STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 11-2770
EASTWINDS OF FLORIDA, INC., d/b/a AZALEA MANOR OF ST. PETERSBURG,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, on November 10, 2011, a formal hearing in this cause was held by video teleconference in St. Petersburg and Tallahassee, Florida, before the Division of Administrative Hearings by its designated Administrative Law Judge Linzie F. Bogan.

APPEARANCES

For Petitioner: Suzanne Suarez Hurley, Esquire
Agency for Health Care Administration
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St. Petersburg, Florida 33701

For Respondent: Thomas W. Caufman, Esquire
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STATEMENT OF THE ISSUES

Whether Respondent committed the violations alleged in the Administrative Complaint, and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

Respondent, Eastwinds of Florida, Inc., d/b/a Azalea Manor of St. Petersburg (Azalea Manor), operates a licensed assisted living facility located at 112 12th Avenue North, St. Petersburg, Florida. On January 20, 2011, an incident occurred between an employee of Azalea Manor and one of the facility's residents that resulted in the resident being intentionally struck by the employee on the forehead with the sole of a sneaker (the incident). Employees of the facility reported the incident to law enforcement officials, the Florida Department of Children and Families (DCF), and Petitioner, Agency for Health Care Administration (AHCA/Department). There were no criminal charges filed against the employee involved in the incident. Pursuant to its investigation of the incident, AHCA charged Azalea Manor with two Class II violations. AHCA seeks $5,000.00 per violation and is requesting that a survey fee of $500.00 be imposed against Respondent.

On April 15, 2011, Azalea Manor filed with the Department a Petition for Formal Administrative Hearing (Petition). On May 31, 2011, the Petition was referred by the Department to the

Division of Administrative Hearings for a disputed fact hearing and the issuance of a recommended order.

A Notice of Hearing by Video Teleconference was issued setting the case for formal hearing on August 16, 2011. On June 24, 2011, an Order was entered granting a Motion to Withdraw filed by Respondent's previous counsel. On July 15, 2011, Respondent's current counsel entered an appearance in this matter and filed a motion for continuance. On July 19, 2011, an Order was entered granting the continuance request and by Order entered on August 12, 2011, the instant matter was scheduled for video teleconference on November 10, 2011.

Petitioner presented the testimony of Katherine Benjamin, Rasheena Wade, Nicole Wiggins, and Jean W. Rice. Petitioner's Exhibit 1 was admitted into evidence. Respondent presented the testimony of Floyd M. McKenzie, Sr. (Mr. McKenzie), who is the owner and administrator for Azalea Manor, and Floyd M. McKenzie, Jr. (Mike). Respondent's Exhibits A, C, E, F, H, I, K, and L were admitted into evidence. There was also a joint exhibit entered into evidence which was identified by the parties as Joint Exhibit 2.

A two-volume Transcript of the proceeding was filed with the Division of Administrative Hearings on November 29, 2011. The parties timely filed Proposed Recommended Orders, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, Azalea Manor operated a licensed 20-bed assisting living facility in St. Petersburg, Florida. Azalea Manor houses its residents primarily in two buildings. The buildings will be referred to herein as the Big House and the Small House.

2. On January 20, 2011, S.M. was a resident of Azalea Manor and resided in the Small House. In addition to certain physical ailments, S.M. suffered from dementia. S.M. is approximately six feet tall, and on the date in question, weighed about 150 pounds. For at least several months leading up to, and including January 20, 2011, S.M. was prescribed medication for psychosis, depression, confusion, and memory loss. On January 20, 2011, S.M. was 65 years of age.

3. On January 20, 2011, Joyce Spiker (Ms. Spiker) was employed by Azalea Manor as a caregiver. On January 20, 2011, the date upon which the instant action is based, Ms. Spiker was 66 years old, five feet, five inches tall, and weighed 300 pounds.

4. Rasheena Nicole Wade (Ms. Wade), an Azalea Manor employee, started working for Azalea Manor on January 13, 2011. Ms. Wade's job duties included waking residents in the mornings and assisting them with getting dressed. Prior to January 20, 2011, Ms. Wade had worked with S.M. on one prior occasion and

was generally unfamiliar with S.M. and her morning preferences and tendencies.

