STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case Nos. 19-5096, 20-0014

TYVAL ASSISTED LIVING FACILITY, LLC,

Respondent.
_____/

TYVAL ASSISTED LIVING FACILITY, LLC,

Petitioner,

vs. Case No. 19-6305

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

_____/

RECOMMENDED ORDER

These cases came before Administrative Law Judge Darren A. Schwartz of the Division of Administrative Hearings ("DOAH") for final hearing on February 19 and 20, 2020, in West Palm Beach, Florida.

APPEARANCES

For Agency for Health Care Administration ("AHCA"):

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For Tyval Assisted Living Facility, LLC ("Tyval"):

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STATEMENT OF THE ISSUES

As to Case No. 19-5096, whether Tyval committed the deficiencies alleged in the Administrative Complaint; and, if so, whether Tyval's license to operate an assisted living facility ("ALF") should be revoked, and/or whether Tyval is subject to administrative fines and survey fees; and, if so, the amount of the administrative fines and survey fees to be imposed. As to Case No. 20-0014, whether Tyval committed the deficiencies alleged in the Administrative Complaint; and, if so, whether Tyval is subject to administrative fines; and, if so, the amount of the administrative fines to be imposed. As to Case No. 19-6305, whether Tyval's application for renewal of its ALF license should be denied.

PRELIMINARY STATEMENT

On August 13, 2019, AHCA issued an Administrative Complaint against Tyval, notifying it of AHCA's intent to revoke Tyval's ALF license and to impose administrative fines in the sum of $10,000.00 and survey fees in the amount of $500.00, based upon two Class II deficient practices identified by AHCA during its survey conducted at Tyval from January 15 through 18, 2019.[1] On September 3, 2019, Tyval timely filed a Petition for Formal

[1] In the Joint Pre-Hearing Statement, the parties stipulated that the August 2019 Administrative Complaint was deemed to be amended to include a claim by AHCA for survey fees in the amount of $500.00.

Hearing. Subsequently, AHCA forward the matter to DOAH to assign an administrative law judge to conduct the final hearing. The matter was assigned to the undersigned under Case No. 19-5096. On September 26, 2019, the undersigned set the final hearing for November 25 and 26, 2019. On November 7, 2019, AHCA filed an unopposed motion to continue the final hearing. On November 15, 2019, the undersigned entered an Order granting the motion and reset the final hearing for January 30 and 31, 2020.

On October 10, 2019, AHCA issued a second Administrative Complaint against Tyval, notifying it of AHCA's intent to impose administrative fines in the sum of $1,500.00, based upon three uncorrected Class III deficient practices identified by AHCA during its surveys conducted at Tyval on January 15 through 18, 2019, March 2, 2019, and May 21, 2019. On November 1, 2019, Tyval timely filed a Petition for Formal Hearing. Subsequently, AHCA forwarded the matter to DOAH to assign an administrative law judge to conduct the final hearing. The matter was initially assigned to Administrative Law Judge June C. McKinney under Case No. 20-0014.

On October 1, 2019, AHCA issued a Notice of Intent to Deem Renewal Application Incomplete and Withdrawn from Further Consideration to Tyval. On October 22, 2019, Tyval timely filed a Petition for Formal Hearing. Subsequently, AHCA forwarded the matter to DOAH to assign an administrative law judge to conduct the final hearing. The matter was initially assigned to Administrative Law Judge June C. McKinney under Case No. 19-6305.

On December 3, 2019, the parties filed a joint motion to consolidate Case Nos. 19-5096 and 19-6305. On December 4, 2019, Case No. 19-6305 was transferred to the undersigned for all further proceedings. On December 9,

2019, the undersigned entered an Order consolidating Case Nos. 19-5096 and 19-6305 and rescheduling the final hearing for February 19 through 21, 2020.

On January 13, 2020, the parties filed their Joint Response to Initial Order in Case No. 20-0014. On January 21, 2020, Case No. 20-0014 was transferred to the undersigned for all further proceedings. On January 27, 2020, the undersigned entered an Order consolidating Case Nos. 19-5096, 19-6305, and 20-0014, and an amended notice of hearing to reflect the issues for the final hearing in all three cases.

