STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 15-4847

FLAMINGO PARK MANOR, LLC,

Respondent.
_____/

RECOMMENDED ORDER

A hearing was conducted in this case pursuant to sections 120.569 and 120.57(1), Florida Statutes (2014),[1/] before Cathy M. Sellers, an Administrative Law Judge ("ALJ") of the Division of Administrative Hearings ("DOAH"), by video teleconference on February 12, 2016, at sites in Miami and Tallahassee, Florida.

APPEARANCES

For Petitioner: Nelson E. Rodney, Esquire
Agency for Health Care Administration
8333 Northwest 53rd Street, Suite 300
Miami, Florida 33166

For Respondent: Peter A. Lewis, Esquire
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STATEMENT OF THE ISSUES

(1) Whether Respondent violated section 429.26(7), Florida Statutes, and Florida Administrative Code Rule 58A-5.0182(1) by failing to appropriately supervise one of its residents, and, if so, the penalty that should be imposed.

(2) Whether Respondent failed to follow its own elopement policy, in violation of Florida Administrative Code Rule 58A-5.0182(8), and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

On April 14, 2015, Petitioner, Agency for Health Care Administration, issued and served on Respondent, Flamingo Park Manor, LLC, a two-count Administrative Complaint. Respondent timely requested an administrative hearing, and the matter was referred to DOAH for assignment of an ALJ to conduct a hearing pursuant to sections 120.569 and 120.57(1). The final hearing initially was set for November 13, 2015. However, pursuant to requests for continuance, which were granted for good cause, the hearing was held on February 12, 2016.

Petitioner presented the testimony of James Byrd Williams and Arlene Mayo-Davis in its case-in-chief, and presented the testimony of Claudia Pace on rebuttal. Petitioner's Exhibits 1 through 4 were admitted over Respondent's standing hearsay objection, as applicable. Respondent presented the testimony of George Hernandez, Jr., Ph.D.; Alaine Dominguez; and Gina

Quinones. Respondent's Exhibits 1 through 5 were admitted over Petitioner's standing hearsay objection, as applicable.

The one-volume Transcript was filed on March 2, 2016. Pursuant to motion, the time for filing proposed recommended orders was extended to April 5, 2016. The parties timely filed their proposed recommended orders, which were duly considered in preparing this Recommended Order.

FINDINGS OF FACT

I. The Parties

1. Petitioner, Agency for Health Care Administration, is the state agency statutorily charged with regulating assisted living facilities ("ALFs") in the state of Florida.

2. Respondent, Flamingo Park Manor, LLC, is a 72-bed limited mental health[2/] ALF licensed pursuant to License No. AL7308 and subject to regulation by Petitioner pursuant to chapter 429, Florida Statutes, and Florida Administrative Code Chapter 58A-5. It is located at 3051 East 4th Avenue, Hialeah, Florida 33013.

II. The Administrative Complaint

3. As the result of a complaint survey conducted on or about February 3, 2015, Petitioner served an Administrative Complaint on Respondent on April 14, 2015.

4. The Administrative Complaint charged Respondent with a Class I violation of section 429.26(7) and rule 58A-5.0182(1)

for failing to appropriately supervise one of its facility residents, R.R., resulting in Respondent not knowing R.R.'s whereabouts for five days.

5. The Administrative Complaint also charged Respondent with a Class II violation of rule 58A-5.0182(8) for failing to follow its own elopement policy and procedures during the time that R.R. was absent from Respondent's facility.

6. The Administrative Complaint seeks to impose administrative penalties of $5,000 for the alleged Class I violation and $2,500 for the alleged Class II violation.[3/]

III. The Events Giving Rise to this Proceeding

7. R.R., a 38-year-old male, admitted himself to, and became a resident of, Respondent's ALF on May 15, 2014. He was classified as a mental health resident.[4/] He had been diagnosed with schizophrenia and had been prescribed medications to address this condition.

8. On the day he was admitted to the ALF, Respondent's administrator completed an Elopement Risk Assessment Form, which evaluated R.R.'s risk for elopement[5/] from the facility. At that time, R.R. was determined not to constitute an elopement risk.[6/]

9. On June 1, 2014, by Joyce Gonzalez, a doctor of osteopathic medicine, performed a health assessment of R.R. She completed the Resident Health Assessment for Assisted Living

Facilities, AHCA Recommended Form 1823 ("Form 1823"), as required by rule.

