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AGENCY CLERK

2020 JUL 14 A 10:30

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

VERO BEACH FACILITY OPERATIONS, LLC d/b/a CONSULATE HEALTH CARE OF VERO BEACH,

Respondent.
_____/

Case No: 2020001263

License No.: 1247096
Facility Type: Nursing Home
RENDITION NO.: AHCA- 20 - 177 **-S-OLC**

FINAL ORDER

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

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (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 pay the Agency $16,000.00. 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 30 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

3. Conditional licensure status is imposed on the Respondent beginning January 10, 2020 and ending February 9, 2020.

ORDERED at Tallahassee, Florida, on this 13th day of July, 2020.

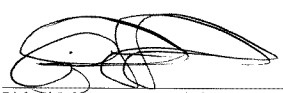
for MM
Mary C. Mayhew, Secretary
Agency for Health Care Administration

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 15th day of July, 2020.



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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Thomas J. Walsh II, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	John E. Bradley, Esq. Counsel for Respondent 5102 West Laurel Street, Suite 700 Tampa, FL 33607 John.E.Bradley@consulatehc.com (Electronic Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

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VERO BEACH FACILITY OPERATIONS, LLC d/b/a CONSULATE HEALTH CARE OF VERO BEACH,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration (hereinafter "Agency"), by and through the undersigned counsel, and files this Administrative Complaint against Vero Beach Facility Operations, LLC d/b/a Consulate Health Care of Vero Beach (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 January 10, 2020 and ending February 9, 2020, to impose administrative fines in the amount of ten thousand dollars ($10,000.00), the imposition of a two (2) year survey cycle and its six thousand dollar ($6,000.00) fee, for a total assessment of sixteen thousand dollars ($16,000.00) based upon Respondent being cited for one (1) isolated State Class I deficient practice.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60 and 400.062, Florida Statutes (2018).

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

EXHIBIT 1

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 one hundred fifty-nine (159) bed nursing home, located at 1310 37th Street, Vero Beach, Florida 32960 and is licensed as a skilled nursing facility license number 1247096.

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. That 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 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).

8. That Florida law provides the following: "'Practice of practical nursing' means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist. A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing." § 464.003(17), Fla. Stat. (2019).

9. That Petitioner completed a survey of Respondent and its operations on January 10, 2020.

10. That based upon observation, the review of records, and interview, Respondent failed to 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, including but not limited to the failure to honor a resident's choice of end-of-life care, the same being contrary to the mandates of law.

11. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Abuse, Neglect, Exploitation, & Misappropriation," dated November 30, 2014, and noted "Neglect" is the failure of the center, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

12. That Petitioner's representative reviewed Respondent's undated policy and procedure entitled "Clinical/Medical Records," dated November 30, 2014, and noted, "Resident's clinical record is readily accessible and systematically organized to facilitate retrieving and compiling

information. Required clinical information pertaining to the residents stay is centralized in the medical record."

13. That Petitioner's representative reviewed Respondent's records related to resident number one (1) and noted:

a. The resident had advanced directives and contained a yellow Florida Do Not Resuscitate (DNR) Order, which was in the front of the chart.

b. This order was signed by a durable power of attorney, the resident's adult child, on January 27, 2009 and signed and dated by a physician on the same date.

c. The resident was one hundred five (105) years old and had a diagnosis of Alzheimer's Disease, dementia, chronic obstructive pulmonary disease, hypertension, atherosclerotic heart disease, anxiety, and diabetes mellitus type.

d. A Minimum Data Set Quarterly Assessment dated December 8, 2019 revealed a BIMS (Brief Interview for Mental Status) of 03 indicating severe cognitive impairment.

e. A care plan initiated on October 30, 2018 was for advanced directives and provided:

i. The resident had a living will and a "Do Not Resuscitate" order.

ii. The goal of the care plan was that the resident will have advanced directives followed and the interventions included a physician order for Do Not Resuscitate DNR.

