STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case Nos. 13-2011
13-2397

PINE TREE MANOR, INC.,
d/b/a PINE TREE MANOR,

Respondent.
_________________________________/

RECOMMENDED ORDER

A final hearing in this cause was held on August 20 and 21, 2013, by video teleconference before the Division of Administrative Hearings by its designated Administrative Law Judge, Linzie F. Bogan, at sites in St. Petersburg and Tallahassee, Florida.

APPEARANCES

For Petitioner: Suzanne Suarez Hurley, Esquire
Agency for Health Care Administration
Suite 330K
525 Mirror Lake Drive, North
St. Petersburg, Florida 33701

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

STATEMENT OF THE ISSUE

Whether Respondent committed the violations alleged in the respective Administrative Complaints, and, if so, whether Petitioner should impose against Respondent an administrative fine, penalty, and survey fee.

PRELIMINARY STATEMENT

Respondent, Pine Tree Manor, Inc., d/b/a Pine Tree Manor (Respondent or Pine Tree Manor), operates a 24-bed assisted living facility located at 10476 131st Street, Largo, Florida. R.D. was a resident of the facility. There were no restrictions on R.D.'s ability to come and go from the facility. The only requirement placed on R.D. by Pine Tree Manor was that he record his absence on the sign-out log or verbally inform staff that he was leaving the facility.

On December 4, 2012, R.D. failed to return to Pine Tree Manor. On December 5, 2012, the sheriff's office was notified that R.D. was missing. Searches for R.D. were unsuccessful, and on December 12, 2012, he was found, deceased, in a wooded area. Pursuant to its investigation of the incident, the Agency for Health Care Administration (Petitioner or Agency), in Division of Administrative Hearings (DOAH) Case No. 13-2397, charged Pine Tree Manor with one Class I violation and sought to impose against Respondent a $6,000.00 administrative fine and a $500.00 survey fee.

On February 12, 2013, B.Y. was a resident of Pine Tree Manor. On this date, B.Y., was in a common area of the facility when she was found to be unresponsive and not breathing. The employee on duty when B.Y. was discovered did not call 911, but, instead, called the facility's administrator who, in turn, contacted emergency personnel. Emergency services arrived, but they were unsuccessful in their efforts to revive B.Y. Petitioner, in DOAH Case No. 13-2011, charged Pine Tree Manor with one Class I violation and sought an $8,000.00 administrative fine and revocation of Respondent's license to operate as an assisted living facility.

Pine Tree Manor filed petitions for formal administrative hearing in the respective cases, and the matters were referred to DOAH where they were consolidated for a disputed fact hearing.

At the final hearing, Petitioner presented the testimony of: Billy L. Snyder, Petitioner's operations management consultant manager; Richard Sherman, firefighter/paramedic; Catherine Anne Avery, who also works for Petitioner as an operations and management consultant manager; Laura Manville, a surveyor/investigator for Petitioner; Ygnacia Rosario, Jennifer Gomez, Laura Munoz and Rosalinda Martinez, Pine Tree Manor employees; and J.M., a resident of Pine Tree Manor. Both Petitioner and Respondent presented testimony from Brent Sparks, owner and administrator of Pine Tree Manor; and Hugh D. Thomas III,

brother and power-of-attorney for resident R.D. Respondent also, through deposition, presented the testimony of James Flatley, who works with the Department of Children and Family Services, Adult Protective Services.

In DOAH Case No. 13-2011, Petitioner's Exhibits A, B, and D through J, Respondent's Exhibits 1, 7, and the deposition of James Flatley were admitted into evidence. In DOAH Case No. 13-2397, Petitioner's Exhibits A through I, and K through M were admitted into evidence. No exhibits were admitted into evidence on behalf of Respondent in DOAH Case No. 13-2397.

A three-volume Transcript of the proceeding was filed with DOAH on September 10, 2013. The parties were granted an extension of time to each file a proposed recommended order. Each party timely filed a Proposed Recommended Order, and the same were considered in the preparation of this Recommended Order.

FINDINGS OF FACT

A. DOAH Case No. 13-2011: Failure to Properly Train, Supervise, and Perform CPR

1. Pine Tree Manor is licensed by the Agency for Health Care Administration to operate a 24-bed assisted living facility. The facility's license number is 8317, and it expires on November 13, 2014.

