STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AVALON'S ASSISTED LIVING, LLC,
d/b/a AVALON'S ASSISTED LIVING,

Petitioner,

vs. Case No. 14-0610

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_____/
AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case No. 14-1339

AVALON'S ASSISTED LIVING, LLC,
d/b/a AVALON'S ASSISTED LIVING,
d/b/a AVALON'S ASSISTED LIVING
AT AVALON PARK,

Respondent.
_____/

RECOMMENDED ORDER

On August 19 through 21, 2014, a final administrative hearing was held in these cases in Orlando, Florida, before J. Lawrence Johnston, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues in these cases are whether the Agency for Health Care Administration (AHCA or Agency) should renew the assisted living facility (ALF) and limited nursing services (LNS) licenses held by Avalon's Assisted Living, LLC, d/b/a Avalon's Assisted Living (Avalon), and whether AHCA should fine Avalon for alleged statutory and rule violations.

PRELIMINARY STATEMENT

In February 2013, Avalon applied to AHCA to renew its biennial ALF and LNS licenses for 2013 and 2014. In December 2013, AHCA gave Avalon notice that it intended to deny the application on several statutory grounds. Avalon requested a

hearing, and the matter was referred to the Division of Administrative Hearings (DOAH), where it was designated DOAH Case 14-0610.

AHCA also filed an Administrative Complaint against Avalon alleging several statutory and rule violations that made up some of the grounds for denying license renewal. Avalon requested a hearing, and the matter was referred to DOAH, designated DOAH Case 14-1339, and consolidated with DOAH Case 14-0610.

AHCA's notice of intent to deny (NOID) was based on: deficiencies from 2010 that were cited in a biennial survey done in 2012 when Avalon applied to renew its biennial licenses for 2010 through 2012;[1/] deficiencies from 2013 that were cited in the biennial survey done in July 2013 for the renewal application for 2013-2014; deficiencies cited in a complaint investigation initiated in September 2013 as a result of an incident that occurred while the deficiencies cited in the July 2013 survey were pending, not having been corrected and cleared; deficiencies cited in a complaint investigation initiated in October 2013, while the September 2013 complaint investigation was still pending; and the denial of an application for licensure filed by Avalon's Assisted Living III (Avalon III), which was controlled by individuals having a controlling interest in Avalon. Prior to the final hearing, Avalon moved in limine to preclude AHCA from relying on the 2010 deficiencies because they were corrected and

Avalon's licenses were renewed for 2010 through 2012. In response to the Motion in Limine, AHCA dropped the 2010 deficiencies and any reliance on them from its grounds for denying renewal of Avalon's licenses in this case.

AHCA's Administrative Complaint (DOAH Case 14-1339) is based on essentially the September and October 2013 complaint investigations.

At the final hearing, AHCA presented the testimony of the following witnesses: Michael D., son of D.D., the alleged victim in the October 2013 complaint investigation; Mary Loftus, a Florida Hospital social worker who was involved in the discharge of R.M., the alleged victim in the September 2013 complaint investigation; Vilma Pellot, an AHCA surveyor who was involved in the 2013 biennial survey and the October 2013 complaint investigation; Myrtus Furbert, who worked on the staff of Avalon's Assisted Living II, LLC, d/b/a Avalon's Assisted Living (Avalon II), which was controlled by individuals having a controlling interest in Avalon and Avalon III, and who testified regarding the September 2013 complaint investigation; Renee Fortinberry, an Orange County Sheriff's Office detective who testified regarding the September 2013 investigation; Kathleen Carroll, an AHCA surveyor and complaint investigator who testified regarding the 2013 biennial survey and September 2013 complaint investigation; Colleen Monroe, R.N., an AHCA surveyor

and complaint investigator who testified regarding the 2013 biennial survey and September 2013 complaint investigation; Lorraine Henry, an AHCA supervisor over the Orlando field office, responsible for the surveys and complaint investigations at issue in this case; and Catherine Avery, R.N., who works in AHCA's Tallahassee headquarters as an ALF manager, oversees the Orlando field office regarding its activities in regard to this case, and represented AHCA's position on the NOID and Administrative Complaint in this case. Agency Exhibits 1 through 21 were received in evidence.[2/]

Avalon called Mr. Robert Walker, Jr., and Mrs. Chiqquittia Carter-Walker in its case-in-chief. Avalon also was allowed to cross-examine some of AHCA's witnesses beyond the scope of direct as part of Avalon's case-in-chief. Avalon Exhibits 1 through 4, 7 through 11, 16, 19, and 20 were received in evidence. Avalon Exhibit 2 is the deposition of Mary Bowen, an AHCA health services and facilities consultant, which was received in lieu of in-person testimony. Avalon also was allowed to submit, post-hearing and in lieu of live testimony, the transcript of the pre-hearing deposition of Hazel Pinard-Davis, R.N., who worked at Avalon, subject to the ruling on AHCA's objections. AHCA moved to strike the deposition transcript when it was filed, and the motion to strike was denied.

