STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

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

Respondent.
_____/

DCA No. 2D14-644

DOAH Nos. 13-2011
13-2397

AHCA No. 2013002572
2013004620
License No. 8317
File No. 11942985
Provider Type: Assisted Living Facility
RENDITION NO.: AHCA- 14 - 0863 **-S-OLC**

AMENDED FINAL ORDER

Having reviewed the Administrative Complaints, Recommended Order, Final Order, Settlement Agreement, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the Respondent the attached Administrative Complaints and Election of Rights forms. (Ex. 1) The Election of Rights forms advised the Respondent of the right to an administrative hearing pursuant to Sections 120.57(1) and 120.57(2), Florida Statutes.

2. The Respondent filed petitions for formal hearing and the matters were forwarded to the Division of Administrative Hearings. After the conclusion of the hearing, the Administrative Law Judge issued a Recommended Order finding and recommending that: (a) the Respondent committed a class II violation and the Agency should assess an administrative fine of $5,000.00 and a survey fee of $500.00, (b) the Respondent committed a class I violation and the Agency should assess an administrative fine of $8,000.00, and (c) the Agency should suspend the Respondent's license for a period of 60 days with a 30-day grace period for the orderly transition of the assisted living facility residents. (Ex. 2)

3. The Agency timely filed Exceptions to the Recommended Order contesting the penalty of license suspension rather than license revocation. Thereafter, the Agency issued a Final Order revoking the Respondent's license to operate this assisted living facility. (Ex. 3)

4. The Respondent timely filed a Notice of Appeal to the District Court of Appeal. During the pendency of the appeal, the parties entered into a Settlement Agreement allowing for a change of ownership of the assisted living facility and imposing other terms and conditions upon the Respondent and its owner. (Ex. 4).

IT IS THEREFORE ORDERED:

5. The Final Order filed on February 5, 2014, is amended to reflect that the Respondent's license is no longer revoked so that it may be the subject of a change of ownership application filed by

Heather Haven III, Inc. The imposition of the $5,000.00 and $8,000.00 administrative fines and the $500.00 survey fee against the Respondent remain in effect.

6. The agreed upon restrictions set forth in the Settlement Agreement as to the Respondent and the Respondent's owner are imposed. The Central Systems Bureau shall maintain an alert in its system in order to enforce these restrictions.

ORDERED in Tallahassee, Florida on this 24 day of October, 2014.

Elizabeth Dudek, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of this Final Order has been furnished by the method designated to the persons named below on this 27th day of October, 2014.

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Jan Mills Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Catherine A. Avery, Unit Manager Assisted Living Unit Agency for Health Care Administration (Electronic Mail)

Finance and Accounting Revenue Management Unit Agency for Health Care Administration (Electronic Mail)	Patricia Caufman, Field Office Manager Local Field Office Agency for Health Care Administration (Electronic Mail)
Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Cynthia Hain, Assistant General Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)
Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Thomas M. Hoeler, Chief Facilities Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)
Donna Damiani, Owner/Representative Heather Haven III, Inc. 725 Edgewater Drive Dunedin, FL 34698 (U.S. Mail)	Theodore Mack, Esquire Powell and Mack 3700 Bellwood Drive Tallahassee, Florida 32303 (U.S. Mail)
Linzie F. Bogan Administrative Law Judge Division of Administrative Hearings (Electronic Mail)	

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No.: 2013002572

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

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

The State of Florida Agency for Health Care Administration (hereinafter "Petitioner" or "Agency"), by and through the undersigned counsel, files this Administrative Complaint against Pine Tree Manor, Inc. d/b/a Pine Tree Manor (hereinafter "Respondent"), pursuant to Section § 120.569 and Section § 120.57, Florida Statutes (2012), and alleges:

NATURE OF THE ACTION

This is an action to impose an administrative fine in the amount of $6,000.00 based upon one State Class I deficiency pursuant to Section § 429.19(2)(a), Florida Statutes (2012) and the imposition of a survey fee of $500.00 pursuant to the provisions of Section § 429.19(7), Florida Statutes (2012), for a total assessment of $6,500.00.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to Section § 20.42, Section § 120.60 and Chapters 408, Part II, and 429, Part I, Fla. Stat. (2012).

EX 1

2. Venue lies pursuant to Florida Administrative Code Rule 28-106.207.

PARTIES

3. The Agency is the regulatory authority responsible for licensure of assisted living facilities and enforcement of all applicable regulations, state statutes and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code.

4. Respondent operates a 24-bed assisted living facility (hereafter "ALF") located at 10476 131st Street, Largo, Florida 33774, and is licensed as an ALF, license number 8317.

5. Respondent was at all times material hereto a licensed facility under the licensing authority of the Agency, and was required to comply with all applicable rules and statutes.

COUNT I – tag A0025

6. The Agency re-alleges and incorporates paragraphs one (1) through five (5) as if fully set forth herein.

7. Pursuant to Florida law:

> **Resident Care Standards:** An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
>
> 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.

Fla. Admin. Code R. 58A-5.0182(1)

***

Resident bill of rights

(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.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(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.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(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.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

Section 429.28, Fla. Stat. (2012)

***

Violations; imposition of administrative fines; grounds

(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* (emphasis supplied).

(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.

Section 429.19, Fla. Stat. (2012)

8. On December 11, 2012, the Agency conducted a complaint inspection, CCR #2012013296, of Respondent's assisted living facility, and found it out of compliance with the above statutes and rule.

9. Based on record review and interviews, the facility failed to maintain a general awareness of a resident's whereabouts. Findings included:

During an interview, Staff #B said that, on December 4, 2012, at approximately 8:00am, Resident #3 informed the facility that he was going to a nearby Congressman's office to discuss an issue. Staff #B also stated that, shortly before 11:00 AM that day, she took a call from the Congressman's

office informing them that the resident was ready to return to the facility. Staff #B said the Administrator was immediately contacted by cell phone and given the message.

During an interview, the administrator said he was at a different location assisting another resident and was unable to pick up Resident #3 right away. He returned to the facility and found out that Resident #3 had not returned. He said he gave a verbal order for the night shift to call him upon the resident's return. However, neither the administrator nor the staff followed up to confirm the resident's whereabouts until the morning of December 5th, at which time (according to the Administrator) Resident #3's family was notified.

Documents in the resident's file revealed that the resident's brother was contacted before breakfast. The Administrator called the Sheriff's office around Noon on December 5th to report that Resident #3 was missing. When questioned as to whether the resident had a history of staying out overnight without the facility knowing the administrator responded "No." When asked for the longest period of time that the resident had stayed away on his own, the administrator was not sure but said it was less than 12 hours.

As of the date of the survey, Resident #3 had still not returned to the facility and his whereabouts remained unknown.

The following day, December 12th at approximately 2:50 PM, the administrator phoned the Agency field office supervisor to report that the sheriff had located Resident #3 but that he had passed away. His body had been found in a wooded area off the road near the facility. By that time, the resident had been missing for more than one week.

10. The Respondent's failure to assure proper supervision and follow-up to assure the safety of all of its residents is unacceptable and violation of law.

11. The Agency determined that this deficient practice was related to the operation and maintenance of a provider or to the care of clients which the agency determined presented an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom..

12. The Agency cited the Respondent for a Class I violation in accordance with Section 429.19(2)(a), Florida Statutes (2012).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $6,000.00 against Respondent, an ALF in the State of Florida, pursuant to Section 429.19(2)(a), Florida Statutes (2012).

COUNT II

14. The Agency re-alleges and incorporates the entirely of this complaint as if fully set forth herein.

15. Pursuant to Section § 429.19(7), Florida Statutes: "[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 that was the subject of the complaint or monitoring visits conducted under s. 429.28(3)(c) to verify the correction of the violations."

16. On December 11, 2012, the Agency conducted a complaint inspection, CCR #2012013296, of Respondent's facility that resulted in violations found that are the subject of the complaint to the Agency.

17. Pursuant to Section § 429.19(7), Fla. Stat. (2012), such a finding subjects the Respondent to a survey fee equal to the lesser of one half of the Respondent's biennial license and bed fee or $500.00.

18. Respondent is therefore subject to a complaint survey fee of $500.00, pursuant to Section § 429.19(7), Fla. Stat. (2012).

WHEREFORE, the Agency intends to impose an additional survey fee of $500.00 against Respondent, an ALF in the State of Florida, pursuant to Section § 429.19(7), Florida Statutes (2012).

NOTICE OF RIGHTS

Respondent is notified of its right to request an administrative hearing pursuant to § 120.569, Florida Statutes. Respondent has the right to retain, and be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Bldg. #3, MS #3, Tallahassee, FL 32308; Telephone (850) 412-3630.

The Respondent is further notified that the failure to request a hearing within 21 days of receipt of this Complaint will result in an admission of the facts alleged in the Complaint and the entry of a final order by the Agency.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Administrative Complaint has been served by U.S. Certified Mail, Return Receipt No. 7011 0470 0000 7951 3197, to Brent Sparks, Administrator and Registered Agent, Pine Tree Manor, 10476 131st Street North, Largo, FL 33774-5504, this 27th day of March, 2013.

