STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MILA ALF, LLC, d/b/a DIXIE LODGE
ASSISTED LIVING FACILITY,

Petitioner,

vs. Case No. 17-1559

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, on January 29 and 30, 2018, a final hearing was held in this case, pursuant to section 120.57, Florida Statutes (2017),[1/] before Administrative Law Judge Yolonda Y. Green of the Florida Division of Administrative Hearings ("Division"), in DeLand, Florida.

APPEARANCES

For Petitioner: John F. Gilroy, III, Esquire
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For Respondent: Thomas J. Walsh, II, Esquire
Agency for Health Care Administration
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STATEMENT OF THE ISSUE

Whether Petitioner's application for change of ownership should be granted or denied on the basis of the allegations set forth in the Second Amended Notice of Intent to Deny ("Second Amended NOID").

PRELIMINARY STATEMENT

On March 21, 2016, the Agency for Health Care Administration ("AHCA," the "Agency," or "Respondent") issued its Second Amended NOID for Mila ALF, LLC, d/b/a Dixie Lodge Assisted Living Facility's ("Dixie Lodge" or "Petitioner") application for change of ownership ("CHOW"). As grounds for the intended denial, AHCA cited 21 deficiencies found in the CHOW survey conducted on September 9, 2015, and the follow-up survey conducted on November 6, 2015. This matter was scheduled for an informal hearing to be conducted on March 16, 2017. On March 13, 2017, Dixie Lodge filed a "Request for Formal Administrative Hearing (Revert from Current Informal Hearing)", which was granted by the Informal Hearing Officer. On March 15, 2017, this matter was referred to the Division for a final hearing.

The hearing was scheduled on May 24 and 25, 2017. On April 13, 2017, Petitioner filed its Motion for Relinquishment and Motion for Continuance. The continuance was granted and the hearing was rescheduled for July 11 and 12, 2017. After

additional motions for continuance, the case was rescheduled for hearing on January 29 and 30, 2018.

On October 2, 2017, in anticipation of the hearing, the parties filed a Joint Pre-hearing Stipulation in which they agreed to a statement of facts admitted. The agreed facts are included in the Findings of Fact below to the extent relevant.

The hearing convened as scheduled on January 29, 2018, and continued until completion on January 30, 2018. At hearing, Dixie Lodge presented the testimony of five witnesses, including: Marifrances Gullo, RN-C, MSN, FNP-BC (an expert); Edward Kornuszko, PsyD (an expert); Annie Ward (a Dixie Lodge employee); and Jeff Yuzefpolsky (owner of Dixie Lodge). Andrea Gockley, PsyD (a consultant employed by Mental Health Center of Florida) was initially offered as an expert. However, Petitioner withdrew that request before the undersigned ruled on whether she met the qualifications to testify as an expert. Ms. Gockley testified as a fact witness. Dixie Lodge offered Exhibits P-1 through P-6, which were admitted. AHCA presented the testimony of the following four witnesses: Robert Dickson (an AHCA field office manager); Lesley Linder (an AHCA health facility evaluator); Jana Meyering (an AHCA operations management consultant); and Linda Walker, R.N. (an AHCA registered nurse specialist). AHCA offered Exhibits R-1 and R-2, which were admitted.

A transcript of the hearing was ordered. At the conclusion of the hearing, the parties requested a 20-day deadline within which to file proposed recommended orders ("PROs"), which was granted.

The three-volume Transcript was filed on February 12, 2018. Both parties timely filed their PROs, which have been carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

The following Findings of Fact are based on exhibits admitted into evidence, testimony offered by witnesses, and admitted facts set forth in the prehearing stipulation.

Parties

1. The Agency is the regulatory authority responsible for licensure of assisted living facilities ("ALFs") and enforcement of applicable state statutes and rules governing assisted living facilities pursuant to chapters 408, part II, and 429, part I, Florida Statutes, and chapters 58A-5 and 59A-35, Florida Administrative Code.

2. In carrying out its responsibilities, AHCA conducts inspections (commonly referred to as surveys) of licensed ALFs to determine compliance with the regulatory requirements. The Agency's evaluation, or survey, of an ALF may include review of resident records, direct observations of the residents, and interviews with facility staff persons. Surveys may be

performed to investigate complaints or to determine compliance as part of a change of ownership process.

3. While the purpose of the survey may vary, any noncompliance found is documented in a standard Agency form entitled "Statement of Deficiencies and Plan of Correction ("Statement of Deficiencies").[2/] The form is prepared by the surveyor(s) upon completing the survey. Deficiencies are noted on the form and classified by a numeric or alphanumeric identifier commonly called a "Tag." The Tag identifies the applicable regulatory standard that the surveyors use to support the alleged deficiency or violation. Deficiencies must be categorized as Class I, Class II, Class III, Class IV, or unclassified deficiencies. § 408.813(2), Fla. Stat. In general, the class correlates to the nature and severity of the deficiency.

