STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. AVALON'S ASSISTED LIVING, LLC, d/b/a AVALON'S ASSISTED AND d/b/a AVALON'S ASSISTED LIVING AT AVALON PARK, AND AVALON'S ASSISTED LIVING II, LLC, d/b/a AVALON'S ASSISTED LIVING AT SOUTHMEADOW, Respondents.	)	Case No. 10-0528
AVALON'S ASSISTED LIVING, LLC, d/b/a AVALON'S ASSISTED LIVING AND d/b/a AVALON'S ASSISTED LIVING AT AVALON PARK, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 10-1672
AVALON'S ASSISTED LIVING II, LLC, d/b/a AVALON'S ASSISTED LIVING AT SOUTHWEST, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 10-1673 *AMENDED AS TO COPIES FURNISHED ONLY

*AMENDED RECOMMENDED ORDER

On September 14 through 16, 2010, a hearing in this case was conducted by videoconference in Tallahassee and Orlando, Florida, by William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings (DOAH).

APPEARANCES

For Agency for Health Care Administration:

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STATEMENT OF THE ISSUES

The issues in DOAH Case No. 10-0528 are whether the allegations set forth in the Administrative Complaint dated December 4, 2009, are correct, and, if so, what penalty should be imposed.

The issue in DOAH Case No. 10-1672 is whether the application for license renewal filed by Avalon's Assisted Living LLC, d/b/a Avalon's Assisted Living and d/b/a Avalon's Assisted Living at Avalon Park (hereinafter Avalon I), should be approved.

The issue in DOAH Case No. 10-1673 is whether the application for license renewal filed by Avalon's Assisted Living

II LLC, d/b/a Avalon's Assisted Living at Southwest (hereinafter Avalon II), should be approved.

PRELIMINARY STATEMENT

By an Administrative Complaint dated December 4, 2009, the Agency for Health Care Administration (hereinafter Agency) sought to revoke the licenses of Avalon I and Avalon II based on alleged violations of certain statutes further identified herein. The licensees disputed the allegations of the Administrative Complaint, and, on January 25, 2010, the licensees requested a formal hearing. On February 4, 2010, the Agency forwarded the request to DOAH, where it was designated as Case No. 10-0528, assigned to the undersigned Administrative Law Judge (ALJ), and scheduled to be heard June 16 through 18, 2010.

By Notice of Intent to Deny dated February 25, 2010, the Agency denied the application for license renewal filed by Avalon I. As grounds for the proposed denial, the Agency asserted that the "applicant is a licensee with a license under revocation" and that the "applicant was found to be operating an unlicensed assisted living facility during a complaint investigation conducted on August 5, 2009." On March 22, 2010, Avalon I filed a Petition for Formal Administrative Proceeding. On March 26, 2010, the Agency forwarded the petition to DOAH, where it was designated Case No. 10-1672.

By a separate Notice of Intent to Deny dated February 25, 2010, the Agency denied the application for license renewal filed by Avalon II, again on the basis that the "applicant is a licensee with a license under revocation" and that the "applicant was found to be operating an unlicensed assisted living facility during a complaint investigation conducted on August 5, 2009." On March 22, 2010, Avalon II filed a Petition for Formal Administrative Proceeding. On March 26, 2010, the Agency forwarded the petition to DOAH, where it was assigned Case No. 10-1673.

DOAH Case Nos. 10-1672 and 10-1673 were assigned to a second ALJ and scheduled for hearing on June 11, 2010. On May 28, 2010, the Agency moved to continue the June 11, 2010, hearing and to consolidate DOAH Case Nos. 10-1672 and 10-1673 with DOAH Case No. 10-0528. The second ALJ granted the continuance, and the two cases were thereafter transferred to the undersigned ALJ who consolidated the three cases.

A separate case (DOAH Case No. 09-6342) involves a challenge by the allegedly unlicensed facility (hereinafter Avalon III) to the Agency's denial of the initial licensure application filed by Avalon III. The dispute was referred to DOAH on November 17, 2009, designed as DOAH Case No. 09-6342, and assigned to a third ALJ. On February 15, 2010, the Agency moved to consolidate DOAH Case No. 09-6342 with the instant cases, but the motion was

opposed by Avalon, and the ALJ to whom the case was assigned declined to consolidate the cases.