5. On the morning of January 20, 2011, Ms. Wade was tasked with helping S.M. get dressed. Ms. Wade asked S.M. to get dressed several times, but for whatever reason, S.M. refused to do so. S.M. told Ms. Wade multiple times that she was not going to get dressed, and in furtherance of her general disposition of defiance, S.M. repeatedly slammed doors throughout her immediate living area. S.M. was obviously in an agitated state and Ms. Wade, being generally unfamiliar with S.M., called to the Big House for assistance. Ms. Spiker fielded Ms. Wade's phone call.

6. In response to Ms. Wade's call for help, Mike, the son of the owner of Azalea Manor, went to the building where S.M. was located. Upon entering the building, Mike noticed that S.M. was not dressed. Mike encouraged S.M. to get dressed, but she refused. S.M. continued slamming doors and otherwise stating that she was not going to get dressed. Mike then advised S.M. that he was going to call Ms. Spiker and have her to come to the Small House to aid her in getting dressed. Mike then left the area where S.M. was located and phoned Ms. Spiker and asked for her assistance. Ms. Spiker, at the time of Mike's call, was still located in the Big House. Mike explained to Ms. Spiker

the difficulty that he was having with S.M. and requested that she take over the situation with S.M.

7. Before Ms. Spiker arrived at the Small House, Mike left the Small House and headed back towards the Big House. En route to the Big House, Mike encountered Ms. Spiker who was on her way to see S.M. During his encounter with Ms. Spiker, Mike again explained to her the difficulty that he was having with S.M. Following his discussion with Ms. Spiker, Mike returned to the Big House and Ms. Spiker went to the Small House and met with S.M.

8. When Ms. Spiker arrived at the Small House, Ms. Wade was still present and witnessed the interaction between Ms. Spiker and S.M. that provides the basis for the instant action. When S.M. saw that Ms. Spiker had arrived at the Small House, she calmed down, went into her room, and started getting dressed. However, after making some progress towards getting dressed, S.M. again started to verbalize that she did not want to get dressed. Ms. Spiker told S.M. to finish getting dressed. Per Ms. Spiker's directive, S.M. finished putting on her clothing items, but refused to put on her sneakers. At this point, S.M. placed one of the sneakers on her bed and announced that she was not going to put the shoe on her foot. In response to S.M.'s pronouncement, Ms. Spiker grabbed the shoe, hit S.M. in the middle of the forehead with the sole of the shoe, then

threw the shoe in S.M.'s lap and told her to put the shoe on her foot. S.M. then grabbed the shoe and threw it at Ms. Spiker. S.M. and Ms. Spiker then launched into a short volley of angry expletives. Soon thereafter, S.M. capitulated and placed the shoe on her foot. Ms. Wade was approximately four feet from Ms. Spiker and S.M. when the exchange occurred. S.M. did not sustain any injuries resulting from being hit on the forehead with the shoe.

9. Within seconds of S.M.'s placing the shoe on her foot, one of the other residents in the Small House informed Ms. Wade that another resident had become very upset after overhearing the fracas between S.M. and Ms. Spiker. Ms. Wade immediately left the area where S.M. and Ms. Spiker were located so that she could tend to the needs of the resident that had become upset. At this point in time, Ms. Spiker was alone with S.M.

10. The evidence is inconclusive regarding the amount of time that Ms. Spiker and S.M. were alone in S.M.'s room. However, what is clear is that Ms. Wade, after having calmed the resident that had become upset, noticed when she saw S.M. about 15 minutes after having left S.M. alone with Ms. Spiker, that S.M. "had red on her lip." Ms. Wade believed that the "red" on S.M.'s lip was lipstick. It was eventually determined that the "red" was not lipstick, but instead was blood. On the day in question, S.M. had extremely dry and cracked lips.