4. Dixie Lodge submitted an application seeking to change ownership of its facility in July 2015 and was issued a provisional license to operate Dixie Lodge as an ALF. At all times material hereto, Dixie Lodge was an ALF under the licensing authority of AHCA.

5. Dixie Lodge has been licensed under previous owners for approximately 30 years. To date, Dixie Lodge operates a 77-bed ALF with limited mental health specialty services.

6. AHCA conducted surveys of Dixie Lodge as it related to Dixie Lodge's CHOW application, commonly referred to as a CHOW survey. The Agency conducted two surveys of Dixie Lodge's assisted living facility. The Agency conducted a CHOW survey on September 9, 2015. On November 6, 2015, the Agency conducted a follow-up survey to determine whether Dixie Lodge had corrected cited deficiencies.

7. AHCA's surveyors documented deficiencies and cited Dixie Lodge for violating statutory and rule requirements in several areas of operation. The deficiencies are incorporated in the Statement of Deficiencies, which were prepared after each survey.

8. When a CHOW survey reveals deficiencies, the Agency can deny the upgrade from a provisional license to a standard license. If a provider has three or more Class II violations, such as alleged in this matter, the Agency may deny the upgrade to a standard license. A Class III violation warrants a follow-up visit to give the licensee or applicant an opportunity to fix the alleged deficiency. The Agency may also consider the severity of the violation.

Allegations Regarding Class II Deficiencies

9. The AHCA surveyor, Lesly Linder, who participated in the CHOW survey on September 9, 2015, found several deficiencies. As set forth in the Statement of Deficiencies for

September 9, 2015, Dixie Lodge was cited for three Class II deficiencies in the following areas: (Tag A0025) resident care-supervision; (Tag A0032) resident care-elopement standards; and (Tag A0165) risk management and quality assurance.

Tag A0032: Resident Care and Supervision

10. Resident care and supervision is addressed in section 429.26(7) as follows:

> (7) 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.

11. Resident care and supervision is also adressed in Florida Administrative Code Rule 58A-5.1082(1) as follows:

> 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 personal 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.

12. During the survey, the surveyor reviewed a sampling of 18 residents' records, and interviewed several facility employees. The allegations regarding resident care supervision were related to Resident No. 16 and Resident No. 17.

13. During the survey on September 9, 2015, Ms. Linder interviewed Employee A and documented in the Statement of Deficiencies that the employee stated that "Resident No. 16 had wandered from the facility about five months ago and the police returned him to the facility." Based on Employee A's statement,

it was determined that Resident No. 16 engaged in elopement approximately five months prior to Petitioner assuming ownership of the facility.

14. Ms. Lindner documented the elopement of Resident No. 16 as a deficiency, even though Petitioner was not the owner of the facility at that time.

15. When asked whether AHCA is seeking to hold Petitioner responsible for the purported elopement of Resident No. 16, AHCA's field office manager, Mr. Dickson, stated, "I don't believe so."

16. The evidence presented at hearing demonstrates that Petitioner was not responsible for the facility at the time Resident No. 16 eloped from the facility and, thus, was not responsible for elopement of Resident No. 16.

17. The surveyor also interviewed Employee F on September 9, 2015. During the interview, Employee F told the surveyor that Resident No. 17 had left the facility without notifying staff.

18. Specifically, Dixie Lodge maintained a "Report Book," which included documentation of incidents during each shift. In the book, the staff documented that on September 3, 2015, they had not seen Resident No. 17 on the property for the entire day. The staff then documented their efforts to locate Resident No. 17. Staff documented that they called the hospital and the

local jail to determine the location of Resident No. 17. After these calls, the staff contacted law enforcement and law enforcement returned Resident No. 17 to the facility. Based on the evidence of record, there was sufficient evidence to demonstrate that the Dixie Lodge staff had a general awareness of the whereabouts of Resident No. 17.

19. A review of the Report Book revealed that Resident No. 17 had also eloped from the facility on September 8, 2015, and had not been found at the time of the survey on September 9, 2015, at 3:30 p.m. At that time, the timeline for a one-day adverse incident had not expired. The surveyor interviewed the then administrator for Dixie Lodge and she disclosed that the facility does not have contact information for next of kin or a case manager for Resident No. 17. Even if the administrator had the contact information, Dixie Lodge would not be required to contact them (regarding the elopement), unless the resident was discharged or had moved out. Here, Resident No. 17 had eloped but returned to the facility.