2. On February 12, 2013, the date of the incident that provides the basis for the instant action, Aurelia Cristobal was employed as a staff member at the facility operated by Pine Tree

Manor. Spanish is Ms. Cristobal's native language, and her ability to speak English is very limited. Brent Sparks, the owner and administrator at Pine Tree Manor, acknowledged, when interviewed as part of the post-incident investigation, that Ms. Cristobal struggles at times with English, especially when under stress. Mr. Sparks was aware of Ms. Cristobal's limitations with English prior to February 12, 2013. Within a few days of B.Y.'s death, Ms. Cristobal left the United States and is believed to be currently living in Mexico. Ms. Cristobal did not testify during the final hearing.

3. For the period June 15, 2011, through June 15, 2013, Ms. Cristobal was certified by the American Safety & Health Institute in the areas of automated external defibrillation (AED), cardiopulmonary resuscitation (CPR), and basic first aid. In the spring of 2011, Ms. Cristobal received training from Pine Tree Manor in the areas of facility emergency procedures and do not resuscitate (DNR) orders.

4. Pine Tree Manor's written emergency procedures provide, in part, as follows:

> In all emergencies, it is important to remain calm and display a sense of control. Upsetting our residents will only induce undue stress.
>
> DIAL "911" EMERGENCY in the following cases:
>
> - A medical emergency such as serious injuries or life threatening incidences.

- Fires

- Bodily harm to staff or residents such as terrorism, robbery, inclement weather.

> Call the administrator if there is any question concerning injury or illness, a resident is missing, security of facility is in doubt, or inspectors enter the facility. In the case of any significant changes or emergency, call the family, guardian and a health care provider. Also, contact the administrator. In cases of non-emergency need for transportation to the hospital or emergency room, call SUNSTAR AMBULANCE SERVICE @ 530-1234. In all cases, use common sense and remain calm, and remember to contact the administrator if in doubt.

5. Pine Tree Manor's policy regarding DNR orders provides that:

> In the event a resident with a signed DNR experiences cardiopulmonary arrest, our policy is for staff trained in CPR/AED to withhold resuscitative treatment. Staff will report to the administrator immediately and in turn notify [the] resident's medical providers and resident representative. For example, staff on duty shall call 911 to report the condition, or if on Hospice [place] a call to (727) 586-4432, the Lavender Team Patient Leader.

6. B.Y. became a resident of Pine Tree Manor on or about December 23, 2010. B.Y. did not execute a DNR directive.

7. On February 12, 2013, between the hours of approximately 5:00 p.m. and 7:00 p.m., Ms. Cristobal was the only employee on site at Pine Tree Manor. According to J.M., who on February 12, 2013, was a resident at Pine Tree Manor, B.Y. entered a common area of the facility where J.M. and other residents were located.

J.M. advised that B.Y. sat on the sofa, and started watching television. While on the sofa, B.Y. stopped breathing. The evidence is inconclusive as to how long B.Y. was incapacitated before others learned of her condition.

8. Although it is not clear from the testimony how Ms. Cristobal was informed of B.Y.'s peril, she did, at some point, learn that B.Y. was incapacitated and was experiencing a medical emergency. After learning of B.Y.'s situation, Ms. Cristobal, according to J.M., became nervous and "didn't know what to do." In fact, Ms. Cristobal was so nervous that she did not call 911, she did not check B.Y. for a pulse, and she did not perform CPR on B.Y. Ms. Cristobal did, however, make several attempts to contact Mr. Sparks. Ms. Cristobal eventually reached Mr. Sparks and advised him of the situation with B.Y. The evidence does not reveal how long B.Y. remained incapacitated before Ms. Cristobal was able to speak with Mr. Sparks.

9. When Mr. Sparks received the call from Ms. Cristobal, he was at his residence in Hillsborough County. Pine Tree Manor is located in Pinellas County. Because Mr. Sparks was in Hillsborough County when he received the call from Ms. Cristobal, he was not able to call 911 and be immediately connected to an emergency operator in Pinellas County. Understanding this limitation, Mr. Sparks called the non-emergency number for the

Pinellas County Sheriff's office, who, in turn, contacted the 911 operator and informed them of the emergency.

10. In the course of discussing the emergency situation with Ms. Cristobal, Mr. Sparks learned that she had not called 911. Knowing the emergency nature of the situation and the fact that he could not call Pinellas County 911 directly, Mr. Sparks should have directed Ms. Cristobal to call 911, since she was located in Pinellas County, but he did not. Mr. Sparks should have also instructed Ms. Cristobal to start CPR on B.Y., but he did not.

