STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF CHILDREN AND FAMILY SERVICES, Petitioner, vs. VELINA R. TREADWELL-RAZZ Respondent.	)	Case No. 00-1423

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on August 1, 2000, at West Palm Beach, Florida, before Judge Michael M. Parrish, an Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Rendell Brown, Esquire
Brown & Brumfield
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West Palm Beach, Florida 33401

For Respondent: Terry Verduin, Esquire
Department of Children and Family Services
111 South Sapodilla Avenue, Suite 201
West Palm Beach, Florida 33401

STATEMENT OF THE ISSUES

The issues in this case concern whether the Respondent is entitled to renewal of her license to provide residential services for persons who are developmentally disabled.

PRELIMINARY STATEMENT

Following receipt of notice that the Department intended to refuse renewal of her license to provide residential services for persons who are developmentally disabled, the Respondent (Mrs. V.R.T.) filed a timely request for hearing on the matter. In due course the matter was referred to the Division of Administrative Hearings, where it was scheduled for hearing on August 1, 2000.

At the final hearing on August 1, 2000, the Department presented the testimony of four witnesses. The Department also offered 14 exhibits into evidence. Objections to the Department's Exhibits 9 and 10 were sustained. The other exhibits offered by the Department were received in evidence. The Respondent testified on her own behalf, but she did not call any additional witnesses. The Respondent also offered 7 exhibits, all of which were received in evidence. One Joint Exhibit[1] was also received in evidence, and official recognition was taken of several rule and statutory provisions.

Neither party filed a transcript of the final hearing held on August 1, 2000. Both parties filed proposed recommended orders containing proposed findings of fact and conclusions of law. The parties' proposals have been carefully considered during the preparation of this Recommended Order.

FINDINGS OF FACT

Introductory and background facts

1. At all times material to this proceeding, the Respondent provided, and was licensed to provide, residential services for persons who are developmentally disabled. The Respondent provided these services in a group home where she had from 4 to 6 clients at any one time. From time to time representatives of the Department would identify deficiencies in the way the Respondent was providing the residential services. Typically, the Department would advise the Respondent of specific deficiencies following a visit to the Respondent's group home. The Respondent would often take steps to correct the identified deficiencies, but some deficiencies tended to occur again and again. The Department attempted to work with the Respondent to help her remedy deficiencies and to help her prevent future deficiencies. Eventually, on February 25, 1999, the Department advised the Respondent by letter that it did not intend to renew her license to provide residential services for persons who are developmentally disabled.

2. The Department's letter of February 25, 1999, advised the Respondent that the "quality of care by your facility does not meet the minimum licensure standard[s] as specified in Chapter 10F-6," and went on to list a number of specific concerns under the major categories of "Administration" and "Health and Safety." The concerns itemized in the letter were as follows:

Administration

- Records of expenditure from individual residents' accounts are not maintained.
- Lack of accountability of client's personal allowances.
- Inappropriate use of client's personal allowance.
- Inadequate receipts for client's expenditures.
- Incomplete employee files.
- Employees without personnel files.

Health and Safety

- Clients locked inside the house without supervision.
- Gate/Entrance chained.
- Lack of evidence of all night supervision.
- Clients left unsupervised during a week-end.
- Inadequate food supply.
- Clients' lack of access to food.
- Food prepared away from residence.
- Menus not posted.

The letter also advised the Respondent of her right to request an administrative hearing if she wished to contest the Department's proposed course of action.

3. After some initial difficulties complying with the Department's requirements, the Respondent's group home (which had been moved from its original location without sufficient notice to the Department) was issued a conditional license on January 1, 1998, followed by a standard license issued on March 1, 1998. The standard license was valid for one year from the date of issuance. In March of 1998 when the standard license was issued, conditions at the Respondent's group home appeared to be satisfactory.

4. For the first few months following the issuance of the standard license, the Department did not have any significant concerns about the manner in which the Respondent's group home was being operated. The Respondent appeared to be responsive to suggestions by Department personnel and appeared to be trying to work with Department personnel to operate her group home in a proper manner. From March through most of June of 1998, there were no major problems at the Respondent's group home.

