STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR PERSONS WITH DISABILITIES, Petitioner, vs. HELP IS ON THE WAY, INC., Respondent.	)	Case No. 11-1620
AGENCY FOR PERSONS WITH DISABILITIES, Petitioner, vs. TIMBERGREEN GROUP HOME, HELP IS ON THE WAY, INC., Respondent.	)	Case No. 11-2455

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on October 15, 2011, and November 7, 2011, by video teleconference at sites in Tallahassee and Lakeland, Florida, before Administrative Law Judge Elizabeth W. McArthur of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Stacy N. Robinson, Esquire
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For Respondent: Charles D. Bavol, Esquire
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STATEMENT OF THE ISSUE

Whether Respondent's licenses to operate two group homes should be renewed, or whether renewal should be denied for the reasons charged in the administrative complaints issued by Petitioner.

PRELIMINARY STATEMENT

Respondent, Help is on the Way, Inc. (Respondent or HIOTW), filed with Petitioner, Agency for Persons with Disabilities (Petitioner or APD), two applications for renewal of licenses to operate two group homes known as Lake Miriam Group Home (Lake Miriam) and Timbergreen Group Home (Timbergreen), in Lakeland, Florida. On March 25, 2011, Petitioner issued a Notice of Application Denial with regard to Respondent's application to renew the Lake Miriam license. On April 29, 2011, Petitioner issued a Notice of Application Denial with regard to Respondent's application to renew the Timbergreen license. In both instances, Petitioner has acknowledged that the renewal application denials are tantamount to revocations in that the renewal denials are predicated on past incidents charged as violations of group home licensure standards. Therefore, as Petitioner agreed, the denial notices should be, and are,

considered administrative complaints for purposes of this proceeding.[1/]

Respondent timely requested administrative hearings to contest the charges in the administrative complaints. The two separate cases were forwarded to the Division of Administrative Hearings for assignment of an Administrative Law Judge and were subsequently consolidated for hearing. Following several continuances, the consolidated cases were ultimately scheduled for final hearing on October 15, 2011, and were transferred to the undersigned, who conducted the hearing as rescheduled. When the parties were unable to complete the hearing in the single day reserved, an additional hearing day was scheduled for November 7, 2011, and the final hearing was concluded then.

At the final hearing, Petitioner presented the testimony of James Rheaume, Ronald Thompson, Melody Taylor, and Heather Monteath. Petitioner's Exhibits 1 through 10 were admitted in evidence. Respondent presented the testimony of LaDonna Bennett, O.J. Bennett, Jeannette Estes, Silas Harris, Aubrey Bell, Schellie Fanfan-Sissoko, and Samuel Cooper. Respondent's Exhibits 2, 3, 5 through 9, 12 through 16, 19, 20, 22, 25 through 28, 32, 33, 39, 40, 44, 47, 49, 50, 52 through 56, 58, 59, 61 through 65, 76, and 105 were admitted in evidence. In addition, Respondent offered the deposition Transcripts of Heather Monteath, Melody Taylor, Jeannette Estes, and Frank

Davis as Respondent's Exhibits 82, 83, 84, and 104, respectively, in addition to, or in lieu of, live testimony. The deposition Transcripts were admitted in evidence subject to rulings on Petitioner's objections, which were filed as permitted after the hearing. Rulings on Petitioner's objections to the deposition testimony are set forth in an Appendix to this Recommended Order.

The two-volume Transcript of the October 15, 2011, portion of the final hearing was filed on November 4, 2011; an additional Transcript volume of the November 7, 2011, conclusion of the final hearing was filed on December 5, 2011. On December 27, 2011, both parties timely filed Proposed Recommended Orders, which have been carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. APD is the state agency charged with licensing and regulating group home facilities. The statewide headquarters, or "central office," is in Tallahassee. Regional offices carry out the licensing and regulatory functions within their designated regions, or "areas," in coordination with the central office. APD Area 14 covers Polk, Hardee, and Highlands Counties.

2. Beginning in 2007 and at all times material to this proceeding, HIOTW has been a provider of various residential and

non-residential services to developmentally disabled persons in Lakeland, Polk County, Florida, within APD Area 14. In 2007, HIOTW was licensed by the Agency for Health Care Administration (AHCA) to provide non-residential homemaker and companion care services. In November 2008, HIOTW became licensed by the APD Area 14 office to operate Paces Trail Group Home to provide residential habilitation services to developmentally disabled adults. Shortly thereafter, HIOTW was licensed by the APD Area 14 office to operate its second group home, Hampton Group Home.

3. HIOTW was licensed by the APD Area 14 office to operate Timbergreen in May 2009. In February 2010, the APD Area 14 office issued a license to HIOTW to operate its fourth group home in Lakeland--Lake Miriam. The group home license renewal of these two group homes, each with a capacity to serve six adult male residents with developmental disabilities, is at issue in this proceeding.

4. After initial licensure of a group home, the license must be renewed annually. All of HIOTW's group homes successfully have gone through the license renewal process one or more times, except for Lake Miriam, which is seeking its first license renewal.