STATE OF FLORIDA, AGENCY FOR HEALTHCARE ADMINISTRATION

Suzanne Suarez Hurley, Esq.
Assistant General Counsel
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Copy to Paul Brown, AHCA Area 5

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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. **Case No.: 2013004620**

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

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

The State of Florida Agency for Health Care Administration (hereinafter "Petitioner" or "Agency"), by and through the undersigned counsel, files this Administrative Complaint against Pine Tree Manor, Inc. d/b/a Pine Tree Manor (hereinafter "Respondent"), pursuant to Section § 120.569 and Section § 120.57, Florida Statutes (2012), and alleges:

NATURE OF THE ACTION

This is an action for revocation of the facility's license and to impose an administrative fine in the amount of $8,000.00 based upon one State Class I deficiency pursuant to Section § 429.19(2)(a), Florida Statutes (2012).

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to Section § 20.42, Section § 120.60 and Chapters 408, Part II, and 429, Part I, Fla. Stat. (2012).

2. Venue lies pursuant to Florida Administrative Code Rule 28-106.207.

PARTIES

3. The Agency is the regulatory authority responsible for licensure of assisted living facilities and enforcement of all applicable regulations, state statutes and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code.

4. Respondent operates a 24-bed assisted living facility (hereafter "ALF") located at 10476 131st Street, Largo, Florida 33774, and is licensed as an ALF, license number 8317.

5. Respondent was at all times material hereto a licensed facility under the licensing authority of the Agency, and was required to comply with all applicable rules and statutes.

COUNT I – tag A0025

6. The Agency re-alleges and incorporates paragraphs one (1) through five (5) as if fully set forth herein.

7. Pursuant to Florida law:

> **Resident Care Standards:** An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
>
> > 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.

Fla. Admin. Code R. 58A-5.0182(1)

***

Resident bill of rights

(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.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(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.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to

provide safekeeping for funds as provided in s. 429.27.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(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.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

Section 429.28, Fla. Stat. (2012)

***

Violations; imposition of administrative fines; grounds

(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* (emphasis supplied).

(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.

Section 429.19, Fla. Stat. (2012)

8. On February 15, 2013, the Agency conducted a complaint survey, CCR #2013001690, of Respondent's assisted living facility, and found it out of compliance with the above statutes and rule.

9. Based on record review and interviews, the 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. Findings included:

The facility failed to provide staff sufficient to oversee the health and wellbeing of Resident #1. It failed to implement its own emergency policies; it did not contact emergency personnel or administer CPR upon discovering that the resident was unresponsive. Once emergency personnel finally did arrive, the staff failed to provide the necessary medical information.

During an interview, the administrator said Employee A had discovered Resident #1 unresponsive and slumped over on a couch in the common area. Employee A told him Resident #1 was "already blue" when discovered. Though Employee A was trained and certified in CPR, he explained, she "panicked" when Resident #1 was found "already blue" and not breathing.

Instead of staying with and assisting the unresponsive resident or calling 911, she ran to a phone to call him. "She calls me in emergencies," he said. He believes he told Employee A to "start compressions," but he did not know if she did.

During the incident, the administrator was at his home in Tampa. The facility is located in Pinellas County. Between 6:05 and 6:10 PM, after being notified by Employee A, he called the Pinellas County Sheriff's non-emergency phone number. "If I had called Tampa 911, they would have had to transfer me."

Employee A was primarily Spanish-speaking, he said, "but she understands English." He denied that there was any language barrier that might have impacted the resident's care. Language difficulties, if any, he said, "were related to "panicking."

During the incident, Resident #7 observed Resident #2 who stayed with Resident #1 on the couch and was trying to help her. He said that Employee A left Resident #1 unresponsive on the couch when she went to call the administrator.

The facility's emergency policy was clearly posted for home health agencies and visitors. It stated, "If an emergency should arise, please notify our staff. Emergency procedures are in place and our staff will call 911."

Employee A's personnel file contained documents indicating that she was trained in CPR, Emergency Procedures and the facility's DNR policies. Yet, no Do Not Resuscitate ("DNRO") Order was found in Resident #1's records.

On February 21, 2013, six days after the survey, the deputy chief of the local fire/rescue agency was interviewed. He said that when EMS arrived, Employee A was not with the resident and there was no evidence or indication to show that she had attempted CPR. Employee A was the only

staff person on duty. The deputy chief knew the sheriff's office had relayed the administrator's call to Pinellas County 911. Had the employee called, he said, his emergency (EMS) crew could have been at the facility within two minutes.

When his EMS team attempted resuscitation, Resident #1 responded with an intermittent heartbeat. However, her heart stopped beating during the transport to the hospital. He also was concerned that, after his EMS team arrived, they had difficulty obtaining Resident #1's medical files. One of them had to leave the resident's side in order to locate Employee A.

Employee A appeared unable to understand English. She gave EMS incorrect records to start with. Then, on being instructed to leave the front door unlocked to allow entry for other medical personnel, she locked the front door. This caused another unnecessary delay in emergency services for Resident #1.

EMS records showed that the 911 call came in (from the sheriff) at 6:11 PM and it's crew was dispatched at 6:12 PM. EMS was listed as "on scene" at 6:15 PM and "with patient/working a code" at 6:17 p.m. The EMS notes also indicated that, upon arriving at the facility, one of the residents opened the door. No staff member could be found. Employee A showed up only after care had been initiated.

The EMS notes reflected Employee A's inability to understand English. When EMS asked Employee A what happened, there was no verbal response. Instead, "she motioned that she did not understand English." The language barrier became even more apparent when an additional EMS unit arrived and could not gain access. There was documentation regarding her locking the front door after having been instructed not to and her inability to understand that they needed Resident #1's medical records.

The February 21, 2013, EMS Patient Care Report noted that CPR was initiated at 6:17 p.m. EMS planned to "terminate efforts" at 6:38 p.m. but continued the rescue effort when a pulse was located. Resident #1 was transported at 6:51 p.m. but her heartbeat stopped at 6:52 p.m. She was pronounced dead on arrival at the hospital.

10. The Respondent's failure to assure proper care and supervision by having staff at the facility who could sufficiently communicate in English, follow policies and procedures in emergencies and assure the safety of residents is unacceptable and serious violation of law.

11. The Agency determined that this deficient practice was related to the operation and maintenance of a provider or to the care of clients which the agency determined presented an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom.

12. The Agency cited the Respondent for a Class I violation in accordance with Section 429.19(2)(a), Florida Statutes (2012).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $8,000.00 against Respondent, an ALF in the State of Florida, pursuant to Section 429.19(2)(a), Florida Statutes (2012).

Count II – Revocation of License

13. The Agency re-alleges and incorporates paragraphs one through five and Count I of this Administrative Complaint as if fully set forth herein.

14. Pursuant to Florida law:

> **License or application denial; revocation.**
>
> (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:
>
> (a) False representation of a material fact in the license application or omission of any material fact from the application.
>
> (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.

(2) If a licensee lawfully continues to operate while a denial or revocation is pending in litigation, the licensee must continue to meet all other requirements of this part, authorizing statutes, and applicable rules and must file subsequent renewal applications for licensure and pay all licensure fees.

Section § 408.815, Fla. Stat. (2012)

***

Administrative penalties

(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.

(b) The determination by the agency that the owner lacks the financial ability to provide continuing adequate care to residents.

(c) Misappropriation or conversion of the property of a resident of the facility.

(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

(e) A citation of any of the following deficiencies as specified in s. 429.19:

1. One or more cited class I deficiencies.

2. Three or more cited class II deficiencies.

3. Five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.

(f) Failure to comply with the background screening standards of this part, s. 408.809(1), or chapter 435.

(g) Violation of a moratorium.

(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.

(i) An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the agency by the local authority having jurisdiction or the State Fire Marshal.

(j) Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter or chapter 400.

(k) Any act constituting a ground upon which application for a license may be denied.

(2) Upon notification by the local authority having jurisdiction or by the State Fire Marshal, the agency may deny or revoke the license of an assisted living facility that fails to correct cited fire code violations that affect or threaten the health, safety, or welfare of a resident of a facility.

(3) The agency may deny a license to any applicant or controlling interest as defined in part II of chapter 408 which has or had a 25-percent or greater financial or ownership interest in any other facility licensed under this part, or in any entity licensed by this state or another state to provide health or residential care, which facility or entity during the 5 years prior to the application for a license closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it.

(4) *The agency shall deny or revoke the license of an assisted living facility that has two or more class I violations that are similar or identical to violations identified by the agency during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.*

(5) An action taken by the agency to suspend, deny, or revoke a facility's license under this part or part II of chapter 408, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the 1facility be heard by the Division of

Administrative Hearings of the Department of Management Services within 120 days after receipt of the facility's request for a hearing, unless that time limitation is waived by both parties. The administrative law judge must render a decision within 30 days after receipt of a proposed recommended order.

(6) The agency shall provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation, on a monthly basis, a list of those assisted living facilities that have had their licenses denied, suspended, or revoked or that are involved in an appellate proceeding pursuant to s. 120.60 related to the denial, suspension, or revocation of a license.

(7) Agency notification of a license suspension or revocation, or denial of a license renewal, shall be posted and visible to the public at the facility.