10. Gonzalez noted on Form 1823 that R.R. had been diagnosed with schizophrenia and asthma, and that he heard voices and exhibited poor judgment.

11. R.R. was evaluated as "independent" for the following activities of daily living: ambulation, bathing, eating, toileting, and transferring. She evaluated him as "needs supervision" for dressing, and "needs assistance" for self-care (grooming).

12. Gonzalez answered "yes" in response to the question "[i]n your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical or psychiatric facility?"

13. R.R. was evaluated as "independent" for the self-care tasks of shopping, making phone calls, handling personal affairs, and handling financial affairs.

14. In the "General Oversight" section of Form 1823, which constitutes an evaluation of the frequency with which R.R. needed general oversight by Respondent's staff, R.R. was determined to need the following services on a daily basis: observing wellbeing, observing whereabouts, and reminders for daily tasks.[7/]

15. On the "Self-Care and General Oversight—Medications" section of R.R.'s Form 1823, Gonzalez listed three medications that R.R. was to receive, some twice daily. Gonzalez indicated on Form 1823 that R.R. needed the assistance of Respondent's staff to self-administer his medications.

16. The Form 1823 completed for R.R. states that he did not constitute an elopement risk.

17. R.R. was involuntarily admitted to a mental health treatment facility (i.e., "Baker-Acted") from May 16 through May 20 and September 29 through October 3, 2014. Both times, after being discharged, he resumed living at Respondent's ALF.

18. When R.R. was discharged from the mental health treatment facility on October 3, 2014, he was taking an anti-psychotic medication to treat his schizophrenia and medications to alleviate the side effects of his anti-psychotic medication. The written patient discharge instructions he received, which were included in Respondent's medical information files for R.R., included descriptions of the medications he had been prescribed. These instructions stated that these medications needed to be taken as directed.

19. The evidence establishes that despite his mental health condition, R.R. was an independent resident who was lucid, alert, self-aware, and oriented regarding time and place. As was the case for the other residents at Respondent's ALF,

R.R. received his meals when he was present in the facility. He also received assistance from Respondent's staff in self-administering his medications, which he was free to refuse to take, and he received supervision and guidance in grooming and dressing himself. In other respects, consistent with the evaluation recorded on Form 1823, R.R. functioned independently.

20. When R.R. was present in the ALF, his wellbeing and whereabouts were observed on a daily basis, as documented by the room censuses, medication logs, shift reports, and resident observation logs that Respondent kept on R.R.

21. During his residency at the ALF, R.R. left the facility at various times of the day, on an almost daily basis. He often would be gone for many hours and would return to the facility.

22. According to Respondent's staff, R.R. told them that he took long walks in the community and that at times, he visited his parents at their home.

23. The credible evidence establishes that during R.R.'s five-month residency at the ALF, although he requently left and often was gone for many hours at a time, he had been absent more than 48 hours only twice,[8/] and absent between 24 hours and 48 hours three times,[9/] prior to his departure on October 15, 2014.

24. If R.R. was not in the facility at the time he was to take his medications, he did not receive them. The medication observation records for R.R. show numerous days throughout his residency on which he did not receive some or all of his medications.

25. Sometime during the day on October 15, 2014, R.R. left the ALF.

26. R.R. received the morning doses of his medications and attended a mental health counseling session before he left that day.

27. Alaine Dominguez, Respondent's shift supervisor on duty that day, and George Hernandez, the psychological counselor who conducted the mental health counseling sessions at the facility, both testified, credibly, that R.R. told them he was leaving for approximately a week to visit his parents at their home.[10/]

28. Dominguez credibly testified that he told R.R. to take his medications with him, but R.R. refused.

29. Respondent's staff did not contact R.R.'s parents to verify that he was going to visit, or was visiting, them.

30. Tragically, R.R. was struck by an automobile late on the evening of October 15, 2014, while walking in the travel lanes of Northwest 79th Street. He was seriously injured and

was taken to Jackson Memorial Hospital, where he died on the morning of October 16, 2014.