11. According to the Pinellas County Emergency Medical Services (EMS) Patient Care Report for B.Y., the 911 call was received by the 911 dispatcher at 6:11 p.m. and an EMS unit was dispatched to Pine Tree Manor at 6:12 p.m. The EMS unit arrived at the facility at 6:15 p.m. and commenced treating B.Y. at 6:16 p.m. EMS personnel worked for nearly 30 minutes to revive B.Y., but their efforts were unsuccessful.

12. Richard Sherman (EMT Sherman) is a firefighter and paramedic for the Pinellas Suncoast Fire District. EMT Sherman was the first paramedic to arrive at Pine Tree Manor on the day in question. Upon arrival at the facility, EMT Sherman attempted to enter through the facility's main door, but could not gain immediate entry because the door was locked. EMT Sherman rang the doorbell and knocked on the door in an attempt to gain entry

into the facility. Resident J.M. opened the door, and EMT Sherman entered the facility.

13. Upon entry, EMT Sherman noticed that B.Y. was unresponsive on the sofa. He also observed at the same time that there were several residents in B.Y.'s immediate area and that there was no staff present. When EMT Sherman arrived, Ms. Cristobal was in another part of the facility assisting a resident who had become upset because the resident was having difficulty satisfying her toileting needs. Approximately a minute after EMT Sherman started resuscitation efforts on B.Y., Ms. Cristobal appeared in the area where B.Y. was located.

14. Because Ms. Cristobal was wearing scrubs, EMT Sherman correctly identified her as a facility employee. EMT Sherman asked Ms. Cristobal if she knew anything about B.Y. and the circumstances surrounding her collapse. Ms. Cristobal did not respond to EMT Sherman's questions. EMT Sherman testified that Ms. Cristobal, after not responding to his questions, simply "looked at [him] and then turned and walked away" towards the main doors of the facility.

15. While continuing to attempt to resuscitate B.Y., EMT Sherman noticed that Ms. Cristobal appeared to be locking the doors that he had just entered. EMT Sherman instructed Ms. Cristobal several times to not lock the doors because more emergency personnel would soon be arriving. Apparently not

understanding EMT Sherman's directives, Mr. Cristobal locked the doors. A few minutes later, district fire chief John Mortellite arrived at the facility. EMT Sherman, while continuing to work on B.Y., heard District Chief Mortellite banging on the locked main doors in an effort to gain entry to the facility. A resident eventually unlocked the doors, and District Chief Mortellite entered the building.

16. When asked why Ms. Cristobal would call him in an emergency situation and not 911, Mr. Sparks explained that it was Ms. Cristobal's practice to always call him in an emergency and that he would, in turn, manage the situation. Mr. Sparks, by allowing Ms. Cristobal "to always call him" in emergency situations instead of 911, created an alternative practice that was directly contrary to the facility's written policy which clearly directs employees to "DIAL '911'" when confronted with a medical emergency. Ms. Cristobal was, therefore, not properly trained.

17. Mr. Sparks, by establishing and, indeed, encouraging a practice that shielded Ms. Cristobal from directly communicating with 911, placed B.Y. in a position where there was an unacceptable delay, though not precisely quantifiable, in contacting emergency personnel on her behalf. In a life or death situation such as that experienced by B.Y., every second matters because, as noted by EMT Sherman, "the longer the delay [in

receiving medical treatment] the less probability of a positive outcome."

18. When EMT Sherman arrived at Pine Tree Manor, he was completely unaware of the fact that the only employee on site spoke little, if any English. It is, therefore, reasonable to infer that Mr. Sparks failed to inform either the Pinellas County Sheriff's Office or the 911 operator of Ms. Cristobal's limitations with the English language.

19. By Ms. Cristobal's not calling 911, and Mr. Sparks' not disclosing to the 911 operator that the only employee on site had limited English language skills, decedent B.Y. was placed in the unenviable position of having EMT Sherman's attention divided between resuscitation efforts and worrying about whether Ms. Cristobal was able to comply with his instructions. EMT Sherman testified that Pinellas County EMS, including 911 operators, has protocols in place for dealing with individuals that may not speak English. Had either Mr. Sparks disclosed to the 911 operator Ms. Cristobal's language limitations or had Ms. Cristobal herself called 911, protocols could have been implemented by emergency personnel that would have triggered certain safeguards designed to ensure that Ms. Cristobal's language limitations did not interfere with the delivery of emergency services to B.Y.

