STATE OF FLORIDA
AGENCY FOR PERSONS WITH DISABILITIES

AGENCY FOR PERSONS WITH DISABILITIES,
Petitioner,

v. DOAH Case #: 18-2751

MIRACLES HOUSE, INC.; AND FELICIA WHIPPLE, AS OWNER AND OPERATOR OF MIRACLES HOUSE, INC., GROUP HOME,
Respondent.
_____/

FINAL ORDER

This cause is before the Agency for Persons with Disabilities (Agency) for entry of a final order following the Division of Administrative Hearing's (DOAH) issuance of a Recommended Order.

On April 16, 2018, the Petitioner filed an administrative complaint against the Respondents. On May 23, 2018, the Respondents filed a "Petition to Request Fromal [sic] Review Hearing on Administrative Complaint". On May 29, 2018, the Agency filed this case with DOAH.

Following an administrative hearing conducted by video teleconference before a designated Administrative Law Judge (ALJ) of DOAH on July 27, 2018, the ALJ issued a Recommended Order on September 17, 2018, recommending the

Agency enter a final order finding Miracles House, Inc. in violation of Rule 65G-2.009(1)(a)1., Florida Administrative Code, and Section 393.0673(1)(a)2., Florida Statutes; suspending its license to operate a group home until its right to furnish Medicaid services and receive payment from Medicaid in Florida is restored; and imposed a fine of $100.00. A copy of the Recommended Order is attached to this final order.

Specifically, the Recommended Order found:

1. Regarding client 1, the Agency did not clearly show that the support plan's statement that the client requires 24 hours of supervision created a legal obligation for the Respondent to provide constant supervision; the Respondent failed to facilitate the implementation of the support plan; and there was no compelling evidence to show that the client was subjected to abuse or exploitation by the Respondent.
2. Regarding client 2, the Agency did not show that the Respondent failed to have written criteria and procedures for termination in place or that they were not consistent with Chapter 65G-3, Florida Administrative Code.
3. The parties stipulated that AHCA had terminated the Respondent's Medicaid provider number in July 2017.

Further, the Recommended Order stated these conclusions of law:

1. **Count I**
    a. Because the Agency is without authority to discipline the Respondent's conduct regarding client 1 without prior action by DCF, the allegation that Respondent violated Rule 65G-2.009(1)(d), Florida Administrative Code, must be rejected.
    b. The Agency proved by clear and convincing evidence that the Respondent failed to facilitate the implementation of client 1's support plans, in violation of Rule 65G-2.009(1)(a)1., Florida Administrative Code.
2. **Count II:** The Agency failed to prove by clear and convincing evidence that the Respondent violated Rule 65G-2.009(3)(a) or 65G-3.002(4), Florida Administrative Code.
3. **Count III:** The Agency proved by clear and convincing evidence that the Respondent violated Section 393.0673(1)(a)2., Florida Statutes.
4. **Penalty:**
    a. The Respondent's seeking to increase supervision of client 1 and believing it was unable to legally restrain him were mitigating factors under Rule 65G-2.0041(2), Florida Administrative Code.

b. The Respondent's loss of the right to furnish Medicaid services and receive Medicaid payments and APD's failure to establish criteria for evaluating the severity of the violation and for determining the fine amount, coupled with the absence of evidence as to the reason for the Medicaid action, precluded revocation of the license.

The Petitioner filed timely exceptions to the Recommended Order, and pursuant to Section 120.57(1)(k), Florida Statutes, the exceptions are addressed individually below.

1. **Exception to Paragraphs 91-94 (Count I) of the Recommended Order:** The Petitioner argues that ALJ misconstrued the law the Petitioner relied upon in its Administrative Complaint, by reading it to require verified findings by DCF whenever the Petitioner seeks to take disciplinary action against a licensee.

   In its Recommended Order on page 23, the ALJ stated that the administrative complaint alleged a violation of Section 393.0673(2)(a)4. That is not the case: The Agency focused on Section 393.0673(1), actually citing to all provisions of (1) on the first page of its complaint to note the Agency's full authority regarding licenses. The Agency then made specific rule and statute references in each of the counts: Rule 65G-2.009(1)(a)1.(d), Florida Administrative Code, and Section

393.13(3)(a), Florida Statutes, in Count 1; to violations of Rules 65G-2.009(3)(a), 3.002(4), and 3.002(5), Florida Administrative Code, in Count 2; and to Section 393.0673(1), Florida Statutes, in Count III concerning penalties.

Section 393.0673(1), Florida Statutes, provides that the Agency may revoke or suspend a license, or impose an administrative fine, if (a) **or** (b) applies. Specifically, (1)(a) states that the license may be revoked or suspended, or an administrative fine imposed, if the licensee has falsely represented or omitted a material fact; had prior action taken against is under Medicaid or Medicare; or failed to comply with the applicable requirements of the statutes or rules. Subsection (1)(a) ends with the word "or" at the end of (1)(a)3., which is followed immediately by Subsection (1)(b),[1] which provide that the license may be revoked or suspended, or an administrative fine imposed, if DCF has made verified findings of abuse.

In its Recommended Order, the ALJ focused on the provisions of Section 393.0673(1)(b), Florida Statutes, in concluding that, because this section

[1] Subsection (1)(b) was added to Section 393.0673, Florida Statutes, in 2008; subsection (1)(a) was already in existence. The 2008 House of Representatives staff analysis of House Bill 7075 clearly indicates that (1)(b) was added to the statute to provide **additional** criteria to the statute to allow the Agency to deny, revoke or suspend a license or impose a fine. See page 4 ("The current statute does not give APD clear authority to deny a license to an applicant who may meet one **or** both of the above criteria.") (emphasis supplied).

requires a DCF verified finding and the Petitioner failed to provide such a finding, the Petitioner is without authority to discipline the Count I conduct regarding Client 1 and the Respondent's failure to properly supervise.

However, as noted above, Count I of the Administrative Complaint did not cite to Section 393.0673(1)(b), Florida Statutes, as the authority for discipline; instead, the complaint cited, in the paragraph before Count I, only to Section 393.0673(1)(a), Florida Statutes. Accordingly, the Agency rejects the ALJ conclusion that the Petitioner is without authority to discipline a licensee without prior action by DCF.

2. **Exception to Paragraph 115 (penalty) of the Recommended Order**:

The Petitioner argues that the ALJ misconstrued Section 393.0673(1)(a)2., Florida Statutes, which provides that APD may revoke or suspend a license, or impose an administrative fine, if the licensee has "[h]ad prior action taken against it under the Medicaid or Medicare program".

