STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

A PLACE CALLED HOME,

Petitioner,

vs. Case No. 15-2042

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

RECOMMENDED ORDER

This case came before Administrative Law Judge Darren A. Schwartz of the Division of Administrative Hearings for final hearing by video teleconference on August 26 and 28, 2015, at sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Nathaniel E. Green, Esquire
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For Respondent: Nelson E. Rodney, Esquire
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STATEMENT OF THE ISSUE

Whether Petitioner, A Place Called Home ("APCH"), committed three Class II deficiencies and an uncorrected Class III deficiency at the time of the survey conducted on January 20

through 27, 2015, so as to justify Respondent, Agency for Health Care Administration ("AHCA"), denying the licensure renewal application of APCH to continue to operate an eight-bed assisted living facility ("ALF") located in Miami, Florida.

PRELIMINARY STATEMENT

By letter titled "Notice of Intent to Deny Renewal Application for A Place Called Home," dated March 10, 2015, AHCA notified APCH of the denial of its renewal license application. APCH timely filed a Petition for Formal Hearing. Subsequently, on April 14, 2015, AHCA referred the matter to the Division of Administrative Hearings ("DOAH") to assign an Administrative Law Judge to conduct the final hearing. On April 17, 2015, the undersigned set the final hearing for June 24, 2015. On June 16, 2015, the undersigned entered an Order granting APCH's unopposed motion for continuance, and reset the final hearing for August 26, 2015.

The final hearing commenced as scheduled on August 26, 2015, and concluded on August 28, 2015, with both parties present. At the hearing, AHCA presented the testimony of Judith Calixte-Joasil, Kristal Branton, and Arlene Mayo-Davis. AHCA's Exhibits 1 through 73, 97 through 99, 101 through 104, and 107 through 115 were received into evidence. APCH presented the testimony of Tory Mays and Linda Mays. APCH's Exhibits 1 through 8 were received into evidence.

The three-volume Transcript of the hearing was filed at DOAH on October 15, 2015. The parties' proposed recommended orders were due on November 4, 2015. AHCA timely submitted Respondent's Proposed Recommended Order on November 4, 2015, which was given consideration in the preparation of this Recommended Order. APCH untimely submitted Petitioner's Proposed Recommended Order on December 8, 2015, which was not given consideration in this Recommended Order. On December 8, 2015, AHCA filed a Motion to Strike Petitioner's Proposed Recommended Order because it was untimely. On December 8, 2015, the undersigned entered an Order striking Petitioner's Proposed Recommended Order.

On August 18, 2015, the parties filed their Joint Pretrial Stipulation, in which they stipulated to certain facts. These facts have been incorporated into this Recommended Order as indicated below.

Unless otherwise stated, all statutory and rule references are to the statues and rules in effect at the time of the alleged violations.

FINDINGS OF FACT

The Parties

1. Since 2013, APCH has been licensed by AHCA to operate an eight-bed ALF located in a duplex at 80-82 Northeast 68th Terrace, Miami, Florida.

2. APCH is licensed to provide limiting nursing and mental health services. Tory Mays has been the Administrator of APCH since its inception in 2013. His wife, Linda Mays, is a Florida licensed advanced registered nurse practitioner, and the contracting nursing care consultant for APCH.

3. AHCA is the state agency responsible for licensing and monitoring assisted living facilities in this state.

The October 21, 2014, Survey

4. On October 21, 2014, AHCA conducted a standard biennial survey at APCH. The October 21, 2014, survey was conducted by Judith Calixte-Joasil, who has conducted thousands of surveys during the past nine years she has been employed by AHCA. Ms. Calixte-Joasil, who is employed by AHCA as a health facility evaluator no. 2, has no nursing background, and she is not a physician. During this survey, Ms. Calixte-Joasil found and cited APCH with seven Class III deficiencies. Ms. Calixte-Joasil issued seven separate "tags" to explain the deficiencies. The following is a summary of the seven Class III deficiencies found by Ms. Calixte-Joasil during the October 21, 2014, survey:

Tag A026--Resident Care--Social & Leisure Activities: Failure to provide scheduled activities posted in the common area and failure to encourage the residents to participate in social, recreational, educational, and other activities within the facility and community.

Tag A078--Staffing Standards: Failure to ensure that a staff member had documentation verifying proof of an annual tuberculosis test result.

Tag A079--Staffing Standards: A staff schedule showed an individual listed on the work schedule for the month of October 2014, but that individual no longer worked at the facility.

Tag A081--Staff In-Service Training: Failure to have proper training hours that are not over the time limits in one day of training (two out of four sampled staff).

Tag A152--Physical Plant--Safe Living Environment/Other: Broken and rotten wood around an air conditioner unit in an outside window area of one of the rooms. Also, peeling paint in front of the air conditioner was observed in this room. Peeling paint was also observed on the ceiling in both common areas. Finally, in another room, there were missing dresser knobs and a broken door with peeling paint.

Tag A160--Records: Failure to have resident elopement response policies and procedures.

Tag AL243--Training: Failure to have documentation ensuring that a staff member completed the minimum six hours of continuing education.

The Incident Involving Resident M.R.

5. M.R. is a current resident at APCH. M.R. became a resident of APCH on December 29, 2014, after transferring from another ALF called Ashley Gardens. Upon transferring to APCH, Ms. Mays examined M.R. and completed AHCA's Form 1823, titled Resident Health Assessment for Assisted Living Facilities.[1/]

6. At the time of her transfer to APCH on December 29, 2014, M.R. was 80 years old, 4'9" inches tall, and weighed 107 pounds. Her medical history and diagnoses were positive for hypertension, Alzheimer's disease, and psychosis.

7. At that time, M.R. had an "unsteady gait." She needed "hands on" assistance for bathing and assistance choosing

clothing, but she could independently ambulate, eat, care for herself, and use the toilet. Her cognitive or behavioral status was "impaired mental status." No nursing, treatment, psychiatric or therapy services were required. No special precautions were necessary, and she was not an elopement risk.

