2020 OCT 20 A 9:45

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

FAIR HAVENS OPCO, LLC, d/b/a FAIR HAVENS CENTER

Respondent.
_____/

AHCA Nos. 2019010507
(moratorium) 2020008373
2020008697
License No. 1147096
File No. 111309
Provider Type: Nursing Home
RENDITION NO.: AHCA- 20-0681 **-S-OLC**

FINAL ORDER

Having reviewed the Administrative Complaints, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the attached Administrative Complaints and Election of Rights forms to the Respondent. (Composite Ex. 1) The parties have since entered into the attached Settlement Agreement, which is adopted and incorporated by reference into this Final Order. (Ex. 2)

2. The Respondent shall comply with the terms of the Settlement Agreement, including but not limited to those relating to the requirements of operation and construction.

3. The Respondent shall pay the Agency $67,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 60 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

Central Intake Unit
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 61
Tallahassee, Florida 32308

4. Conditional licensure statuses are imposed on the Respondent, the first beginning on June 21, 2019, and ending on July 21, 2019, and the second beginning on May 7, 2020.

5. The action seeking license revocation is withdrawn.

6. The Immediate Moratorium on Admissions is lifted upon entry of this Final Order.

ORDERED at Tallahassee, Florida, on this 16 day of October, 2020.

Secretary, for
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 16 day of October, 2020.

Richard L. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Jan Mills, Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Kimberly Smoak, Bureau Chief Bureau of Field Operations Agency for Health Care Administration (Electronic Mail)	Bernard Hudson, Unit Manager Long Term Care Licensing Unit Agency for Health Care Administration (Electronic Mail)

Scott Waltz, Bureau Chief Office of Plans and Construction Agency for Health Care Administration (Electronic Mail)	Arlene Mayo-Davis, Field Office Manager Regional Field Office – 11 Agency for Health Care Administration (Electronic Mail)
Andrew B. Thornquest, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Peter A. Lewis, Esquire Law Offices of Peter A. Lewis, P.L. palewis@petelewislaw.com (Electronic Mail)
Gisela Iglesias, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Amy W. Schrader, Esquire Baker, Donelson, Bearman, Caldwell & Berkowitz, PC aschrader@bakerdonelson.com (Electronic Mail)
Thomas M. Hoeler, Chief Facilities Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Jesika A. Polack, NHA Fair Havens Center 201 Curtiss Parkway Miami Springs, Florida 33166 (U.S. Mail)
Tracie Gerrell Operations & Management Consultant II Division of Health Quality Assurance Agency for Health Care Administration (Electronic Mail)	

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

Case No.: 2019010507
Facility Type: Nursing Home

vs.

FAIR HAVENS OPCO, LLC,
d/b/a FAIR HAVENS CENTER,

Respondent.

/

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration ("Agency"), by and through the undersigned counsel, and files this Administrative Complaint against Fair Havens OPCO, LLC, d/b/a Fair Havens Center (hereinafter "Respondent"), pursuant to §§120.569 and 120.57 Florida Statutes (2019), and alleges:

NATURE OF THE ACTION

This is an action to change Respondent's licensure status from Standard to Conditional commencing June 21, 2019, and to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) based upon Respondent being cited for one (1) isolated Class I deficiency and a survey fee of six thousand dollars ($6,000.00) for a total of sixteen thousand dollars ($16,000.00).

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60 and 400.062, Florida Statutes (2019).

COMPOSITE
EXHIBIT
1

2. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code.

PARTIES

3. The Agency is the regulatory authority responsible for licensure of nursing homes and enforcement of applicable federal regulations, state statutes and rules governing skilled nursing facilities pursuant to the Omnibus Reconciliation Act of 1987, Title IV, Subtitle C (as amended), Chapters 400, Part II, and 408, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

4. Respondent operates a two hundred sixty-nine (269) bed nursing home, located at 201 Curtiss Parkway, Miami Springs, Florida 33166-5291 and is licensed as a skilled nursing facility, license number 1147096.

5. Respondent was at all times material hereto, a licensed nursing facility under the licensing authority of the Agency, and was required to comply with all applicable rules, and statutes.

COUNT I

6. The Agency re-alleges and incorporates paragraphs one (1) through five (5), as if fully set forth herein.

7. Pursuant to Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the "right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and

must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan." § 400.022(1)(k), Florida Statutes (2018). Additionally, the statement shall also assure each resident the "right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the [A]gency." § 400.022(1)(l), Florida Statutes (2018).

8. On or about June 21, 2019, the Agency completed a survey of Respondent and its facility.

9. Based upon the review of records, observation, and interviews, Respondent failed to honor the advance directives of one (1) out of nine (9) residents as evidenced by initiating cardiopulmonary resuscitation (CPR) on one resident with a Do Not Resuscitate Order (Resident #3). This failure had the potential to affect one hundred twenty-one residents residing in Respondent's facility who had Do Not Resuscitate Orders.

10. The Agency's representative conducted a review of Respondent's policy titled, "Advanced Directives" which was revised in December 2016. The policy provided that information about whether or not a resident has executed an advanced directive shall be displayed prominently in the medical record. The plan of care for each resident was required to be consistent with the resident's documented treatment preferences and/or advanced directive. The policy also set forth that a resident has the right to refuse treatment, whether or not he/she has an advanced directive and that a resident will not be given treatment against his/her wishes.

11. Respondent's policy statement titled "Resident Rights" (undated) stated that Federal and State laws guarantee certain basic rights to all residents in its facility. These rights include the

resident's rights to self-determination, participation in decision making regarding care, and participation in his/her care planning and treatment.

12. Further review of Respondent's records revealed that Resident #3 was admitted to the facility on December 29, 2009. Resident #3 was readmitted to Respondent's facility on May 15, 2019 through May 18, 2019. On May 18, 2019, the resident was sent to a local hospital due to shortness of breath. Resident #3 was readmitted to the facility on May 22, 2019 through May 27, 2019. On May 27, 2019, the resident again had shortness of breath (SOB). The resident's oxygen saturation was 83% with oxygen being administered to the resident at a rate of 2 liters/minute, the respiratory rate was 16 breaths/minute, the blood glucose fingerstick was 240, blood pressure was 98/50, breathing was labored and the resident's skin was clammy. The resident was sent to a local hospital by 911/rescue. Resident #3 was subsequently readmitted to Respondent's facility on June 10, 2019 and the resident expired at the facility on June 11, 2019.

13. Resident #3's records revealed that the resident had multiple diagnoses including sepsis, atherosclerotic heart disease, anemia, diabetes mellitus, acidosis, hyponatremia, fluid overload, psychotic disorder, depression, anxiety, epilepsy, metabolic encephalopathy, hypertension, cardiomyopathy, atrial fibrillation, cardiac arrhythmia, congestive heart failure, end stage renal disease with dialysis, and cerebrovascular accident.

14. Resident #3's records also revealed a Do Not Resuscitate order dated May 27, 2019 and signed by two physicians and resident #3's health care proxy. The State of Florida Do Not Resuscitate (DNR) Order form was on file in Resident #3's clinical record. Review of the physician's order sheets for the admissions of May 22. 2019 through May 27, 2019 and June 10, 2019 through June 11, 2019, revealed the code status checked for "Do Not Resuscitate." A

review of Respondent's demographic face sheet for the admission of June 10, 2019 revealed the code status documented as "Full Code."

15. According to the records, Resident #3's last readmission to Respondent's facility was on June 10, 2019, with diagnoses including pleural effusion, pneumonia, and ESRD (end stage renal disease). Physician's orders included the use of a BiPAP (bilevel positive airway pressure) machine at HS (hour of sleep) and prn (as needed). A BiPAP machine is a type of non-invasive mechanical ventilator that can help push air into the lungs. There was also an order for O2 (oxygen) at 4 L (liters) per minute continuous via NC (nasal cannula).

16. Daily skilled nursing notes dated June 11, 2019 showed;

> 12:40 AM Resident received in bed with HOB (head of bed) elevated. Awake, alert. BiPAP and O2 @ 4 L/NC in use. Respirations unlabored. Call bell in reach. No signs or symptoms (s/s) of hypo/hyperglycemic episode. No s/s of distress or discomfort. Vitals assessed. Pleasant demeanor.
>
> 1:15 AM Resident noted unresponsive, eyes open. BiPAP in use with 4 L/NC. Skin warm and dry. No response to name called. Unable to detect vital signs, CPR (Cardiopulmonary Resuscitation) in progress.
>
> 1:20 am Called placed to rescue 911, report reported.
>
> 1:25 AM Rescue arrived at 1:15 @ bedside, [sibling] aware.
>
> 1:30 AM Resident declared expired by rescue. Doctor made aware.
>
> 1:35 AM [Sibling] at bedside with other family members.

17. On June 19, 2019 at 1:38 p.m., the Agency's representative interviewed Staff I, a licensed practical nurse via telephone. Staff I reported that Resident #3 was a resident who was at Respondent's facility for a very long time. Resident #3 was dependent on staff for all care. Resident #3 was not verbal but was able to gesture with his/her needs. The resident had just returned from the hospital the afternoon before he/she expired. The resident was using a Bi-PAP machine and continuous oxygen. When Staff I went to check on Resident #3, the resident was

not responding and was sitting upright in the bed. Resident #3 had the Bi-PAP machine and the oxygen on. When Staff I entered the room, Staff I saw the resident with his/her eyes open, but the resident was not looking at Staff I. Staff I called the resident's name and did not receive a response. Normally, the resident would always look at you. Staff I had just recently checked on Resident # 3 and he/she had been alert and happy to be back at the facility. Staff I immediately called the supervisor who was present on the floor. The supervisor immediately checked on Resident #3 and started to perform cardiopulmonary resuscitation on the resident. While the supervisor was performing cardiopulmonary resuscitation, another nurse called 911 and the crash cart was brought into the room. Cardiopulmonary resuscitation was continued until 911 arrived and took over from there. Staff I stated she was not in the room at this time because she was gathering the paperwork for them. If a resident has a Do Not Resuscitate Order, the staff would check the chart to get that information. The chart and the Medication Administration Record (MAR) have the yellow copy of the Do Not Resuscitate Order. If a resident is found unresponsive, Staff I stated they have to quickly check the chart or the Medication Administration Record to see if the resident has a Do Not Resuscitate Order. Staff I did not remember if Resident #3 had a Do Not Resuscitate Order.