The incident on June 27, 1998[2]

5. On June 27, 1998, an incident occurred at the Respondent's group home that caused the Department a great deal of concern. On that day, at approximately 4:30 p.m., Mr. L. N. arrived at the Respondent's group home, in Boynton Beach, Florida, to visit his son who is mentally retarded. He was unable to enter because the gate to the fence surrounding the home was chained and locked. He observed some of the group home residents in the front yard and others in the house. Still unable to enter the gate later when he returned, Mr. L. N. telephoned police. Road Patrol Officer Susan Gitto responded.

6. At approximately 6:45 p.m., Officer Susan Gitto arrived at the group home and climbed the fence. One of the men at the group home kept pointing to the house next door, north of the group home. Officer Gitto found no one on the premises other than the six mentally handicapped men who were in their pajamas and inside watching television.

7. Based on information from Mr. L. N., Officer Gitto telephoned the responsible agency, the Department of Children and Family Services (DCF). A DCF case worker supervisor, Anna Glowala, arrived at the group home at approximately 9:00 p.m. She described the residents as nervous. Most of them were functioning at a level below the ability to respond to emergencies, that is, unable to telephone 911 or to evacuate in case of a fire. Ms. Glowala prepared a preliminary report on her findings at the group home.

8. Sometime after 9:00 p.m., a woman who identified herself as Elvira Brown arrived with a key to the group home. She intended to take care of the clients that evening, but was sent away by Officer Gitto, who also left the home soon after that.

9. At approximately 12:45 a.m., on June 28, 1998, Ms. Glowala's supervisor, William D. Shea, arrived at the group home. Mr. Shea relieved Ms. Glowala and stayed with the residents for the rest of the night. The six adult residents, according to Mr. Shea, were lower functioning and non-verbal.

10. At 6:15 a.m., a woman who identified herself as Sharon Butler arrived to cook breakfast and supervise the residents. She assured Mr. Shea that she was an employee of the group home and would remain at the group home until the licensed operator returned from an out-of-town trip. After he left, Mr. Shea asked Ms. Glowala to continue to monitor the group home by telephone until the operator returned. Mr. Shea did not check

the woman's identity or determine whether she was, in fact, a qualified employee, as required by DCF.

11. Mr. Shea testified that a group home operator may leave properly screened employees to relieve them when they are absent. The screening includes fingerprinting for police background checks.

12. DCF witness, Sue Pearlman Eaton, received the report of the incident on June 30, 1998. On July 1, 1998, she initiated an investigation by visiting the group home. When she arrived, she found one resident in the front yard sleeping on a lawn chair, and others inside watching television. One resident took her to a room in response to her request for help finding the owner/operator, but no one was there. She noticed where five of the six residents of the home were located, and what they were doing.

13. After approximately twenty minutes to a half hour, Ms. Pearlman-Eaton observed the operator coming into the house. She was angry and said she had been in the backyard with the sixth resident feeding her dogs. She told Ms. Pearlman-Eaton that she hired Ms. Butler to stay at the group home during her previous weekend trip to Tampa. The operator reported that she left at approximately 12 o'clock noon on Saturday, and that Ms. Butler was present when she left.

14. Ms. Pearlman-Eaton also questioned Ms. Butler, as a part of her investigation. As she apparently confirmed,

Elvira Brown, Ms. Butler's cousin, was supposed to stay at the group home from 2:00 p.m. until 10:00 p.m., while Ms. Butler worked at another job. According to Ms. Pearlman-Eaton's report, Ms. Brown telephoned Ms. Butler and told her that her work at the group home was completed between 6:00 p.m. and 7:00 p.m., and that the residents were in bed.

15. The report indicated that Ms. Brown stated that Ms. Butler asked her to help by feeding the residents and getting them ready for bed. Then she was to lock the gate and leave.

16. Based on Ms. Butler's statement to Ms. Pearlman-Eaton that the group home owner/operator Mrs. V. R. T. approved Ms. Butler's plan to have Ms. Brown serve as an interim caretaker, the investigators concluded that both of them were perpetrators of abuse by neglecting clients who require 24-hour supervision. DCF failed to present the testimony of either Ms. Brown or Ms. Butler at the hearing. Therefore, the testimony of Mrs. V. R. T. and her credibility could not be weighed against that of any other person with direct knowledge of the incident on June 27, 1998.