11. Soon after Ms. Wade saw S.M.'s red lips, S.M. left the Small House and went to the Big House where she found Nicole Wiggins (Ms. Wiggins). Upon seeing Ms. Wiggins, S.M. immediately ran to Ms. Wiggins and embraced her around the neck. Ms. Wiggins had worked with S.M. for several months prior to the incident and was someone with whom S.M. would converse with on occasion. S.M. was extremely upset and was literally shaking with fear when she embraced Ms. Wiggins. When Ms. Wiggins freed herself from S.M.'s embrace, she noticed that there was blood on S.M.'s lips. Ms. Wiggins asked S.M. about her bloody lips and S.M. explained that her lips were bloody because Ms. Spiker had pushed and kicked her in the face. Ms. Wiggins took S.M. to the bathroom in order to clean the blood from S.M.'s lips. During the process of trying to remove the blood from S.M.'s mouth, Ms. Wiggins noticed a small puncture wound on the inside of S.M's upper lip that was actively bleeding. Ms. Wiggins applied pressure to the wound and eventually the bleeding stopped. As a consequence of the incident, S.M. was allowed to stay home from work on January 20, 2011.

12. Based on the current record and given Ms. Spiker's physical characteristics, the undersigned is unable to find as a matter of fact that Ms. Spiker kicked S.M. in the face, thereby causing blood to appear on S.M.'s lip.

13. Ms. Wiggins reported the incident to her immediate supervisor and then reported the same to the DCF abuse hot-line (abuse hot-line) and the St. Petersburg Police Department. Additionally, Ms. Wade also reported the incident to the abuse hot-line.

14. On January 20, 2011, an officer from the St. Petersburg Police Department was dispatched at approximately 10:15 a.m., to Azalea Manor to investigate the incident involving S.M. Upon arriving at Azalea Manor, the investigating officer spoke with S.M. and Ms. Wiggins regarding the incident. Ms. Spiker was not present during the officer's initial visit, but she subsequently met with the officer during the afternoon of January 20, 2011. As a part of the investigation, the officer asked Ms. Spiker if she knew Rasheena's (Ms. Wade) surname. Because Ms. Wade was a new employee, Ms. Spiker advised the officer that she did not know Rasheena's surname. In order to assist the officer, Ms. Spiker called Mr. McKenzie, explained to him why she was calling, and handed the phone to the police officer so that he could speak with Mr. McKenzie. The police officer spoke to Mr. McKenzie while in the immediate presence of Ms. Spiker. Although the investigating officer was able to secure Ms. Wade's surname, the officer never interviewed Ms. Wade as part of the investigation. The investigating

officer determined that the allegations were criminally unfounded and the investigation was closed.

15. In response to the abuse hot-line report, DCF, on January 20, 2011, also dispatched an investigator to Azalea Manor. When the DCF investigator arrived at Azalea Manor on the afternoon of January 20, 2011, the officer from the St. Petersburg Police Department was present. The DCF investigator met with Mr. McKenzie and informed him of the reason for her visit. During the meeting with the DCF investigator, Mr. McKenzie advised that he had already spoken with the officer from the St. Petersburg Police Department about the incident involving S.M.

16. On January 21, 2011, the Department was contacted regarding the incident between Ms. Spiker and S.M. In response to notification of the incident, the Department, on January 24, 2011, visited Azalea Manor. While visiting Azalea Manor, the Department interviewed Mr. McKenzie and several employees. The Department's interview with Mr. McKenzie commenced at approximately 11:20 a.m. As a part of the Department's questioning of Mr. McKenzie, inquiry was made as to why he had not filed the initial adverse incident report. In response to this inquiry, Mr. McKenzie advised that he was unaware of the requirement for doing so. Within a few hours of completing his meeting with the Department, Mr. McKenzie filed the initial

adverse incident report, which is officially entitled, "Assisted Living Facility Initial Adverse Incident Report – 1 Day (Day 1 Form)." Mr. McKenzie did not file a 15-day full report.

17. Noted on the Day 1 Form was a check mark signifying that the incident had been reported to law enforcement officials. The Day 1 Form was signed by Mr. McKenzie. On January 24, 2011, Mr. McKenzie also fax filed an incident report with the Agency for Persons with Disabilities. On January 25, 2011, Mr. McKenzie issued a verbal warning to Ms. Spiker and provided her with refresher training on appropriate strategies for dealing with challenging situations. Mr. McKenzie also discussed the incident with S.M.