B. DOAH Case No. 13-2397:
Failure to Remain Generally Aware of the Whereabouts of Resident

20. Most recently, R.D., on September 27, 2010, became a resident of Pine Tree Manor. A demographic data information survey was prepared as part of R.D.'s new resident intake process. R.D.'s intake data showed that he was independent in the areas of ambulation, bathing, dressing, toileting, eating, and transferring. R.D. was identified as needing supervision when performing tasks related to personal grooming. It was also noted that R.D. suffered from anxiety and panic attacks. According to R.D.'s brother Tom, R.D. was under the care of a psychiatrist for many years and "suffered from debilitating panic attacks." When suffering a panic attack, R.D. would often lay on the ground or floor, most often in a fetal position, and remain in this position until help arrived.

21. As a part of the new resident intake process, R.D. was assessed for his risk of elopement. The assessment revealed that R.D. was not at risk for elopement and that he was free to "come and go [from the facility] as he pleases" and that he needed to "sign out" whenever leaving the facility.

22. By correspondence dated March 14, 2011, the administration of Pine Tree Manor reminded R.D. that he needed to adhere to the facility's resident sign-out procedure whenever leaving from and returning to the facility. Approximately ten months after reminding R.D. of the facility's sign-out procedure,

Mr. Sparks, on January 2, 2012, updated R.D.'s risk assessment form and again noted thereon that R.D. "may come and go as he pleases" and he "[n]eeds to remember to sign out" when leaving the facility.

23. On May 23, 2012, R.D. was evaluated by a physician and it was noted, in part, that R.D. could function independently in the areas of ambulation, bathing, dressing, eating, grooming, toileting, and transferring. As for certain self-care tasks, the evaluating physician noted that R.D. needed assistance with preparing his meals, shopping, and handling his personal and financial affairs. It was also noted that R.D. needed daily oversight with respect to observing his well-being and whereabouts and reminding him about important tasks. The evaluating physician also noted that R.D. needed help with taking his medication.[1/] The evaluation was acknowledged by Mr. Sparks as having been received on May 25, 2012.

24. R.D.'s most recent itemization of his medications shows that on October 10, 2012, he was prescribed Clonazepam and Buspirone. The Clonazepam was administered three times a day at 8:00 a.m., noon, and 8:00 p.m. The Buspirone was administered four times a day at 8:00 a.m., noon, 5:00 p.m., and 8:00 p.m. These medications are often prescribed for anxiety, however, R.D.'s medications listing form does not expressly denote why the drugs were prescribed.

25. At 7:58 a.m., on November 10, 2012, an ambulance from the Pinellas County EMS was dispatched to Pine Tree Manor. When the EMS unit arrived at 8:00 a.m., R.D. was found "on the ground or floor" and was complaining of feeling anxious. While being treated by EMS, R.D. took his 8:00 a.m. dose of Clonazepam and was transported to "Largo Med." Less than 24 hours later, EMS, at 4:29 a.m., on November 11, 2012, was dispatched to 13098 Walsingham Road, because R.D. was again complaining of feeling anxious. This location is apparently near Pine Tree Manor, as the EMS Patient Care Report for this service call notes that R.D. "walked to [the] store." Following the evaluation by EMS, R.D. was again transported to "Largo Med."

26. At 12:24 p.m., on November 18, 2012, EMS was dispatched to a location near Pine Tree Manor where R.D. was found "lying supine on [the] sidewalk." According to the EMS report, R.D. advised that he became lightheaded and fell to the ground. R.D. did not complain of any other symptoms and was transported to a medical facility in Largo for further evaluation.

27. At 1:27 p.m., on November 25, 2012, EMS was dispatched to a 7-11 store near Pine Tree Manor. Upon arrival at the store, EMS personnel found R.D. and, when questioned, he advised that he was again feeling anxious. Per R.D.'s specific request, as noted on the EMS report, he was transferred to St. Anthony's Hospital in St. Petersburg.

28. On November 28, 2012, Mr. Sparks made an entry into R.D.'s file and noted that a neurosurgeon evaluated R.D.'s shunt on that date in an attempt to determine if a malfunction was the cause of R.D.'s panic attacks. Mr. Sparks noted in the record that the doctor advised that the shunt was working properly and that the shunt was ruled out as the "cause of [R.D.'s] panic attacks." As of November 28, 2012, Mr. Sparks was aware that R.D. had recently complained of experiencing panic attacks and that the cause of the same had not yet been determined.