On page 37 of the Recommended Order, the ALJ stated that revocation was precluded as a penalty because, although the Respondent had lost the right to furnish Medicaid services, the Petitioner had failed to show the reason for the loss; and the Petitioner failed to establish criteria for

evaluating the severity of the violation and for determining the fine. First, the statute does not require the Petitioner to prove why AHCA terminated the Medicaid Waiver Services Agreement with the Respondent. Instead, the statute states only that a licensee must have "[h]ad prior action taken against it under the Medicaid or Medicare program." The Petitioner proved this with Exhibit 3, which shows that AHCA exercised its right under the agreement to terminate without cause upon 30 days' written notice. AHCA was not required to state a reason for the termination, and the ALJ misconstrued the law by requiring the Petitioner to prove such a reason.

Second, even if the Petitioner did not establish the criteria for evaluating the severity of the violation and for determining the fine, the statute and rule adequately establish these. Specifically, Rule 65G-2.0041(2), Florida Administrative Code, requires consideration of the following factors in determining sanctions for license violations:

(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 Petitioner, 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.

See also Section 393.0673(1), Florida Statutes.

Here, the record shows as follows:

(a) The Respondent's failure to adequately supervise client 1 could have resulted in serious physical or mental injury. See Recommended Order at 25 ("The sheer volume of incidents involving Client [1] amply demonstrates that the supervision he was given was inadequate . . . ."). See the Petitioner's Exhibits 6 – 18.

(b) The Respondent requested an increase in the level of care for RH. See Transcript of Hearing at 25-26.

(c) See (a) above.

(d) See the Petitioner's Exhibit 1, noting a maximum resident capacity of 6.

(e) There is no record evidence that the violations were willful.

(f) There is no record evidence of cooperation. See the Petitioner's Exhibit 6.

(g) The Respondent had a "continuing inability to meet Client [1]'s considerable needs as outlined in the support agreement obligated it to terminate service to him, as it had done once before in **2015**, when it realized it could not meet his needs." Recommended Order at 26 (emphasis supplied). See also the Petitioner's Exhibit 6.

(h) See (a) and (g) above and Transcript of Hearing pages 15 and 21-26 (Client 1 arrested and Baker Acted numerous times, multiple instances of elopement).

An agency cannot reduce or increase the recommended penalty without a review of the "complete record and [stating] with particularity its reasons therefore in the order, by citing to the record in justifying the action." Withers v. Blomberg, 41 So. 3d 398, 400 (Fla. 2d DCA 2010). The purpose of Section 120.57(l), Florida Statutes, "is to provide some assurance that the agency has gone through a thoughtful process of review and consideration before making a determination to change the recommended penalty." Id. (quoting Hutson v. Casey, 484 So. 2d 1284, 1285-86 (Fla. 1st DCA 1986)).

Here, of the eight factors listed in the rule, at least six were substantial issues for the Respondent – (a), (c), (d), (f), (g) and (h). Of these six, (a), (c), (g) and (h) were the most egregious. Given these factors, and the ALJ's misunderstanding of the law noted above, license suspension and a $100 fine are inappropriate penalties. Revocation of the group home license is the more appropriate penalty.

Accordingly, the Agency adopts the Petitioner's exceptions regarding paragraphs 92-94 and 115 of the Recommended Order and revokes the group home license.

DONE AND ORDERED in Tallahassee, Leon County, Florida, on November 13, 2018

Tom Rankin, Deputy Director of Operations
Agency for Persons with Disabilities

NOTICE OF RIGHT TO APPEAL

A party who is adversely affected by this final order is entitled to judicial review. To initiate judicial review, the party seeking it must file one copy of a "Notice of Appeal" with the Agency Clerk. The party seeking judicial review must also file another copy of the "Notice of Appeal," accompanied by the filing fee required by law, with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the rendition of this final order.[2]

Copies furnished to:

Trevor Suter, APD Senior Attorney
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DOAH
Filed via e-ALJ

Jeff Smith, Regional Operations Manager
APD Suncoast Region

I HEREBY CERTIFY that a copy of this Final Order was provided by regular US or electronic mail to the above individuals at the addresses listed on November 15, 2018.

Gypsy Bailey

Gypsy Bailey, Agency Clerk
Agency for Persons with Disabilities
4030 Esplanade Way, Suite 335
Tallahassee, FL 32399-0950
apd.agencyclerk@apdcares.org

[2] The date of "rendition" of this Final Order is the date that is stamped on its first page. The Notices of Appeal must be received on or before the 30th day after that date.

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR PERSONS WITH DISABILITIES,

Petitioner,

vs. Case No. 18-2751FL

MIRACLES HOUSE, INC.; AND FELICIA WHIPPLE, AS OWNER AND OPERATOR OF MIRACLES HOUSE, INC., GROUP HOME,

Respondents.
_____/

RECOMMENDED ORDER

On July 27, 2018, a final hearing was held by video teleconference at sites in Miami and Tallahassee, Florida, before F. Scott Boyd, an Administrative Law Judge assigned by the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Trevor S. Suter, Esquire
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For Respondents: Adres Jackson-Whyte, Esquire
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Miami, Florida 33168

STATEMENT OF THE ISSUES

The issues to be determined are whether Respondent, Miracles House, Inc. (Respondent or Miracles), as licensee of

Miracles House, Inc., a group home facility, violated provisions of section 393.0673, Florida Statutes (2017), and administrative rules,[1/] as alleged in the Administrative Complaint; and, if so, what is the appropriate sanction.

PRELIMINARY STATEMENT

On or about April 16, 2018, Petitioner Agency for Persons with Disabilities (Petitioner or APD) filed an Administrative Complaint against Miracles. Miracles disputed allegations in the complaint and requested a hearing pursuant to section 120.57(1), Florida Statutes. On May 29, 2018, the case was referred to DOAH, where it was scheduled for final hearing by video teleconference[2/] on July 27, 2018.

