STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. GENE COWLES AND AMELIA COWLES, d/b/a HILLANDALE ASSISTED LIVING, Respondents.	)	Case No. 11-3721

RECOMMENDED ORDER

Pursuant to notice, on September 18 through 21, 2012, a formal hearing in this cause was held in New Port Richey, Florida, before Administrative Law Judge Lynne A. Quimby-Pennock of the Division of Administrative Hearings (Division).

APPEARANCES

For Petitioner: James H. Harris, Esquire
Agency for Health Care Administration
The Sebring Building, Suite 330D
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St. Petersburg, Florida 33701

For Respondents: Augustine Smythe Weekley, Esquire
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STATEMENT OF THE ISSUES

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

PRELIMINARY STATEMENT

On June 27, 2011, Petitioner, Agency for Health Care Administration (AHCA), issued a five-count Administrative Complaint (AC) against Respondents, Gene Cowles and Amelia Cowles, d/b/a Hillandale Assisted Living (Hillandale or Respondents). The AC alleged violations of various sections of chapters 408 and 429, Florida Statutes (2010), and various Florida Administrative Code rules. Pursuant to sections 408.815, 429.14, 429.19, and 429.49, AHCA is seeking $20,000.00 in fines, two survey fees of $500.00 each, and the revocation of Hillandale's license.

On July 15, 2011, Hillandale filed a Petition for Formal Administrative Hearing (Petition). On July 26, AHCA referred the Petition to the Division for a disputed-fact hearing and the issuance of a recommended order.

A Notice of Hearing was issued setting the case for formal hearing on August 31, 2011. On August 12, a Joint Motion for Continuance was filed.[1/] The hearing was re-scheduled to November 16 through 18, 2011. On October 28, another Joint Motion for Continuance was filed.[2/] The continuance was granted.

In December 2011, AHCA filed a Motion to Continue Case for Trial and Notice of Substitution of Counsel. Therein, AHCA noted that the case had been continued twice, "the parties wish[ed] to continue to attempt to settle," and there was insufficient time for a new AHCA counsel to prepare for the hearing.[3/] The case was re-scheduled to February 2012.

On January 24, 2012, AHCA filed an Unopposed Motion to Amend Administrative Complaint. The motion was granted, and all future references will be to the Amended Administrative Complaint (AAC) filed with the Division on January 31, 2012. The AAC retained the same allegations as the original AC; however, a new paragraph, numbered 61, was added that alleged a "demonstrated pattern of deficient performance" by Respondents.

On January 31, 2012, a Joint, Agreed Motion to Continue Case for Trial was filed. Both parties expressed their continued desire to resolve the case via settlement. However, both parties had "undertaken [discovery] in earnest," and additional time was needed to secure the depositions of witnesses for both parties and to complete the discovery. Following one additional continuance,[4/] the parties were noticed for hearing on September 18 through 21, 2012.

AHCA presented the testimony of: Jill Sutter; Sergio Soto; Pamela Aromola; Katherine Benjamin; Sally H. Leonard; Patricia Duval Anderson; Jorge Juliab Villalba, M.D.; Gillian

Allane; and Patricia Reid Kaufman.[5/] Ms. Kaufman also provided rebuttal testimony. AHCA's Exhibits 8 through 20[6/] and 22 through 56 were admitted into evidence under seal. AHCA's Exhibits 57 through 64[7/] were also admitted. AHCA's Exhibit 21 was offered into evidence, and that ruling was reserved at hearing. Exhibit 21 is now admitted.

During the hearing, Respondents made an oral motion to strike certain portions of AHCA's Exhibit 58, the deposition of Mr. Rice. That motion is hereby denied.

Hillandale presented the testimony of: Clarice T. Roberts; Marilyn Sue Ward, M.D.; Deborah A. Martinez, registered nurse (R.N.); and John Ross. Beverly Buchan reported to the hearing; however, she became ill prior to being called. The parties agreed to obtain Ms. Buchan's testimony via deposition. Hillandale's Exhibits 2 through 13,[8/] 16 through 30, 55a, 55b, 63, 70, 71, and 76 through 78[9/] were admitted into evidence.

At the conclusion of the hearing, the parties requested 30 days from the filing of Ms. Buchan's deposition in which to submit their respective proposed recommended orders (PROs). The request was granted. Ms. Buchan's deposition was filed on November 19, 2012, and was admitted as Hillandale's Exhibit 79. The six-volume Transcript of the proceeding was filed with the Division on October 12, 2012.