CONCLUSIONS OF LAW

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

19. The general rule is that "the burden of proof, apart from statute, is on the party asserting the affirmative of an issue before an administrative tribunal." Balino v. Dep't of HRS, 348 So. 2d 349, 350 (Fla. 1st DCA 1977). In the instant case, the Department has the burden of proving by clear and convincing evidence that Respondent committed the violations as alleged and the appropriateness of any fine resulting from the alleged violations. Dept. of Banking & Fin., Div. of Sec. &

Investor Prot. v. Osborne, Stern & Co., 670 So. 2d 932 (Fla. 1996).

20. In Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the court held that:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify 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.

A. Count I: Failure to Properly Supervise and Provide a Safe Environment

21. In Count I of the Administrative Complaint (Complaint) the Department alleges, in part, the following:

> The Administrator in an assisted living facility is responsible to supervise and manage the staff and to provide proper and adequate care to the residents. Specifically:
>
> (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, Florida Statutes. Florida Administrative Code Rule 58A-5.019.
>
> Furthermore, residents in an ALF are entitled to a safe environment:
>
> RESIDENT BILL OF RIGHTS. No resident of a facility shall be deprived of any civil or

> legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to live in a safe and decent living environment, free from abuse and neglect [and to] be treated with consideration and respect and with due recognition of personal dignity. . . .

§ 429.28(1)(a-b), Fla. Stat. (2010).[1/]

22. Count I of the Complaint alleges further that "[o]n January 24, 2011, the Agency conducted a complaint inspection, CCR#2011000683, of Respondent's facility, an assisted living facility, and found the facility out of compliance with the above Rule [and that] this deficient practice was related . . . to the personal care of Facility residents, and directly threatened the physical or emotional health, safety, or security of the Facility residents."

23. In Count I of the Complaint, the Department implicitly suggests that Azalea Manor is vicariously liable for the intentional conduct of its employee, Ms. Spiker. The Department's assertion notwithstanding, it is well established that "the principles of respondeat superior . . . have no application in determining whether [a] license should be revoked or suspended." Pic N' Save, Inc. v. Dep't of Bus. Reg., Div. of Alcoholic Beverages & Tobacco, 601 So. 2d 245, 256 (Fla. 1st DCA 1992). What the law requires is "[p]roof by clear and

convincing evidence of a licensee's negligent training or lack of diligence in supervising its employees," and this standard cannot be met by simply demonstrating that an employee of the licensee committed some objectionable act. Id. While it is true that the instant case does not involve an attempt by the Department to revoke or suspend Respondent's license, the principles espoused by the court in Pic N' Save are, nevertheless, controlling because of the penal nature of the instant action.

24. In the context of the instant proceeding, "[t]he imposition of personal responsibility on the licensee for [misconduct] by its employees requires proof of minimum standards of conduct, either by adopted rules, communicated agency policy, or expert testimony, against which the licensee's alleged misconduct can be judged." Pic N' Save at 256. The Department did not offer any evidence of "communicated agency policy, or expert testimony," which establishes the minimum standards of conduct applicable to Respondent in the instant case. The Department did, however, cite Respondent for violating rule 58A-5.019(1). Therefore, consideration of that portion of rule 58A-5.019(1), upon which the Department relies, must be considered when attempting to determine the minimum standard by which Respondent's conduct is to be judged.

25. Rule 58A-5.019(1), as relied upon by the Department in the instant matter, provides, in part, that "[e]very facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter."

26. Section 429.02(2) defines an administrator as "an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility." Through rule 58A-5.019(1), the Department has interpreted the definition of "Administrator" to expressly include responsibility for the "management of all staff and the provision of adequate care to all residents."