Through a joint Pre-hearing Stipulation, the parties stipulated to certain facts, which were accepted and are included among the findings of fact below. Petitioner offered the testimony of four witnesses: Ms. Rosa Llaguno, an operations management consultant for APD; Mr. Kwame Lumumba, a contracted waiver support coordinator; Ms. Leonaise Loriston, another support coordinator; and, on rebuttal, Mr. Tom Rice, a program administrator at APD. An earlier order of APD terminating a Medicaid Waiver Services Agreement, Felicia Whipple, as Owner/Operator of Miracles House, Inc. v. Agency for Persons with Disabilities, Case No. 17-6025FL (Fla. DOAH May 23,

2018; Fla. APD July 12, 2018), was officially recognized upon motion by Petitioner, without objection from Respondent.[3/]

Petitioner offered 22 exhibits, P-1 through P-22, all of which were admitted. Petitioner's Exhibit P-22, a memorandum entitled "Summary of Justification for Dismissal" pertaining to APD's dismissal from employment of Ms. Ruby Joyce Pace, a former part-time licensing and monitoring specialist, was late-filed, as authorized at the hearing.

Respondent presented the testimony of Ms. Felicia Whipple, a member of the board of directors of Miracles and the on-site manager of the group home, and over objection, that of Mr. Lumumba and Ms. Pace. Respondent offered six exhibits, R-1 through R-6, all of which were admitted.

The two-volume Transcript of the proceeding was filed with DOAH on August 15, 2018. Both parties timely submitted proposed recommended orders, which were considered.

FINDINGS OF FACT

1. APD is responsible for regulating the licensing and operation of group home facilities in the state of Florida. APD's clients include vulnerable individuals with developmental disabilities attributed to autism, cerebral palsy, intellectual disabilities, Phelan-McDermid syndrome, Prader-Willi syndrome, or spina bifida.

2. APD's clients can choose to live in an institutional setting, group home, or independently. A client is assisted in this choice by a residential placement coordinator. A group home is a licensed facility providing a living arrangement similar to a family setting. It is the provider's responsibility to provide not only room and board but also safety, transportation, assistance with the activities of daily living, and to attempt to provide all residential habilitation services at the level needed by the client, as established by the client with a waiver support coordinator.

3. A waiver support coordinator is an independent contractor for APD who acts as a case manager and is responsible for coordinating the services provided to a client.

4. Support plans are prepared and submitted to APD by a client's waiver support coordinator. A support plan is a "snapshot" of a client's life. It includes a summary of events and activities that have occurred throughout the year, including hospitalizations, medications, and the client's goals.

5. The resources and capabilities available to a client and his support givers are not always sufficient to meet all of the client's needs. The support plan is implemented to maximize the attainment of habilitative goals. The support plan is periodically reviewed to assess progress toward habilitative and

medical objectives and revised annually after consultation with the client.

6. Each client is assigned a level of care code that relates to payment made to the group home on the client's behalf. As its name suggests, there is some correlation between the level of care code that is assigned and the level of care to be given by the provider, but because additional services may be provided by other individuals and resources, the assigned level of care does not necessarily reflect all needs and services necessary for, or being provided to, the client.

7. If a group home believes that it cannot provide the required residential habilitation services or meet its responsibilities with respect to a particular client, it can make this known to the waiver support coordinator. Adjustments are periodically made to the support plan, including the level of care code. If adjustments sufficient to address the provider's concerns are not made, a group home may request that a client be placed in another facility.

8. APD issued license number 11-1088-GH to Miracles for the purpose of operating a group home located at 113211 Northwest 26th Court, Miami, Florida.

9. Ms. Whipple is a corporate officer of Miracles and the on-site manager of its group home.

10. There was no evidence introduced indicating that Miracles had previously received discipline based upon its group home license.

Client [redacted]

11. At all times material to this case, Client [redacted] was a resident of Miracles' group home, where he has lived for several years. Client [redacted] has an intellectual disability.

12. Mr. Lumumba was a contracted waiver support coordinator working with APD. He began work in this capacity in July of 2016 and was assigned to Client [redacted] at that time. Mr. Lumumba prepared support plans and many incident reports for Client [redacted] after that date. Incident reports prior to Mr. Lumumba's service were also admitted into evidence.

13. Successive support plans repeat much of the narrative from prior plans, and because only selected plans were introduced into evidence, it is difficult to determine exactly when many of the additions or entries were made. Client [redacted] is reported as having suicidal thoughts, and it is noted that when he is under the influence of drugs, he requires support and direction to be safe. He is described as needing reminders, instruction, redirection, and support to avoid danger and to remain healthy and safe. Notations in the support plans and numerous incident reports document a distinct pattern of behaviors by Client [redacted]

14. In an incident report dated January 26, 2015, it was reported that Client [redacted] became agitated, left the group home alone, and walked to the Mental Health Center located at Northwest 27th Avenue and 151st Street. He was later transported by the Mental Health Center staff to Jackson Memorial Behavioral Health Unit and admitted.

15. In an incident report dated February 11, 2015, it was reported that Client [redacted] became agitated and left the group home to go to the store, refusing to be accompanied by staff. He later presented himself at North Shore Medical Center where he was admitted to the Crisis Stabilization Unit.

16. In an incident report dated February 17, 2015, it was reported that Client [redacted] visited his mother, got into an argument with her, left her home, and went to Memorial Regional Hollywood Emergency Room (ER). He was later discharged in the care of Miracles' group home staff.

17. In an incident report dated March 30, 2015, it was reported that Client [redacted] became argumentative and left the group home unaccompanied under the pretext of going to the nearby corner store. He traveled to the North Shore Medical Center ER and was admitted to the Behavioral Health Unit. He was discharged on March 25, 2015, and returned to Miracles by hospital staff.

18. A July 19, 2015, update to the Client [redacted] support plan indicates that Client [redacted] reported that he was not abused at the Miracles' group home, and that he felt safe and wanted to stay there.

19. In an incident report dated August 14, 2015, it was reported that Client [redacted] left the group home and went to the North Shore Medical Center ER, where he was admitted as a psychiatric patient. The group home was informed he would be kept for 72 hours and then discharged.

20. In an incident report dated August 18, 2015, it was reported that Client [redacted] "eloped" from the group home. He later made contact with his mother, began acting in bizarre ways, and said he needed drugs. He ran into the street shouting, began to undress, and lay down in front of cars. He was taken to Aventura Hospital and admitted as a psychiatric patient.

21. A September 21, 2015, update to the support plan reflects that Client [redacted] had moved out of the Miracles group home to stay with his sister.

22. In September of 2015, Client [redacted] was removed from Miracles at Dr. Whipple's request, made 30 days earlier, according to Mr. Lumumba.

23. A December 14, 2015, entry in the support plan indicates that Client [redacted] went to jail in October 2015 for

trespassing and petty theft. When he was released on December 6, 2015, he asked to return to Miracles' group home.