8. From December 29, 2014, until January 14, 2015, M.R. resided at APCH without incident.

9. However, on January 14, 2015, at 4:15 p.m., M.R. fell at the entrance of APCH and suffered injury.

10. Mr. Mays learned of M.R.'s fall shortly after it occurred, when he received a telephone call from Glasna Sterling, a caregiver at APCH. Mr. Mays then called his wife to let her know of the fall. Mr. Mays also called Ben Johnson, M.R.'s guardian, to let him know of the fall.

11. In the meantime, a caregiver at the facility applied some ice to M.R.'s face shortly after the fall. Ms. Mays arrived at APCH on January 14, 2015, and conducted a thorough "face-to-face," "head-to-toe" examination and nursing assessment of M.R. at 7:30 p.m.

12. M.R.'s chief complaint at that time was that her forehead hurt. Upon examination, Ms. Mays observed a two-inch circumference closed hematoma above M.R.'s right eye, which was tender to the touch.[2/]

13. Ms. Mays' examination and nursing assessment of M.R. on January 14, 2015, included checking M.R.'s mentation from her baseline, which was forgetfulness. Ms. Mays examined M.R.'s cognitive abilities and was able to determine her level of orientation and mental status.

14. Ms. Mays observed that M.R.'s eyes were open; she could speak, move, and respond appropriately to voice commands. Ms. Mays examined M.R.'s pupils to see if they were reactive to light and accommodating. Ms. Mays checked the movement of M.R.'s limbs. She checked her lung and bowel sounds. Ms. Mays performed a Glasgow Scale test, which is a test designed to determine a patient's neurological status and any type of neurological change. Ms. Mays found no deficits on the Glasgow Scale.

15. Following her January 14, 2015, examination of M.R., Ms. Mays' assessment was hematoma secondary to head trauma. M.R. also had a bruised knee. Ms. Mays determined that M.R.'s injuries resulting from the fall required first-aid type treatment, only, which could be provided by a person who is trained to perform first-aid.

16. At that time, Ms. Mays' recommended plan of treatment called for ice to be applied to M.R.'s forehead for 15 minutes every two hours for eight hours; the checking of vital signs and alertness for the next eight hours; and required the caregiver,

Mr. Sterling, to call M.R.'s primary doctor (Dr. Moses Alade) if M.R. became confused, dizzy, or there was a change in her level of consciousness.

17. No ambulance or physician was called regarding M.R. on January 14, 2015.

18. Ms. Mays documented her findings and treatment plan in "SOAP" notes dated 7:30 p.m., on January 14, 2015. SOAP notes are a problem-solving focused style of note writing, and provide guidance as to how a nurse might document her assessment of a patient for an issue that is being addressed. The term SOAP is an acronym for the following: S=subject, O=objective, A=assessment, and P=plan. The SOAP notes were maintained in M.R.'s resident file to document her health condition.

19. Ms. Mays and Mr. Sterling were trained and qualified to perform the duties set forth in the "SOAP" notes. Ms. Mays and Mr. Sterling were trained and qualified to provide first-aid to residents. Notably, Mr. Sterling was trained and qualified on how to observe and report any changes in M.R.'s condition to Dr. Alade. Ms. Mays explained to Mr. Sterling that he should contact Dr. Alade if M.R. became dizzy; if she was not waking up; if she was sluggish; if there was any change in her normal alertness; if she was not eating; if she appeared more confused than usual; or if she was combative.

20. Ms. Mays continued to monitor M.R.'s condition over the next two days to ensure that her initial findings were accurate. Ms. Mays also followed-up with Mr. Sterling over the next two days to ensure that he followed her orders.

21. There was no change in M.R.'s level of consciousness during the overnight period of January 14 through 15, 2015.

22. On January 15, 2015, at 5:30 p.m., Ms. Mays returned to APCH and conducted another examination of M.R. At this time, M.R. appeared guarded. Nevertheless, Ms. Mays observed that the hematoma was healing, and had reduced in size from two inches to one inch in circumference. The area was non-tender. There had been no change in M.R.'s level of consciousness. M.R.'s vital signs reflected a blood pressure reading of 122/78 and a heart rate of 82, which are within normal limits.[3/]

23. Notably, by this time, fluid that had collected in the hematoma had begun to collect in the facial tissues, resulting in M.R.'s facial area appearing purple/blue in color. At hearing, Ms. Mays explained that for a geriatric patient such as M.R. with non-elastic skin, it is reasonable that the fluid collected in the hematoma would dissipate downward with gravity in other areas of the body, such as to the face.

24. Based on her examination of M.R. on January 15, 2015, Ms. Mays' assessment remained hematoma secondary to head trauma.

Again, Ms. Mays determined that nothing more than first-aid type treatment was required.

25. Following her examination of M.R. on January 15, 2015, Ms. Mays' recommended treatment called for Tylenol (325mg ii tabs)[4/] and ice to be applied to the forehead, if needed; the checking of alertness; and required the caregiver, Mr. Sterling, to call M.R.'s primary doctor (Dr. Alade) if M.R. became confused, dizzy, or there was a change in her level of consciousness. Ms. Mays again documented her findings and treatment plan in "SOAP" notes dated 5:30 p.m., on January 15, 2015.

26. On January 16, 2015, at 5:35 p.m., Ms. Mays returned to APCH and conducted another examination of M.R. At this examination, M.R. was less guarded. Ms. Mays observed that the hematoma was continuing to heal and had reduced in size from one inch to .75 inch in circumference. The area was non-tender. There had been no change in M.R.'s level of consciousness. M.R.'s vital signs reflected a blood pressure reading of 117/74 and a heart rate of 76, which are within normal limits.

27. However, by this time, Ms. Mays observed a purple/blue discoloration on both sides of M.R.'s face and a dark green and yellow color on the bridge of her nose. This observation was consistent with blood collecting in the tissues of her face as previously determined by Ms. Mays.

28. Based on her examination of M.R. on January 16, 2015, Ms. Mays' assessment remained hematoma secondary to head trauma. Again, Ms. Mays determined that nothing more than first-aid type treatment was required of M.R.

29. Following her examination of M.R. on January 16, 2015, Ms. Mays' treatment plan called for Tylenol (325mg ii tabs), if needed; the checking of alertness; and required the caregiver, Mr. Sterling, to call M.R.'s primary doctor (Dr. Alade) if M.R. became confused, dizzy, or there was a change in level of consciousness. Ms. Mays again documented her findings and treatment plan in "SOAP" notes dated 5:33 p.m., on January 16, 2015.