A Transcript of the final hearing was filed on October 16, 2014, and unopposed motions to extend the time for filing proposed recommended orders were granted. The parties' proposed recommended orders filed on December 18, 2014, have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Avalon's Assisted Living, LLC, d/b/a Avalon's Assisted Living (Avalon) holds a biennial assisted living facility (ALF) and limited nursing services (LNS) license issued by AHCA. Avalon's ALF is in a residence at 1250 Willow Branch Drive in Orlando, Florida. It has a licensed capacity of six beds. There are six bedrooms in the residence. Four are designated as "licensed" on the ALF's floor plan. Two bedrooms are designated as "unlicensed." In February 2013, Avalon applied to AHCA to renew its license for the years 2013 through 2014.[3/]

2. In July 2013, AHCA conducted a biennial survey to determine whether Avalon's license should be renewed. Several deficiencies were noted, including: Tag A0007, Class III, admitting a resident who was ineligible due to inability to transfer from bed to wheelchair with assistance; Tag A0008, Class III, a missing AHCA Form 1823 health assessment; Tag A0009, Class IV, failure to have a resident sign a contract for six months after admission; Tag A0030, Class III, using bedrails without a doctor's order to confine a resident in bed; Tag A0076,

Class III, not having a written policy requiring staff to immediately contact hospice if a resident receiving hospice services suffers cardiopulmonary arrest; Tag A0083, Class III, not having documentation that staff on duty had current CPR and first-aid training; and Tag A0162, Class III, not having documentation of a resident's informed consent as to whether a nurse would oversee Avalon's assistance with self-administration of medication. Avalon did not take issue with the deficiencies or classifications at the time and took prompt action to correct them.[4/]

3. In September 2013, AHCA conducted a follow-up survey, which disclosed that the deficiencies noted in July 2013 were corrected or no longer existed. As a result, Avalon was not fined for those deficiencies. However, during the follow-up survey, it came to the attention of AHCA that an individual, identified by his initials, R.M., to preserve confidentiality, went missing from an ALF operated nearby at 13230 Early Frost Circle by Avalon's Assisted Living II, LLC, d/b/a Avalon's Assisted Living II (Avalon II). Avalon and Avalon II had the same administrator, Chiqquittia Carter-Walker, who had a controlling interest in both facilities. R.M. could not be found despite an all-out police search. As a result, AHCA initiated a complaint investigation and declined to grant Avalon's renewal application pending completion of the investigation.[5/]

4. In October 2013, while the September 2013 incident was being investigated, another apparent deficiency came to the attention of AHCA's surveyors. They noticed that an 81-year-old resident of Avalon's ALF, who is identified by her initials, D.D., to preserve confidentiality, had metal surgical staples in her scalp from her forehead to the crown of her head. There appeared to be dried blood around the staples. At about this time, Avalon's administrator, Mrs. Carter-Walker, observed that D.D. was unable to transfer from bed to wheelchair, which was not normal for her, and appropriately decided to arrange for the resident to be taken to the hospital by ambulance. Further investigation into the metal staples revealed to the surveyors that they had been placed in the resident's scalp when she was hospitalized in July 2013 for medical attention to a head wound incurred when she fell while a resident of Avalon. AHCA initiated a complaint investigation into the reason why the staples remained in the resident's scalp for three months, which became another reason for AHCA's denial of Avalon's renewal application pending completion of the investigation.

September 2013 Complaint Investigation Regarding R.M.

5. The R.M. investigation resulted in six alleged deficiencies: Tag A025 (Resident Care - Supervision), Class II, inadequate resident care and supervision; Tag A0004 (Licensure - Requirements), unclassified, placing R.M. in an unlicensed room

and/or exceeding licensed bed capacity at Avalon's ALF; Tag A077 (Staffing Standards - Administrators), Class III, inadequate supervision of the ALF by the administrator; Tag A079 (Staffing Standards - Levels), Class III, inadequate staffing for the residents, including R.M.; Tag A160 (Records - Facility), Class III, not listing R.M. as a resident on the admission/discharge log; Tag A167 (Resident Contracts), Class III, not having a resident contract for R.M.; Tag A190 (Administrative Enforcement), Class III, having staff not cooperate with AHCA's investigation; and Tag AZ815 (Background Screening; Prohibited Offenses), unclassified, letting Robert Walker provide personal care or services directly to R.M. after being arrested and awaiting disposition on several felony charges.

6. Essential to all of the charges arising out of the September complaint investigation is R.M.'s alleged status as a resident. Avalon's position is that he was a non-resident renter of one of the unlicensed beds, not a resident of its ALF.

7. Avalon's first contact with R.M. was through the discharge staff at Florida Hospital, where he had been admitted after being involuntarily committed under the Baker Act. After telephonic communication about whether Avalon could accept R.M. as a resident in its ALF, Mrs. Carter-Walker and her husband, Robert Walker, went to the hospital on July 19, 2013, to meet

Mary Loftus, a social worker on the hospital's discharge team, and R.M. At the time, Mr. Walker had pending felony charges that disqualified him from working at the ALF or having direct contact with residents.[6/] During the meeting, R.M. was cooperative, pleasant, with euthymic (normal) mood and constricted affect, and some confusion in thought process. R.M.'s participation ended when he agreed to go to Avalon's ALF and stated he would look forward to seeing Mrs. Carter-Walker and her husband on the following Monday. The social worker then further discussed the discharge plan with Mrs. Carter-Walker and her husband and noted R.M.'s "exit-seeking behavior" upon admission at the hospital - meaning, he would try to leave the hospital without being discharged. They also discussed finances, including R.M.'s $1,400 a month Social Security benefit and possible eligibility for Veteran Administration benefits, and R.M.'s nearest relatives, his foster "son" and his "daughter-in-law," Jacqueline Renea Fulcher, who lived in Polk County. The social worker then telephoned to arrange for Mrs. Fulcher also to be at the hospital for the planned discharge.

