STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR PERSONS WITH DISABILITIES,

Petitioner,

vs. Case No. 18-2106FL

ADAMS GROUP HOME, INC., AND JOYCE ADAMS,

Respondents.
_____/

RECOMMENDED ORDER

This case came before Administrative Law Judge Darren A. Schwartz of the Division of Administrative Hearings ("DOAH") for final hearing by video teleconference on June 20, 2018, at sites in Tallahassee and Lauderdale Lakes, Florida.

APPEARANCES

For Petitioner: Trevor S. Suter, Esquire
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950

For Respondents: G. Barrington Lewis, Esquire
Law Office of George B. Lewis
19601 Skyhawk Lane
Loxahatchee, Florida 33470

STATEMENT OF THE ISSUE

Whether Respondents Adams Group Home, Inc., and Joyce Adams' ("Respondents") group home licensure renewal applications should be denied.

PRELIMINARY STATEMENT

By letter dated March 13, 2018, Petitioner Agency for Persons with Disabilities ("APD") notified Respondents of the denial of their group home licensure renewal applications. Respondents timely filed a request for a formal hearing. Subsequently, on April 24, 2018, APD referred the matter to DOAH to assign an Administrative Law Judge to conduct the final hearing. On May 7, 2018, the undersigned set the final hearing for June 20, 2018.

The final hearing was held on June 20, 2018. At the hearing, APD presented the testimony of Bernadette Harding, Michelle Ceville, Martina Pocaterra, Kimberly Robinson, Ashley Cole, Shawn Hallich, and Maria Rubin. APD's Exhibits 1, 2, 4 through 12, 14, and 15 were received in evidence. Respondents presented the testimony of Joyce Adams. Respondents' Exhibits A, D, J, K, and P were received in evidence.

The two-volume final hearing Transcript was filed on July 18, 2018. APD timely filed its Proposed Recommended Order on July 30, 2018, at 4:50 p.m. Respondents filed their Proposed Recommended Order on July 31, 2018, at 10:11 a.m., one day late.

However, there is no prejudice to APD as a result of Respondents' late-filed Proposed Recommended Order. Accordingly, the parties' proposed recommended orders have been considered in the preparation of this Recommended Order.

On June 19, 2018, the parties filed their Pre-hearing Stipulation, in which they stipulated to certain facts. These facts have been incorporated into this Recommended Order.

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

FINDINGS OF FACT

Parties and Background

1. APD is the state agency charged with regulating the licensing and operation of foster care facilities, group home facilities, and residential centers, pursuant to sections 20.197 and 393.067, Florida Statutes.

2. Under section 393.063(19), a group home facility means a residential facility "which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents." The capacity of such a facility must be at least four but not more than 15 residents.

3. Respondents are licensees of two group home facilities, known as Adams Group Home #1, located at 2400 Oleander Drive,

Miramar, Florida 33023, and Adams Group Home #2, located at 7131 Southwest 16th Street, Pembroke Pines, Florida 33023.

4. Respondents' group homes provide a family living environment within a residential, single-family structure with a combined total of not more than 12 adult residents with developmental disabilities.

5. Joyce Adams is Adams Group Homes' corporate officer. Ms. Adams has been licensed through APD to provide group home services for 18 years.

6. Group homes licensed by APD are required to apply for a renewal license every year. The renewal process involves a review of the applications to make sure they are accurate and complete and an observation by a licensing specialist at the facilities to ensure the facilities are in compliance with the applicable statutes and administrative rules.

7. Every year prior to 2018, including 2014 through 2017, Respondents' group home licensure renewal applications for Adams Group Home #1 and Adams Group Home #2 were approved by APD.

8. No evidence was presented at hearing demonstrating that Respondents have ever been the subject of any corrective action plan or proposed disciplinary agency action in the form of an administrative fine, suspension or revocation of a license, or moratorium on admissions, prior to APD's March 13, 2018, denial letter.

The March 13, 2018, Denial Letter

9. Against this backdrop, on December 20, 2017, Respondents submitted applications to APD for renewal of the licenses of Adams Group Home #1 and Adams Group Home #2, which were set to expire in March 2018.

10. By letter dated March 13, 2018, APD notified Respondents of the denial of their group home licensure renewal applications. APD's grounds for the denial of the license applications are set forth in the denial letter in four counts.