30. Following her examination of M.R. on January 16, 2015, Ms. Mays had no further face-to-face contact with M.R. between January 16, 2015, and January 21, 2015.

The January 20 through 27, 2015, Survey and Its Aftermath

31. From January 20 through 27, 2015, a standard biennial revisit survey was conducted at APCH by Ms. Calixte-Joasil.

32. Upon arriving at APCH at 9:15 a.m., on January 20, 2015, to conduct the revisit survey, Ms. Calixte-Joasil observed M.R. sitting on the couch. Ms. Calixte-Joasil observed M.R.'s face with the different discolorations and bruises. Ms. Calixte-Joasil became concerned based on M.R.'s appearance. Ms. Calixte-Joasil proceeded to take three photographs of M.R.'s face.

33. Based on "the way she looked," Ms. Calixte-Joasil believed that M.R. needed to see a doctor "just to be on the safe side to make sure she didn't suffer any other injuries."

34. M.R. had already been scheduled to see Dr. Alade on January 20, 2015, for a "normal appointment," unrelated to her January 14, 2015, fall. Ms. Calixte-Joasil saw M.R. leave APCH on January 20, 2015, accompanied by another caregiver of APCH ("Ms. Esther") who provides transportation. Ms. Calixte-Joasil observed M.R. and Ms. Esther linking arms, with Ms. Esther assisting M.R. walking out of the facility. At that time, Ms. Esther had M.R.'s resident file with her.

35. Ms. Calixte-Joasil assumed Ms. Esther was taking M.R. to see Dr. Alade. Both Ms. Calixte-Joasil and Mr. Mays believed that on January 20, 2015, Ms. Esther took M.R. to Dr. Alade's office on January 20, 2015, for her regularly scheduled appointment.

36. Unbeknownst to Ms. Calixte-Joasil or Mr. Mays on January 20, 2015, however, Ms. Esther did not take M.R. to see Dr. Alade on January 20, 2015, as she was supposed to do.

37. The next day, January 21, 2015, Ms. Calixte-Joasil called Dr. Alade's office directly and found out that he did not see M.R. on January 20, 2015. When Mr. Mays found out that Ms. Esther had not taken M.R. to see Dr. Alade on January 20,

2015, Ms. Ester was suspended by APCH for two weeks and subsequently terminated.

38. On January 21, 2015, Ms. Mays contacted Dr. Alade for the first time regarding M.R.'s fall on January 14, 2015. Ms. Mays contacted Dr. Alade on January 21, 2015, because by this time, AHCA was questioning the care that had been provided to M.R. by APCH.

39. When Ms. Mays spoke to Dr. Alade on January 21, 2015, she explained her examinations, assessments, and treatment of M.R. from January 14 through 16, 2015. No persuasive evidence was adduced at hearing that Dr. Alade recommended that M.R. be taken to the hospital or that he needed to see her for an immediate evaluation.

40. Upon her return to APCH on January 21, 2015, Ms. Calixte-Joasil continued her survey and investigation as to what transpired with M.R.

41. Ms. Calixte-Joasil examined Ms. Mays' "SOAP notes." Ms. Calixte-Joasil's testimony that she was unable to determine from her review of Ms. Mays' notes whether M.R. had made any improvement between January 14 and 16, 2015, is unpersuasive, and not credited. Notably, at hearing, Arlene Mayo-Davis, AHCA's nursing expert, acknowledged that during that time, the SOAP notes reflect that the hematoma was getting better and healing.

42. Ms. Calixte-Joasil made no effort to communicate with Ms. Mays on January 20 or 21, 2015.

43. However, Ms. Calixte-Joasil contacted the Department of Children and Families ("DCF") because of how M.R. looked and after finding out that M.R. did not go to the doctor as scheduled on January 20, 2015. Ms. Calixte-Joasil suspected that M.R. was the victim of abuse "from the way she looked, the fall." Ms. Calixte-Joasil expected DCF "to come out and investigate based on my findings and what I had said."

44. DCF arrived at APCH on January 23, 2015, along with law enforcement. DCF arranged for M.R. to be taken by ambulance to the North Shore Medical Center emergency room.

45. Upon learning that M.R. had been taken to the emergency room, Ms. Mays called Dr. Alade. After talking to Dr. Alade, Ms. Mays met M.R. at the emergency room and provided the emergency room physician with a report as to what happened.

46. Ms. Mays proceeded to the emergency room and provided the emergency room physician with a report as to what happened.

47. M.R. was admitted to the hospital on January 23, 2015.

48. Dr. Alade agreed on January 23, 2015, that M.R. should be admitted to the hospital, and he traced M.R.'s pre-admission work-up.[5/]

49. The emergency physician who examined M.R. at the hospital reviewed Ms. Mays' notes, and Ms. Mays testified that

the emergency room physican agreed with her assessment and treatment of M.R.

50. On January 29, 2015, M.R. was discharged from the hospital with a diagnosis of contusion and urinary tract infection. The discharge diagnosis of contusion confirms that M.R. did not suffer any fractures or a brain injury as a result of the January 14, 2015, fall, and is compatible with the need for first-aid type treatment, only, which was adequately provided by APCH. There is nothing more that APCH could have done that would have changed the course of M.R.'s recovery from her injuries resulting from the fall.

51. Following her discharge, M.R. was returned to APCH on January 29, 2015.

52. On February 3, 2015, Dr. Alade examined M.R. and completed AHCA's Form 1823.

53. Following his examination of M.R. on February 3, 2015, Dr. Alade indicated that M.R.'s facial contusion had resolved. At no time has Dr. Alade expressed any concern about the manner in which M.R. was medically treated at APCH. Dr. Alade recommended that M.R. return to APCH where she has resided ever since. M.R.'s guardian approved of M.R.'s return to APCH.

AHCA's Alleged Deficiencies as a Result of the January 20 through 27, 2015, Survey

54. AHCA's proposed agency action to deny APCH's renewal license is based on three purported Class II deficiencies and one purported uncorrected Class III deficiency. Each of these alleged deficiencies relate to M.R.'s fall on January 14, 2015, and the subsequent January 20 through 27, 2015, survey. The undersigned turns now to specifically address each of these alleged deficiencies upon which AHCA's proposed agency action is based.

