STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

DOS OF CRYSTAL RIVER ALF, LLC d/b/a CRYSTAL GEM ALF,

Respondent.

Case No. 12-2306

RECOMMENDED ORDER

An administrative hearing was conducted in this case on September 13, 2012, in Inverness, Florida, before James H. Peterson, III, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

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

For Respondent: Theodore E. Mack, Esquire
Powell & Mack
3700 Bellwood Drive
Tallahassee, Florida 32303

STATEMENT OF THE ISSUES

Whether Respondent, DOS of Crystal River ALF, LLC, d/b/a Crystal Gem ALF (Crystal Gem or Respondent), should be subjected

to the imposition of administrative fines pursuant to sections 408.813 and 429.19, Florida Statutes,[1/] for (1) failing to have a completed a Resident Health Assessment form for each resident as required by Florida Administrative Code Rule 58A-5.0181, (2) failing to provide appropriate supervision to prevent elopement and failing to properly notify a resident's health care provider and others of a significant change in a resident as required by Florida Administrative Code Rule 58A-5.0182, and (3) neglecting a resident by failing to take adequate measures to protect the resident from eloping as required by section 429.28, Florida Statutes.

PRELIMINARY STATEMENT

On May 29, 2012, the Agency for Health Care Administration (Agency) issued an Administrative Complaint (Complaint) seeking administrative fines totaling $10,500 for Respondent's alleged violations of Florida Administrative Rules 58A-5.0181 and 58A-5.0182, and section 429.28, Florida Statutes. Respondent timely requested an administrative hearing under chapter 120, Florida Statutes. On July 5, 2012, the Agency referred the case to the Division of Administrative Hearings (DOAH).

At the administrative hearing held on September 13, 2012, the Agency presented the testimony of Jeff Clay, a former Agency surveyor; Teresa Cavallaro, a Registered Nurse who is an Agency surveyor; David Knazur, a Protective Investigator with the

Florida Department of Children and Families; and the wife of the resident identified as Resident #1 in the Agency's August 31, 2011, survey of Respondent. Resident #1 shall be identified herein as "J.B." and his wife as "Mrs. B." The Agency offered 14 exhibits received into evidence as Exhibits P-1 through P-14, without objection.

The proceedings were recorded and a transcript was ordered. The parties were given 30 days from the filing of the Transcript within which to submit their proposed recommended orders. The Transcript, consisting of two volumes, was filed on October 10, 2012, and the parties timely filed their respective Proposed Recommended Orders, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. The Agency is the licensing and enforcing authority for assisted living facilities pursuant to chapters 429, Part I, and 408, Part II, Florida Statutes, and Florida Administrative Code Chapter 58A-5.

2. Respondent operates a 70-bed assisted living facility located at 10845 West Gem Street, Crystal River, Florida, and is licensed as an assisted-living facility, license number 10687.

3. Assisted-living facilities are required to have a completed health assessment on Agency Form 1823 for each resident. Agency Form 1823 has three sections. The first two

sections are to be completed by a health care provider, and the third section is to be completed by the facility's administration.

COUNT I: Resident Health Assessments

4. On July 12 and 13, 2011, the Agency conducted a survey of Respondent during which the Agency reviewed Form 1823s on Respondent's residents. During the survey, the Agency identified incomplete Form 1823s on two of Respondent's residents. The first Form 1823 identified by the Agency as incomplete lacked a date on which the assessment was completed. The second Form 1823 lacked a medical history and diagnosis, and had inconsistent statements regarding whether the resident needed assistance with medication.

5. During a follow-up survey of Respondent on August 23, 2011, the Agency found one more Agency Form 1823 that the Agency considered deficient. The form did not indicate the resident's cognitive or behavioral status, or whether the resident needed 24-hour or psychiatric care.[2/] In addition, the form stated that the resident needed assistance taking medication but was not specific regarding the type of help needed.

6. All of the deficiencies cited by the Agency were in the first two sections of the form. According to the Agency, all three Agency Form 1823s that it found to be deficient constituted "Class III" deficiencies, which are conditions or

occurrences that "indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents . . . ." See § 408.813(2)(c), Fla. Stat.

7. In fact, the Agency testified that it considers any incomplete Form 1823 as a "Class III" deficiency.

8. According to the Agency, errors identified in the health care provider's portion of the Agency Form 1823s are Class III violations because complete information is required for the facility to develop the third portion of the form in order to provide proper care to the resident. The Agency, however, offered no evidence indicating that the third portions of the subject forms were not correct, or that any of the deficiencies in the forms identified by the Agency harmed any resident.

