STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

CRESTWOOD NURSING CENTER, INC.,

Respondent.

_____/

AHCA NOS. 2019014456
(Moratorium) 2019013677
RENDITION NO.: AHCA- 20-039 **-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 Respondent the attached Administrative Complaint and Elections of Rights Form (Ex. 1). The parties entered into the attached Settlement Agreement (Ex. 2), which is adopted and incorporated by reference.

2. The parties shall comply with the terms of the Settlement Agreement. The Respondent shall pay the Agency $53,500.00. 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. Should the Respondent fail to comply with the change of ownership terms of the Settlement Agreement, the license shall not renew and the patients shall need to be safely discharged.

4. The immediate moratorium on admissions is lifted.

ORDERED at Tallahassee, Florida, on this 10 day of January, 2020.

for
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 15 day of January, 2020.

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403
Telephone: (850) 412-3630

Jan Mills Facilities Intake Unit (Electronic Mail)	Central Intake Unit Mail Stop #61 (Electronic Mail)
Carlton Enfinger, Esquire Assistant General Counsel Agency for HealthCare Administration (Electronic Mail)	Richard A. Feldman, Esquire 100 North Lake Street Crescent City, Florida 32112 (U. S. Mail)
Kimberly Smoak, Chief Field Office Operations Heath Quality Assurance Agency for Health Care Administration (Electronic Mail)	Alena Garner, Field Office Manager Health Quality Assurance Area 3 Field Office Agency for Health Care Administration (Electronic Mail)
Thomas Hoeler, Chief Facility Counsel Office of General Counsel Agency for Health Care Administration (Electronic Mail)	Bernard Hudson, Unit Manager Health Quality Assurance Agency for Health Care Administration (Electronic Mail)

STATE OF FLORIDA
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vs. AHCA No. 2019014456

CRESTWOOD NURSING CENTER, INC.,

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ADMINISTRATIVE COMPLAINT

The Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), files this Administrative Complaint against the Respondent, Crestwood Nursing Center, Inc., ("the Respondent"), and alleges as follows:

NATURE OF THE ACTION

This is an action against a nursing home to impose an administrative fine of $53,500.00, assign conditional licensure status effective August 29, 2019, and seeking license revocation based upon four class I deficiencies.

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 facilities. Ch. 408, Part II, Ch. 400, Part II, Fla. Stat.; Ch. 59A-4, Fla. Admin. Code. The Agency is authorized to deny, suspend, or revoke a license, and impose administrative fines pursuant to sections 400.121, 400.23, and 408.815, Florida Statutes, assign a conditional license pursuant to subsection 400.23(7), Florida Statutes, and assess costs related to the investigation and prosecution of this case pursuant to section 400.121, Florida Statutes.

2. The Respondent was issued a license by the Agency to operate a skilled nursing facility ("the Facility") and was at all times material required to comply with the applicable statutes and rules governing such facilities.

3. An announced complaint survey was conducted on August 27, 2019 to August 29, 2019 at the Facility. Deficient practice was identified at the time of the survey. Imminent danger, Class I deficiencies, were identified on August 29, 2019 at N060, N074, N201, and N910 for the Facility's failure to ensure residents were free from neglect by not following the physicians medication orders when a resident was identified through lab results with a high blood ammonia level, (too much ammonia in the body can cause psychological problems like confusion, tiredness, and possibly coma or death) for the administration of Lactulose, (used to reduce the amount of ammonia in the blood) for Resident #1. The Facility failed to follow physicians medication orders and standards of practice with the continuation of the administration of morphine (an opioid narcotic used for moderate to severe pain), and Ativan (used for anxiety which acts on the brain and central nerves system), when a resident was assessed to be unresponsive, with decreased respirations, eyes non-reactive to light; Resident #2, (a major drug interaction exists between morphine and Ativan that can lead to serious side effects including respiratory distress, coma, and even death). Resident #2 was transferred to the hospital emergency room and diagnosed by the hospital with an accidental overdose of morphine. The Facility failed to ensure cardiopulmonary resuscitation was initiated immediately when a resident was found unresponsive and absent of vital signs, resulting in a five-minute delay, the resident had a full code status, the resident did not survive, Resident #10. The Facility failed to initiate a plan of correction and thorough investigation into an abuse allegation made by a resident of a staff member punching her in the arm, Resident #1, placing 47 of 47 residents at risk, the facility failed to investigate and initiate a plan of correct for the identified neglect of significant medication errors for Residents #1 and #2, placing 47 of

47 residents at risk for the same deficient practice, and the facility failed to investigate and initiate a plan of correction for the neglect of a five minute delay in the initiation of CPR for Resident #10, with a full code status, when found unresponsive and absent of vital signs, the resident did not survive, places 26 residents with a full code status at risk in a total of 47 residents. The Administrator was notified of the Class I deficiencies on August 29, 2019. The Facility had 47 residents at the time of the survey.

COUNT I
Resident Right to Adequate and Appropriate Health Care

4. Under Florida law, 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).

Survey Findings

5. On or about August 27, 2019, through August 29, 2019, an announced complaint survey was conducted at the Facility.

6. Based on interviews, record reviews, and policy and procedure reviews the facility failed to ensure the Director of Nursing (DON) was responsible and accountable for the supervision and administration of the total nursing services program. The facility failed to ensure residents were free from neglect by not following the physicians medication orders when a resident was identified through lab results with a high blood ammonia level, (too much ammonia in the

body can cause psychological problems like confusion, tiredness, and possibly coma or death) for the administration of Lactulose, (used to reduce the amount of ammonia in the blood) for Resident #1. The facility failed to follow physicians medication orders and standards of practice with the continuation of the administration of morphine (an opioid narcotic used for moderate to severe pain), and Ativan (used for anxiety which acts on the brain and central nerves system), when a resident was assessed to be unresponsive, with decreased respirations, eyes non-reactive to light, Resident #2. (A major drug interaction exists between morphine and Ativan that can lead to serious side effects including respiratory distress, coma, and even death). Resident #2 was transferred to the hospital emergency room and diagnosed by the hospital with an accidental overdose of morphine. The facility failed to ensure cardiopulmonary resuscitation was initiated immediately when a resident was found unresponsive and absent of vital signs, resulting in a five-minute delay, the resident had a full code status, the resident did not survive, Resident #10. The facility failed to initiate a plan of correction and thorough investigation into an abuse allegation made by a resident, of a staff member punching her in the arm, Resident #1, placing 47 of 47 residents at risk, the facility failed to investigate and initiate a plan of correct for the identified neglect of significant medication errors for Residents #1 and #2, placing 47 of 47 residents at risk for deficient practice, and the facility failed to investigate and initiate a plan of correction for the neglect of a five minute delay in the initiation of CPR for Resident #10, with a full code status, when found unresponsive and absent of vital signs, the resident did not survive, places 26 residents with a full code status at risk in a total of 47 residents.