Tag A030: Class II Deficiency

55. As a result of the January 20 through 27, 2015, survey, AHCA charged APCH with the following Class II deficiency:

> Tag A030 58A-5.0182(6) FAC; 429.28 FS
> Resident Care--Rights & Facility Procedures:
>
> * * *
>
> [T]he facility failed to provide access to adequate and appropriate health care consistent with established and recognized standards within the community for one out of eight [M.R.] residents.

56. In support of its position, AHCA presented the expert testimony of Ms. Mayo-Davis. Ms. Mayo-Davis is a licensed registered nurse. She has been licensed since 1988. At hearing, AHCA's counsel offered Ms. Mayo-Davis as an expert in the area of general nursing. Without objection, she was accepted by the undersigned as an expert in general nursing.

57. By way of background, Ms. Mayo-Davis worked as a registered nurse at two hospitals for a total of seven years, focusing on medical, surgical, oncology, and hematology. Since 1995, she has been employed by AHCA. She began her ACHA employment as a registered nurse specialist. She later became a registered nurse supervisor and registered nurse consultant.

58. Ms. Mayo-Davis is currently employed by AHCA as a field office manager. As a field office manager, Ms. Mayo-Davis manages 110 employees in the Delray and Miami, Florida, offices of AHCA. As a field officer manager, Ms. Mayo-Davis reviews deficiencies found at AHCA licensed facility surveys. She reviews hundreds of surveys on an annual basis, but she has not actually performed surveys while employed at AHCA.

59. At hearing, Ms. Mayo-Davis opined that the factual basis supporting this alleged deficiency is that the facility "did not seek additional health evaluation after the resident had a fall." Ms. Mayo-Davis testified that based on her review of the three photographs taken on January 20, 2015, and other documents, her nursing impression is that there was the potential for a brain injury or fracture of the face and that M.R. needed to be assessed by a doctor, not a nurse, and also taken to the hospital to evaluate whether or not some additional diagnostic testing needed to be done (i.e., CAT scan or X-ray). Ms. Mayo-Davis opined that M.R. still needed to go to the

hospital even though by the third day "things were resolving." At hearing, Ms. Mayo-Davis conceded that there is no evidence that M.R. suffered a brain injury or fracture to the face as a result of the fall on January 14, 2015.

60. Importantly, at hearing, Ms. Mayo-Davis conceded that she never saw or examined M.R., and that she has never been to APCH.

61. The undersigned rejects Ms. Mayo-Davis' opinions as unpersuasive.

62. The undersigned accepts and finds Ms. Mays' opinions persuasive.

63. By way of background, Ms. Mays received a bachelor's degree in nursing from the University of Miami in 1999 and a master's degree in nursing for clinical research from Duke University in 2001. She received a post-masters' certificate as a psychiatric nurse practitioner from the University of Florida in 2013 and a doctoral degree in nursing practice from the University of Florida in August 2015.

64. Ms. Mays has been licensed as a registered nurse in Florida since 1997. She is also licensed as a registered nurse in North Carolina and Kentucky. She is also licensed as an advanced registered nurse practitioner in Florida and Kentucky.

65. Ms. Mays received training as an ALF administrator in Florida, and she is certified by the State of Florida to train ALF trainers.

66. Ms. Mays began her work experience as a telemetry nurse for two years at Kendall Regional Medical Center. After that, she studied at Duke University where she became a clinical instructor for nursing students at Vance-Granville Community College, as well as the staff coordinator trainer at a nursing home in North Carolina.

67. After that, Ms. Mays moved to Kentucky for six months where she was hired to be a director of a nursing home. She then returned to South Florida, where she accepted the position of director of nursing for a ventilator unit at Miami Hart Hospital, a position she held for three years. After Ms. Mays received her post-master's certificate as a psychiatric nurse practitioner, she was then hired to work at West Palm Hospital as a psychiatric nurse practitioner. She is currently employed as an assistant professor at the University of Miami for clinical studies in the School of Nursing, in addition to her duties as the nursing care consultant at APCH.

68. At hearing, without objection, Ms. Mays was accepted as an expert in the areas of general nursing, nursing standards, fall management, core training as it relates to ALFs, and nursing as it relates to the administration and management of ALFs.

69. Ms. Mays persuasively opined that the acute course of M.R.'s medical condition occurred between January 14 and 16, 2015. During this time period, there was no change in M.R.'s condition because of her injuries from the fall which necessitated APCH contacting M.R.'s primary care physician or taking her to the hospital. M.R. was able to carry out her same activities of daily living she had done before the fall.

70. Ms. Mays persuasively opined at hearing that had there been any indication of a brain injury as a result of the fall, the symptoms would have manifested during the January 14 through 16, 2015, period. However, no symptoms of a brain injury were presented, and there was no indication of a fracture.

71. The persuasive evidence adduced at hearing establishes that APCH provided the correct course of treatment following M.R.'s fall, and there was no need for any further medical treatment or assessment of M.R. as a result of her injuries from the fall.

72. M.R. was not subject to abuse or neglect by APCH, and AHCA failed to prove an intentional or negligent act by APCH seriously or materially affecting the health of M.R. Based on the particular facts of this case, the first-aid medical treatment provided by APCH as a result of M.R.'s injuries from the fall was adequate, appropriate, and consistent with the established and recognized standards within the community.

Mr. Sterling was trained and qualified to perform the first-aid type treatment that he did and to contact Dr. Alade if there was any change in M.R.'s condition. Mr. Sterling's first-aid treatment of M.R. was consistent with Ms. Mays' protocol. The treatment protocol was sufficiently documented and followed.

73. The preponderance of the evidence presented at hearing fails to establish a violation of Tag A030.

Tag A077: Class II Deficiency

74. As a result of the January 20 through 27, 2015, survey, AHCA also charged APCH with the following Class II deficiency:

> Tag A077: 58A-5.019(1) FAC Staffing Standards--Administrators
>
> * * *
>
> [T]he facility failed to be under the supervision of an administrator who is responsible for the provision of appropriate care for one out of eight [M.R.] residents.