27. According to the testimony of Ms. Katherine Benjamin, who works as a facility evaluator for the Department, Respondent failed in its duty to manage its staff and provide adequate care to S.M. Arguably, the duty to manage one's staff and provide adequate care to residents includes training employees, pursuant to established standards, on how to deal with individuals like S.M. who may be non-compliant. Though Ms. Benjamin concluded that Azalea Manor was "deficient . . . on the supervision for this resident [S.M]," neither she, nor any other witness that testified on behalf of the Department, identified any

established standard by which to judge the alleged deficiency. Purvis v. Dept. of Prof'l Reg., 461 So. 2d 134 (Fla. 1st DCA 1984). The Department did not offer any evidence of applicable standards governing interactions between a caregiver and an agitated resident and the role and responsibilities of management as it relates to the said standards. As instructed by the court in Pic N' Save, the Department, in order to impose personal responsibility on Respondent, must do more than simply show that the incident between Ms. Spiker and S.M. actually occurred.

28. Though awkwardly pled, it can reasonably be suggested that the Complaint, by charging Respondent with a violation of the Resident bill of rights, is relying upon the Resident bill of rights as establishing the standards by which Respondent's conduct is to be judged. As previously noted, the Resident bill of rights provides, in part, that "[n]o resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility." As noted in section 429.29(2), the Resident bill of rights does not impose strict liability on a licensee for the violation of any of its provisions. Therefore, the Resident bill of rights, as charged in the instant matter, must be evaluated within the framework set forth in Pic N' Save. As

to that portion of the Resident bill of rights cited in this paragraph, the Department did not present any evidence establishing that S.M.'s legal or constitutional rights were violated by Azalea Manor.

29. The Department also charged Respondent with violating that portion of the Resident bill of rights which provides that "[e]very resident of a facility shall have the right to live in a safe and decent living environment, free from abuse and neglect." § 429.28(1)(a). The words "abuse" and "neglect" are not defined in chapter 429, but these words are defined in chapter 415, Florida Statutes. Chapter 415 is specifically referenced in section 429.23(6), which like the Resident bill of rights, is included in Part I of chapter 429. Accordingly, it is permissible to look to chapter 415, which was enacted to promote the "care and protection of vulnerable adults," for definitional guidance. See State v. Hagan, 387 So. 2d 943, 945 (Fla. 1980) ("[i]n the absence of a statutory definition, resort may be had to case law or related statutory provisions which define the term . . . .")

30. Section 415.102(1) and (16) provide as follows:

> (1) "Abuse" means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.

* * *

> (16) "Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death. (emphasis added).

31. Ms. Spiker's act of striking S.M. in the forehead with the sole of a sneaker and exchanging expletives with S.M. is reprehensible and should not be tolerated. However, the record evidence establishes that this was an isolated incident that did not result in any physical injury to S.M. While it is true that S.M. was understandably emotionally upset for a short period of time following the incident, the Department did not offer any evidence demonstrating that S.M.'s psychological health was seriously or significantly affected as a result of being hit on the forehead with the shoe. On this record, the incident in question did not result in S.M. being abused or neglected by Respondent.

32. Count I also charges that Respondent, in violation of section 429.28(1)(a), violated S.M.'s right to "[b]e treated with consideration and respect and with due recognition of personal dignity . . . ." The law requires in a penal enforcement proceeding, such as the instant case, that the alleged offending conduct be evaluated through the lens of a "firm standard for uniformity in application or enforcement." Id. The Department offered no evidence of any governing standard by which the undersigned can evaluate Respondent's conduct to determine if the conduct resulted in S.M. not being treated "with consideration and respect and with due recognition of [S.M.'s] personal dignity."

33. Finally, as to Count I of the Complaint, the Department cited Respondent for a Class II violation in accordance with section 429.19(2)(b). Section 408.813, Florida Statutes, which is incorporated by reference into section 429.19, defines Class II violations as "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." Based upon the analysis set forth above, the Department has failed to meet its burden of establishing by clear and convincing evidence that Respondent committed a Class II violation.

B. Count II: Failure to Investigate and Report An Adverse Incident

34. Paragraph 19 of the Complaint provides that "[t]he failure of the Respondent to prepare and file a preliminary incident report with the Agency and the failure to investigate and document the incident is a violation of the law."

