

STATE OF FLORIDA  
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR PERSONS WITH  
DISABILITIES,

Petitioner,

vs.

Case No. 17-3921FL

SMOOTH LIVING GROUP HOME INC.,

Respondent.

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SMOOTH LIVING GROUP HOME INC.,

Petitioner,

vs.

Case No. 17-3922FL

AGENCY FOR PERSONS WITH  
DISABILITIES,

Respondent.

\_\_\_\_\_/

RECOMMENDED ORDER

Administrative Law Judge D. R. Alexander conducted a hearing in these cases by video teleconference at sites in St. Petersburg and Tallahassee, Florida, on December 19, 2017.

APPEARANCES

For Petitioner: Trevor S. Suter, Esquire  
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Agency for Persons with Disabilities  
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For Respondent: M. Sean Moyles, Esquire  
(Smooth Living) Langston, Hess, Augustine,  
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STATEMENT OF THE ISSUES

The issues are (1) whether the group home facility license of Smooth Living, Inc. (Smooth Living), should be revoked; and (2) whether the application of Smooth Living for a license to operate a second group home facility should be approved.

PRELIMINARY STATEMENT

On June 9, 2017, the Agency for Persons with Disabilities (Agency) issued a three-count Administrative Complaint (Complaint) alleging that Smooth Living, which operates a group home facility under the name Smooth Living Group Home, has three verified findings of neglect and has violated numerous statutes and rules. As a sanction, the Agency proposes to revoke Smooth Living's active license. Smooth Living timely requested a hearing to dispute the charges, and the matter was referred by the Agency to the Division of Administrative Hearings (DOAH) and assigned Case No. 17-3921FL.

On June 9, 2017, the Agency also issued a Notice of License Application Denial for Group Home (Notice), which denies Smooth Living's application for a new license to operate a second group home facility. The Notice relies on the charges in the Complaint as the bases for denying the application. Smooth

Living timely requested a hearing, and the matter was referred by the Agency to DOAH and assigned Case No. 17-3922FL. The two cases were consolidated by Order dated July 25, 2017.

At the hearing, the Agency presented the testimony of three witnesses. Agency Exhibits 1 through 5, 7, 10, 11, and 13 through 15 were accepted in evidence, some with limitations discussed below. Smooth Living presented the testimony of two witnesses. Smooth Living Exhibit 50 was accepted in evidence.

A two-volume Transcript of the hearing has been prepared. The parties filed proposed recommended orders (PROs) on February 26 and 27, 2018, and they been considered in the preparation of this Recommended Order.

#### FINDINGS OF FACT

##### A. Background

1. The Agency is charged with regulating the licensing and operation of group home facilities pursuant to chapter 393, Florida Statutes.

2. Section 393.063(19), Florida Statutes, defines a group home facility as "a residential facility licensed under [chapter 373] which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of the resident."

3. When Case No. 17-3921FL arose, Smooth Living held a license to operate a group home facility at 200 South Arcturas

Avenue, Clearwater, Florida. Its owner and president is Willie Sams, a former Agency employee. The license became effective on March 1, 2017, and by its terms, was set to expire on February 28, 2018. For the reasons described in the Complaint, the Agency seeks to revoke the license.

4. On February 23, 2017, Smooth Living also submitted an application for a new (expansion) license to operate Smooth Living Group Home II at 1321 Oxford Court, Clearwater, Florida. Willie Sams is designated as the owner of the new facility. As part of its review of the application, the Agency conducted a search of Department of Children and Families (DCF) records. The search revealed verified findings of neglect against the owner in 2017. In Case No. 17-3922FL, the Agency proposes to deny the application for the same reasons set forth in the Complaint.

B. The Alleged Violations

5. Smooth Living is a behavior-focused facility that serves more difficult or challenging clients. Its full capacity is six residents. According to Mr. Sams, "most" of the residents are what he characterizes as "kids," presumably meaning they are less than 18 years of age. Because its clients have significant behavioral issues, Smooth Living must ensure that staffing requirements, both in terms of numbers and male/female makeup, are maintained at all times.