24. The support coordinator was unable to place Client [redacted] in another group home, and Miracles' group home was requested to take him back, which it did.

25. In an incident report dated February 12, 2016, it was reported that Client [redacted] became agitated, argumentative, and uncontrollable. He walked to the street, pulled down his pants, screamed, and began to roll around in the street. Police were called, and he was arrested and transported to the North Shore Medical Center.

26. In an incident report dated March 9, 2016, it was reported that Client [redacted] was verbally and physically out of control. He went to the street in front of the house, fell to the ground, and began rolling around. He could not be physically restrained or verbally redirected. The police were called, and he was restrained and taken to North Shore Medical Center where he was admitted for psychiatric treatment.

27. In an incident report dated March 17, 2016, it was reported that police arrived at the facility and arrested Client [redacted] for a 2014 charge of stealing church equipment.

28. During the annual support plan meeting on June 1, 2016, Client [redacted] indicated that he still felt comfortable at the group home and said that "Ms. Felicia" (Whipple) was like a

mother to him. Client [redacted] indicated he had been going to church with her every Sunday since he returned to the group home in December.

29. The July 1, 2016, support plan prepared by Mr. Lumumba suggested that the rate for client [redacted] be changed from minimal to moderate and stated:

> [Client [redacted] requires 24 hours' supervision to ensure health and safety as he suffers from insomnia, seizures, psychosis and mood disorder, Bipolar, depression, and drug addictions. The approval of this services request will ensure that [Client [redacted]] receives the support that he needs to achieve his goal and maintain a healthy life style.

30. The July 1, 2016, support plan also noted:

> Consumer has had history of abuse in the past when he was living with his mother. He was abused by mother's boyfriend. However since he has been at Miracle House, there was an abuse allegation made by [Client [redacted] mother, however it was investigated and they have find that the mother was the one who initiated the allegation. There was no foundation on those allegations. No history of abuse or neglect that has been documented in his records.

Mr. Lumumba testified that the notations in the support plans that Client [redacted] required 24-hour supervision were "recommendations" as opposed to "requirements."

31. In an incident report dated July 13, 2016, it was reported that Client [redacted] went to his mother's housing complex unannounced, where security was unable to reach his mother, and

he was denied access. He became agitated, verbally aggressive, and out of control. The police were called, and he was taken to Hialeah Hospital.

32. In an incident report dated July 23, 2016, it was reported that Client [redacted] left the group home without stating where he was going. He failed to return to the group home overnight. His mother called the group home to inform staff that he had been arrested after police approached him and found crack cocaine in his possession.

33. A support plan update dated December 1, 2016, indicates that Miracles requested a change from "minimal" to "moderate" behavioral focus to provide additional services to Client [redacted]

34. In an incident report dated December 5, 2016, it was reported that Client [redacted] was verbally abusive, out of control and agitated, screaming and cursing staff, and running in the street. The report states that police were called, and he was transported to North Shore Medical Center's crisis unit. He was discharged from North Shore Medical Center and returned to the group home on December 7, 2016.

35. In an incident report dated December 28, 2016, it was reported that Client [redacted] went to his mother's housing complex unannounced, where security was unable to reach his mother, and he was denied access. He became agitated, verbally aggressive,

and out of control. The police were called, and he was taken to Hialeah Hospital.

36. In an incident report dated February 25, 2017, it was reported that Client [redacted] informed staff at about 10:00 p.m. that he was going to buy cigarettes from the corner store. He did not return and called the group home from the jail to report that he had been stopped by police, searched, and arrested for possession of crack cocaine.

37. In an incident report dated March 27, 2017, it was reported that Client [redacted] told staff he was going to a store to buy cigarettes. He did not return and was assumed to be at his mother's house. His mother called late in the afternoon to report that he had gone to the North Shore Medical Center ER and been admitted to the crisis unit.

38. Ms. Whipple testified that in March of 2017, Client [redacted] level of care code was changed to Extensive 1.

39. In an incident report dated April 6, 2017, it was reported that Client [redacted] became agitated, combative, and threatening. Staff was unable to de-escalate his behaviors. Police were called, and he was taken to North Shore Medical Center.

40. In an incident report dated April 17, 2017, it was reported that Client [redacted] went to visit his mother on Easter morning. His mother called in late afternoon to report that he

had gone to North Shore Medical Center ER and been admitted to the crisis unit.

41. In an incident report dated April 26, 2017, it was reported that Client [redacted] left the group home in the afternoon for cigarettes. He did not return. His mother called at 10:30 p.m. to report that he had called her from Palmetto General Hospital where the police had taken him.

42. In an incident report dated May 7, 2017, it was reported that Client [redacted] left the group home for cigarettes but walked to the Jackson Memorial Hospital mental health unit instead, where he was admitted.

43. In an incident report dated May 17, 2017, it was reported that Client [redacted] left the group home saying he needed cigarettes from the store. He later called his mother to report that he had been picked up by the police for burglary.

44. In an "annual summary" entry in the support plan, it was noted, in relevant part:

> [Client [redacted] has not make much progress this year. He has been in and out of Crisis and has been Backer Acted too many times and at the time that I'm writing this Support plan, [Client [redacted]] is an crisis since May 17-2017. [Client [redacted]] needs another supportive alternative program to rehabilitate him for his constant going to crisis. He need to be a program where he can be monitored and with a restricted rules and regulation and Medical intervention or his constant substance issues.

45. In an incident report dated May 28, 2017, it was reported that Client [redacted] left the group home to go to his mother's home on May 27, 2017, and did not return as expected. He called the group home on May 28, 2017, and said he was at Jackson Memorial Hospital in the crisis unit. He was released on May 29, 2017.

46. In an incident report dated June 5, 2017, it was reported that Client [redacted] left the group home to go to the store the previous day and failed to return. His mother called to report that he had been arrested for breaking and entering and stealing merchandise from someone's home.

47. Following the 2017 support plan meeting, in which the number of incident reports and alternatives to address Client [redacted] drug issues were discussed, the July 1, 2017, support plan stated that "[Client [redacted] has been unpredictable and it require a lot of man power to really keep [Client [redacted]] living at Miracles House, the group home is asking the Behavior analyst to have [Client [redacted]] level of care has been approved to change from Moderate to Extensive Behavior focus [] 1." Mr. Lumumba noted that no abuse or neglect had been reported since he began working with Client [redacted] in 2015.

48. In an incident report dated August 5, 2017, it was reported that Client [redacted] became verbally agitated and physically aggressive with medical staff while at an appointment

at a mental health provider. The report states that police were called, and Client [redacted] was "taken under Baker Act."