At the hearing, the Agency presented the testimony of 15 witnesses and had Exhibits 3 through 13, 15, 16, 21, 36, 38, 39, and 52 admitted into evidence. Avalon I and Avalon II presented the testimony of four witnesses and had Exhibits 1, 5, 7 through 10, 12, 16, and 23 through 26 admitted into evidence.

The five-volume Transcript of the hearing was filed on November 12, 2010. Proposed Recommended Orders were filed on December 6 and 7, 2010.

FINDINGS OF FACT

1. Avalon I is a six-bed assisted living facility (ALF), operating at 1250 Willow Branch Drive, Orlando, Florida, 32828, and holding license number 10813 with Limited Nursing Services licensure.

2. Avalon II is a six-bed ALF operating at 13230 Early Frost Circle, Orlando, Florida, 32828, and holding license number 11318 with Limited Nursing Services licensure.

3. Avalon I and Avalon II are operated by a limited liability company owned by Chiqquittia Carter-Walker and Robert Walker. Mrs. Carter-Walker acts as the administrator of the facilities.

4. On July 23, 2009, the Agency conducted an inspection of Avalon I and determined that there were three "Class II"

deficiencies, commonly cited as "tags" in reference to applicable regulatory standards.

5. Tag A029 alleged that the training certifications, contained within the facility's personnel files to document the provision of required employee education, were false and that the training had not been provided.

6. The training certificates for one Avalon I staff member were not accurate and falsely indicated that the referenced employee received training that had not been provided. The falsification was deliberate and was not erroneous.

7. The inaccurate documentation of employee training misstated the qualifications of the ALF staff, falsely indicated that the staff was adequately trained, and presented the potential for harm to the health of the residents. The Agency correctly identified the deficiency as Class II.

8. Tag A427 was based on regulatory provisions that permitted a terminally ill resident, no longer meeting the criteria for continued ALF residency, to remain in the ALF under certain conditions. The July 23, 2009, inspection indicated that such a resident continued to reside at Avalon I without compliance with relevant conditions.

9. The conditions under which the terminally ill resident was permitted to remain at the ALF required that the hospice coordinate the care and provision of additional medical services

and that an interdisciplinary care plan be developed and implemented by the hospice in coordination with the ALF.

10. The July 23, 2009, inspection revealed that the interdisciplinary care plan failed to adequately designate responsibility for the various kinds of care required by the resident.

11. The inspection revealed that a terminally ill resident remained in Avalon I without receiving appropriate medication for pain management even though such medications had been authorized.

12. Although the ALF had undertaken the responsibility of administering the pain medication, there were occasions when no Avalon I staff member authorized to administer the pain medication was present at the ALF. Patient records indicated that the hospice representative attempted at several junctures to contact Mrs. Carter-Walker by telephone to resolve the problem and that Mrs. Carter-Walker was not accessible to the hospice representative.

13. The resident unnecessarily suffered pain because the issue was not resolved in a timely manner. The failure to provide a terminally ill resident with appropriate pain medication resulted in a direct threat to the physical and emotional health of the resident, and, therefore, the Agency correctly identified the deficiency as Class II.

14. Tag A700 reflects standards for resident care and requires that appropriate services be provided to residents. The July 23, 2009, inspection indicated that one resident was not being provided a nutritional supplement and that two residents were not being provided appropriate pain-relieving medications.

15. As to the provision of nutritional supplementation, one resident with a history of weight loss had been prescribed a daily can of "Ensure" nutritional supplement. According to the facility records, the supplement had not been acquired by the ALF and had not been provided to the resident.

16. As to the residents who were not receiving proper pain medication, one of the two was the terminally ill resident referenced in relation to Tag A427. As stated previously, the resident unnecessarily suffered pain because medication was not appropriately administered, which resulted in a direct threat to the health of the resident. Therefore, the Agency also correctly identified the deficiency cited as Tag A700 as Class II.