31. R.R.'s parents were notified by the hospital on October 16, 2014, that R.R. had been injured and died.

32. On October 20, 2014, R.R.'s mother and sister visited Respondent's facility and questioned staff regarding R.R.'s whereabouts. Respondent's staff told them that R.R. had left the facility a few days ago to visit his parents. At that point, R.R.'s mother informed Respondent's staff that R.R. had been killed almost five days ago.

33. By the time R.R.'s mother informed Respondent's staff of his death, R.R. had been absent from the ALF for approximately five days.

34. Until R.R.'s mother informed Respondent's staff that he had been killed, they did not know R.R.'s specific whereabouts during the period in which he was absent from the ALF.

35. The evidence establishes that Respondent's staff assumed that, consistent with R.R.'s statements to Dominguez and Hernandez, he had gone to visit his parents at their home.

36. Consequently, Respondent did not report to R.R.'s parents, law enforcement, or any other entity, that R.R. was absent or missing from the ALF.

37. Petitioner presented the testimony of its health care evaluator, James Byrd Williams, who performed the February 3, 2015, complaint survey on Respondent's ALF. Williams testified that R.R.'s mother told him that R.R. did not know the location of his parents' home, so he could not have gone to visit them.[11/]

38. Regardless of whether R.R. knew or did not know the location of his parents' home, the evidence establishes that Respondent's staff believed that R.R. knew the location of his parents' home. Accordingly, it was reasonable for them to accept as true R.R.'s statement that he was leaving the facility to visit his parents at their home.

39. Respondent's staff completed shift reports for October 15 through October 20, 2014. Most of the reports noted that R.R. was "on pass," meaning that he was not present in the ALF. None of the reports contained notations specifically stating that R.R. was visiting his parents or when he was expected to return.

40. Williams testified that in his opinion, Respondent did not adequately supervise R.R., based on the fact that R.R. was a mental health resident, that he frequently left the ALF and was gone for extended periods of time without Respondent knowing his specific whereabouts, that R.R. did not receive his medications when he was out of the ALF, and that Respondent did not contact

his parents at their home to verify that R.R. was, in fact, at their home.

41. As required by rule, Respondent has prepared and implemented an elopement policy,[12/] which states:

> Policy:
>
> It is the policy of this facility to permit and encourage residents to retain their independence and not to infringe upon their right to come and go from the facility as they please.
>
> Procedure:
>
> 1. Residents are informed upon admission and during their stay to notify staff members when they leave the facility and when they will be expected to return.
>
> 2. Each new admission and yearly thereafter, will have an "Elopement Risk Assessment Form" completed.
>
> 3. If elopement risk is determined, the following actions will be taken:
>
> a) an i.d. bracelet will be placed with his/her name and facility contact information;
>
> b) a picture will be placed in the "Elopement Risk Binder" where pertinent resident information will be easily available if reporting is needed; and
>
> c) all staff members will be informed of "at risk" residents and the "Elopement Risk Binder" and its contents.
>
> 4. Each case will be evaluated independently when implementing this policy taking into consideration the resident's usual outing habits.

5. For "At-Risk" identified residents, the following will take place immediately if facility staff determines that the whereabouts of such resident is unknown:

a) a complete grounds search will be conducted by all staff members present at the time, directed by the Shift Supervisor;

b) a complete neighborhood search will be conducted by all staff at the time, directed by the Shift Supervisor;

c) if resident is not located and it has not been determined that he/she left without notifying staff, Shift Supervisor or Administrative staff will be responsible for notifying law enforcement, resident's family, guardian, health care surrogate, attending physician and case manager that the resident's whereabouts are not known.

d) an adverse incident report in the AHCA website will be done.

6. Once the resident has been reported "missing" with the local authorities, a case number will be obtained and placed on the resident's chart.

7. A "Quality Improvement/Missing Person Report Form" will be used to evaluate events and keep track of all daily calls to hospitals, shelters, jails etc[.] made to locate resident.

8. If resident is located by facility staff prior to law enforcement, then the Shift Supervisor or Administrative staff will notify law enforcement, resident's family, guardian, health care surrogate, attending physician and case manager that the resident has been located.

9. Residents who are considered to be "not at risk," from the elopement risk assessment form complete [sic] upon admission, are to

> be reported missing if ou[t] of the facility more than 48 hours. If residents, [sic] behavior is to leave the facility for long periods of time and always returns, this is to be considered to also be "not at risk" and will be reported missing after 48 hours.