f. A review of the physician's orders for the resident revealed a Do Not

Resuscitate DNR order.

g. On January 6, 2020, time not documented:

i. The resident was found by an x-ray technician in the room, unresponsive to verbal stimuli.

ii. The X-Ray technician called for the resident's nurse, staff member "C," a licensed practical nurse.

iii. Staff member "C" responded to the resident's room to do an assessment and found the resident had no pulse or respirations.

iv. The nurse asked the X-Ray technician to call for help while the nurse stayed with the resident.

v. Staff member "C" documented that no one came, and she yelled down the hallway.

vi. Staff member "D," a licensed practical nurse, arrived and verified her findings.

vii. The X-Ray technician was attempting to get an abdominal x-ray that had been ordered by the resident's physician for diarrhea.

14. That Petitioner's representative interviewed Respondent's executive director and risk manager on January 8, 2020 at 1:00 p.m. regarding resident number one (1) and they indicated:

a. Their investigation revealed that the resident was found unresponsive shortly after 7:00 p.m. on January 6, 2010.

b. The resident had a "Do Not Resuscitate" order in the record, but facility staff and Emergency Medical Services (EMS) performed Cardiopulmonary Resuscitation (CPR) on the resident.

c. After staff member "C" located the resident's record at the nurse's station, staff member "C" notified the Emergency Room (ER) where the resident was taken.

d. The resident's death was pronounced at 8:13 p.m. in the emergency room.

e. The facility's immediate response was:

i. The executive director was notified and responded on-site.

ii. A full investigation was initiated.

iii. All nursing staff involved were suspended.

iv. All licensed staff were re-educated regarding cardiopulmonary resuscitation, advanced directives, resident rights, and following the care plan.

v. A facility-wide review of the medical records was initiated reviewing the code status which included the physician orders and "Do Not Resuscitate" forms.

vi. Mock code blue drills were initiated facility wide.

vii. An immediate report was submitted to the State Agency on January 7, 2020 at 7:04 p.m.

15. That Petitioner's representative interviewed Respondent's staff member "B," a certified nursing assistant on January 8, 2020 at 2:57 p.m. regarding resident number one (1) and the assistant indicated:

a. She was the resident's certified nursing assistant for this shift.

b. She had put the resident to bed at 7:00 p.m. and the resident was doing okay at that time.

c. They had a conversation about adjusting the resident's head, she completed the resident's care, and left the room.

d. She was in the shower room with another resident when she heard the code blue called.

e. She thinks it was about 7:30 p.m. but was in the shower room and not sure.

f. After she finished with the resident in the shower, she went to the resident's room.

g. Cardiopulmonary resuscitation was in progress and the room was full of staff from all over the building.

h. She did not assist.

i. She has received education since this event regarding cardiopulmonary resuscitation and "Do Not Resuscitate" orders.

16. That Petitioner's representative randomly interviewed Respondent's nursing staff on January 9, 2020 starting at 10:05 a.m. asking what they would do if they came across an unresponsive resident with no pulse and no respirations and noted as follows:

a. Staff member "F," a licensed practical nurse:

i. She would call for help and to look for code status.

ii. She would look in the record for a yellow "Do Not Resuscitate" form.

iii. If a "Do Not Resuscitate" order was not there she would check the physician orders and that will state whether a resident is a "Do Not Resuscitate" or full code.

iv. If the resident had a "Do Not Resuscitate" order she would not start cardiopulmonary resuscitation.

v. She has had training in cardiopulmonary resuscitation (certified), advanced directives, and code blue.

b. Staff member "G," a registered nurse:

i. This was her first day working in this facility.

ii. She has been trained to look for a yellow "Do Not Resuscitate" form in the front of the record.

iii. She would get help and check code status.

iv. If resident was a "Do Not Resuscitate" then she would contact the physician and family.

v. If resident is a full code, she would initiate cardiopulmonary resuscitation.

c. Staff member "H," a registered nurse:

i. She would call for help and look for the yellow form in the resident's chart.

ii. If not there she would check physician orders.

iii. All staff had advanced directive and "Do Not Resuscitate" training this morning before starting their shift.