17. The second resident had a history of hypertension and hypothyroid issues and had been prescribed a daily Ibuprofen (400mg) for pain. The Avalon I medication records indicated that, on some days, the medication had been provided twice daily to the patient, and, on other days, it had not been provided at all.

18. The evidence establishes that the deficiencies identified in Tags A427 and A700 indicate a failure of the ALF to provide appropriate care and service to the residents of the facility.

19. According to the uncontroverted testimony of Agency investigators as documented by the reports of their inspections, numerous lesser deficiencies were identified at Avalon I between 2007 and 2009, constituting a continuing pattern of inadequate performance and a failure to meet relevant standards.

20. On August 5, 2009, an inspection conducted by the Agency at 1812 Crown Hill Boulevard, Orlando, Florida, 32828, indicated that an unlicensed ALF was operating at that address.

21. On August 5, 2009, the Agency's investigator observed five individual residents in Avalon III. The investigator reviewed health assessments for the residents, all of whom required assistance with activities of daily living, including personal hygiene, ambulation, and meals.

22. Medications for the residents were stored in a central area. The investigator reviewed medication observation records, indicating that the residents self-administered medications with observation by the Avalon III staff.

23. Signage was present at Avalon III that identified Mrs. Carter-Walker as the administrator of the Avalon III facility.

24. During the August 5, 2009, inspection, Mrs. Carter-Walker arrived at Avalon III and identified herself as the administrator of the facility. The investigator was familiar with Mrs. Carter-Walker and knew her as the administrator for Avalon I and Avalon II.

25. Mrs. Carter-Walker identified herself as the Avalon III administrator to other care providers, including a clinical social worker, a registered nurse providing contract health care services to facility residents, and Administrators at other local ALFs.

26. According to the testimony of an employee of Avalon III, there had been residents in the Avalon III location since at least June 16, 2009, at which time the staff member began to work at the facility. She worked five days per week, providing the resident services identified herein. During that time, there were always at least three residents in the facility. The same residents were present on a day-to-day basis. There is no evidence that such residents were transported out of the facility during the evening or that they did not otherwise remain at the Avalon III location overnight.

27. A licensed practical nurse present at the Avalon III location on August 5, 2009, was the person who permitted the Agency's investigator to enter into the facility. The nurse was at the location to provide personal care assistance to a

terminally ill resident receiving care through an agreement between the Mrs. Carter-Walker, as the facility administrator, and the hospice. After Mrs. Carter-Walker arrived at the Avalon III location, she was apparently unhappy that the nurse had permitted the investigator to enter the facility, and directed the nurse to leave immediately without providing further assistance to the resident.

28. On the day of the investigation, the Agency investigator issued a "Notice of Unlicensed Activity/Order to Cease and Desist" to Robert Walker and Chiqquittia Carter-Walker for the Avalon III operation. Mr. Walker arrived during the inspection and identified himself as an owner to the Agency investigator.

29. On August 14, 2009, the Agency received an application for licensure of an ALF at 1812 Crown Hill Boulevard, Orlando, Florida, 32828. The application, submitted by Robert Walker as the administrator, referenced the Avalon I and Avalon II as affiliated with Avalon III through ownership.

30. Both Mr. Walker and Mrs. Carter-Walker submitted affidavits of compliance with background screening requirements as part of the Avalon III application.

31. At no time was Avalon III licensed as an ALF. There was no evidence that the Avalon III residents were related to Mrs. Carter-Walker or her husband.

32. There was no evidence that Avalon III was exempt from, or otherwise not required to comply with, relevant ALF licensing requirements.

CONCLUSIONS OF LAW

33. The Division of Administrative Hearings has jurisdiction over the parties to and subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2010).

34. The Agency for Health Care Administration is responsible for licensure and regulation of ALFs in Florida. See chapters 408 and 429, Fla. Stat. (2010).

35. Section 429.02, Florida Statutes (2009),[1/] sets forth the following applicable definitions:

> 429.02 Definitions.--When used in this part, the term:
>
> (2) "Administrator" means an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility.
>
> * * *
>
> (5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.
>
> * * *

(16) "Personal services" means direct physical assistance with or supervision of the activities of daily living and the self-administration of medication and other similar services which the department may define by rule. "Personal services" shall not be construed to mean the provision of medical, nursing, dental, or mental health services.