The final hearing was held on February 19 and 20, 2020, with both parties present. At the hearing, AHCA presented the testimony of Tikel Wedges-Phoenix, Paul Valerio, Nicolas Frias, Dr. Arthur Bautista, Keisha Woods, and Erika Potter-Morgan. AHCA's Exhibits 1 through 29, 31 through 40, and 42 were received into evidence. Tyval presented the testimony of Valrie Powell. Tyval's Exhibits 1 and 2 were received into evidence.

The three-volume final hearing Transcript was filed at DOAH on March 6, 2020. On March 12, 2020, AHCA filed an unopposed motion to extend the deadline until March 27, 2020, for the parties to file proposed recommended orders. On March 13, 2020, the undersigned entered an Order granting the motion. The parties timely filed their proposed recommended orders, which were given consideration in the preparation of this Recommended Order.

On February 10, 2020, the parties filed their Joint Pre-Hearing Stipulation, in which they stipulated to certain facts. These facts have been incorporated into this Recommended Order as indicated below.

Unless otherwise stated, as to Case Nos. 19-5096 and 20-0014, all statutory and rule references are to the statutes and rules in effect at the

time of the alleged violations. As to Case No. 19-6305, all statutory and rule references are to the 2019 versions.[2]

FINDINGS OF FACT

1. AHCA is the state agency responsible for licensing ALFs in Florida and enforcement of applicable state statutes and administrative rules pursuant to chapters 408, part II, and 429, part I, Florida Statutes, and Florida Administrative Code Chapters 58A-5 and 59A-36.

2. At all times material hereto, Tyval has been licensed by AHCA to operate a six-bed ALF located at 3526 Genevra Avenue, Boynton Beach, Florida 33436. Tyval's facility is located within a single family three-bedroom home. As a licensed ALF, Tyval is required to comply with all applicable state statutes and administrative rules.

3. AHCA conducts inspections, commonly called surveys, of licensed providers and applicants for licensure to determine compliance with the regulatory scheme governing such facilities. AHCA personnel typically conduct the surveys, which may involve an on-site tour of the facility, observing residents, reviewing resident records, reviewing staff files, conducting interviews, and documenting the survey findings. There are different types of surveys, including complaint surveys, monitoring surveys, and revisit surveys.

4. A deficiency or deficient practice is a violation of an applicable statute or rule resulting from a survey. AHCA must classify deficiencies according to the nature and severity of the violation.

5. Pursuant to section 408.813(2), deficiencies are classified as Class I, II, III, and IV. A Class I violation poses an imminent danger to the resident or a

[2] *See Lavernia v. Dep't of Prof'l Reg., Bd. of Med.*, 616 So. 2d 53, 54 (Fla. 1st DCA 1993).

substantial probability of death or serious physical or emotional harm to the resident. A Class II violation directly threatens the physical or emotional health, safety, or security of the resident. A Class III violation indirectly or potentially threatens the physical or emotional health, safety, or security of the resident.

The January 15 through 18, 2019, Survey

6. On January 15 through 18, 2019, AHCA conducted an unannounced complaint survey at Tyval's facility. The complaint was made to AHCA by Paul Valerio, an investigator with the Florida Attorney General's office, who went to the facility on January 14, 2019, to investigate an unrelated complaint.

7. Upon his arrival at the facility on the morning of January 14, 2019, Mr. Valerio spoke with Stacy Smith, who was the only Tyval staff member present at the facility.

8. Mr. Valerio then walked around the inside of the facility, at which time he observed two residents (Resident Nos. 1 and 2) in the living room area sitting in separate recliner chairs with bedsheets tied around their waists. The bedsheets were secured by knots tied to the back of the recliners. Mr. Valerio observed that the two residents were unable to exit the chairs on their own.

9. Mr. Valerio was concerned when he saw the two residents tied to their chairs, so he took pictures of them (AHCA's Exhibit Nos. 14 and 15) and subsequently reported his concerns to AHCA.

10. While Mr. Valerio was still at the facility on January 14, 2019, Valrie Powell, the administrator of Tyval, arrived at the facility. Mr. Valerio introduced himself to Ms. Powell and explained the purpose of his visit. During the visit, Mr. Valerio requested financial documents from Ms. Powell. Ms. Powell then walked through the living room area to a back room and, in doing so, walked past the two restrained residents. Ms. Powell was still at the facility when Mr. Valerio left. When Mr. Valerio left the facility, he observed

the two residents still tied to their chairs. At no point during Mr. Valerio's visit did Ms. Powell remove the restraints or instruct Ms. Smith to remove the restraints.