7. A review of the Florida Nurse Practice Act and the Scope of Nursing, Chapter 6 read: IX. Scope of Practice: . . . . 3. Responsibility of Administration - Health care facilities have a responsibility to provide competent care to patients, which includes competent nursing care. The administration has an obligation to assess each nurse's skills and abilities to provide care to a

specific patient population. This is often accomplished through orientation programs, job, evaluations, training programs, and continuing education courses. The administration also has a responsibility to plan and budget, which includes allocating resources so that adequate and appropriate nursing care is available. Finally, the administration of a health care facility has a responsibility to take appropriate action to prevent or remedy incompetent care. In the event disciplinary action is warranted, the administration has a duty to follow facility discipline policies. 4. Responsibility of the Nurse - A nurse has a duty to provide competent care to patients. This includes clarifying work assignments with management, as well as determining and assessing her own skills, knowledge and abilities. Providing competent nursing care also includes using informed judgement and decision-making. Informed decision-making requires a nurse to use her own knowledge and skills, as well as recognizing when the nurse needs additional assistance.

Resident #1

8. A review of Resident #1's facility record revealed admission to the Facility on 7/10/19 with diagnosis to include Cirrhosis of the liver, muscle weakness, Cystitis, Diabetes Mellitus, and Hypertension.

9. A review of the Minimum Data Set (MDS), initial date 08/14/2019, revealed a BIMS (Brief Interview of Mental Status) score of 15 = no cognitive deficit.

10. A review of the hospital AHCA (Agency for Health Care Administration) Form 5000-3008, dated 8/5/2019, under the section titled, "U. Mental/Cognitive Status At Transfer" Alert, oriented, follows Instructions, was checked.

11. A review of the AHCA Nursing Homes Federal Reporting, dated 08/17/2019, revealed: Description of the Incident: The resident made an allegation of a staff member while changing her that she was punching her in her arm. Resident cried as Social Service was speaking to her. The Facility's Immediate Response revealed: "4. Statements was done by staff. 5. Interview

was done by Social Service."

12. A review of the written statement, dated 8-17-2019 by Staff P, CNA (Certified Nursing Assistant) read: "At about 6:30 p.m. Sat. 8-17-2019 was passing trays for supper. [Resident #1's name] was yelling she was wet and trying to crawl out of bed calling me all kinds of names that no one was changing her one of my co-worker came into her room to help me and she told him to get out, finally I started to change her bed and she was rowdy that I, when and got another co-worker [Staff V, CNA's name] to come and help me in the process of changing her bed she became mad at me for trying to change her and she begin to hit me and I, tried to catch her hands and arms and she was mad with [Staff V, CNA's name] for not helping her, and we trying to change her wet bed. I, call the nurse to tell her what had happen."

13. A review of the written statement, dated 08/17/2019, by Staff V, CNA read: "I was helping [Staff P, CNA's name] in room. The Resident became combative and refused care talking about" her dying.

14. A review of the nursing progress notes, dated 8/27/19 at 3:30 PM, read: "[Resident #1] is agitated making false accusations against staff."

15. On 08/27/19 at 3:44 PM, they read, "Reach out to hospice regards to behavior, staff is afraid to work with her due to false accusations she is making."

16. During an interview on 8/28/19, at 8:55 AM, with the Administrator, a request was made for the complete investigation into the abuse allegation made by Resident #1.

17. The Administrator stated that corrective actions were taken on behalf of Resident 1's abuse allegation.

18. She then pointed to a Posted Note and stated there will be two staff in the room while accommodating her needs. The investigation was completed. Nurses are trained on how to redirect and care for patients. I am not a nurse my expectation is for them to know what they are

doing.

19. When asked if other residents residing on the same unit with Resident #1 were interviewed, to determine if they had suffered abuse, as part of the investigation, the Administrator replied she did not feel this was necessary since there was no abuse.

20. When asked about this being part of the corrective action she stated, "I was not aware that these were items that needed to be implemented as a corrective action when no alleged abuse had occurred."

21. A review of the Posted Note provided by the Administrator read: "Psych Consult. 2 Staff @ all times. All allegations will be reported. Document behaviors. Staff walk away if resident is upset. Ensure resident is safe."

22. During an interview on 8/28/19, at 3:20 PM, Staff P, stated, "[Resident #1 name] was screaming she was soiled, I was passing trays at that time. I stopped and got help to clean her up. The resident started screaming 'you are killing me and cussing' and did not want the male CNA to touch her and all he was doing was helping me hold her and I was cleaning her. I went and got [Staff V, CNA's name] that made her mad she started saying that I was punching her. I was trying not to get punched and clean her up quickly, I felt I was the one who got abused."

23. During an interview on 8/28/19, at 3:45 PM, via telephone Staff V, CNA stated, "I was called by [Staff P, CNA's name] in to help with this resident. I was supporting the [Resident #1's name] and the resident was looking at me and asking why am I allowing this to happen. I tried to reassure her as much as possible. The resident was swinging and cussing at [Staff P, CNA's name] and fussing at me."