17. Ms. Pearlman-Eaton's report noted that the group home clients and facility were neat and clean, with no clients "acting out" or appearing to be in distress. Prior to the time that the group home owner/operator came in from the backyard on July 1, 1998, Ms. Pearlman-Eaton did not look in the backyard or hear a

car arrive. She also did not determine whether or not there were dogs in the yard.

18. During Ms. Pearlman-Eaton's questioning of Ms. Butler, Ms. Butler told her that she also worked at the Flamingo Clusters, another facility licensed by the State to provide developmental services. Clients of Flamingo Clusters are more severely handicapped than those at the V. R. T. group home. Ms. Pearlman-Eaton was initially investigating Ms. Butler and Ms. Brown. She added the group home operator to the neglect report, after she waited for her for up to a half an hour after arriving, on July 1, 1998, to conduct her investigation. While she was waiting to find Mrs. V. R. T., her report indicates that Mrs. Pearlman-Eaton telephoned Anna Glowala, the case work supervisor. She was advised by Ms. Glowala that ". . . it was not necessary for residents to be in eye range of the supervisor continually and its [sic] okay for them to be left alone for no more than 1/4 hr."

19. Anna Glowala also noted the condition of the group home when she stayed with the clients. She remembered there were two large dogs, one a Rottweiler, in the backyard. She also saw a pathway between the two adjacent houses, the group home and the house next door, which is owned by the owner/operator's husband. Ms. Glowala also saw laundry and other items on a sofa in the garage where the owner/operator claims that she sleeps. The garage area also included a refrigerator, washer and dryer.

20. Kay Oglesby, a DCF senior case manager, testified that she had previously warned the owner/operator that the gate to the fence should not be locked and that the residents needed constant supervision. She believed that during her first year supervising the facility, the owner/operator and her husband occupied a master bedroom in the group home. After DCF requested that they take in two additional clients, in May 1998, the owner/operator said she moved to the garage.

21. Ava Kowalczyk, a DCF Human Services Program Specialist, confirmed that only screened and approved employees may work in a group home. The owner/operator has the responsibility for assuring that group home employees are qualified. She expressed concern that the owner/operator may have left the residents with her husband before he was properly trained.

22. Ms. Kowalczyk described the cluttered condition of the sofa in the garage as inconsistent with Mrs. V. R. T.'s assertions that she sleeps in the garage.

23. Finally, DCF employee Martin J. Fortgang confirmed the need for adequate supervision and the DCF's determination that inadequate supervision constitutes neglect.

24. The group home owner/operator, the Respondent, Mrs. V. R. T., testified that two years ago she married her husband, who had lived next door for 18 years. While he lived with her in the group home, her husband's house next door was leased. She knew she was required to live on the premises and

testified that she has done so, initially in the master bedroom. After accepting two more clients, on an emergency basis after another group home closed, she moved to the garage. Her husband has apparently moved back to his home next door.

25. In March 1998, Mrs. V. R. T. submitted to DCF, as confirmed by Ava Kowalczyk, the names of her husband, Sharon Butler, and another employee for screening and approval. The document included fingerprints and a police report, which showed that Ms. Butler had a prior arrest for armed burglary.

26. Mrs. V. R. T. denied ever giving permission for Elvira Brown to substitute for Sharon Butler. Although Sharon Butler had numbers to reach Mrs. V. R. T. by pager and cellular phone, and at her hotel in Tampa, Mrs. V. R. T. denied that Ms. Butler ever telephoned her for approval to leave Ms. Brown at the group home.

27. Despite her arrest record, the documents which Mrs. V. R. T. submitted and received from DCF appear to confirm that Ms. Butler was an acceptable employee. One memorandum labeled a "Routing and Transmittal Slip" dated 3/31/98 states:

> Per your request, I have processed the Transfer of Request Form for Sharon Butler.
>
> Please see enclosed printout and Transfer form. Please maintain the [sic] these in your personnel files.

28. The record indicates that Mrs. V. R. T. received written notice that Sharon Butler was not an approved caretaker on July 16, 1998. In contrast to the apparent approval form of

March 31, 1998, the notice on July 16, 1998, from Ava Kowalczyk asserted that:

> This is to document my visits to your house on June 30, 1998 and July 2, 1998. At that time you informed us that for a year you have had an employee Sharon Butler, who acts as caretaker in your absence. This employee did not meet basic standards of licensing requirements. Ms. Butler's file consisted of her fingerprint card and local law enforcement checks completed on her on or about March 31, 1998. This was the first time you brought to our attention that you employed someone other than yourself and your husband.

