STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR PERSONS WITH DISABILITIES,

Petitioner,

vs.

THRESHOLD, INC.,

Respondent.

Case No. 06-4798

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on February 1 and 2, 2007, in Orlando, Florida, before Administrative Law Judge R. Bruce McKibben of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Stacy N. Robinson, Esquire
Department of Children and Family Services
400 West Robinson Street
Suite S-1106
Orlando, Florida 32801

For Respondent: James Dennis, Esquire
Threshold, Inc.
3550 North Goldenrod Road
Winter Park, Florida 32792

STATEMENT OF THE ISSUES

The issues in this case are whether Respondent violated provisions of Chapter 393, Florida Statutes (2006),[1] in the

operation of its residential group homes and, if so, whether a moratorium on admissions or other sanction is warranted.

PRELIMINARY STATEMENT

Respondent, Threshold, Inc. (Threshold), is licensed by the State of Florida to operate group homes for persons with developmental disabilities. Petitioner, Agency for Persons with Disabilities (APD or the Agency), is responsible for licensing and monitoring the operation of such facilities.

During the summer of 2006, three former employees of Threshold approached employees of the Agency with complaints and stated concerns about how Threshold was operating. Based on those conversations, the area administrator decided to inspect the group homes. A team of inspectors was assembled by the Agency; most of the inspectors came from outside the geographic area where the homes are located.

On September 5 and 6, 2006, the Agency team conducted an investigatory survey of the group homes. Seven problem areas were identified by the Agency team:

> 1) Administration of medications by unlicensed persons who had not received the requisite training;
> 2) Failure to properly maintain a drug count on controlled drugs and prescription medications;
> 3) Failure to follow physician's orders on a client's prescribed medication and making an unauthorized change to the medication;

4) Inappropriate use of restraints, including a physical restraint known as the BARR procedure;
5) Failure to report all incidents and failure to follow through with medical intervention in some reported incidents;
6) Failure to conduct required background screening on some personnel;
7) Failure to maintain proper staffing levels to insure client safety and well-being.

These areas of concern were presented to Threshold during an exit conference upon completion of the survey. Threshold was given the opportunity to submit a response to the findings.

On September 19, 2006, the Agency apparently hand-delivered to Threshold an Order of Immediate Moratorium (Order). However, neither party introduced a copy of the Order into evidence nor is it attached to the pleadings. Threshold was preparing its written response (the "Response") to APD's findings when the Order was served. The Response was quickly finalized and delivered to the Agency on or about October 6, 2006. Threshold received no feedback from the Agency concerning the Response.

On November 17, 2006, the Agency conducted a follow-up inspection of the group homes. The original investigative team was utilized for the follow-up inspection with the exception of one member who had a scheduling conflict. That member did a desk review of the Agency's findings but did not read the Response before issuing her final statement on the matter.

At the final hearing, Petitioner called four witnesses: Jeffrey Coleman, contract manager for the Agency; Colleen Foley, operations management consultant II; Candace Michelle Ledbetter, registered nurse (RN) consultant; and Steve Roth, area administrator. Petitioner offered Exhibits A through N into evidence. All but Exhibits B and G were accepted into evidence. Respondent presented the testimony of four witnesses: John Shadler, assistant behavioral analyst; Latonia Overstreet, human resources technician; Vadim Klochko, chief operating officer; and Dr. Robert E. Wright, chief executive officer/chief nursing officer. Respondent also offered seven exhibits, all of which were received into evidence. Official recognition was taken of the Developmental Disabilities Waiver Services Handbook.

At the close of the evidentiary portion of the final hearing, the parties were allowed 15 days from the filing of the hearing transcript to file their respective proposed recommended orders. A four-volume hearing Transcript was filed at DOAH on March 13, 2007. 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

1. Petitioner is the state agency responsible for licensing and monitoring operations of foster care homes, group

home facilities, and residential habilitation centers. Petitioner has authority to sanction or penalize licensees who do not comply with statutory and rule requirements.

