STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES

LESLIE FUDGE, d/b/a
GOD'S LITTLE BLESSINGS,

Petitioner,

v.

CASE NO. 15-3284
RENDITION NO. DCF-15-193-FO

DEPARTMENT OF CHILDREN AND FAMILIES,

Respondent.
_____/

FILED
DEC 16 2015
DCF Department Clerk

FINAL ORDER

THIS CAUSE is before me for entry of a final order concerning Petitioner's application for licensure as a child care facility pursuant to section 402.308, Florida Statutes, and Rule 65C-22.001(2), Florida Administrative Code. The Recommended Order finds that the Department did not prove that Petitioner had medically neglected or had failed to adequately supervise a developmentally disabled individual in her care. The Department filed timely Exceptions, which are addressed below. Petitioner filed an untimely reply to the Department's Exceptions, which is nevertheless considered herein.

Department Exceptions

1. The principle issue in this case is whether Petitioner's application for a child care facility license should be denied based on a review of Petitioner's background screening, including the Central Abuse Hotline Records. Petitioner otherwise bore the burden to prove compliance with the requirements for licensure. The Administrative Law Judge (ALJ) concluded that the Department was required to prove the findings reflecting in the Central Abuse Hotline Records and failed to do so because most of its

evidence was unreliable or hearsay. The ALJ concluded that Petitioner was not required to prove her compliance with the requirements for licensure because the Department's stated basis for denial was limited to the hotline records. The ALJ recommended that the Department grant the license. The Department's exceptions take issue with the ALJ's requirement to "re-prove" the findings in the Hotline Record, the ALJ's determination that much of the Department's evidence was unreliable or hearsay, the ALJ's failure to recognize admissible hearsay and direct evidence and her recommendation for approval in spite of a lack of evidence that Petitioner met all licensure requirements.

Petitioner's Reply

2. Petitioner filed a reply that was generally supportive of the Recommended Order. Petitioner notes that she met all standard procedures and was cleared under a criminal background check. She argues that her license was being denied based on hearsay and falsified documents and that there was no factual proof of medical neglect or inadequate supervision of the vulnerable adult to whom she had been assigned (R.H.). She notes that two other vulnerable adults mentioned in the Department's report were not her assigned clients and there were no witnesses to testify regarding her actions affecting those clients. She reiterates key findings by the ALJ regarding the age of the Department's report (Exh. 5) and its confusing allegations, making it untrustworthy as evidence that cannot form the basis of denial of her license. She asserts that there was no written policy requiring R.H. to be within arm's reach and that the facility was weaning R.H. off the one on one program to provide him the privacy to go to the restroom and his own bedroom for privacy.

3. Petitioner reiterates that the Department's evidence consisted only of an old unreliable abuse report consisting of uncorroborated hearsay involving clients other than R.H. and the testimony of an investigator who had no personal knowledge of the facts. In summary, Petitioner argues that the Department failed to demonstrate that she neglected, either in supervision or medically, residents who were in her care. She continues by asserting that the evidence shows that she has been caring for or supervising people for many years and has the character and capacity to continue to do so. She closes by asserting that her license should be granted.

Department Exception to Finding of Fact in Paragraph No. 21.

4. In support of its first exception, the Department argues that the ALJ's finding of fact that Petitioner "has been caring for and/or supervising people for many years and has the character and capacity to do so" is not supported by competent substantial evidence. Although this finding is found in the Conclusions of Law, it is to be reviewed as a finding of fact. See *J.D. v. Dep't of Children & Families*, 114 So.3d 1127, 1134 (Fla. 1st DCA 2014). This finding is also found in Finding of Fact Paragraph 7. The Department asserts that a review of the complete record shows that Petitioner's work history or capacity to care for others has never been referenced. Petitioner responds that the record supports the ALJ's finding.

5. A review of the record shows that there is scant evidence regarding Petitioner's history of providing services and no evidence from which the ALJ could make the findings in paragraphs 7 and 21 regarding Petitioner's character and capacity to supervise individuals in her care. It is true that the record shows Petitioner to have had staff and supervisory responsibilities while employed at the Tallahassee

Development Center, but the nature of those duties, as well as the history of Petitioner's performance in supervising clients in that facility and others are not addressed in the record. The Department's exception is granted and similarly extended to paragraph 7.