36. Section 429.04 requires that, with certain specified exemptions, Florida ALFs must be licensed. There was no evidence that any of the ALFs relevant to this proceeding were exempt from licensure requirements.

37. Section 429.14 provides, in relevant part, as follows:

429.14 Administrative penalties.--

(1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee of an assisted living facility for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee of an assisted living facility, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee:

(e) A citation of any of the following deficiencies as specified in s. 429.19:

2. Three or more cited class II deficiencies.

* * *

(k) Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter or chapter 400. (Emphasis supplied)

38. Section 429.19 provides, in relevant part, as follows:

> 429.19 Violations; imposition of administrative fines; grounds.--
>
> (1) In addition to the requirements of part II of chapter 408, the agency shall impose an administrative fine in the manner provided in chapter 120 for the violation of any provision of this part, part II of chapter 408, and applicable rules by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 408.809, for the actions of any facility employee, or for an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
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> (2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:
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> * * *
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> (b) Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation.

39. Section 408.812, Florida Statutes, set forth within Part II of chapter 408, provides, in relevant part, as follows:

> 408.812 Unlicensed activity.--
>
> (1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license

for other than that for which he or she actually holds the license.

(2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.

(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency. (Emphasis supplied)

40. Section 408.813(2)(b) provides the following relevant definition:

Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

41. Section 408.815 provides, in relevant part, as follows:

408.815 License or application denial; revocation.--

(1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:

(a) False representation of a material fact in the license application or omission of any material fact from the application.

(b) An intentional or negligent act materially affecting the health or safety of a client of the provider.

(c) A violation of this part, authorizing statutes, or applicable rules.

(d) A demonstrated pattern of deficient performance. (Emphasis supplied)

42. In these cases, the Agency has the burden of proving, by clear and convincing evidence, the allegations set forth against Avalon I and Avalon II in the Administrative Complaint. The Agency also has the burden of establishing that sufficient cause is present to deny the license renewal applications filed by Avalon I and Avalon II. Dep't of Banking & Fin. v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Coke v. Dep't of Child. & Fam. Servs., 704 So. 2d 726 (5th DCA 1998).

43. The Agency has met the burden. The evidence establishes that the violations identified during the July 23, 2009, inspection of Avalon I posed a direct threat to the physical and emotional health of the residents.

44. The falsification of employee training documentation (cited as Tag A029) deliberately misrepresented the level of information and skill possessed by a staff member. The failure to provide appropriate medication to a terminally ill resident (cited as Tags A427 and A700) resulted in unnecessary pain. The deficiencies constituted a direct threat to the physical and

emotional health of residents and were properly designated as Class II deficiencies.

45. Numerous additional deficiencies, albeit not as severe as those specifically addressed herein, indicated a general failure to meet relevant licensing standards and regulatory criterion. However, even absent the additional deficiencies, revocation of licensure is an appropriate penalty pursuant to section 429.14(1)(e)2.

46. Additionally, the evidence establishes that the Walkers operated an unlicensed ALF, Avalon III. Presumably, since they were already operating Avalon I and Avalon II, they were aware that a license was required to operate an ALF. The failure to apply for licensure prior to operating Avalon III demonstrates a flagrant disregard for licensing requirements.

47. The requirement that an ALF obtain a license to operate is not simply a ritual of red tape. As stated in section 420.01(2), Florida Statutes, the purpose for licensure and regulation of ALFs in Florida is, in part, to "provide for the health, safety, and welfare of residents of assisted living facilities in the state." Section 420.01(3) states as follows:

> 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.

48. Accordingly, the following recommendation is set forth.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration issue a final order revoking the licenses of Avalon I and Avalon II, denying the applications for license renewal filed by Avalon I and Avalon II, and assessing an administrative fine in the amount of $3,000 for the specific Class II deficiencies identified herein.

DONE AND ENTERED this 31st day of January, 2011, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
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Filed with the Clerk of the
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this 31st day of January, 2011.

ENDNOTE

[1/] All references sections and chapters are to Florida Statutes (2009), unless otherwise stated.

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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.