Section 429.14, Fla. Stat. (2012)

15. The Respondent has a duty to provide care and services in accord with the minimum requirements of law and to ensure that residents are protected from harm that could materially affect their health, safety, and welfare.

16. The Respondent intentionally or negligently has failed to comply with these regulatory mandates and the failure to comply has materially or negatively impacted the health or safety of the residents.

17. The Respondent has violated the minimum requirements of law described with particularity in this Administrative Complaint.

18. The Respondent has a duty to maintain its operations in accord with the minimum requirements of law and to provide care and services within the mandatory minimum standards.

19. By failing to assure proper supervision, including the failure to have staff at the facility who could communicate sufficiently in English, follow policies and procedures in emergencies, and assure the safety of its residents, the Respondent created a condition or

practice that directly threatened the physical or emotional health, safety, or security of the residents.

20. This is the second death of a resident at this facility within two months, both of which raise concerns and suggest serious failures on the part of the administration of the facility. *See* Administrative Complaint dated March 27, 2013, attached as *Exhibit A*.

21. This 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., Florida Statutes (2012), above.

22. By failing to maintain its operations in accord with the minimum requirements of law and failing to provide care and services at mandated minimum standards, it is the Agency's contention that:

a. The gravity of these violations, individually and collectively, is severe due to intentional failures, reckless neglect and/or negligent failure to properly staff and/or supervise the facility.

b. After the first incident involving a death in December, 2012, the Respondent failed or refused to put sufficient safeguards into place to protect the health, safety and security of the residents;

c. Even if the previous violation(s) by the Respondent are not found to involve volitional choices which placed the residents in harm's way, such does not alter, negate or otherwise mitigate the severe nature of the egregious violations which support the instant complaint against Respondent; and

d. There is or may have been a financial benefit for the Respondent related to the hiring of someone who could not speak English. That is yet to be determined, as

an accurate assessment of such monetary benefit may only be adequately calculated upon substantive due diligence pursuant to discovery and an analysis of the resulting empirical and related data.

23. By failing to maintain its operations in accord with the minimum requirements of law and failing to provide care and services at mandated minimum standards:

a. Respondent failed to properly care for the residents and created a condition or practice that directly threatened the physical or emotional health, safety, or security of the residents;

b. Respondent committed an intentional or negligent act or omission that materially affected the health or safety of the facility residents; and

c. Respondent violated the authorizing statutes or applicable rules, as cited with particularity above.

24. Licensure is a public trust and a privilege, and not an entitlement. This principle must guide the finder of fact or trier of law at any administrative proceeding or circuit court action initiated to enforce the rules and statutes. *See* Section § 429.63(4), Fla. Stat. (2012).

25. Accordingly, the above facts, both individually and collectively, provide sufficient grounds on which the Agency may revoke Respondent's licensure to operate an ALF in the State of Florida.

WHEREFORE, the Agency intends to revoke Respondent's license to operate an assisted living facility in the State of Florida, pursuant to sections 408.815 and 429.14, Florida Statutes (2012).

NOTICE OF RIGHTS

Respondent is notified of its right to request an administrative hearing pursuant to § 120.569, Florida Statutes. Respondent has the right to retain, and be represented by an

attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Bldg. #3, MS #3, Tallahassee, FL 32308; Telephone (850) 412-3630.

The Respondent is further notified that the failure to request a hearing within 21 days of receipt of this Complaint will result in an admission of the facts alleged in the Complaint and the entry of a final order by the Agency.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Administrative Complaint has been served by U.S. Certified Mail, Return Receipt No. 7011 0470 0000 7951 3296, to Brent Sparks, Administrator and Registered Agent, Pine Tree Manor, 10476 131st Street North, Largo, FL 33774-5504, this 6th day of May, 2013.

STATE OF FLORIDA, AGENCY FOR HEALTHCARE ADMINISTRATION

Suzanne Suarez Hurley, Esq.
Assistant General Counsel
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Copy to Paul Brown, AHCA Area 5

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

EX 2

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

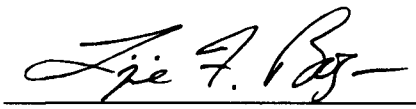
Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration:

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.

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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.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

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

Respondent.
_____/

DOAH CASE NOS. 13-2011
13-2397
AHCA NOS. 2013002572
2013004620
FILE NO. 11942985
LICENSE NO. 8317
FACILITY TYPE: ASSISTED LIVING FACILITY
RENDITION NO.: AHCA-14-0094-FOF-OLC

FINAL ORDER

This cause was referred to the Division of Administrative Hearings where the assigned Administrative Law Judge (ALJ), Linzie F. Bogan, conducted a formal administrative hearing. At issue in this case is whether Respondent committed the violations alleged in the Administrative Complaint, and, if so, what penalty should be imposed. The Recommended Order dated December 5, 2013, is attached to this Final Order and incorporated herein by reference, except where noted infra.

RULING ON EXCEPTIONS

Both the Petitioner and Respondent filed exceptions to the Recommended Order, and Respondent filed a response to the Petitioner's exceptions.

In determining how to rule upon both parties' exceptions and whether to adopt the ALJ's Recommended Order in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow Section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state

EX 3

> with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

Fla. Stat. § 120.57(1)(*l*). Additionally, "[t]he final order shall include an explicit ruling on each exception, but an agency need not rule on an exception that does not clearly identify the disputed portion of the recommended order by page number or paragraph, that does not identify the legal basis for the exception, or that does not include appropriate and specific citations to the record." § 120.57(1)(k), Fla. Stat. In accordance with these legal standards, the Agency makes the following rulings on both parties' exceptions:

Petitioner's Exceptions

In its Exceptions to Recommended Order, Petitioner takes exception to the conclusions of law in Paragraph 72 of the Recommended Order, wherein the ALJ concluded that there were mitigating factors present in this matter that weighed against revocation of Respondent's license. Petitioner argues that Section 429.14(1)(e)1., Florida Statutes (2011), allows the Agency to revoke Respondent's license if there is one or more cited class I deficiencies. Petitioner points out that the ALJ found Respondent had committed one class I deficiency in this matter (See, e.g., Paragraphs 61 and 62 of the Recommended Order). Thus, according to Petitioner, revocation of Respondent's license is warranted. The Agency can only increase the ALJ's recommended penalty if it reviews the complete record and states with particularity its reasons for such an increase by citing to specific portions of the record as justification thereof. Petitioner's exceptions provide no such reasons or record citations other than a general reliance on Section

429.14(1)(e)1., Florida Statutes (2011). Therefore, the Agency cannot increase the ALJ's recommended penalty based solely on Petitioner's exception to Paragraph 72 of the Recommended Order.

However, after conducting a thorough review of the complete record of this matter, the Agency finds that there are specific facts that warrant an increase of the ALJ's recommended penalty of a 60 day suspension to revocation. These facts are:

- Respondent's administrator knew Aurelia Cristobal had a limited ability to communicate with others in English, yet allowed her to be the sole employee at the facility on the date Resident B.Y. died. (See Transcript, Volume II, Pages 316-318).
- Aurelia Cristobal's limited ability to communicate with others in English interfered with the paramedics' delivery of emergency services to resident B.Y. (See Transcript, Volume I, Pages 53-54, 60-61).
- Aurelia Cristobal did not follow Respondent's emergency protocols, which may have caused a delay in paramedics responding to Respondent's facility on the date resident B.Y. died. (See Transcript, Volume I, Pages 51-52; Transcript, Volume II, Pages 307-320; Petitioner's Exhibit E, Page 90).
- Aurelia Cristobal did not perform CPR on Resident B.Y., which may have contributed to the resident's death. (See Transcript, Volume I, Pages 45 and 83; Transcript, Volume II, Pages 186-189).

The Agency believes that Respondent's failures to follow its own protocols are a danger to the health, safety and welfare of its remaining residents. Respondent's license is "a public trust and a privilege and is not an entitlement." § 429.01(3), Fla. Stat. The complete record of this case demonstrates that the Agency can no longer trust Respondent to adequately care for its residents and safeguard them from harm. Thus, Respondent should no longer have the privilege of doing so. Therefore, the Agency hereby increases the ALJ's recommended penalty of a 60-day suspension to revocation, and by doing so implicitly rejects the ALJ's conclusions of law in the last two sentences of Paragraph 72 of the Recommended Order.

Respondent's Exceptions

In Exception No. 1, Respondent takes exception to the underlined title under Section A. of the Findings of Fact. However, that portion of the Recommended Order is not a finding of fact, a conclusion of law or a recommended penalty that the Agency may reject or modify pursuant to Section 120.57(1)(*l*), Florida Statutes (2013). Therefore, the Agency denies Exception No. 1.