24. During an interview on 8/28/19, at 12:45 PM, the Social Services Director stated, "I completed the AHCA 5 day report. I had no training on how to conduct this investigation. I took down the witness statements and asked [Resident #1's name] the questions. Since the DON

(Director of Nursing) was gone, it was given to me to do. [Resident #1's name] had no recollection about the allegation of abuse. I go in and talk to her and she does not remember anything. Yesterday she was fussing at the staff. I would speak to her and she would say nothing."

25. A review of Resident #1's lab dated 8/7/19 revealed: Ammonia 100 High. (too much ammonia in the body can cause psychological problems like confusion, tiredness, and possibly coma or death).

26. A review of the physician's order dated 8/5/19 read: Lactulose (used to reduce the amount of ammonia in the blood of patients) 10 gm/15 ML Solution give 60 ML by mouth every 12 hours. Diagnosis: Cirrhosis of the liver. Dated 8/6/19 at 12:00 AM read: Lactulose 30 ml every 6 hours as needed.

27. A review of the Medication Administration Record (MAR) for 8/1/019 to 8/31/2019 revealed: Lactulose 10 GM/15 ML Solution was administered on 8/5/19 at 9:00 PM and 8/6/19 at 9:00 AM.

28. For the period of 8/6/19 at 9:00 PM to 8/13/19, the MAR did not contain documentation of the medication having been administered and was documented as discontinued on 8/14/19 at 9:00 AM. Lactulose 10 GM/15 ML Solution give 30 ML (20GM) by mouth every 6 hours as needed - Cirrhosis of liver.

29. The documentation showed Lactulose was not administered as needed and was documented as discontinued on 8/14/19 at 9:00 AM.

30. A review of the Discontinued Order - As Needed (Handwritten) form read: Lactulose 10 GM/15 ML (15 grams to 15 milliliters) Solution by mouth. Original Fill Date: 8/6/2019. Give 30 milligram by mouth as needed every 6 hours as needed. Discontinued Date: 8/6/19 at 1:14 PM. Lactulose 10 gm/15 ML Solution. Original Fill Date: 8/5/2019. Give 30 ML (20GM) by mouth every 6 hours as needed. Discontinued Date: 8/14/2019 at 11:03 PM. Lactulose

10 GM/15 ML Solution. Original Fill Date: 8/6/2019. Give 30 Milliliter by mouth as needed every 6 hours. Discontinued Date: 8/20/2019 at 11:03 PM.

31. The Discontinued Orders were completed by licensed nursing staff and did not have a physician's signature line or signature for the discontinuation of the medication.

32. During an interview on 08/27/2019 at approximately 1:12 PM, Resident #1's daughter stated, "My mother would have periods of confusion and craziness and when that happened, I knew it was the ammonia level and she wasn't getting her lactulose."

33. During an interview on 8/27/2019 at approximately 2:00 PM with the Administrator, a request was made for documentation of the administration of Lactulose as ordered by the physician for the period of 8/6/19 at 9:00 PM to 8/19/19 at 9:00 AM (the resident was discharged to the hospital for an unrelated concern at approximately 7:00 PM on 8/19/19) or for the physician's order to discontinue the Lactulose 10/GM/15ML Solution give 60 ml by mouth every 12 hours and Lactulose 30 ml every 6 hours as needed.

34. The Administrator stated she would have nursing provide the documentation.

35. During an interview on 08/28/2019 at approximately 10:00 AM with the Administrator, a request was made for documentation of the administration of Lactulose as ordered by the physician for the period of 8/6/19 at 9:00 PM to 8/19/19 at 9:00 AM (the resident was discharged to the hospital for an unrelated concern at approximately 7:00 PM on 8/19/19) or for the physician's order to discontinue the Lactulose 10/GM/15ML Solution give 60 ml by mouth every 12 hours and Lactulose 30 ml every 6 hours as needed.

36. The Administrator stated she let nursing know the documentation was needed.

37. During an interview on 08/29/2019 at approximately 4:00 PM with the Administrator, a request was made for documentation of the administration of Lactulose as ordered by the physician for the period of 8/6/19 at 9:00 PM to 8/19/19 at 9:00 AM (the resident was

discharged to the hospital for an unrelated concern at approximately 7:00 PM on 8/19/19) or for the physician's order to discontinue the Lactulose 10/GM/15ML Solution give 60 ml by mouth every 12 hours and Lactulose 30 ml every 6 hours as needed.

38. The Administrator did not respond. No additional documentation was provided.

Resident #2

39. A review of Resident #2's facility record revealed admission to the facility on 7/13/19 with diagnosis to include Cirrhosis of the liver with ascites, acute pulmonary edema, hypertension, acute gastro-jejunal ulcer, anemia, and moderate protein-calorie malnutrition.

40. A review of the hospice Treatment or Medication Form,

A. Dated 8/16/19, read Ativan 1 mg oral every 4 hours PRN (as needed).

B. Dated 8/17/19 read: morphine concentrate 20:1 10 mg = 0.5 ml SL (sublingual) every 4 hours ATC (around the clock). Ativan 1 mg SL/PO (by mouth) every 4 hours ATC. May hold for sedation. Please continue morphine sulfate and Ativan every 4 hours PRN (as needed).

C. Dated: 8/18/19, read Lensin/Mycosamine 0.125 mg SL every 4 hours PRN - secretions. D/C (discontinue) nonessential meds d/t (due to) decline.

41. A review of the Controlled Drug Declining Inventory Sheet for Lorazepam (Ativan) 1 mg tablet revealed the medication was signed out for administration on 08/17/2019 at 10:00 AM, at 2:00 PM, at 08:00 PM, and at 12:00 AM, on 08/18/2019 at 4:00 AM, at 8:00 AM, at 10:00 AM, at 12:00 PM, at 2:00 PM, at 5:30 PM, at 8:00 PM, and at 10:00 PM, and on 08/18/2019 at 12:00 midnight.