5. On November 12, 2010, HIOTW submitted an application to the APD Area 14 office to renew its license to operate Lake

Miriam. On March 3, 2011, HIOTW submitted an application to renew its license to operate Timbergreen.

6. By letter dated March 25, 2011, Petitioner denied the Lake Miriam license renewal application (March 25 Denial Letter). Petitioner relies on the following charges alleged in the March 25 Denial Letter as the basis for Petitioner's decision:

> On or about April 14, 2010, an employee of the applicant left two vulnerable adult group home residents alone in a car for at least ten minutes while that employee conducted business inside a bank. One of the adult residents who was left unsupervised in the car had a history of sexually molesting children and other vulnerable adults. The other resident who was left unsupervised in the car was non-verbal. This instance threatened the health, safety, and well being of the applicant's residents in violation of page A-8 of the Developmental Disabilities Waiver Services Coverage and Limitations Handbook and Rule 65G-2.012(15)(b), F.A.C.
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> On or about September 29, 2010, an employee of the applicant was transporting group home residents when one of the residents left the vehicle without the driver's knowledge. The vulnerable adult resident was later located at a neighborhood store. This instance threatened the health, safety, and well being of the applicant's residents in violation of page A-8 of the Developmental Disabilities Waiver Services Coverage and Limitations Handbook and Rule 65G-2.012(15)(b), F.A.C.

7. The March 25 Denial Letter also alleged that HIOTW failed to submit a current approved emergency management plan as

a third reason to deny the license renewal application. However, Petitioner abandoned the third charge at the outset of the final hearing. Petitioner sought to support its proposed denial of the Lake Miriam license renewal application solely as a penal measure based on the two alleged incidents quoted above. As such, but for these two alleged incidents, Petitioner acknowledges that Lake Miriam's license renewal application is otherwise entitled to approval.

8. By letter dated April 29, 2011, Petitioner denied the Timbergreen license renewal application (April 29 Denial Letter). The April 29 Denial Letter set forth the same two charges that were alleged in the March 25 Denial Letter as the basis for Petitioner's decision. In other words, the same two incidents were asserted as grounds for denying both the Lake Miriam license renewal application and the Timbergreen license renewal application. But for these two incidents, Timbergreen's license renewal application, like Lake Miriam's application, is otherwise entitled to approval.

First Alleged Incident (on or about April 14, 2010)

9. The credible evidence established the following facts relevant to the first charged incident. In early April 2010, an employee of HIOTW's licensed companion care service, Frank Davis, was providing companion care to R.O., a developmentally disabled adult. R.O. was not a resident of any HIOTW group

home. Instead, R.O. received only non-residential companion services through HIOTW from its employee Frank Davis. As previously noted, companion care services are licensed and regulated by a different agency, AHCA.

10. R.O. was classified as developmentally disabled due to mild mental retardation and behavioral problems. R.O. had a history of sexually abusing children and vulnerable adults. R.O. also had a known tendency of "telling big whoppers," i.e., he was known to be a habitual liar.

11. R.O. apparently told someone two stories of alleged incidents involving his companion, HIOTW employee Frank Davis. On April 14, 2010, the person to whom R.O. told the stories reported the two alleged incidents to the hotline operated by the Department of Children and Families (DCF), which fields reports of possible abuse or neglect.[2/] One story told by R.O., as reported to DCF, was that Mr. Davis had left R.O. alone with Mr. Davis's three-year-old daughter. The other story told by R.O., as reported to DCF, was that Mr. Davis had left R.O. alone in a car with a non-verbal vulnerable adult for a period of time while Mr. Davis went into a bank to conduct some business. If true, these allegations of R.O. allegedly being left alone with a child in one instance and with a non-verbal vulnerable adult in the other instance would be of great concern. Both the child and the non-verbal vulnerable adult with whom R.O. was allegedly

left alone would have to be considered at great risk of abuse by R.O., given R.O.'s known history of sexually abusing both children and vulnerable adults.

12. With regard to R.O.'s first story, involving Mr. Davis's three-year-old daughter, a DCF adult protective investigator (API) was able to quickly determine that the allegation was completely baseless. In screening this allegation to determine if a formal investigation was warranted, the API spoke with R.O. and then with Samuel Cooper, one of the owners of HIOTW, on April 15, 2010, the day after the hotline call. Mr. Cooper provided a detailed description of the physical appearance of Frank Davis's daughter. When Mr. Cooper's description of Mr. Davis's daughter was compared to R.O.'s description of the girl with whom he was supposedly left alone, the two descriptions were so vastly different that the API was able to, and did, immediately determine that R.O. had fabricated the story, and the matter was closed without a formal investigation.

13. The same API conducted an investigation of R.O.'s second story that he was left in Mr. Davis's car with a non-verbal vulnerable adult while Mr. Davis went into a bank. However, the API did not mention this story when he spoke with Mr. Cooper, nor did the API inform anyone from HIOTW that he was conducting a formal investigation. In conducting his

investigation, the API spoke with R.O., twice with Mr. Davis, and with O.J. Bennett, another owner of HIOTW.