In Exception No. 2, Respondent takes exception to the fifth sentence of Paragraph 2 of the Recommended Order, arguing that the findings of fact in that sentence are not based on competent, substantial evidence. Respondent is partially correct in that the findings of fact in the fifth sentence of Paragraph 2 of the Recommended Order are not entirely accurate. The record evidence of this matter reflects that Ms. Cristobal was not available when Laura Manville went to Respondent's facility four days after the incident (Transcript, Volume I, Page 145), but does not indicate where Ms. Cristobal was at that time. The record evidence of this matter does reflect that Ms. Cristobal was in Mexico at the time of the hearing (Transcript, Volume II, Page 222). Therefore, Exception No. 2 is granted to the extent that the Agency hereby modifies the findings of fact in Paragraph 2 of the Recommended Order as follows:

> 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. Ms. Cristobal was not available when Agency investigators conducted a post-incident investigation ~~W~~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.

In Exception No. 3, Respondent takes exception to the findings of fact in the fourth sentence of Paragraph 9 of the Recommended Order, arguing that the findings of fact in that sentence are not based on competent, substantial evidence. Respondent is correct that the record evidence of this matter reflects that Mr. Sparks called the non-emergency number for the Pinellas County Sheriff's Office, and the operator at the Pinellas County Sheriff's Office connected Mr. Sparks to a 911 operator in Pinellas County. Therefore, the Agency grants Exception No. 3 and modifies the findings of fact in Paragraph 9 of the Recommended Order as follows:

> 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~~ connected him to the 911 operator and he informed them of the emergency.

In Exception No. 4, Respondent takes exception to the findings of fact in the second sentence of Paragraph 10 of the Recommended Order, arguing that the ALJ's finding that "Mr. Sparks should have directed Ms. Cristobal to call 911" is not based on competent, substantial evidence. Contrary to Respondent's argument, the findings of fact in Paragraph 10 of the Recommended Order are based on competent, substantial evidence. See Transcript, Volume I, Pages 102-104 and 147; Petitioner's Exhibit E in DOAH Case No. 13-2011, Page 90. Thus, the Agency cannot reject or modify the findings of fact in Paragraph 10 of the Recommended Order. See § 120.57(1)(*l*), Fla. Stat.; Heifetz v. Dep't of Bus. Reg., 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there is no competent, substantial evidence from which the finding could reasonably be inferred"). Therefore, the Agency denies Exception No. 4.

In Exception No. 5, Respondent takes exception to the last sentence of Paragraph 10 of the Recommended Order, arguing that the finding of fact in that sentence is not based on competent, substantial evidence. A review of the record evidence reveals that Respondent's argument is correct. Transcript, Volume II, Page 312 reflects that Respondent's administrator told Ms. Cristobal to start CPR on B.Y. Therefore, Exception No. 5 is granted and Paragraph 10 of the Recommended Order is modified as follows:

> 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.~~

In Exception No. 6, Respondent takes exception to the last sentence of Paragraph 11 of the Recommended Order, arguing that the finding of fact in that sentence is not based on competent, substantial evidence. Contrary to Respondent's assertion, the finding of fact in the last sentence of Paragraph 11 of the Recommended Order is based on competent, substantial evidence. See Petitioner's Exhibit B in DOAH Case No. 13-2011, Pages 74-78. Thus, the Agency cannot disturb the finding of fact. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Therefore, the Agency denies Exception No. 6.

In Exception No. 7, Respondent takes exception to the findings of fact in Paragraph 16 of the Recommended Order, arguing that they are not supported by clear and convincing evidence. Respondent's argument is not valid. Findings of fact need only be supported by competent, substantial evidence. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. The findings of fact in Paragraph 16 of the Recommended Order are supported by competent, substantial record evidence. See Transcript, Volume II, Pages 309-311; Transcript, Volume III, Pages 415-416; Petitioner's

Exhibit E in DOAH Case No. 13-2011 at Page 90. Therefore, the Agency denies Exception No. 7.

In Exception No. 8, Respondent takes exception to the findings of fact in Paragraph 17 of the Recommended Order, based on its arguments in Exception No. 7. The findings of fact in Paragraph 17 of the Recommended Order are reasonable inferences based on competent, substantial evidence. See Transcript, Volume I, Page 52; Transcript, Volume II, Pages 309-311; Transcript, Volume III, Pages 415-416; Petitioner's Exhibit E in DOAH Case No. 13-2011 at Page 90. Thus, the Agency is not permitted to reject or modify them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Therefore, the Agency denies Exception No. 8.

In Exception Nos. 9 and 10, Respondent takes exception to Paragraph 19 of the Recommended Order as not being supported by any clear and convincing evidence. Respondent again refers to an incorrect standard of review. The findings of fact in Paragraph 19 of the Recommended Order need only be supported by competent, substantial evidence, which indeed they are. See Transcript, Volume I, Pages 42-85. Therefore, the Agency denies Exception Nos. 9 and 10.

In Exception No. 11, Respondent takes exception to the last sentence of Paragraph 30 of the Recommended Order as not being supported by clear and convincing evidence. The finding of fact in the last sentence of Paragraph 30 of the Recommended Order is supported by competent, substantial evidence (See Transcript, Volume II, Page 274) as required by law. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Thus, the Agency cannot reject or modify it. Therefore, the Agency denies Exception No. 11.

In Exception No. 12, Respondent takes exception to the parenthetical phrase "precise time unknown" in the third sentence of Paragraph 36 of the Recommended Order, arguing that

the record reflects Mr. Sparks called Ms. Munoz between 7 and 8:30pm. Respondent's record citation offers competent, substantial evidence for the parenthetical phrase at issue because a time period between 7 and 8:30pm is not precise. Therefore, the Agency denies Exception No. 12.

In Exception No. 13, Respondent takes exception to the last sentence of Paragraph 36 of the Recommended Order, arguing that the findings of fact in that sentence are based solely on hearsay. Respondent's argument is partially correct. A review of the record reveals that there is no competent, substantial evidence that Mr. Sparks knew that "R.D. had never gone unaccounted for a period of greater than 12 hours." However, the rest of the last sentence of Paragraph 36 of the Recommended Order is based on competent, substantial evidence. See Transcript, Volume II, Pages 268-282. Therefore, the Agency grants Exception No. 13 to the extent that Paragraph 36 of the Recommended Order is modified as follows:

> 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~~.

In Exception No. 14, Respondent takes exception to Paragraph 45 of the Recommended Order based on its argument in Exception No. 13. Based upon the ruling in Exception No. 13

supra, the Agency grants Exception No. 14 to the extent that Paragraph 45 of the Recommended Order is modified as follows:

> 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.

In Exception No. 15, Respondent takes exception to the conclusions of law in Paragraph 49 of the Recommended Order, arguing that there was no factual basis for concluding that Respondent lost general awareness of R.D.'s whereabouts at 11:00pm on December 4, 2012. The ALJ's conclusions of law in Paragraph 49 of the Recommended Order are based on the findings of fact in Paragraph 36 of the Recommended Order, which, in turn, are based on competent, substantial evidence. See Transcript, Volume II, Pages 268-282. Therefore, the Agency denies Exception No. 15.

In Exception No. 16, Respondent takes exception to the conclusions of law in Paragraph 54 of the Recommended Order, arguing that the ALJ incorrectly concluded that Section 429.255(4), Florida Statutes, establishes the standard for assisted living facilities with respect to the delivery of CPR. The Agency finds that, while it does have substantive jurisdiction over the conclusions of law in Paragraph 54 of the Recommended Order, it cannot substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency denies Exception No. 16.

In Exception No. 17, Respondent takes exception to Paragraph 55 of the Recommended Order, based on its argument in Exception No. 16. Based upon the ruling on Exception No. 16 supra, the Agency denies Exception No. 17.

In Exception No. 18, Respondent takes exception to the conclusions of law in Paragraph 56 of the Recommended Order, arguing that they have no basis in law or fact. The conclusions of law in Paragraph 56 of the Recommended Order are based on the findings of fact in Paragraphs 10, 16 and 17 of the Recommended Order, which, in turn, are based on competent, substantial evidence. See Transcript, Volume I, Pages 102-104 and 147; Transcript, Volume II, Pages 309-311; Transcript, Volume III, Pages 415-416; Petitioner's Exhibit E in DOAH Case No. 13-2011, Page 90. Therefore, the Agency denies Exception No. 18.

In Exception No. 19, Respondent takes exception to the conclusions of law in Paragraph 57 of the Recommended Order, based on its reasoning in Exception No. 18. Based on the ruling on Exception No. 18 supra, the Agency denies Exception No. 19.

In Exception No. 20, Respondent takes exception to the conclusions of law in Paragraph 58 of the Recommended Order based upon its arguments in Exception Nos. 7 and 19. Based upon the rulings on Exception Nos. 7 and 19 supra, the Agency denies Exception No. 20.

In Exception No. 21, Respondent takes exception to the conclusions of law in Paragraph 59 of the Recommended Order based upon its argument in Exception No. 5. Based upon the ruling on Exception No. 5 supra, the Agency grants Exception No. 21 and hereby rejects the conclusions of law in Paragraph 59 of the Recommended Order.

In Exception No. 22, Respondent takes exception to the conclusions of law in Paragraph 60 of the Recommended Order based on its argument in Exception No. 9. Based upon the ruling on Exception No. 9 supra, the Agency denies Exception No. 22.

