STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case Nos. 20-1469 20-1890

KONA PROPERTIES, LLC, D/B/A GREENLEAF ASSISTED LIVING, LLC,

Respondent.
_____/

RECOMMENDED ORDER

Administrative Law Judge John D. C. Newton, II, of the Division of Administrative Hearings (Division), conducted the final hearing in this matter by Zoom conference on June 15 through 17, 2020.

APPEARANCES

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STATEMENT OF THE ISSUES

A. Did Respondent, Kona Properties, LLC, d/b/a Greenleaf Assisted Living, LLC (Greenleaf), violate section 429.26(7), Florida Statutes (2019),[1] and Florida Administrative Code Rule 59A-36.007(1) and, if so, what penalty should be imposed? (Count I)

B. Did Greenleaf violate section 429.176 and 429.52(4) and (5) and rule 59A-36.010? If it did, what penalty should be imposed? (Count II)

C. Did Greenleaf violate rule 59A-36.010(2) and, if so, what penalty should be imposed? (Count III)

D. Should the Agency impose a survey fee upon Greenleaf pursuant to section 429.19(7)? If so, what amount of fee should be imposed? (Count IV)

E. Did Greenleaf commit one or more Class I violations justifying revocation of its license under section 429.14(1)(e)1.? (Count V)

F. Did Greenleaf violate the background screening requirements of sections 408.809, 429.174, and 435.06(2)(a) through (d)? If so, what penalty should be imposed? (Count VI)

G. Did Greenleaf violate rule 59A-35.110 by not making timely adverse incident reports, and, if so, what penalty should be imposed? (Count VII)

PRELIMINARY STATEMENT

Petitioner, the Agency for Health Care Administration (Agency), is the state agency charged with licensing and regulating assisted living facilities (ALFs). Greenleaf is an ALF licensed by the Agency. In these consolidated cases, the Agency seeks to impose sanctions, including license revocation, upon Greenleaf.

On February 25, 2020, the Agency filed an Administrative Complaint against Greenleaf in Agency Case No. 2020002754 (DOAH Case No. 20-1469).

[1] All references to Florida Statutes are to the 2019 codification unless noted otherwise.

The Agency sought to revoke Greenleaf's license for various alleged violations related to a tragic fire in the ALF. On March 26, 2020, the Agency filed a two-count Administrative Complaint against Greenleaf in Agency Case Nos. 2019008343 and 2020003778 (DOAH Case No. 20-1890). It alleged violations of background screening and adverse incident reporting requirements observed during February 4, 2019, and December 30, 2019, surveys of Greenleaf. The Complaint sought to impose two $500.00 fines. Greenleaf filed petitions requesting formal administrative hearings to dispute the allegations of both complaints. The Agency referred both matters to the Division to conduct the hearings.

The undersigned set Case No. 20-1469 for hearing to be held beginning June 15, 2020. After conducting a pre-hearing conference on May 6, 2020, the undersigned issued a Pre-hearing Order on May 7, 2020, establishing several case management requirements and requiring the Agency to file amended administrative complaints. The undersigned also consolidated the cases upon the joint motion of the parties. The Agency filed a seven-count Amended Administrative Complaint (Administrative Complaint) combining the charges of both complaints. The undersigned noticed the final hearing for the consolidated cases for June 15 through 17, 2020, and conducted it as scheduled.

The Agency presented testimony from Vanessia Bulger, Lorienda Crawford, Lieutenant Stephen Gonella, Linda Gulian-Andrews, Kevin Harman, Lorraine Henry, Vilma Pellot, and Jackie Shelton. Agency Exhibits 1 (limited purposes), 2, 5 (limited purposes), 7, 19 (limited purposes), 21, 23 through 26, 35, 52 (page 15), 55-1, and 55-2 were admitted into evidence. Greenleaf presented testimony from Joann Campbell, Erin Drybola, and Marietta Terredanio. Greenleaf did not offer exhibits into evidence. The four-volume Transcript of the proceeding was filed July 29, 2020. The

undersigned entered an Order extending the date for filing proposed recommended orders to August 27, 2020.[2] The parties timely filed Proposed Recommended Orders. They have been considered in preparation of this Recommended Order.

FINDINGS OF FACT

1. The Agency is the regulatory authority responsible for licensure of ALFs and enforcement of the statutes governing ALFs, codified in chapters 429, part I, and 408, part II, Florida Statutes, as well as the related rules in Florida Administrative Code Chapters 59A-35 and 59A-36.

