STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR PERSONS WITH DISABILITIES,

Petitioner,

vs. Case No. 15-0034FL

V-AGAPE, LLC, d/b/a TRACY COURT GROUP HOME,

Respondent.
_____/

RECOMMENDED ORDER

A final hearing was held in this matter before Robert S. Cohen, Administrative Law Judge with the Division of Administrative Hearings (Division), on July 23, 2015, by video teleconference at sites located in Tampa and Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUE

Whether the Agency for Persons with Disabilities (APD) properly denied the application for licensure renewal sought for the group home facility license held by Tracy Court Group Home, owned and operated by V-Agape, LLC.

PRELIMINARY STATEMENT

Petitioner received an application for licensure renewal from Respondent on June 26, 2014. Petitioner served Respondent with an Administrative Complaint on December 4, 2014, which denied Respondent's application for licensure renewal. Respondent timely requested an administrative hearing before the Division pursuant to section 120.57(1), Florida Statutes (2014). Both parties appeared and were represented by counsel at the video teleconference hearing conducted in Tampa and Tallahassee on July 23, 2015.

At the hearing, Petitioner presented the testimony of Karen Gonzalez, child protective investigator supervisor with the Hillsborough County Sheriff's Office (HCSO); Jennifer Campbell, child protective investigator (CPI) with HCSO; Myra Leitold, residential program supervisor with APD; and Mitchell Turner, a group home monitor with APD; and offered 16 exhibits, all of which were admitted into evidence. Respondent presented the testimony of its owner and operator, Tonya Nelson; Geraldine Williams, former regional operations manager for the Suncoast

Region; Chiquitta Nash, Waiver Support Coordinator for Rendon Support Services; and Myra Leitold and Mitchell Turner of APD; and offered nine exhibits, all of which were admitted into evidence.

Additionally, at Respondent's request, official recognition was taken of section 120.695, Florida Statutes; Florida Administrative Code Chapter 65G-2, as amended July 1, 2014; rules 65G-2.011 and 65G-2.012, effective August 13, 1978; and the Florida Department of Children and Families (DCF) Operating Procedure No. 175-28, Child Maltreatment Index.

A two-volume Transcript of the final hearing was filed on August 5, 2015. Petitioner and Respondent filed their proposed Findings of Fact and Conclusions of Law on August 24, 2015.

References to statutes are to Florida Statutes (2014), unless otherwise noted.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the licensing and operation of foster care facilities, group home facilities, and residential habitation centers pursuant to section 20.197 and chapter 393, Florida Statutes.

2. At all times material to this complaint, Respondent held foster or group home facility licenses issued by APD. The current group home license issued for V-Agape, LLC, located

at 19103 Tracy Court, Lutz, Florida 33548, is owned by Tonya Nelson, the sole managing member.

3. Respondent has contracted with APD to provide the residents with Medicaid waiver developmental disability residential habitation services.

4. HCSO conducts investigations of reports of abuse, neglect, abandonment, and threats of harm to children on behalf of DCF.

5. Investigations of abuse, neglect, abandonment, and threats of harm are initiated by reported incidents through the Florida Abuse Hotline. Karen Gonzalez is the supervisor of the Specialized Investigating Unit. She supervises the CPIs who perform the abuse hotline investigations. Ms. Gonzalez supervised Robert Hoon and Jennifer Campbell, both CPIs.

6. A report was made to the Florida Abuse Hotline on January 24, 2014, that a minor female resident of Respondent's Tracy Court Group Home sustained bruising and a red mark on the back of her hand from being struck on her hands by Tonya Nelson. The resident is non-verbal and intellectually disabled.

7. The subsequent investigation by CPI Hoon, on behalf of DCF, was ultimately closed with verified indicators for physical injury upon the minor resident living in the Tracy Court Group Home, but did not identify the caregiver responsible.

8. CPI Hoon reviewed and discussed the investigation with Supervisor Gonzalez before he prepared the Investigative Summary (IS). When conducting investigations, the CPI reviews the prior history of incidents reported on a group home and its owner/operator.

9. In subsection "D. Prior Reports and Service Records Implications for Child Safety," CPI Hoon reported that:

> There are prior reports on the facility that include concerns for physical discipline in the foster home and to her o[w]n children. There is a verified report in 2012 for physical injury and the aps [adult perpetrators] where [sic] Tonya Nelson and the aunt as it is unknown who caused the injuries.

10. Ms. Gonzalez testified that prior reports are reviewed in conducting their investigations to determine whether a pattern of concern for the health and safety of the children placed in that home and for the caretakers caring for the children in the home exists.

11. The CPIs utilize DCF Operating Procedure (CFOP) 175-28, Child Maltreatment Index, as a guideline in conducting their investigations. A "verified finding" is made when a preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment, or neglect.