In Exception No. 23, Respondent takes exception to the conclusion of law in Paragraph 61 of the Recommended Order, arguing that there was no factual basis for such a conclusion of law. The conclusion of law in Paragraph 61 of the Recommended Order is based on the findings of fact in Paragraphs 16, 17 and 19 of the Recommended Order, which, in turn, are based on competent, substantial evidence. See the rulings on Respondent's Exception Nos, 7, 8, 9 and 10 supra. The Agency cannot re-weigh the evidence in order to arrive at a conclusion of law that differs from that of the ALJ. See Heifetz at 1281. Therefore, the Agency denies Exception No. 23.

In Exception No. 24, Respondent takes exception to Paragraph 62 of the Recommended Order as not supported by clear and convincing evidence. Based on the ruling on Exception No. 23 supra, the Agency denies Exception No. 24.

In Exception No. 25, Respondent takes exception to Paragraph 64 of the Recommended Order as not supported by clear and convincing evidence. Based on the ruling on Exception No. 23 supra, the Agency denies Exception No. 25.

In Exception No. 26, Respondent takes exception to Paragraph 65 of the Recommended Order because there was no testimony presented as to what amount of "institutional control" is expected of an assisted living facility. Based on the ruling on Exception No. 23 supra, the Agency denies Exception No. 26.

In Exception No. 27, Respondent takes exception to Paragraph 66 of the Recommended Order, arguing that the Agency has failed to identify what "general awareness" requires. Paragraph 66 of the Recommended Order deals with the ALJ's consideration of the facts in determining what penalty should be imposed for the violation referenced. Respondent has

offered no record citation that would warrant a mitigation of the proposed penalty recommended in Paragraph 67 of the Recommended Order. Therefore, the Agency denies Exception No. 27.

In Exception No. 28, Respondent takes exception to Paragraph 67 of the Recommended Order "because there should be no deficiency or fine since there was no clear and convincing evidence produced by the Agency to support the allegations in its complaint." This is clearly an attempt by Respondent to have the Agency re-weigh the evidence presented in this matter in order to make conclusions of law favorable to Respondent. The Agency is specifically prohibited by law from doing so. See Heifetz at 1281. Therefore, the Agency denies Exception No. 28.

In Exception No. 29, Respondent takes exception to Paragraphs 69 through 72 of the Recommended Order, arguing against the ALJ's recommended penalties. Respondent's exception is nothing more than another attempt to have the Agency re-weigh the evidence in order to reach conclusions of law that are more favorable to Respondent. As stated in the ruling on Exception No. 28 supra, the Agency cannot do so. Therefore, the Agency denies Exception No. 29.

In Exception No. 30, Respondent takes exception to the ALJ's recommendation of licensure suspension as a penalty. Since the Agency has already addressed that issue in its ruling on Petitioner's Exceptions supra, the Agency denies Exception No. 30 as moot.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order, except where noted supra.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order, except where noted supra.

ORDER

1. In regard to AHCA No. 2012002572, a $5,000 fine and $500 survey fee are hereby imposed on Respondent. In regard to AHCA No. 2013004620, an $8,000 fine is hereby imposed on Respondent, and Respondent's license is hereby REVOKED.

2. Unless payment has already been made, payment in the amount of $13,500 is now due from the Respondent as a result of the agency action. Such payment shall be made in full within 30 days of the filing of this Final Order. The payment shall be made by check payable to Agency for Health Care Administration, and shall be mailed to the Agency for Health Care Administration. Attn. Revenue Management Unit, Office of Finance and Accounting, 2727 Mahan Drive, Mail Stop #14, Tallahassee, Florida 32308.

3. In order to ensure the health, safety, and welfare of the Respondent's clients, the revocation of the Respondent's license is stayed for 30 days from the filing date of this Final Order for the sole purpose of allowing the safe and orderly discharge of clients. § 408.815(6), Fla. Stat. The Respondent is prohibited from accepting any new admissions during this period and must immediately notify the clients that they will soon be discharged. The Respondent must comply with all other applicable federal and state laws. At the conclusion of the stay, or upon the discontinuance of operations, whichever is first, the Respondent shall promptly return the license certificate which is the subject of this agency action to the appropriate licensure unit in Tallahassee, Florida. Fla. Admin. Code R. 59A-35.040(5).

4. In accordance with Florida law, the Respondent is responsible for retaining and

appropriately distributing all client records within the timeframes prescribed in the authorizing statutes and applicable administrative code provisions. The Respondent is advised of Section 408.810, Florida Statutes.

5. In accordance with Florida law, the Respondent is responsible for any refunds that may have to be made to the clients.

6. The Respondent is given notice of Florida law regarding unlicensed activity. The Respondent is advised of Section 408.804 and Section 408.812, Florida Statutes. The Respondent should also consult the applicable authorizing statutes and administrative code provisions. The Respondent is notified that the cancellation of an Agency license may have ramifications potentially affecting accrediting, third party billing including but not limited to the Florida Medicaid program, and private contracts.

DONE and ORDERED this 5 day of January 2014, in Tallahassee, Florida.

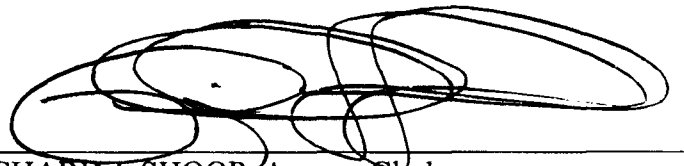
ELIZABETH DUDEK, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. or electronic mail to the persons named below on this 5th day of February, 2014.



RICHARD J. SHOOP, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, FL 32308
(850) 412-3630

Copies furnished to:

Jan Mills Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Shaddrick Haston, Unit Manager Assisted Living Unit Agency for Health Care Administration (Electronic Mail)
Finance & Accounting Revenue Management Unit Agency for Health Care Administration (Electronic Mail)	Pat Caufman, Field Office Manager Area 5/6 Field Office Agency for Health Care Administration (Electronic Mail)
Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Suzanne Suarez Hurley, Esquire Assistant General Counsel Agency for Health Care Administration (Electronic Mail)
Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Brent Sparks, Administrator Pine Tree Manor 131st Street North Largo, Florida 33774-5504 (U.S. Mail)
Honorable Linzie F. Bogan Administrative Law Judge Division of Administrative Hearings The DeSoto Building 1230 Apalachee Parkway Tallahassee, Florida 32399-3060 (Electronic Mail)	Theodore E. Mack, Esquire Powell and Mack 3700 Bellwood Drive Tallahassee, Florida 32303 (U.S. Mail)

NOTICE OF FLORIDA LAW

408.804 License required; display.--

(1) It is unlawful to provide services that require licensure, or operate or maintain a provider that offers or provides services that require licensure, without first obtaining from the agency a license authorizing the provision of such services or the operation or maintenance of such provider.

(2) A license must be displayed in a conspicuous place readily visible to clients who enter at the address that appears on the license and is valid only in the hands of the licensee to whom it is issued and may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily. The license is valid only for the licensee, provider, and location for which the license is issued.

408.812 Unlicensed activity. --

(1) A person or entity may not offer or advertise services that require licensure as defined by this

part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license.

(2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.

(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

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

Respondent.
_____/

DCA No. 2D14-644

DOAH Nos. 13-2011
13-2397

AHCA Nos. 2013002572
2013004620
License No. 8317
File No. 11942985
Provider Type: Assisted Living Facility

SETTLEMENT AGREEMENT

The Petitioner, State of Florida, Agency for Health Care Administration ("the Agency") the Respondent, Pine Tree Manor, Inc. d/b/a Pine Tree Manor ("the Respondent"), the Respondent's owner, Brent Sparks, and the change of ownership for Pine Tree Manor, Heather Haven III, Inc. ("CHOW Applicant), by and through their undersigned representatives, and pursuant to Section 120.57(4), Florida Statutes, agree as follows:

WHEREAS the Agency is the licensing and regulatory authority that oversees assisted living facilities in Florida and enforces the state laws governing such facilities pursuant to Chapter 408, Part II, Florida Statutes, and Chapter 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code; and

WHEREAS, the Respondent was issued a license by the Agency to operate this assisted living facility in Florida; and

WHEREAS, Brent Sparks ("Mr. Sparks") is the 100% owner and a controlling interest of the Respondent; and

WHEREAS, on February 5, 2014, the Agency issued a Final Order revoking the Respondent's license to operate this assisted living facility and imposing a $13,000.00 fine as

Ex 4

well as a $500.00 survey fee; and

WHEREAS, the Respondent filed a Notice of Appeal with the District Court of Appeal challenging the Final Order; and

WHEREAS, the District Court of Appeal issued a conditional stay of the Final Order revoking the Respondent's license, and

WHEREAS, the CHOW Applicant, which is owned by a provider who is currently a licensed provider of a separate assisted living facility and has experience in this field, has filed a change of ownership ("CHOW") application with the Agency and tendered a Commercial Lease agreement to the Agency as part of the CHOW application; and

WHEREAS, per the terms of the Lease Agreement, the CHOW Applicant has agreed to lease the Respondent's assisted living facility property and has the option to purchase said property during the six-year lease term; and

WHEREAS, the status of the assisted living facility license that the CHOW Applicant seeks to obtain is revoked but conditionally stayed pending the appeal; and

WHEREAS, the Agency has the authority to deny the CHOW application based upon the revocation of the Respondent's license; and

WHEREAS, the Agency, Respondent, Mr. Sparks and the Chow Applicant (hereinafter "the Parties") have agreed that a fair and efficient resolution of the above-captioned matters would avoid the expenditure of substantial sums to further litigate these disputes; and

NOW THEREFORE, in consideration of the mutual promises and recitals herein, the Parties, intending to be legally bound, agree as follows:

1. The above recitals are true and correct and are expressly incorporated into the Settlement Agreement ("the Agreement").