18. During a follow up interview with Staff I on June 20, 2019 at 11:44 a.m., Staff I reported that when she found Resident #3 unresponsive, she alerted the supervisor immediately. The resident's room was close to the supervisor's office. The other nurse on the unit called 911. The crash cart was taken into the room and the supervisor started cardiopulmonary resuscitation. Resident #3 was Staff I's patient and she should have checked to see if the resident had a Do Not Resuscitate Order. In the process of all this running around, the staff immediately reacted in the moment and started cardiopulmonary resuscitation. Resident #3 was a young person. After the

cardiopulmonary resuscitation was started, the other nurse called 911 and gathered the papers. Staff J showed the supervisor the Do Not Resuscitate Order and he stopped performing cardiopulmonary resuscitation. Staff J did not know if her supervisor reported this to the Director of Nursing (DON).

19. The Assistant Director of Nursing (ADON)/Risk Manager was interviewed by the Agency's representative on June 20, 2019 at 8:26 a.m. The Assistant Director of Nursing/Risk Manager stated that Resident #3 was a long term resident who had been at Respondent's facility since 2009. Resident #3 had end stage renal disease (ESRD) with dialysis, congestive heart failure (CHF), diabetes, cardiac issues, and seizures. Resident #3 had been stable, but towards the end, the resident's congestive heart failure and fluid overload had been exacerbated. The resident's sibling was the resident's power of attorney and was very involved. Resident #3 was in and out of the hospital from the end of April through the time he/she expired. Resident #3 was readmitted on June 10, 2019 with a diagnosis of pleural efffusion, pneumonia, and end stage renal disease. Resident #3 was readmitted just before 5 p.m. on June 10, 2019, and passed away on the morning of June 11, 2019 at about 1:30 a.m. Resident #3's code status at the time of this admission was "Do Not Resuscitate." A Do Not Resuscitate Order was obtained when Resident #3 was in the hospital on May 27, 2019. The Assistant Director of Nursing/Risk Manager also stated that the resident's sibling stated they tried to intubate Resident #3 at the hospital, but the sibling did not want this and opted to sign a Do Not Resuscitate Order. Resident #3 returned to Respondent's facility with a Bi-PAP machine on June 10, 2019.

20. The Assistant Director of Nursing/Risk Manager reviewed the nurses notes for June 11, 2019 and could not explain why cardiopulmonary resuscitation was implemented for a resident with a Do Not Resuscitate Order. She stated that during all of his/her other admissions, Resident

#3 was a "full code." She added that normally, if a resident is found unresponsive, they will check for vitals. The supervisor is called right away and the chart is checked for Do Not Resuscitate status. Cardiopulmonary resuscitation is started or not depending on the code status. The yellow Do Not Resuscitate Orders are filed in the front of the Medication Administration Record and in the front of the chart binder. She stated she thought they checked Resident #3's status and called 911. She was not aware the staff performed cardiopulmonary resuscitation. This was the first she knew that they performed cardiopulmonary resuscitation on Resident #3. The nurse was very familiar with this resident and the resident had been a full code until May 27, 2019. She further stated that the protocol is simple - you check the vitals, check the chart and start cardiopulmonary resuscitation if the resident is a full code. If the resident has a Do Not Resuscitate Order, they are supposed to call non-emergency services and not perform cardiopulmonary resuscitation. The only reason she could think they provided cardiopulmonary resuscitation to Resident #3 was because Resident #3 had been "full code" for so long.

21. The Assistant Director of Nursing/Risk Manager further stated that if she became aware of a resident who did not have a Do Not Resuscitate Order and did not receive cardiopulmonary resuscitation or a resident received cardiopulmonary resuscitation and had a Do Not Resuscitate Order, an investigation would be conducted and the matter would be reported as an adverse incident. She claimed she never had this situation occur before. She did not report this incident or do an investigation because she was not aware Resident #3 received cardiopulmonary resuscitation. She further stated that part of the staff orientation included training on cardiopulmonary resuscitation and the Do Not Resuscitate process. The nurses receive a three (3) to four (4) day orientation and this training is done by either the nurse on the floor or the

supervisor. The Do Not Resuscitate/cardiopulmonary training is not done annually. It is part of the orientation.

22. The Director of Nursing (DON) was interviewed on June 20, 2019 at 11:55 a.m. She said she was not made aware that cardiopulmonary resuscitation had been administered to Resident #3. She was not aware of this incident until the day of the interview, June 20, 2019. The information she had received was that Resident #3 had been very sick for the past few months and in and out of the hospital. Resident #3's sibling was very involved with the resident's care and prior to this last admission, Resident #3 had always been a "full code." During Resident #3's last hospitalization, the sibling obtained a Do Not Resuscitate Order for the resident. The Do Not Resuscitate Order was in the resident's records. The Director if Nursing further stated that she found out that Resident #3 was found unresponsive and the supervisor was checking the resident's vital signs. The supervisor then started administering cardiopulmonary resuscitation. The nurse came in and advised the supervisor that the resident had a Do Not Resucitate Order and he stopped performing cardiopulmonary resuscitation. They called 911 and the resident was pronounced dead when they arrived. The Director of Nursing added that she did not know how this happened. The nurses know they have to check the chart first before starting cardiopulmonary resuscitation. If the chart is not there, there is even a copy of the Do Not Resuscitate Order in the Medication Administration Record so time would not be lost determining someone's code status. If the staff saw that something like this happened and they made an error, they have to report it to her as the Director of Nursing and the Assistant Director of Nursing/Risk Manager. She would then report it to the administrator. She would have started an investigation, notified the family and started to re-educate the staff. The Director of Nursing

stated that an investigation was now started and she will notify the resident's primary doctor and the Medical Director.

23. The Nursing Home Administrator (NHA) was interviewed on June 20, 2019 at 12:06 p.m. She stated she had no idea that cardiopulmonary resuscitation was initiated on a resident with a Do Not Resuscitate Order in place. She just found out this occurred today (June 20, 2019) when the Director of Nursing and Assistant Director of Nursing/Risk Manager found out. The Nursing Home Administrator added that when an incident like this occurs, they have to do an investigation, an adverse report, notify the family and "in-service" all of the nurses, certified nursing assistants, and everyone involved in the care of residents to make sure this does not happen again. She also stated that she was not aware of Respondent having a policy to address the steps taken in the event of this type of situation. She said that the Do Not Resuscitate Orders are kept in the chart and in the Medication Administration Record, but Respondent does not have a written step by step policy and procedure to address cardiopulmonary resuscitation or Do Not Resuscitate Orders status. After this incident, she would have to sit down with the Director of Nursing to establish a step by step procedure for staff to follow. They do know where the Do Not Resuscitate Orders are located. She also stated she did not think the supervisor had the Do Not Resuscitate Order, so this is why he started cardiopulmonary resuscitation. She expected the staff to contact either the Director of Nursing or the Assistant Director of Nursing/ Risk Manager to report that this occurred and then to notify her so an investigation could be started. She was very upset that this incident was never reported to anyone. The staff is supposed to immediately report an incident such as this to the Director of Nursing immediately. If the Director of Nursing could not be reached, the Assistant Director of Nursing/Risk Manager should have been called.

24. An interview was conducted with Staff L, the Licensed Practical Nurse Supervisor via telephone on June 20, 2019 at 12:41 p.m. Staff L advised that he was the supervisor the night Resident #3 expired. Staff L said he was told the resident was not breathing. He went to Resident #3's room immediately to check the resident's airway. The resident had the Bi-PAP machine on. He checked the resident's pulse and chest to see if the resident was breathing. Resident #3 did not have a pulse. He was in the room and the other nurse was checking the resident's papers. This happened in one or two minutes when he did the assessment. One of the nurses brought him the paper that said the resident had a Do Not Resuscitate Order. They brought the crash cart to the room in case they had to start cardiopulmonary resuscitation.He called all of the nurses to help out but said he did not start cardiopulmonary resuscitation when they brought him the Do Not Resuscitate Order. He told the certified nursing assistant to clean the resident up and call the resident's sibling. The other nurse was on the phone with rescue and the police.

25. Staff N, a certified nursing assistant, was interviewed by telephone by a Spanish speaking Agency representative on June 20, 2019 at 2:26 p.m. Staff N said she was familiar with the resident who passed away not too long ago. Staff I, a nurse, was the one that found the resident. Staff I entered the room and Staff N stated she imagined that when Staff I saw Resident #3, she notified the staff and Staff L, the Licensed Practical Nurse Supervisor. Staff N went to Resident #3's room with the crash cart. The nurses from the North and South and the other staff were involved in what was happening with the resident. Staff I said she found herself in charge of bringing the crash cart and Staff L had started at that moment. He had his hands on the resident's chest. It was a matter of a couple of minutes. In one to two minutes, the nurse came with the yellow paper (the Do Not Resuscitate Order) and everything was stopped. It was a very short

time that had passed. Resident #3 was prepared, cleaned, and changed so the resident would be presentable when the resident's sibling came.

26. An interview with Resident #3's primary care physician who is also the facility's Medical Director was conducted via telephone on June 20, 2019 at 1:26 p.m. The primary care physician/Medical Director said he was the primary care physician for this resident. Resident #3 was at Respondent's facility for a very long time and did not have a Do Not Resuscitate Order until the resident's last hospital stay. The Do Not Resuscitate Order was signed at the hospital and he signed a Do Not Resuscitate Order when the resident was readmitted to Respondent's facility. The Do Not Resuscitate Order was in the chart, so he does not know why cardiopulmonary resuscitation was started. For the last two months of Resident #3's life, the resident only spent five days in Respondent's nursing home and the rest of the time in the hospital. Respondent was very sick and her sibling opted to obtain a Do Not Resuscitate Order. The Do Not Resuscitate Order was in the resident's chart and they should not have started cardiopulmonary resuscitation. As the resident's primary care physician and the Medical Director for the facility, he should have been told that this error occurred. When he was called and advised that the resident had expired, they never mentioned cardiopulmonary resuscitation had been performed on the resident and he and the family should have been told about it.

27. The above reflects Respondent's failure to honor the advance directives of one (1) out of nine (9) residents as evidenced by initiating cardiopulmonary resuscitation (CPR) on one resident with a Do Not Resuscitate Order (Resident #3). This failure had the potential to affect one hundred twenty-one residents residing in Respondent's facility who had Do Not Resuscitate Orders.