35. Section 429.23 provides in part as follows:

> (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:
>
> (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:
>
> 1. Death;
>
> 2. Brain or spinal damage;
>
> 3. Permanent disfigurement;
>
> 4. Fracture or dislocation of bones or joints;
>
> 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
>
> 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or
>
> 7. An event that is reported to law enforcement or its personnel for investigation; or

* * *

> (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
>
> (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (emphasis added).

36. It is undisputed that the incident between Ms. Spiker and S.M. occurred on January 20, 2011, and that Respondent did not file the Day 1 Form with the Department until January 24, 2011. Mr. McKenzie testified during the final hearing that he filed the required report late because he did not learn of the involvement of law enforcement in investigating the incident between S.M. and Ms. Spiker until days after its occurrence. The undersigned is not persuaded by this testimony and finds it to be in direct contradiction to Mr. McKenzie's admission to the Department investigator that he failed to timely file the Day 1 Form because he was unaware of the requirement for doing so. On January 20, 2011, Mr. McKenzie was aware of the fact that the

incident involving S.M. and Ms. Spiker was reported to law enforcement officials, and he failed to notify the Department within one day of its occurrence as required by section 429.23.

37. In Count II, the Department also alleges that Respondent violated section 429.23 when it "failed to investigate and remove a direct care staff member from providing care and services during the investigation of an adverse incident." Contrary to the Department's assertion, section 429.23 does not impose upon an assisted living facility a requirement that a direct care staff member be removed from providing care and services to residents during the investigation of an adverse incident.[2/]

38. In Count II of the Complaint, the Department also alleges that Respondent's late filing of the Day 1 Form constitutes a Class II violation.[3/] The Department did not offer any evidence showing that Respondent's late-filed Day 1 Form "directly threaten[ed] the physical or emotional health, safety, or security" of S.M. as contemplated by section 419.19(2)(b), Florida Statutes. Although the Department failed to establish the existence of a Class II violation resulting from the failure to timely file the Day 1 Form, the clear and convincing evidence nevertheless establishes the existence of a Class III violation resulting from Respondent's omission.[4/] The failure to timely file the preliminary incident report "indirectly or potentially

threatened the physical or emotional health, safety, or security" of S.M., because it deprived the Department of its opportunity to evaluate S.M. and the overall situation at Azalea Manor within the quick response timeframe contemplated by section 429.23(3).

39. In addition to the above, Count II of the Complaint also alleges that Respondent failed to file a full report within 15 days of the adverse incident. Azalea Manor does not dispute that it failed to file the required 15-day report. The Department did not offer any evidence showing that Respondent's failure to file the 15-day full report either directly, indirectly, or potentially "threaten[ed] the physical or emotional health, safety, or security" of S.M., as required by section 419.19(2)(b) and (c). Accordingly, the evidence does not establish the existence of a Class II violation as to this issue.

40. Respondent's failure to file the 15-day full report does, however, establish the existence of a Class IV violation. "Class 'IV' violations are those conditions or occurrences related to the operation and maintenance of a provider or to required reports, forms, or documents that do not have the potential of negatively affecting clients." § 408.813(2)(d), Fla. Stat. In the present case, by the time the 15-day full report was due to be filed by Respondent, the Department was

well aware of the circumstances at the facility and could have at any time conducted an unannounced visit to check on S.M. or any of the other resident as authorized by section 429.34. Respondent's failure to file the 15-day full report, under the circumstances present in the instant case, did not have the potential of negatively affecting clients and, therefore, Respondent's omission constitutes a Class IV violation.

C. Penalties and Survey Fee

41. Respondent has committed one Class III violation and one Class IV violation. Section 429.19(2)(c) provides that for Class III violations "[t]he agency shall impose an administrative fine . . . in an amount of not less than $500 and not exceeding $1,000 for each violation." As for Class IV violations, section 429.19(2)(d) provides that "[t]he agency shall impose an administrative fine . . . in an amount not less than $100 and not exceeding $200 for each violation."

42. Section 429.19(3) provides as follows:

> For purposes of this section, in determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:
>
> (a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner or administrator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the facility of committing or continuing the violation.

(e) The licensed capacity of the facility.

