STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

DOAH NO. 11-33721
AHCA NOs. 2011006466
2011006798

GENE COWLES[1] AND AMELIA COWLES d/b/a HILLANDALE ASSISTED LIVING,

Respondents.
_____/

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

DOAH NO. 13-3111
AHCA NO. 2013005360

GENE COWLES AND AMELIA COWLES d/b/a HILLANDALE ASSISTED LIVING,

Respondents.
_____/

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA NO. 2013011366

GENE COWLES AND AMELIA COWLES d/b/a HILLANDALE ASSISTED LIVING,

Respondents.
_____/

[1] Mr. Cowles passed away on January 23, 2013.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. **AHCA NO. 2013012853**

GENE COWLES AND AMELIA COWLES d/b/a HILLANDALE ASSISTED LIVING,

Respondents.
_____/

GENE COWLES AND AMELIA COWLES d/b/a[2] HILLANDALE ASSISTED LIVING,

Petitioners,

DOAH NO. 13-4783
vs. **AHCA NO. 2012010947**

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. **AHCA NO. 2013010232**

GENE COWLES AND AMELIA COWLES d/b/a AMELIA'S HOUSE,

Respondents.
_____/

[2] The applicants are reflected as the petitioners in the Final Order.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. **AHCA NO. 2013010231**

MAPLE WAY COMMUNITY, INC. d/b/a MAPLE WAY COMMUNITY, **RENDITION NO.: AHCA- 14 -0098 -S-OLC**

Respondent.

_____/

FINAL ORDER[3]

Having reviewed the Administrative Complaint, Notice of Intent to Deny, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency has jurisdiction over Gene Cowles, Amelia Cowles and Maple Way Community Inc. (hereinafter "the Respondents"), pursuant to Chapter 408, Part II, Florida Statutes, and the applicable authorizing statutes and administrative code provisions.

2. The Agency previously issued a Final Order against Gene Cowles and Amelia Cowles d/b/a Hillandale Assisted Living. (Ex. 1). The Cowles appealed the Final Order to the First District Court of Appeal, which stayed the license revocation. The administrative fine of $20,000.00 was paid to the Agency and is non-refundable.

3. The Agency issued the attached Administrative Complaint, Notice of Intent to Deny and Election of Rights forms to the Cowles. (Ex. 2) The Election of Rights form advised of the right to an administrative hearing.

4. The parties have since entered into the attached Settlement Agreement. (Ex. 3)

Based upon the foregoing, it is **ORDERED:**

1. The Settlement Agreement is adopted and incorporated by reference into this Final Order. The parties shall comply with the terms of the Settlement Agreement.

2. The Respondents may not seek licensure nor operate any facility licensed by the Agency.

3. An additional administrative fine and fees of $34,500.00 is imposed against the Respondents, but STAYED for purposes of collection as long as Respondents do not seek any new type of licensure from the Agency. In the event Respondents seeks licensure from the Agency, the Respondents will pay the $34,500.00 before any application for license can be considered.

[3] The Final Order acts as an Amended Final Order as to Case Nos. 2011006466 and 2011006798.

ORDERED at Tallahassee, Florida, on this 13 day of February, 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 CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 13th day of February, 2014.

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Bldg. #3, Mail Stop #3
Tallahassee, Florida 32308-5403
Telephone: (850) 412-3630

Jan Mills Facilities Intake Unit (Electronic Mail)	Shaddrick Haston, Unit Manager Assisted Living Unit Agency for Health Care Administration (Electronic Mail)
Finance & Accounting Revenue Management Unit (Electronic Mail)	Patricia R. Caufman, Field Office Manager Areas 5 and 6 Agency for Health Care Administration (Electronic Mail)

Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Thomas J. Walsh II, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)
Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Tracy George, Chief Appellate Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)
Lynne A. Quimby-Pennock Administrative Law Judge Division of Administrative Hearings (Electronic Mail)	Christina Mesa, Esquire MESA Law, P.A. P.O. Box 10207 Tampa, Florida 33679-0207
Thomas P. Crapps Administrative Law Judge Division of Administrative Hearings (Electronic 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

FILED
AHCA
AGENCY CLERK
2013 APR 16 A 9:41

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GENE COWLES AND AMELIA COWLES d/b/a HILLANDALE ASSISTED LIVING,

Respondent.
_____/

DOAH CASE NO. 11-3721
AHCA NOS. 2011006466
2011006798
LICENSE NO. 10549
FILE NO. 11966321
FACILITY TYPE: ASSISTED LIVING FACILITY
RENDITION NO.: AHCA-13- 0357-FOF-OLC

FINAL ORDER

This cause was referred to the Division of Administrative Hearings where the assigned Administrative Law Judge (ALJ), Lynne A. Quimby-Pennock, conducted a formal administrative hearing. At issue in this case is whether Respondent committed the violations alleged in the Amended Administrative Complaint; and, if so, what penalty should be imposed. The Recommended Order dated January 17, 2013, is attached to this Final Order and incorporated herein by reference, except where noted infra.

RULING ON EXCEPTIONS

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

In determining how to rule upon Petitioner's 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

EXHIBIT 1

> 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 Petitioner's exceptions:

In its exceptions, Petitioner takes exception to the ALJ's recommended penalty, arguing that, in addition to the fine and survey fee imposed by the ALJ, Respondent's assisted living facility license should also be revoked. The Petitioner asks the Agency to either increase the recommended penalty or remand the case back to the ALJ for further consideration of this issue. Respondent filed a response to Petitioner's exceptions, arguing that the exceptions were not in compliance with § 120.57(1)(k), Fla. Stat., because they did not identify the portion of the recommended order to which Petitioner took exception by page number or paragraph and that there are no grounds for increasing the recommended penalty. The Agency rejects Respondent's first argument because in the first numbered paragraph of Petitioner's exceptions, Petitioner identifies the portion of the Recommended Order to which it was taking exception by both page number and paragraph in compliance with § 120.57(1)(k), Fla. Stat. The Agency rejects

Respondent's second argument because, as set forth below, the record supports an increase in the ALJ's recommended penalty to include revocation.

In order to increase an ALJ's recommended penalty, the Agency must review the complete record and state with particularity its reasons for the penalty increase by citing to the record in justifying its action. § 120.57(1)(*l*), Fla. Stat.; Criminal Justice Standards Training Comm'n. v. Bradley, 596 So. 2d 661, 663 (Fla. 1992). A review of the complete record of this case reveals that there is ample record evidence supporting the revocation of Respondent's assisted living facility license. This evidence includes:

- Respondent had previously been cited for failing to provide enough qualified staff to provide a safe living environment for its residents. See Paragraph 17 of the Recommended Order; Petitioner's Exhibit 8.
- During an August 2010 survey, the Agency found three instances in which a resident had been injured and the injury was not properly reported by Respondent. See Paragraph 18 of the Recommended Order; Transcript, Volume I, Pages 95-96 and 99-109; Petitioner's Exhibit 13, 14 and 15.
- Respondent allowed a resident with a known propensity towards violence to continue to reside at its facility after the resident had struck another resident. See Paragraphs 19 through 23 of the Recommended Order; Transcript, Volume II, Pages 170-182; Petitioner's Exhibits 18, 19 and 20.
- Respondent failed to properly report inappropriate behavior exhibited by one of its employees towards a resident. The employee later engaged in sexual conduct with the same resident. See Paragraphs 26 through 33 of the Recommended Order; Transcript, Volume IV, Pages 420-433.

This evidence demonstrates that solely imposing a fine and survey fee in this case would not provide adequate protection to the health, safety and welfare of Respondent's residents. Respondent cares for a very vulnerable segment of Florida's population: young persons with mental and physical problems. Respondent has demonstrated that it cannot adequately care for

such residents and safeguard them from harm. Thus, Respondent should no longer be allowed to have its license.