28. The Agency determined that this deficient practice involved a deficiency that presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.

29. That the same constitutes an isolated Class I violation pursuant to § 400.23(8)(a), Florida Statutes (2018).

30. The Agency cited the Respondent for an isolated Class I violation in accordance with applicable statutes and authorizing rules.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility pursuant to § 400.23(8)(a), Florida Statutes (2018).

COUNT II

31. The Agency re-alleges and incorporates paragraphs one (1) through five (5) and Count I of this Complaint as if fully set forth herein.

32. Based upon Respondent's one (1) cited Class I deficiency, it was not in substantial compliance at the time of the survey with criteria established under Part II of Florida Statutes 400, or the rules adopted by the Agency, a violation subjecting it to assignment of a conditional licensure status under § 400.23(7)(a), Florida Statutes (2018).

WHEREFORE, the Agency intends to assign a conditional licensure status to Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(7), Florida Statutes (2018) commencing June 21, 2019 and expiring on July 21, 2019.

COUNT III

33. The Agency re-alleges and incorporates paragraphs one (1) through five (5) and Count I

of this Complaint as if fully recited herein.

34. That Respondent has been cited with one (1) isolated Class I deficiency and therefore is subject to a six (6) month survey cycle for a period of two years and a survey fee of six thousand dollars ($6,000.00) pursuant to Section 400.19(3), Florida Statutes (2018).

WHEREFORE, the Agency intends to impose a six (6) month survey cycle for a period of two years and impose a survey fee in the amount of six thousand dollars ($6,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.19(3), Florida Statutes (2018).

Respectfully submitted this 5th day of November, 2019.

Gisela Iglesias, Esq.
Fla. Bar. No. 21010
Agency for Health Care Administration
525 Mirror Lake Drive N., 330H
St. Petersburg, FL 33701
727.552.1945 (office)
Gisela.Iglesias@ahca.myflorida.com

DISPLAY OF LICENSE

Pursuant to § 400.23(7)(e), Fla. Stat. (2018), Respondent shall post the most current license in a prominent place that is in clear and unobstructed public view, at or near, the place where residents are being admitted to the facility.

Respondent is notified that it has a right to request an administrative hearing pursuant to Section 120.569, Florida Statutes. Respondent has the right to retain and be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

All requests for hearing shall be made to the attention of: *The Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Bldg #3, MS #3, Tallahassee, Florida, 32308, (850) 412-3630.*

RESPONDENT IS FURTHER NOTIFIED THAT A REQUEST FOR HEARING MUST BE RECEIVED WITHIN 21 DAYS OF RECEIPT OF THIS COMPLAINT OR WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7019 1120 0000 9811 3429 on the 5th day of November, 2019, to Jesika Polack, Administrator, Fair Havens OPCO, LLC, d/b/a Fair Havens Center, 201 Curtiss Parkway, Miami Springs, Florida 33166-5291 and by Regular U.S. Mail to Cogency Global Inc., Registered Agent, Fair Havens OPCO, LLC, d/b/a Fair Havens Center, 115 North Calhoun St., Suite 4, Tallahassee, Florida 32301.

Copy furnished to:
Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: Fair Havens OPCO, LLC d/b/a Fair Havens Center AHCA No. 2019010507

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. The Election of Rights form may be returned by mail or by facsimile transmission, but must be filed with the Agency Clerk within 21 days by 5:00 p.m., Eastern Time, of the day that you received the Administrative Complaint. If your Election of Rights form with your selected option (or request for hearing) is not timely received by the Agency Clerk, the right to an administrative hearing to contest the proposed agency action will be waived and an adverse Final Order will be issued. In addition, please send a copy of this form to the attorney of record who issued the Administrative Complaint.

(Please use this form unless you, your attorney or your qualified representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.) The address for the Agency Clerk is:

Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Building #3, Mail Stop #3
Tallahassee, Florida 32308
Telephone: 850-412-3630 Facsimile: 850-921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _____ I waive the right to a hearing to contest the allegations of fact and conclusions of law contained in the Administrative Complaint. I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the fine, sanction or other agency action.

OPTION TWO (2) _____ I admit the allegations of fact contained in the Administrative Complaint, but I wish to be heard at an informal hearing (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine, sanction or other agency action should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact contained in the Administrative Complaint and request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before

the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Licensee Name:

Contact Person: Title:

Address:

Telephone No. No.

E-Mail

I hereby certify that I am duly authorized to submit this Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed:

Print Name: Title:

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF1147096
CERTIFICATE #: 22921

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

CONDITIONAL

This is to confirm that FAIR HAVENS OPCO, LLC has complied with the rules and regulations adopted by the State of Florida Agency For Health Care Administration, authorized in Chapter 400, Florida Statutes, and as the licensee is authorized to operate the following:

FAIR HAVENS CENTER
201 Curtiss Pkwy.
Miami Springs, FL 33166-5291

TOTAL: 269 BEDS

STATUS CHANGE

EFFECTIVE DATE 06/21/2019

EXPIRATION DATE: 06/16/2021

Molly McKinstry
Director, Division of Health Quality Assurance

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF1147096
CERTIFICATE #: 23320

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

STANDARD

This is to confirm that FAIR HAVENS OPCO, LLC has complied with the rules and regulations adopted by the State of Florida Agency For Health Care Administration, authorized in Chapter 400, Part II, Florida Statutes, and as the licensee is authorized to operate the following:

FAIR HAVENS CENTER
201 Curtiss Pkwy
Miami Springs, FL 33166-5291

TOTAL: 269 BEDS

STATUS CHANGE

EFFECTIVE DATE 07/21/2019

EXPIRATION DATE: 06/16/2021

Molly McKinstry
Deputy Secretary for Health Quality

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

FAIR HAVENS OPCO, LLC d/b/a FAIR HAVENS CENTER

Respondent.

AHCA No.: 2020008697
License No.: 1147096
Provider Type: Nursing Home

AMENDED ADMINISTRATIVE COMPLAINT[1]

Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), files this Administrative Complaint against Respondent, Fair Havens OPCO, LLC d/b/a Fair Havens Center ("Respondent" or "Fair Havens"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2019), and alleges as follows:

NATURE OF THE ACTION

This is an action to: impose administrative fines totaling $45,000.00 for three (3) Class I deficiencies at a widespread level; impose administrative fees totaling in $6,000.00 for one (1) 6-month survey cycle fee, for a total assessment of $51,000.00 in fines and fees; to affirm one conditional licensure status commencing on May 7, 2020; and to revoke Respondent's license to operate a skilled nursing facility.

PARTIES

1. The Agency is the licensing and regulatory authority that oversees skilled nursing facilities (also called nursing homes) and enforces the state statutes and rules governing such

[1] Amended to reflect the correct license number and capacity in the heading and paragraph 2 only.

facilities. Ch. 408, Part II, Ch. 400, Part II, Fla. Stat., Ch. 59A-4, and Ch. 59A-35, Fla. Admin. Code. The Agency is authorized to deny, suspend, or revoke a license, and impose administrative fines pursuant to Sections 400.121, and 400.23, Fla. Stat., (2019), and assign a conditional license pursuant to Subsection 400.23(7), Fla. Stat., (2019).

2. The Respondent was issued a license (#1147096) by the Agency to operate a nursing home with two hundred sixty-nine (269) beds located at 201 Curtiss Parkway, Miami Springs, Florida 33166, and was at all times material required to comply with the applicable statutes and rules governing nursing homes.

COUNT I

Physical Environment – Safe, Clean, Homelike

3. Under Florida statutes, every licensed facility shall comply with all applicable standards and rules of the agency and shall: … (h) maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. § 400.141(1)(h), Fla. Stat., (2019).

4. Pursuant to Florida law, the licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible. Rule 59A-4.122(1), F.A.C., (2019).

Survey Findings

5. On May 6th and 7th, 2020 the Agency conducted a complaint survey at Respondent's Facility.

6. Based on observation and interview, the Agency determined Respondent's Facility failed to maintain a clean and sanitary environment that is free of hazards to ensure the health and safety of the one hundred ninety (190) residents residing in the facility. The facility failed to follow the Centers for Disease Control and Prevention ("CDC") guidelines for infection control, to practice Standard and transmission-based precautions to prevent the spread of a known infection,

Coronavirus Disease 2019 ("COVID 19").

7. The Agency reviewed the facility's policy titled, "Corona Virus Prevention," last revised on March 18, 2020. The policy documented that residents suspected or exposed to COVID-19 are to be in isolation and monitored for fourteen (14) days.

8. The policy documents that staff are to wear appropriate personal protective equipment ("PPE") such as masks, gowns, gloves, shoe covers, etc. It further showed that the facility will follow Standard, Contact, Droplets precautions that are recommended by the CDC for management of residents suspected with COVID-19.

9. The Agency also reviewed the Facility's COVID-19 "Breakout Improvement Plan/Plan" of action, dated April 27, 2020. The plan revealed suspected or exposed residents need to be on isolation and staff are to wear appropriate PPE for droplet precautions.

10. On May 6, 2020 at approximately 10:04 a.m., the Agency's representatives toured the Facility's COVID-19 unit with Respondent's Assistant Director of Nursing ("ADON"). The tour revealed the following:

a. The Agency's representative asked Respondent's ADON how the Facility is managing the trash and laundry on the COVID-19 Unit, which is located on the second floor of the facility. The ADON stated, they have a laundry chute and a trash chute at the end of the hallways.

b. At approximately 11:19 AM, the ADON presented the locked door in the East Wing with a sign on the door that read 'LINEN CHUTE."

c. Also, on the door were paper signs in English and Spanish that read "DO NOT THROW GARBAGE IN THIS BIN".

d. The ADON opened the locked door and stated, "[w]ait a minute this is the

garbage chute."

e. The ADON explained that one chute was being used for laundry and one chute was being used for trash.

f. The ADON was asked about the conflicting signage on the door, the ADON stated that he could not speak to the signage.

g. The ADON was asked how staff would know that this chute was not to be used for linen, the ADON stated that he was not sure how that information was given to the staff.