2. Greenleaf was, at all material times, an ALF in Kissimmee, Florida, operating under the Agency's licensing authority. Greenleaf's license authorized it to operate a 75-bed facility. Greenleaf also held a limited mental health license. This authorized it to care for residents with mental health issues, residents that many facilities will not serve. Greenleaf was required to comply with all applicable statutes and rules. There is no evidence that the Agency has ever imposed sanctions on Greenleaf or determined that it violated statutes or rules. Joann Campbell was the administrator of Greenleaf at all relevant times.

Background Screening

3. On February 4, 2019, the Agency conducted a survey of Greenleaf. As part of the survey, the Agency investigator reviewed personnel files. Investigator Pellot asked Greenleaf's Administrator, Joann Campbell, about background screening for Destiny Castleberry. She asked because the paper background screening report in Ms. Castleberry's personnel file indicated that the background screening report was "awaiting privacy policy." Ms. Campbell acknowledged that was what the document said. She went on to advise Ms. Pellot that the employee had passed the background screening

[2] The parties' agreement to an extension waived the requirements of Florida Administrative Code Rule 28-106.216(1).

and was eligible to serve residents. Ms. Campbell immediately printed a current background screening report showing that Ms. Castleberry had passed background screening and was eligible to serve residents. The Agency representative maintains that an employee's file must have a printed copy of a completed background screening.

4. The Agency also maintains that Ms. Pellot reviewed a personnel file for someone named Eric and that the background screening report in his file was out of date. The Agency did not offer the file into evidence. Ms. Pellot could not remember the employee's last name. A different Agency witness said that she looked for Eric, last name unknown, in the Level II Background Screening Clearinghouse and "it told me that his background screening was not valid." The Agency did not offer a printout demonstrating the information stored in the Clearinghouse or offer persuasive evidence that the investigator even searched for the correct name. The testimony was insufficient to prove this employee did not have a current background-screening document.[3]

Adverse Incident Report

5. Agency Investigator Pellot conducted a complaint survey of Greenleaf on December 30, 2019. Information from this survey is the basis of the charge that Greenleaf did not make a required adverse incident report. Ms. Pellot testified about reports she read of Resident 40 leaving Greenleaf, the staff either being unaware of his departure or thinking he left with family, him falling while not at the facility, and him being taken to a hospital emergency room. The documents she reviewed were reports by individuals who did not testify. The documents were not offered into evidence. Ms. Pellot also testified about the contents of a facility log for Resident 40. (Tr. V. I, p. 144). Her testimony about the interviews of staff and documents she reviewed is

[3] The Agency did not offer an explanation why it waited until it issued the Administrative Complaint in Case No. 20-1890 on March 26, 2020, to take action on an alleged violation on February 4, 2019, over a year earlier.

hearsay. The statements in the documents themselves are also hearsay.[4] Further there is not a record sufficient to establish that the contents of the documents Ms. Pellot described would meet the business records hearsay exception in section 90.803(6), Florida Statutes. The Agency did not offer any of the documents, including the facility log, into evidence.

6. An admission of Greenleaf administrator, Joann Campbell, did establish that Greenleaf had filed a "one-day" adverse incident report about Resident 40 but had not filed a "15-day" adverse incident report. § 90.803(18)(e), Fla. Stat. The admission goes only to filing of a report. It did not involve or prove any of the assertions about the facts of the incident, necessary to determine if the incident was one that had to be reported as the Agency advocates. The Agency did not offer the incident report into evidence.

7. Ms. Campbell tried several times to submit a "15-day" adverse incident report. She was unable to because the website that the Agency requires ALFs to use to submit adverse incident reports was malfunctioning.

Training

8. Due to a tragic fire, the Agency charged Greenleaf with providing inadequate safety training. Greenleaf has a "Fire Safety Plan," which was in effect at all relevant times. It included the following section.

> **Fire Safety Training**
> A record of monthly fire drills is kept and logged by the Assistant Administrator. The day after each drill a staff meeting will be called and mistakes will be discussed and solutions to problems will be recommended.
>
> **Training in Fire Control:**
> In-service for staff regarding Fire Safety and Disaster Plans will be done every first Wednesday of each month on the = Use of fire extinguishers, confining and securing areas in case of fire.

[4] The undersigned noted the reliance upon hearsay and the limits of its use many times during the hearing.

> **Fire Plan:**
> All personnel should be familiar with the plan by frequent in-service. For new employees, copies of disaster plan will be handed. Unannounced fire drills to be conducted on an ongoing basis.

9. Greenleaf did not provide in-service training regarding Fire Safety and Disaster Plans on the first Wednesday of each month as provided in its fire safety plan. It also did not provide training in use of fire extinguishers on the first Wednesday of each month as provided in one "Annex A" to its fire safety plan. (Ex. 35-15). Similarly, it did not conduct monthly fire drills as provided by another "Annex A" to its fire safety plan. (Ex. 35-11).