2. Threshold holds a Standard license for the operation of group homes for the developmentally disabled. Threshold has been licensed as a developmentally disabled group home for over 30 years. Its license had never been sanctioned by the state before this moratorium was imposed. Threshold is enrolled in the Medicaid program and has entered into a Medicaid Waiver Agreement with Petitioner.

3. Threshold owns and operates five group homes located in the greater Orlando area. The homes are licensed for up to 32 beds or clients. At present, as a result of the moratorium on admissions, there are 27 clients in residence. The moratorium's prohibition against filling the empty beds has cost Threshold $277,404.30 in lost revenues as of the date of the final hearing.

4. Threshold's operations are managed by Dr. Bob Wright, its chief executive officer and chief nursing officer, along with Vadim Klochko, its chief operating officer. Wright holds a doctorate in Health Care Administration and is a registered nurse. Klochko studied medicine in Krasnodar, Russia, and did a fellowship in psychiatry before moving to the United States in

2000. He was previously a board-certified behavioral analyst, but has let that certification lapse.

5. The medical staff for Threshold includes the two gentlemen described above and Elena Toporkova, who received her medical degree in St. Petersburg, Russia. Toporkova also holds a master's degree in public health.

6. Threshold's Medicaid Waiver Agreement with the State of Florida outlines the contractual arrangement between the parties. Threshold must comply with terms of the Waiver Agreement in order to receive state funding. Threshold also operates an Adult Day Training program, but funding for that program does not come under the Waiver Agreement. The current Waiver Agreement between the parties was signed and took effect January 11, 2007 (i.e., after the inspections and imposition of a moratorium which are the focus of the instant proceeding).

7. During the Summer of 2006, Steve Roth, area administrator for APD, began receiving anonymous emails concerning alleged improper practices at Threshold. After several such emails, Roth requested and was granted a meeting with the author of those allegations. He met with two former and one current Threshold employee who described their concerns about practices at Threshold.

8. One of the complainants, Vikki Bower, had been a long-time employee of Threshold. During the period of her

employment, Bower was charged and pled nolo contendre to Medicaid fraud. Because of that charge, Wright asked the APD area administrator whether Bower could continue working in her position as chief operating officer of Threshold. Told that she could not continue in that position, Wright created another job for her outside the realm of Medicaid so that she could remain employed. Meanwhile, Threshold had loaned Bower $16,000 to hire legal counsel to defend her in the criminal trial associated with the charge. But Bower would not accept the new position and resigned from Threshold. (At that time, she was already in discussions with APD about alleged violations.)

9. The concerns raised by Bower prompted Roth and his supervisors to take action. Roth assembled a team of surveyors from outside Threshold's service area for the purpose of conducting a fair and objective review of the provider.

10. An unannounced inspection of Threshold's group homes was conducted by Respondent on September 5 and 6, 2006. At the conclusion of the inspection, an exit conference was conducted to advise Threshold of the findings. As a result of the findings, APD imposed a moratorium on admissions, which was communicated to Threshold by way of a letter dated September 19, 2006. Attached to the moratorium letter was a written statement of the deficiencies found during the initial inspection.

11. An announced follow-up inspection was conducted on November 17, 2006. Two months later, by letter dated January 12, 2007, Respondent advised Threshold that there were still some areas of concern, so the moratorium would continue. Threshold was directed to submit a plan of correction and come into compliance with the stated areas of concern. The January 12, 2006, letter acknowledged improvement in the areas of incident reporting, administering medications, drug accountability, and general medical issues. The remaining areas of concern were identified as: "staff development, personnel records, and staffing ratios." Threshold was given 11 days to submit its Plan of Correction to address the concerns. (The Plan of Correction was ultimately submitted on the fourteenth day.)