6. The importance of appropriate staffing was impressed upon Mr. Sams by an Agency inspector in January 2017, after a staffing incident occurred.

7. The Complaint and Notice allege that three incidents occurred at the facility in February, March, and April 2017, which resulted in verified findings of neglect against Mr. Sams. The incidents also form the basis for allegations that the licensee/applicant violated various statutes and rules. After each incident occurred, Smooth Living submitted to the Agency an Incident Reporting Form, as required by Florida Administrative Code Rule 65G-2.010(5)(a) and (b).

a. Count I

8. Count I alleges generally that on the morning of February 26, 2017,<sup>1/</sup> staff inspected a room shared by two male residents, C.B. and E.A., both minors, and observed "[C.B.] engaged in inappropriate sexual behavior with [E.A.]"; E.A.'s shirt was ripped; and there were several scratches on E.A.'s neck. The Complaint alleges that the incident was not reported to the Florida Abuse Hotline until 2:00 p.m. that day. It also alleges "most staff members" were not aware of C.B.'s history of inappropriate sexual behavior. Finally, it alleges that a DCF investigation resulted in verified findings of neglect of a child against Mr. Sams, a Class I violation, the most serious type of violation by a group home. Besides the verified finding

of neglect, the Complaint alleges the actions violate applicable rules and statutory provisions.

9. The record shows that in April 2016, C.B. was placed in the Smooth Living facility. When the first incident occurred on February 26, 2017, C.B. shared a room with E.A., a nonverbal minor. Mr. Sams and the group home manager, Ms. DiPino, acknowledged that C.B had a history of inappropriate sexual behavior, including frequent attempts to masturbate in the common area of the home. Also, Ms. DiPina reported that C.B. had a history of placing his hands onto another person's "private area over clothing." Ms. Stanganelli, a former DCF child protective investigator, added that before C.B. came to Smooth Living, he had "performed oral sex on other minor children" in other homes. Given this background, C.B.'s behavior analyst service plan plainly indicated that he had a history of "inappropriate sexual behavior [with] other peers." The fact that C.B. was funded by the Agency at a moderate rather than a high risk level does not mean that his history of inappropriate sexual behavior could be ignored.

10. Although C.B.'s behavior normally would require him to be placed in a private room, his behavior plan, effective July 11, 2016, did not have this requirement. It provided that he "needs to be under visual supervision at all times except while in the bathroom or bedroom by himself" and that he "should

never be in a bedroom with another peer with the door closed at any time." Although C.B.'s behavior analyst visited the home each week and was aware that he shared a room, the analyst did not recommend any change to this arrangement.

11. Ms. Jackson, a direct care staffer when C.B. was a resident, testified that the door to C.B.'s room was always "cracked" so that staff could peek into the room without disturbing the residents.

12. A resident with a history of inappropriate sexual behavior should have his room checked by a staff member more frequently than other residents. This was confirmed by Ms. Jackson, who acknowledged that C.B. "required more supervision" and "needed more checkups than normal." Therefore, it was appropriate to check the room every 15 to 20 minutes, rather than the usual 30 to 45 minutes.

13. At hearing, both Ms. Jackson and Mr. Sams testified that bed checks on C.B.'s room were made every 15 or 20 minutes. This time frame was contradicted by Ms. DiPino, who performed bed checks on the night the incident occurred, and Ms. Floyd, the other staffer on duty. In her interview with the DCF investigator, Ms. DiPino stated that C.B.'s room was checked every 30 to 45 minutes, while Ms. Floyd stated she was told to make checks every 30 minutes. Their statements are accepted as being the most credible on this issue.