8. When Mrs. Carter-Walker and her husband arrived at the hospital for the discharge on July 23, 2013, they were given an AHCA Form 1823, signed by R.M.'s psychiatrist the day before. The form stated R.M.'s needs could be met in an ALF that is not a medical, nursing, or psychiatric facility. The form stated that

R.M. was born in 1934, had dementia, was forgetful, required fall precautions, required daily observation for his well-being and whereabouts, and required daily reminders for important tasks. The form also listed R.M.'s medications, including 81 mg aspirin, 10 mg simvastatin, 25 mg sertraline, and 50 mg hydroxyzine hydrochloride. The form stated that R.M. did not need help with taking his medications and could use a pill box. The form stated that R.M. could make phone calls independently and could prepare meals, shop, and handle personal and financial affairs with assistance.

9. From the discussions and Form 1823, it was clear to the Florida Hospital discharge team that R.M. was being discharged to Avalon's ALF.[7/] This also was the clear understanding of Mrs. Fulcher. She had asked for a letter signed by R.M.'s psychiatrist to use when they went to the bank to access R.M.'s funds to pay for the ALF. She thought she would need it to explain to bank officials in the event R.M. acted out. She understood that is what happened when staff of R.M.'s previous ALF, Sunrise, took him to the bank to access his funds, which resulted in his involuntary commitment and admission to Florida Hospital on July 3, 2013. The letter she received stated that R.M. was diagnosed with dementia disorder with behavioral disturbances and mood disorder and was unable to make decisions for daily living.

10. R.M. was discharged to Avalon's ALF on July 23, 2013. Mrs. Carter-Walker and her husband drove to Florida Hospital to pick R.M. up and drive him to the ALF. R.M. got into the vehicle with them, and Mr. Walker drove.[8/] Mrs. Fulcher followed in her car. They made a stop at a Walmart to get clothing for R.M. While Mrs. Fulcher was parking her car, the other vehicle parked, and R.M. jumped out and walked quickly or ran into the store, away from Mrs. Carter-Walker and her husband. Mrs. Fulcher went into the store after R.M., who seemed agitated and did not seem to know or trust them. Mrs. Fulcher tried to calm him down and explain the situation to him. It was decided that R.M. should continue on in Mrs. Fulcher's car. They then stopped at a bank to try to access R.M.'s funds to pay Avalon, but they were unsuccessful in doing so because they did not have acceptable identification for R.M. From there, they continued on to Avalon,[9/] where Mrs. Fulcher was shown the room R.M. would be staying in, and they discussed R.M.'s medications, which Mrs. Carter-Walker said she would obtain from the pharmacy, and his identification, which Mr. Walker said he would retrieve from Sunrise ALF.

11. The next day, Mrs. Fulcher was supposed to return to the bank with R.M. and his identification to obtain funds to pay Avalon, but she had a family medical emergency and had to fly to Virginia, where she remained for two weeks. When she returned,

she tried to contact Avalon by telephone and left messages but did not get a call back from Avalon.

12. On August 22, 2013, R.M. signed a document making Mrs. Carter-Walker his Social Security benefit payee, and she began receiving his Social Security benefits at Avalon. At some point in time, she generated statements showing that Avalon was charging R.M., as "tenant," $774.10 as rent for July 2013 (at the monthly rental rate of $2,000, prorated), and $2,400 for August and September 2013 (at the monthly rental rate of $2,400).

13. While AHCA surveyors were at Avalon on Willow Branch Drive on September 11, 2013, conducting a follow-up survey on the deficiencies noted in July 2013, they learned that R.M. had walked away from Avalon II's ALF on Early Frost Circle, refused to come back when asked by the sole staff on duty at the time, did not return, and could not be found despite an all-out police search. Avalon's staff denied having any knowledge about R.M. and deferred all questions to Mrs. Carter-Walker. Mrs. Carter-Walker took the position that R.M. was not a resident of Avalon. She testified that she conducted her own assessment of R.M. and, without notifying either Florida Hospital or Mrs. Fulcher, determined that he did not require the services of an ALF but could be an independent renter of one of Avalon's unlicensed beds. She showed surveyors a pillbox she said R.M. used independently for his medications.