29. Considering the contents of the Routing and Transmittal Slip attached to the documents dated March 31, 1998, it was reasonable for Mrs. V. R. T. to believe that Sharon Butler was an approved employee. One section on the Request for Transfer of Records indicates that Ms. Butler was approved for dual employment at the group home and another facility, having had her screening originally completed on October 3, 1994.

30. DCF has failed to demonstrate, by a preponderance of the evidence, that Mrs. V. R. T. knew that Sharon Butler was not properly screened and approved on June 27, 1998, when she left her in charge of the group home. DCF has also failed to demonstrate that Mrs. V. R. T. knew or approved of plans for Sharon Butler to leave the group home clients in the care of Elvira Brown while she was out-of-town.

Other problems at the Respondent's group home

31. On some occasions the Respondent would lock the doors of the group home while the clients were inside. When she did so, she would leave the door keys on top of the television set inside the group home.[3]

32. On some occasions the Respondent would lock the gate in the fence around the group home property while clients were on the property.

33. The Department usually made monthly review visits to the Respondent's group home. Some of the problems noted during these monthly reviews are described in the paragraphs which follow.

34. During the review visit on June 30, 1998, some of the food for the clients was stored away from the group home premises, and was not readily available to the clients. Specifically, no drinks or snacks were readily available for the clients that day. The required 5-day supply of food was not present on the premises, and the food that was present did not correspond to the menu.

35. During the review visit on August 26, 1998, there were errors in the personal allowance logs of the clients. Also, on this date once again the food supplies did not correspond to the menu.

36. During the review visit on September 22, 1998, the personal allowance logs of the clients were not up to date.

Specifically, there were no receipts, there was no documentation of the personal allowance received by any of the clients, and there was no documentation of the SSI/SSA benefits received by any of the clients. Once again, the food supplies did not correspond to the menu, and there were inadequate food supplies for a hurricane emergency.

37. During the review visit on October 28, 1998, the personal allowance logs for the clients were again incomplete. Receipts for client expenses were missing, and there was inadequate documented information about the expenses. There were no menus posted on this day. Also, the gate to the fence around the Respondent's group home was chained shut when the Department personnel arrived. This condition was of particular concern to the Department personnel, because the chained gate was an obstruction to any emergency evacuation of the group home.

38. During the review visit on November 20, 1998, the personal allowance logs for the clients were again incomplete and inadequate. Again, receipts were missing. Again, the food present at the group home was insufficient to constitute the required 5-day supply of food. Again, no menus were posted. Also, on this occasion the meals for the clients were being prepared next door, rather than in the group home, as required.

39. All of the clients at the Respondent's group home were developmentally disabled adult males. All of the clients functioned at a very low developmental level. Some were just

barely verbal. Clients at this level of disability need constant supervision while they are in the group home. They cannot be left unsupervised without exposing them to serious risk of harm to their well-being. Even at night when such clients are sleeping, a responsible, appropriately trained, adult must be present in the group home to provide supervision and assistance if one of the clients wakes up in the night and needs direction or assistance.

CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Section 120.57, Florida Statutes.

41. In a case of this nature, the Department bears the burden of proving a basis for its proposed denial of the Respondent's license renewal. See The Angelus, Inc. v. Department of Health and Rehabilitative Services, DOAH Case No. 91-6193 (Recommended Order issued May 19, 1992); Edward and Nancy Bristol v. Department of Health and Rehabilitative Services, DOAH Case No. 88-5183 (Recommended Order issued May 9, 1989); and cases cited therein.

42. Section 393.0673(1), Florida Statutes, authorizes the Department to deny, revoke, or suspend a license for a violation of any provision of Sections 393.0655 or 393.067, Florida Statutes, or for violation of any rules adopted pursuant to the cited statutory provisions. Consistent with the foregoing,

Rule 65B-6.003(5), Florida Administrative Code, provides: "A license shall be revoked at any time, pursuant to Chapter 28-6, F.A.C., if the applicant fails to maintain applicable standards or to observe any limitations specified in the license."