14. While making a random check on C.B.'s room around 5:00 a.m. on February 26, 2017, Ms. DiPino and Ms. Floyd observed C.B. performing oral sex on E.A. This was the first known time that C.B. engaged in sexual behavior towards his roommate. After pulling C.B. off of E.A., the employees observed that E.A. had a ripped shirt and scratches on his upper shoulder area.

15. Smooth Living's Incident Reporting Form filed with the Agency shortly after the incident also confirms that C.B. sexually assaulted his roommate. The form states, however, that bed checks on the room were made every 20 minutes, even though the group home manager on duty that evening stated otherwise.

16. The Complaint alleges that Smooth Living did not immediately notify the Florida Abuse Hotline following the incident. There is no evidence as to when notification was actually given.

17. On February 27, 2017, Ms. Stanganelli, who testified at hearing, began her investigation of the incident. During the investigation, she interviewed the residents, staff, and owner. All statements made by the employees were in the course of their employment. After Ms. Stanganelli completed her investigation, she recommended that a finding of inadequate supervision on the part of Mr. Sams be verified.



b. Count II

18. Count II alleges that on March 29, 2017, C.B., then sharing a room with G.M., "destroyed several personal items belonging to [G.M.] as well as bedroom furniture." It further alleges that later that day, an altercation between the two ensued, and C.B. "receive[d] skull lacerations which required treatment at a hospital emergency room." It goes on to allege that only one staff person, Mr. Bryant, was on duty and responsible for supervising four residents with significant behavioral issues, and that a DCF investigation resulted in verified findings of neglect of a child against Mr. Sams. Finally, it alleges that after the incident, C.B. was required to sleep on a couch in the living room for a month. Like Count I, the Complaint alleges the actions by the home violate a number of rules and statutes.

19. The record shows that on March 29, 2017, C.B. was sharing a bedroom with G.M., a minor. According to Smooth Living's Incident Reporting Form, C.B. destroyed personal property of G.M.; an altercation between the two ensued later that day; C.B. suffered a two-inch laceration on the back of his head; and C.B. was taken to an emergency room for medical treatment. The form does not address the issue of whether the facility was properly staffed when the incident occurred. At hearing, Mr. Sams characterized the destruction of the room as a

tantrum. He added that later that day, G.M. punched C.B. "real quick" before staff could intervene but they were quickly separated.

20. An investigation by the Agency revealed that C.B.'s destruction of the room was "massive," only Mr. Bryant was present at that time to oversee four residents, and the staff member was unable to physically restrain C.B. from destroying the property. While C.B. continued to destroy the room, the staffer stood by "trying to keep the other clients out of the way so that C.B. would not hurt them." These facts are drawn from statements made by Mr. Bryant to Ms. Liles, an Agency inspector.

c. Count III

21. Count III alleges that, due to a history of violent behavior, G.M.'s behavior plan restricted access to weapons and cell phones and required daily checks of his backpack and bedroom. It alleges that on April 27, 2017, G.M. threatened a student at school with a pair of scissors and showed the student a picture of him (G.M.) holding a gun; and a search of G.M.'s backpack at school revealed a pair of scissors and two cell phones. The Complaint further alleges that later on that day, a search of G.M.'s bedroom revealed he had a pellet gun, cell phone, knife blade without a handle, scissors, a water gun, a razor blade wrapped in paper, a foot-long key chain, a

screwdriver set, a sewing kit with needles, and material used in constructing an explosive device. It also alleges that Mr. Sams was unaware of the behavior plan, other staffers "knew very little about the supervision requirements found within [G.M.'s] behavior plan," and Mr. Sams admitted that the facility was short-staffed at times. Finally, the Complaint alleges a DCF investigation resulted in verified findings of neglect of a child against Mr. Sams. Again, the Complaint alleges that these actions violate numerous rules and statutes.

22. G.M.'s behavior plan was in the process of being modified shortly before the incident occurred and did not become final until May 1, 2017, or three days after the incident. Prior to May 1, G.M.'s behavior plan did not restrict access to weapons or cell phones, and it did not require bedroom and backpack inspections when he left for school each day and when he returned. Mr. Sams testified that it only required a room check each morning after G.M. left for school.