42. Morphine 100 mg/5 ml concentrate was signed out for administration on 08/17/2019 at 10:00 AM, at 02:00 PM, at 08:00 PM, 08/17/2019 at 12:00 AM, 08/18/2019 at 04:00 AM, 8:00 AM, at 10:00 AM, at 12:00 PM, at 2:00 PM, at 5:30 PM, at 8:00 PM, and at 10:00 PM.

On 8/19/2019 at 12:00 midnight and at 4:15 AM.

43. A review of the care plan revised on 7/25/19 read: "Focus: The resident is on pain medication therapy r/t end stage diagnosis. Goal: The resident will be free of any discomfort or adverse side effects from pain medication. Interventions: Administer Analgesic medications as ordered by physician. Monitor/document side effects and effectiveness Q (every) shift. Ask physician to review medication if side effects persist. Monitor/document/report PRN adverse reactions to analgesic therapy: altered mental status, respiratory distress/decreased respirations, sedation. Focus: Use of psychotropic antianxiety drug places resident at risk for drug-related: Cognitive impairment. Initiated 8/15/19. Goal: Resident will receive the least dosage of the prescribed psychotropic drug (s) to ensure maximum functional ability both mentally and physically. Interventions: Ativan as ordered. Observe for side effects and hold medication for increased lethargy."

44. A review of the nursing progress notes revealed as follows:

A. 8/15/19 at 2:37 PM, "New orders from hospice nurse Ativan 1 mg PO @ HS (by mouth at hour of sleep)."

B. 8/16/19 at 6:21 AM, "Resident is not wanting to take his medications (Lactulose, Oxycodone) Very lethargic and not wanting to open his mouth."

C. 8/16/19 at 9:58 AM, "Resident tried to get out of bed. Stated he forgot he could not walk. Resident fell on his right side on the floor. Resident did not hit his head. Red marks on right hip and right shoulder. DON (Director of Nursing) and MD (Medical Doctor) notified. Resident was reminded to use call light any time he needs to get up."

D. 8/16/19 at 11:11 AM "Resident laying in bed sleeping. Easily arousable. No signs of pain or distress. Resident stated he was just tired and wanted to back to sleep."

E. 8/17/19 at 12:29 AM "This nurse writing called hospice due to Resident making

changes in mental status. Resident is restless, asking for someone to help him, climbing out of bed, not eating or drinking sufficient amount. Hc is c/o (complaint of) abdominal pain. Hospice nurse on called made a visit received new order to increase Ativan, Q 4 hrs. PRN (hours as needed). Resident is being monitored closely to prevent resident injuries."

F. 8/17/19 at 1:38 PM "The resident has had a change is condition. When first observed the resident's jaw was twisted to the right and a CVA (cerebral vascular accident) is suspected. I obtained vital signs and notified hospice as well as his family. Family has been in to see the resident but hospice has not been in at this time 1:41 PM. (There was no documentation of the physician having been notified of the change in condition).

G. 8/18/19 at 10:07 AM read: "Resident is nonresponsive. Family notified and in facility. Hospice nurse in facility. Resident is currently on 4 L (liters) of O2 (oxygen) via nasal cannula r/t apnea (cessation of breathing)."

H. 8/18/19 at 12:23 PM "Resident eyes are no longer reactive to light. RR (respirations) approximately 8 per minutes, on 4 L O2 via nasal cannula."

I. 8/18/19 at 2:24 PM "Being medicated on schedule every 2 hours as instructed by Hospice. Respirations 7 per minute. Currently unarousable again."

J. 8/18/19 at 3:52 PM "Resident is wheezing and moaning. Still asleep. Not arousable. Breathing is slow and labored."

K. 8/19/19 at 3:3 PM Resident is currently lying in bed quietly sleeping with eyes half open. Responds to painful stimuli. Skin warm and dry to touch except for feet is cool. Respirations with long periods of inhale and exhale. No urine output so far this shift. Requires total assistance with ADL's, turning and repositioning. PO (by mouth) meal intake is zero d/t (due to) decrease alertness."

L. 08/19/19 at 9:04 AM Resident only responsive to painful stimuli. Hospice nurse in

to see resident and review orders. Upon assessment determined to send resident to ER (emergency room).

45. A review of the hospice nursing progress notes revealed:

A. 8/19/19 at 8:30 AM - Reason for Focused Visit: Dying process/decline. Medication assessed for: Medicine reconciliation done. Effectiveness. Not taking meds as prescribed. Clinician Narrative Note: When I arrived there patient was unresponsive. Reviewed medications and patient has been getting the Ativan 1 mg every 2 hours and Morphine 10 mg every 2 hours instead of every 4 hours as ordered. Spoke with DON (Director of Nursing) and ADON (Assistant Director of Nursing) and they would like the patient to be sent to the ER for medication overdose. Spoke with sister at the bedside and she would like the patient to be sent out as well. Heat rate: 56. Respirations: 8. Blood Pressure 94/48. O2 Sat (saturation) 92% on 2 LPM (liters per minute).

B. 8/19/19 at 11:35 AM - Clinician Narrative Note: Spoke to ER MD and the RN (Registered Nurse) along with sister at the bedside. Patient was given Narcan to reverse the effects from the Morphine.

C. 8/19/19 [unable to read time] - Clinician Narrative Note: Patient had decline somewhat over the weekend ...possibly transitioning. Pt (Patient) was in hospital ER with sister at Pt's bedside. Cp (Chaplin) spent much time comforting and encouraging pt's sister and later praying with both. Because sister did not want pt to go back to facility from which pt came, sister was looking for other options.

46. A review of the EMS (Emergency Medical Services) note dated 8/19/19 revealed Chief Complaint: Overdose morphine. Meds Admin (Medications Administered) Narcan 0.4 IV (intravenously).

47. A review of the hospital records dated 08/19/19 revealed Chief Complaint: Drug

overdose. History and Physical: Presents to ED via EMS d/t accidental overdose. Pt. sister states Pt has end stage liver failure and is on hospice at Crestwood Nursing home. Pt. was supposed to give (sic) 10 mg every 4 hours but they were giving 10 mg every 2 hours per Pt. sister. EMS gave Pt. Narcan and drastically improved. Pt. denies any other Sx (symptoms) at this time. Free Text: Pt. sister does not like care given to Pt. at Crestwood Nursing home and would like someone else. Re-Evaluation/Progress #1: After Narcan - Re-Eval Status: Improved. Eval Following Treatment: Pt. feels better, Condition improved. Condition: Stable.