The ALJ concluded, and neither party has disputed, that Respondent failed to provide a safe and decent environment free from abuse and neglect and failed to treat its residents with consideration and respect and with due recognition of personal dignity and individuality in violation of § 429.28(1)(a) and (b), Fla. Stat. See Paragraph 50 of the Recommended Order. Also, Respondent was terminated as a Medicaid provider, which is grounds for revocation or denial of licensure under § 408.815(1)(e), Fla. Stat. See Paragraph 51 of the Recommended Order. As stated in the Amended Administrative Complaint, these violations give the Agency the authority to revoke Respondent's assisted living facility pursuant to § 429.14(1)(e)1., Fla. Stat., for having been cited for one or more Class I deficiencies; and pursuant to § 429.14(1)(k). Fla. Stat., for having committed an act constituting a ground upon which an application for licensure may be denied. See Paragraph 60 of the Amended Administrative Complaint. Therefore, the Agency grants Petitioner's exceptions to the ALJ's Recommended Penalty. In addition to the fine and survey fee imposed by the ALJ, the Agency hereby imposes the additional penalty of revocation of Respondent's assisted living facility license. Because the Agency finds that it has grounds to increase the ALJ's recommended penalty, it denies the Petitioner's motion for remand as moot.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order.

ORDER

1. The Agency's Amended Administrative Complaint is UPHELD and the above-named Respondent's license is REVOKED.

2. Additionally, a $20,000 fine and $1,000 survey fee are hereby imposed. Unless payment has already been made, payment in the amount of $21,000 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, FL 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.

ORDERED in Tallahassee, Florida, on this 15 day of April, 2013.

Elizabeth Dudek

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 CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 16th day of April, 2013.

RICHARD J. SHOOP, Agency Clerk
AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Copies furnished to:

Jan Mills Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Shaddrick A. 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)	James H. Harris, Esquire Assistant General Counsel Agency for Health Care Administration (Electronic Mail)
Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Gene Cowles and Amelia Cowles Hillandale Assisted Living 6333 Langston Avenue New Port Richey, Florida 34652 (U.S. Mail)

Honorable Lynne A. Quimby-Pennock Administrative Law Judge Division of Administrative Hearings The DeSoto Building 1230 Apalachee Parkway Tallahassee, Florida 32399-3060 (Electronic Filing)	Augustine Smythe Weekley, Esquire Weekley Schulte Valdes, LLC 1635 North Tampa Street, Suite 100 Tampa, Florida 33602 (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. GENE COWLES AND AMELIA COWLES, d/b/a HILLANDALE ASSISTED LIVING, Respondents.	)	Case No. 11-3721

RECOMMENDED ORDER

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

APPEARANCES

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

For Respondents: Augustine Smythe Weekley, Esquire
Weekley Schulte Valdes, LLC
Suite 100
1635 North Tampa Street
Tampa, Florida 33602

STATEMENT OF THE ISSUES

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

PRELIMINARY STATEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

FINDINGS OF FACT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Sexual abuse" means acts of a sexual nature committed in the presence of a vulnerable adult without that person's informed consent. . . . "Sexual abuse" does not include any act intended for a valid medical purpose or any act that may reasonably be construed to be normal caregiving action or appropriate display of affection.

* * *

"Caregiver" means a person who has been entrusted with or has assumed the responsibility for frequent and regular care of or services to a vulnerable adult on a temporary or permanent basis and who has a commitment, agreement, or understanding with that person . . . that a caregiver role exist. "Caregiver" includes, but is not limited to, . . . employees and volunteers of facilities as defined in subsection (8). . . .

Request that the administrator be told of the report if filed with the hotline as soon as is possible.

Revised July 2009

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

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

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

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

* * *

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

* * *

(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.

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

* * *

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

* * *

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

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

* * *

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

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

ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter.

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

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

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

* * *

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

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

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

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

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

* * *

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

* * *

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

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

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

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

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

* * *

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

* * *

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

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

* * *

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

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

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

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

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

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

44. Section 429.02 provides, in pertinent part:

(5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

45. Section 429.075 provides, in pertinent part:

An assisted living facility that serves three or more mental health residents must obtain a limited mental health license.

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

(2) Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.

46. Section 429.14 provides, in pertinent part:

> (1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee:
>
> (a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
>
> * * *
>
> (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.
>
> * * *
>
> (h) Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.
>
> * * *
>
> (k) Any act constituting a ground upon which application for a license may be denied.

47. Section 429.19 provides, in pertinent part:

> (1) In addition to the requirements of part II of chapter 408, the agency shall

impose an administrative fine in the manner provided in chapter 120 for the violation of any provision of this part, part II of chapter 408, and applicable rules by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 408.809, for the actions of any facility employee, or for an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:

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

(b) Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation.

* * *

(3) For purposes of this section, in determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

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

(c) Any previous violations.

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

(e) The licensed capacity of the facility.

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

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

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

(7) In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under s. 429.28(3)(c) to verify the correction of the violations.

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

48. Section 408.815 provides, in pertinent part:

> (1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:
>
> (b) An intentional or negligent act materially affecting the health or safety of a client of the provider.
>
> (c) A violation of this part, authorizing statutes, or applicable rules.
>
> (d) A demonstrated pattern of deficient performance.
>
> (e) The applicant, licensee, or controlling interest has been or is currently excluded, suspended, or terminated from participation in the state Medicaid program, the Medicaid program of any other state, or the Medicare program.

49. Section 408.813 provides, in pertinent part:

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

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

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

> cited class I violation. A fine shall be levied notwithstanding the correction of the violation.
>
> (b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

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

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

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

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

RECOMMENDATION

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

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

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

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of January, 2013.

ENDNOTES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COPIES FURNISHED:

Augustine Smythe Weekley, Esquire
Weekley Schulte Valdes, LLC
Suite 100
1635 North Tampa Street
Tampa, Florida 33602

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

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 1
Tallahassee, Florida 32308

Stuart Williams, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

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,

vs.

Case No. 2013005360

GENE COWLES AND AMELIA COWLES d/b/a HILLANDALE ASSISTED LIVING,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, the Agency for Health Care Administration ("Agency") and files this Administrative Complaint against Gene Cowles and Amelia Cowles d/b/a Hillandale Assisted Living ("Respondent" or "Respondent Facility"), pursuant to §§ 120.569 and 120.57, Fla. Stat., and alleges:

NATURE OF THE ACTION

This is an action to revoke Respondent's license to operate an assisted living facility in the State of Florida, to impose an administrative fine in the amount of twenty thousand dollars ($20,000.00) and to impose a survey fee of five hundred dollars ($500.00) based on two State Class I deficiencies pursuant to §§ 408.813 and 429.19, Fla. Stat.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 20.42, 120.60, 408.802, and Chapter 429, Part I, Fla. Stat.

EXHIBIT 2

2. Venue lies pursuant to Fla. Admin. Code R. 28-106.207.

PARTIES

3. The Agency is the regulatory authority licensing assisted living facilities and enforcing all applicable state statutes and rules governing assisted living facilities pursuant to Chapters 408, Part II, and 429, Part I, Fla. Stat., and Chapter 58A-5 Fla. Admin. Code.

4. Respondent operates a 24-bed assisted living facility ("ALF") located at 6333 Langston Avenue, New Port Richey, Florida 34652, and is licensed by the Agency as an ALF, license number 10549, with licensure for limited mental health.

5. At all times material to the allegation of this complaint, Respondent was required to comply with all applicable rules and statutes.

6. Section 429.02, Florida Statutes, defines:

> (1) "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar tasks.
> (2) "Administrator" means an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility.
> . . .
> (5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

. . .
(7) "Community living support plan" means a written document prepared by a mental health resident and the resident's mental health case manager in consultation with the administrator of an assisted living facility with a limited mental health license or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.
(8) "Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited mental health license in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.

7. Section 429.075, Florida Statutes, requires:

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

(2) Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.
(3) A facility that has a limited mental health license must:
(a) Have a copy of each mental health resident's community living support plan and the cooperative agreement with the mental health care services provider. The support plan and the agreement may be combined.
(b) Have documentation that is provided by the Department of Children and Family Services that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility with a limited mental health license.
(c) Make the community living support plan available for inspection by the resident, the resident's legal guardian, the resident's health care surrogate, and other individuals who have a lawful basis for reviewing this document.
(d) Assist the mental health resident in carrying out the activities identified in the individual's community living support plan.
(4) A facility with a limited mental health license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

8. Rule 58A-5.0182, Florida Administrative Code, requires:

An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
(1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:
. . .
(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) . . .
(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.
. . .
(4) ACTIVITIES OF DAILY LIVING. Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident. Residents shall be encouraged to be as independent as possible in performing ADLs.
. . .
(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.
(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
. . .
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's alcohol and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
. . .
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private

communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.