11. Later, at approximately 11:23 a.m., the tour continued on the West Wing of the Facility. The Agency representatives noted the following observations:

a. The ADON presented the locked linen chute on the West Wing hall. The ADON was unable to unlock the door and called Respondent's employee "Staff W," a housekeeper to unlock the door.

b. Staff W was wearing a white full body suit PPE.

c. Staff W unzipped the full body suit and reached inside and took out a key chain with an approximate twenty-four (24) inch nylon lanyard attached.

d. Staff W opened the stainless-steel door to the chute, on the inside of the door was a copious amount of a raised dried brown organic substance.

e. The stainless-steel door jamb of the linen chute was observed to have compacted dried brown organic substance.

f. Staff W's PPE remained unzipped while opening the linen chute, Staff W then removed the key chain with the 24-inch nylon lanyard and placed it back inside the full body suit PPE.

12. During the environmental tour of the COVID-19 Unit on May 6, 2020 at approximately 10:52 a.m., Resident #51 was observed in bed with full side rails and full padded bumpers.

13. The bumpers were torn open exposing the foam padding over approximately fifty percent (50%) of the length of the bumper. The exposed padding was observed to be pitted and stained.

14. The Agency's representative asked the ADON how staff were cleaning and disinfecting the exposed pitted foam. The ADON stated, "I don't know, those need to be replaced immediately."

15. During the environmental tour of the COVID-19 unit on May 6, 2020, at approximately 10:59 a.m. the Agency's representative observed a mechanical lift in the shower room with brown dried material on both handles.

16. Later on the COVID-19 unit tour, at approximately 12:00 p.m., the Agency's representative observed an unlabeled clear spray bottle was in the doffing area of the COVID-19 Unit. Doffing is the practice of employees removing work-related PPE.

17. Upon making this observation the Agency interviewed the Respondent's ADON about the doffing process. The ADON stated the following:

a. In order to conserve PPE Facility staff were washing the protective face shields then spraying the face shield with the liquid in the unlabeled spray bottle.

b. The ADON was asked what was in the unlabeled spray bottle, the ADON stated that he did not know.

c. The ADON was asked what the contact time for the unknown liquid product in the unlabeled spray bottle, the ADON stated, "I think it is ten (10) minutes."

d. The ADON was asked what staff did **with** the face shield after disinfecting them, and the ADON stated, "they take them home, so they don't lose them."

e. The ADON was asked to clarify that facility staff working in the COVID-19 unit are instructed to take used PPE home, and the ADON stated, "yes, the face shields because we do not have a lot of them."

f. The ADON was asked if it is the facility's expectation that all staff exiting the COVID-19 unit doff all PPE and cleanse their face shield and stand in the COVID-19 unit with no PPE on for the ten (10) minutes to disinfect the face shield. The ADON stated that the staff can put the masks in a plastic bag.

g. The ADON stated that there should be plastic bags in the soiled utility room.

h. The ADON was asked what education had been provided to the staff when the facility opened the COVID-19 unit or when new protocols are introduced.

i. The ADON stated that the Staff Developer, a Registered Nurse, had done a tremendous amount of training and in-servicing related to the COVID-19 unit.

18. It was observed at the time of the above interview that there were no plastic bags in the COVID-19 Unit doffing area. The soiled utility room is located approximately thirty (30) feet away from the doffing area.

19. On May 7, 2020 at approximately 1:20 p.m., the Agency's representative observed Respondent's housekeeper, Staff W, placing soiled laundry in the linen chute on the COVID-19 unit without a face shield.

20. On May 7, 2020 at approximately 04:30 p.m., the Infection Control Nurse/Staff Developer was asked what education had been provided to the staff that related to the opening of and/or the daily staffing rolls and responsibilities of the COVID-19 unit. The Infection Control

Nurse/Staff Developer stated, no education had been provided.

21. Based upon the above allegations, the Agency determined the Facility's actions and inactions as cited constitute a Class I deficiency at a widespread level.

Requested Remedy

22. Pursuant to Florida law, as a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. § 408.813, Fla. Stat. (2019).

23. Under Section 400.23(8)(a), Florida Statutes, in pertinent part, "[a] class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correct." § 400.23(8)(a), Fla. Stat. (2019).

24. Under Section 400.23(8)(a), Florida Statutes, in pertinent part, "A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency." § 400.23(8)(a), Fla. Stat. (2019).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $15,000.00 on the Respondent.

Pursuant to Florida law, in pertinent part:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
>
> (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

§ 400.022(1)(l), Fla. Stat., (2019).

26. On May 6th and 7th, 2020 the Agency conducted a complaint survey at Respondent's Facility.

27. Based on observation, record review, and staff interviews, the Agency determined that Respondent's Facility failed to follow the Centers for Disease Control and Prevention ("CDC") guidelines to practice standard and transmission-based precautions to prevent the spread of a known infection, Coronavirus Disease 2019 ("COVID-19"). Respondent failed to immediately isolate eleven (11) residents whose roommates tested positive for COVID-19. The facility cohabitated the eleven (11) residents with fifteen (15) residents that tested negative and did not have known direct exposure to COVID-19 positive residents. Additionally, Respondent failed to place the eleven residents on droplet precautions (actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions).

28. On May 6, 2020, at approximately 9:30 a.m., the Agency representatives noted sixty-one (61) residents at Respondent's Facility were positive for COVID-19 (Residents #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, #101, #102, #103, #104, #105, #106, #107). These residents were placed on a droplet/contact isolation unit on the second floor of the Facility. This floor is referred to as the COVID-19 unit.

29. The remaining residents were placed on the first floor, in various rooms.

30. On May 6, 2020 at approximately 10:00 a.m., Respondent's Administrator and the Director of Nursing ("DON") were asked to identify the roommates of the sixty-one (61) COVID-19 positive residents at the time of the testing. The Administrator provided a list of eleven (11) residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11).

31. The Agency then reviewed the Facility's census, which showed that the eleven (11) exposed residents who had roommates that were positive for COVID-19 were placed in rooms with fifteen (15) other residents who tested negative for COVID-19 and did not have known direct exposure to COVID-19.

32. The fifteen (15) residents that tested negative included, Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26.

33. Observation of these identified residents revealed, none were on droplet precautions.

34. The Agency then reviewed Respondent's policy titled "Coronavirus Prevention," last revised on March 18, 2020. The policy documented that residents suspected or exposed to COVID-19 are to be in isolation and monitored for fourteen (14) days. The policy documents that

staff are to wear appropriate personal protective equipment ("PPE") such as masks, gowns, gloves, shoe covers, etc. It further showed that the facility will follow Standard, Contact, Droplet precautions that are recommended for the management of residents suspected with COVID 19 by the CDC.

35. The Agency also reviewed Respondent's "COVID-19 Breakout Improvement Plan/Plan of action," dated April 27, 2020, which revealed suspected or exposed residents need to be on isolation and staff are to wear appropriate PPE for droplet precautions. The document revealed that the Assistant Director of Nursing ("ADON") and the Staff Developer are responsible for these action items as part of the COVID-19 Breakout Improvement Plan/Plan of action.

36. Review of the CDC guidelines titled "Responding to Coronavirus in Nursing Homes," revealed residents of residents with COVID 19 should be considered exposed and potentially infected and should not share a room with other residents. It further showed that they need to remain asymptomatic and test negative for COVID-19 fourteen (14) days after their last exposure.

37. The Agency reviewed of the clinical records for the eleven (11) exposed residents who had roommates who tested positive for COVID-19, which showed the following:

a. Resident #1 is ninety-one (91) years old, and has diagnoses that included Diabetes. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

b. Resident #2 is sixty-nine (69) years old, and has diagnoses of Chronic Obstructive Pulmonary Disease ("COPD") and Type 2 Diabetes. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

c. Resident #3 is seventy-three (73) years old, and has diagnoses of Type 2

Diabetes and Hypertension. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

d. Resident #4 is ninety-four (94) years old, and has diagnoses of Hypertension and Hyperlipidemia. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

e. Resident #5 is eighty-one (81) years old, and has diagnoses of COPD, Hyperlipidemia and Hypertension. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

f. Resident #6 is ninety (90) years old, and has diagnoses of COPD and Type 2 Diabetes. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

Resident #7 is eighty-one (81) years old, and has diagnoses of Type 2 Diabetes, Heart Failure and COPD. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

h. Resident #8 is eighty-four (84) years old, and has diagnoses of Hypertension, Parkinson's, and Heart Disease. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

i. Resident #9 is seventy-six (76) years old, and has diagnoses of Type 2 Diabetes, Hypertension and Parkinson's. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

j. Resident #10 is eighty-two (82) years old, and has diagnoses of COPD, Heart Disease and Cardiac Arrhythmias. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

j. Resident #11 is ninety-six (96) years old, and has diagnoses of type 2 Diabetes, Acute Renal Failure and Cerebrovascular Disease. The resident had a known exposure to a positive COVID-19 resident on April 27, 2020.

38. Record review of the (15) residents who were located in the same room with the (11) exposed residents revealed the following:

a. Resident #12 is eighty-six (86) years old, and has diagnoses of Heart Disease, Hypertension and Type 2 Diabetes. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

b. Resident #13 is ninety-three (93) years old, and has diagnoses of Heart Failure, Chronic Pulmonary Disease and Hypertension. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

c. Resident #14 is seventy-five (75) years old, and has diagnoses of Heart Disease, Hypertension and Parkinson's disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

d. Resident #15 is eighty-one (81) years old, and has diagnoses of type 2 Diabetes, Heart Disease and Pulmonary Obstructive Disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

e. Resident #16 is eighty-seven (87) years old, and has diagnoses of type 2 Diabetes and Hypertension. The resident was exposed to COVID-19 on April

27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

f. Resident #17 is ninety-one (91) years old, and has diagnoses of Hypertension, and Heart Disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

g. Resident #18 is eighty (80) years old, and has diagnoses of Hypertension and Hyperlipidemia. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

h. Resident #19 is eighty-two (82) years old, and has diagnoses of type 2 Diabetes, Parkinson's disease, and Hyperlipidemia. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

i. Resident #20 is fifty-nine (59) years old, and has diagnoses of Hyperlipidemia and Heart Disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

j. Resident #21, is ninety-five (95) years old, and has diagnoses of Pulmonary Obstructive Disease, Heart Failure and Hyperlipidemia. The Resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

k. Resident #22 is seventy-six (76) years old, and has diagnoses of type 2 Diabetes and Hyperlipidemia. The resident was exposed to COVID-19 on April 27, 2020

by a roommate who had a previous roommate that tested positive for COVID-19.

l. Resident #23 is sixty-nine (69) years old, and has diagnoses of Hypertension and Pulmonary Obstructive Disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

m. Resident #24 is ninety-three (93) years old, and has diagnoses of Hyperlipidemia, Hypertension and Cerebral Vascular Infarction. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

n. Resident #25, is sixty-nine (69) years old, and has diagnoses of Type 2 Diabetes and Heart Disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

o. Resident #26, is eighty-nine (89) years old, and has diagnoses of Heart Disease, Hypertension and Pulmonary Obstructive Disease. The resident was exposed to COVID-19 on April 27, 2020 by a roommate who had a previous roommate that tested positive for COVID-19.