Tag A0032: Elopement Standards

20. Elopement is when a resident leaves a facility without following facility policies and procedures and without the knowledge of facility staff.

21. The elopement standards are described in rule 58A-5.0182(8), which provides as follows:

(8) ELOPEMENT STANDARDS

(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision.

1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention must be directed towards residents assessed at high risk for elopement, with special attention given to those with Alzheimer's disease or related disorders assessed at high risk.

2. At a minimum, the facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification within 10 days of admission or within 10 days of being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.

(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.

22. AHCA alleged that Dixie Lodge failed to follow its elopement policies and procedures for Resident Nos. 16 and 17. The Statement of Deficiencies also alleged that Dixie Lodge failed to ensure that at least two elopement drills per year had been conducted with all staff at the facility.

23. Regarding Resident No. 16, evidence of record demonstrates that Petitioner was not responsible for the facility at the time Resident No. 16 eloped from the facility and, thus, was not responsible for elopement of Resident No. 16.

24. Although the elopement occurred before Petitioner assumed ownership of the facility, Resident No. 16 was designated as being at risk for elopement. As such, the facility was required to have photo identification (ID) on file for the Resident. Investigation by the AHCA surveyor revealed that there was a photo on file but that it was of such poor quality that the photo was not readily recognizable. The surveyor did not provide further description of the photo.

Dixie Lodge's owner, Jeff Yuzefpolsky, testified that because Resident No. 16 had been incarcerated, his picture would be immediately accessible, if needed, from the Department of Corrections' inmate database, and that Mr. Yuzefpolsky was familiar with accessing such photographs. While there was testimony offered regarding the photo, the photo was not offered into evidence. Based on the evidence in the record, the undersigned finds there was not sufficient evidence to demonstrate that Dixie Lodge failed to maintain a photo ID for Resident No. 16.

25. Regarding Resident No. 17, Dixie Lodge had an elopement policies and procedure manual and the staff followed their policies and procedures as it relates to Resident No. 17.

26. Regarding the elopement drills, Ms. Walker discovered documentation of two elopement drills. While the drills did not include record of the staff who participated, there is not a requirement for such in the elopement standards. Dixie Lodge met the requirement by completing the drills and maintaining documentation of the drills.

27. The undersigned finds that the citation for deficiency Tag A0032, a Class II deficiency, was not supported by the evidence in the record.

Tag A0165: Risk Management-Adverse Incident Report

28. AHCA also alleged that Dixie Lodge failed to prepare and file adverse incident reports.

29. Each ALF is required to file adverse incident reports as set forth in section 429.23, which, in pertinent part, provides:

> (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.
>
> (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:
>
> (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:
> 1. Death;
> 2. Brain or spinal damage;
> 3. Permanent disfigurement;
> 4. Fracture or dislocation of bones or joints;
> 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
> 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or

7. An event that is reported to law enforcement or its personnel for investigation; or

(b) Resident elopement, if the elopement places the resident at risk of harm or injury.

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

30. Rule 58A-5.0241 identifies the requirements for filing adverse incident reports as follows:

(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting.

(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting.

31. AHCA alleged that Dixie Lodge was required to file an adverse incident report for elopement incidents involving Resident Nos. 16 and 17 and an injury related to Resident No. 3.

32. During the survey, the surveyor observed Resident No. 3 with a one-inch laceration above his left eye that was covered in dried blood. On September 9, 2015, at 12:14 p.m., the surveyor conducted an interview of Employee A. The surveyor asked the assistant administrator about the laceration on Resident No. 3's eye. The assistant administrator responded that she learned of the injury at 10:30 a.m. AHCA took issue with the lack of an adverse incident report. However, the timeframe for preparing and filing a report had not expired. Thus, AHCA did not demonstrate by clear and convincing evidence the alleged deficiency for failure to file an adverse incident report regarding Resident No. 3.

33. As referenced above, the adverse incident requirements related to Resident No. 16 should not be imputed to Petitioner, as Petitioner was not the owner of Dixie Lodge at the time of the incident that would trigger the compliance requirement.

34. At the time of the survey, approximately five days after Resident No. 17 eloped, there was no documentation that a one-day adverse incident report had been filed. The elopement required a one-day adverse incident report because Resident No. 17 eloped and the incident involved law

enforcement. Thus, a citation for failure to complete an adverse incident report for the September 3, 2015, elopement incident involving Resident No. 17, a Class II violation, is supported by clear and convincing evidence.