10. Greenleaf did, however, provide fire safety and emergency training to its employees. Greenleaf conducted four fire drills per shift per year for its employees, resulting in each employee participating in four drills per year. Employees, including Ms. Drybola and Ms. Terredanio, and residents, participated in the drills. The drills included review of use of a fire extinguisher. The review did not include physically using a fire extinguisher. Verbal and video instruction was provided. Use of a fire extinguisher is one of the first trainings Greenleaf provided new employees. The drills did not specifically address the circumstance of a resident literally catching fire or a resident being covered with flaming fabric.

11. The undersigned recognizes that some employees testified, albeit inconsistently, that they had not been trained. However, other testimony of the same employees about what they did and why indicates that they had received training. For instance Ms. Drybola, when asked what she would have done based on a normal fire drill, responded by saying she would assist a resident with clothes on fire by using a wet or fireproof blanket. When asked if the day's event went like previous fire drills, she responded "no." She did not respond that there had been no fire drills. She also stated, "This time we had a real person," implying that she had been through the procedures before without "a real person." (Tr. V. 3, p. 425). This testimony indicates she

had received training. Ms. Drybola also acknowledged receiving emergency training on August 26, 2019.

12. The testimony of Mr. Harman similarly indicates that Greenleaf trained its employees. He said that he had not received training. Yet he said he received verbal instructions on how to respond to an emergency for evacuation. (Tr. V. I, p. 122). He also referred to having had a fire drill two or three months before the incident. (Tr. V. I, p. 127). Mr. Harman also referred to the fire drill training as mandatory. Ms. Terredanio's testimony also supports finding that Greenleaf trained its employees in fire safety and other emergency procedures. The fact that she could describe how to use the fire extinguisher enhanced her credibility and persuasiveness. Furthermore, Ms. Terredanio described other emergency responsibilities and procedures. (Tr. V. IV, pp. 465-468).

13. The employees received training in emergency procedures, including fire safety procedures. The statements of some employees about not receiving training appear to be due to difficulty understanding questions, nervousness, and a lack of clarity in questions about what "training" is. The training was irregular. The Agency did not prove that the training was inadequate. It did not prove what the training consisted of or how frequently it occurred, even though Agency employees knew Greenleaf's plan provided for a training log that could have been offered into evidence. The Agency could have offered personnel files into evidence to demonstrate employees had not received training. The Agency did not do this. In addition, the Agency did not offer testimony from a witness qualified under section 90.702 to offer an opinion about what adequate emergency training would be.

The Fire

14. A tragic and fatal fire on January 25, 2020, is the genesis of Case No. 20-1469. The incident was recorded by a video camera facing down a hallway. The 15 minute, 33 second video records events occurring on one section of one hallway in a two-story building. The findings here are based on review of the

video recordings and testimony from two employees who worked to save the resident. The recordings and employee testimony are the only direct and persuasive evidence of events.

15. The fire started in room 9 on the first floor. Resident 1, a smoker with lung problems who used an oxygen concentrator, lived in Room 9. That day an oxygen concentrator was in the room. Around 1:25 on the afternoon of January 25, Erin Drybola, who served Greenleaf residents as a caregiver and provided housekeeping services to Greenleaf, heard a fire alarm sounding off. She ran toward the alarm and found a fire in room 9, where Resident 1 was. Smoke began to fill the hallways. The fire sprinklers activated and emergency lights began flashing.

16. Ms. Drybola beckoned for help and entered the room. She found Resident 1 in her wheelchair, beside the bed, engulfed in flames. Ms. Drybola called for Marietta Terredanio to come help. Smoke quickly grew thicker. Another employee in the hall, closer to the lobby, began directing residents toward the lobby exit on the south side of the building. A worker dressed in scrubs also evacuated residents through a west side exit on the dining room end of the hall. A male staff member ran down the hall toward another area of the facility to assist residents with evacuation.

17. Ms. Drybola ran to get a telephone and returned with it, calling as she ran. This took approximately 23 seconds. More residents hastened toward the dining room, west exit area, with encouragement from staff. Ms. Drybola re-entered the room with the fire. Resident 1's wheelchair and a lap blanket or wrap of some sort covering her lower body were burning.

18. Ms. Drybola and Ms. Terredanio tried to extinguish the flames with a blanket, although it was not a "fire blanket." Their efforts failed. Ms. Drybola and Ms. Terredanio moved Resident 1 in the flaming wheelchair from room 9 to the hall because of the danger that the oxygen concentrator posed. At this time, approximately one minute and 27 seconds after the alarm sounded, smoke made it almost impossible to see except the area around the

wheelchair illuminated by the fire. Ms. Drybola pushed the wheelchair down the hall to a more open area in front of an elevator. This kept the burning wheelchair and resident from blocking the hall. At this point, the smoke was so thick, only the resident and her wheelchair are visible in the recording.