29. It was not confirmed, although it was certainly believed by Mr. Sparks, that R.D. was manipulating medical personnel at local treatment facilities for the purpose of securing medication beyond that prescribed by his regular treating physicians. This belief by Mr. Sparks is reasonable especially in light of R.D.'s request to EMS personnel on November 25, 2012, that he was to be transported to a medical facility other than "Largo Med" for treatment related to his feelings of anxiety.[2/]

30. R.D.'s medication record for December 4, 2012, shows that he was given his prescribed medication for the 8:00 a.m. dispensing time. Soon after receiving his medication, R.D. left Pine Tree Manor for the purpose of visiting his local congressman's office. According to the survey notes from the investigation related hereto, the congressman's office is located

approximately two miles from Pine Tree Manor. Although it cannot be confirmed, it reasonably appears that R.D. walked to the congressman's office.

31. R.D. did not sign out of the facility when he left Pine Tree Manor on the morning of December 4, 2012. R.D. did, however, inform facility staff that he was going to the congressman's office to discuss an issue.[3/]

32. Security video from the building where the congressman's office is located established that R.D. arrived at the congressman's office at 9:50 a.m. At approximately 10:45 a.m., a representative from the congressman's office called Pine Tree Manor and informed them that R.D. was ready to return to the facility.

33. The person receiving the message from the congressman's office contacted Mr. Sparks and informed him that R.D. was requesting a ride back to Pine Tree Manor from the congressman's office. Mr. Sparks was assisting another resident at a local hospital when he received the request to transport R.D. and was, therefore, unable to transport R.D. from the congressman's office. Pine Tree Manor had no obligation to provide transportation services to R.D.

34. Surveillance video from the building where the congressman's office is located confirmed that R.D. exited the building on December 4, 2012, at approximately 10:50 a.m. R.D.'s

body was found on December 12, 2012. It is not known what happened to R.D. between the time he left the congressman's office and when his body was eventually discovered.[4/]

35. When Mr. Sparks returned to Pine Tree Manor on December 4, 2012, he was advised by staff that R.D. had not returned from the congressman's office. According to the posted work schedule for December 4, 2012, Mr. Sparks worked from 7:00 a.m. to 5:00 p.m. When Mr. Sparks left Pine Tree Manor on December 4, 2012, R.D. had not returned. Mr. Sparks, upon leaving the facility for the day, instructed staff (Aurelia Cristobal) to call him when R.D. returned. Ms. Cristobal's shift ended at 8:00 p.m.

36. Pine Tree Manor employee Laura Munoz worked from 7:00 p.m. on December 4, 2012, to 7:00 a.m. on December 5, 2012. Ms. Munoz was not responsible for assisting R.D. with his medication, so it is unlikely that she would have known that R.D. missed receiving his medication prior to her arrival at work. Because Mr. Sparks left Pine Tree Manor on December 4, 2012, before Ms. Munoz arrived for work, he called Ms. Munoz after her shift started (precise time unknown) and requested that she call him upon R.D.'s return. There were no instructions given to Ms. Munoz by Mr. Sparks as to what she should do if R.D. did not return by some time certain. On December 4, 2012, Mr. Sparks knew that R.D. had never spent the night away from Pine Tree

Manor without someone at the facility knowing R.D.'s whereabouts and that R.D. had never gone unaccounted for a period greater than 12 hours.

37. On December 5, 2012, Mr. Sparks' scheduled work time was from 7:00 a.m. to 5:00 p.m. Prior to reporting to the facility on the morning of December 5, 2012, Mr. Sparks learned that R.D. had not returned to his room during the night shift. The exact time is not known when Mr. Sparks acquired this information, but it was likely sometime around 6:30 a.m.

38. After learning that R.D. was still unaccounted for, Mr. Sparks immediately began canvassing the area near Pine Tree Manor. Around this same time, Mr. Sparks contacted R.D.'s brother and apprised him of the situation. At approximately noon on December 5, 2012, Mr. Sparks contacted the Pinellas County Sheriff's Office and reported R.D. missing.

39. Pine Tree Manor has an elopement and missing residents policy that provides, in part, as follows:

> Residents may come and go as they please and shall not be detained unless family/resident representative and administrator agree supervision is required.
>
> A resident leaving the facility should either sign out by the front door or inform a staff member of their departure and provide an estimated time of return. The staff person should sign the resident out and notify other staff on duty. . . .
>
> If a resident . . . is deemed missing, staff shall immediately search the entire

> facility inside and around the facility grounds. . . . Whenever a resident is not found within the facility or its premises, the Administrator will:
>
> - Notify the resident's representative.
> - Notify the County Sheriff's Department by calling 911.
> - Provide staff and searching parties with information and photo I. D.
> - Instruct the staff to search inside the facility and the premises, the adjacent residential properties to the facility, up and down 131st Street, 102nd Avenue and the cross streets.