49. In an incident report dated August 14, 2017, it was reported that Client [redacted] left the group home for cigarettes. He called later to say that he had checked himself in at Jackson Memorial Hospital ER.

50. In an incident report dated November 29, 2017, it was reported that Client [redacted] left the group home to purchase cigarettes and did not return. His mother called to report that he had been arrested for property theft.

51. In an incident report dated January 27, 2018, it was reported that Client [redacted] became agitated and said he wanted to go to the crisis unit. He called the police, and when they arrived, he was outside running up and down in front of the home and saying he wanted to go to the hospital. He was taken to North Shore Medical Center Crisis Unit.

52. In an incident report dated February 12, 2018, it was reported that Client [redacted] began screaming uncontrollably. He became verbally aggressive, ran outside the facility, said he wanted to kill himself, and asked for the police to be called. After unsuccessful attempts to de-escalate the situation, police were called, and he was taken to North Shore Medical Center's crisis unit.

53. In an incident report dated March 26, 2018, it was reported that Client [redacted] left to get items from the corner store and did not return. North Shore Medical Center called to say he had arrived there. He was admitted.

54. In an incident report dated May 30, 2018, it was reported that Client [redacted] left the group home to get items from the store. He called in the afternoon saying he had gone to Jackson Memorial Hospital ER and been admitted into the crisis unit.

55. In an incident report dated June 2, 2018, it was reported that Client [redacted] went to his mother's home for a visit, where he initiated an altercation with his mother. He was taken to the North Shore Medical Center Crisis Unit.

56. In an incident report dated June 12, 2018, it was reported that Client [redacted] left the group home. His mother later advised that he had walked to Jackson North and checked himself into the Crisis Unit.

57. In an incident report dated June 26, 2018, it was reported that Client [redacted] left the group home to go to the store. He wandered in to North Shore Medical Center and stated he was not feeling well. He was admitted as a medical patient.

58. Ms. Whipple testified that Client [redacted] was a competent adult and that she was legally unable to restrain him. She testified that he always asked for permission to leave. But

when they told him he could not go, she testified, he would get mad and storm out the door anyway.

59. Ms. Whipple recognized that Client [redacted] required a great deal of supervision, and she requested that his level of care code be increased, so that she would be compensated in part for her increased responsibilities, but she testified that she was never focused that much on the amount of money she was receiving.

60. Ms. Whipple testified that she trained her staff to redirect Client [redacted] behaviors to ensure that he would not run off. She stated that an Extensive 1 level meant that he should be closely watched, and that is what the staff at Miracles' group home was trained to do.

61. Mr. Lumumba testified that he had tried to place Client [redacted] in other group homes, but that Miracles' group home was the only place that he knew Client [redacted] would survive.

62. The notations in these incident reports and support plans strongly support Mr. Lumumba's sentiment that Client [redacted] "needs another supportive alternative program to rehabilitate him for his constant going to crisis."

63. APD did not clearly show that the support plan's statement that Client [redacted] "requires 24 hours' supervision" created a legal obligation for Miracles to literally provide constant supervision.

64. APD did clearly and convincingly show that Miracles failed to facilitate the implementation of Client [redacted] support plan, because, taken as a whole, it obviously required a very high level of supervision that Miracles could not, or did not, provide.

65. APD does not argue, and there was no evidence to show, that Client [redacted] dignity was infringed, that his right to privacy was violated, or that he was subjected to inhumane care, harm, unnecessary physical, chemical or mechanical restraint, isolation, or excessive medication.

66. There was no evidence that the Department of Children and Families (DCF) verified that Miracles was responsible for any abuse, neglect, or exploitation of Client [redacted] The record contains evidence of a single DCF investigation into allegations of maltreatment and inadequate supervision, opened on November 30, 2017, and closed on January 22, 2018. That investigation concluded that the allegations were not substantiated, that no intervention services or placement outside the home was needed, and that Client [redacted] needs were being met.

67. There was no compelling evidence to show that Client [redacted] was subjected to abuse or exploitation by Miracles while at the group home.

Client [redacted]

68. Client [redacted] has an intellectual disability and lived at Miracles' group home from May until December of 2017.

69. In an incident report filed by Ms. Loriston dated December 14, 2017, it was reported, in relevant part, that:

> On 12/14/17 at 6:15 pm wsc received a phone call from Ms. Felicia Whipple stating that she threw the consumer's belonging in the front yard as she is no longer welcome to her group home. Ms. Whipple also stated that [Client [redacted]] is on the way home from her part-time job, she contacted [Client [redacted] to let her know of her belongings bein in the front yard. [Client [redacted] contacted law enforcement because she feared for her safety, WSC immediately was able to find an emergency accommodation at Paradise Gaine Group Home.

70. While she testified that her report was accurate, Ms. Loriston described the events a bit differently at hearing. She testified that Ms. Whipple called her to say that Client [redacted] could no longer come back to the group home and that her belongings would be waiting for her in front of the door. She specifically testified that Ms. Whipple did not tell her that she threw Client [redacted] belongings in the front yard, but rather told her that they were at the front door. Ms. Loriston testified that when she arrived at Miracles' group home, she did not see the belongings, that the incident was over, and the police were gone.

71. In an incident report filed by Ms. Whipple, dated December 16, 2017, it was reported that:

> Consumer receives her Social Security Disability Check and she is currently employed at MACY's. From these funds she refused to pay Room and Board and refused to move from the facility. Following a confrontation requesting payment, she left the facility and returned later with 2 cars loaded with family and associates to the facility to threaten the owner and the facility. Police were called and APD, Residential Services Coordinator, Carey Dashif. He along with the WSC coordinated the transition of consumer to another group home in the interest of safety for Miracles House residents and staff.

72. Ms. Loriston's account of events was less than clear and convincing due to the discrepancies between her statement in the incident report and her testimony at hearing. She did not actually see any of the events of that evening and did not remember distinctly the exact admissions of Ms. Whipple, the critical competent evidence in the case. She was consistent in her testimony that Ms. Whipple admitted she had moved Client [redacted] belongings. Her remaining testimony was largely hearsay.

73. While Ms. Whipple's account of events was less than credible, it was not her burden to prove what happened.

74. Ms. Llaguno testified that the proper procedure to terminate services to Client [redacted] would have been for Miracles to send a 30-day notice terminating the placement. Ms. Loriston similarly testified that this was also her understanding.