19. Ms. Terredanio ran to get pitchers of water from the kitchen adjacent to the dining room to pour on the flames. Ms. Drybola did too. These trips resulted in the resident being left alone for brief periods. The resident struggled to leave the wheelchair. Although the video does not have sound, Resident 1's moving lips and heaving chest indicate she was crying or screaming. Ms. Drybola made three trips, each with two pitchers of water. Ms. Terredanio made one trip.

20. Ms. Drybola and Ms. Terredanio substantially extinguished the fire within three minutes and thirty-nine seconds of Ms. Drybola hearing the alarm.

21. Ms. Drybola and Ms. Terredanio directed more residents down the hall toward the dining room exit. Ms. Drybola supported one resident as he walked.

22. Three rooms down from room 9 and on the other side of the hall, a fire extinguisher hung on the wall. Ms. Drybola and Ms. Terredanio did not use the fire extinguisher on Resident 1 because they feared that the chemicals in it were dangerous to a human. Their trainings had not addressed what to do when a person is aflame.

23. A police officer arrived at about 1:29 p.m., four minutes after the alarm sounded. At almost the same time, Ms. Drybola escorted some of the last of the residents visible from the area. The officer pulled charred, still smoking fabric from the back of Resident 1's chair and from Resident 1. He was carrying a fire extinguisher. The officer put down the fire extinguisher. Like Ms. Drybola and Ms. Terredanio, the officer elected to use pitchers of water to extinguish smoldering spots on the wheelchair. Like Ms. Drybola

and Ms. Terredanio, he prioritized extinguishing the fire and briefly left Resident 1 alone while he obtained more water.

24. After giving the officer another pitcher of water, Ms. Drybola went to a barely visible area off the lobby to escort two more residents out. Another employee identified one last resident in a room beside the elevator and, along with an officer, directed him out of the area toward the dining room exit.

25. Firefighters did not arrive until the fire was extinguished and police officers were in charge of the scene. At the time the firefighters arrived, at least three officers were tending to Resident 1, managing the scene, and directing the activities of Greenleaf employees.

26. The video records a horrific, chaotic scene: a burning resident struggling in a burning wheelchair and smoke so thick a person could not see past her extended arm. Ms. Drybola and Ms. Terredanio acted bravely and quickly in an effort to save Resident 1 and other residents. They made their best judgment about the risks of using a fire extinguisher, a judgment validated by the officer's election to use water, not his fire extinguisher.

27. While the events described above played out on the first floor, Kevin Harman evacuated residents from the second floor. Mr. Harman was working as cook that afternoon. He had been trained that when the fire alarm sounded the "cook is supposed to go upstairs, going door-to-door, knocking on them, opening them, making sure everybody is out." (Tr. V. I, p. 121) As soon as he heard the alarm, that is what he did. Mr. Harman went upstairs and started evacuating residents.

28. One resident in a wheelchair had difficulty walking. Mr. Harman started taking the resident down the stairs, step by step in his wheelchair. The resident was anxious, and Mr. Harman feared he would fall. Mr. Harman changed to helping the resident scoot down the stairs on his behind. By the time they got about halfway down the stairs, two officers arrived and took over. They supported the resident walking down the stairs and out the

exit. Mr. Harman fulfilled his responsibilities and evacuated the upstairs residents quickly.[5]

29. With the exception of fire extinguisher use, Greenleaf employees, visible in the video recording complied with the facility's fire safety plan. It is also important to note that the video records activities on one segment of one hall on one floor of a two-story facility. The only evidence about activities in other parts of the facility is the testimony about Mr. Harman successfully fulfilling his responsibilities. Smoke from the fire quickly obscured visibility in the hall. Moreover, the horrific, extraordinary sight and sound of Resident 1 burning was enough to cause panic in anyone, regardless of training. To the extent there is such a thing as an ordinary emergency, this was no ordinary emergency.

30. Greenleaf took several actions after the fire. It brought in counselors to provide long-term services to residents and employees. It dramatically increased emergency training frequency, especially for fires.