CONCLUSIONS OF LAW

40. DOAH has jurisdiction over the parties and subject matter of this proceeding. §§ 120.569 & 120.57(1), Fla. Stat. (2012).[5/]

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

42. 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.

C. DOAH Case No. 13-2397: Failure to Maintain General Awareness of Resident R.D.'s Whereabouts

43. Florida Administrative Code Rule 58A-5.0182(1)(c) provides, in part, that an assisted living facility shall maintain "[g]eneral awareness of the resident's whereabouts." At what point is it reasonable to conclude that Pine Tree Manor ceased being generally aware of R.D.'s whereabouts?

44. The undisputed evidence establishes that the last contact that Pine Tree Manor had with R.D. occurred at approximately 10:45 a.m., on December 4, 2012, when staff from the congressman's office called and advised that R.D. was requesting transportation back to Pine Tree Manor. While it is true that on December 4, 2012, R.D. missed his noon, 5:00 p.m., and 8:00 p.m. medication intervals at Pine Tree Manor, this was insufficient in and of itself to alert Pine Tree Manor that R.D. was missing, given that R.D. was known to routinely seek medication from health facilities in the community.

45. Given that Mr. Sparks knew that R.D. had never gone unaccounted for more than 12 consecutive hours and that R.D. had never stayed away from the facility overnight without his whereabouts being known, Mr. Sparks, when he spoke with Ms. Munoz during the evening hours of December 4, 2012, should have instructed Ms. Munoz to call him if R.D. had not returned by 11:00 p.m. Consequently, it was at 11:00 p.m., on December 4, 2012, when Pine Tree Manor reasonably lost general awareness of R.D.'s whereabouts.

46. As noted in the Findings of Fact, Mr. Sparks started searching for R.D. at approximately 6:30 a.m., on December 5, 2012. R.D. was missing for nearly eight hours before anyone from Pine Tree Manor started trying to determine his whereabouts.

47. There is evidence that R.D.'s pacemaker showed an accelerated heart rate twice during the morning hours of December 5, 2012. However, there is no competent evidence as to the significance of R.D.'s elevated heart rate in terms of establishing an approximate time of death, and the autopsy report does not otherwise set forth when R.D. likely died.

48. Section 408.813(2)(a), Florida Statutes, which is incorporated by reference into section 429.19, Florida Statutes, defines Class I violations as "those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines 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."

49. While it is certainly the case that a situation involving a missing resident constitutes a "major incident," as defined by rule 58A-5.0131, it cannot be said on the record in the instant case that Pine Tree Manor was confronted with circumstances between 11:00 p.m. on December 4, 2012, and 6:30 a.m. on December 5, 2012, that clearly and convincingly put the facility on notice that R.D. was in "imminent danger of death or serious physical harm." The evidence does, however, establish a Class II violation because a nearly eight-hour delay in commencing the search for R.D. was clearly a direct threat to his physical or emotional health, safety, or security within the meaning of section 408.813(2)(b).

D. DOAH Case No. 13-2011: Failure to Properly Respond in Emergency Situation

50. Paragraph 9 of the Complaint alleges that "[t]he facility failed to provide appropriate care and supervision in an emergency situation where time was of the essence. CPR needed to be, but was not, immediately started and 911 needed to be, but was not, immediately called. The resident died."

51. Section 429.02(10) defines an "emergency" to mean "a situation, physical condition, or method of operation which presents imminent danger of death or serious physical or mental

harm to facility residents." B.Y. at all times relevant hereto was in an emergency situation.

52. Rule 58A-5.0182(1)(b) provides that assisted living facilities shall offer personal supervision, as appropriate, for each resident, which shall include "[d]aily 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."

53. Section 429.28(1)(j) provides that every resident of a facility shall have the right of "[a]ccess to adequate and appropriate health care consistent with established and recognized standards within the community."

54. Section 429.255(4) provides, in part, as follows:

> Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 . . . . The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

This section establishes the standard for assisted living facilities with respect to the delivery and non-delivery of CPR.