The Deficiencies

12. At the time of the November 17, 2006, follow-up survey (which was an announced visit), the group homes were essentially in compliance. However, due to the Agency's prior finding of significant understaffing and lack of training, it decided to continue the moratorium. Each of the findings from the September investigation which support the moratorium will be addressed below:

Administering, Counting and Reporting Control Medications

13. The Agency could not ascertain from Threshold's records which employees had the responsibility for giving medications, and whether persons giving medications had received the required training and validation. Each employee assisting with medications must be trained and then validated, i.e., supervised in the actual administering of medications to a patient. Although assured by Threshold that all necessary training and validation had been done, the Agency did not find acceptable proof of such during its initial inspection. Also, even though the facility had appropriate storage for controlled medications, drug counts did always match the report sheets.

14. Most of the cited records reviewed by APD involved employees who did not actually assist in administering medications. Those persons would not need documentation of training in their files. One employee (identified as "D.P.") was initially trained in medication administration in July 2006. She was not validated until September 15, 2006, i.e., after the initial survey by APD but before the follow-up survey. There are no specific time frame requirements for validation after the training.

15. In its written Response to APD, Threshold acknowledged the drug count errors. Changes were made in personnel and increased staffing hours to address the problem. At the time of

the re-survey, the Agency's citations had been properly resolved.

16. Threshold had a valid program for training its employees who assisted with medications. All such employees were required to take two tests, a written examination on relevant terms and then a hands-on competency test. These tests exceed the requirements for training. Threshold could not produce copies of the written tests, but there is no requirement that they be retained in an employee's files.

Incorrect Count of Controlled Substances

17. The survey team found instances of incomplete doses or missed doses of medications. This constitutes an incorrect count and should be reported to the Agency as an "incident." Threshold failed to make all such reports.

18. Threshold improved oversight responsibilities by its program managers to address this issue. Additionally, changes in key staff positions were made to re-ensure compliance. At the time of the follow-up survey, the discrepancy had been corrected and policies put in place to prevent re-occurrence.

Providing Medications Contrary to Doctor's Orders

19. The survey team found one instance of a client receiving drugs, which were contrary to a physician's prescription. The client, M.N., was given a different medication than the one prescribed by his treating physician.

20. M.N.'s situation involved an obese client who had been on a regimen of Risperdal. On August 15, 2006, M.N.'s current treating physician saw M.N. and ordered a change from Risperdal to Geodon. The physician was unaware at that time that M.N. had a history of adverse reactions to Geodon. Threshold's behavioral analyst noticed the change in medication when M.N. returned to the home. He immediately notified the RN on staff and called the physician to advise him about the possible problem. Threshold's RN had the staff administer the Risperdal instead of the Geodon, pending return of a call from the physician. When the doctor called, he wholeheartedly concurred that the prescription of Geodon was in error and that Risperdal should be continued. This matter did not constitute a deficiency during the follow-up survey and is not currently a problem.

<u>Improper Use of Restraints</u>

21. Two instances of improper restraints were noted by the survey team. In the first, a client had been physically restrained using a "BARR procedure" (wherein employees use physical techniques to lower a client to the ground and keep him in a prone position until he is no longer a threat to himself or others). The client was left lying on a mat near a doorway, concerning the Agency that he would be stepped on. Further, the

length of time he was down on the mat caused some concern to the survey team.

22. Threshold evinced a valid reason for using the BARR procedure on this difficult client. They had been caring for this client for a number of years. The client became aggressive almost every day after lunch and wanted to go home. He was physically strong and was able to inflict injury on himself and others. When he began to show aggression, he had to be restrained. The BARR restraint was used in conjunction with a procedure known as "extinction," the practice of not providing attention to the person's bad behavior. In this case, the client was put down to the mat and then effectively ignored until he realized his behavior would not be rewarded. At that point, he was allowed to get up and rejoin activities.

23. In the second instance, an obese person was restrained using the BARR procedure for an undetermined amount of time. The Agency surveyor was concerned about him being restrained absent the presence of a clock on the wall to time the restraint period.

24. Threshold has been treating this client for ten years, and his physician is aware of the use of this procedure. Time is kept by the employees using a wall clock (which was missing the day of the survey), watches, and/or cell phone clocks.