Smoking Policies and Practices

31. Greenleaf permitted residents to have and use tobacco products, including cigarettes. Rule 59A-36.007(6)(d) requires an ALF to have rules and procedures that must address the facility's policies about alcohol and tobacco use. This necessarily contemplates ALF residents smoking. Greenleaf had a tobacco policy. But it was not offered into evidence. Greenleaf prohibited smoking inside the building. Gleaning from a resident's tobacco use policy acknowledgement (Ex. 52-15), the policy designated a smoking area,

[5] Mr. Harman's testimony presents a good example of the weaknesses and ambiguity of the Agency's evidence. He said that he had no emergency response training. (Tr. V. I, p. 121). Yet in the next sentence he said he "was verbally told what I was supposed to do, but there was no training connected to it." Training would encompass being "verbally told what to do." Training is teaching. No specific method is required. *https://www.merriam-webster.com/dictionary/train* (last visited November 15, 2020.) Even the Agency's counsel's questions acknowledge verbal instruction as training. ("[Y]ou said that the only training you received was verbal instruction … ." [Tr. V. I, p. 122]). Mr. Harman was able to describe his responsibilities in an emergency. (Tr. V. I, p. 121). And he drew on that training to care for second-floor residents.

prohibited smoking in bedrooms or anywhere else inside the building, and required residents to acknowledge that smoking inside the building endangered residents, staffs, and visitors. The policy apparently also provided that a resident would be given a 45-day notice or evicted for violating the smoking policy. Until the fire, Greenleaf permitted residents to keep their cigarettes and lighters in their rooms.

32. Greenleaf employed Jackie Shelton from sometime in June 2019 to about March 31, 2020. Two or three months after she began working at Greenleaf, Ms. Shelton observed signs of residents smoking in the facility. This was no earlier than August 2019 to no later than mid-October 2019. The signs included smelling smoke in a room and seeing cigarette butts in the garbage. She verbally reported the signs of residents smoking in the facility to Ms. Campbell, the facility administrator. Ms. Campbell told Ms. Shelton that she would "look into it." Greenleaf did not have a process for monitoring resident compliance with smoking rules. There is, however, no rule or statute that requires a process. There is also no testimony from an expert qualified under section 90.702 to offer opinions that could support a finding that an ALF should have a policy for monitoring smoking by residents.

33. The Agency maintains that Ms. Campbell knew that Resident 1 smoked in her room. The Agency, however, did not prove this. It offered only hearsay evidence of statements allegedly made by residents to Agency employees. It did not offer testimony from any of the residents.

34. Greenleaf did learn that Resident 2 smoked in the bathroom the day after the fire. It promptly issued a warning and a "45 day notice" of eviction to Resident 2. By the time of the hearing, Greenleaf had not evicted Resident 2 because it could not find a placement for him due to his mental health issues and the limited number of ALFs with mental health licenses.

35. After the fire, Greenleaf changed its smoking practices. It now requires residents to give their smoking materials to staff. Greenleaf staff places the materials in plastic containers kept in the kitchen or medicine

room. Residents must ask for them when they wish to smoke. Greenleaf still only permits smoking in a designated outside area.

CONCLUSIONS OF LAW

Jurisdicition and Burden of Proof

36. Sections 120.569 and 120.57(1), Florida Statutes (2020), grant the Division jurisdiction over the parties to and the subject matter of this proceeding.

37. This case involves the Agency's prosecution of an administrative complaint seeking to impose fines on Greenleaf and revoke its license. The Legislature has charged the Agency with the responsibility of licensing ALFs. Ch. 429, Part I, Fla. Stat. This includes responsibility for imposing sanctions for violations of statutes or rules. §§ 408.813 & 429.14, Fla. Stat. The Agency must prove the grounds for sanctioning Greenleaf by clear and convincing evidence. *Dep't of Banking & Fin. v. Osborne Stern & Co.*, 670 So. 2d 932 (Fla. 1996); *Ferris v. Turlington*, 510 So. 2d 292 (Fla. 1987); *Coke v. Dep't of Child. & Fam. Servs.*, 704 So. 2d 726 (Fla. 5th DCA 1998).

38. The opinion in *Evans Packing Company v. Department of Agriculture and Consumer Services*, 550 So. 2d 112, 116 n. 5 (Fla. 1st DCA 1989), defined clear and convincing evidence as follows:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence 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 the firm belief of 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).

39. This well known, long established, standard of proof plays a role in the Agency's failure to prove some charges. For example the Agency seeks to

sanction Greenleaf for failure to have a current background screening for an employee whose last name the Agency witness cannot remember based upon testimony about a document and computer screen observed over nine months ago. The evidence is not precise or explicit, distinctly remembered, or lacking in confusion.

40. Also, in disciplinary proceedings, the statutes and rules for which a violation is alleged must be strictly construed in favor of a respondent. *Elmariah v. Dep't of Prof'l Reg.*, 574 So. 2d 164 (Fla. 1st DCA 1990); *Taylor v. Dep't of Prof'l Reg.*, 534 So. 2d 782, 784 (Fla. 1st DCA 1988).