39. On May 6, 2020 at approximately 10:30 a.m. the Agency interviewed Respondent's employee the DON. The DON stated the following:

a. Eleven (11) roommates who were exposed to positive COVID-19 residents remained in the facility and were not placed on isolation.

b. The Facility had a full in-house testing for COVID-19 which was provided by

a private laboratory on April 25, 2020.

c. On April 27, 2020 the Facility received the results for all the residents. However, two (2) residents (Residents #46 and #120) did not receive their results until April 29, 2020.

d. The Facility immediately isolated all positive residents for COVID-19 on the second floor on April 27, 2020.

40. On May 7, 2020, in further interview with the DON at approximately 5:00 p.m. the DON, who is also the Respondent's Risk Manager, stated that the area of focus was the multiple residents that tested positive when the Facility did the mass testing. The DON stated, the "Risk Management COVID-19 Breakout Improvement Plan," dated April 27, 2020, was the tool the facility had developed to interact the COVID 19 virus spread.

41. The DON was asked to address the COVID-19 Breakout Improvement Plan Action steps for suspected or exposed residents needing to be on isolation and staff are to wear appropriated PPEs for Droplet precautions. The DON stated the following in response:

a. We discussed how we were managing the relocation of the residents.

b. We were focused on getting the positives onto the COVID Unit.

c. We were thinking a negative could cohort with another negative, and we are surveilling everyone.

d. The residents with exposure should have been isolated and on droplet precautions.

e. We have placed everyone on precautions.

42. On May 6, 2020 at approximately 12:30 p.m., the Agency interviewed Respondent's Vice President of Operations. The Vice President was asked why they did not place

the eleven (11) residents who were exposed to positive COVID-19 roommates on droplet/contact isolation. Furthermore, why the Facility cohabitated those eleven (11) residents with the other fifteen (15) residents who tested negative and were not previously exposed.

43. The Vice President of Operations stated the following:

a. If the Facility had to isolate the eleven (11) residents who were exposed, they would run out of PPE in one (1) week.

b. The Facility also had thirty-two (32) staff members who tested positive for COVID-19, and if they had to isolate all residents who were exposed to them it will be the entire facility.

44. On May 6, 2020 at approximately 10:50 a.m., the Agency representatives observed Respondent's employee, "Staff T" on a covid-19 unit donning her gown. The observed Staff T who had been pushing the gown on the dirty side of her left sleeve, pulled the gown off and place it on the biohazard trash can.

45. On May 6, 2020 at approximately 10:51 a.m., the Agency interviewed Staff T and asked if she was supposed to touch the outside of the gown. Staff T stated that she removed her gloves and took the gown off. Staff T further stated, that she is not supposed to touch the outside of the gown.

46. On May 6, 2020 at approximately 11:20 a.m., the Agency representatives conducted a tour of the facility's first floor north unit. The observations revealed the following:

a. Respondent's employee "Staff C," a Licensed Practical Nurse ("LPN"), was in front of a medication cart. Resident #141 was sitting in a wheelchair out in the hallway wearing a mask.

b. Staff C and Resident #141 were observed to be approximately three (3) feet

apart, not in accordance six (6) feet, as per CDC guidelines.

c. Resident #142 and Resident #143 were sitting in a wheelchair next to each other out in the hallway next to their room door and were approximately three (3) feet distanced from Resident #142 and approximately two (2) feet distanced from Staff C.

d. Further, observations revealed no evidence of Staff C attempting to separate the residents or to provide education regarding social distancing.

47. On May 6, 2020 at approximately 11:25 a.m., the Agency interviewed Resident #142. Resident #142 stated that he/she is supposed to be six (6) feet apart from others and confirmed that he/she was not distanced. Resident # 143 was asleep and not able to be interviewed.

48. On May 6, 2020 at approximately 11:30 a.m., the Agency interviewed Staff C. Staff C stated that she is supposed to keep her residents six (6) feet apart.

49. At 11:35 a.m. that same day, observations revealed Staff C left the medication cart with medications in her hand and entered a resident's room. Staff C did not move Resident #142 and Resident #143 six (6) apart from each other after the interview.

50. The Agency then reviewed Resident #141, #142, and #143's Minimum Data Set quarterly assessments ("MDS"). The review revealed the following:

a. Resident #141's MDS dated February 17, 2020 documented the resident's brief interview for mental status ("BIMS") score was fourteen (14) out of fifteen (15), indicative of little to no cognitive impairment.

b. Resident #142's MDS dated February 10, 2020 documented the resident's BIMS score was fourteen (14) out of fifteen (15), indicative of little to no cognitive impairment.

c. Resident #145's BIMS dated February 12, 2020 demonstrated the resident's BIMS score was twelve (12) out of fifteen (15), indicative of little to no cognitive impairment.

51. On May 6, 2020 at approximately 11:50 a.m. during the continued tour of the first floor north unit revealed the following:

a. Resident #144 and Resident #145 sitting in wheelchairs outside their room in the hallway distanced approximately three (3) feet, and not six (6) feet as recommended by the CDC guidelines.

b. Resident #145 was wearing a mask underneath the resident's chin and talking to the people walking in front of the resident.

c. The unit secretary walked in front of Resident #144 and Resident #145 and did not acknowledge that the residents were not six (6) feet apart and did not attempt to place Resident #145's mask on properly.

52. On May 6, 2020 at approximately 11:52 a.m., an attempt was made to interview Resident #144 and Resident #145, which revealed they were not able to follow the questions asked.

53. On May 6, 2020 at approximately 12:01p.m., the Agency interviewed Respondent's employee "Staff D," a registered nurse ("RN"). The interview revealed the following:

a. Staff D was asked to observe and tell the surveyor what was wrong between Resident #144 and Resident #145.

b. Staff D kept looking at both residents and was not able to state what was wrong.

c. Staff D was asked about social distancing and stated that they are to keep residents six (6) feet apart.

d. Staff D was asked to demonstrate how she measured the six (6) feet and

proceeded to go to the front of both residents and counted from wheelchair leg rest to wheelchair leg rest.

e. Staff D was asked to count how many feet were between the residents' side-by-side and she counted four (4) feet.

f. Staff D confirmed that Resident #144 and Resident #145 were not six feet apart as per CDC guidelines and proceeded to distance Resident #144.

g. Staff D moved away from Resident #145 and did not attempt to place or to ask the resident to place the resident's mask properly.

h. Staff D was asked about the resident wearing the mask on her chin. Staff D stated that she had educated the resident about keeping the mask in place, but that the resident [illegible]

i. Staff D failed to approach Resident #145 to place the mask on the resident's face despite the concern brought to her attention by the surveyor that the resident was not wearing a mask properly.

54. The Agency then reviewed Residents #144 and #145's MDS assessments. The assessments revealed the following:

a. Resident #144's MDS dated February 12, 2020 documented the resident's BIMS score was six (6) out of fifteen (15), indicative of severe cognitive impairment.

b. Resident #145's MDS dated February 11, 2020 documented the resident's BIMS score was eight (8) out of fifteen (15), indicative of moderate cognitive impairment.

55. On May 6, 2020 at approximately 5:50 p.m., observation revealed Respondent's

employee "Staff U," a receptionist at the Facility's entry point blew her nose, place the tissue into the trash can without hand sanitation, and then she moved to the screening desk, retrieved a surgical mask from a box located at the desk, placed the mask on her face, and answer the phone.

56. On May 6, 2020 at approximately 5:59 p.m., the Agency interviewed Staff U. Staff U confirmed that she blew her nose and did not do hand sanitation. Staff U stated she should have wash her hand after blowing her nose and added that she will do so now.

57. CDC guidelines titled "Corona Virus Disease 2019 (COVID-19) How to protect yourself or others" last reviewed on April 24, 2020 documents that "everyone should wash hands ...after blowing your nose[.]"

58. The Agency also reviewed the Facility's policy titled "Corona Virus Prevention" revised on March 18, 2020, which documents "wash your hands often ...especially after ...blowing your nose[.]"

59. On May 6, 2020 at approximately 6:02 p.m., the Agency toured the Facility's "Kellogg unit." Observation revealed Respondent's employee "Staff A" and "Staff B," both Certified Nursing Assistants ("CNAs") in the lunchroom.

60. On May 6 at approximately 6:05 p.m., the Agency interviewed Staff A. Staff A stated she usually worked the day shift but was asked to work the evening shift.

61. The Agency asked about Staff A's assigned residents and she proceeded to their rooms one by one. The following observations were made while accompanying Staff A:

a. Staff A entered a random resident's room, donned one glove without hand sanitation, re-arranged the resident's cover sheet, removed the glove without hand sanitation, and proceeded to a different room.

b. In the second room Staff A, donned one glove, pulled the window curtain to

doing it, then removed the gloves.

c. Staff A moved on to a third room and without hand sanitation, donned gloves, removed the resident's food tray, removed her gloves. Finally after removing the third pair of gloves, Staff A performed hand sanitation.

62. During a second interview after the room observations at approximately 6:19 p.m., Staff A stated the following:

a. She did hand sanitation.

b. Staff A was asked about her face shield care and stated that she uses a face shield during work and before she goes home.

c. She stated she cleans the face shield with soap and water, then wipes it with alcohol pads, places it in a plastic bag and leaves it in her car for her to use the next day.

63. The Agency reviewed Respondent's policy titled "Hand washing/hand hygiene" revised on August 2015. The policy documents "use an alcohol-based hand rub ...or alternatively, soap and water for the following situations ...before donning gloves ...after removing gloves[.]"

64. On May 6, 2020 at approximately 6:20 p.m., the Agency interviewed Staff B. Staff B stated that she uses a face shield during work. Before she goes home, she cleans the face shield with soap and water, then wipes it with alcohol pads, places it in a plastic bag and leaves it in her car for her to use the next day.