43. As for the Class III violation, the evidence shows that the preliminary adverse incident report was faxed to the Department four days after it was due. By requiring that the preliminary incident report be filed with the Department within 24 hours of the occurrence of a reportable incident, the Legislature, in keeping with its commitment to protect vulnerable adults, has made it clear that the filing of the report is of critical importance. Respondent's failure to timely file the preliminary adverse report and its failure to even know of the requirement for filing the same constitute a serious violation which warrants imposition of the maximum fine allowed for a Class III violation. Having considered all of the factors set forth in section 429.19(3), the undersigned concludes that there are no mitigating factors that weigh in favor of a lesser fine.

44. As for the Class IV violation, the evidence shows that Respondent simply did not file the 15-day full report required by section 429.23(4). The complete failure to file the required

report warrants imposition of the maximum fine allowed for a Class IV violation. Having considered all of the factors set forth in section 429.19(3), the undersigned concludes that there are no mitigating factors that weigh in favor of a lesser fine.

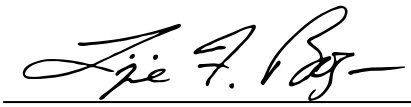
45. Count III of the Complaint seeks to impose against Respondent a $500 survey fee pursuant to section 429.19(7). Section 429.19(7) provides, in part, that "[i]n addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation . . . ." In light of the Conclusions of Law set forth above, the $500 survey, which the Department seeks to impose against Respondent, is appropriate.

RECOMMENDATION

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

RECOMMENDED that Petitioner, Agency for Health Care Administration, enter a final order and, therein, dismiss Count I of the Administrative Complaint and assess against Respondent, Eastwinds of Florida, Inc., d/b/a Azalea Manor of St. Peterburg, an administrative fine of $1,200 and a survey fee of $500.

DONE AND ENTERED this 19th day of January, 2012, in Tallahassee, Leon County, Florida.



LINZIE F. BOGAN
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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of January, 2012.

ENDNOTES

[1/] All future references to Florida Statutes will be to 2010, unless otherwise indicated.

[2/] Ms. Benjamin testified that it is "standard procedure, when there is an allegation of . . . a staff member hitting a resident, to remove th[e] staff member [during the investigation] from the proximity of the resident in order to protect th[e] resident." However, the Department presented no agency rule requiring that the alleged offending staff member be removed from having contact with the resident during the pendency of any investigation into an alleged incident, and there was no expert testimony that the so-called "standard procedure" was a generally-accepted standard within the assisted living industry. K.M.T. v. Dep't of HRS, 608 So. 2d 865, 873 (Fla. 1st DCA 1992)("HRS presented no agency rule stating that aged persons and disabled adults may not be left unattended for a few minutes in a nursing home's restorative dining room, and there was no expert testimony that [the facility's] 'tacitly understood' policy was a generally-accepted standard within the nursing home industry.").

[3/] Ms. Benjamin testified that when she visited Azalea Manor on January 24, 2011, Respondent was unable to provide her

"documentation of [the] event" and further that Respondent was unable to demonstrate that an investigation of the incident had occurred. Ms. Benjamin visited the facility well in advance of the due date for the 15-day full report required by section 429.23(4). Section 429.23(3), unlike section 429.23(4), does not contain express language requiring disclosure of the results of the facility's investigation into the adverse incident. To the extent that the Department is suggesting, through the testimony of Ms. Benjamin, that section 429.23(3) imposes such a requirement, the said suggestion is rejected as being inconsistent with the express provisions of section 429.23. While there is clearly a duty to investigate adverse incidents which result in the filing of an incident report, the failure of an assisted living facility to undertake such duty becomes actionable only within the context of the full report required by section 429.23(4).

[4/] Paragraph 16 of the Complaint provides, in part, that "[l]icensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section." The quoted language tracks that which is found in section 423.23. During the final hearing and in its post-hearing submittal, the Department now argues that electronic filing is the only way by which Respondent could have filed its Day 1 Form. It is well established that the Complaint governs the scope of the proceeding, see Travisani v. Department of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005), and any penalty assessed herein will not be based upon the Department's new allegation that Respondent failed to file the Day 1 Form by electronic means.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.