17. That Petitioner's representative telephonically interviewed Respondent's staff member "C," a licensed practical nurse on January 9, 2020 at 10:55 a.m. regarding resident number one (1) and the nurse indicated:

a. She was the resident's nurse for the evening of January 6, 2020.

b. The resident was in the Essex Unit, which is a locked memory care unit.

c. An x-ray tech called her to the room saying the resident was not arousable.

d. The resident had just eaten and was put to bed.

e. She assessed the resident and noticed the resident had vomited, had no pulse and was not breathing.

f. She turned the resident on the side and told the x-ray tech to get help.

g. When no one came to help, she yelled down the hallway and stayed with the resident.

h. Staff member "D," a licensed practical nurse, arrived along with other nurses.

i. Someone yelled the resident was a full code from the hallway but does not know who it was.

j. She initiated cardiopulmonary resuscitation.

k. The resident had been having diarrhea and was not feeling well.

l. An abdominal x-ray was ordered for the persistent diarrhea.

m. The resident was sleeping more than normal and seemed a bit weak.

n. She does not know who called 911 or who checked the chart for the code status.

o. She found the chart sitting by the phone after emergency medical services left with the resident and noticed the yellow "Do Not Resuscitate" form in the front of the record.

p. She had taken care of this resident many times and knew this resident well.

q. She has not been back to the facility since this event occurred.

18. That Petitioner's representative telephonically interviewed Respondent's staff member "D," a licensed practical nurse on January 9, 2020 at 11:15 a.m. regarding resident number one (1) and the nurse indicated:

a. She was working on the Canterbury unit when she heard a code blue called

over head to Essex.

b. It was a man's voice and very jumbled, so she went over to see what was going on.

c. The unit was very chaotic.

d. She arrived at the resident's doorway and asked staff member "C" if the resident was a full code.

e. Staff member "C" responded "Yes," so staff member "D" took over compressions.

f. The resident had food in the mouth and there was a lot of fluid in the throat.

g. She asked for someone to get the chart but was informed that the chart could not be found, so they continued cardiopulmonary resuscitation until emergency medical services arrived and took over.

h. Staff member "S" called 911 but could not locate the chart.

i. The chart is supposed to be brought into the room when there is a code blue.

j. They used to have more mock code blue drills but lately have not been having them, possibly because they have had more code blues.

k. She felt more drills needed to be conducted.

19. That Petitioner's representative interviewed Respondent's staff member "E," a registered nurse on January 9, 2020 at 11:05 a.m. regarding resident number one (1) and the nurse indicated:

a. She was working on the Friar unit when she heard the code blue called to Essex.

b. She responded to the room with the crash cart and was hooking up the suction

when emergency medical services arrived.

c. She is not sure who contacted 911.

d. She asked the primary nurse, staff member "C," if the patient was a full code because the chart could not be located.

e. Staff member "C" stated "Yes, the resident is a full code."

f. Mock code blues are done, but the last one was six (6) to seven (7) months ago.

g. She is certified in cardiopulmonary resuscitation and current.

h. To check for code status, she would look in the record to see if there was a yellow "DNR" form and check the physician orders.

20. That Petitioner's representative interviewed Respondent's executive director on January 9, 2020 at 1:50 p.m. regarding resident number one (1) and the director indicated:

a. The nurse managers do the mock code drills with the staff.

b. The director provided sign-in sheets for the mock code blue drills done over the past year.

c. Two (2) of the four (4) nurses involved in the event on January 6, 2020 were noted on the code blue drill forms.