11. The next morning, January 15, 2019, Nicolas Frias, an AHCA medical and health care analyst, arrived at Tyval to conduct the survey in response to Mr. Valerio's complaint. Upon his arrival, Mr. Frias explained the purpose of the visit and requested records. Mr. Frias conducted his physical survey at the facility on January 15 and 16, 2019.

12. Mr. Frias could not interview Resident Nos. 1 and 2 because they were mentally incapable of being interviewed. Mr. Frias interviewed Resident No. 3, who recalled seeing Resident No. 1 previously being tied with a bedsheet to a chair. On January 16, 2019, Ms. Powell informed Mr. Frias that she was not aware of any residents being restrained and that Ms. Smith had not reported any incidents on January 14, 2019. However, Ms. Powell acknowledged that residents are susceptible to harm if they are restrained.

13. During his survey, Mr. Frias observed a half-bed rail attached to Resident No. 2's bed. Mr. Frias took a photograph of Resident No. 2's bed and the half-bed rail attached to the bed. AHCA's Ex. 17.

14. Resident No. 2 was incapable of properly utilizing or avoiding the half-bed rail without assistance, and there was no physician's order or consent from the resident or resident's representative to allow for the use of the half-bed rail.

15. During his survey, Mr. Frias also observed that Tyval staff members had not been adequately trained to recognize and report abuse and neglect of residents, and they were not familiar with the State of Florida's abuse prevention hotline. In addition, staff member files lacked adequate documentation of training regarding assisting residents with self-administration of medications and staff member files were unavailable for review.

16. During his survey, Mr. Frias also observed that resident medications were stored on the top of the medication cart located in the dining room of the facility, and therefore, the medications were accessible by any person who was inside the dining room facility. Staff members also had not received adequate training regarding assisting residents with self-administration of medications.

17. During his survey, Mr. Frias also observed that Tyval's comprehensive emergency management plan ("CEMP") dated October 29, 2018, indicated that the facility needed to have 32 gallons of fuel immediately available to operate its power generator for 96 hours in the event of an emergency. However, Mr. Frias observed a power generator inside a shed located on the south side of the property with only 25 gallons of fuel stored inside the shed. Mr. Frias also observed that Tyval did not have a portable generator on the property, and that Tyval failed to prepare a detailed emergency environmental control plan ("EECP") to address the event of loss of primary power in the facility during an emergency.

18. AHCA cited Tyval with two Class II deficiencies resulting from the January 15 through 18, 2019, survey.

19. Tyval was cited for a Class II deficient practice (Tag 0030) for failing to honor resident rights and provide a safe and decent living environment free from abuse and neglect, including the use of physical restraints, in violation of section 429.28 and rule 58A-5.0182(6).[3]

20. Tyval was also cited for a Class II deficient practice (Tag 0077) for Ms. Powell's failure to provide adequate management of staff by not ensuring staff members were adequately trained to recognize and report incidents of abuse and neglect, and for Ms. Powell's failure to implement actions to

[3] On July 1, 2019, rule 58A-5.0182(6) was transferred to rule 59A-36.007(6).

continually honor resident rights to prevent hazardous situations, in violation of section 429.52 and rule 58A-5.019(1).[4]

21. AHCA also cited Tyval with a Class III deficiency (Tag 0055) for failing to adequately store resident medications, by not keeping the medications locked in the medication cart at all times, in violation of rule 58A-5.0185(6).[5]

22. AHCA also cited Tyval with a Class III deficiency (Tag 0161) for failing to maintain a staff member's personnel record, in violation of section 429.275(2) and rule 58A-5.024(2).[6]

23. AHCA also cited Tyval with a Class III deficiency (Tag 0200) for failing to prepare a detailed EECP to address the event of loss of primary electrical power in the facility because of an emergency, in violation of rule 58A-5.036.[7]

March 2 and May 21, 2019, Revisit Surveys

24. On March 2, 2019, Mr. Frias conducted a revisit survey at Tyval. During the March 2019 revisit survey, Ms. Powell informed Mr. Frias that she terminated Ms. Smith, a staff member who had restrained residents.