Count I (Section 429.26(7) and Rule 59A-36.007(1))

41. Section 429.26(7) requires a facility to "notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment." The Agency does not address this alleged violation in its Proposed Recommended Order and therefore has abandoned it.[6] The Agency also did not prove a violation of this statute.

42. Rule 59A-36.007(1), under the heading "SUPERVISION," requires an ALF to "provide care and services appropriate to the needs of the residents … ." It lists six specific requirements such as maintaining a general awareness of residents' whereabouts and notifying healthcare providers and family members of significant changes in a resident. The Agency did not prove a violation of this rule. The Agency's theory is that Greenleaf violated this rule by its response to the fire and failure to monitor residents' smoking.

[6] The Proposed Recommended Order is the most recent and complete statement of the Agency's claims. Any violation not included in the Proposed Recommended Order is deemed abandoned, as are violations asserted without citation to the record support for them. *Cf. D.H. v. Adept Cmty. Servs.*, 271 So. 3d 870 (Fla. 2018) (Claims of error not raised in initial brief deemed abandoned); *Wickham v. State*, 124 So. 3d 841, 860 (Fla. 2013) (Failure to pursue a claim amounts to abandonment of the claim.); *Downs v. Moore*, 801 So. 2d 906, 912, n. 9 (Fla. 2001) (Failure to propose jury instruction on an issue is deemed abandonment of the issue).

None of the Agency's assertions fall within any reasonable construction of the rule, let alone a strict construction. The Agency did not prove Count I of its Administrative Complaint.

Count II (Sections 429.176 and 429.52(4) and (5) and Rule 59A-36.010)

43. Section 429.176 requires an ALF to notify the Agency if the ALF owner changes administrators. The Agency offered no evidence of a violation of this statute. It also did not refer to the alleged violation in its Proposed Recommended Order. The charge is therefore abandoned.[7]

44. Section 429.52(4) imposes training, education, and testing requirements for newly employed ALF administrators. Section 429.52(5) imposes continuing education requirements on ALF administrators. The Agency offered no evidence tending to prove a violation of either statute.

45. Rule 59A-36.010, titled "Staffing Standards," establishes standards for an ALF administrator in paragraph (1) and for ALF staff in paragraph 2. It also imposes facility staffing standards. Rule 59A-36.010(1) states that an 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 as required by [law and rule]."

46. Rule 59A-36.010(2), titled "STAFF," imposes several requirements for ALF staff. The Agency relies upon a requirement that "[s]taff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience." Fla. Admin. Code R. 59A-36.010(2)(b). Rule 59A-36.010(2)(c) mandates that staff "comply with the training requirements of rule 58A-5.0191." That rule has been renumbered as rule 59A-36.011. The only part of the rule applicable here is rule 59A-36.011(3)(b)2. It requires ALFs to provide direct care staff "a minimum of 1 hour in-service training within 30 days of employment that covers," among other things, "[f]acililty emergency procedures including chain-of-command

[7] *See* footnote 6, *supra*.

and staff roles relating to emergency evacuation." The relevant evidence related to this requirement that the Agency could have, but did not, offer includes the training log (or absence thereof) referred to in Greenleaf's fire safety plan and training documentation from employee personnel files.

47. The Agency's primary theory for the alleged violation is that the Greenleaf staff's response to the horrific fire of January 25, 2020, proves that the staff were not qualified due to inadequate training. Opinions have recognized that employees failing to perform as trained is not clear and convincing evidence that their employer failed to satisfy its training obligations. *See Pic N' Save Cent. Fl., Inc. v. Dep't of Bus. Reg, Div. of Alcoholic Bev. & Tobacco*, 601 So. 2d 245 (Fla. 1st DCA 1992) (Employees violating law prohibiting selling alcohol to minors did not prove that employer had not fulfilled its obligation to train them.). Also the Agency did not offer persuasive evidence showing what training employees should have had or what training they had.[8] Furthermore it did not offer expert opinion evidence demonstrating how trained employees would necessarily react in the extreme circumstances of this case.