21. That Petitioner's representative interviewed Respondent's executive director and risk manager on January 9, 2020 at 2:55 p.m. regarding resident number one (1) and they indicated:

a. The director was notified about 8:30 p.m. on January 6, 2020 that there was an error made on reading the "Do Not Resuscitate" for a resident.

b. The director called and spoke to Staff member "C" and asked her how it occurred and who was with her.

c. The regional nurse and corporate risk manager for the facility were notified.

d. Staff member "C" was notified that she had to be sent home immediately and was suspended pending investigation.

e. Spoke with staff member "D" who responded to the overhead page.

f. Staff member "D informed the director that staff member "C" had initiated compression and had already confirmed code status.

g. The director arrived at facility at 10:45 p.m.

h. The director indicated staff member "C" saw the "Do Not Resuscitate" order immediately after emergency medical services left with the resident.

i. The resident arrived at the Emergency Room (ER) at 7:37 p.m. and had been intubated.

j. The facility called the emergency room at 7:51 p.m. and notified them of the "Do Not Resuscitate" status and faxed them the form.

k. The resident was extubated, and death pronounced at 8:13 p.m.

l. The director stated the other three (3) nurses involved in the event were suspended pending investigation prior to leaving their shift.

m. The on-coming shift of 11:00 p.m. to 7:00 a.m. were educated on the cardiopulmonary resuscitation policy prior to starting their shift.

n. The 7:00 a.m. to 3:00 p.m. shift the following day were educated prior to the start of their shift.

o. An immediate report was submitted on January 7, 2020 at 7:00 p.m.

p. The education is still ongoing and code drills are being done on every shift.

q. The director stated the crash carts and documentation were looked over to see

what staff had available to them.

r. All nursing staff were re-educated on the code blue documentation sheet.

s. Audits were completed for "Do Not Resuscitate" forms and physician orders.

t. These audits were previously being done weekly by social service personnel.

u. The director stated that "This was a nurse not following the protocols the facility has in place."

22. That Petitioner's representative telephonically interviewed Respondent's medical director on January 9, 2020 at 5:37 p.m. regarding resident number one (1) and the doctor indicated:

a. It is expected if staff find a resident who is down, they should initiate cardiopulmonary resuscitation until you can get help.

b. They cannot wait until someone locates a chart and let that person wait.

c. "The nurse taking care of residents should know the code status of everyone they are taking care of. There is no excuse to not know the code status on a patient you are taking care of."

d. "This is what needs to be addressed, knowing every resident they are taking care of."

23. That in this case, Respondent neglected to ensure the advanced directive was followed as per the resident's/resident representatives' wishes potentially causing physical harm, pain and mental anguish due to resuscitation efforts. The resident was transferred to the hospital intubated (breathing tube placed) and was receiving further interventions. The facility neglected to ensure the medical record was readily available for staff to verify code status.

24. That Respondent's removal plan dated January 10, 2020 included the following:

a. Corrective Action for resident affected - Resident number one (1) was sent to

the emergency room on January 6, 2020.

b. Identification of other residents to be affected by deficient practice - all other residents have the potential to be affected.

c. Systemic Corrective Actions:

i. On January 6, 2020 during the 3:00 to 11:00 shift, the facility administrator reported to the center and initiated an investigation.

ii. Staff education began with the 3:00 to 11:00 shift regarding cardiopulmonary resuscitation, Do Not Resuscitate (DNR) policy and Abuse/neglect.

iii. A code drill was completed on January 6, 2020 with the 3:00 to 11:00 and 11:00 to 7:00 staff on shift. Thirty-five (35) staff members participated in this code drill.

iv. Nurse "A" who was assigned to the resident and initiated cardiopulmonary resuscitation was suspended pending investigation on the evening of January 6, 2020.

v. The immediate report to the agency was completed around 7:00 p.m. on January 7, 2020, the abuse registry was notified at approximately 6:30 p.m. the same day, and the police department was notified at approximately 6:25 p.m. on January 7, 2020.

vi. The other three (3) nurses, "B," "C," and "D," involved with the mock code drill were suspended on January 7, 2020 and did not work after their 3:00 to 11:00 shift was completed on January 6, 2020.

vii. Mock code drills with re-education were initiated on January 6, 2020 and

were ongoing during the survey.