14. HIOTW initially learned of R.O.'s story about the bank trip by a phone call from R.O.'s waiver support coordinator. Mr. Bennett immediately investigated the matter, speaking with Mr. Davis and also with the bank manager who was present and had personally observed the events that day. Mr. Bennett's report from his investigation was that when Mr. Davis drove up to the bank with R.O., he left R.O. in the car only to walk about nine feet from the car to the bank's glass entrance area. Mr. Davis signaled to a bank employee who came to the door. Mr. Davis told the employee he wanted to set up an account to make direct deposits of his paycheck. When Mr. Davis was told he would have to come into the bank and it would take a few minutes, Mr. Davis went back to the car for R.O. and brought him into the bank to wait while Mr. Davis set up the account. R.O. remained in Mr. Davis's sight at all times.

15. Based on Mr. Bennett's report, which he reviewed with Mr. Cooper, HIOTW determined an unusual incident report (UIR) was not required, because there was no reason to suspect neglect of R.O. Several weeks later, when HIOTW learned from an APD employee that DCF was conducting a formal investigation, HIOTW submitted a UIR that set forth the details of Mr. Bennett's investigation and concluded that R.O. had been in Mr. Davis's

sight and adequately supervised at all times. The APD Area 14 administrator confirmed in her testimony that if the facts were as Mr. Bennett found them to be in his investigation, there would not have been inadequate supervision, and there would have been no reason to submit a UIR.

16. Of greatest significance with regard to R.O.'s story about the bank incident, the API determined that R.O. had lied about being left with a non-verbal vulnerable adult. Instead, the API found that Mr. Davis drove to a bank with R.O., and no one else, in the car.

17. The DCF investigator's report summarized the differing versions of events told to him by R.O. and by Mr. Davis. R.O.'s version was that Mr. Davis left him in the car for the whole time that he went into the bank. Of course, R.O. also said that he was left with another adult, and that was not true. Therefore, R.O.'s statement to the DCF investigator could not be considered credible or reliable.

18. According to the DCF investigator, Mr. Davis told him that he left R.O. alone in the car to go into the bank, but came back out of the bank to get R.O., who he then brought into the bank to wait while he conducted his business. However, Mr. Davis testified that he only told the DCF investigator that he walked up to the bank while R.O. was in the car.

19. Mr. Davis's version of what happened and what he told the DCF investigator is more credible than the DCF investigator's report of what Mr. Davis told him. Mr. Davis's version was corroborated by the hearsay account of the bank manager, who told Mr. Bennett that Mr. Davis brought R.O. in the bank with him, only having left R.O. alone to walk up to the bank entrance. The bank manager confirmed Mr. Davis's testimony that R.O. was in Mr. Davis's sight at all times.

20. In crediting Mr. Davis's version of events, corroborated by the bank manager, the undersigned finds it significant that Mr. Bennett told the DCF investigator about the bank manager eyewitness, and Mr. Bennett was under the impression that the DCF investigator would follow up by calling the bank manager. But the DCF investigator did not attempt to interview anyone at the bank, despite the fact that persons at the bank would have been the only other eyewitnesses besides Mr. Davis, who had a self-interest in the incident, and R.O., the habitual liar whose other story about Mr. Davis had been proven false.

21. Petitioner did not undertake its own investigation of the facts, either at the time of the incident or at the time it was considering whether to rely on the incident as grounds to, in effect, revoke two of HIOTW's group home licenses. Instead, according to the area administrator for APD Area 14, Petitioner

simply relied on the DCF investigation report. Indeed, the area administrator did not even seem to understand the DCF report, because at the hearing, she was adamant in her belief that DCF confirmed the allegation that Mr. Davis left R.O. in a car with a vulnerable non-verbal adult group home resident. The area administrator conveyed her misimpression to the central office in discussions to consider whether to non-renew two HIOTW group home licenses based on this incident. Ultimately at hearing, the area administrator conceded that she was improperly interpreting the DCF report, thinking that the allegation portion of the report contained the actual DCF findings. Even so, she steadfastly (and erroneously) asserted that she did not give any false information to the central office regarding HIOTW.[3/]

22. In addition to the misimpression conveyed about the R.O. incident, the area administrator testified that she had an employee convey numerous reports of allegations or suspicions of HIOTW improprieties to the central office in a single packet for the purpose of a decision on whether to renew the two HIOTW group home licenses. The area administrator explained other information about allegations and suspicions were sent in the same package so that the central office could also consider whether to terminate HIOTW's Medicaid waiver provider agreement at the same time. However, she admitted that the whole packet

of material was sent for the purpose of review and a decision on whether to non-renew HIOTW's two group home licenses. As such, it would be difficult to ignore the extraneous allegations when making decisions regarding the license renewal applications, "[o]f course, you have all of that in your mind[.]" The actual transmittal package to the central office was not produced, apparently because it was sent by electronic mail, and there were some APD email system problems that got in the way of producing the email transmittal package. Nonetheless, the area administrator's description of what she believes was sent in a single package to the central office was sufficient to paint the picture of a litany of negative missives regarding HIOTW, intended, in part, to support the area administrator's recommendation to deny license renewal.[4/]

23. Petitioner did not allege in the administrative complaints and did not prove at the hearing that HIOTW itself was blameworthy for the R.O. incident.