Remarkably, no APD rule establishing this policy was recognized or identified at hearing, however. Neither were Miracles' written criteria or procedures for termination of residential services introduced. Though Ms. Loriston's testimony that she had to immediately find other housing for Client [redacted] is credited, violation of APD rules was not clearly shown.

75. APD did not show that Miracles failed to have written criteria and procedures for termination in place or that they were not consistent with Florida Administrative Code Chapter 65G-3.

Medicaid Action

76. As stipulated by the parties, in July of 2017, the Agency for Health Care Administration took action against Miracles by terminating its Medicaid provider number.

77. As stipulated by the parties, Miracles lost its Medicaid provider authorization, and has lost the right to furnish Medicaid services and receive payment from Medicaid in Florida.

78. No evidence as to the basis for, or purposes of, the Medicaid termination was introduced.

79. There was no evidence that Miracles previously had its license to operate a residential facility revoked by APD, DCF, or the Agency for Health Care Administration.

CONCLUSIONS OF LAW

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

81. Petitioner is responsible for regulating the licensing and operation of group home facilities pursuant to section 20.197 and chapter 393, Florida Statutes.

82. Petitioner seeks to take action against Respondent's group home license pursuant to section 393.0673. In a proceeding to impose discipline against a license, Petitioner bears the burden to prove the allegations in the Administrative Complaint by clear and convincing evidence. § 120.57(1)(k), Fla. Stat.; Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

83. The clear and convincing standard requires that:

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

In re Henson, 913 So. 2d 579, 590 (Fla. 2005)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

84. The Administrative Complaint cites section 393.0673, which at the time of the alleged offenses, provided, in relevant part:

> (1) The agency may revoke or suspend a license or impose an administrative fine, not to exceed $1,000 per violation per day, if:
>
> (a) The licensee has:
>
> * * *
>
> 2. Had prior action taken against it under the Medicaid or Medicare program; or
>
> 3. Failed to comply with the applicable requirements of this chapter or rules applicable to the licensee;

While the Administrative Complaint also alleged a violation of section 393.0673(2)(a)4. (relating to prior revocation of a residential facility license by the agency, DCF, or the Agency for Health Care Administration), it is clear from the statutory language that this provision is not applicable to an Administrative Complaint, but only to denial of applications for licensure.[4/]

Count I

85. In Count I, Petitioner asserts that Client [redacted] Support Plan stated that he "requires 24-hour supervision" that was not provided by Respondent. Petitioner asserts that Client [redacted] should never have been allowed to leave the group home without someone supervising, but that Respondent allowed him to

freely leave the group home. Petitioner asserts that Respondent did not take responsibility to ensure Client [redacted] health, safety, and welfare.

86. Petitioner alleges that these actions violated portions of Florida Administrative Code Rule 65G-2.009(1):

> (1) MINIMUM STANDARDS. Residential facility services shall ensure the health and safety of the residents and shall also address the provision of appropriate physical care and supervision.
>
> (a) Each facility shall:
>
> 1. Facilitate the implementation of client support plans, behavior plans, and any other directions from medical or health care professionals as applicable.
>
> * * *
>
> (d) The facility shall adhere to and protect resident rights and freedoms in accordance with the Bill of Rights of Persons with Developmental Disabilities, as provided in Section 393.13, F.S., Violations of Section 393.13(3)(a), F.S., relating to humane care, abuse, sexual abuse, neglect, or exploitation and all violations of Section 393.13(3)(g), F.S., shall constitute a Class I violation.

87. The introductory language in subsection (1) of the rule is best interpreted in conjunction with the more detailed provisions in the paragraphs which follow. Subparagraph (a)1. of the rule does not require a group home to "implement" client support plans, but instead requires it to "facilitate the implementation" of such plans. This "softer" language is

interpreted to require active good faith efforts and substantial compliance with the plans, but not to impose strict responsibility for every implementation failure.

88. The waiver support coordinator, Mr. Lumumba, who drafted the support plans for Client [redacted] testified that the notations on 24-hour supervision were "recommendations" of the support plan as opposed to "requirements" of the support plan. But Count I was not predicated on such a narrow ground, for the broader services and goals established for Client [redacted] by the plans clearly indicated, when taken as a whole, that Client [redacted] was schizoaffective, chronically depressed, and often under the influence of drugs. His pattern of running away from the group home and becoming involved with police or being admitted to medical facilities was undeniable. The sheer volume of incidents involving Client [redacted] amply demonstrates that the supervision he was given was inadequate, and for enough of these, the responsible party was Respondent.

89. Regardless of whether Respondent was required to literally provide 24-hour supervision of Client [redacted], it clearly was required to facilitate the implementation of the support plan, which amply documented and required a high level of supervision to ensure Client [redacted]'s health and safety. This Miracles failed to do.

90. Miracles admits, to a point, that it was unable to provide the support Client [redacted] required, noting in defense that it had requested a higher level of care code to obtain more resources and that it could not legally restrain Client [redacted], who was a competent adult. However true, Miracles' continuing inability to meet Client [redacted] considerable needs as outlined in the support agreement obligated it to terminate services to him, as it had done once before in 2015, when it realized it could not meet his needs. Miracles' implicit (and reasonably convincing) further argument that Client [redacted] was in fact better off at Miracles than in the care of any other group home--while possibly a persuasive indictment of the overall system of group home care for the developmentally disabled--is similarly unavailing as a defense against the charged violation of rule 65G-2.009(1)(a)1.

91. As for rule 65G-2.009(1)(d), the Administrative Complaint was not clear as to which of Client [redacted] resident rights or freedoms were allegedly violated. There was no compelling evidence or argument that Client [redacted] dignity was infringed, that his right to privacy was violated, or that he was subjected to unnecessary physical, chemical, or mechanical restraint, isolation, or excessive medication.

92. Section 393.0673(1)(b) provides that Petitioner may take disciplinary action against a licensee if the DCF has

verified that the licensee is responsible for the abuse, neglect, or exploitation of a vulnerable adult.[5/] This legislative interjection of DCF action as a necessary predicate to such discipline is duplicated in those provisions applicable to initial licensure, perhaps as a "check" or "balance" of APD's administrative power in order to deter the type of selective prosecution asserted, but never shown, by Respondent. But whatever its purpose, it cannot be ignored.