viii. Licensed nursing staff received education beginning on January 6, 2020 to January 9, 2020 to include following advanced directives, resident rights, abuse and neglect, and mock code drills.

ix. On January 9, 2020, one hundred ten (110) of one hundred seventeen (117) nursing staff members received education either in-person or telephonically. For those we were unable to reach telephonically, staff were sent a certified letter as of January 9, 2020 indicating they may not return to work until the education is received. Seven (7) letters were mailed.

x. On January 9, 2020, education was initiated with licensed nurses regarding safeguarding medical records with an emphasis on storage and placement of the medical record at the nurse's station. This education is ongoing and will continue until all nurses are educated. The education will be received prior to working assigned shift. Newly hired staff will receive education in orientation.

xi. All active charts were audited on January 7, 2020 by licensed nurses to ensure that resident code status orders matched the advanced directive documents present in the chart.

xii. An Ad-hoc Quality Improvement Performance Committee meeting was held on January 9, 2020 to review the plan with the following team members in attendance: Executive Director, Director of Clinical Services, Medical Director via telephone, Assistant Administrator, Regional

Director of Clinical Services, and Risk Manager. The Ad-hoc QAPI Committee approved the recommendations and the plan is set forth to continue.

xiii. Mock code drills will continue weekly, minimally one (1) per shift for the next six (6) weeks and monthly thereafter to ensure staff are responding appropriately to cardiopulmonary resuscitation CPR events and understand their responsibility during the event. Results of these drills will be submitted to QAPI for further recommendations.

xiv. On January 10, 2020, the information in the facility's removal plan was verified.

(a) Ten (10) additional staff members were interviewed to confirm the implementation of the facility's removal plan including five nurses, one (1) certified nursing assistant, one (1) housekeeper, one (1) dietary staff, and two (2) rehab staff members.

(b) Multiple resident records were randomly chosen to ensure they were easily accessible and code status was verified in all records.

25. That the above reflects Respondent's failure to 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, including but not limited to:

a. The failure to ensure the medical record was readily available for staff to verify code status for a resident.

b. The failure to honor a resident's end-of-life health care decisions.

c. The failure to assure systems to honor end-of-life decisions for the facilities one hundred forty-four (144) residents were operational.

26. That the above described noncompliance caused or is likely to cause serious injury, harm, impairment, or death to residents.

27. That the Agency determined that this deficient practice 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, and cited Respondent with an isolated Class I deficient practice.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(8)(a), Florida Statutes (2019).

COUNT II

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

29. Based upon Respondent's one (1) State Class I deficiency, it was not in substantial compliance at the time of the surveys with criteria established under Part II of Florida Statute 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 (2019).

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 (2019) commencing January 10, 2020 and ending February 9, 2020.

COUNT III

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

31. That Respondent has been cited with for one (1) State 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) pursuant to Section 400.19(3), Florida Statutes (2019).

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 Section 400.19(3), Florida Statutes (2019).

Respectfully submitted this 24 day of March, 2020.

Thomas J. Walsh II, Esquire
Fla. Bar. No. 566365
Agency for Health Care Admin.
525 Mirror Lake Drive, 330G
St. Petersburg, FL 33701
727.552.1947 (office) / 727.552.1440 (Fax)
walsht@ahca.myflorida.com

DISPLAY OF LICENSE

Pursuant to § 400.23(7)(e), Fla. Stat. (2019), 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.

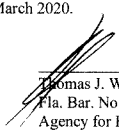
Respondent is notified that it has a right to request an administrative hearing pursuant to Section 120.569, Florida Statutes. Respondent has the right to retain, and be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

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.

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7018 2290 0001 4174 2008, to Nicole Jordan, Administrator, Vero Beach Facility Operations, LLC d/b/a Consulate Health Care of Vero Beach, 1310 37th Street, Vero Beach, Florida 32960, and by Regular U.S. Mail to Corporation Service Company, Registered Agent for Vero Beach Facility Operations, LLC, 1201 Hays Street, Tallahassee, Florida 32301, this 5 day of March 2020.