11. In Counts I and II, APD alleges the Department of Children and Families ("DCF") commenced investigations which resulted in DCF's verified findings of abuse, neglect or exploitation against Ms. Adams in February 2014 and December 2015, respectively. APD further alleges that based on section 393.0673(2), it "may" deny an application for licensure based solely on DCF's verified findings.

12. In Count III, APD alleges Respondents used video cameras in the common areas in 2016 and 2017 without written consents for the common areas in violation of Florida Administrative Code Rule 65G-2.009(7), which constitutes a Class II violation.

13. In "Count IIII," APD alleges that after Hurricane Irma struck south Florida on September 10, 2017, Respondents had "no power at the group home," Respondents utilized a "makeshift

grill" less than ten feet from the structure, and failed to care for its residents. APD specifically alleges that on September 19, 2017, a resident of Adams Group Home #2 "was taken to the emergency room at Memorial Regional Hospital for confusion and fever."

14. APD further alleges that Respondents' conduct described in "Count IIII" constitutes Class I violations, and that the conduct violates rule 65G-2.009(1)(d) with regard to the minimum standards of facilities to ensure the health and safety of the residents and address the provision of appropriate physical care and supervision; adhering to and protecting resident rights and freedoms in accordance with the Bill of Rights of Persons with Developmental Disabilities, as provided in section 393.13; and section 393.13(3)(a) and (g), relating to humane care, abuse, neglect, or exploitation.

Count I

15. The parties stipulated that on December 29, 2013, DCF commenced an investigation of Respondents' group homes, and that on February 25, 2014, DCF closed its investigation with verified findings of abuse, neglect, or exploitation on the part of Ms. Adams.

16. APD was aware of DCF's verified findings upon completion of DCF's investigation.

17. At hearing, APD provided no witnesses with first-hand knowledge of the specific facts involved in the violation. Instead, APD presented unsigned DCF investigative reports and a DCF supervisor's testimony regarding the general investigative process.

18. At hearing, Ms. Adams explained the facts and circumstances surrounding the violation. Ms. Adams testified the incident involved M.K., a 41-year-old female resident of Respondents' group home since 2006, who is developmentally disabled.

19. According to Ms. Adams, on Sunday, December 29, 2013, M.K. was taken by personal car to the emergency room at Memorial Hospital, Pembroke Pines, where she was admitted. Ms. Adams testified that M.K. had been coughing for a few days, and she had consulted with a nurse practitioner about M.K.'s condition on Thursday, December 26, 2013. However, M.K.'s condition had not improved by Sunday, she looked weak, and Ms. Adams did not want to wait until Monday for M.K. to be seen by a doctor.

20. M.K. was transported to the hospital on Sunday, December 29, 2013, by a facility employee. Emergency (911) had been called for M.K. on approximately eight occasions prior to December 29, 2013. Ms. Adams persuasively and credibly testified she would not have hesitated to call 911 for M.K. if she felt it was necessary.

21. On Monday, December 30, 2013, the next business day, Ms. Adams provided an incident report to APD. Ms. Adams also immediately notified M.K.'s waiver support coordinator.

22. M.K. returned to Respondents' group home after her release from the hospital where she has continued to reside since then.

Count II

23. The parties stipulated that on November 4, 2015, DCF commenced an investigation of Respondents' group homes, and that on December 12, 2015, DCF closed its investigation with verified findings of abuse, neglect, or exploitation on the part of Ms. Adams.

24. APD was aware of DCF's verified findings upon completion of DCF's investigation.

25. At hearing, Ashley Cole, regional program supervisor for the southeast region of APD, testified about the facts and circumstances surrounding the violation.

26. The violation involved the use of residents' funds to request a new support coordinator.[1/]

27. Specifically, in November 2015, Ms. Cole conducted a review of client files at one of Respondents' group homes, including a review of financial ledgers, and saw disbursements of money from three residents to an attorney, totaling $1,300.00.

28. When asked about this by Ms. Cole, Ms. Adams explained that the funds were used to pay an attorney to write letters on behalf of the three residents requesting new support coordinators.

29. The funds were used to benefit the three residents and the letters were written by Respondents' attorney on behalf of the three residents.