24. The APD Area 14 administrator testified that in recommending non-renewal of the two HIOTW group home licenses, a significant factor that she took into account was that HIOTW failed to promptly submit a UIR to report the R.O. incident. The facts found with respect to the R.O. incident do not demonstrate that a UIR was required. Moreover, HIOTW was not

charged, in either administrative complaint, with a violation of its UIR reporting obligations.

25. The DCF incident report concluded with a verified finding of inadequate supervision. The DCF investigator testified that it was his finding that "[p]rimarily, Mr. Davis was responsible for the inadequate supervision" of R.O. When asked whether HIOTW was also responsible as Mr. Davis's employer, the investigator said, "being his employer, and trainer, yes." However, neither the DCF investigator, nor Petitioner, presented any evidence to suggest that HIOTW was negligent in its hiring, training, or supervision of its companion care employees, generally, or Mr. Davis, in particular. Nor was there any evidence that HIOTW failed to appropriately respond to the R.O. incident once it was made aware of the incident.

26. The DCF incident report found that Mr. Davis was an appropriately screened employee with no adverse history. Petitioner presented no evidence to the contrary.

27. Both the DCF investigator and the area administrator for APD Area 14 concluded that HIOTW took appropriate action regarding the R.O. incident, by removing Mr. Davis from serving as R.O.'s companion and by putting Mr. Davis through additional "zero-tolerance" training. Mr. Davis's employment was

terminated shortly thereafter for reasons unrelated to the R.O. incident.

28. Although the DCF incident report verified a finding of inadequate supervision, the report concluded that the overall risk associated with the finding was low because of appropriate corrective action taken by HIOTW.[5/] The area administrator for APD Area 14 candidly admitted at the final hearing that HIOTW handled the R.O. incident appropriately and took corrective action that was deemed sufficient by APD and alleviated any health and safety concerns. Inexplicably, she continued to support the charges in the two denial letters, which alleged that the R.O. incident "threatened the health, safety, and well being of the applicant's residents," because R.O., with his history of being sexually abusive, had allegedly been left alone with a vulnerable, non-verbal adult group home resident.

29. Since the R.O. incident did not involve any HIOTW group home residents, but rather, involved non-residential services provided under HIOTW's companion care license, one would expect that if licensure disciplinary action was warranted against HIOTW at all for this incident, it would have been initiated by AHCA as the licensing agency for companion care services. No evidence was presented that AHCA took any disciplinary action against HIOTW's companion care license. Instead, the evidence established that HIOTW's companion care

license remained in good standing as of the final hearing, more than one and one-half years after the R.O. incident.

30. Notwithstanding APD's knowledge in June 2010 of the DCF report and findings regarding the R.O. incident, APD proceeded to renew annual licenses for the period of October 1, 2010, through September 30, 2011, for two other HIOTW group homes--Pace's Trail Group Home and Hampton Group Home. The license certificates state that the facilities comply with the licensure rules of APD. No evidence was presented that APD issued administrative complaints seeking to revoke these group homes' licenses; however, the area administrator made clear that she did not intend to renew any licenses for any HIOTW group homes in the future.

Second Alleged Incident (on or about September 29, 2010)

31. The facts regarding the second alleged incident involving HIOTW employee Donyell Goodman, were not disputed. At the time of the incident, Ms. Goodman had been employed by HIOTW for three years, with a very good, unblemished employee record. On the day in question, she was serving as a van driver to transport several HIOTW companion care clients to various sites within the local community. E.K. was one of those clients receiving companion care services that day; E.K. also was a resident of HIOTW's Lake Miriam Group Home. E.K. is

developmentally disabled due to his diagnosis of mental retardation.

32. Ms. Goodman stopped to let off one client, and she watched the client walk to the appropriate destination and go inside. She then resumed driving. When she had driven for about five minutes, she glanced in her rear view mirror and realized that E.K. was not there. Ms. Goodman immediately called LaDonna Bennett, the third owner of HIOTW, to report that E.K. must have snuck out of the van at her last stop, and she was going back to find him. Ms. Bennett also headed over to where Ms. Goodman said she had stopped, to assist.

33. When Ms. Goodman returned to the site of her last stop, she found E.K. there, inside the corner store. E.K. was fine and returned to the van without incident. E.K. apparently admitted to sneaking out of the van, saying he just wanted some fresh air. The entire incident spanned about ten minutes.

34. Ms. Bennett and Ms. Goodman both immediately prepared and submitted UIRs to report the incident. Ms. Goodman received a written reprimand in her HIOTW personnel file and was suspended for several days. When she resumed work, she underwent additional training, was removed from the van driver position, and reassigned to the "third shift" with no direct interaction with residents.