25. During the March 2, 2019, revisit survey, Mr. Frias observed that a staff member's personnel record failed to indicate she held a current and valid cardiopulmonary resuscitation ("CPR") certification. This employee worked alone in the facility each week from Friday to Monday. Rule 58A-5.0191(5) requires that a staff member who holds a valid card documenting CPR certification be in the facility at all times.[8]

[4] On July 1, 2019, rule 58A-5.019(1) was transferred to rule 59A-36.010(1).

[5] On July 1, 2019, rule 58A-5.0185(6) was transferred to rule 59A-36.008(6).

[6] On July 1, 2019, rule 58A-5.024(2) was transferred to rule 59A-36.015(2).

[7] On July 1, 2019, rule 58A-5.036 was transferred to rule 59A-36.025.

[8] On July 1, 2019, rule 58A-5.0191(5) was transferred to rule 59A-36.011(5).

26. During the March 2, 2019, revisit survey, Mr. Frias observed that Tyval had still not prepared a detailed EECP to address the event of loss of primary electrical power in the facility because of an emergency, in violation of rule 58A-5.036.

27. AHCA cited Tyval with an uncorrected Class III deficient practice (Tag 0161) for failing to maintain a personnel record for a staff member, which contained the staff member's valid CPR certification in violation of section 429.275(2) and rule 58A-5.024(2).

28. AHCA also cited Tyval with an uncorrected Class III deficient practice (Tag 0200) for failing to prepare a detailed EECP to address the event involving the loss of primary electrical power in the facility during an emergency in violation of rule 58A-5.036.

29. During the May 21, 2019, revisit survey, Tyval provided a detailed EECP, dated March 21, 2019, and a letter from the local emergency management agency, dated April 17, 2019, approving this EECP. At the May 21, 2019, revisit survey, Mr. Frias observed a propane tank and a portable power generator, which was connected to the propane tank. Mr. Frias also observed an electrical switch attached to the exterior wall of the facility's building. Nevertheless, AHCA cited Tyval with an uncorrected Class III deficient practice (Tag 0200) following the May 21, 2019, revisit survey for Tyval's purported failure to acquire an alternate power source and fuel supply that was in accordance with the Florida Building Code, in violation of rule 58A-5.036.

30. The persuasive evidence adduced at hearing clearly and convincingly demonstrates that Tyval committed the two Class II violations alleged in the Administrative Complaint in Case No. 19-5096. A Tyval staff member's tying of Resident Nos. 1 and 2 to recliner chairs with bed sheets, so they cannot exit the chairs on their own, and imposing a half-bed rail on Resident No. 2's bed without proper consent or a physician's order were improper physical restraints, which directly threatened Resident Nos. 1 and 2's physical or

emotional health, safety, or security. As such, Tyval failed to provide Resident Nos. 1 and 2 with a safe and decent living environment free from abuse or neglect in violation of section 429.28 and rule 58A-5.0182(6). These actions were intentional or negligent acts by Tyval or its staff members, which seriously affected the health, safety, or welfare of Resident Nos. 1 and 2. Moreover, as the administrator of Tyval, Ms. Powell failed to provide adequate management of staff by not ensuring staff members were adequately trained to recognize and report incidents of abuse and neglect, and Ms. Powell failed to implement actions to continually honor resident rights to prevent hazardous situations, in violation of section 429.52 and rule 58A-5.019(1). Ms. Powell's actions were intentional or negligent and seriously affected the health, safety, or welfare of Resident Nos. 1 and 2.

31. The persuasive evidence adduced at hearing clearly and convincingly demonstrates that Tyval committed an uncorrected Class III deficient practice by failing to maintain a personnel record for a staff member, which contained the staff member's valid CPR certification in violation of section 429.275(2) and rule 58A-5.024(2). This practice indirectly or potentially threatened the physical or emotional health, safety, or security of Tyval residents.

32. The persuasive evidence adduced at hearing clearly and convincingly demonstrates that Tyval committed an uncorrected Class III deficient practice by failing to prepare, as of the March 2, 2019, revisit survey, a detailed EECP to address the event involving the loss of primary electrical power in the facility during an emergency in violation of rule 58A-5.036. This practice indirectly or potentially threatened the physical or emotional health, safety, or security of Tyval residents.