35. A review of the Report Book also revealed that Resident No. 17 had eloped from the facility on September 8, 2015, and had not been found at the time of the survey on September 9, 2015, at 3:30 p.m. Although Resident No. 17 had eloped, the timeline for a one-day adverse incident report had not expired. Thus, the Class II citation for failing to file a one-day adverse incident report for the September 8, 2015, elopement incident involving Resident No. 17 incident was not supported by the evidence.

Allegations Regarding Class III Deficiencies

36. In addition to the Class II deficiencies, the surveyor cited 18 Class III deficiencies in the following areas: (A0008) admissions-health assessment; (A0026) resident care-social and leisure activities; (A0029) resident care-nursing services; (A0030) resident care-rights and facility procedures; (A0052) medication-assistance with self-administration; (A0054) medication-records; (A0056) medication-labeling and orders; (A0076) do not resuscitate orders; (A0077) staffing standards-administrators; (A0078) staffing standards-staff; (A0081) training-staff in-service; (A0082) training-HIV/AIDS;

(A0083) training-first aid and CPR; (A0090) training-do not resuscitate orders; (A0093) food service-dietary standards; (A0160) records-facility; (A0161) records-staff; and (A0167) resident contracts.

37. Section 400.23(8)(c) provides in part: "A citation for a class III deficiency must specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, a civil penalty may not be imposed." Section 408.811(4) provides that a deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency. Section 408.811(5) provides: "The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required."

38. On September 17, 2015, AHCA sent Dixie Lodge a Directed Plan of Correction ("DPOC").

39. However, the DPOC was not offered at hearing. There was testimony regarding the content of the DPOC, but that testimony alone, without corroborating admissible evidence, is not sufficient to support a finding of fact regarding Petitioner's failure to comply with the DPOC.

40. The Findings of Fact below are made regarding the Class III deficiencies alleged in subsection 2, paragraph 1, of the Seconded Amended NOID.

Tag A0008: Admission-Health Assessment

41. AHCA alleged that Dixie Lodge failed to ensure that it obtained and maintained complete health assessments for Dixie Lodge residents. Specifically, the Amended NOID alleged that the files for two residents were missing health assessments.

42. The first resident, Resident No. 16, allegedly had been re-admitted after a seven-month absence from the facility without an updated health assessment. While the readmission and the initial timeframe for updating the health assessment expired before Petitioner took possession of the property, the facility was responsible for updating the records so information is available for the facility to determine the appropriateness of the resident's continuous stay in the facility. There is clear and convincing evidence to demonstrate that Dixie Lodge violated Tag A008 and that it indirectly or potentially poses a risk to patients.

Tag A0026: Resident Care-Social and Leisure Activities

43. AHCA alleged that Dixie Lodge failed to ensure that residents were provided a minimum weekly number of hours of leisure and social activities. The logbook reflected there were

no activities offered during the month of September 2015. There is sufficient evidence to demonstrate that Dixie Lodge failed to provide a minimum weekly number of hours of leisure and social activities. Dixie Lodge's failure to provide leisure and social activities constitutes an indirect or potential risk to residents.

Tag A0029: Resident Care-Nursing Services

44. AHCA alleged that Dixie Lodge failed to ensure that it provided nursing services as required for resident care by permitting a certified nursing assistant to change wound dressings instead of a nurse. The certified nursing assistant did not testify, nor did the administrator. Therefore, there was no admissible evidence to support the allegation.

Tag A0030: Resident Care-Rights and Facility Procedures

45. AHCA alleged Dixie Lodge failed to ensure residents' rights were addressed. Specifically, it is alleged that residents had grievances regarding not being paid for gardening labor performed, and Dixie Lodge's then administrator acknowledged those grievances. In addition, a resident reported a grievance regarding the resident's roommate. The administrator acknowledged the grievances and admitted the grievances were not documented. As a result, Dixie failed to ensure residents' rights were implemented.

Tag A0052: Medication-Assistance/Self-Administration

46. AHCA alleged that Dixie Lodge failed to ensure that it provided assistance with self-administration of medications for residents. Specifically, Dixie Lodge failed to assist a resident with self-administration of Depakene (an anti-seizure medication). The resident self-administered two doses of the medication without assistance. As a result, Dixie Lodge failed to meet the parameters for self-administration.

Tag A0054: Medication-Records

47. AHCA alleged that Dixie Lodge failed to maintain accurate and up-to-date medication observation records for residents receiving assistance with self-administration of medications by failing to properly document medication administration. The medication administration records were not offered at hearing. However, the surveyor testified about her observations while conducting the survey. Dixie Lodge did not dispute her testimony. Thus, the evidence was clear and convincing that Dixie Lodge failed to maintain accurate and up-to-date medication observation records related to administration of anti-psychotic medications.