14. The position taken by Avalon as to R.M.'s status is inconsistent with clear and convincing evidence to the contrary. Myrtus Furbert was the sole staff on duty at Avalon II on September 10, 2013. She testified that R.M. spent the previous night there, having been brought there by Mrs. Carter-Walker with a bag of clothing, but no medications. When Ms. Furbert asked about his medications, Mrs. Carter-Walker told her he had no medications because Avalon was not being reimbursed for them. R.M. had no cell phone, wallet, or personal or ALF identification because Mrs. Carter-Walker did not trust him not to lose them. He also did not have a key to either Avalon on Willow Branch Drive or Avalon II on Early Frost Circle. When R.M. absconded, Ms. Furbert notified Mrs. Carter-Walker, who notified the police, essentially following Avalon's elopement policy for ALF residents.

15. Ms. Furbert also testified convincingly that she and other staff were instructed by Mrs. Carter-Walker to be cautious about discussing potential deficiencies with surveyors and to defer those kinds of questions, and in particular questions regarding R.M., to her. Consistent with that testimony, staff at Avalon told AHCA's surveyors that they knew nothing about R.M., and Ms. Furbert was not forthright initially when questioned about him. Mrs. Carter-Walker testified, and Avalon took the position, that staff did not know anything about R.M. because he

was an independent boarder, not an ALF resident. Her testimony and Avalon's position are rejected as implausible and contrary to the clear and convincing evidence to the contrary.

16. R.M. was a resident of Avalon's ALF, notwithstanding Avalon's position to the contrary and its failure to give him the services he should have had.

17. The facts alleged in the deficiency tags arising out of the September 2013 complaint investigation were proven by clear and convincing evidence.

October 2013 Complaint Investigation Regarding D.D.

18. Avalon gave excuses for not having the metal staples removed from D.D.'s scalp for over three months. Mrs. Carter-Walker testified that the doctor who came monthly to Avalon's ALF stopped accepting D.D.'s insurance and that she tried to telephone D.D.'s son to get the name of her doctor, got no answer at first, and later talked to him and learned that D.D. had no other doctor. She testified that she then asked the Florida Hospital doctor who placed the staples to remove them, but that doctor declined. She testified that she did not take D.D. to a walk-in clinic or emergency room to have the staples removed because D.D.'s son had a durable power of attorney, and he would have to be present to authorize the removal of the staples.

19. D.D.'s son did not recall getting any telephone calls from Mrs. Carter-Walker before October 10, 2013, and that he

first learned about the staples when he went to Florida Hospital the next day. His testimony was clear and convincing and is accepted. Her testimony was self-serving and is rejected, if it was intended to mean that she took appropriate steps to notify the son about the staples and ask him to give consent to have them removed prior to October 10, 2013.

20. The evidence was clear and convincing that it was inappropriate medically for the staples to remain in D.D.'s scalp for three months. Although there was no clear and convincing evidence that the staples caused an infection or that skin grew over them so as to require additional surgery to remove them, both were possible results from leaving the staples in too long.

21. D.D.'s son relied on Avalon to care for his mother. Avalon should have taken appropriate steps to have the staples removed before October 10, 2013.

Pattern of Deficient Performance

22. The tags noted in the July 2013 re-licensure survey reflect several relatively minor deficiencies, some little more than paperwork deficiencies, which were corrected promptly. They do not, in themselves, reflect a pattern of deficient performance.

23. The tags from the September 2013 complaint investigation involving R.M. arose from an isolated incident, in that there was no evidence that any resident eloped before or

since. However, the tags include more than just an elopement. The deficiencies actually arose from a decision by Mrs. Carter-Walker, whether before or after the elopement, not to treat R.M. appropriately as an ALF resident or provide the ALF services he should have been given, while she and Avalon collected R.M.'s Social Security benefits intended to pay for those services. Avalon's decision was not disclosed to Florida Hospital, to Mrs. Fulcher, or to AHCA. This decision contributed to R.M.'s ultimate elopement. When Avalon's actions were disclosed through R.M.'s elopement, Mrs. Carter-Walker attempted to manage the consequences through her instructions to her ALF staff not to provide certain information to AHCA's surveyors, except through her.

24. The tags from the October 2013 complaint investigation involving D.D. arose from an isolated incident, in that there was no evidence that any resident was medically neglected before or since. However, these deficiencies also arose from a decision by Mrs. Carter-Walker not to provide the ALF services D.D. should have been given. D.D.'s son, who was her health care surrogate, was not kept apprised of D.D.'s medical condition or asked to cooperate in having the metal staples removed from his mother's scalp. Avalon also did not disclose metal staples to AHCA directly or by making reference to them in D.D.'s ALF records. AHCA happened to become aware of them when its surveyors happened

to notice the staples while they and Mrs. Carter-Walker were attending to D.D. for an apparent change in her medical condition that occurred while a survey was being conducted. When the staples were noticed and investigated, Mrs. Carter-Walker and Avalon attempted to avoid responsibility by blaming D.D.'s son and her Florida Hospital doctor.

25. The tags arising out of the R.M. and D.D. investigations, while relatively small in number, reflect a troubling pattern of deficient performance involving inadequate supervision and lack of appropriate attention to the needs of ALF residents, together with attempts to hide the deficient performance from family members and AHCA, and the development of an unhealthy relationship with the AHCA surveyors and regulators that has resulted in a mutual lack of trust.