30. At hearing, Ms. Cole testified that it is typical for an APD client or the client's guardian to request a new support coordinator, not the group home owner, and that it is not required that a request for a new support coordinator be in writing.

31. Although it may not be typical for the group home owner to request a new support coordinator in writing on behalf of the residents, it is not prohibited by law.

32. None of the three residents had guardians or family members to assist in the handling of their affairs. Ms. Adams testified that she had attempted to obtain assistance from the current support coordinator to act on the residents' behalf, but to no avail.

33. Two of the residents still resided at Respondents' group home as of the beginning of 2018; the other resident died about a year after the incident for reasons unrelated to the written requests for a new support coordinator.

Count III

34. Delmarva Foundation, n/k/a Qlarant, has contracted with the State of Florida to evaluate the performance of group home providers such as those operated by Respondents.

35. On May 31, 2016, Delmarva Foundation Quality Assurance Reviewer Martina Pocaterra performed an unannounced observation visit at one of Respondents' group homes. Ms. Pocaterra observed video cameras in the common areas of the group home.

36. The next morning, Respondents provided consent forms from residents for use of cameras in the bedrooms, but not for use in the common areas of the group home. Because there were no consent forms signed by residents allowing the use of video cameras in the common areas, an alert notification form was submitted to APD.

37. On October 3, 2017, Delmarva Foundation Quality Assurance Reviewer Michelle Ceville performed a provider discovery review at one of Respondents' group homes. On this occasion, Ms. Ceville observed video cameras in the common areas of the group home.

38. Respondents again provided consent forms from residents for use of cameras in the bedrooms, but not for use in the common areas. Because there were no consent forms signed by residents allowing the use of video cameras in the common areas, an alert notification form was submitted to APD.

39. The clear and convincing evidence adduced at hearing demonstrates that Respondents violated rule 65G-2.009(7)(a) and (b) by failing to obtain written consent of residents for the use of video monitoring equipment in the common areas.

"Count IIII"

40. On September 10, 2017, Hurricane Irma struck Florida. After the hurricane, APD contacted group homes to ensure that the homes had electricity, lights, and air conditioning, and that the homes were safe.

41. On September 15, 2017, Adams Group Home, Inc., informed APD that Adams Group Home #2 had electricity and running water, and that Adams Group Home #2 residents had not been evacuated.

42. On September 19, 2017, Kimberly Robinson, an APD human services program analyst, conducted a wellness check at one of Respondents' group homes. It is unclear from Ms. Robinson's testimony which group home she actually visited. However, Ms. Robinson observed that the home had air conditioning, and that "everything in the home was fine."

43. On September 19, 2017, Pembroke Pines Assistant Fire Marshal Shawn Hallich visited Adams Group Home #2 and conducted an inspection. He testified that he "did a walk around real quick," and that on the enclosed outdoor patio on the back porch of the home, he noticed "a pot on two blocks with two pieces of

wood and an open flame with charcoal, and something . . . being cooked on it."

44. According to Mr. Hallich, the cooking device was located on the back patio "approximately, probably 10 feet from the sliding glass door, maybe a little bit less than that." Mr. Hallich did not use any device to measure the distance of the cooking device from the structure of the home. Mr. Hallich testified that the cooking device was a safety hazard because there was an open flame and there was nothing to prevent the cooking device from being tipped over or falling over on its own.

45. During his inspection, Mr. Hallich also observed that there was no air conditioning inside the home. There was some electricity inside the home, but not enough voltage necessary for the air conditioning system to operate.

46. However, there were fans located and operating in every room of the home, and the windows were open. Mr. Hallich testified it was hot, but he did not use any device to measure the temperature inside the home. Mr. Hallich also acknowledged that if the fans were on inside the home, the circulation would have made it feel cooler inside the home.

47. On September 19, 2017, Mr. Hallich issued a Notice of Violation, stating the nature of the violation as: "No air conditioning and unsafe cooking practices being conducted." Mr. Hallich recommended the following action be taken:

(1) "Must relocate all residence [sic] until all power has been restored[; (2)] All cooking must be conducted at least 10 feet away from the structure using a commercial cooking appliance."

48. As to the violation found by Mr. Hallich with respect to the outside cooking device, Ms. Adams asked Mr. Hallich whether she could use it outside, and he told her that "it had to be 10 feet away from the structure for cooking."