12. CPI Campbell explained the application of CFOP during an investigation:

> [I]t . . . breaks down the different maltreatments that are investigated under the umbrella of abuse, neglect, and abandonment, and it provides a guideline for the definitions of what the different maltreatments are, and the different types of supporting evidence and documents that may be needed when supporting a maltreatment when the investigator comes up with the findings. It's basically a guideline for investigations, because when a report comes in it may not be just one maltreatment, there may be a number of different maltreatments; or an investigator may identify a maltreatment during the course of an investigation, and so this provides a guideline for the investigator.

13. On May 20, 2014, a report was made to the Florida Abuse Hotline about a minor resident of Respondent's Tracy Court Group Home. An investigation was commenced concerning unexplained bruises observed on the resident, a vulnerable minor.

14. CPI Campbell completed the investigation and prepared the IS. She discussed the verified findings with Supervisor Gonzalez. CPI Campbell is an experienced investigator, having had 11 years of service with HCSO following five years' experience as a CPI in Michigan.

15. The report of May 20, 2014, was a "Supplemental" report since, according to Supervisor Gonzalez, it came in right after the initial risk sequence. Rather than creating an entire new report, this one became supplemental to the prior one.

16. The IS stated that the resident had a large bruise on her left thigh and bruises on her left arm and the back of her leg. Ms. Nelson was not able to explain how the minor resident sustained the bruises on her leg and arm.

17. CPI Campbell became involved with Ms. Nelson and the investigation of the group home when Supervisor Gonzalez gave her the task of completing the investigation initiated by CPI Krisita Edwards. At the time CPI Campbell took over the investigation, CPI Edwards had been assigned to other duties.

18. CPI Campbell explained that it was not unusual for a second investigator to complete work begun by another since all their notes are kept on a central database known as the Florida Safe Families Network (FSFN), where all contacts are noted, as well as the investigative summary.

19. CPIs Edwards and Campbell collaborated on the investigation in this case. CPI Edwards entered her initial findings in the FSFN, which was picked up and continued by CPI Campbell when she took over the case. The two CPIs have collaborated on other cases in a similar fashion.

20. The initial documentation by CPI Edwards was performed within 48 hours of the call coming into the abuse hotline as required. CPI Campbell's completion of the report and investigation occurred after she had spoken with CPI Edwards and discussed the matter with Supervisor Gonzalez.

21. The result of the investigation concerning the bruises on the minor resident was that the bruises were "indeterminate for physical abuse" and "indeterminate for supervisory neglect" due to the fact that a specific cause of the injuries could not be determined. Further, since the minor resident had been removed to another group home, the report concluded that there existed no continuing threat to the resident's well-being.

22. Even though the resident had been removed from the Tracy Court Group Home and, therefore, was not in any danger of being further harmed, CPI Campbell continued to have serious concerns about the care of residents in the group home. She believed that several allegations of the same type of harm were being made in the group home and that they could not ask the resident how she received her injuries since she was non-verbal.

23. Myra Leitold, an APD residential licensing supervisor, had monitored the Tracy Court Group Home for the previous nine and one-half years. On December 28, 2012, she observed that a door lock to the office and bedroom was keyed so that it could be readily opened from the inside which, she believed, created a safety hazard.

24. Between December 2012 and August 2014, the group home was cited for ten violations of Medication Administration Procedures. On one of her visits, in December 2012, Ms. Leitold noted that no current prescription was present for one of the

residents, and that the label on the prescription bottle did not match the prescription drugs inside the bottle. Additionally, she found that the accounting for one of the resident's finances was not current and that the temperature inside the group home was a chilly 65 degrees Fahrenheit.

25. Mitchell Turner, human services program specialist for APD, recorded numerous medication administration violations at the group home. He noted on May 30, 2013, that the medication prescriptions and instructions for the Medical Administration Record (MAR) did not match. On June 18, 2013, he discovered that the wrong dosage of prescription was being given to a resident, and Ms. Nelson admitted this mistake.

26. Mr. Turner grew so concerned about the prescription irregularities that he requested Pamela Lassiter, a medical case management registered nurse, to review the group home. Nurse Lassiter was sent to the home where she discovered and cited the home for three additional prescription violations.

27. Even following Nurse Lassiter's visit, on another trip to the group home on April 9, 2014, Mr. Turner cited an additional MAR violation. He believed these violations posed a health and safety risk to the residents affected and exhibited a pattern of neglect by Respondent to the health and safety of vulnerable children.

28. During the period when prescription and other violations were noted, on January 11, 2013, Ms. Nelson exceeded the maximum licensed capacity of three in the group home when she accepted a fourth resident. She did not have prior written approval from APD to exceed her licensed capacity of residents.

29. On September 25, 2013, Mr. Turner issued a Notice of Non-Compliance (NNC) because Ms. Nelson again exceeded the licensed capacity for the number of residents in the group home without prior written approval from APD. Mr. Turner expressed his concerns over the repeated violations by Respondent.