93. While APD rules regarding discipline sometimes do (e.g., rule 65G-2.0041) and sometimes do not (e.g., rule 65G-2.009) acknowledge this statutorily assigned role for DCF, it is clear that to the extent a rule purports to impose discipline for such violations, it must give way to the clear requirements of the statute. § 120.57(1)(e)1., Fla. Stat. Therefore, although the Administrative Complaint cites rule 65G-2.009(1)(d) in alleging abuse, sexual abuse, neglect, and exploitation in violation of section 393.13(3) (part of the Bill of Rights of Persons with Developmental Disabilities), APD cannot thereby simply bypass and neutralize section 393.0673(1)(b), which specifically requires verified findings by DCF as a prerequisite to such disciplinary action. The more specific procedural requirements of section 393.0673(1)(b) cannot be avoided by simply charging the same conduct covered by that paragraph more generally as a violation of statutory provisions or rules under

section 393.0673(1)(a)3. Bloch Bros. Corp. v. Dep't of Bus. Reg., 321 So. 2d 447, 448 (Fla. 2d DCA 1975)(when Legislature provides that an administrative power shall be exercised in a certain way, it cannot be done another way); State v. McTigue, 387 So. 2d 454, 456 (Fla. 1st DCA 1980)(if a statute has both a specific provision, and also a general one that in its most comprehensive sense would include the matters embraced in the former, the particular provision prevails, and the general provision is interpreted to affect only such cases as are not within the terms of the particular provision).

94. While the evidence was clear that Client [redacted] was a vulnerable adult, there was no evidence that the Department of Children and Families ever made a verified finding of abuse, neglect, or exploitation of him by Respondent. APD is without authority to discipline such conduct without prior action by DCF, and the allegation that Respondent violated rule 65G-2.009(1)(d) must be rejected.

95. Petitioner proved by clear and convincing evidence that Respondent failed to facilitate the implementation of Client [redacted] support plans, in violation of rule 65G-2.009(1)(a)1.

Count II

96. Count II alleges violation of rule 65G-2.009(3)(a), entitled "Transfer and Placement of Clients," which at the time of the alleged offense provided:

> The licensee shall have written criteria and procedures in place for the admission or termination of residential services for clients; termination procedures must be consistent with Chapter 65G-3, F.A.C.

97. The Administrative Complaint then goes on to identify the provisions of rule chapter 65G-3 with which Respondent's termination procedures are allegedly inconsistent. The only operative language of rule chapter 65G-3 that is set forth[6/] in the complaint reads as follows:

> If the client is found not to meet the service provider's written criteria for admissions and services, the area office is responsible for removing the client within a maximum of 25 calendar days of receipt of certified notice to the Agency, and providing alternative service arrangements necessary to ensure client safety and prevent regression, unless the service provider agrees to extend the probationary period.

98. In addition to this provision, the Administrative Complaint cites portions of rule 65G-3.001, which do not, standing alone, have any operative effect, but which instead define terms found elsewhere in the rule chapter:

> (1) "Adequate Notice" means a written notice informing the provider, client and

the client's authorized representative of at least the following:

(a) The action the Agency and/or service provider proposes to take.

(b) The reason for the action.

(c) The effective date of the action.

(d) The specific law, regulation and policy supporting the action.

(e) The responsible state agency, including the name and address of a specific person, with whom a state appeal may be filed.

(f) The appeal procedures including deadlines for filing appeals.

* * *

(h) For clients and authorized representatives, an explanation of how the service provider plans to continue services to clients during the period when the proposed action of the service provider is under appeal, including a statement that services shall not be terminated during the appeal.

* * *

(13) "Residential Program" means a facility licensed under Section 393.067, F.S., providing room and board and personal care for persons with developmental disabilities. This does not include providers covered under the provisions of Part VIII of Chapter 400, F.S.

* * *

(17) "Termination" means the involuntary, permanent discharge or discontinuation of services in a residential or non-residential program by the provider when such action is

not included in the habilitation plan. Termination does not mean a discontinuation of services to a client by a service provider due to the unavailability of funds to the provider by the Agency.

99. The cited definitions of two of these three terms, "adequate notice" and "residential program," are irrelevant here because they do not appear anywhere in the substantive provisions that the Administrative Complaint alleges were violated by Respondent. While the definition of the third term, "termination," seems relevant, and Respondent's method of termination of Client [redacted] may seem inappropriate, Petitioner did not show that the provisions of rule 65G-2.009 and rule chapter 65G-3[7/] that were alleged to have been violated apply to the facts of this case.

100. First, rule 65G-2.009(3)(a) requires a licensee to have certain written criteria and procedures in place relating to termination and requires them to be consistent with rule chapter 65G-3. There was no evidence at hearing as to what written criteria and procedures, if any, Respondent had in place, and certainly nothing about whether they were or were not consistent with rule chapter 65G-3. In another type of case, it might possibly be argued that the concluding phrase "termination procedures must be consistent with Chapter 65G-3, F.A.C." could somehow be interpreted as a reference to procedures actually followed in a given case, as opposed to a reference to the

written criteria and procedures just referenced in the first part of the rule (though such an interpretation completely ignores the context). But here, in a disciplinary case, any such ambiguity would have to be resolved in favor of Respondent. Beckett v. Dep't of Fin. Servs., 982 So. 2d 94, 100 (Fla. 1st DCA 2008)(where statutory language implicates sanctions or penalties, ambiguity is to be interpreted in favor of the licensee).

101. Second, even if rule 65G-2.009 could be interpreted as directly governing a licensee's conduct, as opposed to its policies, rule 65G-3.002(4), claimed to be inconsistent with Respondent's actions, is itself inapplicable here. Rule 65G-3.002(4) by its terms directs the "area office," not the service provider, to take certain actions in response to a certified notice provided to APD. Respondent cannot be found in violation of a rule that imposes no responsibilities upon it.

102. Finally, even if a respondent could be charged in such a backdoor manner with violating the precedent requirement (found in a different rule) for a provider to notify Petitioner in writing by certified mail, rule 65G-3.002 seems only applicable to an initial 90-day "probationary" period for clients (though the rule is far from clear, again interpretation favorable to the licensee must prevail). Rule 65G-3.002(4) expressly states that Petitioner will provide the alternative

service arrangements "unless the service provider agrees to extend the probationary period."

103. The unrefuted testimony was that Client [redacted] had been at Respondent's group home since May of 2017, about seven months before the incident charged, well beyond any 90-day probationary period. In short, rule 65G-3.002(4) prescribes duties on the "area office," not a provider, and furthermore applies only during a probationary period.

104. It was not shown that Respondent failed to have written criteria and procedures for termination in place or that they were not consistent with the requirement that the "area office" promptly remove a client and provide alternative services within the probationary period.