33. The persuasive evidence adduced at hearing does not clearly and convincingly demonstrate that Tyval committed an uncorrected Class III deficient practice by failing to acquire an alternate power source and fuel supply that was in accordance with Florida's Building Code, in violation of

rule 58A-5.036. As detailed above, during the May 21, 2019, revisit survey, Tyval provided a detailed EECP, dated March 21, 2019, and a letter from the local emergency management agency, dated April 17, 2019, approving this EECP. At the May 21, 2019, revisit survey, Mr. Frias observed a portable power generator, which was connected to a propane tank. Mr. Frias also observed an electrical switch attached to the exterior wall of the facility's building.

Tyval's Incomplete Renewal Application

34. On July 16, 2019, Tyval applied to renew its ALF license. Accompanying the application was a check written by Tyval made payable to AHCA to purportedly cover the required filing fee for renewal.

35. AHCA did not accept Tyval's renewal application because the amount handwritten on the legal line of the check ("Seven Hundred and Forty nine") was inconsistent with the amount handwritten in the numerical box on the check ("777.49/100"). Based on this inconsistency, AHCA could not deposit the check, the filing fee payment was not received by AHCA, and AHCA did not deem the application received.

36. The application specifically advised Tyval that: "**Applications will not be considered for review until payment has been received.**" (emphasis in original).

37. The application further advised Tyval that: "The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice." (emphasis in original).

38. On July 22, 2019, AHCA returned the application and check to Tyval with a cover letter stating the following reason for the return: "LEGAL LINE DOES NOT MATCH NUMERIC BOX."

39. On August 1, 2019, AHCA received the same renewal application from Tyval along with another check made payable to AHCA in the amount of

$777.49. AHCA deposited the check and was therefore officially in receipt of the renewal application on August 1, 2019.

40. Subsequently, Erika Potter-Morgan, a health services and facilities consultant for AHCA, processed and reviewed the renewal application and identified the following errors or omissions: (1) section 1.B. of the application did not list Tyval Assisted Living Facility, LLC, as the licensee name; (2) section 2.C. did not list the total number of beds; (3) the total license fee was $789.49, so the check received by AHCA on August 1, 2019, was $12.00 short; (4) failing to submit documented proof of business liability insurance; (5) failing to submit documentation that Tyval has received a satisfactory sanitation inspection within the previous 365 days conducted by the county health department; and (6) failing to provide the name of a safety liason contact person regarding Tyval's EECP.

41. On August 16, 2019, Ms. Potter-Morgan emailed a letter to Ms. Powell at the email addressed identified by Ms. Powell in the renewal application. The letter outlined the errors and omissions and indicated the application was incomplete. The letter informed Ms. Powell that if the errors and omissions were not corrected within 21 calendar days, then the renewal application would be withdrawn from consideration.[9]

42. The requested documentation was due to AHCA no later than September 6, 2019. No response to the August 16, 2019, letter was received by AHCA.

43. On October 1, 2019, AHCA issued the Notice of Intent to Deem Application Incomplete and Withdrawn based on Tyval's failure to provide the documentation and information required by the August 16, 2019, letter.

44. On October 31, 2019, AHCA received additional documentation from Tyval. However, the error in section "B" of the application had not been corrected and the liability insurance and safety liaison information was not

[9] The renewal application specifically provided: "By providing your e-mail address, you agree to accept e-mail correspondence from the Agency."

provided. As of the date of the final hearing, AHCA still had not received a correction to section "B" of the application, the documentation regarding liability insurance, or the safety liaison information.

45. In its proposed recommended order, Tyval contends that AHCA is precluded by section 120.60, Florida Statutes, from denying the renewal application because it failed to process the application within 30 days of July 16, 2019, and the letter requesting omitted items was not sent to Tyval until August 16, 2019, more than 30 days after July 16, 2019. However, as detailed above, Tyval's application was not deemed received by AHCA on July 16, 2019, because the check received by AHCA on July 16, 2019, had inconsistent amounts written on it, so the check could not be deposited by AHCA and it was instead returned to Tyval. AHCA did not deem Tyval's application received until August 1, 2019, when Tyval resent its original renewal application along with a check that AHCA could deposit. The omissions letter was sent within 30 days of August 1, 2019.