75. The facility administrator, Mr. Mays, is responsible for the provision of appropriate care for the residents. At hearing, Ms. Calixte-Joasil testified that it is the administrator's responsibility to ensure that the resident receive appropriate care. She testified that the reason she cited APCH for this deficiency is because Mr. Mays, "never ensured that she saw a doctor," there was no documentation that she saw a doctor, and then when she contacted the doctor's office, Dr. Alade had not seen her.

76. Again, this deficiency is based on M.R.'s fall, and AHCA's position that M.R. did not receive appropriate care as a result of her injuries from the fall.

77. However, as detailed above, the undersigned has found that M.R. received adequate and appropriate care as a result of her injuries from the fall.

78. The preponderance of the evidence presented at hearing fails to establish a violation of Tag A077.

Tag A025: Class II Deficiency

79. As a result of the January 20 through 27, 2015, survey, AHCA also charged APCH with the following Class II deficiency:

> Tag A025: 58A-5.0182(1) FAC Resident Care-Supervision
>
> * * *
>
> [T]he facility failed to maintain a written record of any significant change for one out of eight residents [M.R.].

80. At hearing, Ms. Calixte-Joasil testified that the factual basis for this alleged deficiency is that APCH did not have any written record of any "significant change" for M.R. following the fall.

81. The determination of whether a resident suffered from a "significant change" in behavior or mood cannot be made by a non-medical professional. Nevertheless, Ms. Calixte-Joasil made the determination that M.R. suffered from a "significant change" in

her health status because of the "bump" on her head and "discoloration of the resident's eyes." The contusion caused by M.R.'s fall, which later resolved, did not result in a significant change in her health status. As detailed above, the injuries M.R. sustained as a result of the fall were short-term, requiring first-aid treatment, only. M.R. was able to continue to carry out her same activities of daily living before and after the fall. The credible and persuasive evidence adduced at hearing establishes that M.R. did not suffer from a "significant change" in her health status as a result of her injuries from the fall on January 14, 2015.

82. The preponderance of the evidence presented at hearing fails to establish a violation of Tag A025.

Tag A152: Uncorrected Class III Deficiency

83. As a result of the January 20 through 27, 2015, survey, AHCA also charged APCH with the following Class III uncorrected deficiency:

> Tag A152: 58A-5.023(3) FAC Physical Plant-- Safe Living Environ/Other
>
> * * *
>
> [T]he facility failed to maintain a safe living environment free from hazards.

84. This alleged deficiency is premised on Ms. Calixte-Joasil's belief that M.R.'s fall was caused by her tripping over a metal threshold at the entrance of APCH. At

hearing, Ms. Calixte-Joasil testified that her belief is based on a conversation she had with Mr. Sterling on January 27, 2015.

85. However, a review of Ms. Calixte-Joasil's survey notes reflects that Mr. Sterling told her that his back was toward M.R. when she fell, and he did not actually see when M.R. fell.

86. At hearing, Ms. Calixte-Joasil further testified that Ms. Mays told her that M.R. fell as a result of the metal threshold. However, Ms. Calixte-Joasil acknowledged that this purported statement is not in her survey notes. At hearing, Mr. Mays denied making the purported statement to Ms. Calixte-Joasil.

87. No persuasive and credible evidence was adduced at hearing to demonstrate what caused M.R. to fall on January 14, 2015. Although APCH did not dispute in its Petition for Formal Hearing that M.R. "fell at the entrance of the facility," that does not mean that she tripped over the metal threshold at the entrance of the facility.

88. No witnesses who actually saw M.R. fall testified at the hearing. M.R. could have tripped over her own two feet at the entrance to the facility. Ms. Calixte-Joasil's testimony that M.R. fell because she tripped over the metal threshold is not credited. Mr. Mays' testimony is credited. In sum, the persuasive evidence adduced at hearing fails to establish that M.R. tripped over the metal threshold at the entrance door to

APCH on January 14, 2015, which caused her to fall and suffer injuries.[6/]

89. Moreover, the evidence presented at hearing fails to establish that the metal threshold was a hazardous or potential hazardous condition. At hearing, Ms. Calixte-Joasil testified that when she observed the metal threshold during her January 2015 inspection, "[i]t was elevated a little bit." Based on her belief that M.R. fell on January 20, 2015, she cited this deficiency as a repeat environmental hazard.

90. APCH was unaware that the metal threshold was a potential hazard prior to the January 20 through 27, 2015, survey. There is no history of anyone ever tripping over the metal threshold prior to January 14, 2015.

91. The metal threshold is not an uncorrected deficiency from the October 21, 2014, survey. The metal threshold was in the same condition on January 20, 2015, as it was at the time of the October 21, 2014, survey. The metal threshold was in the same condition it had been in when APCH commenced operations in 2013.

92. Ms. Calixte-Joasil had been to APCH on multiple occasions prior to the October 21, 2014, survey, and used the same entrance where the metal threshold is located. Notably, Ms. Calixte-Joasil did not cite the metal threshold as an environmental hazard at any time prior to the October 21, 2014,

survey, or when she conducted the October 21, 2014, survey. Ms. Calixte-Joasil made no mention to APCH of any issue with the metal threshold prior to the January 20 through 27, 2015, survey, and APCH was never made aware by AHCA that the metal threshold was a tripping hazard prior to the January 20 through 27, 2015, survey.[7/]

93. At hearing, Ms. Calixte-Joasil conceded that by the time of the January 20 through 27, 2015, survey, all of the items cited in the October 21, 2014, survey had been timely repaired.

94. APCH's license was set to expire on February 26, 2015. On February 23, 2015, AHCA conducted a standard biennial second revisit survey at APCH, at which time no deficiencies were found. At hearing, Ms. Calixte-Joasil conceded that all of the January 20 through 27, 2015, citations were timely corrected prior to the February 23, 2015, survey. Thus, there were no deficiencies at the facility for weeks prior to the March 10, 2015, denial letter. [8/]

CONCLUSIONS OF LAW

95. The Division of Administrative Hearings has jurisdiction over the subject matter and parties pursuant to sections 120.569 and 120.57(1), Florida Statutes (2014).

96. In the instant case, APCH has applied for the renewal of its license to operate an ALF and challenges AHCA's decision to deny the renewal license application.