30. Ms. Nelson testified that she had received verbal approval for the placements in excess of the home's licensed capacity from Meisha Stewart, residential placement coordinator for APD, and that on a prior occasion in 2012, she had accepted a resident after receiving verbal approval. This testimony was rebutted by both Geraldine Williams, the former regional operations manager for APD's Suncoast Region, and Ms. Leitold, who testified she had never known APD to give verbal approval for a placement of a resident in a group home. With the high volume of referrals APD makes to group homes, they cannot operate in a system where verbal placements occur. All placements must be made in writing.

31. When a provider receives a NNC, the provider is required to submit and successfully complete a Corrective Action

Plan (CAP). Mr. Turner testified that Ms. Nelson did not submit or successfully complete a CAP for the MAR violations.

32. On January 17, 2013, Ms. Leitold visited the group home and observed the following violations: volatile materials were not stored in approved metal containers and three prescriptions for a resident's medications were not present. The gasoline, charcoal, and lighter fluid found by Ms. Leitold were required to be stored in approved metal containers. Keeping these materials in the open posed a safety hazard for the minor residents by giving them access to volatile materials.

33. On November 4, 2014, Ms. Nelson sent an email to Meisha Stewart advising her she intended to accept a non-APD client for placement in the Tracy Court Group Home without APD's prior approval. Ms. Nelson testified that since that same resident had been placed in the Tracy Court Group Home for a six-month period in 2013, she believed she did not need a new approval in 2014.

CONCLUSIONS OF LAW

34. The Division of Administration Hearings has jurisdiction over the subject matter of and the parties to this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2015).

35. Petitioner, as the party asserting the affirmative of the issue in this proceeding, has the burden of proof. Balino v. Dep't of Health & Rehabilitative Servs., 348 So. 2d 349 (Fla. 5th DCA 1977); Dep't of Agric. & Consumer Servs. v. Strickland, 262

So. 2d 893 (Fla. 1st DCA 1972). The level of proof is generally a preponderance of the evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996). See also, Davis v. Dep't of Child. & Fam. Servs., 160 So. 3d 854, 857 (Fla. 2015). However, case law exists that indicates the standard may be clear and convincing when the denial of the renewal is based upon violations of the law and rules concerning licensure.

36. This case is a license renewal case, not an initial licensure case as in Davis. It involves allegations of wrongdoing by the licensed group home and termination of Respondent's ability to operate a group home. Although the context is license renewal, the action is to impose a penalty for violation of the law. Consequently, the proper burden of proof is clear and convincing evidence. Coke v. Dep't of Child. & Fam. Servs., 704 So. 2d 726 (Fla. 5th DCA 1998). Applying the standard for initial licensure when an agency denies renewal because of alleged wrongdoing would allow an agency to manipulate the system to avoid the clear and convincing standard by denying renewal, rather than instituting a disciplinary action. See Posey v. Fla. Game & Fresh Water Fish Comm'n, Case No. 89-4700 (Fla. DOAH Jan. 3, 1990, p. 12) ("Once a determination is made by the Department that Petitioner's licenses can be revoked based upon the trial court's disposition of the misdemeanor, the

Department must treat its decision not to renew the licenses as a revocation proceeding.").

37. The burden of proof for group home licensure is not established by statute or an issue committed to the agency by the Legislature. It is a procedural matter governed by case law, not one over which the Legislature has given the agency substantive jurisdiction. G.E.L. Corp. v. Dep't of Envtl. Prot., 875 So. 2d 1257 (Fla. 5th DCA 2004). In this case, since the agency proved its allegations by clear and convincing evidence, the result is the same regardless of which standard of proof is applied.

38. APD is charged with regulating the licensing and operation of foster care facilities, group home facilities, residential habitation centers, and comprehensive transitional education programs pursuant to section 20.197 and chapter 393.

39. Section 393.067 sets forth the agency's responsibilities concerning application procedures and provider qualifications. Section 393.0673 sets forth further considerations pertaining to licensure. Section 393.0673(2) provides as follows:

> The agency may deny an application for licensure submitted under s. 393.067 if:
> (a) The applicant has:
> 1. Falsely represented or omitted a material fact in its license application submitted under s. 393.067;
> 2. Had prior action taken against it under the Medicaid or Medicare program;

> 3. Failed to comply with the applicable requirements of this chapter or rules applicable to the applicant; or
> 4. Previously had a license to operate a residential facility revoked by the agency, the Department of Children and Family Services, or the Agency for Health Care Administration; or
> (b) The Department of Children and Family Services has verified that the applicant is responsible for the abuse, neglect, or abandonment of a child or the abuse, neglect, or exploitation of a vulnerable adult.