48. A review of the hospital Emergency Patient Record dated 08/19/19 revealed: Priority: 2/Emergent. Ingestion - Presenting signs/symptoms: Decreased Resp (respirations), Decreased LOC (level of consciousness). Emergency Notes: 08/19/19 Assumed care of Pt. from previous RN. Pt. is alert when name is spoken to. Pt. has sister and hospice rep (representative) at bedside. Pt. is showing no signs of distress. Per Pt. advocate, Pt's family is requesting new hospice representation. Pt. is to be DC (discharged) to new facility when it is determined. At 12:04 PM Pt. is resting comfortably with family at his side. No signs of distress noted.

49. During an interview on 08/27/2019, at 2:02 PM, Staff A, Unit Manager/LPN (Licensed Practical Nurse) stated, "I am responsible for the unit, both of them since the other Unit Manager quit. I was involved in [Resident #2's name] transfer to the hospital. The hospice nurse came to me and told me the Resident had been given morphine and Ativan every two hours the day before and was obtunded (lethargy in which the patient has a lessened interest in the environment, slowed responses to stimulation, and tends to sleep more than normal with drowsiness in between sleep states) with a very low respiratory rate. We told the DON who said to transfer the resident if that's what the sister wanted. The Administrator was called by the DON and told that the resident had a medication error and needed to go to the ED. So, I called 911 and got him to the hospital. That's all the involvement I had, except that I told The Administrator that

the resident wasn't coming back because the sister didn't want him to. I called the hospital for an update and the hospice nurse let us know too. I didn't make out an incident report. When a resident gets medication, we should be monitoring them for any side effects and holding them and calling the doctor or the hospice nurse for any further orders if there are side effects. It is my expectation that I be informed of any changes in the residents' condition so that the resident can be assessed, and the problem can be addressed with the doctor. I expect the nurses to assess the residents for signs of over sedation. If a resident is sedated, hold medications until they check with hospice or the doctor and document all of that in the chart."

50. During an interview on 08/27/2019, at 4:55 PM, the Hospice Nurse for Resident #2 stated, "I did his initial consult on 08/15/2019, and saw him again on 08/16/2019, and when I saw him on Monday 08/19/2019 there was a big difference, he was unresponsive when I saw him. It was reported to me that he had multiple falls over the weekend and agitation. The Resident's sister told me that he had been given medication every two hours per our orders and I knew that we did not have any orders for medications every two hours. When I checked our orders, we still had Morphine 0.5 ml every 4 hours and a PRN (as needed) order for every 4 hours. But we did not give orders to medicate every 2 hours. After talking to the Director of Nursing and assessing the patient, we were all in agreement that the patient should be sent to the ED and the Resident's sister agreed. I followed up on him once he went to the ED. He received Narcan and was much more alert when I saw him, he was agitated but responsive. Our goal in pain control in end of life is to provide and promote comfort, we want our patients to be pain free, without anxiety. We want our patients to have enough medication to remain comfortable, not overmedicate them to a point where they require reversal agents. I was shocked because the man I saw on Monday was nowhere near the man I saw on Thursday. That was gross overmedication. The patient's sister did not want him to go back to Crestwood, and because we don't have another facility, we discharged him to another

hospice, so the family had a sense of peace and comfort with his care. This Nurse should be reported because this was negligent."

51. During a telephone interview on 08/28/2019, at 10:45 AM, the Hospice Doctor stated, "I am the Physician for hospice and am aware of [Resident #2]. He began hospice sometime in July. When he was first on service, he was taking Oxycodone I believe and the switch to Morphine began just a few days before he went to the emergency room. We routinely order Morphine and Ativan for comfort and anxiety. Our goal is anxiety reduction, symptom control and pain freedom at end of life. We medicate according to the patient's symptomology and frequently have routine orders and orders for breakthrough pain or anxiety. If I or any other of the hospice Physicians thinks medication more frequently than every four hours is necessary, we would order more frequent routine administration of narcotic analgesics. Although, in my field I seldom have to worry about morphine administration and the concomitant use of benzodiazepines such as Ativan. There would be a significant CNS (central nervous system) depression and respiratory depression effects particularly acute in a patient with liver and kidney disease. I would not have recommended every two hours around the clock administration of these drugs to [Resident #2] especially because of his diagnosis. We did not give or instruct the nurses at Crestwood to administer morphine and Ativan every two hours. In this case, he was overmedicated, and I would expect any nurse to call to speak with either the nurses or the doctor on call to determine if the medication should continue at the prescribed times or be adjusted and held. My understanding is [Resident #2's name] was obtunded (lethargy in which the patient has a lessened interest in the environment, slowed responses to stimulation, and tends to sleep more than normal with drowsiness in between sleep states) with a respiratory rate of 6-8 with long apneic (cessation of respiration) periods, this was discussed with family and the nursing home and the decision to send the patient out to the hospital for treatment was made by the family, staff and our

staff followed the family wishes. Our nurse followed up in the emergency room and the patient had a significant change in alertness with Narcan administration which overall tells us that he was overmedicated and that was not recognized by the staff at Crestwood. Overdosage and the need to use reversal agents has a profound effect on the patients that I treat, not only physical but psychological as well for both patients and their families."