35. The UIR reports triggered a DCF investigation. The AIP who conducted the investigation confirmed the facts that were set forth in the two UIRs. The AIP's investigation included an assessment of E.K. at the Lake Miriam Group Home where E.K. was a resident. The DCF incident report concluded as follows:

> Victim Safety Factors Implications: No implications for the [victim's] safety.
>
> [Perpetrator] Factors Implications: Based on the informaiton [sic] rec'd, API has determined the [adult perpetrator] to pose no threat to the [victim]. No implication [sic] for the [victim's] safety.
>
> Facility Factors Implications: Based on the [victim] to the grouphome [sic], API has determined the [victim] to not be at any risk.

The API found that the overall safety assessment was low; however, based on the UIRs and interviews with Ms. Goodman and Ms. Bennett, the incident report concluded with a verified finding of inadequate supervision.

36. The API who conducted the investigation testified at hearing and confirmed that the inadequate supervision finding was directed to Ms. Goodman. When asked if HIOTW was also responsible because it was Ms. Goodman's employer, the API said he did not know and could not answer that question.

37. Petitioner did not allege in the administrative complaints, and did not prove at the hearing, that HIOTW itself was blameworthy for the E.K. incident.

38. Neither the DCF investigator, nor Petitioner, offered any evidence that HIOTW had negligently hired, trained, or supervised its employees, including Ms. Goodman in particular.

39. Both the DCF investigator and the APD Area 14 area administrator agreed that HIOTW acted appropriately in response to the E.K. incident to alleviate any concerns about health and safety, by imposing appropriate discipline against Ms. Goodman for her lapse that caused the incident, and by taking steps to ensure no reoccurrence of the incident.

40. In 2011, well after APD had knowledge of the DCF reports and findings on both the R.O. and E.K. incidents, APD issued a series of temporary or conditional licenses to both Lake Miriam and Timbergreen during the license renewal process to give HIOTW time to respond to certain identified omissions in the renewal applications, such as dental records, fire inspection reports, and the like. The temporary and conditional license certificates issued in February and March 2011 state on their face that the facilities comply with the licensure rules of APD.

41. According to the APD Area 14 administrator, each of the DCF reports on the R.O. and E.K. incidents resulted in "a

verified abuse finding." The area administrator testified that any DCF report resulting in a verified abuse finding is classified as a Class I offense, which is the most serious class of offenses and is sufficient, without more, to give APD legal authority to deny licensure or renewal of a license to a licensed applicant named in the report.

42. Yet, despite the verified finding regarding the R.O. incident, Petitioner did not deny license renewal applications for other HIOTW group homes. Despite the verified findings in both the R.O. and E.K. incidents, Petitioner issued temporary and conditional licenses to Timbergreen and Lake Miriam during the license renewal process. Thus, Petitioner has not exercised its discretion consistently in dealing with HIOTW.

43. Petitioner has not exercised its discretion consistently in contexts far more egregious than the two incidents charged here. For example, Petitioner acknowledged that a recent incident of abuse and neglect, resulting in the death of a group home resident, did not trigger action by Petitioner to take away all of the group home licenses held by the licensee. Instead, Petitioner only acted to suspend the license of the specific group home where the deceased resident had resided. Petitioner did not attribute this very serious incident to all facilities licensed by the same entity.

44. It would be unreasonable for APD to automatically, without discretion, equate all verified findings--whether of abuse or neglect, whether deemed low risk or high risk, whether risk of death or imminent bodily injury was found or not found. A protracted period of abuse or neglect that actually causes death of a group home resident is on a different plane, in terms of seriousness, from a brief employee lapse in which an individual is not caught when he sneaks away, but is recovered without harm or incident ten minutes later. No explanation was offered by Petitioner as to why, in the more serious situation where a verified incident resulted in death, action was not taken to revoke all group home licenses held by the licensee, whereas here, two incidents verified as low risk situations by DCF (one of which was not proven at the hearing), would cause Petitioner to act more harshly.

CONCLUSIONS OF LAW

45. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2011).

46. As Petitioner acknowledges, this is a penal action in which Petitioner bears the burden of pleading and proving the alleged violations by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

47. As stated by the Florida Supreme Court:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005), (quoting Slomowitz v. Walker, 492 So. 2d 797, 800 (Fla. 4th DCA 1983); accord Westinghouse Electric Corp., Inc. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991)) ("Although this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous").

48. It is incumbent on Petitioner to plead the facts and law relied on to charge Respondent in this penal proceeding; Petitioner cannot impose discipline for violations not charged in the administrative complaints. United Wisconsin Life Ins. Co. v. Office of Ins. Reg., 849 So. 2d 417, 422 (Fla. 1st DCA 2003); Cottrill v. Dep't of Ins., 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996); Willner v. Dep't of Prof. Reg., Bd. of Med., 563 So. 2d 805, 806 (Fla. 1st DCA 1990).

49. The administrative complaints charge Respondent with violating group home licensure requirements set forth in section 393.13(3)(g), Florida Statutes (2009)[6/] and page A-8 of the

Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook (Handbook), incorporated by reference in Florida Administrative Code Rules 59G-13.083(2) and 65G-2.012(15)(b). Petitioner relies on the provision in section 393.0673(2) that authorizes Petitioner to deny applications for license renewal based on the applicant's failure to comply with applicable requirements in the group home licensure statute and rules.