46. In sum, Tyval's renewal application was incomplete and, therefore, properly deemed withdrawn and denied by AHCA.

CONCLUSIONS OF LAW

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

48. A license to operate an ALF is a public trust and a privilege, not an entitlement. § 429.01(3), Fla. Stat.

49. As to Case Nos. 19-5096 and 20-0014, AHCA seeks to revoke Tyval's ALF license and impose administrative fines and survey fees based on instances of deficient practices, noted above as "Tags."

50. AHCA has the burden to prove by clear and convincing evidence the deficient practices alleged in the administrative complaints. *Ferris v. Turlington*, 510 So. 2d 292 (Fla. 1987). The clear and convincing evidence standard requires "that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony

must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established." *Slomowitz v. Walker*, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

51. Section 429.28(1) provides, in pertinent part:

> (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
>
> (a) Live in a safe and decent living environment, free from abuse and neglect.
>
> (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

52. Under section 429.41(1)(k), the use of physical restraints is limited to half-bed rails as prescribed and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative.

53. Rule 58A-5.0182(6)(g) further provides that a facility's use of half-bed rails as a physical restraint must be reviewed by the resident's physician annually unless the resident chooses to use and can remove or avoid the half-bed rail without assistance.

54. Section 429.52 requires that ALF facility administrators and their staff members receive training regarding resident rights and identifying and reporting abuse, neglect, and exploitation.

55. Rules 58A-5.019(1) and 58A-5.0191(3)(c) further require that staff providing direct care to residents who have not completed the core training program, shall receive a minimum of one hour in-service training within 30 days of employment that covers resident rights and facility specific

procedures for recognizing and reporting resident abuse, neglect, and exploitation.

56. Pursuant to rule 58A-5.019(1), a facility administrator is responsible for the operation and maintenance of the facility, including the management of all staff and the provision of appropriate care to all residents.

57. As detailed above, a Tyval staff member's tying of Resident Nos. 1 and 2 to recliner chairs with bed sheets so that they cannot exit the chairs on their own and imposing a half-bed rail on Resident No. 2's bed without proper consent or a physician's order were improper physical restraints, which directly threatened Resident Nos. 1 and 2's physical or emotional health, safety, or security. As such, Tyval failed to provide Resident Nos. 1 and 2 with a safe and decent living environment free from abuse or neglect in violation of section 429.28 and rule 58A-5.0182(6). These actions were intentional or negligent acts by Tyval or its staff members, which seriously affected the health, safety, or welfare of Resident Nos. 1 and 2. Moreover, as the administrator of Tyval, Ms. Powell failed to provide adequate management of staff by not ensuring staff members were adequately trained to recognize and report incidents of abuse and neglect, and Ms. Powell failed to implement actions to continually honor resident rights to prevent hazardous situations, in violation of section 429.52 and rules 58A-5.019(1) and 58A-5.0191(3)(c). Ms. Powell's actions were intentional or negligent and seriously affected the health, safety, or welfare of Resident Nos. 1 and 2.

58. Section 429.275(2) requires that the facility administrator maintain personnel records for each staff member, which contains, at a minimum, documentation of compliance with all training requirements of chapter 429, part I, or applicable rule, and a copy of all licenses or certification held by each staff member.

59. Rule 58A-5.024(2) further provides that documentation of compliance with all staff training and copies of licensing or certifications for all staff be contained within the staff member's personnel file.

60. As detailed above, Tyval committed an uncorrected Class III deficient practice for failing to maintain a personnel record for a staff member which contained the staff member's valid CPR certification in violation of section 429.275(2) and rule 58A-5.024(2).

61. Rule 58A-5.036(1) requires that an ALF shall prepare a detailed EECP to serve as a supplement to its CEMP, to address emergency environmental control in the event of the loss of primary electrical power in the ALF. The EECP must include information regarding the acquisition of a sufficient alternate power source, such as a generator, maintained at the facility, to ensure that the facility will be equipped to ensure ambient air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of 96 hours in the event of the loss of primary electrical power. The alternative power source and fuel supply shall be located in an area in accordance with local zoning and the Florida Building Code.