52. During an interview on 08/28/2019, at 9:37 AM via telephone, the DON stated, "I did not evaluate [Resident #2]. The first I heard about it was when the ADON/Educator told me he had been medicated every two hours with morphine and he was unarousable with a respiratory rate of 6 or 7 per minute. She stated he needed to be transferred out because we were killing him with medications, which he was obtunded and unable to respond to painful stimuli. The hospice nurse and sister wanted to transfer him to the hospital for evaluation and treatment. I never went to evaluate the resident he was already seen by the hospice nurse and the ADON, so I just started getting the transfer started. I trusted their judgement that he needed to be transferred. I did not do any investigation, there was no time to as I was suspended on 08/20/2019. I did not review the Narcotic Administration sheets. I did not look at any of the nurses' documentation or check any physician orders. I did not know that it was an adverse incident. I was told that he was administered medication every two hours of morphine and Ativan, but that he did not have orders to medicate that frequently. I did not instruct the nurses to make out an incident report. The Administrator knew the patient went to the hospital, got administered Narcan, and the sister did not want him to come back because of this. We were notified that day that he would not be returning. I really did not get to investigate any of this, I just started in February and it takes time to determine that processes are broken. We have a lot of work to do to improve the care we deliver. We don't have a code blue sheet that we fill out if a resident codes. I wasn't aware that the policy stated we had one. I would think that if someone has a CPR card, they are proficient according to

the American Red Cross. I didn't do anything to assess the staff competency in CPR or their comfort level in CPR. Anyone who is CPR certified can start CPR. I did not look at any of the Code Blues that we started and was not tracking them or looking at the documentation, that is the responsibility of the Unit manager to do that and bring any concerns to me and the Administrator during the morning meetings. I was not aware that a resident did not have CPR started for five minutes. We don't have an AED (Automated External Defibrillator) that I am aware of. I'm not the Risk Manager, that's the ADON's job. I realize that there are problems here and some staff are not liking the changes that I tried to start, I wanted to do a good job and make changes. Ultimately, as the DON I am responsible for those things and everything that the nursing staff does and the interactions between departments to make sure things are done correctly."

53. During an interview on 08/29/2019 at 3:30 PM the ADON stated, "The last time I worked was on 08/18/2019, the 11-7 AM shift, the morning that [Resident #2] medication mistake was found. I was involved because I was finishing up and his sister asked me about medications, and the last time a medication mistake was discovered."

54. An attempt was made to interview the nurse, via telephone to her last known telephone number, who administered Ativan and morphine to Resident #2.

55. The nurse is no longer employed by the Facility, after resigning from her position.

56. The message received was that the telephone number had been changed or was no longer in service.

Resident #10

57. A review of Resident #10's facility record revealed an admission date of 08/02/2019.

58. Diagnosis included Acute Respiratory Failure, Chronic Pain Syndrome, Aortic Valve Replacement, Chronic Obstructive Pulmonary Disease, and Hypertension. The resident had

a Full Code Status.

59. A review of the nursing progress note dated 8/11/2019 at 10:45 PM read: "While receiving report from off going nurse, nursing assistant called for assistance to patient's room. Upon entering the room patient was assessed with no response to verbal stimuli. Pulse palpated without result. Code Blue called, crash cart was brought to room. At 10:50 PM compressions were started. 911 was called. 6 rounds of compressions and breaths were performed. EMS arrived assessed the patient, transported patient to hospital."

60. A review of Resident #10's record revealed there was no documentation of a "Code Blue" form.

61. A review of the hospital records for Resident #10 dated 08/11/2019 at 11:28 PM revealed HPI (History of Present Illness) Chief Complaint: Cardiac arrest, found down. Arrest Circumstances: Unwitnessed arrest. Context: Resuscitation Epinephrine IV X 2 (for two doses). Context of Onset: Found unresponsive in cardiac arrest. Severity: Onset Severe. Severity: Current Severe. Free Test HPI Notes: Found unresponsive at nursing home with no pulse, EMS called and found pulseless. Alertness: Unresponsive. Pupils: Dilated, Nonreactive. Resp/Chest: No spontaneous Respirations. Cardiovascular: Pulseless. Neurologic: Unresponsive. Re-Evaluation: After extended effort to resuscitate she never regained pulses. Bedside ultrasound showed no cardiac activity. Patient Discharge & Departure: Condition: Expired. Disposition Decision: 2358 (11:58 PM). Date: 08/10/19.

Facility Personnel Interviews

62. During an interview on 08/27/2919 at 2:25 PM Staff B, LPN stated, "I work over at our sister facility I'm only helping out here. We share the same policies and procedures. I would not administer morphine to a resident that was lethargic or unresponsive. If the doctor did not write a hold for sedation order I would hold the medication and call them so that they could adjust the

dose or timing of the medications or send the resident out to be evaluated. I am CPR certified and its current. I don't know where the emergency cart is, I am just helping out here. If I didn't know the resident's code status, I would not start CPR until I checked the chart. There is no other way to know that information. It's on my report sheet, but I don't always have that on me. I don't know how long that would take; maybe five minutes or less. You can't start CPR on a resident who is a DNR, so I would not start CPR until I knew for sure. I haven't gotten any training on code blue policy, medication policy or anything else recently."

63. During an interview on 08/28/2019 at 8:40 AM, Staff I, LPN stated, "I just started about one month ago, I got a week of orientation. I'm a brand-new nurse and still feel a little overwhelmed at times. My orientation was passing medications with another nurse. They didn't give me any type of check off sheet or competency to have anyone fill out. I did not go over any policies on code blue or any other policy during orientation. If a resident had orders to medicate with morphine and Ativan around the clock, I would not administer the medications if the resident was lethargic or difficult to wake up or had shallow respirations. That would be contraindicated. I would call the doctor or the hospice nurse to let them know. Pain control in a resident who in end of life care is keeping them comfortable, not making them unresponsive. You should not administer more medication when you have respirations at or under 8 or 10, I think. I would let my Charge Nurse know so they can give me direction on what else to do. I have never done CPR, but I would start it as soon as I discovered a resident without a pulse. I don't think they have an emergency cart. I don't know where it is if they do. We don't have an AED we only do CPR until EMS arrives."

64. During an interview on 08/27/2019 at 9:45 AM, Staff D, CNA (Certified Nursing Assistant) stated, "If I have any issues, I go to the Unit Manager, we don't have a Director of Nursing right now, he quit I guess, and the other Unit Manager quit too. I think it was on Monday.