Tag A0056: Medication-Labeling and Orders

48. AHCA alleged that Dixie Lodge failed to ensure that it complied with requirements to take reasonable steps to timely re-fill medication prescriptions for residents. It was further

alleged that Dixie Lodge had not scheduled a face-to-face visit for a patient as required to obtain a prescription refill. However, there were no records offered at hearing to support the allegations. The surveyor's testimony was based on an interview she conducted with a resident and her review of medical records, which was not corroborated by any admissible evidence. There is no clear and convincing admissible evidence in the record to support the violation.

Tag A0076: Do Not Resuscitate Orders

49. AHCA alleged that Dixie Lodge failed to develop and implement a policy and procedure related to "Do Not Resuscitate Orders ("DNRs)." The AHCA surveyor relied upon statements made during an interview by phone of Dixie Lodge employees. The employees interviewed did not testify at hearing. The testimony presented by the surveyor was based on uncorroborated hearsay, which could not be relied upon for a finding of fact.

Tag A0077: Regarding Staffing Standards-Administrators

50. The surveyor noted that the administrator of record failed to provide adequate supervision over the facility by failing to notify the Agency of an adverse incident report for three of the patients sampled (i.e., Resident Nos. 3, 16, and 17). The facts of the incidents are set forth above.

51. Regarding Resident No. 3, the evidence offered at hearing was sufficient to demonstrate that the deficiency found

was appropriate. Regarding Resident No. 16, Petitioner was not the owner of the facility at the time of the resident's elopement and, thus, Petitioner is not responsible for the incident that occurred prior to it assuming ownership of the facility. Regarding Resident No. 17, the evidence offered at hearing was sufficient to demonstrate that the cited deficiency was appropriate.

52. On November 6, 2015, the Agency conducted a follow-up survey wherein the surveyor cited an uncorrected deficiency regarding Tag A0077. No evidence was offered at hearing to refute the allegation that the deficiency was not corrected. Thus, the Class III uncorrected deficiency citation was appropriate. The evidence offered at hearing was sufficient to demonstrate that the cited deficiency was appropriate.

Tag A0078: Staffing Standards-Staff

53. AHCA alleged that Dixie Lodge failed to ensure within 30 days that it had obtained and maintained in the personnel file of each direct health care provider, verification that the staff member was free from communicable disease. The surveyor testified that she reviewed the records for two staff members and discovered there was no documentation in the personnel file of the staff members to demonstrate compliance with the communicable disease-testing requirement. The evidence

presented at hearing supports a violation for the allegations related to Tag A0078, which is an indirect risk to residents.

Tag A0081: Training-Staff In-Service

54. AHCA alleged that Dixie Lodge failed to ensure that staff members completed required in-service training programs, including training related to HIV and AIDS. An employee's file contained a roster of staff members who completed a training course in HIV and AIDS. Although the roster was not dated and did not include a certificate of completion, there was evidence to demonstrate that the employee had completed the training. Based on the evidence presented at hearing, there was no clear and convincing evidence that Petitioner failed to provide HIV and AIDS training to staff.

Tag A0082: Training-HIV/AIDS

55. AHCA alleged that Dixie Lodge failed to ensure that a staff member had completed a required HIV/AIDS course within 30 days of employment. Specifically, the personnel file for Employee B included a training roster which reflected that she received the training. The surveyor noted that there was no date on the roster and no certificate of completion. The evidence of record demonstrates that Employee B completed the training. Regarding maintaining documentation, the roster was not offered into evidence to determine whether the requisite information was included on the roster. In addition, Petitioner

had not assumed ownership of the facility during the timeframe that the training was required and, thus, there was not sufficient evidence presented at hearing to demonstrate that Petitioner is responsible for the alleged deficiency.

Tag A0083: Training-First Aid and CPR

56. AHCA alleged that Dixie Lodge failed to ensure that a staff member who had completed courses in First Aid and Cardiopulmonary Resuscitation ("CPR") was in the facility at all times. The allegation was supported by the record. The failure to ensure at least one staff member on each shift is trained in First Aid and CPR presents an indirect or potential risk to patients.

Tag A0090: Training-Do Not Resuscitate Orders (DNRs)

57. AHCA alleged that Dixie Lodge failed to ensure that staff members timely completed a required training course in DNRs. The surveyor's review of the personnel files of employees A, B, and C revealed that the files did not include sufficient documentation to demonstrate that the three employees completed required training in DNRs. Employees A and C had certificates indicating that they completed the training, but the certificates did not include the duration of the course. Employee B's file did not include a certificate indicating she completed the training within 30 days, as required. Based on

the evidence offered at the final hearing, there is sufficient clear and convincing evidence to support the citation for Tag 0090.