97. A license to operate an ALF is a public trust and a privilege, not an entitlement. § 429.01(3), Fla. Stat.

98. Generally, the applicant for licensure has the burden of proof to demonstrate, by a preponderance of the evidence, that it satisfies the requirements for licensure and is entitled to receive the license. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996); M.H. v. Dep't of Child. & Fam. Servs., 977 So. 2d 755, 762 (Fla. 2d DCA 2008).

99. However, in the instant case, it is undisputed that AHCA did not base its licensing decision on anything having to do with the renewal application itself. Rather, AHCA based its licensing decision on specific instances of alleged wrongdoing on the part of APCH resulting from alleged deficiencies found in surveys. Accordingly, the burden in this particular proceeding belongs to AHCA to establish, by a preponderance of the evidence, that APCH committed the alleged deficiencies upon which it relies for its decision to deny the renewal license. Osborne, 670 So. 2d at 934; M.H., 981 So. 2d at 762.[9/]

100. AHCA's denial of APCH's renewal license is based on the following provisions of the Florida statutes: sections 429.14(1)(a), 429.14(1)(e)2., 429.14(1)(k), 408.806(7)(a), 408.815(1)(b), and 408.815(1)(e).

101. Section 429.14(1)(a) authorizes AHCA to deny a license for an intentional or negligent act seriously affecting

the health, safety, or welfare of a resident of an ALF. Section 429.14(1)(e)2. authorizes AHCA to deny a license for three or more Class II deficiencies. Section 429.14(1)(e)3., which AHCA does not rely on, authorizes AHCA to deny a license for five or more Class III deficiencies that have been cited on a single survey and have not been corrected within the times specified. Section 429.14(1)(k) authorizes AHCA to deny a license for any act constituting a ground upon which an application may be denied. Section 408.806(7)(a) provides that an applicant must demonstrate compliance with the requirements in this part, authorizing statutes, and applicable rules during an inspection pursuant to section 408.822, as required by authorizing statutes. Section 408.815(1)(b) authorizes AHCA to deny a license for an intentional or negligent act materially affecting the health or safety of a resident of an ALF. Section 408.815(1)(e) authorizes AHCA to deny a license for a violation of this part, authorizing statutes, or applicable rules.

102. As detailed above, AHCA failed to demonstrate by a preponderance of the evidence that APCH committed the three Class II deficiencies and an uncorrected Class III deficiency at the time of the January 20 through 27, 2015, survey.

103. Class II violations are those deficiencies which directly threaten the physical or emotional health, safety, or security of residents. Class III violations are those

deficiencies which indirectly or potentially threaten the physical or emotional health, safety, or security of residents. §§ 408.813(2)(a) & (b), Fla. Stat.

104. As to Tag A030 (Class II deficiency), AHCA relies on sections 429.28(1)(a) and (j), Florida Statutes, which provide, in pertinent part:

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

105. A health care provider "means a physician or physician's assistant licensed under Chapter 458 or 459, F.S., or advanced registered nurse practitioner licensed under Chapter 464, F.S." Fla. Admin. Code R. 58A-5.0131(16).

106. As detailed above, AHCA failed to prove, by a preponderance of the evidence, that M.R. lived in an unsafe living environment; that she was subjected to abuse and neglect; or that she was denied access to adequate and appropriate health

care consistent with established and recognized standards within the community.

107. The persuasive evidence adduced at hearing establishes that at all times material hereto, M.R. has lived in a safe and decent living environment at APCH, free from abuse and neglect, and that she was provided access to adequate and appropriate health care consistent with established and recognized standards within the community.

108. As to Tag A077 (Class II deficiency), AHCA relies on Florida Administrative Code Rule 58A-5.019, which provides in pertinent part as follows:

> **58A-5.019 Staffing Standards.**
>
> (1) ADMINISTRATORS. Every facility must 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 appropriate care to all residents as required by Chapters 408, Part II, 429, Part I, F.S. and Rule Chapter 59A-35, F.A.C., and this rule chapter.

109. In its proposed recommended order, AHCA argues that APCH "failed to provide appropriate supervision by the administrator in that M.R. was not provided with adequate medical care at the time of her fall in January 2015 and in her lack of follow-up medical care afterward."

110. As detailed above, AHCA failed to prove, by a preponderance of the evidence, that M.R. was not provided

adequate medical care for the injuries she received as a result of the fall.

111. The persuasive evidence adduced at hearing establishes that M.R. was provided adequate medical care for the injuries she received as a result of the fall.

112. As to Tag A025 (Class II deficiency), AHCA relies on rule 58A-5.0812(1), which provides as follows:

> **58A-5.0182 Resident Care Standards.**
>
> An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.
>
> (1) SUPERVISION. Facilities must offer personnel supervision as appropriate for each resident, including the following:
>
> (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.
>
> (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
>
> (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
>
> (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.

> (e) 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.

113. A "significant change" is defined in rule 58A-5.0131(32) as follows:

> (32) "Significant Change" means 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. Ordinary day-to-day fluctuations in functioning and behavior, a short-term illness such as a cold, or the gradual deterioration in the ability to carry out the activities of daily living that accompanies the aging process are not considered significant changes.

114. As detailed above, AHCA failed to prove, by a preponderance of the evidence, that M.R. suffered a significant change in her health status as a result of her injuries from the fall. The persuasive evidence adduced at hearing establishes that M.R. did not suffer from a significant change in her health status as a result of her injuries from the fall. The injuries M.R. sustained as a result of the fall were short-term, requiring first-aid treatment, only. M.R. was able to carry out her same activities of daily living before and after the fall.[10/]

115. As to Tag A152 (Uncorrected Class III deficiency), AHCA relies on rule 58A-5.023(3), which provides as follows:

> **58A-5.023 Physical Plant Standards.**
>
> (3) OTHER REQUIREMENTS
>
> (a) All facilities must:
>
> 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.;
>
> 2. Be maintained free of hazards; and
>
> 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.
>
> (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:
>
> 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident;
>
> 2. A closet or wardrobe space for hanging clothes;
>
> 3. A dresser, chest or other furniture designed for storage of clothing or personal effects;
>
> 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and
>
> 5. A comfortable chair, if requested.

116. As detailed above, the preponderance of the evidence fails to establish that the metal threshold was a hazardous or potential hazardous condition.

