosed with psychotic dementia. She was oriented as to person, but not as to time and place. However, Resident 1 knew where her room was and that she lived at the facility. Resident 1 lacked insight into her illness, but was compliant with medications.

13. Resident 1's condition had been stable for a considerable period of time. She was attached to staff and engaged in conversations with other residents, although she was sometimes delusional and sometimes hostile. Her delusions, which were never paranoidal, were harmless, such as her claim that she and the physician's assistant had been childhood friends in another state. She never suffered any hallucinations. She never expressed a desire to leave the facility; to the contrary, she enjoyed living there.

14. Based on their monthly examinations of Resident 1 and the administration of psychotropic medications, the physician's assistant and physician reasonably concluded that there was no need to recommend that Resident 1 be placed in a locked room.

15. During the pre-dawn hours in question, a staffperson performed a bedcheck at about 3:30 a.m. and found Resident 1 sleeping in her bed. At about 6:00 a.m., a staffperson discovered Resident 1 was not in her bed and was not in the building.

16. Without delay, staff conducted an extensive search of the buildings and grounds. After they had confirmed that Resident 1 was not on the property, they contacted law enforcement and Resident 1's daughter. Shortly after contacting law enforcement, Resident 1's body was found in the canal.

17. In the discussion of Tag A 503 in its proposed recommended order, Petitioner argues that staff could not immediately reach the acting administrator.

18. Petitioner has not proved that staff could not immediately contact the acting administrator or that, if there was any delay in contacting him, the delay was material. Staff on duty at the time of the discovery that Resident 1 was missing complied without delay with the facility's policy for missing residents.

19. In the discussion of Tag A 504 in its proposed recommended order, Petitioner argues that staff was not trained in emergency-reporting policies, except that they were shown a policy and that the policy required them to notify a "charge nurse," even though the facility lacked such a position.

20. Petitioner has not proved that staff were untrained in emergency-reporting policies. They complied with the facility's policy and did everything that they could have done, in a timely fashion, following the discovery that Resident 1 was missing.

21. In the discussion of Tag A 511 in its proposed recommended order, Petitioner argues that its surveyor relied on the records and calculations performed by one of Respondent's staffpersons.

22. Petitioner has not proved that Respondent violated applicable staffing ratios. To the contrary, Respondent complied with applicable staffing ratios.

23. In the discussion of Tag A 512 in its proposed recommended order, Petitioner argues that Respondent failed to provide sufficient staff to meet the needs of the residents, given their condition and mental status.

24. Petitioner has not proved that Respondent failed to provide sufficient staff to meet the needs of its residents. Except for one incident of wandering involving a different resident, the evidence addresses only Resident 1. The evidence supports the determination of Respondent's staff to provide Resident 1 only with the supervision that they did provide on the morning in question. In particular, the record does not support the inference that Respondent unreasonably failed to place Resident 1 in a locked room or monitor her more closely.

25. Shortly after the death of Resident 1, Petitioner conducted a survey and cited, among other deficiencies, the deficiencies discussed in this recommended order. Petitioner imposed a moratorium upon new admissions to the facility, but lifted the moratorium shortly after imposing it.

## CONCLUSIONS OF LAW

1. The Division of Administrative Hearings has jurisdiction over the subject matter. Section 120.57(1), Florida Statutes. (All references to Sections are to Florida Statutes. All references to Rules are to the Florida Administrative Code.)

2. Petitioner argues that this case is moot, essentially because Respondent has suffered no injury. Although this may be

true, this argument actually presents the affirmative defense of standing. The Administrative Law Judge raised this issue at the start of the hearing, and counsel for Petitioner disclaimed any reliance on this defense. As an affirmative defense, standing, if not timely asserted, is waived. Petitioner has waived standing in this case.

3. Section 400.402 provides in part:

> (2) The purpose of this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decisionmaking ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state, to promote continued improvement of such facilities, to encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes, to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, the Department of Health, assisted living facilities, and other community agencies. To the maximum extent possible, appropriate community-based programs must be available to state-supported residents to augment the services provided in assisted living facilities. The Legislature recognizes that assisted living facilities are an important part of the continuum of long-term care in the state. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated and regulated

> as residential environments with supportive services and not as medical or nursing facilities. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible. Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences.
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> (3) The principle that a license issued under this part is a public trust and a privilege and is not an entitlement should guide the finder of fact or trier of law at any administrative proceeding or in a court action initiated by the Agency for Health Care Administration to enforce this part.

1. The burden of proof is on Petitioner, which is attempting to demonstrate the existence of several deficiencies in connection with Respondent's operation of the facility and the death of Resident 1. It is unnecessary to address the standard of proof applicable in this case. In an abundance of caution, the Administrative Law Judge has used the preponderance standard.

2. Rule 58A-5.019(4) sets staffing standards. Petitioner has failed to prove a violation of any of these standards.

3. Rule 58A-5.0191 sets staff-training requirements. Petitioner has failed to prove a violation of any of these requirements.

4. The most substantive charge concerns Tag A 512, which requires, in addition to minimum staffing levels to satisfy applicable staffing ratios, sufficient staff to meet the needs of

the residents. Petitioner has failed to prove a violation of this standard.

## RECOMMENDATION

It is

RECOMMENDED that the Agency for Health Care Administration enter a final order striking the deficiencies listed in Tags A 503, A 504, A 511, and A 512 and retroactively canceling the moratorium imposed against the facility.

DONE AND ENTERED this 21st day of December, 1999, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of December, 1999.

COPIES FURNISHED:

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## NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order must be filed with the agency that will issue the final order in this case.