Tag A0093: Food Service-Dietary Standards

58. AHCA alleged that Dixie Lodge failed to maintain a three-day supply of food in case of an emergency. Specifically, the surveyor observed that three proteins had expired. The failure to ensure sufficient resident nutrition is an indirect risk to residents. There was clear and convincing evidence to prove the cited deficiency.

Tag A0160: Records-Facility

59. AHCA alleged that Dixie Lodge failed to maintain facility records for admission and discharge. Specifically, a review of the facility's admission and discharge log incorrectly reflected that 80 residents resided in the facility. It was discovered that the discharge log had not been updated to reflect that five residents no longer resided in the facility. The evidence supports the citation for a deficiency for failure to properly maintain the discharge log.

Tag A0161: Records-Staff

60. AHCA alleged that Dixie Lodge failed to maintain personnel records with required documentation. Specifically, the Statement of Deficiencies alleges that the personnel files of four Dixie Lodge employees did not include documentation of

required trainings. The surveyor reviewed personnel files for the employees. Employees A, B, and C did not include documentation of first aid or CPR training. Employee D's file did not include updated Level 2 eligibility records. Failure to maintain proper and complete personnel files for employees does not pose an indirect risk to residents so as to constitute a class III violation.

Tag A0167: Resident Contracts

61. AHCA alleged that Dixie Lodge failed to provide 30 days' notice prior to an increase in resident rates for services. The surveyor reviewed the records of two residents and discovered that the two residents received notice of the rate increase less than 30 days before they were implemented. However, the rate increase occurred prior to Dixie Lodge assuming ownership of the facility. Thus, Petitioner was not responsible for the rate increase notice and therefore, there was not sufficient evidence to support the deficiency.

Impact on Residents

62. Petitioner seeks to maintain operation of the facility so as not to prevent a negative impact on residents. Marifrances Gullo, RN-C, MSN, FNP-BC, is the owner of Advanced Practical Nursing Services, a behavioral health and addictions management practice. She was accepted as an expert in the field of psychiatric mental health nursing, and testified about the

lack of availability of appropriate placements for Dixie Lodge residents should Dixie Lodge be closed. Nurse Gullo provides mental health services to facilities such as Dixie Lodge. She testified that the dislocation of Dixie Lodge residents would likely lead to extremely detrimental effects on many residents.

63. Edward Kornuszko, PsyD, was accepted as an expert in the provision of psychiatric and mental health services. Dr. Kornuszko has more than five years of experience seeking residential placements for patients similarly situated to those at Dixie Lodge. He testified that the task of placing up to 77 chronically ill Dixie Lodge residents at once would be "nearly impossible." If placements were found for residents who had been at Dixie Lodge for at least 5 to 10 years, he would expect to see "considerable decompensation" in these residents.

Ultimate Findings of Fact

64. AHCA demonstrated by clear and convincing evidence that the cited deficiencies were appropriate for Tag A0165, a Class II deficiency. There was also clear and convincing evidence to demonstrate that the cited deficiencies were appropriate for the following Class III deficiencies: Tag A0008, Tag A0026, Tag A0030, Tag A0052, Tag A0054, Tag A0077, Tag A0078, Tag A0083, Tag A0090, and Tag A0093.

65. Dixie Lodge demonstrated a potential negative impact on residents should Dixie Lodge close its doors.

CONCLUSIONS OF LAW

66. The Division has jurisdiction of the parties and subject matter of these proceedings. §§ 120.569 and 120.57(1), Fla. Stat. (2017).

67. Section 408.806(7)(a) provides, in pertinent part, "[a]n applicant must demonstrate compliance with the requirements in this part, authorizing statutes, and applicable rules during an inspection pursuant to s. 408.811, as required by authorizing statutes."

68. Section 429.19(2) provides, in pertinent part:

> Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:
>
> * * *
>
> (b) Class "II" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation.
>
> (c) Class "III" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation.

69. Section 429.14(1) provides, in pertinent part:

> (1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under

this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, any person subject to level 2 background screening under s. 408.809, or any facility staff:

(a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

* * *

(e) A citation for any of the following violations as specified in s. 429.19:

* * *

2. Three or more cited class II violations.

* * *

(k) Any act constituting a ground upon which application for a license may be denied.

70. Section 408.815 provides, in pertinent:

(1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:

* * *

(b) An intentional or negligent act materially affecting the health or safety of a client of the provider.