Department Exceptions 2 and 3: Finding of Fact Paragraph No. 4.

6. In support of its second exception, the Department argues that the record does not support the conclusion that "there was no credible evidence that the person could not be alone in the restroom . . . or that such observation was not varied according to the behavior plan for an individual resident." The Department points to the testimony of Joanne Hodges that "one-to-one" supervision meant the staff person assigned "could never leave [the person] alone." Therefore, according to the Department, leaving a resident alone in the restroom or the office, as Petitioner admitted, was a violation of the one-to-one supervision. According to the Department, the ALJ's conclusion to the contrary was contradicted by the very evidence she relied upon to support the finding. Petitioner's reply responds by stating that there was no written policy that a client on one-to-one must be within arm's reach and that the facility was trying to wean R.H. off of one-to-one supervision to give him more privacy.

7. In reviewing the Findings of Fact in a Recommended Order, I remain mindful that it is the Administrative Law Judge's function to consider all evidence, resolve conflicts, judge the credibility of witnesses, draw permissible inferences from the evidence, and reach ultimate findings of fact.[1] An agency may not reweigh the

[1]See *Belleua v. Dep't of Environmental Regulation*, 695 So. 2d 1305, 1307 (Fla. 1st DCA 1997). The weighing of evidence and judging of the credibility of witnesses by the Administrative Law (footnote cont.)

evidence.[2] Similarly, an agency may not reject or modify Findings of Fact in a Recommended Order if they are supported by competent substantial evidence.[3] However, it may do so if such findings are not supported by competent substantial evidence. Notably, neither the Department's exceptions nor Petitioner's reply constitute evidence.

8. Finding of Fact Paragraph No. 4, provides:

> Ms. Fudge was the only person who testified at the hearing with personal knowledge about the events of March 5, 2003. She testified, and such testimony is accepted, that on or around March 5, 2003, she was not a shift supervisor, but was assigned as a direct care aide with "one-to-one" supervision of R.H. The testimonial evidence from Ms. Fudge and other employees of the Center during 2003 demonstrated that Tallahassee Developmental Center employees were trained that one-to-one supervision meant that "the person had always to be watched" and "you could never leave [the person] alone." There was no credible evidence that the person could not be alone in the restroom, that the staff assigned to watch the person had to be within arm's length of the resident, or that such observation was not varied according to the behavior plan for an individual resident. Further, the testimonial evidence showed that staff and Ms. Fudge knew R.H. would run away usually to hide in a particular office, but occasionally with the police being called if R.H. were to leave the building and could not be found. The evidence did not demonstrate that R.H. behaviorally was aggressive or dangerous to others, but only

(footnote cont.)

Judge are solely the prerogative of the Administrative Law Judge as finder of fact. See *Strickland v. Fla. A & M Univ., 799 So.2d 276* (Fla. 1st DCA 2001).

[2]When determining whether to reject or modify findings of fact in a recommended order, the agency is not permitted to weigh the evidence, judge the credibility of the witnesses, or interpret the evidence to fit its ultimate conclusions. See *N.W. v. Dep't of Children & Family Servs.*, 981 So.2d 599 (Fla. 3d DCA 2008); *Rogers v. Dep't of Health*, 920 So.2d 27, 30 (Fla. 1st DCA 2005); *Aldrete v. Dep't of Health, Board of Medicine*, 879 So.2d 1244, 1246, (Fla. 1st DCA 2004). *Gross v. Dep't of Health*, 819 So.2d 997, 1001 (Fla. 5th DCA 2002).

[3]See *Rogers v. Dep't of Health*, 920 So.2d 27, 30 (Fla. 1st DCA 2005); *Fugate v. Fla. Elections Comm'n*, 924 So.2d 74, 77 (Fla. 1st DCA 2006).

> that he would run away and hide. Finally, the testimonial evidence showed that the facility was in the process of trying to wean R.H. off of one-to-one supervision by implementing a plan of moving away from him and permitting him times of less supervision.