23. The evidence shows that on April 27, 2017, Mr. Sams received a call from the school principal advising that G.M. was being sent home because he had a gun in his possession, he was threatening students, and he was having "behavior concerns." As it turned out, G.M. had been expelled from school for those actions. After G.M. returned to the facility, a search of his room revealed that he had in his possession the items described

in the Complaint. The search was conducted in the presence of Agency personnel and a DCF investigator. An Agency inspector noted that no one on the staff was "taking it seriously to actually do the searches the way they should have been done." And after expressing surprise to learn that scissors were found in G.M.'s guitar case, Mr. Sams stated "he would never have thought to look in the guitar case." He also acknowledged that the facility was short-staffed during that period of time. Even though G.M.'s plan required only a morning search of his room each day, a thorough search of his room by staff should have uncovered the contraband. The DCF investigator testified that the investigation was closed with verified findings of maltreatment/inadequate supervision against Mr. Sams.

24. Mr. Sams contends that no contraband was in the room when G.M. left for school and that all items must have been obtained from outside the home. He further surmises that the items were hidden by G.M. after he returned from school. However, these assertions are simply speculation, without evidentiary support. Mr. Sams also pointed out that the gun was merely a broken pellet gun, but in today's environment, even a fake gun can be threatening to other residents and staff.

25. In Agency interviews with staff that day, members of the staff acknowledged that they did not routinely check backpacks of residents when they left the facility in the

morning for school and when they returned that afternoon. Comprehensive inspections are especially important for a resident who exhibits signs of violent behavior.

26. Smooth Living's Incident Reporting Form is somewhat vague. The form acknowledges that DCF advised Mr. Sams that it intended to close the investigation with a verified finding of inadequate staff supervision. DCF also informed him that "staff [should] start looking for another job because [the facility] would be closed down in a couple of months." However, the form fails to include any information regarding the items uncovered during the search of G.M.'s room or acknowledge that staff failed to perform a thorough search of his room in the morning, as required by the behavior plan.

27. Based on the violations associated with the three incidents, Smooth Living closed its facility in June 2017. If its appeal in this case is successful, Smooth Living presumably intends to reopen the facility.

C. The Abuse Reports, Statements, and Incident Reports

28. To support the allegations, the Agency relies upon the abuse reports on the theory they are business records and admissible as an exception to the hearsay rule. See Pet'r Ex. 3 and 11. At hearing, it also relied on employee/owner statements made to Ms. Stanganelli and two Agency employees, Ms. Liles and Ms. Leitold, and statements contained in the Incident

Reporting Forms filed with the Agency after each incident.

Smooth Living objects to each category of statements/documents on the ground they constitute hearsay, not subject to an exception.

29. To lay a foundation for the business record exception, Ms. Stanganelli testified that 1) she prepared the abuse reports and 2) they were prepared near or at the time the events occurred. There is no testimony that these reports are kept in the ordinary course of DCF's business, or that it is a regular practice of DCF to make such a record. Also, no showing was made that she is a qualified person to make those assertions. As to statements made by employees to the DCF and Agency, they concern a matter connected to a duty within the scope of employment. The statements by Mr. Sams to DCF and the Agency, and his written reports to the Agency after each incident, are obviously statements made by an adversary.

#### CONCLUSIONS OF LAW

30. This case combines a Complaint seeking to revoke Smooth Living's license with Smooth Living's challenge to a denial of an application for a second license.

31. In the enforcement case, the Agency has the burden of proving the alleged violations by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996). In the initial license application case, the

Agency has the burden of proving the licensee's lack of fitness to hold a license by a preponderance of the evidence. If it does, Smooth Living must prove by a preponderance of the evidence that its application should be approved, notwithstanding any violations that are proven. Fla. Dep't of Child. & Fam. v. Davis Fam. Day Care Home, 160 So. 3d 854, 857 (Fla. 2015) (Canady, J., dissenting).