(c) A violation of this part, authorizing statutes, or applicable rules.

(d) A demonstrated pattern of deficient performance.

71. AHCA seeks to deny Dixie Lodge's CHOW application. Dixie Lodge has the burden of proving that it meets all the requirements for licensure by the preponderance of the evidence.

72. In licensure denial actions, such as here, an agency is required to prove by the preponderance of the evidence, the acts or omissions, which disqualify the applicant from licensure. See Fla. Dep't of Transp. v. J.W.C. Co., Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); Balino v. Dep't of Health and Rehab. Servs., 348 So. 2d 349 (Fla. 1st DCA 1977).

73. In contrast, the burden of proof to impose an administrative fine is by clear and convincing evidence. This principal was explained by the Florida Supreme Court in Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996). The Court wrote, "[t]he denial of registration pursuant to section 517.161(6)(a), Florida Statutes (1989), is not a sanction for the applicant's violation of the statute, but rather the application of a regulatory measure . . . . (citations omitted). The clear and convincing evidence standard is also inconsistent with the discretionary authority granted by the Florida legislature to administrative agencies responsible for regulating profession under the State's police power." Id. at 934. In reaching this conclusion, the

Court quoted from the opinion of Judge Booth in Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987), explaining:

> The general rule is that a party asserting the affirmative of an issue has the burden of presenting evidence as to that issue. Thus, the majority is correct in its observation that appellants had the burden of presenting evidence of their fitness for registration. The majority is also correct in its holding that the Department had the burden of presenting evidence that appellants had violated certain statutes and were unfit for registration. The majority's conclusion, however, that the Department had the burden of presenting its proof of appellants' unfitness by clear and convincing evidence is wholly unsupported by Florida law and inconsistent with the fundamental principle that an applicant for licensure bears the burden of ultimate persuasion at each and every step of the licensure proceedings, regardless of which party bears the burden of presenting certain evidence. This holding is also equally inconsistent with the principle that an agency has particularly broad discretion in determining the fitness of applicants who seek to engage in an occupation the conduct of which is a privilege rather than a right.

74. The "clear and convincing" standard requires:

> [T]hat 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 any belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

75. Pursuant to the Amended NOID, AHCA seeks to deny Dixie Lodge's CHOW application on several different grounds.

76. First, section 408.815(l)(b) provides that the Agency may revoke or deny assisted living facility licensure where an intentional or negligent act materially affects the health or safety of a resident. Similarly, section 429.14(1)(a) provides that the Agency may revoke or deny assisted living facility licensure where an intentional or negligent act seriously affects the health, safety, or welfare of a resident.

77. Here, AHCA demonstrated that Dixie Lodge failed to prepare an adverse incident report after Resident No. 17 eloped. This incident, alone, is not sufficient to demonstrate that Dixie Lodge engaged in intentional or negligent acts affecting the health, welfare, and safety of residents.

78. Second, section 429.14(1)(e) provides that the Agency may deny, revoke, and suspend any assisted living facility licensure where the licensee, any person subject to level 2 background screening, or any facility staff are cited for three or more Class II violations.

79. Based on the evidence presented at the final hearing, AHCA demonstrated that Dixie Lodge failed to comply with the requirement to file an adverse incident report related to the September 3, 2015, elopement incident involving Resident No. 17.

Based on the foregoing, there was only sufficient evidence to support one citation for deficient practices. See § 408.813(2)(b), Fla. Stat. (2015). Therefore, AHCA did not demonstrate that Dixie Lodge violated section 429.14(1)(e).

80. Third, in addition to the Class II deficiencies, section 429.14(1)(h) provides that AHCA may deny, revoke, and suspend any assisted living facility licensure where a licensee holding provisional licensure fails to meet minimum licensure requirements of chapter 429, part I, governing assisted living facilities; chapter 408, part II, covering all provider types under the authority of the Agency's regulation; and chapter 58A-5, governing assisted living facilities. Similarly, section 408.815(1)(c) provides that the Agency may revoke or deny assisted living facility licensure where the provider has been shown to have violated the provisions of chapter 429, part I, governing assisted living facilities; chapter 408, part II, covering all provider types under the authority of the AHCA's regulation; and chapter 58A-5, governing assisted living facilities.

81. These provisions do not mandate Agency action, but rather grants discretion to AHCA by the Legislature's use of the term "may." This provision does not limit the Agency's consideration for licensure action to only violations that reach

the most severe classifications of identified deficient practice, but encompasses the totality of violations that the Agency has identified.