Avalon III Amended Final Order

26. Mrs. Carter-Walker had a controlling interest in Avalon and in Avalon III, which applied for a license to operate an ALF at a third location in Orlando. AHCA gave notice of intent to deny the application for licensure on several grounds, including: unlicensed operation of an ALF at 1812 Crown Hill Boulevard in Orlando in July and August 2009; expiration of the applicant's lease on the facility to be licensed; and the disqualification of Mr. Walker, who was a controlling interest, administrator, and financial officer on the application.

27. Avalon III requested a hearing, and a Recommended Order of Dismissal was entered on the ground that Mrs. Carter-Walker and Mr. Walker took the Fifth and declined to answer discovery questions relevant to the grounds for denial of Avalon III's application. As a result, Avalon III essentially chose not to meet its burden to prove entitlement to licensure. The Recommended Order of Dismissal was adopted in an Agency Amended Final Order. Avalon III appealed, and the First District Court of Appeal issued a per curiam affirmance on December 17, 2014. Avalon, etc. v. AHCA, Case 1D13-5972, per curiam aff'd (Fla. 1st DCA Dec. 17, 2014). There was no request for rehearing, and the Mandate issued on January 5, 2015. Id.

CONCLUSIONS OF LAW

28. This case combines the denial of an application to renew an ALF and LNS license on various grounds (DOAH Case 14-0610) and an Administrative Complaint to assess fines on some of the same grounds (DOAH Case 14-1339). A threshold legal issue to be determined is the burden of proof to apply.

Burden of Proof

29. AHCA takes the position that because section 429.01(3), Florida Statutes (2013),[10/] makes an ALF license "a public trust and a privilege and . . . not an entitlement" and states that this principle should guide the trier of fact, the burden of proof is on Avalon to prove compliance with all applicable

statutes and rules and to prove entitlement to renewal of its license in DOAH Case 14-0610. Avalon takes the position that the burden is on AHCA to prove alleged violations by clear and convincing evidence.

30. Davis Family Daycare Home v. Department of Children and Family Services, 117 So. 3d 464, 467-69 (Fla. 2d DCA 2013), was a case in which the Department of Children and Family Services (DCF) denied an application to "step up" from a family daycare to a large daycare license and took the position that its only burden in the disputed-fact hearing was to present competent, substantial evidence of alleged violations. The court rejected DCF's position and held that DCF had the burden to prove alleged violations by clear and convincing evidence. The court saw a direct conflict with Haines v. Department of Children and Families, 983 So. 2d 602, 607 (Fla. 5th DCA 2008), which held that the preponderance of the evidence standard applied in a license revocation proceeding, and certified the question to the Florida Supreme Court, which has accepted jurisdiction. Dep't of Child. & Fam. Servs. v. Davis Fam. Daycare Home, 130 So. 3d 691 (Fla. 2013).

31. If the Supreme Court rules on the certified direct conflict between the second and fifth district courts, it is unclear whether it will address the interplay between that conflict (i.e., as to the standard of proof on the governmental

agency to prove alleged violations) and the concept of the "ultimate burden of persuasion," which the Supreme Court has held remains on a license applicant. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996). In N.W. v. Department of Children and Family Services, 981 So. 2d 599 (Fla. 3d DCA 2008), it was held that the ultimate burden of persuasion remains on the applicant for a renewal license. In Coke v. Department of Children and Family Services, 704 So. 2d 726 (Fla. 5th DCA 1998), it was held that the burden of proof is on the agency denying an application for a renewal license to prove the violations that were the grounds for denial. On this point, the court in Davis Family Daycare Home noted the similarity between a license renewal application and an application to step up to a higher level of a license--namely, in both cases, the agency previously found the applicant worthy of licensure. It also noted that the Davis Family Daycare Home proceeding was initiated by the filing of a "self-proclaimed administrative complaint" and was determined by the agency to be disciplinary in nature, which made section 120.57(1)(j), Florida Statutes, applicable: "Findings of fact shall be based upon a preponderance of the evidence, except in penal or licensure disciplinary proceedings . . . ." Based on those factors, which are similar, if not identical, to the facts of this case, the Davis Family Daycare Home court placed the burden of proof on DCF.

32. The best way to reconcile and harmonize the conflicting decisions on the burden and standard of proof is to place the burden on AHCA to prove alleged violations by clear and convincing evidence and, if it does, allow Avalon to prove by a preponderance of the evidence that its license should be renewed, notwithstanding any violations that are proven.

33. It is clear that the burden in DOAH Case 14-1339 is on AHCA to prove the allegations in its Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., supra; Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

34. The Supreme Court has stated:

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

In re Henson, 913 So. 2d 579, 590 (Fla. 2005)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

License Renewal Requirements

35. An applicant for renewal of an ALF license must demonstrate compliance with "this part [II of chapter 408, Florida Statutes, the licensing statute], authorizing statutes,

and applicable rules during an inspection pursuant to section 408.811, as required by authorizing statutes." § 408.806(7)(a), Fla. Stat. Section 408.811(1)(b) provides for re-licensure inspections "biennially unless otherwise specified by authorizing statutes or applicable rules." The July 2013 survey was the biennial inspection for Avalon's renewal application that is the subject of DOAH Case 14-0610. Although the deficiencies noted in the July 2013 survey were corrected and cleared by the end of September 2013, it was not possible for AHCA to conclude that Avalon was in compliance with part II, authorizing statutes, and applicable rules because the September 2013 complaint investigation regarding R.M. had been opened and was pending. Before that investigation was concluded, another complaint investigation was opened regarding D.D. It could not be concluded that Avalon was in compliance with part II, authorizing statutes, and applicable rules until both those investigations were completed.