. . .

(8) ELOPEMENT STANDARDS.

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

. . .

(b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:

1. An immediate staff search of the facility and premises;

2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;

3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and

4. The continued care of all residents within the facility in the event of an elopement.

(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S.

(9) OTHER STANDARDS. Additional care standards for residents residing in a facility holding a limited mental health, extended congregate care or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

9. Section 429.28(1), Florida Statutes, guarantees each resident of an assisted living facility:

§ 429.28. 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.
. . .
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
. . .
(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal.
(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.
(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.

(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.
(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

10. Section 415.102, Florida Statutes, defines:

(1) "Abuse" means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.
(2) "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.
. . .
(4) "Caregiver" means a person who has been entrusted with or has assumed the responsibility for frequent and regular care of or services to a vulnerable adult on a temporary or permanent basis and who has a commitment, agreement, or understanding with that person or that person's guardian that a caregiver role exists. "Caregiver" includes, but is not limited to, relatives, household members, guardians, neighbors, and employees and volunteers of facilities as defined in subsection (8). For the purpose of departmental investigative jurisdiction, the term "caregiver" does not include law enforcement officers or employees of municipal or county detention facilities or the Department of Corrections while acting in an official capacity.
. . .
(8) "Facility" means any location providing day or residential care or treatment for vulnerable adults. The term "facility" may include, but is not limited to, any hospital, state institution, nursing home, assisted living facility, adult family-care home, adult day care center, residential facility licensed under chapter 393, adult day training center, or mental health treatment center.
. . .

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

. . .

(19) "Protective investigation" means acceptance of a report from the central abuse hotline alleging abuse, neglect, or exploitation as defined in this section; investigation of the report; determination as to whether action by the court is warranted; and referral of the vulnerable adult to another public or private agency when appropriate.

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

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

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

(23) "Psychological injury" means an injury to the intellectual functioning or emotional state of a vulnerable adult as evidenced by an observable or measurable reduction in the vulnerable adult's ability to function within that person's customary range of performance and that person's behavior.

. . .

(26) "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or

her own care or protection is impaired due to a mental, emotional, long-term physical, or developmental disability or dysfunctioning, or brain damage, or the infirmities of aging.

11. Rule 58A-5.019, Florida Administrative Code, requires:

(1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter.

12. Section 429.23, Fla. Stat., requires:

(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:
(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:
1. Death;
2. Brain or spinal damage;
3. Permanent disfigurement;
4. Fracture or dislocation of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's

investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

13. Rule 58A-5.0241, Florida Administrative Code, requires:

58A-5.0241 Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, January 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated January 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule.

COUNT I

14. The Agency re-alleges and incorporates paragraphs one (1) through thirteen (13), as if fully set forth in this count.

15. The Agency conducted a complaint investigation survey of Respondent on April 29 and 30, 2013.

16. Based on the Agency's surveyor's review of Respondent's records and interviews, the Agency determined that Respondent failed to protect Respondent's residents from suffering violations of resident's rights while residing in the Respondent's assisted living facility and failed to adequately train Respondent's staff.

17. On April 29, 2013, at approximately 10:30 a.m., the Agency's surveyor requested the Respondent's log of Incident Reports from Respondent's staff #A. Staff #A did not know of any Incident Log being kept. Staff #A told the Agency's surveyor, "We don't document all incidents unless they're bad enough."

18. On 4/29/13 at approximately 11:30 a.m., the Agency's surveyor requested the log of Incident Reports from the facility Administrator. The Administrator responded: "I don't keep a log of the incidents, but I have plenty of Incident Reports." The Administrator handed the Agency's surveyor a folder containing 5 Incident Reports dated 2012 and 11 Incident Reports dated 2011. The Agency's surveyor made copies of the 2012 reports for purposes of the survey.

19. On 4/30/13 at approximately 11:00 a.m., a representative of another State agency observed copies of the

reports given to the Agency's surveyor by Respondent's Administrator and provided 2 more reports. The representative of the other State agency stated that the Administrator had pulled the 2 reports out from under his desk mat. The reports were not included in the file presented to the Agency's Surveyor on 4/29/13.

20. The Agency's surveyor reviewed the 7 Incident Reports provided for 2012. All reports involved Resident #23. Resident #23 became a resident of Hillandale on 4/5/2012. The following events, as documented in Hillandale's records, show an escalating pattern of aggression towards others, which the facility failed to redirect:

1. On 5/6/12, "<Resident #23> was upset over relationship break-up ... got aggressive ... wouldn't comply with staff ... fell on floor, hit staff." Actions taken: "<Resident #23> called 911. Police came out took report. I spoke to Administrator." Notified Administrator 5/6/12 at "12:30 noon" Staff I and B added note at bottom of page: "5/7/12-spoke with sheriff they stated <Resident #23> was cop shopping to get what s/he wanted. Not Adverse. No one knows how incident happened--she has made wild accusations not supported by witnesses," initialed "JR." The initials "JR" are the initials of Respondent's Administrator, John Ross. Nothing is written in the

"Follow Up" section at the end of the Incident Report form. There was no documentation of efforts made to prevent reoccurrence.

2. 6/2/12 "Assault on Resident-Living Room 6/2/12 at 10:15 (am/pm not provided)." "<Resident #23> and <Resident #24> (not listed as current resident) got into a squabble. <Resident #24> thought <Resident #23> was going to hit <Resident #24>. <Resident #24> hit <Resident #23>." Laceration & Bite--treated by physician: Northbay 6/2/12 at 11 a.m. "Steps taken to prevent recurrence: <Resident #24> to get evaluated at hospital." This report was prepared by Staff B 6/2/12 at 1:15, a.m. or p.m. not provided. Note at bottom: "<Resident #23> is having mental lapses." The Incident Report was faxed to Consult Care and FACT. No additional follow-up was provided. There was no documentation of efforts made to prevent reoccurrence.

3. 6/12/12 "Client was outside trying to kill a spider. S/he fell trying to kill the spider and twisted ankle." Called 911, Notified <Administrator> 6/12/12 at 4:10 p.m. Follow Up: "primary care/doctor" (no results provided)

4. 9/18/12 "<Resident #23> signed (out) September 13, 2012 Did not return" "Called 911, filed missing persons Report, Baker Acted while in community" Notified <Administrator> 9/18/12 (changed to 9/17/12) at 4:00 p.m.-

-Physician & Case Manager completed by Administrator ... Staff H & C ... Follow Up: "<Resident #23> was Baker Acted the 14th of September. S/he is now in treatment at Largo Medical Center in Indian Rocks." This report was dated as written 5 days after the resident signed out from the facility and did not return.

5. undated; 2/26/13 ? "<Resident #23> adamantly refuses to cooperate with staff, been aggressive toward other clients and staff, walking around the facility with feces and urine, refuses to shower." "Talked to FACT Team and <Resident #23> will be baker acted." Notified doctor and Case Manager on 2/26/13 at 1:30 p.m. --Attached: "<Resident #23> was attacking "<Resident #13>, <Resident #21>, and <Resident #8>, also 2 staff members. <Resident #23> is walking around smearing feces on the walls, couches, and people, walking around without clothes and refuses to cooperate, take shower. This is the 3rd time law enforcement have been called. FACT Team member signed form for her to be baker acted." Follow Up: blank -- There was no documentation of efforts made to prevent reoccurrence. There was no documentation of effects of, or potential harm caused by, being attacked for the 3 residents, Residents #13, #21, and #8.

6. 3/24/13 "<Resident #21> went into "<Resident #23>'s

room to get Christmas iPad and "<Resident #23> just started hitting <Resident #21> for no reason." Staff D - Called 911-Baker Acted Resident #23; "3/24/13 8:40"- Notified: blank; Administrator listed--not as being contacted. Follow Up: blank -- There was no documentation of efforts made to prevent reoccurrence.