25. Both of the above-described incidents occurred at the Adult Day Training site rather than at one of the group homes.

Reporting of Incidents and Medical Follow-up

26. The Agency found 55 incidents, which it felt met the requirements for reporting to APD. Of these, only 22 were reported to APD. There were also 22 incidents that the Agency felt warranted medical intervention, but for which no intervention had been provided. At final hearing, that number was reduced to nine incidents. Each of those was minor in nature. For example, a client named D. slipped when getting out of the shower. He hit the side of his face on the counter, resulting in a slight scratch. Two days later the scratch was gone. The Agency contends a doctor should have been called or he should have been taken to the emergency room. There is no competent and substantial evidence to support that contention.

27. All minor incidents are evaluated by Threshold's RN on staff. If the injury requires only minimum first aid (called "mommy care"), then it is not necessary to have further medical intervention. There is a policy in place for evaluating each incident on its own merits so that any event requiring further medical attention receives it timely. An RN evaluating a client at the time of the incident can do so much better than a person reviewing the record at a later date.

Background Screening and Employee Files

28. In its review of employee files, only two of seven files contained evidence of medication training and validation. One staff member did not have an Affidavit of Good Moral Character; another member had an affidavit that had not been notarized. In five of ten files, local law enforcement checks had not been submitted within five days. There was no record of law enforcement checks at all in three files. Two employees' records did not include a copy of their high school diplomas.

29. As stated in the Response, the missing affidavit was in a "to be filed" folder and the un-notarized affidavit was awaiting a new notary (and has now been completed). The late-filed law enforcement checks were due to APD's own mistake over whether they were required. Threshold was initially told by APD they weren't necessary; when APD reversed its opinion, the checks were immediately submitted. One employee without a high school diploma in his file is a graduate of Florida State University. His college diploma was provided. The other person is a foreign national who worked only temporarily, and her diploma was never received.

Staffing Ratios did not Meet Requirements

30. As part of the survey, the Agency requested and was provided time sheets for employees. Utilizing the provided time sheets and comparing them to the number of clients served and

number of hours worked, APD concluded that Threshold's staffing levels were inadequate. APD also raised a concern over the amount of overtime hours by some staff.

31. According to the Agency's review, Threshold was understaffed by some 3,025 hours during four identified pay periods. The surveyor used the staffing ratios identified by the Agency for four different levels of client. Level I requires .3 staff to each client; Level II is .6 to 1; Level III is .8 to 1; and Level IV is 1 to 1. The surveyor, who had not previously reviewed homes with a tiered system, did not utilize an FTE (full time equivalent) methodology to compare staff to client ratios. Instead, she rounded up to nearest whole number. This methodology completely abrogates the ratio concept and is not credible. Further, the surveyor did her calculations on all five group homes as a whole, despite the fact each is individually licensed. Thus, her conclusions concerning staffing were skewed. This particular surveyor had never reviewed a group home with a four-level tiered system for intensive clients. Her findings are not persuasive.

32. Some lead staff perform a considerable amount of hands-on care with clients. This time would not show up on time sheets because they are salaried employees. House managers also get involved in care, and their time would not be included in the time cards. Administrative staff who work overtime to fill

a position would have time showing up as administrative, but which is actually direct care time. Contract employees, furnished through a contract with a local provider (VicDon Staffing), also would not show up on time cards.

33. Counting all persons who actually provided direct care to clients during the four time periods at issue would result in a considerable over-staffing. Even so, Petitioner was concerned that using administrative staff for client care needs could result in too much overtime, thus possibly putting clients at risk due to employee exhaustion. No evidence was presented to suggest that overtime work by staff members was creating such a problem.

Follow-up Survey

34. At the time of the follow-up survey, there was no indication of any threat to the life, safety or welfare of clients at the group home.

35. Using Threshold's methodology (which is more credible than the Petitioner's method) for counting staff hours, Threshold provided well in excess of the staffing hours required under its contract with the state.

36. With the exception of one employee, Elorine Feacher, all employee training records, proof of training, and education records were up to date. Feacher was a prior employee who had recently returned to work at Threshold. Her new application and

records had not yet made it to an employee file. That discrepancy is minor in nature.