42. Respondent's administrator testified that paragraph 1 of Respondent's elopement policy superseded all of the other paragraphs of the policy, so that if a resident told a member of Respondent's staff that he or she was leaving the ALF, that resident would not be considered to have eloped, even if he or she were absent longer than the time period specified in paragraphs 5 and 9 for residents considered "at risk" and "not at risk" for elopement. Only if the resident did not follow the procedure set forth in paragraph 1 when leaving the facility would the other provisions of the elopement policy apply, depending on whether the resident was "at risk" or "not at risk" for elopement.

43. As noted above, none of the documents prepared by Respondent to keep track of which residents were present or absent from the facility, including the shift reports or room census reports, contained notations regarding where R.R. had told staff he was going when he left on October 15, 2014, or when he anticipated returning. However, Respondent's administrator testified that, based on verbal communications

from Dominguez, "we were all aware of how long it was going to be."

44. She further testified that if R.R. had told them he was going to be gone a week and then was gone for a longer period, the elopement policy would have been triggered and Respondent would have contacted R.R.'s family and law enforcement and filed a missing person report pursuant to the applicable policy provisions.

IV. Findings of Ultimate Fact

45. Florida courts consistently hold that the issue of whether an individual's or entity's actions violate a statute or deviate from an established standard of conduct is an issue of ultimate fact to be determined based on the evidence in the record. See Gross v. Dep't of Health, 819 So. 2d 997, 1003 (Fla. 1st DCA 2002); Goin v. Comm'n on Ethics, 658 So. 2d 1131, 1138 (Fla. 1st DCA 1995); Langston v. Jamerson, 653 So. 2d 489, 491 (Fla. 1st DCA 1995).

Failure to Provide Appropriate Supervision

46. Petitioner did not prove, by clear and convincing evidence, that Respondent failed to provide appropriate supervision to R.R., in violation of section 429.26(7) or rule 58A-5.0182(1).

47. Section 429.26(7) states:

> The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

48. R.R. was diagnosed with schizophrenia before becoming a resident at Respondent's ALF. However, the evidence does not establish that R.R. suffered from dementia or cognitive impairment. To that point, when R.R. was admitted to the facility, the evaluating doctor determined that his needs could be met in an ALF, rather than a medical facility. There are no notations in the resident observation logs or in any other records that Respondent kept on R.R. indicating that he suffered from dementia or cognitive impairment.

49. Additionally, although R.R. would not receive his medications on many occasions, Petitioner failed to establish that R.R.'s refusal or failure to take his medication somehow constituted a "changed condition" that required Respondent to notify a physician of his condition.

50. Further, even if the evidence had shown that R.R. exhibited dementia, cognitive impairment, or a changed condition, Petitioner failed to present evidence establishing when Respondent's staff acknowledged these conditions for purposes of commencing the 30-day statutory notification period. Accordingly, it cannot be discerned when the notification period ended for purposes of determining whether Respondent violated the notification requirement.

51. For these reasons, it is determined that Petitioner failed to prove that Respondent violated section 429.26(7), as charged in the Administrative Complaint.

52. Rule 58A-5.0182(1), which establishes the standard of care for supervision of ALF residents, states in pertinent part:

> (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:
>
> * * *
>
> (b) Daily observation by designated staff of the activities of the resident <u>while on the premises</u>, and awareness of the general health, safety, and physical and emotional well-being of the resident.
>
> (c) Maintaining a <u>general</u> awareness of the resident's whereabouts. <u>The resident may travel independently in the community</u>.
>
> (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.

Fla. Admin. Code R. 58A-5.0182(1)(emphasis added).

53. The evidence establishes that Respondent appropriately supervised R.R. under his specific personal circumstances.

54. As discussed above, when R.R. was present in the facility, Respondent's staff observed and documented his wellbeing and whereabouts. The evidence shows that in most respects, R.R. was an independent resident who only required assistance with a limited number of tasks.