49. In issuing the Notice of Violation with respect to the cooking device, Mr. Hallich specifically relied on section 10.10.6.1 of the Florida Fire Prevention Code which provides as follows:

> For other than one- and two-family dwellings, no hibachi, grill, or other similar devices used for cooking, heating, or any other purpose shall be used or kindled on any Balcony, under any overhanging portion, or within 10 ft (3 m) of any structure.

50. Mr. Hallich's reliance on section 10.10.6.1 of the Florida Fire Prevention Code is misplaced because Adams Group Home #2 is a single-family dwelling. As a single-family dwelling, Respondents' group home is exempt from section 10.10.6.1. In any event, APD failed to present clear and convincing evidence that the cooking device was located within ten feet of the single-family dwelling.

51. In addition, APD failed to present clear and convincing evidence that any residents of the group home were taken to the

hospital or were not properly cared for by Respondents because of the lack of air conditioning.

52. In sum, APD failed to present clear and convincing evidence at hearing to demonstrate a violation of rule 65G-2.009(1)(d) and section 393.13.

CONCLUSIONS OF LAW

53. DOAH has jurisdiction over the subject matter and parties pursuant to sections 120.569 and 120.57(1), Florida Statutes (2018).

54. In the instant case, Respondents have applied for the renewal of their group home licenses and challenge APD's decision to deny the renewal applications.

55. Generally, the applicant for licensure has the burden of proof to demonstrate, by a preponderance of the evidence, that it satisfies the requirements for licensure and is entitled to receive the license. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996).

56. In this particular proceeding, however, APD states in paragraph 13 of its Proposed Recommended Order that "it has been held that the denial of the renewal application is penal in nature and APD has the burden of proof by clear and convincing evidence."

57. The "clear and convincing evidence" standard requires that the evidence be found 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); Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

58. Moreover, the statutory and rule provisions upon which APD relies "must be construed strictly, in favor of the one against whom the penalty would be imposed." Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992).

59. Turning to the instant case, as to Counts I and II, section 393.0673(2)(b) expressly provides that APD "may" deny an application for licensure if DCF "has verified that the applicant is responsible for the abuse, neglect or abandonment of a child or the abuse, neglect, or exploitation of a vulnerable adult." As detailed above, it is undisputed that DCF made verified findings of abuse, neglect, or exploitation against Ms. Adams.

60. Although APD "may" deny an application for license based on verified findings by DCF, the question remains whether Respondents' licensure renewal applications should be denied. Relying solely on the stipulation regarding DCF's verified

findings of abuse, neglect, or exploitation and section 393.0673(2)(b), APD argues that non-renewal of Respondents' licensure applications is justified.[2/]

61. In Comfortable Living in Good Hands v. Agency for Persons With Disabilities, 2014 Fla. Div. Admin. Hear. LEXIS 361, *10 (Fla. DOAH July 2, 2014), upon which APD relies, a pro se litigant's application for initial licensure of a foster care facility was denied by APD because of inaccurate answers in the application. One of the questions asked if the applicant had ever been identified as responsible for the abuse or neglect of a child, to which she answered "no." During APD's review of the application and verification process, APD found there had been eight verified findings of neglect against her. At hearing, the applicant contended that some of the allegations pertaining to the DCF verified findings of neglect "may not have been completely accurate." Id. at *10. Judge David Watkins stated: "whether the allegations were true or not is not relevant to this proceeding (nor does DOAH lack jurisdiction to reconsider the findings on those allegations in this proceeding)." Id.

62. Unlike Comfortable Living, the instant case involves proposed discipline against a facility already licensed. As APD acknowledges in its Proposed Recommended Order, the instant case is penal in nature.

63. The undersigned agrees that DOAH and APD lack jurisdiction to reconsider DCF's verified findings of abuse, neglect, or exploitation against Ms. Adams. However, the specific facts and circumstances and other factors pertaining to the violations are relevant to the dispositive issue of whether Respondents' licensure renewal applications should be denied based on DCF's verified findings of abuse, neglect, or exploitation against Ms. Adams.