Following the conclusion of the hearing, the undersigned, Petitioner's counsel, Respondents' counsel, and Mr. Ross, Respondents' representative, conducted a walk-through of the Hillandale facility. No testimony was taken, nor was any descriptive commentary allowed; the participants simply walked through the facility.

On October 25, 2012, a Joint, Agreed Motion to Increase Page Limit for Proposed Order, Rule 28-106.215, Fla. Admin. Code was filed. Therein, the parties requested that the page limitation be increased to 80 pages per party. An Order was issued on October 29, allowing each party 50 pages in which to present its respective PRO. Each party timely submitted its PRO, and each PRO has been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, Hillandale operated as a 24-bed limited mental health care (LMHC), assisted living facility (ALF) located at 6333 Langston Avenue, New Port Richey, Florida. Hillandale's license number is 10549.

2. AHCA is the regulatory agency that has jurisdiction over Hillandale, pursuant to chapter 408, Part II, and chapter 429, Part I, Florida Statutes (2012),[10/] and Florida Administrative Code Chapter 58A-5.

3. On June 13, 2011, AHCA notified Hillandale by certified letter that its Medicaid Provider Agreement in Florida was being terminated.[11/]

4. Zero tolerance is a collective name "given to all of our [Florida] state laws, administrative rules, policies, procedures, standards of care, et cetera, related to abuse, neglect and exploitation." Although initially instituted in response to reported sexual abuse instances, in either 2004 or 2005, the zero tolerance initiative was expanded to include all forms of abuse, neglect, and exploitation involving persons with developmental disabilities.

5. Caregivers for persons with developmental disabilities must be properly trained to assist in some of the most intimate tasks of daily living. Additionally, those caregivers must be aware of the reporting requirements for any known or suspected abuse, neglect or exploitation.

6. Amelia Cowles is a co-owner, with her husband Gene Cowles, of Hillandale. Mrs. Cowles continues to hold credentials to be an administrator of the ALF. At times when John Ross is not at the facility, Mrs. Cowles serves as its administrator.

7. Mr. and Mrs. Cowles also own three other ALFs: Mapleway Community, Inc.,[12/] in Safety Harbor, Florida; and Amelia's House and 80 Place, both located in Pinellas Park, Florida.

8. Mr. Ross serves as the administrator for Hillandale and Mapleway. He has served Hillandale since its opening in 2005. Mr. Ross has a high school diploma.[13/] He does not have any specialized training in health care, but has some training in health care administration.

9. Mr. Baez provided direct care to residents at Hillandale. His exact length of service at Hillandale is unknown, although he was terminated in May 2011. Mr. Ross explained his reasoning for hiring Mr. Baez as, Mr. Ross "needed someone to work there [Hillandale]," he (Mr. Baez) passed his background screening," he had a military background, he got high recommendations, he had done some work in a church, and Mr. Baez's "pastor spoke very highly of him." Mr. Baez did not have any health care-related training prior to working at Hillandale. Mr. Baez may have had cardiopulmonary resuscitation (CPR) training when he started at Hillandale. Mr. Ross updated Mr. Baez's CPR and provided the following training classes: first aid; HIV and infection control; major incident reporting; emergency disaster planning; food and nutrition; elopement; DNRO[14/]; zero tolerance[15/]; and abuse, neglect, and exploitation.[16/]

10. Hillandale first opened its doors for operation in 2005. The facility has approximately 12 sleeping rooms, two living areas, four bathrooms, a laundry room, a dining room, a kitchen, a closet, and an office. Hillandale is laid out in two

zones. The number of staff present at any given time fluctuates based on the day and time and how many residents are present. During peak weekday periods (between 3:00 p.m. and 7:00 p.m.), there are three staff members present. However, on the weekends, there are only two staff members present.

11. Hillandale, along with its sister facilities (Amelias House and Mapleway), has "Abuse Reporting" guidelines that require the following:

> The purpose of this is to establish guidelines for reporting abuse. If [a] Client has [an] active case worker with the agency [sic] for Persons with Disabilities it must be reported to them within 24 hours. AHCA has eliminated the adverse Incident requirement as of July 2009.
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> The Florida Statutes on the reporting of Abuse 415.1034
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> Any person, including, but not limited to, any:
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> * * *
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> 4. Nursing home staff; assisted living facility staff; adult day care center staff; . . . social worker; or other professional adult care, residential, or institutional staff;
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> * * *
>
> who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline.