55. Although R.R. frequently left the facility for long periods of time, Respondent's staff generally were aware, based on R.R.'s statements to them, that he was walking around in the community——which he clearly was entitled to do without being supervised, pursuant to the plain language of rule 58A-5.0182(1)(c).[13/]

56. With respect to the specific event giving rise to this proceeding, the persuasive evidence establishes that when R.R. left the ALF on October 15, 2014, he told Respondent's staff that he was going to be gone for approximately a week to visit

his parents at their home, and that Respondent's staff had no reason to question the truth of this statement. The evidence establishes that Respondent's staff believed R.R. was at his parents' home. This is sufficient to meet the rule requirement that Respondent maintain a general awareness of R.R.'s whereabouts——particularly given that there is no statute or rule that would require Respondent to "check up on" or verify that a resident was at the specific location that he or she purported to be going when leaving the facility.

57. Petitioner also failed to present evidence showing that R.R. exhibited a "significant change" in condition[14/] or that he had been discharged or moved out of the facility, any of which would have triggered the requirement to notify his health care provider or family.

58. The evidence also fails to establish that Respondent failed to maintain adequate written records of significant changes in R.R.'s condition, illnesses that R.R. suffered resulting in medical attention, changes in the method of R.R.'s medication administration, or other changes resulting in the provision of additional services. To the contrary, the written records Respondent kept regarding R.R.'s condition and medication administration specifically noted when he had been Baker-Acted and when he took or did not take his medications.

Petitioner did not present any evidence showing that these records were inaccurate or incomplete.

59. For these reasons, Petitioner failed to prove, by clear and convincing evidence, that Respondent violated rule 58A-5.0182(1), as charged in the Administrative Complaint.

Failure to Follow Elopement Policy

60. Petitioner also failed to prove, by clear and convincing evidence, that Respondent violated rule 58A-5.0182(8) by failing to follow its own elopement policy with respect to reporting R.R. missing.

61. Rule 58A-5.0182(8) requires ALFs to develop written rights and facility procedures for responding to a resident elopement. The rule states in pertinent part:

> (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:
>
> 1. An immediate search of the facility and premises;
>
> 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
>
> 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and

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

62. "Elopement" is defined as "an occurrence in which a resident leaves a facility without following facility policies and procedures." Fla. Admin. Code R. 58A-5.0131(14)(emphasis added).

63. As noted above, Respondent has developed an elopement policy pursuant to rule 58A-5.0182(8), and the sufficiency of this policy is not at issue in this proceeding.

64. As a threshold matter, Respondent's elopement policy requires residents to notify staff members when they leave the facility and when they will be expected to return. If a resident complies with this requirement, he or she has followed the "facility's policies and procedures," so has not eloped under rule 58A-5.0313(14).

65. Here, the persuasive evidence establishes that when R.R. left the facility on October 15, 2014, he informed Respondent's staff that he was leaving the facility and that he expected to return in approximately one week, in compliance with Respondent's policies and procedures regarding notification when the resident leaves the facility. Therefore, R.R.'s departure from the facility that day did not constitute "elopement" as defined in rule 58A-5.0131(14).

66. Because R.R. did not elope from the facility on October 15, 2014, he was not considered "missing" for purposes of triggering paragraph 9 of Respondent's elopement policy, which would have required Respondent to report him missing after being out of the facility for 48 hours.

67. For these reasons, Petitioner failed to prove, by clear and convincing evidence, that Respondent violated rule 58A-5.0182(8), as charged in the Administrative Complaint.

CONCLUSIONS OF LAW

68. DOAH has jurisdiction over the parties to, and subject matter of, this proceeding pursuant to sections 120.569 and 120.57(1).

69. In this proceeding, Petitioner seeks to discipline Respondent for alleged violations of section 429.26(7) and rule 58A-5.0182(1) and (8), and to impose administrative fines as sanctions for these violations. Thus, Petitioner bears the ultimate burden of persuasion, by clear and convincing evidence, to establish that Respondent committed the alleged violations. See Coke v. Dep't of Child. & Fam. Servs., 704 So. 2d 726 (Fla. 5th DCA 1998); Dubin v. Dep't of Bus. Reg., 262 So. 2d 273, 274 (Fla. 1st DCA 1972); Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 933-34 (Fla. 1996). This standard of proof has been described as follows:

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

In re Davey, 645 So. 2d 398, 404 (Fla. 1994)(citing Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

70. In Count I of the Administrative Complaint, Petitioner has charged Respondent with violating section 429.26(7) and rule 58A-5.0182(1) by failing to provide appropriate supervision for R.R.