64. Rule 65G-2.0041, which APD references in its denial letter, represents APD's interpretation and application of the discretionary term "may" contained within section 393.0673(2)(b). Rule 65G-2.0041 sets forth various factors APD "shall" consider in determining whether to pursue disciplinary action in response to verified findings of abuse, neglect, or exploitation by DCF. In other words, rule 65G-2.0041 dictates when an application for a renewal license should be denied, where, as in the instant case, APD's denial is based on DCF's verified findings of abuse, neglect, or exploitation on the part of the facility owner. In its Proposed Recommended Order, APD fails to address rule 65G-2.0041.

65. Rule 65G-2.0041 provides as follows:

> **65G-2.0041 License Violations – Disciplinary Actions.**
>
> (1) Determination of disciplinary action involving abuse, neglect, or exploitation. In

determining whether to pursue disciplinary action in response to verified findings by the Department of Children and Families of abuse, neglect, or exploitation involving the licensee or direct service providers rendering services on behalf of the licensee, the Agency will consider the licensee's corrective action plan and other actions taken to safeguard the health, safety, and welfare of residents upon discovery of the violation. Considerations shall include the following:

(a) Whether the licensee properly trained and screened, in compliance with Section 393.0655, F.S., the staff member(s) responsible for the violation;

(b) Whether, upon discovery, the licensee immediately reported any allegations or suspicions of abuse, neglect, or exploitation to both the Florida Abuse Hotline as well as the Agency;

(c) Whether the licensee fully cooperated with all investigations of the violation;

(d) Whether the licensee took immediate and appropriate actions necessary to safeguard the health, safety and welfare of residents during and after any investigations.

(e) Whether the occurrence is a repeat violation and the nature of such violation.

(f) The specific facts and circumstances before, during, and after the violation.

(2) Factors considered when determining sanctions to be imposed for a violation. The Agency shall consider the following factors when determining the sanctions for a violation:

(a) The gravity of the violation, including whether the incident involved the abuse, neglect, exploitation, abandonment, death, or serious physical or mental injury of a

resident, whether death or serious physical or mental injury could have resulted from the violation, and whether the violation has resulted in permanent or irrevocable injuries, damage to property, or loss of property or client funds;

(b) The actions already taken or being taken by the licensee to correct the violations, or the lack of remedial action;

(c) The types, dates, and frequency of previous violations and whether the violation is a repeat violation;

(d) The number of residents served by the facility and the number of residents affected or put at risk by the violation;

(e) Whether the licensee willfully committed the violation, was aware of the violation, was willfully ignorant of the violation, or attempted to conceal the violation;

(f) The licensee's cooperation with investigating authorities, including the Agency, the Department of Children and Families, or law enforcement;

(g) The length of time the violation has existed within the home without being addressed; and

(h) The extent to which the licensee was aware of the violation.

(3) Additional considerations for Class I violations, repeated violations or for violations that have not been corrected.

(a) Subject to the provisions of subsection 65G-2.0041(1), F.A.C., in response to a Class I violation, the Agency may either file an Administrative Complaint against the licensee or deny the licensee's application for renewal of licensure.

(b) A second Class I violation, occurring within 12 months from the date in which a Final Order was entered for an Administrative Complaint pertaining to that same violation, shall result in the imposition of a fine of $1000 per day per violation, revocation, denial or suspension of the license, or the imposition of a moratorium on new resident admissions.

(c) The intentional misrepresentation, by a licensee or by the supervisory staff of a licensee, of the remedial actions taken to correct a Class I violation shall constitute a Class I violation. The intentional misrepresentation, by a licensee or by the supervisory staff of a licensee, of the remedial actions taken to correct a Class II violation shall constitute a Class II violation. The intentional misrepresentation, by a licensee or by the supervisory staff of a licensee, of the remedial actions taken to correct a Class III violation shall constitute a Class III violation.

(d) Failure to complete corrective action within the designated timeframes may result in revocation or non-renewal of the facility's license.

(4) Sanctions. Fines shall be imposed, pursuant to a final order of the Agency, according to the following three-tiered classification system for the violation of facility standards as provided by law or administrative rule. Each day a violation occurs or continues to occur constitutes a separate violation and is subject to a separate and additional sanction. Violations shall be classified according to the following criteria:

(a) Class I statutory or rule violations are violations that cause or pose an immediate threat of death or serious harm to the health, safety or welfare of a resident and which require immediate correction.