The foregoing does not cite to a specific portion of the record to support the underlined finding. However, both Petitioner and her former coworker, Joanne Hodges, testified about the requirements of "one-on-one" or "one-to-one" supervision of clients at the Tallahassee Developmental Center.

9. Ms. Hodges testified as follows regarding client supervision standards at the Tallahassee Developmental Center:

> Q. Okay. So what is the meaning of "one-to-one supervision" at the Tallahassee Developmental Center?
>
> A. One-to-one supervision, that was for a person you could never leave alone.
>
> Q. He always had to be watched?
>
> A. The person always had to be watched.
>
> (Transcript, page 58)

Petitioner testified as follows as follows regarding supervision standards at the Tallahassee Developmental Center:

> THE COURT: So there's a window that you look into the living room?
>
> THE WITNESS: Yes, Ma'am. And he doesn't need to be at arm's reach, because we were trying to get him to be ambulatory and trying to reinforce him to do better so he could be a better person and be on his own without one-on-one supervision.
>
> (Transcript, page 65)

The foregoing testimony supports the ALJ's finding that there was no credible evidence . . . that such observation was not varied according to the behavior plan for an individual resident. The Department did not object to Petitioner's testimony that the staff didn't need to be at arm's reach because the staff was trying to get him to ambulatory. This testimony was sufficient to establish some adjustment in the standards for one-to-one supervision at the facility, depending on the needs of the client.

10. Based on the foregoing, the record does not support the Department's exception to the ALJ's finding that there was no credible evidence . . . that such observation was not varied according to the behavior plan for an individual resident. On the other hand, the record and the ALJ's own findings do support the Department's exception to the ALJ's finding there was no credible evidence that the person could not be alone in the restroom. Simply put, the ALJ found that the employees were trained that one-to-one supervision meant that "the person had always to be watched" and "you could never leave [the person] alone." That finding is supported by competent substantial evidence and cannot be overturned. The ALJ's subsequent characterization of the evidence was an implicit finding that the facility's policy permitted a client to be left alone in a restroom, which is not supported by any evidence in the record. The record therefore supports the Department's exception to the ALJ's finding that there was no credible evidence that a person could not be left alone in a restroom.

Department Exception 3: Finding of Fact Paragraph No. 4.

11. The Department argues that the ALJ inappropriately relied upon Petitioner's testimony regarding the facility's attempt to wean the client off of one-to-one supervision. The Department argues that this hearsay testimony was not corroborated

nor supported by appropriate expert testimony. As noted above, the Department did not object to Petitioner's testimony in this regard at the time it was presented (TR 65). There was no challenge to the predicate for the testimony and no voir dire or other challenge to Petitioner's ability to so testify. However, the following characterization of the facility's plans to wean the client,

> [f]inally, the testimonial evidence showed that the facility was in the process of trying to wean R.H. off of one-to-one supervision by implementing a plan of moving away from him and permitting him times of less supervision,

Is not supported by competent substantial evidence. Petitioner only testified that the client need not be "within arm's reach." There was no testimony that there was any "plan" to permit staff to allow supervision to be reduced to the point where a client could be alone in a room and then move unrestricted to another location where he or she could lock him or herself away from staff, which the record clearly shows occurred (TR 66, 75). Petitioner testified that "we were" trying to get him to be ambulatory and trying to reinforce him to do better so he could be a better person and be on his own without one-on-one supervision." That is the extent of the record on a "plan." The Department's exception to this portion of paragraph 4 is granted.

Department Exception 4: Finding of Fact Paragraph No. 5:

12. Implicitly challenged in the Department's exceptions is the last sentence in paragraph 5, which states that, "[g]iven R.H.'s behavior, plan, none of these facts establish neglect by Ms. Fudge in the supervision of R.H." Petitioner argues to the contrary in her reply. As noted above, the record does not support a finding that there was a "plan" that allowed supervision of R.H. to be reduced to the point where he could

be alone in the restroom and then move unrestricted to an office where he could lock himself away from Petitioner.