105. Ms. Llaguno testified that the appropriate procedure to terminate services to Client [redacted] would have been for Respondent to send a 30-day notice terminating her placement, but that rule, if it exists, was not cited,[8/] and Respondent was not charged with its violation.

106. Petitioner failed to prove by clear and convincing evidence that Respondent violated rule 65G-2.009(3)(a) or rule 65G-3.002(4).

Count III

107. Count III alleges violation of section 393.0673(1)(a)2., which provides that the agency may revoke or

suspend a license or impose fines if the licensee had prior action taken against it under the Medicaid program.

108. Petitioner showed that the Agency for Health Care Administration took action against Respondent by terminating its Medicaid provider number by letter dated August 3, 2017. Respondent lost its Medicaid provider authorization and has lost the right to furnish Medicaid services and receive payment from Medicaid in Florida.

109. Petitioner proved by clear and convincing evidence that Respondent violated section 393.0673(1)(a)2.

Penalty

110. Section 393.0673(1) provides that APD may revoke or suspend a license or impose an administrative fine, not to exceed $1,000 per violation per day, on a licensee which has had prior action taken against it under the Medicaid or Medicare program or failed to comply with the applicable requirements of chapter 393 or applicable rules.

111. Section 393.0673(7) directed APD to establish by rule criteria for evaluating the severity of violations and for determining the amount of fines imposed. APD has adopted rule 65G-2.009, entitled Resident Care and Supervision Standards, and rule 65G-2.0041, entitled License Violations—Disciplinary Actions.

112. Rule 65G-2.009(1)(g) provides that a violation of rule 65G-2.009(1)(a)1., as alleged and proven in Count I, constitutes a Class III violation.[9/] Rule 65G-2.0041(4)(c)1. provides that Class III violations may be penalized by a fine of up to $100 per day for each violation.

113. Section 393.0673(1) provides that a violation of section 393.0673(1)(a)2., as alleged and proven in Count III, may be penalized by revocation or suspension of a license or imposition of an administrative fine, not to exceed $1,000 per violation per day. However, the parties did not cite, and the undersigned could not identify, a rule establishing the criteria for evaluating the severity and for determining the amount of fine to be imposed when a licensee has had prior action taken against it under the Medicaid program, notwithstanding section 393.0673(7).

114. Rule 65G-2.0041(2) lists the following factors to be considered when determining sanctions to be imposed 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.

115. Respondent's failure to adequately supervise might have resulted in serious physical or mental injury, but there is no indication that the violation was willful. While Respondent's inadequate supervision of Client [redacted] extended for a period of time, this was after Petitioner requested that Respondent resume care for him. Respondent repeatedly sought to have a higher level of care code assigned to increase supervision of Client [redacted] and believed it was unable to legally restrain Client [redacted] Although this does not constitute a

defense, it is a mitigating factor. Respondent has lost the right to furnish Medicaid services and receive payment from Medicaid, but Petitioner's failure to establish criteria for evaluating the severity of the violation and for determining the amount of fine, coupled with the absence of record evidence as to the reason for the Medicaid action, precludes revocation. Suspension of Respondent's license until the right to provide Medicaid services has been restored should provide a penalty inherently commensurate with the Medicaid action.

RECOMMENDATION

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

RECOMMENDED that the Agency for Persons with Disabilities enter a final order finding Miracles House, Inc., as licensee of Miracles House, Inc., Group Home, in violation of Florida Administrative Code Rule 65G-2.009(1)(a)1. and section 393.0673(1)(a)2., Florida Statutes; suspending its license to operate a group home until its right to furnish Medicaid services and receive payment from Medicaid in Florida is restored; and imposing a fine in the amount of $100.

DONE AND ENTERED this 17th day of September, 2018, in Tallahassee, Leon County, Florida.

F. Scott Boyd

F. SCOTT BOYD
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of September, 2018.

ENDNOTES

[1/] All references to Florida Statutes or administrative rules are to the versions in effect on the dates of the alleged violations, except as otherwise indicated.

[2/] It is determined that a hearing by video teleconference with one site in Miami, as requested by the parties, meets the requirement in section 393.0673 that hearings be held within the county in which the licensee operates.

[3/] It appears the style of the waiver case may not have been technically correct, referencing as it does Ms. Whipple as an "operator" of the corporation holding the waiver agreement, but the agency action letter and action taken appear properly directed toward the corporation. The style of the instant case has similarly been adjusted to reflect the proper Respondent licensee, consistent with the stipulations of the parties.

[4/] While evidence at hearing indicates that Miracles' license was to expire on July 31, 2018, this case was brought by APD as disciplinary action through Administrative Complaint rather than by Miracles as an application to contest denial of a renewal application. The record does not indicate if Miracles' license has subsequently had monthly extensions.

[5/] Reporting of suspected abuse, neglect, or exploitation of a vulnerable adult to DCF is mandatory under chapter 415, Florida Statutes.

[6/] While the complaint also referred to subsection (5) of the rule, the recitation of only the language of rule 65G-3.002(4) in the complaint raises a question about whether Respondent was given sufficient notice of this other subsection to consider it as an additional basis for the complaint. It provided:

> The provider shall continue to provide services in the facility until the client is removed by the Agency. The removal shall be completed within a maximum of 25 calendar days from the date of receipt of certified notice to the department unless otherwise agreed upon by the Agency and the provider.

Assuming adequate notice in the Administrative Complaint, reliance upon rule 65G-3.002(5) fails for the same reasons discussed above in connection with subsection (4). While subsection (5) states that the provider shall continue to provide services, it similarly pertains to the period of time in the probationary period after a certified notice has been provided. Rules must be read in context.

[7/] Rule chapter 65G-3 was last amended some 25 years ago, in 1993, and its logic, structure, and terminology are in need of updating.

[8/] Rule 65G-3.005, entitled "Rules for Termination of Services by the Provider," states in subsection (1) that written notice of intent to terminate services shall be received by certified mail within 15 business days prior to the proposed effective date, but this rule was not cited in the Administrative Complaint.

[9/] The "catch all" provision of paragraph (g) applies because there was no proof of violation of Client [redacted] right to dignity, privacy, or humane care, or his right to be free from abuse, including sexual abuse, exploitation, harm, including unnecessary physical, chemical, or mechanical restraint, isolation, or excessive medication. Additionally, as discussed above, licensee discipline for abuse, neglect, or exploitation of a vulnerable adult requires a verified finding from DCF.

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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.