1. Class I violations include all instances where the Department of Children and Families has verified that the licensee is responsible for abuse, neglect, or abandonment of a child or abuse, neglect or exploitation of a vulnerable adult. For purposes of this subparagraph, a licensee is responsible for the action or inaction of a covered person resulting in abuse, neglect, exploitation or abandonment when the facts and circumstances show that the covered person's action, or failure to act, was at the direction of the licensee, or with the knowledge of the licensee, or under circumstances where a reasonable person in the licensees' position should have known that the covered person's action, or failure to act, would result in abuse, neglect, abandonment or exploitation of a resident.

2. Class I violations may be penalized by a moratorium on admissions, by the suspension, denial or revocation of the license, by the nonrenewal of licensure, or by a fine of up to $1,000 dollars per day per violation. Administrative sanctions may be levied notwithstanding remedial actions taken by the licensee after a Class I violation has occurred.

3. All Class I violations must be abated or corrected immediately after any covered person acting on behalf of the licensee becomes aware of the violation other than the covered person who caused or committed the violation.

(b) Class II violations are violations that do not pose an immediate threat to the health, safety or welfare of a resident, but could reasonably be expected to cause harm if not corrected. Class II violations include statutory or rule violations related to the operation and maintenance of a facility or to the personal care of residents which the Agency determines directly threaten the physical or emotional health, safety, or

security of facility residents, other than Class I violations.

1. Class II violations may be penalized by a fine of up to $500 dollars per day per violation.

If four or more Class II violations occur within a one year time period, the Agency may seek the suspension or revocation of the facility's license, nonrenewal of licensure, or a moratorium on admissions to the facility.

2. A fine may be levied notwithstanding the correction of the violation during the survey if the violation is a repeat Class II violation.

(c) Class III violations are statutory or rule violations related to the operation and maintenance of the facility or to the personal care of residents, other than Class I or Class II violations.

1. Class III violations may be penalized by a fine of up to $100 dollars per day for each violation.

2. A repeat Class III violation previously cited in a notice of noncompliance may incur a fine even if the violation is corrected before the Agency completes its survey of the facility.

3. If twenty or more Class III violations occur within a one year time period, the Agency may seek the suspension or revocation of the facility's license, nonrenewal of licensure, or moratorium on admissions to the facility.

(d) The aggregate amount of any fine imposed pursuant to this section shall not exceed $10,000.

66. In the instant case, Respondents fully cooperated in the investigations; the conduct was not willful; there were no previous or repeat occurrences of the violations; the violations were isolated and short in duration; and APD did not require a corrective action plan.

67. In fact, APD decided not to propose any disciplinary action against Respondents based on DCF's verified findings of abuse, neglect, or exploitation until the March 2018 denial letter--more than four years after DCF's verified findings in 2014, and three years after DCF's verified findings in 2015.

68. Moreover, despite having knowledge of DCF's verified findings upon completion of DCF's investigations, APD renewed Respondents' license for each of the years since the findings until the most recent renewal period for the licenses set to expire in March 2018.

69. The specific facts and circumstances before, during, and after the violations militate in favor of the renewal of Respondents' license applications.

70. As to Count III, rule 65G-2.009(7)(b) expressly provides, with respect to video monitoring, that: "[m]onitoring shall be permitted only with the written consent of resident . . . . The facility must explain when and where monitoring will occur and the purposes of the monitoring system."

71. As detailed above, Respondents violated rule 65G-2.009(7)(b) because the written consents did not allow for video monitoring in the common areas.

72. However, the lack of written consents, a Class II violation, does not support a denial of Respondents' renewal applications.

73. As detailed above, APD failed to prove the allegations in "Count IIII" by clear and convincing evidence.

74. In sum, APD did not require any corrective action plan or take any proposed disciplinary action against Respondents for several years following DCF's verified findings; renewed Respondents' applications for every year following the verified findings; and waited until March 2018 to attempt to deny the instant licensure renewal applications. This indicates that APD did not consider DCF's verified findings of abuse, neglect, and exploitation on the part of Ms. Adams and the lack of consent forms for video cameras in the common areas, standing alone at the time of these occurrences, as justifying any disciplinary action or non-renewal of Respondents' licenses.