62. As detailed above, Tyval committed an uncorrected Class III deficient practice by failing to prepare an EECP by the March 2, 2019, revisit survey.

63. However, AHCA failed to present clear and convincing evidence that Tyval failed to acquire an alternate power source and fuel supply that was not in accordance with Florida's Building Code, in violation of rule 58A-5.036 by the May 21, 2019, revisit survey.

64. Pursuant to section 429.14(1), AHCA may revoke an ALF license and impose an administrative fine against a licensee for a violation of any provision of chapters 408, part II, and 429, part I, or applicable rules, for actions by a licensee or facility staff involving an intentional or negligent act which seriously affects the health, safety, or welfare of a resident of the facility. Section 408.815(1) further provides that AHCA may revoke an ALF license for actions by a controlling interest which constitute an intentional or negligent act which materially affects the health or safety of a resident or which violate the provisions of chapters 408, part II, and 429, part I, or applicable administrative rules.

65. Pursuant to section 408.813(2)(b), for each Class II violation, AHCA shall impose an administrative fine as provided by law. A fine shall be levied notwithstanding the correction of the violation.

66. Pursuant to section 429.19(2)(b), AHCA shall impose an administrative fine for a cited Class II violation in an amount not less than $1,000.00 and not exceeding $5,000.00 for each violation.

67. Pursuant to section 429.19(2)(c), AHCA shall impose an administrative fine for a cited Class III violation in an amount not less than $500.00 and not exceeding $1,000.00 for each violation.

68. Section 429.19(3) sets forth the following factors AHCA must consider in determining if a penalty should be imposed and in fixing the amount of the fine:

> (a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.
>
> (b) Actions taken by the owner or administrator to correct violations.
>
> (c) Any previous violations.
>
> (d) The financial benefit to the facility of committing or continuing the violation.
>
> (e) The licensed capacity of the facility.

69. Pursuant to section 429.19(7), in addition to any administrative fine imposed, AHCA may assess a survey fee in the amount of $500.00, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted to verify the correction of the violations.

70. Applying the foregoing legal principles to the instant case and for the reasons detailed above, the undersigned concludes that the following action is warranted: (1) revocation of Tyval's ALF license; (2) a total administrative fine of $11,000.00; and (3) a survey fee of $500.00. As to the two Class II deficiencies, revocation of Tyval's ALF license is particularly warranted under the egregious facts of this case given the severe and inhumane acts of a staff member's tying of residents to recliner chairs as an unlawful means of imposing a physical restraint; unlawful use of the half-bed rail on Resident No. 2 as an unlawful physical restraint; and Ms. Powell's lack of management, supervision, and failure to properly train staff members on identifying and reporting abuse and neglect. For the same reasons detailed above, the maximum amount of fine is warranted for the two Class II deficient practices. As to the two uncorrected Class III deficiencies, the minimum amount of fine for each violation is warranted given that the deficiencies involve minor record keeping issues.

71. As to Case No. 19-6305, because AHCA seeks to deny the renewal license based on errors or omissions with regard to the application and not specific acts of misconduct, Tyval has the burden to demonstrate, by a preponderance of the evidence, that it satisfies the requirements for licensure and is entitled to receive the renewal license. *Dep't of Banking & Fin. v. Osborne Stern & Co.*, 670 So. 2d 932, 934 (Fla. 1996); *M.H. v. Dep't of Child. & Fam. Servs.*, 977 So. 2d 755, 761-63 (Fla. 2d DCA 2008).

72. Pursuant to section 408.806(3)(b), requested information omitted from an application for license renewal must be filed with AHCA within 21 days after AHCA's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

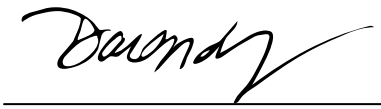
73. Applying the foregoing legal principles to the instant case and for the reasons detailed above, Tyval failed to prove by a preponderance of the

evidence that it satisfies the requirements for licensure and is entitled to receive the license.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Agency for Health Care Administration enter a final order: (1) revoking Tyval's ALF license; (2) imposing a total administrative fine of $11,000.00; (3) imposing a survey fee of $500.00; and (4) denying Tyval's renewal license application.

DONE AND ENTERED this 30th day of April, 2020, in Tallahassee, Leon County, Florida.



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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.