I don't know where the emergency code cart is. I think it's in the supply room, but I don't know. If a patient is unresponsive, I would go get the nurse. I'm CPR certified but I don't feel comfortable doing it. They don't give us any training on that here. I just go get the nurse to check out the resident if I think they have something wrong. I wouldn't start CPR until I got the nurse to see if they needed it. We don't get any training here on code blue policy for resident care. I just get an evaluation every year. I orient new people. They get two days with me. I just watch them do the work, we don't have any sign off sheet or anything. If I don't think they are good I tell the Unit Manager."

65. During an interview on 08/27/2019 at 10:05 AM, Staff E, CNA stated "The Director of Nursing and the other Unit Manager/ADON both quit. I don't know who to go to except the Nurse Manager. There is no one else to go to. If a resident is not breathing, I'll go get the nurse. I would not start CPR, I've never done it. I would just go get the nurse. I'll look for the medication cart to find the nurse and tell her what's happening and have her check the resident out and do what she tells me to. I'm not comfortable doing CPR."

66. During an interview on 08/27/2019 at 11:00 AM Staff F, CNA stated "The Director of Nursing quit or was fired, and the other Unit Manager quit too just yesterday, I think. I think the Director of Nursing got suspended for his behavior like bullying the staff. No one has told us who to call if we have a problem. I guess, if I have any problems, I'll just go to one of the nurses until we have a new DON. If a resident is not breathing, I go get the nurse. I wouldn't feel comfortable doing CPR. I've never done it. We don't have any emergency code cart or equipment. They just do CPR until EMS arrives. Sometimes when we need the nurse to check the resident they don't always come right away if they are in the middle of dressings or something."

67. During an interview on 08/27/2019 at 11:15 AM, Staff G, CNA stated, "I would get the nurse if I thought someone stopped breathing, call for help. I have never done CPR, so I don't feel comfortable doing it. I just do what the nurses tell me to. I don't think we have an

emergency code cart. I would let the Unit Manager know about any problems that I had since we don't have a DON right now. I haven't been told I could call anyone else."

68. During a follow up interview on 08/27/2019 at 2:35 PM Staff A, LPN/Unit Manager (UM) stated, "I don't know where the emergency code cart is, the supply room, I think; let's see."

69. Upon entering the supply room, there was no emergency cart observed.

70. The UM continued to say, "I'm sorry I don't know where it is, this is so bad."

71. A tour was conducted of the entire second floor where all of the residents' rooms are located until the emergency cart was located in the restorative dining room in the corner at 2:48 PM.

72. The cart contained a suction machine on the top and was unlocked with additional suction tubing, gloves and other supplies such as intravenous insertion kits that did not contain needles or sharp objects.

73. The emergency cart log had no signatures of having been checked since 08/08/2019 and multiple missing signatures from June and July.

74. The UM stated, "I don't know who is supposed to check this, I didn't know it needed to be checked. I don't know the policy and procedure for checking the emergency cart. I don't even know what is supposed to be in the crash cart. I guess we have an issue that if I don't know where this is others probably don't. I haven't had anyone code since I got here. I expect the staff to start CPR on anyone that's a full code. It is not acceptable to wait five minutes to start CPR. I expect all staff will start CPR immediately on full codes, anyone who is CPR certified can start CPR we just do CPR until EMS arrives. I don't think that we have an AED, I've not seen one here."

75. During an interview on 08/28/2019 at 7:15 AM Staff H, CNA stated, "I don't know who besides the Unit Manager that I would call if I had any problems. I haven't seen any other

DON here since the other one was suspended. If I found a resident unresponsive, I would check to see if they are breathing and if they have a pulse, and then go get the nurse. I wouldn't start CPR, I don't always know if they are a DNR so I would get the nurse. I'm not comfortable doing CPR, it's scary and I haven't ever done it. We don't have an emergency code cart that I know of. We just call 911 if there is a resident that needs CPR.

76. During an interview on 08/28/2019 at 3:15 PM, Staff K, CNA, stated, "I do not have BLS/CPR (Basic Life Support) certification. I did once, I can't remember when it expired. They are trying to get me a class. I have worked here for ten years. We don't have an emergency cart so I couldn't go get it for a nurse if the resident is getting CPR or whatever."

77. During an interview on 08/28/2019 at 3:20 PM, Staff L, LPN stated, "I am CPR certified. If I don't know what the resident's code status is, I would check the chart before I started CPR. Depending on how far away from the nurses' station I am, it might take about five minutes to find out. I would not start CPR until I knew definitely that the resident was not a DNR. I don't know where the emergency cart is. I think it's in the supply room. We don't have a code sheet we fill out we just call 911 and do CPR until they arrive. We only have a suction machine that is on the emergency cart. We have not had any mock drills or mock codes. I would not administer any medication that has a sedating effect to a resident who is not responding, that includes a hospice patient. Hospice usually will give an order to hold narcotics if a resident is sedated, but really its standard of practice to hold medication if a resident is unarousable or has a low respiratory rate."

78. During an interview on 08/28/2019 at 3:55 PM, Staff J, LPN stated, "I don't know where the crash cart is. I think it is in the supply room, but I don't know. I would start CPR immediately on a resident after I called for help. I'm not sure, but I don't think that we have an AED. If I don't know the code status, I would go check the chart before I start CPR. They have not given me any education regarding medications or the code blue policy."