75. It was only after the conduct alleged in "Count IIII," which was not proven by clear and convincing evidence, that APD decided to take proposed disciplinary action against Respondents' license in the form of the denial of their most recent licensure renewal applications. APD attempts to justify its most recent

and only proposed agency action against Respondents' licenses based largely on conduct that occurred years earlier, for which APD took absolutely no action other than approving Respondents' prior licensure renewal applications, and the conduct alleged in "Count IIII," which was not proven by clear and convincing evidence.

76. Of course, APD may properly consider an applicant's entire performance while licensed, including DCF's verified findings, in determining whether renewal of a license is appropriate.

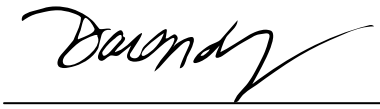
77. Although denial of Respondents' renewal licenses may be statutorily authorized under section 393.0673(2)(b) based on DCF's verified findings of abuse, neglect, or exploitation against Ms. Adams, one must question whether, in this case, it would be appropriate. Braddy v. Dep't of Health & Rehab. Servs., 1988 Fla. Div. Admin. Hear. LEXIS 4755, *12 (Fla. DOAH Dec. 12, 1988).

78. For the detailed reasons discussed above and based on the unique and particular facts of this case, Respondents' instant licensure renewal applications should not be denied based on DCF's verified findings of abuse, neglect, or exploitation on the part of Ms. Adams and the lack of written consents for video cameras in the common areas.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that that the Agency for Persons with Disability enter a final order granting Respondents' applications for licensure renewal.[3/]

DONE AND ENTERED this 22nd day of August, 2018, in Tallahassee, Leon County, Florida.



DARREN A. SCHWARTZ
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 22nd day of August, 2018.

ENDNOTES

[1/] A support coordinator is defined in section 393.063(41) as follows:

> "Support coordinator" means a person who is designated by the agency to assist individuals and families in identifying their capacities, needs, and resources, as well as finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; advocating on behalf of the individual and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and

> services to determine the extent to which they meet the needs and expectations identified by the individual, family, and others who participated in the development of the support plan.

[2/] Based on the stipulation of the parties, it is unnecessary for the undersigned to make a specific factual finding as to whether APD proved the allegations contained in Counts I and II by clear and convincing evidence.

[3/] As to Counts I and II of the denial letter, the only specific conduct alleged to support APD's non-renewal of Respondents' licensure renewal applications is the fact of DCF's verified findings of abuse, neglect, or exploitation on the part of Ms. Adams, which was stipulated by the parties.

At hearing and in its Proposed Recommended Order, APD does not rely on rule 65G-2.009(1)(d) as grounds for denial. Rather, APD contends that based on the verified findings, denial was justified based solely on section 393.0673(2)(b).

Although rule 65G-2.009(1)(d) is referenced in Counts I and II of the denial letter, APD is precluded from relying on this rule as a separate ground for denial because the only alleged conduct supporting denial is DCF's verified findings of abuse, neglect, or exploitation on the part of Ms. Adams. Smith v. Fla. Dep't of Bus. & Prof'l Reg., 182 So. 3d 767, 769 (Fla. 1st DCA 2015).

Moreover, rules 65G-2.009(1)(d) and 65G-2.0041 were adopted on July 1, 2014, after DCF's verified finding of February 25, 2014. Accordingly, these rules cannot be applied to the violation alleged in Count I because they did not exist at the time of the violation. Jordan v. Dep't of Prof'l Reg., 522 So. 2d 450, 453 (Fla. 1st DCA 1988).

Although rule 65G-2.0041 does not apply to the verified finding in Count I, and the undersigned is prohibited from applying the rule in determining whether Respondents' group home licensure renewal applications should be denied based on the February 2014 verified finding, the statutory law in effect at the time of the violation, specifically section 393.0673(2)(b), allows the undersigned and APD to consider various factors, some of which were subsequently codified by APD in the rule.

COPIES FURNISHED:

G. Barrington Lewis, Esquire
Law Office of George B. Lewis
19601 Skyhawk Lane
Loxahatchee, Florida 33470
(eServed)

Trevor S. Suter, Esquire
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950
(eServed)

Gypsy Bailey, Agency Clerk
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 335E
Tallahassee, Florida 32399-0950
(eServed)

Richard D. Tritschler, General Counsel
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950
(eServed)

Barbara Palmer, Director
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 380
Tallahassee, Florida 32399-0950
(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.