7. 4/10/13 "<Resident #23> was attacking other clients then requested something was wrong. <Resident #23> wanted to cut (own) throat. S/he requested to call 911 and be Baker Acted." Staff D and E-called 911; Admin and FACT Team notified at 6 p.m. ... Follow Up: blank.

21. The Agency's surveyor interviewed the Respondent's Administrator on 4/29/13 at approximately 3:00 p.m. Respondent's Administrator stated that Resident #23 had been discharged on 4/10/13. Resident #23 was listed as admitted to the facility on 4/5/12; but no discharge date or information is recorded on the facility Admission /Discharge log. There was no documentation of facility efforts to prevent reoccurrence of incidents involving Resident #23, or to provide adequate protection for the health, safety, and welfare of other facility residents.

22. The Agency's surveyor's review of the Respondent's resident records revealed:

22.(a) Resident #13 became a resident on 11/26/2011. A

plenary guardian was appointed for Resident #13 on 11/10/2008. Resident #13's diagnoses include schizophrenia, grand mal seizures and pseudo-seizures.

22.(b) Resident #21 became a resident of the facility on 6/1/2012. A plenary guardian was appointed for Resident #21 on 11/2/2011. Resident #21's diagnoses include bipolar affective disorder, attention deficit hyperactivity disorder (ADHD), learning disorder and Asperger's syndrome. An evaluation dated 6/29/2011 states: "He needs constant redirection ... He appears to have developed aggressive behaviors as a manipulative technique . . . " A 3/27/2012 evaluation states that Resident #21 "has a tendancy [sic] to become extremely physically violent . . . "

22.(c) An evaluation of Resident #23 dated February 27, 2013, recounts: " This is a __-year-old female, admitted under BA52 [Baker Act] from the ALF Hillandale, where she had been found with a large amount of urine and feces on her body, smeared on the walls, aggressive with clients, attempted to burn another resident with cigarettes, slapped and attacked two staff members, refusing medications. While in the ER, the patient lunged at the ER nursing staff. She also pushed her fingernails into the arm of another nurse."

23. Resident interviews were conducted by the Agency's

surveyors beginning 4/29/13 at 11:50 a.m. The interviews further confirmed instances of resident abuse and Respondent's failure to provide adequate protection for the health, safety, and welfare of facility residents:

23.(a) In the Agency's surveyor's interview with Resident #9 on 4/29/13 at 11:50 a.m., the resident stated: "Staff and residents get into fights. I just stay out of it. <Resident #10> started smacking me on my head. All were on the couch watching TV."

23.(b) In the Agency's surveyor's interview with Resident #17 on 4/29/13 at 12:45 p.m., the resident stated: "<Resident #21> moved out ... won't be coming back ... 2 incidents ... got up in my face and pushed all the time ... <Resident #21> moved back home and won't be coming back... got in a fight with <Resident #23> perfume given to my roommate s/he was trying to claim, pushed <resident> down ... <resident> had a water bottle ...water went all over. I pushed <resident> out of my room and locked my door. I heard <Resident #23> was evicted, not allowed back due to tantrums and running away. <There's a> hole in back fence. <Residents> sneak away or slip out when car comes through."

23.(c) In the Agency's surveyor's interview with Resident #5 on 4/29/13 at 1:05 p.m., the resident stated, when asked if he has been attacked or hit by any staff or

residents: "<Resident #4 ... not that much ... Staff make threats but don't hit. They say, 'If you don't go to bed, I will put you in time out." Resident stated he likes his freedom and likes to be out walking, wants more privileges at night.

23.(d) In the Agency's surveyor's interview with Resident #11 on 4/29/13 at 1:20 p.m., the resident stated s/he goes to the Clubhouse during the day because the Adult Day Training program in Tarpon Springs "has been shut down for a while." Resident #11 stated: "<Resident #12>, my roommate, stabbed me on the arch of my foot, but there was no blood, no skin cut, no wound ... No, I didn't go to the doctor. They <staff> said it was okay."

23.(e) In the Agency's surveyor's interview with Resident #8 on 4/29/13 at 1:30 p.m., the resident stated, when asked about staff treatment of residents: "We're treated like doormats and 2nd class citizens here. I believe they <staff> steal things, but I've never seen them. They're rude to me and others." When asked about resident fighting, Resident #8 stated, "I never hit anybody. <Resident #23> got locked up."

23.(f) In the Agency's surveyor's interview with Resident #14 on 4/30/13 at 11:30 a.m., the resident stated: "I don't feel safe. <Resident #12> punched me one time in

the back."

24. The Incident Reports provided to the Agency's surveyor were all pertaining to Resident #23, who was named frequently during resident interviews. No Incident Reports were provided to the Agency's surveyor by Respondent's Administrator pertaining to other residents or to incidents mentioned during interviews, and no records were found of Respondent's staff's interventions or attempts to protect residents from violence.

25. The Pasco Sheriff's Department provided a log of calls from the Hillandale facility resulting in visits by deputies during the period from 3/20/13 to 5/1/13. When the Agency's surveyor reviewed the six calls in the Sheriff's Department's log, two - calls on 3/24/13 and 4/10/13 - had written Incident Reports. Following are the 4 additional incidents involving police intervention:

1. "3/20/13 Missing person <Resident #19> left facility 2 days ago and has not returned, does not have meds with her -- staff said "Because she leaves so frequently it is normally not reported right away . . . -reported missing 4 times in the past year." There was no documentation of facility interventions to provide adequate protection for the health, safety, and welfare of Resident #19.

2. "4/2/13 at 6:57 p.m. dispatched to facility regarding runaway/missing person <Resident #19>. <Staff D> reported

that resident escaped out of facility on 3/13/13 3 p.m. by climbing through a hole in the fence." Clearwater Police picked up resident and transported to Morton Plant Hospital. There was no documentation of the 3/13/13 elopement and no documentation of the 4/2 report; there was no evidence of concern regarding the 20 days that passed between elopement and police dispatch.

3. "4/7/13 simple battery <Resident #21> Suspect <Resident #23> attacked <Resident #21> standing in line for medicine when <Resident #23> attacked <Resident #21>. <Staff F> said <Resident #23> started to slap and scratch <Resident #21> on neck, face, and back. <Resident #21> said s/he was standing in line for meds; Staff <F> said it happened when <Resident #23> came out of <own bedroom>. <Resident #23> said <Resident #21> attacked <Resident #23> & hit <Resident #23> in the face--case transferred to State Attorney's Office." A facility incident report dated 4/10/13 was provided--referencing Resident #23 "attacking other clients," but no documentation of the 4/7/13 incident. There was no documentation of facility interventions to provide adequate protection for the health, safety, and welfare of either of Residents #21 or #23. On 4/10/13, Resident #23 said she knew something was wrong, wanted to cut (own) throat, and requested facility

staff call 911 to be Baker Acted. There was no evidence of staff concern for resident welfare.

4. 4/15/13 7:20 p.m. Responded in reference to suicide threats; reported by Staff F - <Resident #18> harming himself-upset that he lost game charger-threw picture frame-" began bashing his head into the wall, causing a laceration on his forehead. <Staff F> brought <Resident #18> into office and attempted to calm down. <Resident #18> then began bashing his head into the wall, causing a laceration on his forehead. <Staff F> immediately called the Pasco Sheriff's Office to report the incident and have <Resident #18> Baker Acted for safety." Transported to Trinity Hospital to be treated for injury; Baker Act form completed while at Trinity. On 4/29/13 and 4/30/13, two Agency surveyors were approached multiple times, 2-3 times each, by Resident #18 regarding needing a charger for his game. There were no documented attempts by the facility to assist the resident with concern causing him considerable distress and documented suicide threat. There was no documentation of efforts by facility to prevent reoccurrence of resident self-harm.

26. The Agency determined that Respondent's above violation of residents' rights is a condition or occurrence related to the operation and maintenance of a provider or to the

care of clients which the agency determines presents an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result, and which the Agency determined to be a class I violation for the purposes of sections 408.813 and 429.19, Florida Statutes.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $10,000.00 against Respondent, pursuant to §§ 408.813 and 429.19, Florida Statutes, or such further relief as this tribunal deems just.