40. DCF made two verified findings regarding Respondent, one against Tracy Court Group Home and one against Ms. Nelson, personally, as the caregiver responsible for her residents. Ms. Nelson did not credibly refute the verified findings against her.

41. Respondent's failure to provide appropriate supervision; safeguard the health, safety, and well-being of the residents; and to provide an environment free from abuse and neglect constitutes a violation of section 393.13(3)(a) and (g) and rule 65G-2.012(4) and (5)(c).

42. The issue of whether the verified finding against Respondent, based upon an investigation started by CPI Edwards and completed by CPI Campbell under the direction of Supervisor Gonzalez, is resolved in favor of Petitioner. The greater weight of evidence supports the conclusion that investigators routinely work in teams or a successor investigator often takes over for one who initiated the investigation due to scheduling and

reassignment. Accordingly, Respondent's argument that the findings of the investigation are invalid because multiple investigators were involved, rather than the initial investigator handling the case to its completion, fails, and the results of the investigation shall form a basis for the decision in this case.

43. The verified findings by the HCSO in the child protective investigations against Tonya Nelson and Tracy Court Group Home are sufficient grounds, in and of themselves, under the above-cited statutes and rules to deny renewal of the group home license. Respondent did not provide sufficient evidence to overcome the proof offered by Petitioner regarding the verified findings by the DCF investigators.

44. Regarding the medication issues raised by Petitioner, rule 65G-7.002(3) and (5) provides as follows:

> (3) The medication assistance provider must maintain a current Authorization form, reviewed by the client's physician, physician assistant, or ARNP at least annually and upon any change to the client's medical condition or self-sufficiency which would affect the client's ability to self-administer medication or to tolerate particular administration routes.
>
> * * *
>
> (5) In addition to an executed Authorization for Medication Administration and before providing a client with medication assistance, a provider must also obtain from the client or the client's authorized

representative an "Informed Consent for Medication Administration" APD Form 65G7-02 (3/30/08) incorporated herein by reference.

45. Mr. Turner found repeated violations of the MAR at the group home. The repeated violations and the failure to submit and successfully complete the CAPs for the cited violations clearly demonstrates a pattern of prescription drug mismanagement by the group home and a dereliction of responsibility towards the residents of the group home by Ms. Nelson.

46. The violations noted by Ms. Leitold on her January 17, 2013, inspection regarding the failure to adequately and appropriately store volatile materials created an imminent threat of harm to minor residents. The garage was not locked, and residents had access to the garage area where the volatile materials such as gasoline, charcoal, and lighter fluid were left out in the open, rather than stored in appropriate containers. This constitutes violations of rules 65G-2.011(8) and 65G-7.005(2).

47. Three incidents involving Ms. Nelson's violation of the admissions procedure were raised in this proceeding. Ms. Nelson admitted to Mr. Turner that, on two occasions, she violated the requirement to obtain prior approval from the agency before admitting new clients to the Tracy Court Group Home. As to the third instance of admitting a client without prior approval, Ms. Nelson testified that she had prior verbal approval of the

agency to place the client, but did not have written approval. The agency's witnesses testified that they always give written approval and that they would never expect a provider to rely upon verbal approval with the high volume of placements the agency has to make on a regular basis. Ms. Nelson's testimony regarding the verbal approval was rebutted by both Mses. Leitold and Williams, whose testimony and description of agency practice for approval is more credible than Ms. Nelson's version.

48. Respondent argues that the violations set forth in the Administrative Complaint giving rise to the denial of its application for renewal constitute only minor offenses that can be corrected without penalty. Further, Respondent argues in its Conclusions of Law that since Petitioner failed to allege what class each of the alleged violations falls within, adverse findings cannot be made against Respondent. Further, argues Respondent, Petitioner failed to allege or prove that any allegations in the Administrative Complaint constituted repeat or continued violations.

49. Respondent's argument that it was not properly placed on notice of the statutory and rule violations is ingenuous, at best. While it is true that the violations set forth in the 12 counts of the Administrative Complaint were not assigned a class for the nature of the violation, the charging document clearly set forth the charges against the group home and,

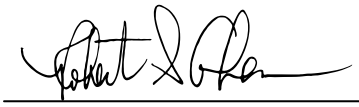
together with the extensive testimony at hearing, provided clear and convincing evidence supporting the violations. Further, the evidence and testimony at hearing made clear the continuing and repeated nature of the violations, especially those dealing with mishandling of the residents' prescriptions and the repeated attempts to add residents in excess of the number of approved residents for the group home.

50. Petitioner has met its burden of proving, by clear and convincing evidence, that Respondent's application for renewal of its group home license should be denied.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Persons with Disabilities enter a final order denying V-Agape, LLC, d/b/a Tracy Court Group Home's application for license renewal.

DONE AND ENTERED this 6th day of November, 2015, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 6th day of November, 2015.

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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.