Department Exception 5: Finding of Fact Paragraph No. 6:

13. The Department contends that Finding of Fact Paragraph No 6 erroneously limited the report to allegations regarding medical neglect of two other clients. In so doing, the ALJ failed to recognize the non-hearsay evidence in the report regarding the care of client "JH," who was under one-to-one supervision by Petitioner. Petitioner's reply argued that it was proper to do so and that there was no non-hearsay evidence to support the charge of neglect. The ALJ's confusion may have been engendered by Petitioner's testimony at hearing and a reading of the redacted version of the report (Resp. Exh. 5), but the unredacted version of the report (also Exh. 5) made clear that the client under one-to-one supervision by Petitioner was the very same client (RH) about whom she testified at hearing. Thus, Finding of Fact Paragraph No. 6 is generally unsupported by competent substantial evidence. The latter potion of Finding of Fact No. 3 includes a characterization of the Department's report quite similar to Finding of Fact Paragraph No 6. To the extent that paragraph 6 errs, so does paragraph 3.

14. While the ALJ (and Petitioner) chose to emphasize the allegations in the Department's report (both redacted and that were not supported by other competent evidence, key portions were, and they supported a finding of neglect of a vulnerable adult. The following portion of the Department's report is a statement taken from Petitioner, which is not hearsay but a statement by a party:

> Interview with Leslie Fudge/PRP, STD received phone call & was not on for too long. STD there was another call from

> employee who wanted her to get her things out of her desk. Laronda told her she needed the phone [other VA] was having seizure. Stated her & [R.H] went down the hall. Then she had another call. Laronda told her [R.H.] was missing, she knew he did not leave the facility because the alarm did not go off. 3 weeks prior VA had done the same thing. She kept telling staff where he was. Found nurse with a key & found him under desk. She does not see why VA can not go in his room, not be on 1 1 for 24 hours.[4]

The foregoing is admissible over objection in a civil action and competent evidence of statements by Petitioner.[5] It is comparable to Petitioner's own testimony at hearing:

> THE WITNESS: And when RH went down the hall to use the restroom while I was – I told the – I can't remember who it was. I think it was Caroline White was the nurse; a nurse was present. Like Ms. Reid say, a nurse was present, and I called the nurse, and I said, "RH locked himself up in Pam office. He left out of the bathroom, and ran in Pam office and locked himself up. Can you come with a key?" Because we supposed to keep her door locked.
>
> And the nurse said, "Is he in danger?"
>
> I said, "No, I see him. He's hiding -- he's hiding." Because he wasn't up under; he was behind the desk.
>
> So Larisha Moore came and said, "You know RH ran?"
>
> I said, "RH is in that office up under the desk in Pam office."
>
> "No, he's not. No, he's not."
>
> And so they telling, "You need to go look for him." They want me to go out the house to look for someone when I know where he was, because I had on the alarm and I told her that: He never left because he was going down to use the restroom and coming right back.
>
> I said, "He ran in Pam's office."

[4]The term PRP" means "perpetrator" and the term "STD" means "stated." (TR 33).

[5]Section 90.803(18)(a), Florida Statutes.

"No, he's not. "No, he's not."

So I said, "Girl, I already called the nurse." So when the nurse came --

THE COURT: Slowly now. Slowly. She's taking it down.

THE WITNESS: I'm sorry. I am sorry.

And so when they called -- when I called the nurse, the nurse came over. She said when she finished with the client, she would be over to let him out, that he's okay. And when she came, she opened the door. He was fine. And -- but they tried to say he left the facility -- he ran, trying to leave the facility. RH never left the facility since I worked there.

(TR, 66-67)

The facts recited in the report regarding Petitioner's supervision of her assigned client align directly with Petitioner's own testimony at hearing.[6] The report placed Petitioner on notice of the claims of institutional neglect and she responded at hearing to each claim. It is true that the testimony at hearing does not support the statements in the report that Respondent medically neglected a client (by remaining on the phone for an extended period of time and refusing to relinquish the phone for a call to support another client that reportedly suffered a seizure), but they do show an instance of neglect of a vulnerable adult through failure to follow the facility's supervisory policies. Regardless, Petitioner's own testimony is direct evidence of the events reflected in the report. Thus the latter portion of Finding of Fact Paragraph No. 3 and all of paragraph 6 are generally unsupported by competent substantial evidence.