COUNT II

27. The Agency re-alleges and incorporates paragraphs one (1) through thirteen (13), as if fully set forth in this count.

28. Based on observations, interviews, and record review, the assisted living facility failed to ensure residents lived in a safe and decent living environment, specifically allowing a continued and ongoing bed bug infestation, originally identified on August 2, 2012, and identified on April 29 and 30, 2013, as directly effecting at least 7 residents - Residents #1, #2, #10, #11, #12, #14 and #15 - of 20 current residents and failed to follow all recommended procedures set forth by the County Health Department on 4/30/13 to include removing residents from the affected rooms immediately, until pest control is complete.

29. The Agency's surveyor's review of a County Department

of Health inspection report dated 8/02/12 revealed "Per conversation with the... administrator, inspector was advised of the presence of the pests (beg bugs) two weeks ago."

30. The Agency's surveyor's review of a County Department of Health inspection report dated 10/09/12 revealed the county inspector identified the presence of bed bugs. The report indicated: "Violation #27 Live bedbugs observed in rooms 3 and 8. Residents must be removed from these rooms until problem resolved. Staining on some beds in other rooms may indicate previous or current infestation. All bedding must be thoroughly inspected and situation monitored on ongoing basis."

31. The Agency's surveyor's review of a County Department of Health inspection report dated 1/09/13 revealed the county inspector identified the presence of bed bugs. The report indicated: "Violation #27 Active widespread bedbug infestation."

32. The Agency's surveyor observed several of Respondent's residents waiting for medications on 4/30/13 at approximately 7:05 a.m. Resident #10 was among the residents standing in line. Resident #10 was observed to scratch his back and left shoulder and make a guttural noise, "ugh." When the surveyor asked if he was ok, he indicated, "those (deleted word) bugs." Upon the Agency's surveyor's request, Resident #10 removed his long-sleeved jacket. He was observed to wear a sleeveless t-shirt under the long-sleeved jacket. His left arm was observed

to have multiple red blotches on the lower half, while his shoulder and upper part of his arm were covered with multiple bumps characteristic of bedbug bites.

33. The Agency's surveyor observed Respondent's resident room #7 at 7:40 a.m. on 4/30/13. A twin size bed was up against the west wall, with the head of the bed against the north wall. This was the only bed in the room. The bed was made. The surveyor pulled the top sheet back. Multiple live insects, which looked like bedbugs, were observed on the top sheet of the bed. The pillow was pulled up and the surveyor viewed the area where the fitted sheet and mattress abutted the head board. Insects were observed to scurry upon exposure. The top sheet was pulled back from the foot of the bed. Two insects were observed on the fitted sheet along the seam. The insects that were observed on this bed were ovoid in shape, flattened, reddish brown in color and many of them were observed to have distended abdomens. Many of the insects were the size of apple seeds. A single insect was picked up by the surveyor from the top sheet, placed on the floor and stepped on with the tip of his right shoe. The bug exploded, and red fluid, resembling blood, spattered on the floor. The above actions were witnessed by Respondent's employee #A.

34. The Agency's surveyor observed Respondent's room #8 at approximately 7:50 a.m. on 4/30/13. Two beds were present. One

of the beds abutted the north wall, with the head of the bed against the east wall. The bed linens were pulled up to the head of the bed. The bedspread and top sheet were pulled back from the head of the bed. A few small rust colored spots were observed on the pillow and the sheet. Two insects were observed on the southern, long outside, edge of the bed. One bug was the size of an apple seed. It was reddish brown in color with a distended abdomen.

35. In an interview with Respondent's employee #A, after the observations on 4/30/13 at approximately 8 a.m., the Agency's surveyor was told that employee #A would remove the residents' bed linens and their clothes and wash them as well as spray the beds.

36. The Agency's surveyor observed the spray utilized by, and concurrently interviewed, employee #A on 4/30/13 at 9:30 a.m. Respondent's employee #A stated that she had removed bed linens from rooms #7 and #8. According to employee #A, the product she used to spray the beds was an ecologically friendly product. The main ingredient in this product was listed as 95% d-limonene, per the label that was affixed to the can of spray. She indicated this is the product the pest control company uses.

37. An interview was conducted with a representative of the County Health Department 4/30/12 at 11: 40 a.m. She indicated there was a current infestation of bed bugs. She

confirmed that the insects identified by the surveyor in room #7 and #8 were bedbugs. She indicated that bedbugs are very resistant to poisons so the best methods of extermination are heat or freezing. She also indicated the bugs she observed at Respondent's assisted living facility were well fed.

38. A County Health Department inspection report dated 4/30/12 with a beginning time of 11:00 a.m. and an ending time of 11:50 a.m. documented: "Violation #27 Active infestations observed in rooms 1, 7, 8, and 10. Residents must be removed from these rooms until professional pest control is completed. All linens and clothing must be washed and dried on high heat and room, furniture and mattresses thoroughly vacuumed."

39. On April 30, 2013, at 9:20 a.m., the Agency's surveyor conducted an interview with Resident #10.

39.(a) 10:10 a.m. - I meet with resident #10, who resides in room #7. He was oriented to self, place and date.

39.(b) He stated that he had been getting bitten by bugs in his room for approximately one month.

39.(c) He stated he informed the administrator, and that staff #A had sprayed his room. He was not sure of the specific date.

39.(d) Observation of his arms, back and lower legs and feet revealed visible small red marks covering his upper

back, upper and lower arms and his lower legs including his feet. He indicated he has not seen a doctor for the bites.

40. The Agency's surveyor conducted an interview with Respondent's staff #A on 4/30/13 at 12:45 p.m. regarding Resident #10 in room #7. She indicated she was not aware of Resident #10 bringing to the facility's attention that he was being bitten by bedbugs. She stated that she contacted the pest control company that Respondent has contracted with to provide pest control. She stated that the pest control company will come out "this Friday," May 3, 2013, and treat for bedbugs. When asked about moving the residents in the infested rooms to uninfested rooms, she indicated she would wash all bed linens in affected rooms in hot water and dry with high heat. She also stated that she is spraying the bedframes with pesticide, 95% d-limonene, which was provided by the pest control company to treat for bedbugs. She confirmed there was an empty room available in the building with 2 beds.

41. On 4/30/13 at approximately 12:55 p.m., the Agency's surveyor conducted a telephone interview with the branch manager of the pest control company with whom Respondent contracted. He confirmed that a representative of the pest control company will be on-site at the Respondent's building on Friday, May 3, 2013, to treat for bedbugs. He stated they are going to all rooms in the facility. He also stated that they will be using liquid

nitrogen to provide freezing treatment for bedbugs.

42. On 4/30/13 at approximately 1:45 p.m., the Agency's surveyor was able to interview Resident #11. She stated that the bedbugs have affected her. She showed the Agency's surveyor her lower arms. Observed were small red marks on each arm, appearing to be bedbug bites.

43. A County Health Department inspection report was reviewed on 5/8/13. The report was dated 5/7/13 and indicated: "Live adult bedbugs observed in bed on right side of room 10."

44. The Agency determined that Respondent violated resident's rights by not immediately taking the corrective action indicated by the County Health Department inspector on April 30, 2013, to immediately remove the residents from infected rooms #1, #7, #8 and #10, and that this violation is a condition or occurrence related to the operation and maintenance of a provider or to the care of residents which the agency determined presents an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result, which the Agency determined to be a class I violation for the purposes of sections 408.813 and 429.19, Florida Statutes.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $10,000.00 against Respondent, pursuant to §§ 408.813 and 429.19, Florida Statutes, or such further relief

as this tribunal deems just.

COUNT III SURVEY FEE

45. The Agency re-alleges and incorporates above Counts I and II, as if fully set forth in this count.

46. Pursuant to Section 429.19(7), Florida Statutes, in addition to any administrative fines imposed, the Agency may assess a survey fee equal to the lesser of one half of a facility's biennial license and bed fee, or $500, to cover the cost of conducting an initial complaint investigation that results in the finding of a violation that was the subject of the complaint, or to cover the cost of a future monitoring survey where the current survey finds one or more Class I or Class II violations.

47. On or about April 29 and 30, 2013, the Agency conducted a complaint investigation at the Respondent Facility which resulted in the finding of a violation that was the subject of the complaint to the Agency, or which found one or more Class I violations, or both.