Thomas J. Walsh II, Esquire
Fla. Bar. No. 566365
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Copy furnished to:
Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Admin.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

January 23, 2020

Nicole Jordan, Administrator
Consulate Health Care Of Vero Beach
1310 37th St
Vero Beach, FL 32960-4860

File Number: 93102
License Number: 1247096
Provider Type: Nursing Home

RE: 1310 37th St, Vero Beach

Dear Administrator:

The enclosed Nursing Home license with license number 1247096 and certificate number 23743 is issued for the above provider effective January 10, 2020 through September 30, 2020. The license is being issued for: approval of status change to conditional during licensure period application.

Review your certificate thoroughly to ensure that all information is correct and consistent with your records. If errors are noted, please contact the Long Term Care Services Unit.

Please take a short 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) 412-4434 or by email at Lacshauna.Finch@ahca.myflorida.com.

Sincerely,

Lacshauna Finch
Health Services and Facilities Consultant
Long Term Care Services Unit
Division of Health Quality Assurance

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF1247096
CERTIFICATE #: 23743

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

CONDITIONAL

This is to confirm that VERO BEACH FACILITY OPERATIONS, 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 is authorized to operate the following:

CONSULATE HEALTH CARE OF VERO BEACH
1310 37th St
Vero Beach, FL 32960-4860

Total: 159 Beds

EFFECTIVE DATE 01/10/2020

EXPIRATION DATE: 09/30/2020

Mary C. Mayhew

Secretary, Agency for Health Care Administration

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

February 20, 2020

Nicole Jordan, Administrator
Consulate Health Care Of Vero Beach
1310 37th St
Vero Beach, FL 32960-4860

File Number: 93102
License Number: 1247096
Provider Type: Nursing Home

RE: 1310 37th St, Vero Beach

Dear Administrator:

The enclosed Nursing Home license with license number 1247096 and certificate number 23901 is issued for the above provider effective February 9, 2020 through September 30, 2020. The license is being issued for: approval of status change to standard during licensure period application.

Review your certificate thoroughly to ensure that all information is correct and consistent with your records. If errors are noted, please contact the Long Term Care Services Unit.

Please take a short 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) 412-4434 or by email at Lacshauna.Finch@ahca.myflorida.com.

Sincerely,

Lacshauna Finch
Health Services and Facilities Consultant
Long Term Care Services Unit
Division of Health Quality Assurance

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF1247096
CERTIFICATE #: 23901

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

LICENSED

This is to confirm that VERO BEACH FACILITY OPERATIONS, 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 is authorized to operate the following:

CONSULATE HEALTH CARE OF VERO BEACH
1310 37th St
Vero Beach, FL 32960-4860

Total: 159 Beds

EFFECTIVE DATE 02/09/2020

EXPIRATION DATE: 09/30/2020

Secretary, Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: VERO BEACH FACILITY OPERATIONS, LLC d/b/a CONSULATE HEALTH CARE OF VERO BEACH

AHCA Number: 2020001263

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: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (Optional) _____

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: _____ Date: _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

VERO BEACH FACILITY OPERATIONS, LLC d/b/a
CONSULATE HEALTH CARE OF VERO BEACH,

Respondent.
_____/

Case No: 2020001263
License No.: 1247096
Facility Type: Nursing Home

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondent, Vero Beach Facility Operations LLC d/b/a Consulate Health Care of Vero Beach (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondent is a nursing home licensed pursuant to Chapters 400, Part II, and 408, Part II, Florida Statutes, Section 20.42, Florida Statutes and Chapter 59A-4, Florida Administrative Code; and

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondent, pursuant to Chapters 400, Part II, and 408, Part II, Florida Statutes; and

WHEREAS, the Agency served Respondent with an administrative complaint dated March 5, 2020, notifying the Respondent of its intent to impose administrative fines in the

EXHIBIT 2

amount of ten thousand dollars ($10,000.00), the imposition of a two-year survey cycle and its six thousand dollar ($6,000.00) fee, and the imposition of conditional licensure; and

WHEREAS, the Agency has determined that licensure revocation under Section 400.121(3), Florida Statutes is inappropriate under the circumstances; and

WHEREAS, the parties have negotiated 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. Both parties agree that the "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 related to this state proceeding 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 no agreement herein shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement.