[6]They also align with the statements provided by the facility administrator and other staff to the extent that they each stated that V.A. had been found in an office.

Department Exception No. 6: Conclusion of Law No. 17:

15. The Department takes exception to paragraph 17 in a rather extensive discussion, stating that it incorrectly determines all abuse reports, regardless of the facts contained therein, to be unreliable as a matter of law. The Department contends that this Conclusion of Law does not consider the Department's internal review process and improperly requires the Department to re-prove the allegations of an abuse report in order to rely on its findings. The Department further argues that the ALJ ignored corroborating evidence and Petitioner's own admissions. The Department also argues that ignoring verified reports of abuse or neglect by applicants for child care licenses improperly places children at risk. The Department points to Ms. Reid's testimony as to the creation, verification and preservation of the report at issue in this case and the fact that it was accepted as a business record.

16. The Department argues that the determination that the record is unreliable is inconsistent with acceptance as a business record. Petitioner responds that the report's age, confusing allegations and uncorroborated hearsay make it untrustworthy as evidence.

17. In this instance, the Department presented the testimony of the author of the record, Jan Reid, who explained that it was made at the time of the investigation, by or from information provided by a person with knowledge, kept in the normal course of business, and that the Department had a regular business practice of making such a record. Ms. Reid's testimony explained the purpose of the record, the process of its creation and review and then discussed its actual contents in detail. This was followed by a proffer of the report as a business record and acceptance into evidence as such

(TR 22). However, the ALJ also correctly recognizes that fairness entitles an applicant to challenge the veracity of a report that affects his or her application.

18. Certainly, to the extent that it contains non-hearsay evidence, the Department's report (Exh. 5) can be competent to show the truth of the facts alleged. In this instance, the report contained statements by Petitioner. With one exception, those statements were entirely consistent with Petitioner's testimony.[7] Additionally, there was other direct evidence provided as to the requirements of one-to-one supervision which the report could be used to supplement or explain. In fact, many of the facts in the report are actually repeated in the Findings of Fact in the Recommended Order. What was not found by the ALJ were facts to support a finding that Petitioner medically neglected a client. Facts supporting this finding were only presented in the report and Petitioner testified to the contrary.

19. The Department may not set aside the ALJ's finding that the Department did not demonstrate that Petitioner had neglected a vulnerable adult. That particular finding rests upon a consideration of the burden of proof, the determination of the relative weight of the evidence and judgment as to the credibility of witnesses. Because such functions rest with the ALJ, and not the Department, the Department may not reject the ALJ's finding that the Department did not demonstrate that Petitioner had neglected a vulnerable adult.

Conclusions of Law, Paragraph 20

20. Although not the subject of a Department exception, in Paragraph 20 the ALJ erroneously states that, in order to meet her burden to show that she is entitled to a

license, Petitioner need not address the constellation of factors relevant to licensure, but only the particular concerns identified in the Department's denial letter. The ALJ relied on *M.H. v. Dep't of Child. & Fam. Servs.*, 977 So. 2d 755 (Fla. 2d DCA 2008), and *L.J. v. Dep't of Child. & Fams.*, Case No. 13-4666 (Fla. DOAH Aug. 25, 2014), to support this proposition. However, such reliance is misplaced, as *M.H.* relied upon precedent involving disciplinary actions, and the Supreme Court has since determined that Department license denials based upon applicant unfitness are not disciplinary actions. See *Fla. Dep't of Children & Families v. Davis Family Day Care Home*, 160 So.3d 854 (Fl. 2015). *L.J.* is similarly inapplicable.