48. The Agency argues that because no one greeted firefighter Stephen Gonnella to direct him to the fire when he arrived at the facility the facility did not train its staff properly in compliance with its emergency plan. The proof for this claim is insufficient for several reasons. First, the building had two entrances. Greenleaf staff would have no way of knowing which entrance to monitor for emergency personnel. They would also have had to leave the duties of evacuating residents to wait to greet the arriving personnel. Second, the firefighters were not the first responders. Police officers were. Third, firefighters came into the building through at least two entrances. The fact

[8] Expert testimony is an appropriate way to prove the adequacy of training. *See, e.g., Russo v. City of Cincinnati*, 953 F.2d 1036, 1047 (6th Cir. 1992) (Expert opinion that police training was inadequate was sufficient to preclude summary judgment for the City.); *Parker v. D.C.*, 850 F.2d 708, 713 (D.C. Cir. 1988) (Expert opinion testimony about inadequate training for police officers supported judgment against police force.)

that someone did not greet Mr. Gonnella and direct him to the fire does not mean that the firefighters coming in other entrances were not properly directed. The smoking entrance to Resident 1's room was visible from the lobby door through which several firefighters entered. Finally, by the time the firefighters arrived, the officers, Ms. Drybola, and Ms. Terredanio, had extinguished the fire, and the officers had taken over responsibility for caring for Resident 1 and directing staff's activities. Any duty to direct emergency responders to the site of the emergency had been fulfilled. The Agency did not prove Count II of the Administrative Complaint by clear and convincing evidence.

Count III (Rule 59A-36.010(2))

49. The Agency's charge and arguments for Count III rehash the charge and arguments of Count II. They have been addressed above. The Agency did not prove Count III of the Administrative Complaint.

Count IV (Section 429.19(7))

50. Section 429.19(7) authorizes the Agency to assess a survey fee "equal to the lesser of one half of the facility's biennial license and bed fee or $500," to cover the cost of complaint investigations resulting in a finding of a violation. The Agency offered no evidence to prove the amount of Greenleaf's biennial license and bed fee. This makes conducting the analysis required by section 429.19(7) to determine which is less $500.00 or one-half of the facility's biennial license and bed fee impossible. Consequently, the Agency may not impose a survey fee. *Cristal Palace Resort PB, LLC v. Ag. for Health Care Admin.*, Case No. 19-1667 (Fla. DOAH March 17, 2017), *adopted in part*, AHCA No. 2019000548 (AHCA May 5, 2020). The Agency did not prove Count IV of the Administrative Complaint.

Count V (Section 429.14(1)(e)1.)

51. Section 429.14(1) empowers the Agency to revoke a license and impose fines for violations of Part I (governing ALFs), Chapter 429 of the Florida Statutes. Section 429.14(1)(e)1. specifically authorizes license revocation for

one or more Class I violations of section 429.19. Section 408.813(2)(a) defines Class I violations as follows:

> Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.

52. The Agency has not proven a Class I violation. Therefore it has not proven Count V.

Count VI (Sections 408.809, 429.174, and 435.06(2)(a through d))

53. The statutes the Agency relies upon for the charges in Count VI impose background screening requirements for ALF employees. The Agency argues that Greenleaf violated these requirements for Eric (last name unknown) and Ms. Castleberry. The Agency did not prove the charges by clear and convincing evidence. When the Agency cannot even provide the last name of "Eric," the evidence surely is not distinctly remembered, precise, and explicit. The Agency cannot dispute that Ms. Castleberry did not have a current background screening. It certainly did not prove it by clear and convincing evidence. Ms. Campbell was able to immediately print a copy of a background screening for Ms. Castleberry when asked about it.

54. The Agency relies upon a theory that the background screening does not satisfy the statutory requirements unless a printed copy is physically in an employee's file. (Tr. V. I, p. 137). The Agency did not charge a violation of

rule 59A-35.090(3)(c) which requires an employer to maintain eligibility results of employee screening in the employee's personnel file. Consequently, it may not impose a fine for violation of that rule. *Klein v. Dep't of Bus. & Prof'l Reg.*, 625 So. 2d 1237 (Fla. 2d DCA 1993). *See also Trevisani v. Dep't of Health*, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005)("A physician may not be disciplined for an offense not charged in the complaint."); *Marcelin v. Dep't of Bus. & Prof'l Reg.*, 753 So. 2d 745, 746-747 (Fla. 3d DCA 2000)("Marcelin first contends that the administrative law judge found that he had committed three violations which were not alleged in the administrative complaint. This point is well taken… . We strike these violations because they are outside the administrative complaint."); and *Delk v. Dep't of Prof'l Reg.*, 595 So. 2d 966, 967 (Fla. 5th DCA 1992)("[T]he conduct proved must legally fall within the statute or rule claimed [in the administrative complaint] to have been violated.").

55. The Agency has not proven Count VI.

Count VII (Rule 59A-35.110)

56. Rule 59A-35.110(2)(a)2. requires ALFs to report adverse incidents. It states:

> Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, April 2017, which is hereby incorporated by reference and availiable [sic] at: *https://www.flrules.org/Gateway/reference.asp?No=Ref-08778*, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: *https://apps.ahca.myflorida.com/SingleSignOnPortal.*

57. Section 429.23(2)(a) defines "adverse incident" as "[a]n event over which facility personnel could exercise control rather than as a result of a

resident's condition and results in" a list of incidents and conditions such as brain damage, bone fractures, and transfer to a facility providing more acute care. The alleged adverse incident is a fall while the resident was not in the facility and the consequences of that fall. Due to its reliance upon hearsay testimony, the Agency did not prove that an "adverse incident" triggering the reporting requirement occurred. If it had proved the alleged incident, the incident was not an event over which facility personnel could exercise control. The Agency has not proven Count VII.