September 2013 Complaint Investigation Regarding R.M.

36. Avalon is an ALF. § 429.02(5), Fla. Stat. R.M. was a resident. § 429.02(19), Fla. Stat. He was discharged from Florida Hospital to Avalon. Avalon accepted him as a resident. Avalon did not notify Florida Hospital, AHCA, or R.M.'s nearest relative that it was not accepting R.M. as a resident.

37. Avalon was required to provide R.M. with care and services appropriate to his needs. Fla. Admin. Code R. 58A-5.0182.[11/] This included personal supervision. Id. at (1). Personal supervision includes: daily observation by designated staff and awareness of the general health, safety, and physical and emotional well-being of the resident; general awareness of the resident's whereabouts; contacting the resident's health care provider and other appropriate parties, such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change, is discharged, or moves out; maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. Id. at (b)-(e). An ALF is required to offer supervision of or assistance with activities of daily living (ADLs) as needed by the resident. Fla. Admin. Code R. 58A-5.0182(4). Supervision means reminding residents to engage in ADLs and the self-administration of medication and, when necessary, observing or providing verbal cuing. § 429.02(23), Fla. Stat. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. Fla. Admin. Code R. 58A-5.0182(8)(a). An ALF must make, at a

minimum, a daily effort to determine that at-risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number; staff attention must be directed towards residents assessed at high risk for elopement. Id. at 1.

38. The evidence was clear and convincing that Avalon was not in compliance with these requirements, which resulted in Tag A025 (Resident Care - Supervision). This was a Class II violation because it directly threatened R.M.'s physical or emotional health, safety, or security (but was not a Class I violation because it did not present an imminent danger to R.M. or a substantial probability that death or serious physical or emotional harm would result). § 408.813(2)(a)-(b), Fla. Stat.

39. Rule 58A-5.016(3) prohibits a change in the use of space that increases or decreases a facility's capacity, without prior approval from AHCA's Central Office. Rule 58A-5.016(4) prohibits converting an area to resident use not previously inspected for such use, without prior approval from AHCA's Field Office. The evidence was clear and convincing that Avalon violated these rules by placing R.M. in an unlicensed bedroom, which resulted in Tag A077 (Staffing Standards - Administrators). This was an unclassified violation under section 408.813(2).

40. Rule 58A-5.019(4) sets out staffing standards that required 212 staff hours for the seven Avalon residents

(including R.M.) in September 2013 and also required a written work schedule reflecting Avalon's 24-hour staffing pattern. The evidence was clear and convincing that Avalon was not in compliance with this rule, resulting in Tag A079 (Staffing Standards - Levels), a Class III violation under section 408.813(2).

41. Rule 58A-5.024 requires that an ALF maintain and make available for inspection certain resident records, including an up-to-date admission and discharge log. The evidence was clear and convincing that Avalon was not in compliance with this rule because the log did not reflect R.M. having been admitted, which resulted in Tag A0160 (Records - Facility), a Class III violation under section 408.813(2).

42. Section 429.24 and rule 58A-5.025 require that ALFs enter into resident contracts. The evidence was clear and convincing that Avalon was not in compliance with this statute and rule because it had no resident contract with R.M., which resulted in Tag A0167 (Resident Contracts), a Class III violation under section 408.813(2).

43. Rule 58A-5.033 requires that ALF staff cooperate with AHCA personnel during surveys, complaint investigations, monitoring visits, implementation of correction plans, license application and renewal procedures, and other activities necessary to ensure compliance. AHCA personnel are required to

interview staff privately to determine compliance with resident care standards. Id. at (1). The evidence was clear and convincing that Avalon was not in compliance with this rule because Mrs. Carter-Walker instructed staff not to answer surveyor questions that might lead to findings of deficiencies, except through her, and staff followed those instructions by not cooperating with AHCA personnel during the R.M. complaint investigation, which resulted in Tag A0190 (Administrative Enforcement), a Class III violation under section 408.813(2).

44. Section 408.809(1)(e) requires Level 2 background screening for any person seeking employment with a licensee who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients. Persons required to undergo background screening must not have an arrest awaiting final disposition on a disqualifying felony charge. Id. at (4)(a). See also § 435.06(1)-(2), Fla. Stat. The evidence was clear and convincing that Mr. Walker met with R.M. at Florida Hospital, drove him part way to Avalon's ALF, and participated in showing R.M. and Mrs. Fulcher where R.M. would be staying at the ALF. Since he was awaiting the disposition of disqualifying felony charges, this was a violation of the screening requirements, which resulted in Tag AZ815 (Background Screening - Prohibited Offenses), an unclassified violation under section 408.813(2).