65. The Agency subsequently reviewed the CDC guideline titled "Strategies for Optimizing the Supply of Eye Protection" last reviewed on March 17, 2020. The guideline documents "Options for Reprocessing Eye Protection: While wearing gloves, carefully wipe the inside, followed by the outside of the face shield ...using a clean cloth saturated with neutral

detergent solution or cleaner wipe. Carefully wipe the outside of the face shield ... using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. Wipe the outside of face shield ...with clean water or alcohol to remove residue."

66. On May 7, 2020, at approximately 9:50 a.m., the Agency representative observed two (2) residents smoking outside the Facility with a cigarette ash tray container between them. The residents were approximately three (3) feet apart, not six (6) feet apart as per CDC guidelines.

67. Further observation revealed the Facility's DON walking outside facing the two residents, and the DON did not attempt to separate them or educate them, or the Facility's aide supervising the residents, regarding social distancing.

68. On May 7, 2020 at approximately 9:55 a.m., the Agency interviewed Respondent's employee "Staff E," a CNA, who was outside with the residents smoking in Facility's patio and the following:

a. She is watching the two (2) residents smoking because they can't be alone.

b. Staff E was asked how many feet apart the residents must be and she stated six (6) feet.

c. Staff E was asked if the two random residents were six (6) feet apart and she stated, no, they are not and added that she keeps telling them, but they do not listen.

d. Staff E was informed that the Agency representative had been standing behind the residents inside the facility observing them and her, and that she did not attempt to separate them until surveyor asked her.

e. Staff E acknowledged the findings.

69. On May 7, 2020 at approximately 4:35 p.m., the Agency interviewed Respondent's

DON about the smoking residents. The DON stated that they educated the residents on keeping the social distancing and they don't listen.

70. The DON was apprised that Staff F did not attempt to separate them during the observations and did it after an interview with the surveyor.

71. On May 7, 2020 at approximately 1:35 p.m., the Agency representative observed five (5) staff members (Staff G, Staff H, Staff I, Staff J and Staff K, all CNAs) sitting in a ten by ten (10 x 10) lunchroom table located on the Facility's first floor north unit lunchroom without keeping social distancing, they were observed almost elbow to elbow.

72. The Agency's representative walked by the room three (3) times, the staff looked at the representative and they continued to eat and stay in the small room.

73. Later that same day at approximately 1:50 p.m., the surveyor's employee "Staff L" - the unit supervisor was called to observe the five (5) staff members in the lunchroom.

74. Staff F stated to the Agency representative that the staff members were not six (6) feet apart and that they know that only two (2) staff members at a time are allowed in the room. Staff F added that Staff J was doing documentation and was not supposed to be there.

75. Beginning at approximately 1:40 p.m., the Agency interviewed the staff members in the lunchroom. The interviews reviewed the following:

a. Staff G stated that she was finished and was ready to leave the room. Staff G stated that she is aware of the social distancing and confirmed that she was not six feet apart.

b. At approximately1:42 p.m., Staff H stated "we got the education, but I did it wrong today."

c. Staff H confirmed that she was not six feet apart from Staff G during lunch.

d. At approximately 1:46 p.m., Staff J stated that she is aware of the social distancing and confirmed that she was not six feet apart from Staff J.

At approximately 1:46 p.m., Staff J stated, that she is aware of the social distancing and confirmed that she was in between Staff G and Staff J, less that one (1) foot apart from Staff G and Staff J.

f. Staff J also confirmed that she was in the lunchroom documenting and it was not her time to be in the room.

g. At approximately 1:46 p.m., The Agency asked to interview Staff K, but was informed that she left the unit. Staff K was not available for an interview.

76. On May 7, 2020 at approximately 1:50 p.m., the Agency interviewed Staff G again, about her assigned duties. Staff G stated she had six (6) residents in three (3) rooms that had a room capacity of three to four (3 – 4) residents in each room that were on droplet precautions assigned to her.

77. Subsequent observation revealed all the assigned rooms for droplet precautions had room doors that were wide open.

78. Staff G was asked if those room doors were supposed to be open and she stated that she kept them open because she likes to see her residents.

79. Staff G was not aware that the doors were supposed to be closed due to the droplet precautions.

80. Accordingly, the Agency cited Respondent with a Class I violation at a widespread level due to the above allegations.

[illegible]

81. Pursuant to Florida law, as a penalty for any violation of this part, authorizing

statutes, or applicable rules, the agency may impose an administrative fine. § 408.813(1), Fla. Stat. (2019).

82. Under Section 400.23(8)(a), Florida Statutes, in pertinent part, "[a] class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correct." § 400.23(8)(a), Fla. Stat. (2019).

83. Under Section 400.23(8)(a), Florida Statutes, in pertinent part, "A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency." § 400.23(8)(a), Fla. Stat. (2019).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $15,000.00 on the Respondent.

84. Under Florida law, in addition to the grounds listed in Part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee: (1) an intentional or negligent act materially affecting the health or safety of residents of the facility. § 400.102(1), Fla. Stat., (2019).

85. The Agency re-alleges and incorporates by reference the allegations contained in Count II of this complaint.

86. On May 6th and 7th, 2020 the Agency conducted a complaint survey at Respondent's Facility.

87. Based on observations, interviews, and record reviews, the Agency determined that Respondent's Facility acted negligently by not providing the quality of care necessary to prevent further harm to the residents from the spread of COVID-19. To wit, the Facility failed to immediately isolate eleven (11) residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, & #11) who were roommates of other residents that tested positive for COVID-19. Furthermore, the Facility cohabitated the eleven (11) residents with fifteen (15) other residents (Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26) that tested negative and who were not previously exposed to COVID-19. Finally, the facility failed to place the eleven (11) residents on droplet precaution and contact precautions.

88. These findings revealed Respondent did not follow the Center for Disease Control and Prevention ("CDC") guidelines, or its own policy for COVID-19 precautions for isolating the eleven residents.

89. On or about May 6, 2020 the Agency reviewed Respondent's policy titled "Coronavirus prevention" last revised on March 18, 2020. The policy documented the following:

a. Any residents suspected or exposed to COVID-19 infection will be removed from other residents and placed in separate rooms.

b. The residents will further be in isolation and monitored for fourteen (14) days.

c. The facility will follow Standard, Contact, and Droplets precautions that are

[illegible] by the agency of residents [illegible] infection by the CDC.

90. The Agency then reviewed the CDC guidelines titled "Responding to Coronavirus in Nursing Homes." The CDC guideline revealed that roommates of residents with COVID-19 should be considered exposed and potentially infected and should not share a room with other residents. It further showed that a positive resident's roommates need to remain asymptomatic and test negative for COVID-19 fourteen (14) days after their last exposure.

91. By May 6, 2020, Respondent's Facility housed sixty-one (61) residents who tested positive for COVID-19 and were placed in a droplet/contact isolation unit on the Facility's second floor.

92. The remaining residents were placed on the first floor, in various rooms.

93. During tours of Respondent's Facility, the Agency representatives observed thirteen (13) residents were placed on droplet/contact isolation for various reasons on the first floor.

94. The Agency reviewed the Facility's census dated May 6, 2020, which showed one hundred ninety (190) in-house residents. Further record review showed that the eleven (11) exposed residents who had roommates that were positive for COVID-19 were placed in rooms with the fifteen (15) other residents who tested negative for COVID-19, and had not been previously exposed to COVID-19.

95. According to the CDC guidelines titled "People Who Are at Higher Risk for Severe Illness," adults over the age of sixty-five and who have serious underlying medical conditions might be at a higher risk for serious severe illness from COVID-19. These medical conditions may include chronic lung disease, heart conditions, obesity, diabetes and liver disease.

96. All of the eleven (11) residents whose roommates had tested positive for COVID-19 were over the age of sixty-five (65) with serious underlying medical conditions. All but one (1) of the fifteen (15) residents who were cohabitated with these eleven (11) exposed residents were over the age of sixty-five (65). Each of the fifteen (15) residents who were cohabitated with the eleven (11) exposed residents had a serious underlying medical condition.

97. On May 6, 2020 at approximately 10:30 a.m., the Agency interviewed Respondent's Director of Nursing ("DON"). The DON stated the following:

a. Currently they have ninety-three (93) residents that tested positive for COVID-19.

b. Thirty-two (32) of the residents that tested positive for COVID-19 were admitted to the hospital.

c. The eleven (11) roommates who were exposed to the positive COVID-19 residents remained in the facility and were not placed on isolation.

d. The Facility had full in-house testing for COVID-19 which was provided by a private laboratory on April 25, 2020.

e. On April 27, 2020 they received the results for all the residents. However, two residents (Residents #46 and #120) did not receive their results until April 29, 2020.

f. According to the DON, the Facility immediately isolated all positive residents for COVID-19 on the second floor on April 27, 2020.

98. On May 6, 2020 at approximately 12:30 p.m., the Agency interviewed Respondent's Vice President of Operations ("the VP of Ops."). The VP of Ops. stated the following during the interview:

The Agency asked why the Facility did not place the eleven (11) residents who were exposed to residents positive for COVID-19 on droplet/contact isolation and why they cohabitated those eleven (11) residents with the other fifteen (15) residents who tested negative and were not previously exposed.

b. The VP of Ops. stated if they had to isolate the eleven (11) residents who were exposed, they would run out of Personal Protective Equipment (PPE) in one (1) week.

c. The Facility also had thirty-two (32) staff members who tested positive for COVID-19.

d. If the Facility had to isolate all residents who were exposed to them it would be the entire facility.

99. On May 6, 2020 at approximately 3:00 p.m., the Agency interviewed Respondent's Vice President of Clinical Services ("the VP of C.S."). The VP of C.S. stated the following:

a. The eleven (11) residents who had positive COVID-19 roommates were not placed on isolation because they did not show any symptoms of COVID-19.

b. All residents in the facility are being monitored every shift for any signs and symptoms of COVID-19.

100. On May 6, 2020, at approximately 5:00 p.m. the Agency's representatives observed the eleven (11) residents who were exposed to positive COVID-19 residents. These residents were not on any type of contact isolation/droplet precautions and were not separated from the fifteen (15) residents who tested negative that were not previously exposed to COVID-19.

101. On or about May 6, 2020, the Agency also reviewed Respondent's two (2) weeks staffing documentation of the combined nursing and Certified Nurse Assistant ("CNA") ratio.