32. The Agency is authorized to revoke a license or deny an application for licensure if the licensee or applicant has failed to comply with the applicable requirements of chapter 393 or applicable rules in chapter 65G-2. § 393.0673(1)(a)3., Fla. Stat. The same action may be taken if the applicant/licensee has a verified report of abuse. § 393.0673(1)(b), Fla. Stat.

33. In its PRO, the Agency assumes the abuse reports are admissible as business records under section 90.803(6), and, by themselves, sustain the proposed agency action. The PRO does not address any alleged rule violations cited in the Complaint or otherwise identify the rules that were violated and the evidence adduced at hearing to support those charges.

34. Statements made by a party opponent are admissible as substantive evidence. § 90.803(18), Fla. Stat. Therefore, Mr. Sams' statements and the Incident Reporting Forms may be used to prove the allegations. Employee statements also are admissible, so long as they concern a matter within the

employees' scope of employment and are made during the existence of the employer-employee relationship. § 90.803(18)(d), Fla. Stat. Finally, because the four elements enumerated in section 90.803(6)(a) were not satisfied, the undersigned admitted the abuse reports as hearsay that could be used only to supplement or explain other competent evidence. § 120.57(1)(a), Fla. Stat. However, while the reports as a whole are not admissible as a business record, employee/owner statements in the reports made to Ms. Stanganelli during her investigations are admissible. See, e.g. Lee v. Dep't of Health & Rehab. Servs., 698 So. 2d 1194, 1200 (Fla. 1997) (while investigative report as a whole not admissible as a public record, employee statements contained in report were admissible as a statement by a party opponent). The rulings at hearing regarding the disputed statements, and their use, are consistent with these principles.

35. Regardless of whether the abuse reports are admissible as substantive evidence,<sup>2/</sup> there is clear and convincing evidence to revoke the license for failing to comply with the requirements applicable to a group home licensee. Likewise, there is sufficient competent and substantial evidence to deny the application for an extended license.

36. The Complaint alleges that Smooth Living violated various provisions within rules 65G-2.0041, 65G-2.007,



65G-2.009, and 65G-2.010, as well as section 393.13(3) (a) and (g). The foregoing rules and statutory provisions must be strictly construed in favor of the one against whom the penalty would be imposed. See, e.g., Djokic v. Dep't of Bus. & Prof'l Reg., Div. of Real Estate, 875 So. 2d 693, 695 (Fla. 4th DCA 2004). If proven, a Class I violation is a sufficient basis to revoke a license or deny an initial application. This is because a Class I violation "cause[s] or pose[s] an immediate threat of death or serious harm to the health, safety, or welfare of a resident and which require immediate correction." Fla. Admin. Code R. 65G-2.0041(4) (a)1.

Count I

37. Based on the February 26, 2017, incident, the Complaint alleges that Smooth Living violated rules 65G-2.0041 and 65G-2.0041(4) (a), 65G-2.009(a) (1), (1), (1) (d), (6) (a) and (c), (9) (9), and (9) (c), and 65G-2.010(5) (a), as well as sections 393.13(3) (a) and (g). However, the citations to rules 65G-2.009(a) (1) and (9) (9) are incorrectly numbered, and except for rule 65G-2.0041(4) (a), it is unclear which portions of rules 65G-2.0041 and 65G-2.009(1) are at issue.

38. There is clear and convincing evidence that Smooth Living failed to perform a room check on a resident with a history of inappropriate sexual behavior within the prescribed timeframe (every 15 to 20 minutes), which resulted in a resident

being sexually assaulted. Given C.B.'s history of sexual behavior, the home's failure to perform room checks in a timely manner constituted an immediate threat of serious harm to E.A.'s safety and welfare. Therefore, Smooth Living has violated section 393.13(3) (a) and (g) and rules 65G-2.0041(4) (a) and 65G-2.009(1) (d), (6) (d), and (9) (c), which are Class I violations. The remaining violations have not been established.