50. Section 393.13(3)(g) provides that "[p]ersons with disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect."

51. Rule 59G-13.083(2) incorporates by reference the May 2010 version of the Handbook. Petitioner did not offer into evidence the excerpt from either the May 2010 version of the Handbook or the prior version of the Handbook that was in effect when the first charged incident occurred. According to the administrative complaints, the Handbook provision, relied on from page A-8 of an unidentified version of the Handbook, requires that each provider of waiver services must agree "to safeguard the health, safety, and well being of all recipients receiving services from the provider."

52. Rule 65G-2.012 sets forth the licensure standards for group home facilities. Paragraph (15)(b) provides as follows:

> The facility shall take all reasonable precautions to assure that no client is exposed to, or instigates, such behavior as might be physically or emotionally injurious to him/herself or to another person.

53. Section 393.0673(2)(a)3. authorizes Petitioner to deny an application for group home license renewal if the applicant has "[f]ailed to comply with the applicable requirements of this chapter or rules applicable to the applicant."

54. With regard to the first alleged incident involving R.O., Petitioner failed to prove the charges in the administrative complaints. The allegation that there were two vulnerable adult group home residents left alone in a car was proven to be false. There were not two vulnerable adults, nor were there any group home residents involved in this incident. While the evidence showed that one adult with a history of sexually molesting children and other vulnerable adults was left briefly in a car, the critical allegation that that individual (who was not an HIOTW group home resident) was left with a non-verbal, vulnerable adult resident of an HIOTW group home was not proven. There was no such other individual and that would have been clear to Petitioner had any fair investigation of the charges been made before they were lodged against Respondent. Finally, and most significantly, Petitioner presented no evidence to support the charge that the R.O. incident in any way

threatened the health, safety, or well-being of a single resident of HIOTW.

55. Petitioner did not prove, by clear and convincing evidence or even by a preponderance of the evidence, that R.O. was left alone in a car while an HIOTW employee went into the bank. Although the evidence was in dispute, the evidence established that R.O. was left in the car only while Mr. Davis walked nine feet away from the car to the bank entrance; that when Mr. Davis went into the bank, he took R.O. with him; and that at all times, R.O. was within Mr. Davis's sight. As the APD area administrator conceded, these circumstances do not constitute neglect or failure to supervise by Mr. Davis.

56. Had the first incident been proven to occur the way the DCF investigator reported, that R.O. was left by himself in the car, not with a non-verbal vulnerable adult, for up to ten minutes while Mr. Davis went into the bank, the incident would still not give rise to disciplinary action against two of four HIOTW group home licenses. Instead, such proof would have only established inappropriate conduct by Mr. Davis. APD conceded that HIOTW acted appropriately to address the incident, by requiring that Mr. Davis undergo "zero tolerance" training and by removing Mr. Davis as R.O.'s designated companion.

57. In the language of Petitioner's own rule under which Respondent was charged for the R.O. incident, Petitioner failed

to prove that Respondent did not "take all reasonable precautions to assure that" no client was harmed or caused harm. Instead, the evidence established that Respondent took all reasonable precautions.

58. Petitioner did not prove the Handbook/rule language it claimed was in effect so as to establish the record basis for the charged violation of a Handbook provision. However, assuming the applicable Handbook provision was as quoted in the administrative complaints, Petitioner failed to prove that Respondent violated a requirement to safeguard the health, safety, and well-being of recipients of services.

59. The second incident can only be described as an obvious and admitted single negligent lapse by an otherwise good employee with an unblemished record. APD acknowledged that HIOTW acted swiftly and appropriately to report the incident and to completely alleviate any health or safety concerns. The employee received a reprimand, suspension, and training and was reassigned to ensure no possible reoccurrence. As such, Petitioner failed to prove that Respondent did not take "all reasonable precautions," as required by the rule allegedly violated. Nor did Petitioner prove that Respondent failed to "safeguard the health safety, and well being" of service recipients, which Petitioner contends, but did not establish, is a requirement of the Handbook.

60. APD suggested that while neither incident alone might have sufficed to discipline HIOTW, the concern was with the "pattern" of multiple incidents. No such "pattern" was proven. Instead, the two incidents were separate, involving two different employees, completely different circumstances, different clients, different concerns and separated by five months. The two different incidents did not involve the same licensed facility; indeed, neither incident occurred at either group home whose licenses are in jeopardy. No evidence was presented to link these two incidents, such as that the two employees were inadequately trained at the same time or that both employees were trained using the same inadequate training protocol. Indeed, the first so-called incident cannot fairly be characterized as an incident as charged by Petitioner.

61. In penal proceedings to sanction a licensee, particularly by seeking to, in effect, revoke licenses, the licensing body cannot rely solely on wrongdoing or negligence committed by an employee of the licensee; instead, the licensing body must prove that the licensee was at fault somehow for the employee's conduct, due to the licensee's own negligence, intentional wrongdoing, or lack of due diligence. The First District Court of Appeal discussed the development of the rule in a line of cases and articulated the rule as follows in Pic N' Save Central Florida, Inc. v. Department of Business Regulation,

Division of Alcoholic Beverages and Tobacco, 601 So. 2d 245, 251 (Fla. 1st DCA 1992):

> [B]efore [a licensee's] license can be suspended or revoked for a violation of law [committed by his employees] on his premises, the licensee should be found to have been culpably responsible for such violation through or as a result of his own negligence, intentional wrongdoing, or lack of diligence.