> "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 act and omissions.
>
> "Sexual abuse" means acts of a sexual nature committed in the presence of a vulnerable adult without that person's informed consent. . . . "Sexual abuse" does not include any act intended for a valid medical purpose or any act that may reasonably be construed to be normal caregiving action or appropriate display of affection.
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> * * *
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> "Caregiver" means a person who has been entrusted with or has assumed the responsibility for frequent and regular care of or services to a vulnerable adult on a temporary or permanent basis and who has a commitment, agreement, or understanding with that person . . . that a caregiver role exist. "Caregiver" includes, but is not limited to, . . . employees and volunteers of facilities as defined in subsection (8). . . .
>
> Request that the administrator be told of the report if filed with the hotline as soon as is possible.
>
> Revised July 2009

12. Hillandale caters to a younger-age clientele who have mental health issues with cognitive impairments or developmental disabilities. Each of Hillandale's residents (at any given time there could be 20 to 24 residents, also known as clients) has a variety of medical or psychological conditions including (but not limited to): autism; mental retardation; Asperger's; traumatic

brain injury; Down syndrome; schizoaffective; post traumatic stress disorder; bipolar; impulse control disorder; depressive disorder; mood disorder; attention deficit and hyperactivity disorder; borderline intellectual functioning; low IQ; and/or seizures of various types. These residents are vulnerable individuals, who need assistance in many aspects of daily living and need to be kept safe as they may be unable to act or react in self-defense. Vulnerable individuals may be unable to distinguish between right and wrong, good and bad, and/or dangerous or innocent gestures or situations.

13. Since opening its doors in 2005, there have been behavioral problems with the residents at Hillandale because that is "the nature of the population that's being served." The behavioral problems include: yelling; screaming; cursing; getting into other people's business; elopement; and threats of physical violence. This diversity in residents requires more oversight from well-trained staff.

14. All of these conditions are manageable, to some degree, when routines are established and adhered to. Hillandale's residents are considered vulnerable adults. Some residents are violent; others are slow or have conditions that cause them to react to new or different routines in unusual ways. The residents can be hurt during altercations.

15. The residents who are able to perform their own activities of daily living do so, and they are allowed wide latitude in such. However, when another resident gets upset or bothered by either a change in routine or by someone's words or gestures, a violent outburst can erupt with fighting, hitting, and/or biting.

16. The Hillandale staff did not have adequate training to manage the residents, other than moving them from one activity to another.

17. In 2007, an Administrative Complaint was issued alleging Hillandale had failed to provide enough qualified staff to provide a safe living environment for the residents. Hillandale was alleged to have violated the residents rights to live in a safe and decent living environment, free from abuse and neglect, and the residents were not treated with consideration, respect, and due recognition of their personal dignity. Hillandale admitted the allegations, and, on January 3, 2008, AHCA issued a Final Order finding that Hillandale was in violation of section 429.28(1)(a) and (b), Florida Statutes (2007). An administrative fine was imposed as well as a fee for the survey.

18. In August 2010, Katherine Benjamin was at Hillandale to conduct a survey. In conducting that survey, Ms. Benjamin reviewed several Facility Event Reports (reports). In each

report reviewed, a resident had suffered some kind of injury, either self-inflicted or caused by another resident. These reports, when initially reviewed by the surveyor, did not contain documentation that the residents' health care provider, the residents' representative, or their appropriate case worker had been notified. Further, the report form specifically directs that the date and time that those persons were notified should be recorded. That specific information was not present. These reports are required to be completed by Hillandale staff to document what happened and how the events were resolved. Ms. Benjamin found deficiencies in three different instances. Mr. Ross described the discrepancies as merely "a paperwork problem" that was corrected. When other deficiencies or problems were pointed out by surveyors, Mr. Ross discounted, disputed or otherwise found fault with the surveyors as opposed to accepting that there was or might be a problem and embracing the opportunity to improve the care.

19. In February 2011, L.T. became a resident at Hillandale. Mr. Ross first met L.T. through FACT.[17/] L.T. suffered from mental illness, was about to turn 18 years old, and was about to age out of the foster care system. Although Mr. Ross testified that he had received a large fax from FACT regarding L.T., Mr. Ross claimed that he did not know of L.T.'s propensity for violence. The fax included information that, in 2009, L.T. had

been fighting with his peers at school, had threatened or stated that he heard the devil tell him to hit his sister, and, in late 2010, L.T. was incarcerated on a charge of battery on the elderly (his foster father). Despite this information being available, Mr. Ross, as Hillandale's administrator, admitted L.T. to Hillandale without appropriately accounting for L.T.'s propensity for violence.