9. While the Agency argued that missing information in the health assessments could cause potential problems for the subject residents, those arguments were merely speculative, considering the fact that the Agency did not find deficiencies in those portions of the forms filled out by Respondent relating to the actual care received by the residents. Further, the Agency did not show that any of the subject residents were receiving improper care.

10. Although the clear and convincing evidence demonstrated that there were deficiencies in the three Agency

Form 1823s identified by the Agency, the evidence was insufficient to show that the deficiencies "indirectly or potentially threaten[ed] the physical or emotional health, safety, or security of facility residents."

COUNTS II & III: THE WANDERING RESIDENT

11. On August 3, 2011, Mrs. B. first brought her husband, J.B., to Respondent's facility for an initial evaluation. Although unknown at the time he first arrived, J.B. was suffering from a rare brain disorder known as Creutzfeldt - Jakob disease. The initial valuation diagnosed J.B. as suffering from cerebral vascular accident, dementia, depression and anxiety and found that J.B.'s needs could be met in an assisted living facility.

12. On Friday, August 5, 2011, Mrs. B. brought J.B. back to the Respondent's facility to stay. At the request of the family, J.B. was placed in Respondent's Level 1, non-secure unit, which has keypad locks accessible by certain residents and family.

13. From the time J.B. arrived, Respondent's staff noticed that J.B. liked to wander. Although wandering or danger of elopement was not mentioned in J.B.'s initial evaluation, the fact that J.B. tended to wander was no surprise to the staff because they knew that people with dementia often wander.

14. According to opinions offered by witnesses for both Respondent and Petitioner who are familiar with the habits of patients with dementia, anywhere from 75 to 90 percent of patients with dementia tend to wander.

15. That first day, J.B. wandered throughout the Level-1 unit of Respondent's facility, and may have wandered into a Level-1 accessible courtyard that very first day.[3/]

16. The next day, Saturday, August 6, 2011, J.B. continued to wander within the facility. Shannon Kissel was the resident care aide assigned to Level-1 on the weekends that J.B. was at Respondent's facility. Tiffany Stanley was the resident care aide assigned to Level-2 on those weekends. Both Ms. Kissel and Ms. Stanley worked 16-hour shifts on the weekends, 7:00 a.m. to 11:00 p.m., Saturday and Sunday.

17. Both Ms. Kissel and Ms. Stanley were aware that J.B. wandered and that dementia patients tend to wander.

18. After dinner on the evening of August 6, 2011, between 8:30 p.m. and 9:00 p.m., Ms. Kissel could not locate J.B. She notified Ms. Stanley and the two of them looked all through the facility, both Levels 1 and 2. They eventually found him just outside the front door, standing on the side of the building.

19. They took him back inside, got him cleaned up, and put on his pajamas. He had no bruises, scratches, or apparent injuries.

20. Neither Respondent's facility administrator nor its resident care coordinator was on site at the time of the incident because they do not work weekends. Ms. Kissel and Ms. Stanley contacted the facility administrator and the resident care coordinator by telephone and advised them that J.B. had "eloped" from the facility. They all agreed that, under the circumstances, it was best to move J.B. to the Level-2 "lock-down" portion of the facility.

21. By 10:00 p.m. that same evening, J.B. was moved to a room in Level 2.

22. On Sunday, August 7, 2011, J.B.'s wife and son came to Respondent's facility and helped move the rest of J.B.'s personal belongings to his new room in Level 2.

23. Thirty-minute checks were instituted for J.B., so that that staff checked on him every 30 minutes.[4/]

24. That afternoon, after his family had left, J.B. once again got out of the facility. This time, Ms. Stanley discovered that J.B. was absent, after not seeing him for about 20 minutes. She immediately began searching the entire facility for J.B., following protocol that called for opening the doors between Level 1 and Level 2, so that staff members could check the entire building while also keeping an eye on other residents.

25. Eventually, Ms. Stanley checked room 22 in Level 2 and noticed a window open. She looked out of the window and discovered J.B. standing just outside, right next to the window. She called another employee named Amy, who came and kept an eye on J.B. while Ms. Stanley went around to an exit door and outside to J.B.'s location.

26. J.B. was standing right next to the building in a grassy area. Ms. Stanley was able to coax him back into the building with promises of an "Orange Crush" soft drink.

27. Once inside, Ms. Stanley gave J.B. an Orange Crush and then he was showered and cleaned up. Even though the window that J.B. had apparently crawled through to get outside was quite small when compared to his large size, Ms. Stanley did not notice any bruises or scrapes on J.B. In her testimony, Ms. Stanley explained:

> Well the bruises aren't going to show up instantly, but there were no cuts, no scrapes, no -- you know, he wasn't complaining of any pain. You know, he just wanted to be outside.