117. In its proposed recommended order, AHCA argues that APCH also failed to provide "furnishings in good working order." AHCA does not identify in its proposed recommended order the purported "furnishings" it contends are not in "good working order." Nevertheless, the undersigned presumes AHCA may be referring to missing bedroom dresser door knobs identified in Tag A152 from the October 21, 2014, survey, because the dresser is the only "furnishing" identified in this tag.

118. A plain reading of rule 58A-5.023(3)(a)3., however, reflects that the phrase "good working order" pertains to "existing architectural, mechanical, electrical systems, and appurtenances, only." This rule does not pertain to personal furnishings inside a bedroom, such as a bedroom dresser.

119. Moreover, at hearing, Ms. Calixte-Joasil testified that she cited APCH in the October 2014 survey for the missing dresser door knobs because of the requirement that residents live in a "safe and clean environment." Ms. Calixte-Joasil did not rely at all on rule 58A-5.023(3)(a)3.

120. Be that as it may, the alleged deficiencies found in the October 2014 survey are irrelevant except to the limited extent of determining whether the metal threshold cited in the

January 20 through 27, 2015, survey is an "uncorrected" deficiency. In other words, whether APCH actually committed the specific deficiencies identified in the October 2014 survey is irrelevant because AHCA's proposed action to deny the renewal license is not based on the specific deficiencies cited in the October 2014 survey.[11/]

121. At hearing, Ms. Calixte-Joasil further acknowledged that by the time of the January 20 through 27, 2015, survey, all items identified in the October 2014 survey had been repaired.

122. AHCA's attempt to characterize the metal threshold as an uncorrected Class III deficiency because it fell under the same general physical plant tag of "Tag A152- Physical Plant – Safe Living Environment/Other," is without merit. AHCA attempts to take numerous alleged deficiencies from the October 2014 survey, all of which were corrected by the time of the January 2015 survey, and use them to characterize the metal threshold as an uncorrected Class III deficiency.

123. Although the alleged deficiencies from the two surveys are all under the same broad umbrella tag category (Tag A152), they are not the same. AHCA's attempt to take numerous prior citations and make them the same based upon the same broad tag number upon which they were cited is misplaced.

124. To accept AHCA's position would allow it unfettered discretion to decide, in any case, that any purported new

deficiency is an uncorrected deficiency, even though the deficiencies identified in the two surveys are not the same. AHCA could, as it has attempted to do so here, enter a facility and cite as an uncorrected deficiency any item that had not even been mentioned or cited before, simply because the item falls within the same general broad category of a prior deficiency, and even though the item was in the same condition at the time of both surveys. Such unchecked authority would award AHCA for either intentionally ignoring, or negligently missing, an item in a prior survey and then calling it "uncorrected" in a subsequent survey, just because the item falls with the same general category of a tag. Such purported authority is even more troubling in the instant case, because AHCA concedes that all of the items identified in the October 2014, survey had been repaired by the time of the January 20 through 27, 2015, survey, and AHCA concedes that APCH was unaware that the metal threshold posed a potential hazard prior to the January 20 through 27, 2015, survey.[12/]

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that AHCA enter a final order granting APCH's license renewal application.

DONE AND ENTERED this 9th day of December, 2015, in Tallahassee, Leon County, Florida.

DARREN A. SCHWARTZ
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of December, 2015.

ENDNOTES

[1/] The Mays' Foundation is a non-profit foundation, which represents both APCH and Ashley Gardens. M.R. was a resident of Ashley Gardens from 2007 until her transfer to APCH on December 29, 2014. Ms. Mays was already familiar with M.R. when M.R. transferred to APCH because Ms. Mays had known M.R. during the time in which M.R. resided at Ashley Gardens.

[2/] A hematoma or contusion is a bruise to an area of the body. Tenderness indicates there may have been swelling in the area. Eye discoloration, bruising, a cut on the face, and swelling, are all consistent with the finding of a contusion/hematoma.

[3/] Mr. Sterling was trained and qualified to measure M.R.'s heart rate and take M.R.'s blood pressure, both of which were conducted by a machine, which automatically recorded the heart rate and blood pressure readings.

[4/] M.R. was able to communicate if she needed Tylenol.

[5/] No persuasive evidence was adduced at hearing to establish that Dr. Alade believed M.R. should be admitted to the hospital because of anything having to do with the fall. Dr. Alade did not testify. Any suggestion by AHCA that Dr. Alade believed M.R.

should be admitted to the hospital because of anything having to do with the fall is rejected as speculative. Indeed, it could be that Dr. Alade believed M.R. should be hospitalized because of a pre-admission chief complaint of hypertension, urinary tract infection, or electrolyte imbalance, all of which were unrelated to M.R.'s injuries from the fall.

[6/] At hearing, Ms. Calixte-Joasil testified there was a "broken--cracked" . . . "cement area which I described in the tag what I saw and took pictures also of that." Contrary to Ms. Calixte-Joasil's testimony, however, no broken cracked cement area is described under Tag A152. The alleged environmental hazard referred to under Tag A152 is the metal threshold, only. Accordingly, any purported reliance by AHCA on the broken, cracked, "cement area" as a basis for the alleged uncorrected Class III deficiency is rejected.

[7/] Kristal Branton, an AHCA health facility evaluator supervisor, reviewed the survey conducted by Ms. Calixte-Joasil. Ms. Branton also went to APCH on January 27, 2015, and observed the metal threshold area. Ms. Calixte-Joasil's and Ms. Branton's testimony that even if no one had fallen there [at the metal threshold], there still would have been a citation for environmental hazard, is rejected as unpersuasive.

Moreover, Ms. Branton described the metal threshold area as "not flush with what a typical threshold looks like." She testified that when she observed the area on January 27, 2015, there was "a big gap in which a--like about an inch in which something can like trip . . ." At hearing, no evidence was presented of any measurements taken of the metal threshold by Ms. Branton or Ms. Calixte-Joasil. The undersigned also rejects Ms. Branton's testimony as unpersuasive.

[8/] Notably, Ms. Calixte-Joasil testified as to the alleged uncorrected Class III deficiency, based on her "training and experience . . . [u]ncorrected mean[s] you go into the facility and you go to survey to make sure that they corrected the previous survey's sufficiency. However, under that deficiency if you find something else that falls under that deficiency, you can re-cite them for the same deficiency again."