20. Mr. Ross learned that L.T. had struck a Hillandale resident in late February 2011. A mental health case manager was interviewing L.T. in the common area. Another resident, C.J., apparently felt compelled to answer the questions for L.T. L.T. took exception to C.J.'s repeated interruptions of his interview, and, after C.J. pushed L.T., L.T. hit C.J. C.J. then called the police who arrested L.T. Although Mr. Ross conducted the investigation, he failed to obtain the name of or interview the mental health case manager who was with L.T. at the time. Mr. Ross attended the court hearings regarding L.T. L.T. spent approximately 22 days in jail. Once he was released, L.T. returned to Hillandale. Mr. Ross felt he had dealt with the situation by having C.J. leave Hillandale, as he felt she was the instigator. There was no evidence that this incident was reported to the abuse hotline.

21. In April or May 2011, L.T. was accused of hitting or attempting to hit another resident, M.A. The police were called;

yet, they declined to intervene because neither person was injured. Mr. Ross was "chewed out" by the police for this call. Mr. Ross believed he was chewed out because the police were frustrated with the repeated calls from Hillandale residents for minor incidents for which police involvement was not warranted. Mr. Ross did not institute any new staff procedures to reduce or eliminate the unwarranted calls by residents to the police.

22. Sometime in May 2011, L.T. started telling the Hillandale staff he did not have to listen to them tell him (L.T.) what to do. Mr. Ross contacted FACT and asked that FACT move L.T. to another location.

23. In late May, prior to L.T. being moved, L.T. was arrested for touching another resident, A.W. Hillandale staff witnessed L.T. slapping A.W. across his face. L.T. was told to stop slapping A.W., and he refused. The police were called, and L.T. was arrested for battery. There was no evidence that this incident was reported to the abuse hotline.

24. M.A. was initially a resident/client of Mapleway. Prior to her admission to Mapleway, Mr. Ross had reviewed M.A.'s psychological evaluation, psychological workup, and her discharge paper from a crisis stabilization unit. Mr. Ross accepted M.A. because the Mapleway staff had worked with similar individuals for approximately 15 years. M.A. suffers from mental retardation

(autism) and is in her 20s, however, she acts like a person in her teens.

25. After approximately four to six months[18/] at Mapleway, M.A. transferred to Hillandale in early 2011. The stated reasons for transferring M.A. to Hillandale were for her to be with people around her own age, and there were more staff to watch her. M.A. required a lot of attention. M.A. wanted or needed a lot of attention from the Hillandale staff because she had lots of questions and wanted answers. M.A. could not receive that kind of attention at the other facility.

26. Mr. Baez became a caregiver to M.A. on the day she moved into Hillandale. Mr. Baez was told that M.A. suffered from autism.

27. In April 2011, Mrs. Cowles confronted Mr. Baez after hearing from residents that Mr. Baez had kissed the resident, M.A. Mrs. Cowles told Mr. Baez that he was not to kiss a resident again. Mr. Baez conceded to Mrs. Cowles that he had kissed M.A. on the cheek, "like a child." Mrs. Cowles did not report her conversation with Mr. Baez to any abuse hotline as required or to the administrator, Mr. Ross, at the time of the confrontation, because she thought she had "take[n] care of the situation."

28. On April 27, 2011, Mr. Ross conducted a "full staff meeting," wherein Mr. Ross "restated the need for the client-

caregiver relationship to be respected and used the Zero Tolerance outline for DD [developmentally disabled] clients and let them [staff] know that this was to be taken very seriously." Specifically, Mr. Ross told Mr. Baez he needed to establish an appropriate boundary with M.A., as she was interfering with Mr. Baez's work commitments. Mr. Baez did not ask or tell M.A. to do other things, and she continually followed Mr. Baez around the Hillandale facility.

29. On April 30, 2011, three days after this staff meeting with the zero tolerance instruction, Mr. Ross suspended Mr. Baez from his Hillandale employment for four days. The basis for the suspension was Mr. Baez's inability to establish a proper boundary with M.A. Mr. Ross testified he became aware that Mr. Baez had kissed resident M.A. "just before" Mr. Ross suspended Mr. Baez.