71. For the reasons discussed above, it is concluded that Respondent provided appropriate supervision of R.R., so did not violate section 429.26(7) or rule 58A-5.0182(1).

72. In Count II of the Administrative Complaint, Petitioner has charged Respondent with failing to follow its own elopement policy, in violation of rule 58A-5.0182(8).

73. For the reasons discussed above, it is concluded that Respondent followed its elopement policy with respect to R.R., so did not violate rule 58A-5.0182(8).

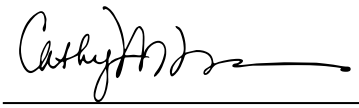
74. Accordingly, it is concluded that Petitioner failed to prove, by clear and convincing evidence, that Respondent

committed any of the statutory or rule violations charged in the Administrative Complaint.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration, enter a final order dismissing the Administrative Complaint against Respondent, Flamingo Park Manor, LLC.

DONE AND ENTERED this 9th day of May, 2016, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of May, 2016.

ENDNOTES

[1/] Unless otherwise stated, all references are to the 2014 version of Florida Statutes, which was in effect on the date of the alleged violations.

[2/] Because Respondent is a limited mental health ALF, its staff members must be trained to care for residents who have mental health issues. See § 429.075(1), Fla. Stat.

[3/] The Administrative Complaint also states that Petitioner seeks to fine Respondent pursuant to sections 408.809(1)(e) and 429.174, Florida Statutes. These statutes address background screening requirements applicable to employees of ALFs. However, the Administrative Complaint did not allege any facts that, if proven, would constitute violations of these statutes, and Petitioner did not present any evidence regarding any alleged violations of these statutes.

[4/] "Mental health resident" is defined as "an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation." § 429.02(15), Fla. Stat.

[5/] "Elopement" is defined as "an occurrence in which a resident leaves a facility without following facility policies and procedures." Fla. Admin. Code R. 58A-5.0131(14).

[6/] The Elopement Risk Assessment Form instructions state that the form is to be completed upon admission, 30 days after admission, and with significant change in condition/mental health status. As noted, the form was completed the day R.R. was admitted to Respondent's ALF; however, it cannot be determined whether Respondent complied with the form's instructions by completing the form 30 days after R.R.'s admission to the ALF, because the record does not include a completed form as of that date. Nonetheless, Petitioner did not charge Respondent with inaccurately assessing R.R. as not being at risk for elopement in the Administrative Complaint, and Petitioner was not permitted at the final hearing to expand the scope of the charges to include alleged inaccuracy of the elopement risk assessment for R.R.

[7/] The key for oversight frequency in the "General Oversight" section of Form 1823 consists of "independent, "weekly," "daily," and "other."

[8/] According to Respondent's room census documents, R.R. was absent from the ALF for approximately 55 hours starting at or before 2 p.m. on June 4, 2014, until midnight on June 7, 2014, and also was absent from the ALF for approximately 53 hours starting at or before 5 p.m. on September 10, 2014, until midnight on September 12, 2014.

[9/] According to Respondent's room census documents, R.R. was absent from the ALF for approximately 33 hours starting at or before 8 p.m. on July 16, 2014, until 3 a.m. on July 18, 2014; for approximately 28 hours starting at or before 8 p.m. on July 19, 2014, until 10 p.m. on July 20, 2014; and approximately 31 hours starting at 8 p.m. on July 29, 2014, until 3 a.m. on July 31, 2014.

[10/] This testimony is not hearsay because it is not being offered for the truth of the matter asserted in R.R.'s out-of-court statement——i.e., that he was going to visit his parents at their home. Rather, the testimony was offered to establish that Respondent's staff believed that R.R. was going to visit his parents at their home.

[11/] This testimony is hearsay that does not fall within an exception to the hearsay rule, and there is no other competent evidence in the record independently establishing that R.R. did not know the location of his parents' home. Accordingly, this testimony is not afforded weight.

[12/] Petitioner has not charged Respondent with having an insufficient elopement policy.

[13/] See also § 429.28(1), Fla. Stat. This statute states that every resident of an ALF shall have the right to, among other things, be treated with consideration and with due recognition of individuality and the need for privacy, and to achieve the highest possible level of independence, autonomy, and interaction within the community.

[14/] The term "significant change" is defined in rule 58A-5.0131(32) as:

> 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.

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(eServed)

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

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.