102. The ratio was above three and a half (3.5). Nursing was above one (1.0) and CNAs were above two and a half (2.5). These ratios indicated the facility had no issues with staffing or lack of staffing for the last two (2) weeks in the facility.

103. On May 7, 2020 at approximately 10:00 a.m., the Agency's representative observed the facility's multiple supply rooms. The observations revealed the following:

a. The supply rooms showed boxes of PPE available.

b. The boxes were a combination of gowns, masks, face shields, and gloves.

c. During the observation, the VP of Ops. reported, the facility has plenty of supplies, and they always made sure that they have two (2) weeks of supplies on hand.

d. No concerns or issues were reported during this observation and nothing related to purchasing supplies or shortage of supplies.

104. Respondent's representatives did not provide further explanations or reasons why the eleven (11) residents who had roommates test positive for COVID-19 were not isolated after discovering their exposure.

105. Respondent's negligent actions as alleged constitute a Class I widespread deficiency.

106. Pursuant to Florida law, as a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. § 408.813, Fla. Stat. (2019).

107. Under Section 400.23(8)(a), Florida Statutes, in pertinent part, "[a] class I deficiency is a deficiency that the agency determines presents a situation in which immediate

corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correct." § 400.23(8)(a), Fla. Stat. (2019).

108. Under Section 400.23(8)(c), Florida Statutes, in pertinent part, "A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine may be levied notwithstanding the correction of the deficiency." § 400.23(8)(c), Fla. Stat. (2019).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $15,000.00 on the Respondent.

[illegible]

109. The Agency re-alleges and incorporates by reference the allegations in Count I, II, and III of this complaint.

110. Under Florida law, a conditional licensure status is assigned to a Facility due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the Agency, leaving the Facility not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the agency. If the Facility has no class I, class II, or class III deficiencies at the time of the follow-up survey, a standard licensure status may be assigned. § 400.23(7)(b), Fla. Stat. (2019).

111. Due to the existence of these (3) Class I deficiencies, Respondent was not in substantial compliance at the time of the survey with Part II of Florida Statute 400 and the rules adopted by the Agency.

112. Accordingly, the Agency assigned Respondent conditional licensure status with an action effective date of May 7th, 2020. The conditional license is attached to this Administrative Compliant as Exhibit 1.

WHEREFORE, the Agency requests the assignment of a conditional licensure status to Respondent, a nursing facility, in the State of Florida be confirmed pursuant to §400.23(7), Florida Statutes.

113. The Agency re-alleges and incorporates by reference the allegations in Counts I, II, and III of this complaint.

114. Under Florida law:

> The Agency shall every 15 months conduct at least one unannounced inspection to determine compliance by the licensee with statutes, and with rules promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the

Agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to the provisions of chapter 110.

§ 400.19(3), Fla. Stat. (2019).

115. On May 5th and 7th, 2020 the Agency conducted a complaint survey at Respondent's Facility.

116. As a result of the survey, Respondent was cited with three (3) Class I deficiencies.

117. Therefore, Respondent is subject to a six-month survey cycle for a period of two years, commencing on May 7, 2020 through May 7, 2022, and the accompanying survey fee of an thousand dollar ($6,000.00). § 400.19(3) Fla. Stat. (2019).

WHEREFORE, Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose a six-month survey cycle for a period of two years and impose a survey fine of **$6,000.00.**

118. Under Florida law, in pertinent part:

> (1) The agency may deny an application, revoke or suspend a license, and impose an administrative fine, not to exceed $500 per violation per day for the violation of any provision of this part, part II of chapter 408, or applicable rules, against any applicant or licensee for the following violations by the applicant, licensee, or other controlling interest:
> (a) A violation of any provision of this part, part II of chapter 408, or applicable rules;
>
> * * *
>
> (3) The agency shall revoke or deny a nursing home license if the licensee or controlling interest operates a facility in this state that:

... **(c)** Is cited for two class I deficiencies arising from unrelated circumstances during the same survey or investigation.

§ 400.121(1)(c) & (3)(c), Fla. Stat., (2019).

118. The Agency re-alleges and reincorporates by reference all of the allegations contained in Counts I, II, and III this complaint.

120. On May 6th and 7th, 2020 the Agency conducted a complaint survey at Respondent's Facility. This survey resulted in the citation of three (3) widespread Class I deficiencies as detailed herein.

121. The Agency has provided evidence of multiple violations of provisions of Chapter 400, Part II and applicable rules committed by Respondent and its staff.

122. The deficient practices found in Count I, as cited herein, entail Respondent's physical plant conditions in responding to a COVID-19 outbreak.

123. The Deficient practices found in Count II and Count III, as alleged herein detail Respondent's staffing and resident care deficiencies in responding to a COVID-19 outbreak.

124. The deficient practices found in Count I were cited during same survey as Count II and Count III. The circumstances in Count I are unrelated to circumstances of Counts II and III.

125. Separately and collectively, these violations as alleged allow the Agency to seek revocation of Respondent's license to operate a nursing home, license number 4859.

WHEREFORE, Petitioner, State of Florida, Agency for Health Care Administration, seeks to revoke Respondent's license to operate a skilled nursing facility.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to enter a final order that:

1. Renders findings of fact and conclusions of law as set forth above.

2. [illegible]

Respectfully Submitted,

Andrew B. Thornquest, Assistant General Counsel
Florida Bar No. 0104832
Agency for Health Care Administration
525 Mirror Lake Drive N., Suite #330
St. Petersburg, Florida 33701
Telephone: 727-552-1942
Facsimile: 727-552-1440
andrew.thornquest@ahca.myflorida.com

Pursuant to Section 120.569, F.S., any party has the right to request an administrative hearing by filing a request with the Agency Clerk. To avoid [illegible] the Division of Administrative Hearings [illegible] this request for an administrative hearing must be received by the Agency Clerk within twenty-one (21) days from the receipt of this Administrative Complaint. [illegible]

For Election of Rights forms or request for hearing must be filed with the Agency Clerk for the Agency for Health Care Administration within 21 days of the day the Administrative Complaint was received. If the Election of Rights form or request for hearing is not timely received by the Agency Clerk by 5:00 p.m. Eastern Time on the 21st day, the right to a hearing will be waived. A copy of the Election of Rights form or request for hearing must also be sent to the attorney who issued the Administrative Complaint at his or her address. The Election of Rights form shall be addressed to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 3, Tallahassee, FL. 32308; Telephone (850) 412-3630, Facsimile (850) 921-0158.

Any party who appears in any agency proceeding has the right, at his or her own expense, to be accompanied, represented, and advised by counsel or other qualified representative. Mediation under Section 120.573, F.S., is available if the Agency agrees, and if available, the pursuit of mediation will not adversely affect the right to administrative proceedings in the event mediation does not result in a settlement.

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form were served to the below named persons/entities by the method designated on this 2nd day of June 2020.

Andrew B. Thornquest, Assistant General Counsel
Florida Bar No. 0104832
Agency for Health Care Administration
525 Mirror Lake Drive N., Suite 330G
St. Petersburg, Florida 33701

Suite 101

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: Fair Haven OFCO, LLC d/b/a Fair Haven Center AHCA No.: 202000869

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. It may be returned by mail or facsimile transmission, but must be received by the Agency Clerk within 21 days, by 5:00 pm, Eastern Time, of the day you received the Administrative Complaint. If your Election of Rights form or request for hearing is not received by the Agency Clerk within 21 days of the day you received the Administrative Complaint, you will have waived your right to contest the proposed agency action and a Final Order will be issued imposing the sanction alleged in the Administrative Complaint.

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your Election of Rights form to this address:

Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308
Telephone: 850-412-3630 Facsimile: 850-921-0158

E-mail: AHCA.AgencyClerk@ahca.myflorida.com

OPTION ONE (1) _____ **I admit to the allegations of fact and conclusions of law alleged in the Administrative Complaint and waive my right to object and to have a hearing.** I understand that by giving up the right to object and have a hearing, a Final Order will be issued that adopts the allegations of fact and conclusions of law alleged in the Administrative Complaint and imposes the sanction alleged in the Administrative Complaint.

OPTION TWO (2) _____ **I admit to the allegations of fact alleged in the Administrative Complaint, but wish to be heard at an informal proceeding** (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed agency action is too severe or that the sanction should be reduced.

OPTION THREE (3) _____ **I dispute the allegations of fact alleged in the Administrative Complaint and request a formal hearing** (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing **OPTION THREE (3)**, by itself, is NOT sufficient to obtain a **formal hearing.** You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings, under Section 120.57(1), Florida Statutes. It must be

received by the Agency Clerk at the address above within 21 days of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

Licensee Name:

Contact Person:

Title:

Telephone No.

E-Mail (optional)

I hereby certify that I am duly authorized to submit this Election of Rights form to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed:

Date:

Printed Name:

Title:

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

May 15, 2020

Jesika Polack, Administrator
Fair Havens Center
201 Curtiss Pkwy
Miami Springs, FL 33166-5291

File Number: 111309
License Number: 1147096
Provider Type: Nursing Home

RE: 201 Curtiss Pkwy, Miami Springs

Dear Ms. Polack:

The enclosed Nursing Home license with license number 1147096 and certificate number 24174 is issued for the above provider effective May 7, 2020 through September 14, 2021. The license is being issued for: approval of the change during licensure period application

Review your certificate thoroughly to ensure that all information is correct and consistent with your records. If it is not as noted, please contact the Long Term Care Services Unit.

Please take a brief customer satisfaction survey on our website at ahca.myflorida.com/survey/ to let us know how we can serve you better. Additional licensure information can be found at http://ahca.myflorida.com/longtermcare.

If we may be of further assistance, please contact me by phone at (850) 412-4422 or by email at Tracey.Weatherspoon@ahca.myflorida.com.

Sincerely,

Tracey Weatherspoon
Health Services and Facilities Consultant
Long Term Care Services Unit
Division of Health Quality Assurance

2727 Mahan Drive •MS#33
Tallahassee, FL 32308
AHCA.MyFlorida.com

LICENSE #: SNF1147096
CERTIFICATE #: 24174

Florida
CARE ADMINISTRATION
QUALITY ASSURANCE
NG HOME
DITIONAL

Total: 269 Beds

Secretary, Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

AHCA Nos.: 2019010507
2020008373
2020008697

v.

FAIR HAVENS OPCO, LLC d/b/a FAIR HAVENS CENTER

License No.: 1147096

Respondent.