30. It is unclear when Mr. Baez's suspension actually started or ended. However, Mr. Baez's scheduled days to work were Tuesday, Wednesday, Friday, Saturday, and Sunday, the 3:00 p.m. to 11:00 p.m. shift. Mr. Baez returned to work on or after Thursday, May 5.

31. According to Mr. Ross, upon Mr. Baez's return to work following the suspension, Mr. Baez was not allowed "to work solo at any time." Additionally, Mr. Ross directed other Hillandale staff members to watch Mr. Baez to make sure he respected the

boundary issues. Mr. Ross "had him [Mr. Baez] watched just to see about the boundary issue, and that was all." There was no evidence that additional staff were on duty to watch both the residents and Mr. Baez, possibly diminishing the staff's ability to care for the residents.

32. On May 14, 2011, less than ten days after serving a four-day suspension, Mr. Baez was terminated from his Hillandale employment. The basis for the termination was Mr. Baez's "failure to keep an appropriate boundary with her [M.A.] as far as the amount of time he spent." The written Hillandale report, created on May 14 by Mr. Ross when Mr. Baez was terminated, recorded that Mr. Ross was told by other staff (at Hillandale) that Mr. Baez had been accused of "having sex with a client [M.A.]." The report continued in part:

> [O]n May 14th a client made accusation I brought Orlando into the office and he said he was guilty of not setting the boundary and was not thinking clearly. He had also been talked with by two other staff members (Joseph Costa and Erasmo Cintron) encouraging him to set the boundary, he told me he did not listen as he did not think it was that serious. I also asked him about photos of her on his phone he admitted he took them and had them[.] I informed him that was a HIPPA violation and he needed consent from her guardian. All of this is a clear cut violation of facility policies and state guidelines of client care.

33. Although Mr. Costa and Mr. Cintron jointly or individually advised Mr. Ross of the accusation, neither staff

took it upon themselves to contact the hotline until Mr. Ross directed them to do so. The staff may not have known specifics of the alleged liaison; however, an "immediate" call to the hotline might have altered the course of events. The staff did not have adequate training to handle the circumstance.

34. The termination of Mr. Baez's employment ended the possibility for Mr. Baez being a perpetrator, but the overall lack of staff training persisted.

35. As the owner of several ALFs, including Hillandale, the Cowleses have been previously aware of the vulnerability of their clientele. In particular, in 2005, Richard Langston was an employee at Mapleway when he was arrested and ultimately convicted of lewd or lascivious molestation of a disabled adult. The fact pattern of the Mapleway allegation is similar to the alleged abuse herein.

36. Hillandale's abuse policy (which is the same policy for Mapleway) requires specific reporting and documenting, yet Mrs. Cowles failed to follow that policy.

CONCLUSIONS OF LAW

37. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding, pursuant to sections 120.569, 120.57(1), and 429.19, Florida Statutes.

38. In the instant case, AHCA has the burden of proving by clear and convincing evidence that Hillandale committed the violations as alleged and, if there are violations, the appropriateness of any fine resulting from the alleged violations. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292, 294 (Fla.1987).

39. 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.

40. In pertinent part, rule 58A-5.0182 provides:

> An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
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> (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:
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> * * *
>
> (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual.

(c) General awareness of the resident's whereabouts. The resident may travel independently in the community.

* * *

(4) ACTIVITIES OF DAILY LIVING [ADL]. Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident. Residents shall be encouraged to be as independent as possible in performing ADLs.

* * *

(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.

(a) A copy of the Resident Bill of Rights . . . shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.

* * *

(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's alcohol and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.

* * *

(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified

telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.

* * *

(9) OTHER STANDARDS. Additional care standards for residents residing in a facility holding a limited mental health, . . . are provided in Rules 58A-5.029, . . . F.A.C., respectively.

41. In pertinent part, rule 58A-5.019(1) provides:

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, F.S., and this rule chapter.

42. Section 415.102, Florida Statutes, provides the following definitions:

(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.

(2) "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.

* * *

(19) "Protective investigation" means acceptance of a report from the central abuse

hotline alleging abuse, neglect, or exploitation as defined in this section; investigation of the report; determination as to whether action by the court is warranted; and referral of the vulnerable adult to another public or private agency when appropriate.

(20) "Protective investigator" means an authorized agent of the department who receives and investigates reports of abuse, neglect, or exploitation of vulnerable adults.