Acceptance and Substitution of Portions of Recommended Order

21. The ALJ's Findings of Fact, paragraphs 1 and 2 are approved and adopted. Paragraphs 3, 4 and 5 are revised to read as follows:

> 3. While not stating the specific facts regarding the background screening and abuse record search, the evidence demonstrated that the denial was based on one confirmed report of neglect (Abuse Report 2003-031849-01) against Ms. Fudge for inadequate supervision of resident R.H., and medical neglect of residents R.G. and J.D. Both incidents occurred at about the same time on or about March 5, 2003, while Ms. Fudge was employed at Tallahassee Development Center (Center). The Center provided residential and direct care to developmentally disabled residents at its facility. At the time, Ms. Fudge was employed as care staff

(footnote cont.)

[7]Petitioner testified that she was not told that Mr. G. was having a seizure (TR 74). Her statement in the report was that she had been told he was having a seizure (exh. 5).

responsible for providing direct one-to-one care to R.H. She was not assigned to provide care to R.G. Other than Ms. Fudge, no witness with personal knowledge of these incidents testified at the hearing. Consequently, many of the statements contained in the 2003 abuse report remain hearsay which was not corroborated by any competent substantial evidence.

4. Ms. Fudge was the only person who testified at the hearing with personal knowledge about the events of March 5, 2003. She testified, and such testimony is accepted, that on or around March 5, 2003, she was not a shift supervisor, but was assigned as a direct care aide with "one-to-one" supervision of R.H. The testimonial evidence from Ms. Fudge and other employees of the Center during 2003 demonstrated that Tallahassee Developmental Center employees were trained that one-to-one supervision meant that "the person had always to be watched" and "you could never leave [the person] alone." There was no credible evidence that the staff assigned to watch the person had to be within arm's length of the resident. Further, the testimonial evidence showed that staff and Ms. Fudge knew R.H. would run away usually to hide in a particular office, but occasionally with the police being called if R.H. were to leave the building and could not be found. The evidence did not demonstrate that R.H. behaviorally was aggressive or dangerous to others, but only that he would run away and hide. However, it was clear that "one-to-one" supervision did not contemplate a situation where a

client would be able to run to an office and lock the door, leaving staff outside and unable to reach the client (although he could be observed) until another staff member produced a key.

5. On March 5, 2003, the testimonial evidence demonstrated that Ms. Fudge, R.H., and other residents were gathered in the living room of the house where they lived. The phone in the adjoining office rang and Ms. Fudge answered it. While on the phone she could observe R.H. through the window between the rooms. At some point, R.H. was sent to go to the restroom. It was unclear who sent him. After finishing in the restroom, he did not return to the living room, but "left out of the bathroom" to another office, locked the door and hid behind the desk. Ms. Fudge could see him in the office and called a nurse to bring the key so that the office could be unlocked. At the time, R.H. was not in danger and there was no evidence that demonstrated he was in danger. There was some evidence that another staff person mistakenly may have believed that R.H. had left the building. However, the better evidence showed that Ms. Fudge knew where R.H. was, could see R.H. in the room in which he was locked, and that he was not in danger at the time. Although R.H. was not in danger, these facts show that Ms. Fudge failed to comply with the facility's one-to-one supervisory policy. However, the Department has not demonstrated neglect by Ms. Fudge in the supervision of R.H.

22. Findings of Fact, paragraph 6 is revised to read as follows:

6. There was no credible, non-hearsay evidence presented at hearing as to the abuse report's allegations regarding resident R.G. or J.D.

23. The ALJ's Findings of Fact, paragraph 7 is revised to read as follows:

7. Given the foregoing findings, the Department has demonstrated that Ms. Fudge was assigned to provide one-to-one supervision of a vulnerable adult (R.O. ¶3), which did not require that the client be within arm's reach (R.O. ¶4) but did require that "he had always to be watched" and "you could never leave [the person] alone." (R.O.¶4). This particular client had a habit of running away (Id). While under one-to-one supervision by Ms. Fudge, that client was alone in a restroom (R.O. ¶5) and in an office (id), the latter he locked (Id). The client could be observed and was not in danger (Id), but Ms. Fudge was unable to reach him for a period of time while she waited for a key (Id). These facts show that Ms. Fudge failed to abide by the facility's one-to-one supervisory policy. However, the Department had failed to prove that Ms. Fudge neglected a vulnerable adult. As to the medical neglect charge, the Department failed to demonstrate that Ms. Fudge medically neglected a vulnerable adult. The only evidence to support this charge was the Department's report (Exh. 5), which was refuted by Ms. Fudge's testimony (TR 74).