Similarly, Ms. Branton testified that even if the metal threshold was not cited in the October 21, 2014, survey, it was an "uncorrected" deficiency because there were other items (missing door knob on a dresser) which fell under the same tag category of Tag A152: 58A-5.023(3) FAC Physical Plant--Safe

Living Environ/Other, which were cited in the October 21, 2014, survey. No basis was provided for Ms. Branton's testimony. The undersigned rejects Ms. Calixte-Joasil's and Ms. Branton's testimony, and the factual bases for Ms. Calixte-Joasil's testimony, as unpersuasive.

[9/] Recent decisions from two other Administrative Law Judges (ALJs) indicate that in the context of the denial of a renewal license based on specific acts of misconduct, the agency has the burden to establish the alleged misconduct by "clear and convincing evidence." See Kirk Ziadie v. Dep't of Bus. & Prof'l Reg., Case No. 15-5037 (Fla. DOAH Nov. 25, 2015); Ag. for Pers. with Disab. v. Daniel Madistin, LLC #1, Case No. 15-2422FL (Fla. DOAH Nov. 25, 2015). Whether the burden is clear and convincing or a preponderance of the evidence in this specific context is unsettled. The ALJs in these cases acknowledge and discuss in substantial detail the unsettled nature of the law.

Notably, in the instant case, neither party raised the issue of whether the appropriate burden of proof is on AHCA to establish the alleged deficiencies by clear and convincing evidence. In fact, in their prehearing stipulation filed on August 18, 2015, the parties stipulated that "Petitioner [APCH] bears the burden of proof in this proceeding that they were in compliance with the applicable statutes and rules so as to be eligible for licensure as an Assisted Living Facility in the State of Florida. The standard of proof is by a preponderance of the evidence." AHCA reiterates this position in its proposed recommended order.

The undersigned is not bound by the parties' pre-hearing stipulation on an issue of law. Moreover, the question of the appropriate burden of proof is not an issue within the agency's area of expertise.

Upon receipt of the parties' pre-hearing stipulation, the undersigned scheduled a pre-hearing telephone conference with counsel for the parties. The pre-hearing telephone conference was held on August 24, 2015, with counsel for both parties participating in the conference. During the pre-hearing telephonic conference, the undersigned indicated that based on the Osborne and M.H. decisions, AHCA bears the burden in this proceeding to establish the alleged deficiencies by a preponderance of the evidence. The undersigned reiterated this position at the outset of the final hearing.

Notably, in M.H., the court did not have an occasion to specifically address whether the stricter clear and convincing evidence burden applied to the denial of a renewal license based on specific instances of misconduct. Rather, because the day care facility prevailed before the ALJ in that case and no issue was raised as to whether the burden was clear and convincing, the court needed only to address that the correct standard is no less than preponderance of the evidence.

Similarly, because neither party in the instant case raised the issue of whether AHCA bears the burden to establish the alleged deficiencies by clear and convincing evidence, the undersigned need not address this issue now. The undersigned's conclusion that AHCA bears the burden of proof, in the instant case, to establish the alleged deficiencies by a preponderance of the evidence, should not be read as a definitive ruling that in all non-renewal licensure cases, the preponderance of the evidence standard applies.

Indeed, the timing of the Notice of Intent to Deny could militate in favor of a "clear and convincing" standard. AHCA issued its Notice of Intent to Deny 17 days after APCH's renewal license expired, and 20 days after the February 23, 2015, survey, at which time no deficiencies were found. The Notice of Intent to Deny seeks to impose the ultimate penalty of non-renewal, only, although the events giving rise to the Notice of Intent to Deny occurred many months earlier while APCH was duly licensed and acting in its capacity as a licensee. Had AHCA not waited until after the expiration of the license to take action, and instead, filed an administrative complaint seeking either the penalty of a fine or revocation, there would be no question that the burden of proof on AHCA in such a proceeding would be by clear and convincing evidence.

Nevertheless, the undersigned declines to address the specific issue of whether the clear and convincing burden applies for the first time now because it is unnecessary to do so, and because the issue was not raised by the parties prior to the hearing or the issuance of this Recommended Order.

Suffice it to say, however, that because AHCA has not met its burden in the instant case by a preponderance of evidence, it certainly cannot meet a stricter burden to establish the deficiencies by clear and convincing evidence.

[10/] Notably, AHCA's survey specifically states that rule 58A-5.0182(1) was "not met as evidenced by: Surveyor 27207[.]

Based on observation, interview and record review the facility failed to maintain a written record of any significant change for one out of eight residents." (Emphasis added).

The survey findings in support of this tag go on to address alleged deficiencies regarding the lack of documentation in the written record of APCH, only. At hearing, Ms. Calixte-Joasil's testimony in support of this tag was limited to her criticism of the written record, only.

In its proposed recommended order, AHCA argues for the first time that rule 58A-5.0182(1) was violated because "[APCH] failed to provide proper supervision for resident M.R. in that the Administrator did not contact the resident's primary care physician after the resident exhibited a significant change." (Emphasis added). This point was not asserted in the survey, notice of intent to deny, or at the final hearing. Accordingly, AHCA is precluded from making this argument for the first time in its proposed recommended order. Even if AHCA was not precluded from making this argument, however, its position still lacks merit because the evidence adduced at hearing establishes that M.R. did not suffer from a significant change as defined by applicable law.

[11/] Notably, the rule upon which AHCA relies does not require a "clean" environment, only a "safe" environment.

[12/] The determination of whether the metal threshold constitutes an uncorrected Class III deficiency is not an issue within the agency's area of expertise. Indeed, no evidence or argument has been presented in support of such a proposition. At hearing, Ms. Calixte-Joasil merely testified that she relied on her training and experience in reaching her conclusion, and Ms. Branton provided no basis for her testimony. Nevertheless, AHCA conceded at hearing that a facility only has a duty to correct a potential hazard if it is aware of the potential hazard, and the evidence presented at hearing establishes that both APCH and AHCA were unaware that the metal threshold posed a potential hazard prior to the January 20 through 27, 2015, survey.

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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.