(21) "Protective services" means services to protect a vulnerable adult from further occurrences of abuse, neglect, or exploitation. Such services may include, but are not limited to, protective supervision, placement, and in-home and community-based services.

(22) "Protective supervision" means those services arranged for or implemented by the department to protect vulnerable adults from further occurrences of abuse, neglect, or exploitation.

* * *

(25) "Sexual abuse" means acts of a sexual nature committed in the presence of a vulnerable adult without that person's informed consent. "Sexual abuse" includes, but is not limited to, the acts defined in s. 794.011(1)(h), fondling, exposure of a vulnerable adult's sexual organs, or the use of a vulnerable adult to solicit for or engage in prostitution or sexual performance. "Sexual abuse" does not include any act intended for a valid medical purpose or any act that may reasonably be construed to be normal caregiving action or appropriate display of affection.

* * *

(27) "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

43. Section 429.28 (known as the Resident's Bill of Rights) provides:

(1) 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:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

* * *

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

* * *

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

* * *

(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.

(5) No facility or employee of a facility may serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

44. Section 429.02 provides, in pertinent part:

> (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.

45. Section 429.075 provides, in pertinent part:

> An assisted living facility that serves three or more mental health residents must obtain a limited mental health license.
>
> (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected deficiencies or violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. Such designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training will be provided by or approved by the Department of Children and Family Services.
>
> (2) Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.

46. Section 429.14 provides, in pertinent part:

> (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 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, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee:
>
> (a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
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> * * *
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> (e) A citation of any of the following deficiencies as specified in s. 429.19:
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> 1. One or more cited class I deficiencies.
>
> 2. Three or more cited class II deficiencies.
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> * * *
>
> (h) Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.
>
> * * *
>
> (k) Any act constituting a ground upon which application for a license may be denied.

47. Section 429.19 provides, in pertinent part:

> (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.

(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:

(a) Class "I" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation.

(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.

* * *

(3) 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.

(4) Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(5) Any action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license when a facility administrator fraudulently misrepresents action taken to correct a violation.

(6) Any facility whose owner fails to apply for a change-of-ownership license in accordance with part II of chapter 408 and operates the facility under the new ownership is subject to a fine of $5,000.

(7) In 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 that was the subject of the complaint or monitoring visits conducted under s. 429.28(3)(c) to verify the correction of the violations.

(8) During an inspection, the agency shall make a reasonable attempt to discuss each violation with the owner or administrator of the facility, prior to written notification.

48. Section 408.815 provides, in pertinent part:

> (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:
>
> (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.
>
> (e) The applicant, licensee, or controlling interest has been or is currently excluded, suspended, or terminated from participation in the state Medicaid program, the Medicaid program of any other state, or the Medicare program.

49. Section 408.813 provides, in pertinent part:

> As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine.
>
> (1) Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in s. 55.03 for each day beyond the date set by the agency for payment of the fine.

(2) Violations of this part, authorizing statutes, or applicable rules shall be classified according to the nature of the violation and the gravity of its probable effect on clients. The scope of a violation may be cited as an isolated, patterned, or widespread deficiency. An isolated deficiency is a deficiency affecting one or a very limited number of clients, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency in which more than a very limited number of clients are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same client or clients have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the provider. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the provider or represent systemic failure that has affected or has the potential to affect a large portion of the provider's clients. This subsection does not affect the legislative determination of the amount of a fine imposed under authorizing statutes. Violations shall be classified on the written notice as follows:

(a) Class "I" 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 present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a

> cited class I violation. A fine shall be levied notwithstanding the correction of the violation.
>
> (b) 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.

50. AHCA has established by clear and convincing evidence that Hillandale has failed to provide a safe and decent environment free from abuse and neglect and has failed to treat its residents with consideration and respect and with due recognition of personal dignity and individuality. Hillandale failed to ensure that its residents were not abused by either other residents or staff members. Hillandale's administration failed to appreciate the significant vulnerability of its residents when screening potential new residents and then failed to implement staff training to ensure a safe environment. §§ 429.14(1)(a) and (e); 429.19(2)(a) and (5); and 429.28(1)(a) and (b), Fla. Stat.

51. AHCA has established by clear and convincing evidence that Hillandale's participation in the state Medicaid provider network has been terminated. § 408.815(1)(e), Fla. Stat.