2. The Parties agree that the above recitals are binding findings on the Parties.

3. Upon full execution of this Agreement, the Respondent agrees to a withdrawal of any request for administrative proceeding filed for the above referenced actions, agrees to waive any and all proceedings and appeals under Chapter 120, Florida Statutes, to which they may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), a formal proceeding under Subsection 120.57(1), appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or tribunal (DOAH) of competent jurisdiction, and agree to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled as to this matter. Provided, however, that this Agreement shall not be a waiver by any party of the right to the judicial enforcement of this Agreement.

4. Upon full execution of this Agreement, the Parties stipulate as follows:

a. Mr. Sparks, individually, agrees that he shall never:

(i) apply for or hold, directly or indirectly, any Agency license;

(ii) obtain or hold any type of ownership interest, directly or indirectly, in any type of entity that holds a license issued by the Agency;

(iii) obtain or hold any type of ownership interest, directly or indirectly, in any real property that is the site of an Agency licensee, except for Heather Haven III, Inc, for the Pine Tree Manor facility under the Commercial Lease agreement submitted with the CHOW application;

(iv) obtain or hold any type of ownership interest, directly or indirectly, in any management company or other entity that operates or manages an Agency licensee;

(v) exercise any type of control, directly or indirectly, over any Agency licensee;

(vi) be a controlling interest, officer, board member, director, manager or administrator, of any Agency licensee; and

(vii) hold any type of position with the day-to-day control of the operation (regardless of position title) or as a financial officer, either full-time or part-time, either through direct employment or contracted employment, of any Agency licensee.

The term "directly or indirectly" shall be given a broad interpretation in favor of the Agency. It includes any form of ownership, control or exercise of authority through any means and through any individual, business entity, trust or other type of ownership. It includes Mr. Sparks' family members, friends, business partners, employees and other business acquaintances. A violation of this Agreement shall constitute a basis to deny any application for licensure or revoke any license held by Mr. Sparks.

b. The Respondent agrees to voluntarily dismiss with prejudice its appeal in the above-styled mater pending in the District Court of Appeal.

c. Upon dismissal of the appeal by the District Court of Appeal, the Agency agrees to issue an Amended Final Order adopting the terms of this Agreement and issue a provisional license to the CHOW Applicant, Heather Haven III, Inc. All Parties will cooperate with each other with respect to any papers that need to be filed with the District Court of Appeal to carry out the terms of this Agreement.

d. The Agency agrees to process the CHOW application filed by Heather Haven III, Inc., for the Respondent's Pine Tree Manor facility. Once the CHOW Applicant has completed the initial review of the CHOW application, the Agency will issue the CHOW Applicant a provisional license subject to a survey. Once the survey has been successfully completed, the CHOW Applicant's provisional license is qualified to be upgraded to a standard license. The CHOW Applicant must meet the statutory and rule requirements for licensure in order to receive a standard license.

e. The CHOW Applicant agrees to make its best efforts to execute the option in the Commercial Lease and purchase the real property which is the site of the Respondent's Pine Tree Manor facility during the six-year lease term. The CHOW Applicant recognizes that restrictions placed on the Respondent and Mr. Sparks in this Agreement and will not engage in any action that would constitute a violation of those restrictions.

5. Venue for any action brought to interpret, challenge or enforce the terms of this Agreement or the Final Order entered pursuant to this Agreement shall lie solely in the State Circuit Court of Leon County, Florida.

6. The Respondent and Mr. Sparks acknowledge that this Agreement does not affect in any manner any other type of action that is or may be initiated against them by any other government agency, regardless of the type of action or the forum in which the action is brought. They also acknowledge that this Agreement may not be admitted into evidence in any type of

action that is or may be initiated against them.

7. Each party shall bear its own costs and attorney's fees.

8. This Agreement shall become effective on the date upon which it is fully executed by all of the Parties.

9. The Respondent and Mr. Sparks, for themselves and for any related or resulting organizations, successors or transferees, attorneys, heirs, and executors or administrators, discharge the Agency and its agents, representatives, and attorneys of all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to the above referenced actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including claims arising out of the subject of this Agreement, by or on behalf of the Respondent or related or resulting organizations.

10. This Agreement is binding upon all Parties and those persons and entities identified in the aforementioned paragraph of this Agreement.

11. In the event that the Respondent was a Medicaid provider at the subject time of the occurrences alleged in the Administrative Complaints, this Agreement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues.

12. The undersigned have read and understand this Agreement and have authority to bind their respective principals. The Parties and their representatives have the legal capacity to execute this Agreement. The Parties have right to consult with their own counsel and have done so in knowingly and freely entering into this Agreement. The Respondent and Mr. Sparks understand that Agency counsel represents solely the Agency and that Agency counsel has not provided any legal advice to them, or influenced them, in the decision to voluntarily enter into this Agreement.

13. This Agreement contains the entire understandings and agreements of the Parties. This Agreement supersedes any prior oral or written understandings and agreements between the Parties. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

14. All Parties agree that an electronic signature suffices for an original signature and that this Agreement may be executed in counterpart.

15. The following representatives acknowledge that they are duly authorized to enter into this Agreement.

Molly McKinstry, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive MS# 3
Tallahassee, Florida 32308

DATED: 10/15/14

Brent Sparks, Owner/Representative
Pine Tree Manor, Inc. d/b/a
Pine Tree Manor
131st Street North
Largo, Florida 33774-5504

DATED: 10/3/2014

Stuart F. Williams, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida, 32308

DATED: 10/11/14

Brent Sparks, Individually

DATED: 10/3/2014

Cynthia Hain, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 10/7/2014

Theodore E. Mack, Esquire
Powell and Mack
3700 Bellwood Drive
Tallahassee, Florida 32303
Counsel for Pine Tree Manor, Inc.

DATED: 10/6/14

Donna Damiani, Owner/Representative
Heather Haven III, Inc.
725 Edgewater Drive
Dunedin, FL 34698

DATED: 10/3/2014

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

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

Respondent.
_____/

DOAH CASE NOS. 13-2011
13-2397
AHCA NOS. 2013002572
2013004620
FILE NO. 11942985
LICENSE NO. 8317
FACILITY TYPE: ASSISTED LIVING FACILITY
RENDITION NO.: AHCA-14- 0094-FOF-OLC

FINAL ORDER

This cause was referred to the Division of Administrative Hearings where the assigned Administrative Law Judge (ALJ), Linzie F. Bogan, conducted a formal administrative hearing. At issue in this case is whether Respondent committed the violations alleged in the Administrative Complaint, and, if so, what penalty should be imposed. The Recommended Order dated December 5, 2013, is attached to this Final Order and incorporated herein by reference, except where noted infra.

RULING ON EXCEPTIONS

Both the Petitioner and Respondent filed exceptions to the Recommended Order, and Respondent filed a response to the Petitioner's exceptions.

In determining how to rule upon both parties' exceptions and whether to adopt the ALJ's Recommended Order in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow Section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state

> with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

Fla. Stat. § 120.57(1)(*l*). Additionally, "[t]he final order shall include an explicit ruling on each exception, but an agency need not rule on an exception that does not clearly identify the disputed portion of the recommended order by page number or paragraph, that does not identify the legal basis for the exception, or that does not include appropriate and specific citations to the record." § 120.57(1)(k), Fla. Stat. In accordance with these legal standards, the Agency makes the following rulings on both parties' exceptions:

Petitioner's Exceptions

In its Exceptions to Recommended Order, Petitioner takes exception to the conclusions of law in Paragraph 72 of the Recommended Order, wherein the ALJ concluded that there were mitigating factors present in this matter that weighed against revocation of Respondent's license. Petitioner argues that Section 429.14(1)(e)1., Florida Statutes (2011), allows the Agency to revoke Respondent's license if there is one or more cited class I deficiencies. Petitioner points out that the ALJ found Respondent had committed one class I deficiency in this matter (See, e.g., Paragraphs 61 and 62 of the Recommended Order). Thus, according to Petitioner, revocation of Respondent's license is warranted. The Agency can only increase the ALJ's recommended penalty if it reviews the complete record and states with particularity its reasons for such an increase by citing to specific portions of the record as justification thereof. Petitioner's exceptions provide no such reasons or record citations other than a general reliance on Section

429.14(1)(e)1., Florida Statutes (2011). Therefore, the Agency cannot increase the ALJ's recommended penalty based solely on Petitioner's exception to Paragraph 72 of the Recommended Order.