45. Avalon contends that Mr. Walker's contact with R.M. was not a violation because, at the time, rule 59A-35.090(4)(d) stated: "An alleged offense is not disqualifying until such time as there has been a disposition." That rule language, which was removed by amendment in December 2013, must be harmonized with the statutes, if possible. That can be done by interpreting the rule language to mean that the statutory prohibition is lifted when charges are dismissed.

October 2013 Complaint Investigation Regarding D.D.

46. Avalon was required to provide D.D. with care and services appropriate to her needs. Fla. Admin. Code R. 58A-5.0182. This included personal supervision. Id. at (1). Personal supervision includes: daily observation by designated staff and awareness of the general health, safety, and physical and emotional well-being of the resident; contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change, is discharged or moves out; maintaining a written record, updated as needed, of any significant changes, any illnesses that result in medical attention, changes in the method of medication administration, or other changes that result in the provision of additional services. Id. at (b), (d), and (e). In order to facilitate resident access to needed health care, an ALF must

assist residents in making appointments for medical services, provide or arrange transportation to needed medical services. Id. at (3)(a)-(b). Rule 58A-5.025(1)(j) requires that resident contracts have a provision that upon a determination by the ALF administrator that a resident needs services beyond those the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. The evidence was clear and convincing that Avalon violated the statute and rule by not taking appropriate steps to have the metal staples removed from D.D.'s scalp for three months, which resulted in Tag A025 (Resident Care - Supervision), a Class II violation under section 408.815(2)(a)-(b).

47. Avalon argues that the evidence regarding D.D. does not support a violation of rule 58A-5.0182(1)(d)-(e) because the failure to take steps to remove the metal staples in D.D.'s scalp did not amount to a "significant change" under the definition in rule 58A-5.0131(32): "a sudden or major shift in behavior or mood inconsistent with the resident's diagnosis, or a deterioration in health status such as unplanned weight change, stroke, heart condition, enrollment in hospice, or stage 2, 3, or

4 pressure sore." On this point, Avalon's argument has merit. Violations of rule 58A-5.0182(1)(d)-(e) were not proven.

July 2013 Re-Licensure Survey

48. The deficiencies tagged as a result of the July 2013 re-licensure survey were proven by clear and convincing evidence. All those deficiencies were either Class III or Class IV deficiencies that were promptly corrected and were cleared by AHCA, and Avalon cannot be fined or disciplined for them. They can be considered in determining whether AHCA proved a pattern of deficient performance that would warrant license discipline under section 408.815(1)(d), Florida Statutes. But see Conclusion of Law 52, infra.

Amended Final Order Denying Avalon III Application

49. Under section 429.14(3), AHCA "may deny a license to any applicant or controlling interest as defined in part II of chapter 408 which has or had a 25-percent or greater financial or ownership interest in any other facility licensed under this part, or in any entity licensed by this state or another state to provide health or residential care, which facility or entity during the 5 years prior to the application for a license closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it." The evidence was clear and convincing that this ground for

denial of Avalon's re-licensure exists by virtue of the Amended Final Order entered in DOAH Case 09-6342, which was affirmed on appeal.

50. Avalon argues that section 429.14(3) does not apply because Avalon III did not have a license. That strained interpretation of the statute is rejected. As used in the statute, denial of a license means denial of an application for a license, as well as denial of an application for renewal of a license. Contrary to Avalon's argument, the wording of section 408.815 supports this conclusion.

Pattern of Deficient Performance

51. Under section 408.815(1)(d), AHCA may deny a license for a "demonstrated pattern of deficient performance." There is no case law construing this phrase. An accepted definition of the word "pattern" is: "the regular or repeated way in which something happens or is done." Merriam-Webster Online Dictionary (2015).

52. Avalon argues that there was no clear and convincing evidence of a pattern of deficient performance because R.M.'s elopement and D.D.'s scalp staples were isolated incidents, and the deficiencies from the July 2013 re-licensure survey were minor and cleared. The minor, cleared deficiencies noted in the July 2013 survey do not contribute to the relevant pattern of deficient performance. The deficiencies arising out of the R.M.

and D.D. complaint investigations reflect a troubling pattern. See Finding of Fact 23-25, supra. It is not necessary for AHCA to allow such a pattern to continue for a longer period of time before taking action under section 408.815(1)(d).

Other Grounds for Denial of Application for Renewal

53. Section 429.14(1) authorizes denial or revocation of a license for: an intentional or negligent act seriously affecting the health or safety of a resident of a facility; failure to comply with the background screening standards of part II of chapter 408 or a violation of part II of chapter 429, section 408.809(1), or chapter 435; failure of a licensee during re-licensure to meet the minimum license requirements of part II of chapter 429, or related rules, at the time of license application or renewal; or any act constituting a ground to deny an application for a license. Id. at (a), (f), (h), and (k).

54. Section 408.815(1)(b)-(c) authorizes denial or revocation of a license for: an intentional or negligent act materially affecting the health or safety of a client of a provider (i.e., in this context, a resident of an ALF); or a violation of part II of chapter 408, authorizing statutes, or applicable rules.

55. The clear and convincing evidence also proved these charges and grounds (although they add nothing to the other proven charges and grounds).