28. According to observation notes in a log that Respondent kept on J.B., on Monday, August 8, 2011, staff caught J.B. halfway out of a window in another attempt to escape.

29. Staff contacted J.B.'s health care provider on August 8, 2011, and advised of J.B.'s escaping behavior.

30. The observation notes also document that on Tuesday, August 9, J.B. escaped from the Level-2 lockdown and had to be redirected back into Level 2. The note does not indicate whether J.B. escaped by walking through the door into Level 1, or into the patio area at the back of Level 2. The patio area at the back of Level 2 is surrounded by a secure, seven-foot high fence and is accessible to Level 2 residents.

31. J.B. was showered by staff on Tuesday, August 9, 2011, and there was no report of bruising.

32. There is no evidence that J.B. escaped or attempted to escape after August 9, 2011.

33. On August 13, 2011, while bathing J.B., Respondent's staff noticed bruises. While J.B. may have incurred the bruises while attempting to crawl out of a window or escape from the facility, the evidence was inconclusive as to exactly how he incurred the bruises. That same day, an adult protective services investigator with the Florida Department of Children and Families observed J.B. and noticed bruising on his abdomen, as well as a small bruise on his head and rash on his inner thigh.

34. The next day, Sunday, August 14, 2011, J.B. was sent to the hospital complaining of abdominal pain. He was treated and released back to Respondent's care that same day with a catheter because he had been retaining fluid in his bladder.

There is no evidence that he was treated, or needed treatment, for any bumps or bruises.

35. At all pertinent times, Respondent had policies and procedures in place regarding elopement as required by Florida Administrative Rule 58A-5.0182. The Agency has not alleged that the Respondent's policies do not meet rule requirements.

36. According to Respondent's policy and procedures in effect at the time of the incidents involving J.B., elopement occurs when a resident leaves the facility property beyond the perimeter of the parking lot.

37. The evidence does not show that J.B. ever went beyond the perimeter of Respondent's parking lot.

38. There was no evidence that any other resident had ever escaped from Respondent's facility.

39. While the Agency submitted additional evidence in the form of statements taken from an administrator of Respondent's facility, Rebecca Bilby, Ms. Bilby was not called as a witness. While Ms. Bilby's statements may be admissible as an admission[5/] or on other grounds, Ms. Bilby was not present at Respondent's facility when the incidents regarding J.B. occurred. The testimonies of staff actually present during J.B.'s escapes and escape attempts were more persuasive than statements obtained from Ms. Bilby.

40. The evidence was insufficient to demonstrate that Respondent's lack of supervision was the cause of J.B.'s escapes, attempted escapes, or injuries. Rather, the evidence adduced at the final hearing indicated that although Respondent's staff knew that J.B. had wandering behavior, his actual escapes were not reasonably foreseeable under the circumstances. There was no evidence that anyone had previously escaped from Respondent's facility.

41. Rather than showing that staff did not provide appropriate supervision of J.B., the evidence showed that on those occasions that J.B. escaped, Respondent's staff reacted quickly and appropriately to bring J.B. back inside before he wandered beyond the immediate exterior wall area of the building.

42. Moreover, considering Respondent's definition of "elopement," there was no actual elopement by J.B. There is no indication that J.B. ever went into, much less farther, than the parking lot of Respondent's facility.

43. Further, given J.B.'s proclivity to wander prior to his escapes, J.B.'s actual escapes and attempted escapes did not constitute "significant changes"[6/] in J.B.'s behavior. Nevertheless, the family was notified either the night of, or the next morning, after J.B. escaped and was moved to the

secure, Level 2, portion of the facility. In addition, J.B.’s health-care provider was notified on Monday.

44. Finally, the evidence was insufficient to show that Respondent was careless or neglected[7/] to take adequate measures to protect J.B. from eloping or danger. The 30-minute checks instituted by Respondent resulted in quick responses before J.B. had an opportunity to go beyond the immediate edge of Respondent's facility and the supervision provided by Respondent's staff prevented his exposure to any real danger.

CONCLUSIONS OF LAW

45. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. See §§ 120.569, 120.57(1), Florida Statutes (2012).

46. The Agency is the state agency responsible for licensure of ALFs and enforcement of all applicable Federal regulations, state statutes, and rules governing ALFs pursuant to the chapter 429, part I, Florida Statutes, and Florida Administrative Code Rule 58A-5.