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), and Respondent, Fair Havens OPCO, LLC d/b/a Fair Havens Center ("Respondent"), pursuant to Section 120.57(4), Florida Statutes, enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondent is skilled nursing facility, commonly referred to as a nursing home, licensed pursuant to Chapter 408, Part II, and Chapter 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code, and

WHEREAS, the Agency has jurisdiction by virtue of being the licensing and regulatory authority over Respondent; and

WHEREAS, the Agency conducted a survey of Respondent's nursing home on June 21st, 2019. The Agency later issued Respondent an Administrative Complaint **(AHCA #2019010507)** on November 5th, 2019. In the Administrative Complaint the Agency alleged one (1) isolated Class I deficiency for failing to ensure one (1) resident's advanced directive was followed. This alleged deficiency could result in the imposition of an administrative fine in the amount of ten thousand dollars ($10,000.00); the imposition a six (6) month survey cycle and its accompanying

EXHIBIT 2

fee of six thousand dollars ($6,000.00) for a total monetary assessment of sixteen thousand dollars ($16,000.00); and the affirmation of a conditional licensure period beginning on June 21, 2019 and expiring on July 21, 2019; and

WHEREAS, the Agency conducted a survey of Respondent's nursing home on May 6th and 7th, 2020. The Agency subsequently issued an Immediate Moratorium on Admissions (**AHCA #2020008373**) on Respondent due to the alleged immediate serious danger to the public health, safety, or welfare resulting from alleged failure to monitor its resident's status related to COVID-19 and to appropriately respond with increased levels of supervision from properly equipped staff.

WHEREAS, The Agency later issued Respondent an Amended Administrative Complaint (**AHCA #2020008697)** on June 2nd, 2020. In the Complaint the Agency alleged three (3) widespread Class I deficiencies for the following: failing to maintain a clean and sanitary environment by failing to follow CDC guidelines relating to the COVID-19 infections; failing to honor resident's rights to receive adequate and appropriate health care by failing to immediately quarantine eleven (11) residents exposed to COVID-19 infections; and for acting negligently by not providing the quality of care necessary to prevent further harm to residents from the spread of COVID-19. These alleged deficiencies could result in the revocation of Respondent's license to operate a skilled nursing facility; the imposition of an administrative fine in the amount of forty-five thousand dollars ($45,000.00); the imposition a six (6) month survey cycle and its accompanying fee of six thousand dollars ($6,000.00) for a total monetary assessment of fifty-one thousand dollars ($51,000.00); and the affirmation of a conditional licensure period beginning on May 7, 2020; and

WHEREAS, the Respondent has requested hearings by filing election of rights forms and petitions for hearing to participate in a formal hearing pursuant to § 120.57(1), Fla. Stat.; and

WHEREAS, the parties have agreed that a fair, efficient, and cost effective resolution of this dispute would avoid the expenditure of substantial sums to litigate the dispute; and

WHEREAS, the parties stipulate to the adequacy of considerations exchanged; and

WHEREAS, the parties have negotiated in good faith and agreed that the best interest of all the parties will be served by a settlement of this proceeding; and

NOW THEREFORE, in consideration of the mutual promises and recitals herein, the parties intending to be legally bound, agree as follows:

1. All recitals herein are true and correct and are expressly incorporated herein.

2. All parties agree that the above "whereas" clauses incorporated herein are binding findings of the parties.

3. Upon full execution of this Agreement, Respondent agrees to waive any and all appeals and proceedings to which it may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that this agreement shall not be deemed a waiver by either party of its right to judicial enforcement of this Agreement.

4. Upon full execution of this Agreement:

   a. Respondent shall comply with the following terms:

      i. Have contracted with an outside consultant, for a period of no less than two years from the date of the Final Order, who shall review and evaluate the Respondent's current infection control practices, make recommendations to management, and provide education and training to the nursing staff

members. The consultant's credentials must be provided to the Agency's local field office in advance for approval; and

ii. Have a full-time infection control/preventionist ("ICP") be a certified infection control nurse, or have the current full-time infection control staff nurse obtain such certification within thirty (30) days of the Final Order adopting this Agreement; and

iii. Have the ICP, Director of Nursing ("DON") and Assistant Director of Nursing ("ADON") complete Quality, Safety & Education Portal ("QSEP") training in Universal Infection Prevention and Control, consisting of 28 hours, 2.5 CEU, within three (3) months of the Final Order adopting this Agreement, and for turnover, all new staff must be trained within thirty (3) days for the duration of no less than two (2) years from the date of a final order; and

iv. Have all staff (including housekeeping and maintenance personnel) take on-line training program or have in-person training provided to all staff by a credible infection control provider. The trainer's credentials must be provided to the Agency's local field office in advance for approval. The requirement does not apply to temporary staff members, including staff members hired through an agency on a temporary basis. This training must be completed within sixty (60) days of the Final Order adopting this Agreement. All new staff trained within thirty (30) days for the duration of no less than two (2) years from the date of a final order; and

v. Transfer seventy-eight (78) beds of the current two hundred sixty-nine (269) active beds to an inactive status within ninety (90) days of the date of a final

order. Respondent intends to construct a seventy-eight (78) bed wing that will be completely private rooms which will be made up of the seventy-eight (78) inactive beds. The Agency must receive and application to re-activate these seventy-eight (78) beds no more than twenty-four (24) months after the date given for the inactive status; and

vi. Convert and maintain all rooms at either private or semi-private status (meaning no more than two (2) residents per room) with each resident room having at least one (1) bathroom (containing a sink and commode/toilet) per room no later than 90 days from the date of a Final Order. No resident(s) shall reside in a room that does not have a single designated restroom in that room. Respondent must maintain this type of room status for the duration of its licensure.

vii. Pay the Agency a sum of sixty-seven thousand dollars ($67,000.00) within sixty (60) days of the entry of the Final Order; and

viii. Accept all requested conditional licensure periods contained in the complaints.

ix. Accept both six-month survey cycles the first commencing June 21st, 2019, and the second commencing May 7th, 2020; and

x. Failure to comply with any of the elements listed in sub paragraph "i" through subparagraph "ix" of this Agreement shall result in the revocation of Respondent's license to operate a skilled nursing facility without further action necessary from the Agency; and

b. The Agency shall comply with the following terms:

i. Withdraw Count VI of the Administrative Complaint AHCA #2020008697

seeking license revocation through the entry of the Final Order adopting this Agreement.

ii. Lift the Immediate Moratorium on Admissions AHCA #2020008373 through the entry of the Final Order adopting this Agreement.

5. Venue for any action brought to interpret, enforce or challenge the terms of this Agreement and its corresponding Final Order shall lie solely in the Circuit Court of Florida, in and for Leon County, Florida.

6. Respondent does not admit to the facts and legal conclusions raised in the above-referenced Administrative Complaints and Immediate Moratorium on Admissions; but the Agency asserts their validity thereof. Neither the acceptance of, nor performance under, nor the execution of this Agreement shall be construed as an admission of any fault, mistake, wrongdoing, or liability by either party. Nothing in this Agreement shall be deemed to preclude the Agency from imposing a penalty against Respondent for any deficiency or violation of statute or rule identified in a future survey of Respondent's skilled nursing facility. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency, but the Agency agrees that it will not impose any administrative penalty against Respondent based solely on the allegations in the above-referenced Administrative Complaint. Further, Respondent acknowledges that this Agreement shall not preclude or estop any other federal, state or local agency or office, outside the jurisdiction of the Agency, from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the Administrative Complaint.

7. Upon full execution of this Agreement, the Agency shall enter a Final Order adopting and incorporating the terms of this Agreement and closing the above-styled case.

8. Each party shall bear its own costs and attorney's fees.

9. This Agreement shall become effective on the date upon which it is fully executed

by all parties.

10. Respondent, for itself and its related or resulting organizations, successors, transferees, attorneys, heirs, and executors or administrators, discharges the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys, of and from all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter and the Agency's actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement, by or on behalf of the Respondent or its related or resulting organizations.

11. This Agreement is binding upon all parties and those persons and entities that are identified in the above paragraph.

12. In the event that Respondent was a Medicaid provider at the time of the occurrences alleged in the Notice of Intent, this Agreement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any further sanctions pursuant to Rule 59G-9.070, Florida Administrative Code. This Agreement does not settle any pending or potential Federal issues against Respondent. This Agreement does not prohibit the Agency from taking any action regarding Respondent's Medicaid provider status, conditions, requirements or contract, if applicable.

13. Respondent agrees that if any funds to be paid under this Agreement to the Agency are not timely paid as set forth in this Agreement, the Agency may deduct the amounts assessed against the Respondent in the Final Order, or any portion thereof, owed by Respondent to the Agency from any present or future funds owed to Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to Respondent by the Agency for said amounts until paid.

14. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. Respondent has the legal capacity to execute this Agreement. Respondent understands that it has the right to consult with its own independent counsel and has knowingly and freely entered into this Agreement. Respondent understands that Agency counsel represents only the Agency and that Agency counsel has not provided any legal advice to, or influenced, Respondent in its decision to enter into this Agreement.

15. This Agreement contains the entire understandings and agreements of the parties. This Agreement supersedes any prior oral or written agreements between the parties. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

16. All parties agree that a facsimile signature suffices for an original signature.

The following representatives acknowledge that they are duly authorized to enter into this Agreement.

Molly McKinstry, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Bldg. #3
Tallahassee, Florida 32308

DATED: 10/16/2020

Jessica M. Polack, NHA Jessika
Fair Havens OPCO, LLC d/b/a Fair Havens Center
201 Curtiss Parkway
Miami Springs, Florida 33166

DATED: 9.30.20

William H. Roberts, Esquire
Acting General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #7
Tallahassee, Florida 32308

DATED: 10/5/20

Peter A. Lewis, Esquire
Law Offices of Peter A. Lewis, P.L.
Attorney for Respondent
3023 N. Shannon Lakes, Suite 101
Tallahassee, Florida 32309

DATED:

Andrew Thornquest, Esquire
Assistant General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive N., Suite 330
St. Petersburg, Florida 33701

DATED: 10/1/2020

Amy W. Schrader, Esquire
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
Attorney for Respondent
101 N. Monroe Street, Suite 925
Tallahassee, Florida 32301

DATED: 09/30/2020

Gisela Iglesias, Esquire
Assistant General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive N., Suite 330
St. Petersburg, Florida 33701

DATED: 10/1/20