Fines Assessed in DOAH Case 14-1339

56. Under section 429.19(2)(b), AHCA shall impose an administrative fine for Class II violations in an amount not less than $1,000 or more than $5,000 per violation. AHCA seeks a fine of $2,500 for the Class II violation regarding R.M. and $2,000 for the Class II violation regarding D.D. These fines are reasonable under section 429.19(3).

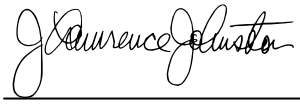
57. Under section 408.813(3), AHCA may impose an administrative fine of not more than $500 per unclassified violation (unless otherwise specified by law). AHCA seeks $500 fines for each of the two unclassified violations arising out the complaint investigations, which is appropriate.

RECOMMENDATION

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

RECOMMENDED that AHCA enter a final order denying Avalon's license renewal application and fining Avalon $5,500.

DONE AND ENTERED this 21st day of January, 2015, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of January, 2015.

ENDNOTES

[1/] Avalon's application and AHCA's survey for the 2010-2012 biennial license renewal were delayed because AHCA's revocation of Avalon's license (AHCA Cases 2009009965, 2009009966, 2009011074, 20100002136, and 20100002138; DOAH Cases 10-0528, 10-1672, and 10-1673) was on appeal to the First District Court of Appeal (Case 1D11-1411). The revocation was reversed by the court in December 2011, and Avalon applied for renewal for the years 2010 through 2012, which was granted in February 2013.

[2/] Agency Exhibits 6 and 16 were received in evidence, but no findings of fact are based solely on these documents or hearsay contained in them, unless the hearsay would have been admissible over objection in civil actions. § 120.57(1)(c), Fla. Stat. (2014). See Harris v. Game and Fresh Water Fish Comm'n, 495 So. 2d 806 (Fla. 1st DCA 1986); Scott v. Dep't of Prof. Reg., 603 So. 2d 519 (Fla 1st DCA 1992); Juste v. Dep't of HRS, 520 So. 2d 69 (Fla. 1st DCA 1988).

Agency Exhibit 8, the transcript of the deposition of Jacqueline Renea Fulcher, the "foster daughter-in-law" of R.M., the alleged victim in the September 2013 complaint investigation, was received. Avalon objected on the ground that the witness was

available to testify at the hearing, but the exhibit supports its use in lieu of live testimony.

Agency Exhibits 20 and 21, the transcripts of depositions of Chiqquittia Carter-Walker, who owns Avalon and is its administrator, were received for rebuttal and impeachment purposes, and to support AHCA's renewed motion for sanctions on the ground that Mrs. Carter-Walker frequently took the Fifth and refused to answer questions during the deposition (AHCA's pre-hearing motion for sanctions having been denied at the outset of the final hearing). The renewed motion for sanctions is denied.

AHCA was allowed to late-file Agency Exhibit 22, AHCA's discovery requests and Avalon's responses regarding video surveillance that were supposed to rebut and impeach the testimony of Mrs. Carter-Walker and the position of Avalon that AHCA could have placed the video surveillance in evidence (something Avalon also did not do) to resolve some critical factual disputes between the parties. However, AHCA did not file Agency Exhibit 22, which is deemed withdrawn.

[3/] See Endnote 1, supra.

[4/] Avalon took the position that some of the deficiencies were corrected so quickly that they should not be considered deficiencies at all. This argument is rejected. They can be considered in deciding whether there was a pattern of deficient performance. See Conclusion of Law 48. Avalon also argued that all the Class III tags actually were Class IV. That distinction need not be determined because all were promptly corrected and cleared, so it did not matter if they were Class III or Class IV.

[5/] Avalon seemed to be taking the position that, once the deficiencies noted in the July 2013 survey were cleared, AHCA was obligated to renew Avalon's license, regardless of the new complaint investigation. This argument, which was not maintained in Avalon's proposed recommended order, is rejected.

[6/] By the time of the final hearing, the charges were dropped. Avalon takes the position that Mr. Walker was not disqualified, but that position is rejected. See Conclusion of Law 45, infra. The subsequent nolle prosequi of the charges does not alter Mr. Walker's status in July 2013.

[7/] The Form 1823 stated that the discharge was to Avalon II on Early Frost Circle, and there was other evidence that R.M. spent

time and even possibly at least one overnight at Avalon II's ALF, but Avalon maintained that R.M. never spent a night at Avalon II, and AHCA now accepts that R.M. was not a resident at Avalon II.

[8/] Mrs. Carter-Walker and her husband denied that he drove. Although who drove probably is not a critical distinction, the testimony of Mrs. Fulcher is accepted on this point, and it is found by clear and convincing evidence that Mr. Walker was driving.

[9/] Mrs. Fulcher thought the ALF was on Early Frost Circle, which would have been Avalon II. If it was, it is not clear from the evidence if R.M. actually stayed there or how long he stayed there. See Endnote 7, supra.

[10/] Unless otherwise stated, all statutory references are to the 2013 codification of the Florida Statutes, which reflects the statutes in effect at the time of the alleged violations.

[11/] Unless otherwise stated, all rule references are to the Florida Administrative Code rules in effect at the time of the alleged violations.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.