82. The Agency conducted a licensure survey on September 9, 2015, to determine if Dixie Lodge, a provisional licensee, met the minimum licensure standards of law. In addition to the single Class II deficient practices discussed above, AHCA alleged that Dixie Lodge was noncompliant with 18 other requirements.

83. The Amended NOID also asserts as grounds for licensure denial section 429.14(l)(k), which provides for administrative penalties for acts constituting a ground upon which application for a license may be denied.

84. The Class III deficient practices involved several areas involving the operation of the facility. As stated by AHCA in its PRO, the scope of Dixie Lodge's noncompliance supports the conclusion that Dixie Lodge's administrator failed to exercise control over facility operations to ensure the provision of resident care and management of staff.

85. The Agency has demonstrated that Dixie has failed to demonstrate that its operations meet the minimum licensure requirements of law.

86. Fourth, section 408.815(l)(d) provides that the Agency may revoke or deny assisted living facility licensure based upon

a demonstrated pattern of deficient practice. The decision to take licensure action is discretionary with the Agency.

87. A "demonstrated pattern of deficient practice" is not defined by law. See § 408.815(l)(d), Fla. Stat. (2015). The term "demonstrated pattern of deficient performance" is not defined in rule or statute. There is no case law, which can be relied upon to ascertain exactly what would constitute such a pattern. In AHCA v. W.T. Holdings, Case No. 95-0128 (Fla. DOAH Sept. 30, 1996; AHCA Nov. 4, 1996), Administrative Law Judge Parrish found a "pattern of deficiencies" to have existed. In that case, each of the deficiencies had been found to exist on the basis of final orders that had been entered, not simply upon the allegations set forth in a survey report.

88. Here, the evidence presented at hearing supports the cited deficiencies for a single Class II deficiency, Tag 0165, and 10 Class III deficiencies, including Tag A0008, Tag A0026, Tag A0030, Tag A0052, Tag A0054, Tag A0077, Tag A0078, Tag A0083, Tag A0090, and Tag A0093. The deficiencies demonstrate issues during the provisional licensure. However, the Second Amended NOID reflects that only one uncorrected deficiency was found in the follow-up survey. That being the case, there is insufficient evidence to prove there was a pattern of deficiencies.

89. AHCA attempts to allege numerous citations based upon the tag number under which they are cited. While some of the deficiencies were similar in nature, they were based on the same incident or occurrence and occurred during the same timeframe.

90. Upon consideration of all the evidence, although it is clear that Dixie Lodge could be operated more efficiently, there is insufficient evidence to deny the CHOW application based upon a pattern of deficient performance. The number of deficiencies cited alone does not constitute a "pattern of deficient performance." This concept fails to consider the nature of the deficiencies, whether the deficiencies were challenged as untrue, or whether the facility was provided a reasonable opportunity to contest or correct the cited deficiencies.

91. Based on the foregoing, Dixie Lodge failed to meet certain minimum requirements during the provisional licensure process, for which it was properly cited.

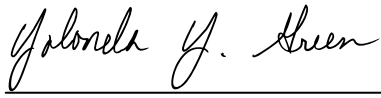
92. However, the analysis does not end there. Dixie Lodge demonstrated a significant negative impact on residents should Dixie Lodge close its doors. Considering the population it serves, the relatively minor nature of the Class II violation proven, and the fact that the evidence of the Class III violations was uncorrected within the time allowed by AHCA rules, the potential negative impact on residents would be far

too great to warrant denial of the CHOW application. Whether AHCA elects to issue Dixie Lodge a conditional license is within AHCA's discretion.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Respondent, Agency for Health Administration, enter a final order rescinding its Amended Notice of Intent to Deny Change of Ownership Application.

DONE AND ENTERED this 10th day of May, 2018, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 10th day of May, 2018.

ENDNOTES

[1/] Unless otherwise provided, citations herein to Florida Statutes are to the 2017 codification, and citations to rules in Florida Administrative Code are to the current versions, for ease of reference.

[2/] All of the Statements of Deficiencies, or survey reports, were admitted in evidence. However, Petitioner maintained an

objection to any hearsay statements contained within the survey reports (such as surveyor statements describing what they were told by residents whom they interviewed). Those statements are not relied on as the sole basis for any finding of fact, but may be considered to the extent they supplement or explain other non-hearsay evidence. Further, any statements that qualify for an exception to hearsay, such as party admissions (see § 90.803(18), Fla. Stat.), may be relied on for findings of fact. See Lee v. Dep't of Health & Rehab. Servs., 698 So. 2d 1194, 1200-1201 (Fla. 1997) (statements made to investigator by employees regarding matters within the scope of their employment, contained in an investigative report, were admissible against the employer as admissions).

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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.