Count II

39. Based on the March 28, 2017 incident, Count II alleges Smooth Living violated rules 65G-2.0041, 65G-2.007(5) (f), and 65G-2.009(1), (1) (a)1., (1) (d), (3) (b), and (6) (a) and (c), as well as section 393.13(3) (a) and (g). Without more specificity, it is unclear which parts of rules 65G-2.0041 and 65G-2.009(1) are allegedly violated. Also, rule 65G-2.009(6) (c) simply tells us that a violation of paragraph (6) (a) is a Class I violation.

40. There is clear and convincing evidence that Smooth Living violated rule 65G-2.009(6) (a), which requires each facility to provide a level of supervision necessary to protect residents from harm. By having only one staff member on duty to oversee four residents with significant behavioral issues, this caused or posed an immediate threat of serious harm to the safety and welfare of the residents, in violation of rule 65G-2.009(1) (d). And by failing to provide the proper supervision,

Smooth Living violated section 393.13(3)(g), which provides that residents have a right to be free from harm. These are all Class I violations. The remaining violations have not been established.

Count III

41. The Complaint alleges that Smooth Living violated rules 65G-2.0041 and 65G-2.0041(4)(a), 65G-2.009(a)(1), (1), (1)(d), (3)(b), (6)(a) and (c), and (9)(9), and 65G-2.010(5)(a), as well as section 393.13(3)(a) and (g). Again, citations to rule 65G-2.009(a)(1) and (9)(9) are incorrectly numbered. Also, except for paragraph (4)(a) in rule 65G-2.0041, it is unclear which provisions in rules 65G-2.0041 and 65G-2.009(1) are allegedly violated.

42. There is clear and convincing evidence that Smooth Living's staff did not perform an adequate search of G.M.'s bedroom on April 27, 2017, in violation of rules 65G-2.0041(4)(a) and 65G-2.009(6)(a). Because the possession of dangerous items constituted a potential threat to the health and safety of the residents and staff, this action also violated rule 65G-2.009(1)(d). Finally, by failing to keep all clients in the facility free from harm, section 393.13(3)(g) was violated. All are Class I violations.

43. Because the Notice relies on the same charges, the Agency has established that Smooth Living is unfit for

licensure, which evidence was not overcome by the applicant. Therefore, its application for a new license should be denied.

44. In summary, by clear and convincing evidence, the Agency has proven that Smooth Living is guilty of the above Class I violations, and that revocation of its license is an appropriate sanction. Also, by a preponderance of the evidence, the Agency has established that Smooth Living is unfit for a new license, which was not contradicted by the applicant.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Agency for Persons with Disabilities enter a final order revoking Smooth Living's license in Case No. 17-3921FL and denying its application for a new license in Case No. 17-3922FL.

DONE AND ENTERED this 21st day of March, 2018, in Tallahassee, Leon County, Florida.



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D. R. ALEXANDER  
Administrative Law Judge  
Division of Administrative Hearings  
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Filed with the Clerk of the  
Division of Administrative  
Hearings  
this 21st day of March, 2018.

ENDNOTES

<sup>1/</sup> There is some confusion on when the first incident occurred. The date of the incident is redacted from the Complaint and Notice. Smooth Living's Incident Reporting Form reflects the incident occurred at 5:25 a.m. on February 26, 2017. The DCF investigator testified the incident occurred on February 27, the same day that she began her investigation. The undersigned has used February 26 as the correct date of the incident.

<sup>2/</sup> Ordinarily, Smooth Living would not be able to contest verified findings in an abuse report. See Comfortable Living, In Good Hands v. Ag. for Persons with Disab., Case No. 14-0689 (Fla. DOAH July 2, 2014; APD July 18, 2017). In this unusual case, however, the abuse reports were not admitted as substantive evidence.

COPIES FURNISHED:

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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.