48. Pursuant to Section 429.19(7), Florida Statues, such a finding as specified in above paragraph 47 subjects the Respondent Facility to a survey fee equal to the lesser of one half of the Respondent's biennial license and bed fee, or $500.00.

49. Respondent is therefore subject to an additional

survey fee of five hundred dollars ($500.00), pursuant to Section 429.19(7), Florida Statutes, in addition to the fine applicable to the violations found at the above Agency survey of April 29 and 30, 2013.

WHEREFORE, the Agency intends additionally to impose a survey fee of five hundred dollars ($500.00) against Respondent, pursuant to Section 429.19(7), Florida Statutes.

COUNT V REVOCATION OF LICENSE

50. The Agency re-alleges and incorporates paragraphs one (1) through thirteen (13) and above Counts I and II, as if fully set forth in this count.

51. Pursuant to section 429.01, Florida Statutes:

> (2) The purpose of this act [the Assisted Living Facilities Act] is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decisionmaking ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state, to promote continued improvement of such facilities, to encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes, to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, the Department of Health, assisted living facilities, and other community agencies. To the maximum extent possible, appropriate community-based programs must be available

to state-supported residents to augment the services provided in assisted living facilities. The Legislature recognizes that assisted living facilities are an important part of the continuum of long-term care in the state. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated and regulated as residential environments with supportive services and not as medical or nursing facilities. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible. Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences.
(3) The principle that a license issued under this part is a public trust and a privilege and is not an entitlement should guide the finder of fact or trier of law at any administrative proceeding or in a court action initiated by the Agency for Health Care Administration to enforce this part.

52. Section 408.815(1), Florida Statutes, provides that:

In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:
. . .
(b) An intentional or negligent act materially affecting the health or safety of a client of the provider.
(c) A violation of this part, authorizing statutes, or applicable rules.
(d) A demonstrated pattern of deficient performance.
(e) The applicant, licensee, or controlling interest has been or is currently excluded, suspended, or terminated from participation in the state Medicaid program, the Medicaid program of any other state, or the Medicare program.

53. Pursuant to Section 429.14, Florida Statutes, administrative penalties include:

(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.
. . .
(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.
. . .
(h) Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.
. . .
(k) Any act constituting a ground upon which application for a license may be denied.
. . .
(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.

54. Section 429.11, Florida Statutes, requires:

(1) Each applicant for licensure must comply with all provisions of part II of chapter 408 and must:
. . .
(5) The applicant must furnish documentation of a satisfactory sanitation inspection of the facility by the county health department.

55. Pursuant to a complaint investigation survey concluded on August 15, 2007, Respondent was cited, among other violations of residents' rights, alleging that Respondent had committed a Class II violation, in summary:

55.(a) Based upon record review, staff interview and observation, the Respondent failed to provide a safe and decent living environment, in that residents were subjected to unpredictable and violent behaviors from other facility residents, resulting in injury, due to incomplete or absent medical examination reports, inappropriate placement of residents with a history of aggressive behavior, insufficient staffing to meet resident supervision needs, the failure to report changes in resident conditions and behaviors to the appropriate parties and the maintenance of a written record of such, for 4 of 4 sampled discharged residents, Former Residents #20, #21, #22 and #23, and 20 of 20 current residents, Residents #1 through #19 and #24.

55.(b) An administrative complaint based on the above was served on Respondent on November 27, 2007.

55.(c) On December 5, 2007, Respondent filed with the Agency's clerk an Election of Rights which admitted the allegations of fact and law contained in the Agency's Administrative Complaint which had been served on

Respondent on November 27, 2007.

55.(d) On January 7, 2008, the Agency entered a final order determining that the allegations of the administrative complaint served on Respondent on November 27, 2007, were a Class II violation, fining Respondent $1,000 and imposing a survey fee of $167.50.

56. On April 16, 2013, the Agency entered a Final Order against Respondent, a true and correct copy of which is attached as exhibit A to this administrative complaint, which states on page 4 of the Final Order:

> The ALJ [Administrative Law Judge from the Division of Administrative Hearings] concluded, and neither party has disputed, that Respondent failed to provide a safe and decent environment free from abuse and neglect and failed to treat its residents with consideration and respect and with due recognition of personal dignity and individuality in violation of § 429.28(1)(a) and (b), Fla. Stat. See Paragraph 50 of the Recommended Order.

57. Paragraphs 16, 17 and 18 of the ALJ's Recommended Order of January 17, 2013, find:

> 16. The Hillandale staff did not have adequate training to manage the residents, other than moving them from one activity to another.
>
> 17. In 2007, an Administrative Complaint was issued alleging Hillandale had failed to provide enough qualified staff to provide a safe living environment for the residents. Hillandale was alleged to have violated the residents rights to live in a safe and decent living environment, free form abuse and neglect, and the residents were not treated with consideration, respect, and due recognition of their personal dignity. Hillandale admitted the allegations, and, on January 3, 2008, AHCA [the

Agency] issued a Final Order finding that Hillandale was in violation of section 429.28(1)(a) and (b), Florida Statutes (2007). An administrative fine was imposed as well as a fee for the survey.

18. In August 2012, Katherine Benjamin [an Agency surveyor] was at Hillandale to conduct a survey. In conducting that survey, Ms. Benjamin reviewed several Facility Event Reports (reports). In each report reviewed, a resident had suffered some kind of injury, either self-inflicted or caused by another resident. These reports, when initially reviewed by the surveyor, did not contain documentation that the residents' health care provider, the residents' representative, or their appropriate case worker had been notified. Further, the report form specifically directs that the date and time that those persons were notified should be recorded. That specific information was not present. These reports are required to be completed by Hillandale staff to document what happened and how the events were resolved. Ms. Benjamin found deficiencies in three different instances. Mr. Ross described the discrepancies as merely "a paperwork problem" that was corrected. When other deficiencies or problems were pointed out by surveyors, Mr. Ross discounted, disputed or otherwise found fault with the surveyors as opposed to accepting that there was or might be a problem and embracing the opportunity to improve the care.

58. Paragraph 50 and 51 of the ALJ's Recommended Order of January 17, 2013, find:

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

429.28(1)(a) and (b), Fla. Stat.

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

59. Each of Counts I and II of this administrative complaint are individually the Respondent's intentional or negligent acts materially affecting the health or safety or welfare of a resident of Respondent's assisted living facility, for purposes of §§ 408.815(1)(b) and 429.14(1)(a), Fla. Stat., each count individually providing the Agency with a ground to revoke Respondent's license as an assisted living facility.

60. Each of Counts I and II of this administrative complaint are individually the Respondent's violations of Chapter 429, Part I, Fla. Stat., or Rule Chapter 58A-5, Fla. Admin. Code, or both for purposes of § 408.815(1)(c), Fla. Stat., each count individually providing the Agency with a ground to revoke Respondent's license as an assisted living facility.

61. Count I, together with paragraphs 55 through 58 of this administrative complaint are a demonstrated pattern of deficient performance for purposes of § 408.815(1)(d), Fla. Stat. Specifically, Respondent has repeatedly failed to provide a safe and decent environment free from abuse and neglect and has failed to treat its residents with consideration and respect and with due recognition of personal dignity and individuality,

thus providing the Agency with a ground to revoke Respondent's license as an assisted living facility.

62. As set forth in above paragraph 58, the Respondent was terminated from the State of Florida's Medicaid program, thus providing the Agency with a ground to revoke Respondent's license pursuant to § 408.815(1)(e), Fla. Stat.

63. Each of Counts I and II of this administrative complaint are individually the Respondent's class I deficiencies, for purposes of § 429.14(1)(e), Fla. Stat., each count individually providing the Agency with a ground to revoke Respondent's license as an assisted living facility.

64. Count II of this administrative complaint demonstrates that due to the on-going, over nine months long bedbug infestation of Respondent's assisted living facility, Respondent cannot furnish documentation of a satisfactory sanitation inspection of the facility by the county health department, a requirement for license under § 429.11(5), Fla. Stat., thereby furnishing the Agency with a ground to revoke Respondent's license pursuant to § 429.14(1)(h) and (k), Fla. Stat.