52. Pursuant to sections 408.813(2)(a) and 429.19, an administrative fine of not less than $5,000.00 and not exceeding $10,000.00 shall be imposed for a Class I violation, even after the condition or practice has been eliminated. The removal of a violent resident and the employment termination of a staff member were warranted.

53. Pursuant to section 429.19(7), the agency may assess a survey fee of $500.00 to cover the cost of conducting the investigation.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration enter a final order finding that Gene Cowles and Amelia Cowles, d/b/a Hillandale Assisted Living, violated sections 429.28(1)(a) and (b) and 408.815(1)(e), imposing an administrative fine of $20,000.00, and assessing a survey fee of $1,000.00 ($500.00 for each investigation) associated with this case.

DONE AND ENTERED this 17th day of January, 2013, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of January, 2013.

ENDNOTES

[1/] This joint motion expressed that Respondents had secured different counsel for representation and needed additional time to complete discovery.

[2/] The second joint motion expressed that "The parties expect to amicably resolve their differences raised by the Administrative Complaint in a proposed Settlement Agreement" and that the parties were "actively pursuing settlement options" and had delayed additional discovery to seek a resolution.

[3/] The original counsel for AHCA left the agency without notice, leaving the current counsel with little recourse other than to ask for additional time to prepare. Although Respondents objected to the continuance, the motion reflected that continued settlement discussions were being explored, to which Respondents did not object.

[4/] The last request for continuance was to allow AHCA to petition in circuit court for the enforcement of a properly-noticed, non-party expert witness who was scheduled for a deposition and failed to attend. The outcome of that action was not disclosed.

[5/] Respondents had also listed some of these witnesses for its own case-in-chief. To provide an orderly hearing flow and allow Respondents the opportunity to elicit the direct testimony of each witness, the undersigned allowed Respondents' cross examination to go beyond Petitioner's direct.

[6/] Exhibit 12 indicates it is eight pages in length, and it is. However, the last sentence on the eighth page is incomplete, giving the impression that there was more to the document.

[7/] Exhibits 57 through 61 include the deposition testimony of: Marilyn Ward, M.D.; Tom Rice; Rachel Agustines, M.D.; Amelia Cowles; and John Ross, respectively. Exhibits 63 and 64 are the depositions of Carmen Cintron and Erasmo Cintron, respectively.

[8/] Hillandale's Exhibit 13, Mr. Ross' employment file, has been rearranged in chronological order in order to follow his training and certifications.

[9/] Hillandale's Exhibit 78, a not-to-scale sketch of the facility, was created at the hearing at the request of the undersigned. Both parties reviewed the sketch prior to its admission into evidence, and a copy of the sketch was provided to both parties.

[10/] All future references to Florida Statutes will be to 2012, unless otherwise indicated.

[11/] The letter stated the agreement would terminate 30 days after the date of the letter. On July 13, 2011, the agreement ended.

[12/] Mapleway Community, Inc., was referred to as Mapleway throughout the hearing.

[13/] It is noted that several of Mr. Ross' training certificates or notification letters are addressed to "Dr. John Ross" or "John Ross, Ph.D." Between 2006 and February 2011, Professional Crisis Management wrote Mr. Ross no less than four letters addressing him as "Dr. Ross." In 2010, Vanguard Advanced Pharmacy Systems issued a continuing education certificate of attendance to "John Ross, Ph.D." These distinct designations are unwarranted as Mr. Ross does not have the requisite education to utilize the titles.

[14/] DNRO was never defined. It is assumed to be "Do Not Resuscitate Order."

[15/] The only certificate evidencing Mr. Baez's "zero tolerance sexual abuse prevention" is dated "November 30, 2008."

[16/] Several of Mr. Baez's certificates of completion, executed by Mr. Ross, contain his title as "Dr. John Ross IT Trainer," "John Ross, Ph.D. Instructor," or "John Ross, Ph.D. Administrator." These distinct designations are unwarranted, as Mr. Ross does not have the requisite education to utilize the titles.

[17/] Both parties asked witnesses about FACT. Neither party provided an overview of the services provided by FACT. The undersigned finds that generally FACT is an organization that somehow facilitates services to and monitors progress of those persons affected by significant mental health issues in the Tampa Bay area.

[18/] In his deposition, Mr. Ross responded "Five or six months" to the question of how long M.A. had been a resident at Mapleway. Yet, a moment later, Mr. Ross recounted and stated "I don't believe I said six months" and instead stated "I believe I said four to five [months]" was how long M.A. was at Mapleway.

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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.