47. The Agency, as the party asserting the affirmative in this proceeding, has the burden of proof. See, e.g., Balino v. Dep’t of Health & Rehabilitative Servs., 348 So. 2d 349 (Fla. 1st DCA 1977). Because the Petitioner is seeking to prove violations of a statute and impose administrative fines or other penalties, it has the burden to prove the allegations in the

complaint by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

48. Clear and convincing evidence:

> requires that 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 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, 429 So. 797, 800 (Fla. 4th DCA 1983)).

49. Section 429.19(2) which governs administrative fines against assisted living facilities for violations of applicable rules and laws, provides for fines of $5,000 to $10,000 for Class I violations; $1,000 to $5,000 for Class II violations; $500 to $1,000 for Class III violations; and $100 to $200 for Class IV violations. Section 429.19(3) further provides:

> 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.

50. Section 408.813(2)(a)-(d) defines the classes of violations used in section 429.19, 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.
> (c) Class "III" 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 indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The agency shall impose an administrative fine as

> provided in this section for a cited class III violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.
> (d) 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. These violations are of a type that the agency determines do not threaten the health, safety, or security of clients. The agency shall impose an administrative fine as provided in this section for a cited class IV violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, a fine may not be imposed.

51. Florida Administrative Code Rule 58A-5.0181(2), in pertinent part, requires the completion of a health assessment for admission into an assisted living facility, as follows:

> (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection.
> (a) A medical examination completed within 60 calendar days prior to the individual's admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following:
> 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations;
> 2. An evaluation of whether the individual will require supervision or assistance with

the activities of daily living;
3. Any nursing or therapy services required by the individual;
4. Any special diet required by the individual;
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication;
6. Whether the individual has signs or symptoms of a communicable disease which is likely to be transmitted to other residents or staff;
7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual’s needs can be met in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident’s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, October 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident’s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily

require an additional face-to-face
examination for completion.
b. The facility may obtain the omitted
information either verbally or in writing
from the licensed health care provider.
c. Omitted information received verbally
must be documented in the resident’s record,
including the name of the licensed health
care provider, the name of the facility
staff recording the information and the date
the information was provided.
2. The facility administrator, or designee,
must complete Section 3 of the form,
Services Offered or Arranged by the
Facility, or may use electronic
documentation, which at a minimum includes
the elements in Section 3. This requirement
does not apply for residents receiving:
a. Extended congregate care (ECC) services
in facilities holding an ECC license;
b. Services under community living support
plans in facilities holding limited mental
health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph
(a) that is not contained in the medical
examination report conducted prior to the
individual’s admission to the facility must
be obtained by the administrator within 30
days after admission using AHCA Form 1823.

52. Despite the requirements of rule 58A-5.0181(2), as noted in the Findings of Fact, above, the evidence failed to demonstrate that the deficiencies in the three Agency Form 1823s identified by the Agency "indirectly or potentially threaten[ed] the physical or emotional health, safety, or security of facility residents." See § 408.813(2)(c), Fla. Stat. (quoted above). Therefore, the Agency failed to prove its charge

against Respondent that the deficiencies in Respondent's Agency Form 1823's were Class III violations. Id.

53. That is not to say, however, that the Agency did not prove that Respondent violated rule 58A-5.0181(2). Although Respondent argues that the charges in the Complaint should be limited to an alleged Class III violation, a fair reading of the Complaint shows that Count I of the Complaint was broad enough to encompass lesser classes of violations.

54. Under the circumstances, it is concluded that the uncorrected deficiency in the Agency Form 1823 found during the revisit constituted a Class IV deficiency as defined in section 408.813(2)(d), and that an administrative fine in the amount of $100 for that violation, pursuant to section 429.19(2)(d), Florida Statutes, is appropriate.

55. Count II of the Complaint alleges that Respondent failed to provide appropriate supervision to prevent J.B.'s elopement and did not properly notify J.B.'s health care provider and others of a significant change in J.B. as required by Florida Administrative Code Rule 58A-5.0182. That rule provides:

> An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
>
> (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for

each resident, including the following:
(a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.
(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.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.
(2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community.
(a) The facility shall provide an ongoing activities program. The program shall provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests.
(b) The facility shall consult with the residents in selecting, planning, and scheduling activities. The facility shall demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of

communication appropriate to the size of the facility.

(c) Scheduled activities shall be available at least six (6) days a week for a total of not less than twelve (12) hours per week. Watching television shall not be considered an activity for the purpose of meeting the twelve (12) hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required twelve (12) hours per week of scheduled activities. An activities calendar shall be posted in common areas where residents normally congregate.

(d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to three (3) hours may be counted toward the required activity time.

(3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to needed health care, the facility shall, as needed by each resident:

(a) Assist residents in making appointments and remind residents about scheduled appointments for medical, dental, nursing, or mental health services.