65. Count I, together with paragraphs 56 through 58 of this administrative complaint are 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,

for purposes of § 429.14(4), Fla. Stat, requiring that the Agency revoke Respondent's license as an assisted living facility. Specifically, by the Agency's surveys of May 28 and June 1 and 6, 2011, the Agency identified two Class I violations due to Respondent's failure to provide Respondent's residents with a safe and decent environment free from abuse and neglect, and Respondent's failure to treat its residents with consideration and respect and with due recognition of personal dignity and individuality, as set forth in above paragraph 56, 57 and 58. As set forth in Count I of this administrative complaint, by the Agency's survey or April 29 and 30, 2013, the Agency has again identified a Class I violation due to Respondent's failure to provide Respondent's residents with a safe and decent environment free from abuse and neglect and Respondent's failure to treat its residents with consideration and respect and with due recognition of personal dignity and individuality. Since the Agency's survey of April 29 and 30, 2013, is within two years of the Agency's surveys of May 28 and June 1 and 6, 2011, the Agency is statutorily required to revoke Respondent's license as an assisted living facility.

WHEREFORE, the Agency intends additionally to revoke Respondent's license as an assisted living facility in the State of Florida.

NOTICE OF RIGHTS

Respondent is notified that it has a right to request an administrative hearing pursuant to Section 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, whose telephone number is 850-412-3630.***

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 will be served by Personal Service on the day and date indicated on the Return Service Receipt to Hillandale Assisted Living, 6333 Langston Avenue, New Port Richey, Florida 34652.

James H. Harris
Assistant General Counsel
Fla. Bar. No. 817775
Agency for Health Care Administration
525 Mirror Lake Drive, 330D
St. Petersburg, Florida 33701
727-552-1944 (office)
727-552-1440 (facsimile)
james.harris@ahca.myflorida.com

Copies furnished to:

Paul Brown, HFE Supervisor, St. Petersburg

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: Gene Cowles and Amelia Cowles **CASE NO. 2013005360**
d/b/a Hillandale Assisted Living

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine** or **Administrative Complaint.**

Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308.
Phone: 850-412-3630 Fax: 850-921-0158.

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fine or Fee, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I wish to be heard at an informal proceeding** (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes.

It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed administrative action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

I hereby certify that I am duly authorized to submit this Notice of Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____Date: _____

Print Name:_____ Title: _____

Late fee/fine/AC

2012010947

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

October 9, 2012

RECEIVED
GENERAL COUNSEL
OCT 10 2012
Agency for Health Care Administration

JOHN ROSS, ADMINISTRATOR
HILLANDALE
P.O. BOX 1778
SAFETY HARBOR, FL 3

Certified Article Number
7196 9008 9111 8144 7419
SENDERS RECORD

RE: Case Number: 2012010947

NOTICE OF INTENT TO DENY

Dear Mr. Ross:

It is the decision of this Agency that Hillandale renewal application for the Assisted Living Facility license to be DENIED.

The Specific Basis for this determination is the failure to meet minimum licensure standards pursuant to Sections 408.15 (1) (b) & (c), Florida Statutes, (F. S.). The facility has a revocation pending AHCA case numbers 2011006798 and 2011006566 completed by Area Office for survey deficiencies. Two Class I deficiencies were cited on May 28 and June 1, 2011 related to the facility failed to protect the rights of residents to live in a safe and descent free from abuse. Therefore the renewal is denied in accordance with Chapter 408, Part II; and Sections 429.28(a) and 429.14 (1) (a), (e) 1. (h) & (k), F. S.

EXPLANATION OF RIGHTS

Pursuant to Section 120.569, Florida Statutes, (F.S.) you have the right to request an administrative hearing. In order to obtain a formal proceeding before the Division of Administrative Hearings under Section 120.57(1), F.S., your request for an administrative hearing must conform to the requirements in Section 28-106.201, Florida Administrative Code (F.A.C), and must state the material facts you dispute.

SEE ATTACHED ELECTION OF RIGHTS FORM

Sincerely,

Shaddrick A. Haston, Manager
Assisted Living Unit
Bureau of Long Term Care Services

SH/spicerp

Copy to: Saint Petersburg Field Office - 05
LTCOC District 05
[redacted]

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

DOAH NO. 11-33721
AHCA NOs. 2011006466
2011006798

GENE COWLES[1] AND AMELIA COWLES d/b/a
HILLANDALE ASSISTED LIVING,

Respondent.

_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

DOAH NO. 13-3111PH
AHCA NO. 2013005360

GENE COWLES[2] AND AMELIA COWLES d/b/a
HILLANDALE ASSISTED LIVING,

Respondent.

_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA NO. 2013011366

[1] Gene Cowles passed away January 23, 2013.
[2] Gene Cowles passed away January 23, 2013.

EXHIBIT 3

GENE COWLES[3] AND AMELIA COWLES d/b/a
HILLANDALE ASSISTED LIVING,

Respondent.

_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA NO. 2013012853

GENE COWLES[4] AND AMELIA COWLES d/b/a
HILLANDALE ASSISTED LIVING,

Respondent.

_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA NO. 2012010947
DOAH NO. 13-4783

GENE COWLES[5] AND AMELIA COWLES
d/b/a HILLANDALE ASSISTED LIVING,

Respondents.

_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA NO. 2013010232

[3] See footnote 1.
[4] See footnote 1.
[5] Gene Cowles passed away on January 23, 2013.

GENE COWLES[6] AND AMELIA COWLES d/b/a
AMELIA'S HOUSE,

Respondent.

_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA NO. 2013010231

MAPLE WAY COMMUNITY INC. d/b/a
MAPLE WAY COMMUNITY,

Respondent.

_____/

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondents, Gene Cowles and Amelia Cowles (hereinafter "Cowles), and Maple Way Community Inc. (hereinafter "Maple Way"), (Cowles and Maple Way are hereinafter also referred to as "Respondents"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondents, at all times relevant, were assisted living facilities licensed pursuant to Chapters 408, Part II and 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code; and

[6] See footnote 1.

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondents, pursuant to Chapters 408, Part II and 429, Part I, Florida Statutes; and

WHEREAS, the Agency entered a Final Order in Agency Case numbers 2011006798 and 2011006466, revoking Cowles' assisted living facility license, license number 10549, and imposing twenty thousand dollars ($20,000.00) in administrative fines and one thousand dollars ($1,000.00) in survey fees[7]; and

WHEREAS, the Final Order in this above referenced is currently pending on appeal before the First District Court of Appeal assigned case number 1D13-1948. On April 30, 2013, the District Court of Appeal entered an order staying the revocation of Cowle's license during the pendency of the appeal; and

WHEREAS, the Agency served Cowles with an administrative complaint on or about June 19, notifying Cowles of the Agency's intent to impose administrative fines in the amount of twenty thousand dollars ($20,000.00), impose a survey fee of five hundred dollars ($500.00), and revoke the licensure of the Hillandale Assisted Living facility, license number 10549, in AHCA Number 2013005360; and

WHEREAS, the Agency intends to serve an administrative complaint on Cowles notifying Cowles of the Agency's intent to impose administrative fines in the amount of one thousand dollars ($1,000.00) based upon a survey completed on July 25, 2013 at Hillandale Assisted Living facility, license number 10549, in AHCA number 2013011366; and

WHEREAS, the Agency intends to serve an administrative complaint on Cowles notifying Cowles of the Agency's intent to impose administrative fines in the amount of seven

[7] The financial sanctions in this cause have been paid and are considered satisfaction of the assessments levied in the Final Order.

thousand five hundred dollars ($7,500.00) based upon a survey completed on October 15, 2013 at Hillandale Assisted Living facility, license number 10549, in AHCA number 2013012853; and

WHEREAS, the Agency served Cowles with a Notice of Intent to Deny the application for renewal of licensure of Hillandale Assisted Living facility, license number 10549, in AHCA number 2012010947, Division of Administrative Hearings number 13-4783; and

WHEREAS, the Agency intends to serve an administrative complaint on Cowles notifying Cowles of the Agency's intent to impose administrative fines in the amount of five thousand dollars ($5,000.00), impose a survey fee of five hundred dollars ($500.00), and revoke the licensure of the Amelia's House Assisted Living facility, license number 10402, based upon a survey dated June 2, 2011, in AHCA Number 2013010232; and

WHEREAS, the Agency intends to serve an administrative complaint on Maple Way Community, Inc. notifying Maple Way of the Agency's intent to revoke the licensure of the Maple Way Community Assisted Living facility, license number 10785, based upon administrative actions against the Hillandale Assisted Living facility in AHCA Number 2013010231; and

WHEREAS, the parties have negotiated and agreed that the best interest of all the parties will be served by a settlement of this proceeding; and

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

1. All recitals herein are true and correct and are expressly incorporated herein.

2. Both parties agree that the "whereas" clauses incorporated herein are binding findings of the parties.

3. Upon full execution of this Agreement, Respondent agrees to waive any and all appeals and proceedings to which it may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that no agreement herein shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement. Respondent specifically waives the necessity of the drafting of or service of an Administrative Complaint for the relief stipulated to in this Agreement as the same relates to case numbers 2013011355,2013012853, 2013010232, and 2013010231.