55. B.Y. did not execute a DNR order and Ms. Cristobal was not a physician. Ms. Cristobal, as the CPR trained staff member on duty at the time of B.Y's emergency, was required to perform

CPR on B.Y., as directed by section 429.255(4), and she failed to do so.

56. As dictated by the statutorily-imposed duty to ensure that B.Y. had access to adequate and appropriate health care, Ms. Cristobal was required to immediately call 911 upon discovering that B.Y. was in peril, and her failure to do so was a breach of the legal duty owed to B.Y.

57. As required by the legal duty to ensure that B.Y. had access to adequate and appropriate health care, Pine Tree Manor, acting through Mr. Sparks, was required to properly train Ms. Cristobal as to appropriate ways to respond in an emergency situation. Mr. Sparks failed to properly train Ms. Cristobal as to how to respond in an emergency situation, and this failure resulted in a breach of the duty owed to B.Y. to ensure that she had access to adequate and appropriate health care.

58. The failure of Mr. Sparks to instruct Ms. Cristobal to call 911 breached Pine Tree Manor's duty to B.Y. to ensure that she had access to adequate and appropriate health care.

59. The failure of Mr. Sparks to instruct Ms. Cristobal to start CPR on B.Y. breached Pine Tree Manor's duty to B.Y. to ensure that she had access to adequate and appropriate health care.

60. Mr. Spark's failure to inform emergency personnel that the sole staff person at Pine Tree Manor had limited English

language skills breached Pine Tree Manor's duty to B.Y. to ensure that she had access to adequate and appropriate health care.

61. Respondent's conduct constitutes a Class I violation within the meaning of section 429.19(2)(a).[6/]

E. Administrative Fines and Survey Fees

62. Respondent committed one Class I violation and one Class II violation. Section 429.19(2)(a) provides that for Class I violations, the agency shall impose an administrative fine "in an amount of not less than $5,000 and not exceeding $10,000 for each violation." As for Class II violations, section 429.19(2)(b) provides that "[t]he agency shall impose an administrative fine . . . in an amount not less than $1,000 and not exceeding $5,000 for each violation."

63. Section 429.19(3) provides as follows:

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

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

(e) The licensed capacity of the facility.

64. As for the Class II violation involving R.D., the near eight-hour delay in recognizing that R.D. was missing constitutes a serious violation of the applicable laws and rules governing assisted living facilities. This factor weighs in favor of imposing the maximum fine allowed.

65. Respondent was previously cited for a Class III violation for the failure to maintain a general awareness of R.D.'s whereabouts. On March 13, 2011, R.D. was being seen at a local hospital for an apparent anxiety attack. When personnel from the hospital called Pine Tree Manor to confirm that R.D. was a resident at the facility, the employee fielding the call advised the hospital that R.D. was in his room when it was clear that he was not. The March 13, 2011, and December 4, 2012, incidents collectively establish that Pine Tree Manor lacks institutional control and weigh in favor of imposing the maximum fine allowed for the instant Class II violation.

66. In the case involving R.D., the facility maintains that it did nothing wrong. The evidence shows otherwise. There has been no showing that Respondent has taken steps to ensure that appropriate safeguards have been implemented that will allow the facility to generally keep track of the whereabouts of its residents. This factor weighs in favor of imposing the maximum

fine allowed. The other factors have been considered and do not weigh in favor of a lesser fine.

67. As for the Class I violation stemming from the complaint involving B.Y., the undersigned considered all of the factors set forth in section 429.19(3) and concludes that there are no mitigating factors that weigh in favor of a fine less than that recommended by Petitioner.

68. Petitioner seeks to impose against Respondent in DOAH Case No. 13-2397 a $500 survey fee pursuant to section 429.19(7). Section 429.19(7) provides, in part, that "[i]n addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation . . . ." In light of the Conclusions of Law set forth above, the $500 survey, which Petitioner seeks to impose against Respondent, is appropriate.

F. Administrative Penalty

69. Petitioner, pursuant to section 429.14, seeks to revoke Respondent's license to operate as an assisted living facility. As grounds for revocation, Petitioner contends in its Administrative Complaint in DOAH Case No. 13-2011, that revocation is appropriate because the "facility has been charged with two Class I deficiencies within a two month time span,

giving the Agency more than sufficient grounds for license revocation under section 429.14(1)(e)1." Section 429.14(1)(e)1. allows for license revocation where a licensee commits one or more Class I deficiencies.