4. Upon full execution of this Agreement, Respondent agrees to pay sixteen thousand dollars ($16,000.00) in fines and fees to the Agency within thirty (30) days of the entry of the Final Order and accepts imposition of conditional licensure commencing January 10, 2020 and ending February 9, 2020. Respondent accepts the imposition of the survey cycle.

5. Venue for any action brought to enforce the terms of this Agreement or the Final Order entered pursuant hereto shall lie in Circuit Court in Leon County, Florida.

6. By executing this Agreement, Respondent denies, and the Agency asserts the validity of the allegations raised in the administrative complaint referenced herein.

7. The Agency agrees that it shall not use the allegations contained in the Administrative Complaint as the sole basis to deny, terminate, or revoke Respondent's license to operate the facility. The Agency may use the allegations of the Administrative Complaint to impose a future penalty related to a "repeat" deficiency identified in a future survey of Respondent's facility that is provided under Chapters 400, Part II, 408, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code. In said event, Respondent retains the right to challenge the factual allegations related to the deficient practices/ violations alleged in the Administrative Complaint or an action that the Agency files against the Respondent. The Agency may also use the allegations of the Administrative Complaint to support any action it is authorized to take based upon a demonstrated pattern of deficient performance, provided that demonstrated pattern is not based solely on the allegations of the Administrative Complaint. In said event, Respondent retains the right to challenge the factual allegations related to the deficient practices/ violations alleged in the Administrative Complaint.

8. Subject to the provisions of paragraph seven (7) above, no agreement made herein shall preclude the Agency from using the deficiencies from the surveys identified in the administrative complaint in any decision regarding licensure of Respondent, including, but not limited to, a demonstrated pattern of deficient performance. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Respondent acknowledges and agrees that this Agreement shall not preclude or estop any other

federal, state, or local agency or office 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 Survey. This agreement does not prohibit the Agency from taking action regarding Respondent's Medicaid provider status, conditions, requirements or contract.

9. 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.

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

11. This Agreement shall become effective on the date upon which it is fully executed by all the parties.

12. Respondent for itself and for its related or resulting organizations, its successors or transferees, attorneys, heirs, and executors or administrators, does hereby discharge 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 Respondent or related facilities.

13. This Agreement is binding upon all parties herein and those identified in paragraph twelve (12) of this Agreement.

14. In the event that Respondent was a Medicaid provider at the subject time of the occurrences alleged in the complaint herein, this settlement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any sanctions pursuant to Rule 59G-9.070, Florida Administrative Code.

15. Respondent agrees that if any funds to be paid under this agreement to the Agency are not paid within thirty-one (31) days of entry of the Final Order in this matter, the Agency may deduct the amounts assessed against 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.

16. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it.

17. This Agreement contains and incorporates the entire understandings and agreements of the parties.

18. This Agreement supersedes any prior oral or written agreements between the parties.

19. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

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

The following representatives hereby 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, Building #1
Tallahassee, Florida 32308

DATED: 7-13-20

John E. Bradley, Esq.
Counsel for Respondent
5102 West Laurel Street
Suite 700
Tampa, Florida 33607
Florida Bar No. 105523

DATED: 05/27/2020

Stefan Grow, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Florida Bar No. 93585

DATED: 7-6-20

Name: Nicole Jordan
Title: Executive Director
Vero Beach Facility Operations LLC d/b/a
Consulate Health Care of Vero Beach

DATED: 5/21/2020

Thomas V. Walsh II, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive North, Suite 330G
St. Petersburg, Florida 33701
Florida Bar No. 966365

DATED: 6/4/20