However, after conducting a thorough review of the complete record of this matter, the Agency finds that there are specific facts that warrant an increase of the ALJ's recommended penalty of a 60 day suspension to revocation. These facts are:

- Respondent's administrator knew Aurelia Cristobal had a limited ability to communicate with others in English, yet allowed her to be the sole employee at the facility on the date Resident B.Y. died. (See Transcript, Volume II, Pages 316-318).
- Aurelia Cristobal's limited ability to communicate with others in English interfered with the paramedics' delivery of emergency services to resident B.Y. (See Transcript, Volume I, Pages 53-54, 60-61).
- Aurelia Cristobal did not follow Respondent's emergency protocols, which may have caused a delay in paramedics responding to Respondent's facility on the date resident B.Y. died. (See Transcript, Volume I, Pages 51-52; Transcript, Volume II, Pages 307-320; Petitioner's Exhibit E, Page 90).
- Aurelia Cristobal did not perform CPR on Resident B.Y., which may have contributed to the resident's death. (See Transcript, Volume I, Pages 45 and 83; Transcript, Volume II, Pages 186-189).

The Agency believes that Respondent's failures to follow its own protocols are a danger to the health, safety and welfare of its remaining residents. Respondent's license is "a public trust and a privilege and is not an entitlement." § 429.01(3), Fla. Stat. The complete record of this case demonstrates that the Agency can no longer trust Respondent to adequately care for its residents and safeguard them from harm. Thus, Respondent should no longer have the privilege of doing so. Therefore, the Agency hereby increases the ALJ's recommended penalty of a 60-day suspension to revocation, and by doing so implicitly rejects the ALJ's conclusions of law in the last two sentences of Paragraph 72 of the Recommended Order.

Respondent's Exceptions

In Exception No. 1, Respondent takes exception to the underlined title under Section A. of the Findings of Fact. However, that portion of the Recommended Order is not a finding of fact, a conclusion of law or a recommended penalty that the Agency may reject or modify pursuant to Section 120.57(1)(*l*), Florida Statutes (2013). Therefore, the Agency denies Exception No. 1.

In Exception No. 2, Respondent takes exception to the fifth sentence of Paragraph 2 of the Recommended Order, arguing that the findings of fact in that sentence are not based on competent, substantial evidence. Respondent is partially correct in that the findings of fact in the fifth sentence of Paragraph 2 of the Recommended Order are not entirely accurate. The record evidence of this matter reflects that Ms. Cristobal was not available when Laura Manville went to Respondent's facility four days after the incident (Transcript, Volume I, Page 145), but does not indicate where Ms. Cristobal was at that time. The record evidence of this matter does reflect that Ms. Cristobal was in Mexico at the time of the hearing (Transcript, Volume II, Page 222). Therefore, Exception No. 2 is granted to the extent that the Agency hereby modifies the findings of fact in Paragraph 2 of the Recommended Order as follows:

> 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. Ms. Cristobal was not available when Agency investigators conducted a post-incident investigation ~~W~~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.

In Exception No. 3, Respondent takes exception to the findings of fact in the fourth sentence of Paragraph 9 of the Recommended Order, arguing that the findings of fact in that sentence are not based on competent, substantial evidence. Respondent is correct that the record evidence of this matter reflects that Mr. Sparks called the non-emergency number for the Pinellas County Sheriff's Office, and the operator at the Pinellas County Sheriff's Office connected Mr. Sparks to a 911 operator in Pinellas County. Therefore, the Agency grants Exception No. 3 and modifies the findings of fact in Paragraph 9 of the Recommended Order as follows:

> 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~~ connected him to the 911 operator and he informed them of the emergency.

In Exception No. 4, Respondent takes exception to the findings of fact in the second sentence of Paragraph 10 of the Recommended Order, arguing that the ALJ's finding that "Mr. Sparks should have directed Ms. Cristobal to call 911" is not based on competent, substantial evidence. Contrary to Respondent's argument, the findings of fact in Paragraph 10 of the Recommended Order are based on competent, substantial evidence. See Transcript, Volume I, Pages 102-104 and 147; Petitioner's Exhibit E in DOAH Case No. 13-2011, Page 90. Thus, the Agency cannot reject or modify the findings of fact in Paragraph 10 of the Recommended Order. See § 120.57(1)(*l*), Fla. Stat.; Heifetz v. Dep't of Bus. Reg., 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there is no competent, substantial evidence from which the finding could reasonably be inferred"). Therefore, the Agency denies Exception No. 4.

In Exception No. 5, Respondent takes exception to the last sentence of Paragraph 10 of the Recommended Order, arguing that the finding of fact in that sentence is not based on competent, substantial evidence. A review of the record evidence reveals that Respondent's argument is correct. Transcript, Volume II, Page 312 reflects that Respondent's administrator told Ms. Cristobal to start CPR on B.Y. Therefore, Exception No. 5 is granted and Paragraph 10 of the Recommended Order is modified as follows:

> 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.~~

In Exception No. 6, Respondent takes exception to the last sentence of Paragraph 11 of the Recommended Order, arguing that the finding of fact in that sentence is not based on competent, substantial evidence. Contrary to Respondent's assertion, the finding of fact in the last sentence of Paragraph 11 of the Recommended Order is based on competent, substantial evidence. See Petitioner's Exhibit B in DOAH Case No. 13-2011, Pages 74-78. Thus, the Agency cannot disturb the finding of fact. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Therefore, the Agency denies Exception No. 6.

In Exception No. 7, Respondent takes exception to the findings of fact in Paragraph 16 of the Recommended Order, arguing that they are not supported by clear and convincing evidence. Respondent's argument is not valid. Findings of fact need only be supported by competent, substantial evidence. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. The findings of fact in Paragraph 16 of the Recommended Order are supported by competent, substantial record evidence. See Transcript, Volume II, Pages 309-311; Transcript, Volume III, Pages 415-416; Petitioner's

Exhibit E in DOAH Case No. 13-2011 at Page 90. Therefore, the Agency denies Exception No. 7.

In Exception No. 8, Respondent takes exception to the findings of fact in Paragraph 17 of the Recommended Order, based on its arguments in Exception No. 7. The findings of fact in Paragraph 17 of the Recommended Order are reasonable inferences based on competent, substantial evidence. See Transcript, Volume I, Page 52; Transcript, Volume II, Pages 309-311; Transcript, Volume III, Pages 415-416; Petitioner's Exhibit E in DOAH Case No. 13-2011 at Page 90. Thus, the Agency is not permitted to reject or modify them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Therefore, the Agency denies Exception No. 8.

In Exception Nos. 9 and 10, Respondent takes exception to Paragraph 19 of the Recommended Order as not being supported by any clear and convincing evidence. Respondent again refers to an incorrect standard of review. The findings of fact in Paragraph 19 of the Recommended Order need only be supported by competent, substantial evidence, which indeed they are. See Transcript, Volume I, Pages 42-85. Therefore, the Agency denies Exception Nos. 9 and 10.

In Exception No. 11, Respondent takes exception to the last sentence of Paragraph 30 of the Recommended Order as not being supported by clear and convincing evidence. The finding of fact in the last sentence of Paragraph 30 of the Recommended Order is supported by competent, substantial evidence (See Transcript, Volume II, Page 274) as required by law. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Thus, the Agency cannot reject or modify it. Therefore, the Agency denies Exception No. 11.

In Exception No. 12, Respondent takes exception to the parenthetical phrase "precise time unknown" in the third sentence of Paragraph 36 of the Recommended Order, arguing that

the record reflects Mr. Sparks called Ms. Munoz between 7 and 8:30pm. Respondent's record citation offers competent, substantial evidence for the parenthetical phrase at issue because a time period between 7 and 8:30pm is not precise. Therefore, the Agency denies Exception No. 12.

In Exception No. 13, Respondent takes exception to the last sentence of Paragraph 36 of the Recommended Order, arguing that the findings of fact in that sentence are based solely on hearsay. Respondent's argument is partially correct. A review of the record reveals that there is no competent, substantial evidence that Mr. Sparks knew that "R.D. had never gone unaccounted for a period of greater than 12 hours." However, the rest of the last sentence of Paragraph 36 of the Recommended Order is based on competent, substantial evidence. See Transcript, Volume II, Pages 268-282. Therefore, the Agency grants Exception No. 13 to the extent that Paragraph 36 of the Recommended Order is modified as follows:

> 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~~.

In Exception No. 14, Respondent takes exception to Paragraph 45 of the Recommended Order based on its argument in Exception No. 13. Based upon the ruling in Exception No. 13

supra, the Agency grants Exception No. 14 to the extent that Paragraph 45 of the Recommended Order is modified as follows:

> 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.

In Exception No. 15, Respondent takes exception to the conclusions of law in Paragraph 49 of the Recommended Order, arguing that there was no factual basis for concluding that Respondent lost general awareness of R.D.'s whereabouts at 11:00pm on December 4, 2012. The ALJ's conclusions of law in Paragraph 49 of the Recommended Order are based on the findings of fact in Paragraph 36 of the Recommended Order, which, in turn, are based on competent, substantial evidence. See Transcript, Volume II, Pages 268-282. Therefore, the Agency denies Exception No. 15.