70. Petitioner's belief that Respondent's license should be revoked seems to be motivated primarily by its belief that Respondent committed two Class I violations "within a two month time frame." While Petitioner charged Respondent with committing two Class I deficiencies, the evidence only establishes the existence of one Class I and one Class II deficiency.

71. Petitioner, in its Administrative Complaint in DOAH Case No. 13-2011, also alleges that the facts, "both individually and collectively, provide sufficient grounds on which the Agency may revoke Respondent's licensure to operate an assisted living facility in the State of Florida." This charge by Petitioner recognizes, and certainly provides notice to Respondent that a single Class I violation may provide grounds for the revocation of its license in the instant proceeding.

72. In the opinion of the undersigned, Respondent committed two very serious violations, and the recommended total fine of $13,000.00 supports this conclusion. While it is certainly arguable that the nearly eight-hour delay in starting the search for R.D. could have been a contributing factor in his demise, the Department failed to establish by clear and convincing proof that

the delay was, in fact, a contributing legal cause in R.D.'s death. Similarly, in B.Y.'s case it is clear that Pine Tree Manor failed to properly train and supervise its staff and that there was an unacceptable delay in contacting 911. The Department failed, however, to establish by clear and convincing proof that these factors contributed to the unsuccessful efforts of EMS personnel to revive B.Y. These factors militate against license revocation. The other factors enumerated in section 429.13(3) have been considered, and they do not sway the recommendation in favor of license revocation.

RECOMMENDATION

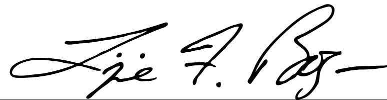
Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration:

1) Enter in Agency Case No. 2013002572 (DOAH Case No. 13-2397) a final order finding that Respondent, Pine Tree Manor, Inc., d/b/a/ Pine Tree Manor, committed a Class II violation and assessing an administrative fine of $5,000.00 and a survey fee of $500.00.

2) Enter in Agency Case No. 2013004620 (DOAH Case No. 13-2011) a final order finding that Respondent, Pine Tree Manor, Inc., d/b/a/ Pine Tree Manor, committed a Class I violation and assessing an administrative fine of $8,000.00.

It is also RECOMMENDED that the final order not revoke Respondent's license to operate an assisted living facility in the State of Florida, but, instead, suspend Respondent's license for a period of 60 days.[7/]

DONE AND ENTERED this 5th day of December, 2013, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 5th day of December, 2013.

ENDNOTES

[1/] On February 24, 2012, a resident health assessment was completed, and it was noted therein that R.D. "[n]eeds assistance with self-administration of medications." The physician that evaluated R.D. in May 2012 also noted that R.D. needed help with taking his medication, but failed to check the box to indicate whether R.D. needed help with self-administration or needed to have his medication administered to him. Either way, Pine Tree Manor was on notice that R.D. needed assistance when taking his medication.

[2/] Mr. Sparks' belief as to R.D.'s acts of manipulation are further supported by an entry made by Mr. Spark in R.D.'s file on November 3, 2012, wherein it was noted that R.D. had made his "weekly visit to the ER," that there were "no issues," and that R.D. "just thinks he needs to go" to the emergency room.

[3] Admitted into evidence is a copy of a "resident sign out" registry showing that R.D. signed out of the facility at "9:00" on December 5, 2012, to go to his congressman's office and that his estimated time of return was "11:00." Mr. Sparks admitted that he, and not R.D., actually made the registry entries. The facility's governing policy authorizes either the resident or staff to make entries in the registry. Although the registry reflects that R.D. was estimated to return at 11:00 (no a.m. or p.m. designation noted), there was no evidence establishing that R.D. informed facility personnel of his expected return time. The "11:00" entry was arbitrarily created by Mr. Sparks.

[4] R.D. wore a pacemaker. It is reported that an analysis of the pacemaker showed that on the morning of December 5, 2012, R.D.'s heart rate was elevated to a high level on two occasions.

[5] All subsequent references to Florida Statutes will be to 2012, unless otherwise indicated.

[6] Respondent's reliance on Pic N' Save, Inc. v. Department of Business Regulation, Division of Alcoholic Beverages & Tobacco, 601 So. 2d 245, 256 (Fla. 1st DCA 1992), is misplaced as the instant case is not based on principles on respondeat superior, but, instead, on Respondent's failure to properly train and supervise its employees.

[7] In order to allow for an orderly transition and to minimize any resulting disruption to the residents of the facility and their families or other responsible individuals, it is recommended that the final order provide a 30-day grace period before the period of suspension commences.

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.