(b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxicabs, public buses, and agencies providing transportation for persons with disabilities.

(c) The facility may not require residents to see a particular health care provider.

(4) ACTIVITIES OF DAILY LIVING. 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.
(5) NURSING SERVICES.
(a) Pursuant to Section 429.255, F.S., the facility may employ or contract with a nurse to:
1. Take or supervise the taking of vital signs;
2. Manage pill-organizers and administer medications as described under Rule 58A-5.0185, F.A.C.;
3. Give prepackaged enemas pursuant to a physician’s order; and
4. Maintain nursing progress notes.
(b) Pursuant to Section 464.022, F.S., the nursing services listed in paragraph (a) may also be delivered in the facility by family members or friends of the resident provided the family member or friend does not receive compensation for such services.
(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.
(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council 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.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with Disabilities, 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.

(d) The statewide toll-free telephone number of the Florida Abuse Hotline "1(800)96-ABUSE or 1(800)962-2873" shall be posted in full view in a common area accessible to all residents.

(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.

(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.

(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.

(h) Pursuant to Section 429.41, F.S., the use of physical restraints shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall

review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical restraint.

(7) THIRD PARTY SERVICES. Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, contracting, and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies may require the third party to coordinate with the facility regarding the resident's condition and the services being provided pursuant to subsection 58A-5.016(8), F.A.C. Pursuant to subsection (6) of this rule, the facility shall provide the resident with the facility's policy regarding the provision of services to residents by non-facility staff.

(8) ELOPEMENT STANDARDS.

(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision.

1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with Alzheimer's disease and related

disorders assessed at high risk.
2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident's family/caregiver.
(b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:
1. An immediate staff search of the facility and premises;
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and
4. The continued care of all residents within the facility in the event of an elopement.
(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S.
(9) OTHER STANDARDS. Additional care standards for residents residing in a facility holding a limited mental health, extended congregate care or limited nursing services license are provided in Rules 58A-

5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

56. Count III of the Complaint alleges that Respondent neglected J.B. by failing to take adequate measures to protect him from eloping as required by section 429.28, Florida Statutes. Section 429.28 is entitled "Resident bill of rights," and the pertinent part of that section recited in Count III of the Complaint 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.

57. The Agency contends that the alleged violations in Counts II and III of the Complaint constitute "Class I violations." However, considering the standards set forth in rule 58A-5.0182 and section 429.28 in light of the evidence as outlined in the Findings of Fact, above, it is concluded that the Agency failed to prove, by clear and convincing evidence, that Respondent violated those standards.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration issue a final order finding:

1. Respondent violated the standards set forth in Florida Administrative Code Rule 58A-5.0181, by having an uncorrected "Class IV" deficiency, and imposing a $100 administrative fine for that violation in accordance with section 409.19(2)(d), Florida Statutes; and

2. Respondent did not violate Florida Administrative Code Rule 58A-5.0182 or section 429.28, Florida Statutes, and dismissing Counts II and III of the Complaint.

DONE AND ENTERED this 28th day of December, 2012, in Tallahassee, Leon County, Florida.

JAMES H. PETERSON, III
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of December, 2012.

ENDNOTES

[1/] Unless otherwise indicated, all references to Florida statutes or rules are to current versions, the pertinent portions of which have not changed since the dates of the alleged violations.

[2/] However, as pointed out in Respondent's Proposed Recommended Order (PRO), "immediately below the unanswered question, the health care provider did indicate that the resident's needs could be met by an assisted living facility, which is not a medical, nursing, or psychiatric facility." Respondent's PRO, ¶12.

[3/] The fact that J.B. may have wandered into Respondent's Level 1 courtyard may have been reported to J.B.'s wife and to one or more of Respondent's employees. That wandering, however, was not part of the allegations in the Complaint.

[4/] Apparently, the 30-minute checks were only conducted from 7:00 a.m. to 11:00 p.m. There was no evidence submitted, however, indicating that J.B. tended to wander between 11:00 p.m. and 7:00 a.m.

[5/] See § 90.803(18), Fla. Stat.

[6/] Florida Administrative Code Rule 58A-5.0131(33) states:

> "Significant change" means a sudden or major shift in behavior or mood, or a deterioration in health status such as unplanned weight change, stroke, heart condition, or stage 2, 3, or 4 pressure sore. Ordinary day-to-day fluctuations in functioning and behavior, a short-term illness such as a cold, or the gradual deterioration in the ability to carry out the activities of daily living that accompanies the aging process are not considered significant changes.

[7/] Section 415.102, Florida Statutes, provides:

> "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.

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.