In Exception No. 16, Respondent takes exception to the conclusions of law in Paragraph 54 of the Recommended Order, arguing that the ALJ incorrectly concluded that Section 429.255(4), Florida Statutes, establishes the standard for assisted living facilities with respect to the delivery of CPR. The Agency finds that, while it does have substantive jurisdiction over the conclusions of law in Paragraph 54 of the Recommended Order, it cannot substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency denies Exception No. 16.

In Exception No. 17, Respondent takes exception to Paragraph 55 of the Recommended Order, based on its argument in Exception No. 16. Based upon the ruling on Exception No. 16 supra, the Agency denies Exception No. 17.

In Exception No. 18, Respondent takes exception to the conclusions of law in Paragraph 56 of the Recommended Order, arguing that they have no basis in law or fact. The conclusions of law in Paragraph 56 of the Recommended Order are based on the findings of fact in Paragraphs 10, 16 and 17 of the Recommended Order, which, in turn, are based on competent, substantial evidence. See Transcript, Volume I, Pages 102-104 and 147; Transcript, Volume II, Pages 309-311; Transcript, Volume III, Pages 415-416; Petitioner's Exhibit E in DOAH Case No. 13-2011, Page 90. Therefore, the Agency denies Exception No. 18.

In Exception No. 19, Respondent takes exception to the conclusions of law in Paragraph 57 of the Recommended Order, based on its reasoning in Exception No. 18. Based on the ruling on Exception No. 18 supra, the Agency denies Exception No. 19.

In Exception No. 20, Respondent takes exception to the conclusions of law in Paragraph 58 of the Recommended Order based upon its arguments in Exception Nos. 7 and 19. Based upon the rulings on Exception Nos. 7 and 19 supra, the Agency denies Exception No. 20.

In Exception No. 21, Respondent takes exception to the conclusions of law in Paragraph 59 of the Recommended Order based upon its argument in Exception No. 5. Based upon the ruling on Exception No. 5 supra, the Agency grants Exception No. 21 and hereby rejects the conclusions of law in Paragraph 59 of the Recommended Order.

In Exception No. 22, Respondent takes exception to the conclusions of law in Paragraph 60 of the Recommended Order based on its argument in Exception No. 9. Based upon the ruling on Exception No. 9 supra, the Agency denies Exception No. 22.

In Exception No. 23, Respondent takes exception to the conclusion of law in Paragraph 61 of the Recommended Order, arguing that there was no factual basis for such a conclusion of law. The conclusion of law in Paragraph 61 of the Recommended Order is based on the findings of fact in Paragraphs 16, 17 and 19 of the Recommended Order, which, in turn, are based on competent, substantial evidence. See the rulings on Respondent's Exception Nos, 7, 8, 9 and 10 supra. The Agency cannot re-weigh the evidence in order to arrive at a conclusion of law that differs from that of the ALJ. See Heifetz at 1281. Therefore, the Agency denies Exception No. 23.

In Exception No. 24, Respondent takes exception to Paragraph 62 of the Recommended Order as not supported by clear and convincing evidence. Based on the ruling on Exception No. 23 supra, the Agency denies Exception No. 24.

In Exception No. 25, Respondent takes exception to Paragraph 64 of the Recommended Order as not supported by clear and convincing evidence. Based on the ruling on Exception No. 23 supra, the Agency denies Exception No. 25.

In Exception No. 26, Respondent takes exception to Paragraph 65 of the Recommended Order because there was no testimony presented as to what amount of "institutional control" is expected of an assisted living facility. Based on the ruling on Exception No. 23 supra, the Agency denies Exception No. 26.

In Exception No. 27, Respondent takes exception to Paragraph 66 of the Recommended Order, arguing that the Agency has failed to identify what "general awareness" requires. Paragraph 66 of the Recommended Order deals with the ALJ's consideration of the facts in determining what penalty should be imposed for the violation referenced. Respondent has

offered no record citation that would warrant a mitigation of the proposed penalty recommended in Paragraph 67 of the Recommended Order. Therefore, the Agency denies Exception No. 27.

In Exception No. 28, Respondent takes exception to Paragraph 67 of the Recommended Order "because there should be no deficiency or fine since there was no clear and convincing evidence produced by the Agency to support the allegations in its complaint." This is clearly an attempt by Respondent to have the Agency re-weigh the evidence presented in this matter in order to make conclusions of law favorable to Respondent. The Agency is specifically prohibited by law from doing so. See Heifetz at 1281. Therefore, the Agency denies Exception No. 28.

In Exception No. 29, Respondent takes exception to Paragraphs 69 through 72 of the Recommended Order, arguing against the ALJ's recommended penalties. Respondent's exception is nothing more than another attempt to have the Agency re-weigh the evidence in order to reach conclusions of law that are more favorable to Respondent. As stated in the ruling on Exception No. 28 supra, the Agency cannot do so. Therefore, the Agency denies Exception No. 29.

In Exception No. 30, Respondent takes exception to the ALJ's recommendation of licensure suspension as a penalty. Since the Agency has already addressed that issue in its ruling on Petitioner's Exceptions supra, the Agency denies Exception No. 30 as moot.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order, except where noted supra.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order, except where noted supra.

ORDER

1. In regard to AHCA No. 2012002572, a $5,000 fine and $500 survey fee are hereby imposed on Respondent. In regard to AHCA No. 2013004620, an $8,000 fine is hereby imposed on Respondent, and Respondent's license is hereby REVOKED.

2. Unless payment has already been made, payment in the amount of $13,500 is now due from the Respondent as a result of the agency action. Such payment shall be made in full within 30 days of the filing of this Final Order. The payment shall be made by check payable to Agency for Health Care Administration, and shall be mailed to the Agency for Health Care Administration, Attn. Revenue Management Unit, Office of Finance and Accounting, 2727 Mahan Drive, Mail Stop #14, Tallahassee, Florida 32308.

3. In order to ensure the health, safety, and welfare of the Respondent's clients, the revocation of the Respondent's license is stayed for 30 days from the filing date of this Final Order for the sole purpose of allowing the safe and orderly discharge of clients. § 408.815(6), Fla. Stat. The Respondent is prohibited from accepting any new admissions during this period and must immediately notify the clients that they will soon be discharged. The Respondent must comply with all other applicable federal and state laws. At the conclusion of the stay, or upon the discontinuance of operations, whichever is first, the Respondent shall promptly return the license certificate which is the subject of this agency action to the appropriate licensure unit in Tallahassee, Florida. Fla. Admin. Code R. 59A-35.040(5).

4. In accordance with Florida law, the Respondent is responsible for retaining and

appropriately distributing all client records within the timeframes prescribed in the authorizing statutes and applicable administrative code provisions. The Respondent is advised of Section 408.810, Florida Statutes.

5. In accordance with Florida law, the Respondent is responsible for any refunds that may have to be made to the clients.

6. The Respondent is given notice of Florida law regarding unlicensed activity. The Respondent is advised of Section 408.804 and Section 408.812, Florida Statutes. The Respondent should also consult the applicable authorizing statutes and administrative code provisions. The Respondent is notified that the cancellation of an Agency license may have ramifications potentially affecting accrediting, third party billing including but not limited to the Florida Medicaid program, and private contracts.

DONE and ORDERED this 5 day of January 2014, in Tallahassee, Florida.

ELIZABETH DUDEK, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. or electronic mail to the persons named below on this 5th day of February, 2014.

RICHARD J. SHOOP, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, FL 32308
(850) 412-3630

Copies furnished to:

Jan Mills Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Shaddrick Haston, Unit Manager Assisted Living Unit Agency for Health Care Administration (Electronic Mail)
Finance & Accounting Revenue Management Unit Agency for Health Care Administration (Electronic Mail)	Pat Caufman, Field Office Manager Area 5/6 Field Office Agency for Health Care Administration (Electronic Mail)
Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Suzanne Suarez Hurley, Esquire Assistant General Counsel Agency for Health Care Administration (Electronic Mail)
Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Brent Sparks, Administrator Pine Tree Manor 131st Street North Largo, Florida 33774-5504 (U.S. Mail)
Honorable Linzie F. Bogan Administrative Law Judge Division of Administrative Hearings The DeSoto Building 1230 Apalachee Parkway Tallahassee, Florida 32399-3060 (Electronic Mail)	Theodore E. Mack, Esquire Powell and Mack 3700 Bellwood Drive Tallahassee, Florida 32303 (U.S. Mail)

NOTICE OF FLORIDA LAW

408.804 License required; display.--

(1) It is unlawful to provide services that require licensure, or operate or maintain a provider that offers or provides services that require licensure, without first obtaining from the agency a license authorizing the provision of such services or the operation or maintenance of such provider.

(2) A license must be displayed in a conspicuous place readily visible to clients who enter at the address that appears on the license and is valid only in the hands of the licensee to whom it is issued and may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily. The license is valid only for the licensee, provider, and location for which the license is issued.

408.812 Unlicensed activity. --

(1) A person or entity may not offer or advertise services that require licensure as defined by this

part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license.

(2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.

(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency.

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

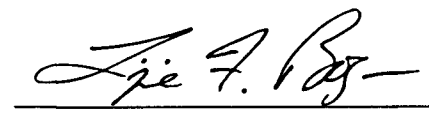
Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration:

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.

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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.