CONCLUSIONS OF LAW

37. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes.

38. The Agency, as the party asserting the affirmative of the issue, has the burden of proof in this matter. See Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). The attempt to sanction Threshold's "valuable business or professional license" must be proven by clear and convincing evidence. See Ferris v. Turlington, 510 So. 2d 292, 294 (Fla. 1987).

39. Threshold owns and operates group home facilities, which are defined in Subsection 393.063(15), Florida Statutes, as:

> [A] residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility shall be at least 4 residents but not more than 15 residents.

40. The Threshold group homes also fall within the definition of "Residential Facility" found at Subsection

392.063(26), Florida Statutes. Subsection 393.067, Florida Statutes, outlines the licensure requirements for group homes and/or residential facilities.

41. Subsection 393.0673, Florida Statutes, reads in pertinent part as follows:

> (1) The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $1,000 per violation per day, if the applicant or licensee:
>
> *   *   *
>
> (c) Has failed to comply with the applicable requirements of this chapter or rules applicable to the applicant or licensee.
>
> *   *   *
>
> (4) The department may issue an order immediately suspending or revoking a license when it determines that any condition in the facility presents a danger to the health, safety, or welfare of the residents in the facility.
>
> (5) The department may impose an immediate moratorium on admissions to any facility when the department determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility.

42. APD Operating Procedure No. 10-002 addresses the requirement for reporting adverse incidents. Subsection 3 of 10-002 includes the process for reporting "Reportable Incidents," which include:

> (a) Altercations - A physical confrontation occurring between a consumer and a member of the community, a consumer and provider, or two or more consumers at the time services are being rendered and that results in law enforcement contact. . . .
>
> (b) Consumer Injury - An injury sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while receiving services from an APD operated, licensed or contracted provider, Medicaid waiver provider, or ICF/DD that requires medical attention in an urgent care center, emergency room or physician office setting.
>
> (c) Consumer Arrest - [Not relevant to the facts of this case]
>
> (d) Missing Competent Adult -[Not relevant to the facts of this case]
>
> (e) Suicide Attempt - [Not relevant to the facts of this case]
>
> (f) Other - Any event not listed above that jeopardizes a consumer's health, safety or welfare. Examples may include but are not restricted to severe weather condition damage (e.g. tornadoes or hurricanes), criminal activity by providers or employees, fires or other hazardous events or conditions, etc. If the event may generate unfavorable media attention, it is to be reported as a critical incident.

43. There is no competent substantial evidence that any of the incidents at issue required additional medical treatment. Thus, all required incidents were reported to APD.

44. Each of the deficiencies uncovered by Petitioner during its initial survey of the group homes was fully and

satisfactorily resolved. There is no further basis for sanctions or continuation of the moratorium on admissions.

45. As of December 11, 2006 (i.e., after the two inspections but prior to the Agency's continuation of the moratorium on admissions), Shelly Brantley, director of APD, issued a Memorandum concerning how to impose disciplinary actions against APD-licensed homes. Under the terms of that Memorandum, the violations by Threshold would not support imposition of a moratorium.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a final order be entered by the Agency for Persons with Disabilities withdrawing the Moratorium effective immediately. No further action against Respondent's license is warranted.

DONE AND ENTERED this 17th day of April, 2007, in Tallahassee, Leon County, Florida.

S

R. BRUCE MCKIBBEN
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of April, 2007.

ENDNOTE

1/ All references to Florida Statutes are to Florida Statutes (2006), unless otherwise indicated.

COPIES FURNISHED:

James Dennis, Esquire
Threshold, Inc.
3550 North Goldenrod Road
Winter Park, Florida 32792

Stacy N. Robinson, Esquire
Department of Children and Family Services
400 West Robinson Street, Suite S-1106
Orlando, Florida 32801

Michael McGuckin, Agency Clerk
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950

John Newton, General Counsel
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950

Barney Ray, Interim Executive Director
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950

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.