62. In Pic N' Save, the court applied this rule to reverse the revocation of a store's liquor license, which had been predicated on three illegal sales by three different cashiers who failed to require identification to verify the age of the purchasers. The violations were on three different days in a five-month period. After each incident, the store management conducted training sessions. Although the Department characterized the training sessions as "relatively limited efforts to [educate] its employees so as to prevent those violations," Id. at 249, the court held as follows:

> Because the three illegal sales relied on by the Division are so widely separated in time and involve only single incidents by each participant, we hold that these incidents cannot legally provide a basis for the inference of negligence and lack of due diligence necessary to support the Division's imposition of discipline.

Id. at 250. The facts of this case are even less supportive of discipline against the licensee for two unrelated incidents (one of which was not proven to rise to the "incident" level),

involving two different employees, not on the same premises, and separated by an equally wide time span.

63. APD agency precedent has recognized and applied the foregoing principles from Pic N' Save in the precise regulatory context at issue here, group home licensure. In Agency for Persons with Disabilities v. Amanda and Co., Inc., d/b/a Loving Hearts Group Home, Case No. 08-1812 (Fla. DOAH Oct. 29, 2008; Fla. APD Feb. 3, 2009), APD adopted the Administrative Law Judge's recommendation to dismiss an administrative complaint seeking to discipline a group home's license. The complaint charged the group home with failing to ensure that a vulnerable 17-year old female resident was not abused.[7/] The facts proven at the administrative hearing were that an employee of the group home physically abused the vulnerable young resident. DCF conducted an investigation and issued a report containing verified findings that the group home licensee failed to protect the resident from harm and that the employee was responsible for maltreatment and physical injury inflicted on the resident. The group home terminated the employee. Based on these facts, the Administrative Law Judge concluded that the abused resident was not in any danger of further abuse after the employee had left the facility and that the evidence was not clear and convincing that the licensee's group home license should be disciplined. APD adopted the recommended findings and conclusions and entered

its Final Order determining that "Respondents' license is not subject to discipline for failure to protect [the vulnerable resident.]" APD Final Order at p. 2, Rendition No. APD 09-1895-FO.

64. The clear and convincing evidence fails to establish that Respondent's license should be disciplined for the two charged incidents in the administrative complaints.

RECOMMENDATION

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

RECOMMENDED that a final order be entered by Petitioner, Agency for Persons with Disabilities, approving Respondent's applications to renew its annual licenses to operate Lake Miriam Group Home and Timbergreen Group Home and issuing standard licenses for one-year terms to those facilities.

DONE AND ENTERED this 3rd day of February, 2012, in Tallahassee, Leon County, Florida.

ELIZABETH W. MCARTHUR
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of February, 2012.

ENDNOTES

[1/] Because the APD Notices of Application Denial are properly considered administrative complaints, the parties agreed at the outset of the final hearing that APD should be deemed the Petitioner, with the burden of going forward and the burden of proving the charges in the administrative complaints as grounds to take penal action against HIOTW. Therefore, the style of these consolidated cases was amended to reflect the proper alignment of the parties. Previously, the pleadings were not consistent. Case No. 11-1620 was transmitted to the Division of Administrative Hearings by APD with a case style reflecting APD as Petitioner and HIOTW as Respondent, whereas the order was reversed in Case No. 11-2455. At some point, the cases were consolidated and the case styles showed APD as Respondent in both cases. Therefore, caution should be used in reviewing record references to "Petitioner" and "Respondent" because of the confusion and changes in usage of those references before the final hearing.

[2/] DCF operates the hotline pursuant to chapter 39, Florida Statutes (child protective services), and chapter 415, Florida Statutes (adult protective services). These same chapters impose obligations on providers and their employees who serve children and vulnerable adults to submit incident reports when

they have reason to believe that abuse or neglect of a child or vulnerable adult may have occurred. The hotline calls and incident reports are screened by DCF to determine if a formal investigation is warranted. If a formal investigation is warranted, then DCF will open a case and conclude the case by issuing a report that either verifies findings of abuse or neglect, or finds no substantiation of abuse or neglect. See, e.g., §§ 415.103, 415.1034, and 415.104, addressing hotline reports, incident reporting requirements, and investigations regarding possible abuse or neglect of vulnerable adults.

[3/] The area administrator testified that the two denial letters were prepared by the central office, but that she reviewed them for accuracy before they were sent out to HIOTW. The two denial letters allege that the R.O. incident involved "two vulnerable adult group home residents [left] alone in a car[,]" one of whom had a history of sexually abusing children and vulnerable adults, and the "other resident who was left unsupervised in the car was non-verbal." These allegations were proven to be false and the information for the allegations came from the APD Area 14 office.