Conclusion

58. This is a proceeding under chapter 120. Sections 120.569 and 120.57 give citizens and businesses a right to an administrative hearing when they dispute the facts that a government agency relies upon to take an action, such as revoking a license. *Buchheit v. Dep't of Bus. & Prof'l Reg., Div. of Fla. Land Sales, Condos & Mobile Homes*, 659 So. 2d 1220 (Fla. 4th DCA 1995). As reviewed earlier, long established, well known principles require an agency to prove charges for which it intends to impose a sanction by clear and convincing evidence. This standard is more rigorous than the "preponderance of the evidence" standard in civil proceedings, but not as rigorous as the "beyond a reasonable doubt" standard of criminal proceedings. *State v. Graham*, 240 So. 2d 486, 488 (Fla. 2d DCA 1970).

59. Section 120.57(1)(c) permits hearsay evidence in administrative hearings but specifies that hearsay evidence alone is not sufficient to support a finding of fact unless it would be admissible over objection in circuit court. Application of the hearsay rule is no mere legal technicality. The hearsay rule is one of the oldest and most effective means of ensuring decisions that determine people's lives and fortunes are based on reliable information. Florida's Fifth District Court of Appeal described the importance of the rule as follows:

> Rules governing the admissibility of hearsay may cause inconvenience and complication in the presentment of evidence but the essence of the

> hearsay rule is the requirement that testimonial assertions shall be subjected to the test of cross examination. 5 Wigmore on Evidence, § 1362 (Chadbourne Rev. 1974). As stated by Professor Wigmore, the hearsay rule is "that most characteristic rule of the Anglo-American law of evidence -- a rule which may be esteemed, next to jury trial, the greatest contribution of that eminently practical legal system to the world's methods of procedure." 5 Wigmore on Evidence, at § 1364.

Dollar v. State, 685 So. 2d 901, 903 (Fla. 5th DCA 1996).

60. Application of the clear and convincing burden of proof and the limits upon the use of hearsay play a material role in the resolution of this case. Overlooking these principles has contributed to the inability of agencies to prove charges in other proceedings. *See, e.g., Cristal Palace Resort PB, LLC v. Ag. for Health Care Admin.*, Case No. 19-1667 (Fla. DOAH Mar. 17, 2020), *modified in part*, AHCA No. 2019000548 (AHCA May 5, 2020)[9]; *Hospice of Fla. Suncoast, Inc. v. Ag. for Health Care Admin.*, Case No. 18-4986 (Fla. DOAH Sept. 17, 2019), *modified in part* (Fla. AHCA Oct. 16, 2019); *Ag. for Health Care Admin. v. Blue Angel Enterprises, Inc.*, Case No. 18-6677 (Fla. DOAH July 5, 2019), *modified in part*, AHCA Nos. 2018004077 and 2018004263 (Fla. AHCA Sept. 17, 2019); *Ag. for Health Care Admin. v. Cristal Palace Resort PB, LLC*, DOAH Case No. 17-2149 (Fla. DOAH June 29, 2018) *modified in part,* Case No. 2017004532 (Fla. AHCA Aug. 15, 2018); *MILA ALF, LLC v. Ag. for Health Care Admin.*, Case No. 17-1559 (Fla. DOAH May 10, 2018), *modified in part*, AHCA No. 2015010344 (Fla. AHCA July 12, 2018); and *Dep't Child. & Fam. v. Early Years Child Dev. Ctr.*, Case No. 16-6249 (Fla. DOAH Mar. 30, 2017), *modified in part* Rendition No. DCF-17-285FO (Fla. DCF Dec. 22, 2017). Like the agencies in these cases, the Agency in this proceeding relied upon hearsay reports of interviews of

[9] The undersigned advised counsel of this Order during a pre-hearing conference and cited it in the Pre-hearing Order entered May 7, 2020.

residents, hearsay in survey notes, and hearsay testimony about what documents said. This and the standard of proof contributed to the outcome in this proceeding.

61. The Agency failed to prove the charges of the Amended Administrative Complaint by clear and convincing evidence.

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 dismissing the Amended Administrative Complaint.

DONE AND ENTERED this 25th day of November, 2020, in Tallahassee, Leon County, Florida.

JOHN D. C. NEWTON, II
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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.