4. Except as provided in paragraph five (5) below, no fine shall be payable by Cowles at this time and a fine of thirty-three thousand five hundred dollars ($33,500.00), and survey fees of one thousand dollars ($1,000.00)[8], are stayed.

5. Cowles and Maple Way further stipulate as follows:

a. The parties stipulate and agree that this Agreement shall not be effective until such time as the First District Court of Appeal issues an order relinquishing jurisdiction over the pending appeal, Appeal Number 1D13-1948, so that the parties may carry out the settlement terms of this Agreement. The parties agree to promptly file a joint motion to relinquish jurisdiction in the First District Court of Appeal, DCA Case number 1D13-1948; Agency Case numbers 2011006466 and 2011006798; and DOAH Case number 11-3721.

[8] These sums represent monetary sanctions imposed in Agency Case numbers 2013005360, 2013011366, 2013012853, and 2013010232.

b. All residents in the Hillandale Assisted Living facility, license number 10549, shall be discharge on or before January 31, 2014, unless the Agency has, prior thereto, issued a "Change of Ownership" licensure to another person or entity.

c. After the cancellation of the license or issuance of the "Change of Ownership" license for the Hillandale Assisted Living facility, Cowles shall promptly file a notice of voluntarily dismissal of the appeal in the First District Court of Appeal, Appeal Number 1D13-1948.

d. All residents in the Amelia's House assisted living facility, license number 10402, shall be discharge on or before March 31, 2014, unless the Agency has, prior thereto, issued a "Change of Ownership" licensure to another person or entity.

e. All residents in the Maple Way Community assisted living facility, license number 10785, shall be discharge on or before January 31, 2014, unless the Agency has, prior thereto, issued a "Change of Ownership" licensure to another person or entity.

f. Effective at 5:00 p.m., January 31, 2014, the assisted living facility licenses of Hillandale Assisted Living, license number 10549, and Maple Way Community, license number 10785, shall be deemed relinquished and cancelled, unless the Agency has issued a "Change of Ownership" license to another person or entity to operate the facility, respectively.

g. Effective at 5:00 p.m., March 31, 2014, the assisted living facility license of Amelia's House, license number 10402, shall be deemed relinquished and cancelled, unless the Agency has issued a "Change of Ownership" license to another person or entity to operate the facility, respectively. Should Respondents file an application for licensure renewal for Amelia's House prior to March 31, 2014, the provisions of sub-

paragraph (5)(i) below shall not be invoked provided, however, should a "Change of Ownership" license not be issued to a third party on or before March 31, 2014, any license renewal application filed by Respondents for Amelia House shall be deemed withdrawn by Respondents and deemed denied effective April 1, 2014.

h. The Notice of Intent to Deny in Agency Case number 2012010947, DOAH Case number 13-4783, shall be deemed dismissed as moot.

i. Cowles, individually, further stipulates and agrees that Cowles and Maple Way, and any business entity in which Cowles, individually, or Maple Way, holds an interest, shall not apply for future licensure administered by law by the Agency for Health Care Administration, nor shall Maple Way or Cowles, individually, obtain any interest in any business entity which holds licensure administered by law by the Agency for Health Care Administration. For the purposes of this paragraph, the term "business entity" shall not include any business entity publicly traded on a recognized stock exchange. Should Maple Way or Cowles, individualy, apply for licensure from the Agency for Health Care Administration, either as a principal or as one holding an ownership interest in any business entity applying for licensure, the administrative fines and fees assessed in these causes shall be deemed immediately due and payable in the total sum of thirty-four thousand five hundred dollars ($34,500.00), such payment constituting a condition precedent to licensure.

6. Venue for any action brought to enforce the terms of this Agreement or the Final Order entered pursuant hereto shall lie in Circuit Court in Leon County, Florida.

7. By executing this Agreement, Cowles and Maple Way neither admit nor deny the allegations set forth in the Administrative Complaint and surveys referenced herein, and the

Agency asserts the validity of the allegations raised in the administrative complaint referenced herein. No agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, which constitutes a "repeat" or "uncorrected" deficiency from surveys identified in the administrative complaint. The parties agree that in such a "repeat" or "uncorrected" case, the deficiencies from the surveys identified in the administrative complaint shall be deemed found without further proof.

8. No agreement made herein shall preclude the Agency from using the deficiencies from the surveys identified in the administrative complaint in any decision regarding licensure of Maple Way and Cowles, individually, including, but not limited to, licensure for limited mental health, limited nursing services, extended congregate care, or a demonstrated pattern of deficient performance. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Maple Way and Cowles, individually, acknowledges and agrees that this Agreement shall not preclude or estop any other federal, state, or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the administrative complaint and surveys referenced herein. This agreement does not prohibit the Agency from taking action regarding Maple Way and Cowles' Medicaid provider status, conditions, requirements or contract.

9. Upon full execution of this Agreement, the Agency shall enter a Final Order adopting and incorporating the terms of this Agreement and closing the above-styled case.

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

11. This Agreement shall become effective on the date upon which it is fully executed by all the parties.

12. Maple Way and Cowles, individually, for themselves and for their related or resulting organizations, successors or transferees, attorneys, heirs, and executors or administrators, do hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from 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 this matter and the Agency's actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement, by or on behalf of Respondent or related facilities.

13. This Agreement is binding upon all parties herein and those identified in paragraph twelve (12) of this Agreement.

14. In the event that Respondent was a Medicaid provider at the subject time of the occurrences alleged in the complaint herein, this settlement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any sanctions pursuant to Rule 59G-9.070, Florida Administrative Code.

15. Respondent agrees that if any funds to be paid under this agreement to the Agency are not paid within thirty-one (31) days of entry of the Final Order in this matter, the Agency may deduct the amounts assessed against Respondent in the Final Order, or any portion thereof, owed by Respondent to the Agency from any present or future funds owed to Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to Respondent by the Agency for said amounts until paid.

16. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. Maple Way and Cowles, individually, has the capacity to execute this Agreement.

17. This Agreement contains and incorporates the entire understandings and agreements of the parties.

18. This Agreement supersedes any prior oral or written agreements between the parties.

19. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

20. All parties agree that a facsimile signature suffices for an original signature.

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

Molly McKinstry
Deputy Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

DATED: 1/31/14

Amelia Cowles
Amelia Cowles, Individually, and as President of Maple Way Community, Inc.

DATED: 1/3/2014

Stuart F. Williams, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Florida Bar No. 670731

1/30/14

Christina C. Mesa, Esq.
MESA Law, P.A.
P.O. Box 10207
Tampa, Florida 33679-0207
FL BAR 932388
813-832-6372
mesalaw@hotmail.com
Counsel for Respondents

1/21/14

DATED:_____

Thomas J. Walsh II, Senior Attorney
Florida Bar No. 566365
Agency for Health Care Administration
525 Mirror Lake Drive, Suite 330G
St. Petersburg, Florida 33701

DATED: 1/24/14

DATED: _____

Tracy George, Chief Appellate Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Florida Bar No. 879231
Board Certified Appellate Attorney

DATED: 1/29/14