24. Conclusions of Law, paragraphs 8 through 16 are approved and adopted. Paragraph 17 is modified to read as follows, which I find to be as or more reasonable than the modified paragraph:

17. Chapter 2000-349, Laws of Florida, repealed section 415.1075. However, what is clear from these various amendments is that the right to an administrative name-clearing hearing on verified abuse reports was no

longer available, since no substantial interest of a person involved in the report was impacted by the maintenance of such a report. The Department retains the burden to demonstrate that the information in the central abuse hotline for licensing purposes is correct when that information is being presented in a formal administrative hearing.

25. Conclusions of Law, paragraphs 18 and 19 are approved and adopted. Conclusion of Law, paragraph 20, is rejected as a misstatement of law and replaced with the following , which I find to be as or more reasonable than the rejected paragraphs:

20. The record does not reflect Department agreement that Ms. Fudge met all requirements for licensure, sans fitness. The Department's determination that Ms. Fudge was rendered unfit by her neglect of a vulnerable adult did not negate her overall burden of proof. Ms. Fudge therefore retained her burden to prove that she satisfied all requirements for licensure. Petitioner presented no evidence that she or her facility at 1920 South Monroe Street, in Tallahassee, meets the requirements of Rule 65C-22.001. Thus, regardless of the fitness issue, Ms. Fudge has not shown her entitlement to the issuance of a license for her facility

26. Conclusions of Law, paragraph 21 is replaced by the following , which I find to be as or more reasonable than the modified paragraph:

21. In this case, the Department failed to prove that Ms. Fudge neglected a vulnerable adult. However, Ms. Fudge did not present evidence to show that her facility at 1920 South Monroe Street, in

Tallahassee meets the licensure requirements of the Department's rules. Under the circumstances, Ms. Fudge should be granted a 60-day provisional license for her facility at 1920 South Monroe Street, in Tallahassee, subject to Department confirmation that the facility meets the Department's licensing requirements and is ready to serve children.

Accordingly, Petitioner is granted a 60-day provisional license for her proposed facility at 1920 South Monroe Street, in Tallahassee, subject to Department confirmation within that same period that the facility meets the Department's licensing requirements and is ready to serve children. Otherwise, such license will lapse. No extension of the provisional license will be granted.

DONE AND ORDERED in Tallahassee, Leon County, Florida, this 16 day of December, 2015.

Mike Carroll, Secretary

NOTICE OF RIGHT TO APPEAL

THIS ORDER CONSTITUTES FINAL AGENCY ACTION AND MAY BE APPEALED PURSUANT TO SECTION 120.68, FLORIDA STATUTES, AND RULES 9.110 AND 9.190, FLORIDA RULES OF APPELLATE PROCEDURE. A PARTY WHO IS ADVERSELY AFFECTED BY THIS ORDER IS ENTITLED TO JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE DEPARTMENT OF CHILDREN AND FAMILIES AT 1317 WINEWOOD BOULEVARD, BUILDING 2, ROOM 204, TALLAHASSEE, FLORIDA 32399-0700, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, IN THE DISTRICT COURT OF APPEAL WHERE THE PARTY RESIDES OR IN THE FIRST DISTRICT COURT OF APPEAL. THE NOTICE OF APPEAL MUST BE FILED (RECEIVED) WITHIN 30 DAYS OF RENDITION OF THIS ORDER.[8]

Copies furnished to the following via U.S. Mail on date of Rendition of this Order.

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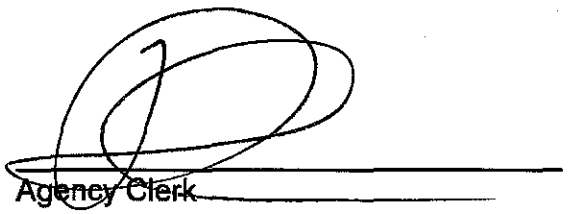

[8]The date of the "rendition" of this Order is the date that is stamped on its first page.