43. Rule 65B-6.010, Florida Administrative Code, contains the standards applicable to group home facilities. Section (3)(a)7 of that rule requires that the facility establish and maintain on the premises an individual record for each client, which shall include, among other things, "an accounting of the client's funds received and/or distributed by the vendor." The facts in this case demonstrate that the Respondent was frequently in violation of this rule provision, because on numerous occasions the Respondent's client accounting records were incomplete and/or incorrect.

44. Section (5) of Rule 65B-6.010, Florida Administrative Code, addresses the qualifications of the staff hired to work at group home facilities. The requirements of Section (5) include the following:

> (a) Sufficient staff shall be provided to ensure that facility operation is not dependent upon the use of clients or volunteers. . . .
> (b) . . . Written evidence of the qualifications of the direct care staff shall be maintained. Minimum criteria shall be demonstrated ability to meet the written established job description, appropriate life experience, and eighth grade education.
> (c) Staff shall be of suitable physical and mental ability to care for the clients they propose to serve; have knowledge of the needs of the clients; be capable of handling

> an emergency situation promptly and intelligently; and be willing to cooperate with the supervisory staff.

45. The findings of fact demonstrate that the Respondent violated the rule provisions quoted immediately above in more than one way. The most serious violation occurred on June 27, 1998, when the staff left in charge of the Respondent's clients abandoned the clients and left them totally unsupervised for several hours. If nothing else, such conduct shows that the staff had no knowledge of the needs of the clients. Such conduct also constitutes neglect of the clients within the meaning of Chapter 415, Florida Statutes. The Respondent also violated the rule provisions quoted immediately above by failing to maintain written evidence of the qualifications of the direct care staff.

46. Section (7)(b)10 of Rule 65B-6.010, Florida Administrative Code, provides that at group homes, "all doors with locks must be readily opened from the inside." Section (7)(b)12 of the same rule provides that at group homes "no exit, stairway, corridor, ramp, fire escape, or other means of exit shall . . . be obstructed from use in case of emergency." The findings of fact demonstrate that the Respondent violated both of these rule provisions by leaving clients inside the locked group home, and by locking the gate to the fence around the property.

47. Section (9)(c) of Rule 65B-6.010, Florida Administrative Code, includes the following provisions regarding food service at group homes:

> 2. Menus shall be planned and written at least two days in advance and dated. Menus, as served, shall be kept on file for a minimum of one month.
> 3. Fresh food supplies sufficient for two days and staple food supplies sufficient for at least five days shall be available at the facility at all times.

48. The findings of fact demonstrate that the Respondent violated the rule provisions quoted immediately above on numerous occasions by not having menus available and by not having available the minimum amounts of food required by the rule.

49. In view of the numerous rule violations described above, renewal of the Respondent's license should be denied pursuant to Section 393.0673(1), Florida Statutes. This is especially the case because of the occasions on which the Respondent's clients have been exposed to risk of serious harm by being left unsupervised, by being left locked in the house, and by having the gate locked.

RECOMMENDATION

On the basis of all of the foregoing, it is RECOMMENDED that the Department of Children and Family Services District issue a Final Order in this case denying the renewal of the Respondent's group home license.

DONE AND ENTERED this 30th day of October, 2000, in Tallahassee, Leon County, Florida.

MICHAEL M. PARRISH
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of October, 2000

ENDNOTES

1/ The joint exhibit consists of the Final order and the Recommended Order in Department of Children and Family Services v. V. R. T., DOAH Case No. 99-1174C (Recommended Order issued October 21, 1999). In Case No. 99-1174C, these same parties litigated many of the facts that are relevant to the disposition of this case. During the course of the evidentiary hearing in this case, the parties stipulated that the facts found in Case No. 99-1174C should be taken as established facts in this case. Accordingly, the facts found in the Recommended Order in Case No. 99-1174C have been incorporated in the Findings of Fact in this Recommended Order.

2/ Consistent with the stipulation of the parties, all of the findings of fact in paragraphs 5 through 30 are taken verbatim from the Findings of Fact in the Recommended Order in DOAH Case No. 99-1174C.

3/ The Respondent testified that all of the clients were capable of using the keys to unlock the door if they needed to get out. The Respondent's testimony in this regard is not credited. Other testimony about the low level at which the Respondent's clients functioned makes it most unlikely that in an emergency such clients could find a key and then effectively use the key to unlock a door and escape.

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 should be filed with the agency that will issue the Final Order in this case.