[4/] HIOTW attempted to, but was not permitted to, fully explore the merits of the litany of negative allegations regarding HIOTW which were included in the packet of material transmitted to the central office for the purpose of making decisions regarding HIOTW's pending license renewal applications and regarding possible termination of HIOTW's Medicaid waiver provider contract. The other negative allegations were not charged as grounds to deny renewal of Lake Miriam's license or Timbergreen's license, and, therefore, these peripheral matters cannot be considered as grounds to act on the license renewal applications. However, HIOTW was permitted to go into such peripheral matters to a limited extent for the purpose of establishing the rather poisoned atmosphere and relationship between HIOTW and APD Area 14 office personnel, up through the area administrator. A severe communication chasm developed, seemingly borne of the belief held by some area office personnel in the unfounded suspicions about HIOTW. This apparent bias was established and bears on the credibility of Petitioner's witnesses in continuing to support the grounds charged in the March 25 Denial Letter and the April 29 Denial Letter.

[5/] The DCF report included a section called "Facility Factors Implications." In this section, the DCF investigator noted that AHCA's web site showed no recent deficiencies for HIOTW. However, an update to this finding was as follows: "APD stated

there have been some questions concerning the characture [sic] of the owners of [HIOTW] recently, the risk is increased." Notwithstanding the apparent risk due to concerns expressed by APD about the character of HIOTW's owners, the overall safety assessment in the DCF incident report was that the overall risk was low due to HIOTW's corrective actions. Presumably, the "questions" alluded to by APD about the character of HIOTW owners had to do with the negative suspicions and allegations that APD was collecting and ultimately transmitted to the central office in early 2011. It is not clear whether or to what extent the DCF incident report may have been influenced by APD's raising "questions" about the character of HIOTW owners. As discussed in endnote 4, these negative aspersions about HIOTW by the APD Area 14 office, never charged or substantiated, do little to instill confidence that HIOTW was been treated fairly and without bias.

[6/] The administrative complaints do not refer to which particular year of statute or rule or which edition of the Handbook provision Petitioner intended to charge. Because this is a penal proceeding, unless otherwise indicated, all references to the Florida Statutes or Florida Administrative Code rules are to the 2009 version, which was the law in effect at the time of the first alleged incident cited as grounds to not renew Respondent's group home licenses. Changes to the law in 2010, in effect at the time of the second alleged incident, are immaterial to the charges.

[7/] As in this case, APD also sought to prove and argue in the Loving Hearts Group Home case that the licensee did not immediately submit a UIR after the employee "casually mentioned" that she had an incident with the resident the night before, but that it was no big deal. As in this case with the R.O. incident, the evidence tended to confirm the licensee's good faith belief that there was no reportable incident at that time. Also as in this case, the resolution of this issue in the recommended and final orders was that the matter would not be considered because the administrative complaint failed to charge a violation of the reporting requirements for incidents of abuse or neglect as required by sections 39.201 and 415.1034.

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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.

APPENDIX TO RECOMMENDED ORDER
DOAH CASES 11-1620 and 11-2455

The undersigned has considered Petitioner's Objections to Depositions, filed on November 14, 2011, and Respondent's response to Petitioner's objections, filed on December 8, 2011.

Petitioner's filing asserted a single blanket relevancy objection, without elaboration, but with separate line items for designated lines and pages to which the blanket objection applied. In many instances, Petitioner designated many-page chunks of deposition testimony, sometimes covering 20- or 30-page blocks of questioning and answering, some of which may have been irrelevant, but some of which was at least of marginal relevance.

Petitioner's blanket objection to a single large designated chunk of deposition testimony has not been sustained where the designated chunk included some relevant testimony. It was up to Petitioner to lodge specific objections to irrelevant deposition testimony, and Petitioner cannot by its blanket objection, shift the burden to Respondent or to the undersigned to sort through the relevant and irrelevant portions within large chunks of testimony when Petitioner failed to identify just those irrelevant passages. However, where such deposition testimony was not relevant to the issues to be determined here, or was not relevant to such permissible matters as credibility/impeachment of the deponents, then such testimony was not used as the basis for any findings of fact.

Accordingly, the following specific rulings are made on Petitioner's designated relevancy objections:

Respondent's Exhibit 82
Copy of Deposition Transcript
Heather Monteath, October 5, 2011

Petitioner's relevancy objections to testimony portions cited in line items a. through c. and e. through j. are overruled.

Petitioner's relevancy objection d. (page 77, line 6 through page 78, line 16) is sustained.

Respondent's Exhibit 83
Copy of Deposition Transcript
Melody Taylor, October 7, 2011

Petitioner's relevancy objections a. through h. are overruled.

Petitioner's relevancy objection i. (page 175, line 4 through page 175, line 24) is sustained.

Respondent's Exhibit 84
Copy of Deposition Transcript
Jeannette Estes, October 6, 2011

Petitioner's relevancy objections a. through e., g. through i., and k. through l. are overruled.

Petitioner's relevancy objection f. (page 142, line 24 through page 143, line 20) is sustained.

Petitioner's relevancy objection j. (page 200, line 12 through page 202, line 19) is sustained.