79. An interview was attempted with the nurse responding to the resident.

80. The nurse no longer works at the Facility.

81. Messages were left at the last known telephone number without response.

82. During an interview on 08/27/2019 at 2:30 PM, the Administrator stated, "I wasn't aware [Resident #2] was unresponsive with a respiratory rate of 7 per minute. I didn't know that he had received medications every two hours. If I knew I would have made sure the investigation was completed. The DON should have done that right after he knew about the incident. I was not aware that an incident report was not filled out. Both of those things should have been done. The nurse who found the mistake should have written an incident report before she left for the day. The DON should have checked to make sure that it was done and followed up on that. We don't review medication errors in our morning meeting. The Unit Managers all run a documentation report on all the charting that occurred and if they see something out of line, they should be telling the DON or myself. I am in the building two days one week and three the next week and I am always available by phone. They all know they should call me with anything. During our morning meetings, we go over all the falls and anything else that happened overnight. I'm not a nurse so I leave it up to them to evaluate that. The DON is the Risk Manager. I don't get a list of all the incident reports that have been written, but I can pull the list myself. I wouldn't know if something was a very big medication error. I leave that to the nurses, the DON, and ADON. My expectation is that the DON inform me of all potential adverse incidents. When the nurses are administering any medications, they need to assess the residents for any side effects and if they need to hold the medication, they call the doctor with the first dose missed. Nurses are expected to follow physician orders when they administer any medications and call if there are any questions. I expect the staff to address all patient safety issues at the time and let us know. I don't know what is on the emergency cart and I don't know where the AED is. I'm sure we have one. For the concerns you

have gone over with me, we have not started to put anything in place for the plan of correction. We have not done any committee meetings or started addressing how to correct these. I don't have a DON or an ADON. The DON is on suspension and the ADON resigned. The DON from our sister facility is in charge now but she has been sick this week. She will be responsible for both facilities until we determine if the DON is coming back or we need to find a replacement. All staff that are trained in CPR are expected to start CPR on all residents who are not a DNR (Do Not Resuscitate) per our policy. CPR starts immediately with the first person who responds that is CPR certified. I don't determine who can do that and who can't. If they are CPR certified they must be competent. I am not certified in CPR so I wouldn't do it, but all licensed nurses have to be. I don't know if five minutes is to long to wait to start CPR."

83. On 8/29/19 at 9:25 AM, the interim DON arrived and was introduced by the Administrator.

84. The interim DON stated, "I was originally hired for the sister facility. My date of hire was 8/21/19. I was sent to Crestwood on the 8/22/19 and got ill. I returned to work today, 8/29/19. I have no expectations at this moment with a clear plan to integrate mock drills for CPR and other skills to make the nursing staff proficient related to the actual events."

85. The Administrator was present and stated, "My position is to support the DON in her position."

86. The allegation of abuse was reviewed with the Administrator.

87. The Administrator stated, "The corrective action was never implemented. It was not done because the resident was not in the building."

88. The Administrator was asked if it was her responsibility to make sure all the residents are safe by ultimately investigating whether or not the resident making the allegation is in the Facility and whether other residents residing on the same unit as Resident #1 were

interviewed to determine if they had suffered abuse.

89. The Administrator replied, "I did not feel this was necessary since there was no abuse."

90. When asked about this being part of the corrective action, she stated "I was not aware that these items needed to be implemented as a corrective action when no alleged abuse had occurred."

91. During an interview on 08/29/19 at 4:00 PM, the Administrators stated, "My expectation is the staff have competency, follow physicians' orders, if they don't understand an order, they need to call the physician and get clarification."

92. When asked for clarification related to her expectations of the nurses' skills and competencies the Administrator stated, "They are licensed, and they should know what they are doing when they come to work."

93. When asked who the Risk Manager was the Administrator stated, "The Risk Manager is the DON and he also is the Abuse Coordinator."

Facility Policy and Procedures

94. A review of the policy and procedure titled, "Abuse Prevention Policy & Procedure," revised 4/19/18, read: Purpose: The purpose of this written Resident Abuse, Neglect and Misappropriation Prevention Program (RANMP) is to outline the preventative steps taken by this facility to reduce the potential for the mistreatment, neglect and abuse of residents and the misappropriation of resident property, and to review those practices and omissions, which if allowed to go unchecked, could lead to abuse. 1. Policy Statement: This facility shall not condone any acts of resident mistreatment, neglect, verbal, sexual, physical and/or mental abuse, corporal punishment, involuntary seclusion or misappropriation of resident property by any facility staff member, other residents, consultants, volunteers, staff of other agencies serving the resident,

family members, legal guardians, friends, or other individuals. Through it cannot guarantee that such occurrences will not occur at this facility, preventative steps will be taken to reduce the potential for such occurrences. Report all allegations of abuse immediately to the Director of Nursing and Administrator. Any allegation of abuse is reported immediately to the state agency and to all other agencies as required, per state and federal guidelines. "Immediately" means, as soon as possible, but should not exceed 24 hours after the discovery of the incident, in absence of a shorter state timeframe requirement. Physical Abuse: the infliction of physical pain or injury, includes but is not limited to: slapping, pinching, hitting, kicking, or shoving. It also includes controlling behavior through corporal punishment. Neglect: The failure to fulfill a care-taking obligation to provide goods or services necessary to avoid physical harm, mental anguish or mental illness; e.g., denial of food or health-related services, abandonment. Reporting/Investigation/ Response Policy - any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect, whether physical, verbal, mental or sexual, involuntary or voluntary, is to be thoroughly reported, investigated and documented in a uniform manner as detailed below. Procedure: Reporting - All employees are required to immediately notify the administrative or nursing supervisory staff that is on duty of any compliant, allegation, observation or suspicion of resident abuse, mistreatment or neglect, so that the resident's needs can be attended to immediately and investigation can be undertaken promptly. Response at Completion of Investigation: 2. Written notification to the State Health Department and other required regulatory agencies summarizing the incident, investigation results and facility actions take (sic) to protect the resident(s) and prevent a similar occurrence. This report is to be completed per the guidelines of individual state reporting requirements. Discipline: 1. Any employee suspected of abuse, neglect or mistreatment must be suspended as soon as the incident is reported pending outcome of the investigation. 3. After the investigation is completed, the appropriate disciplinary action, if any,

is to be taken. Counseling regarding abuse and neglect must occur at the time of the disciplinary action."

95. A review of the policy and procedure titled, "Acute Condition Changes - Clinical Protocol," revised December 2012, read: Assessment and Recognition: 2. In addition, the Nurse shall assess and document/report the following baseline information: a. Vital Signs, b. Neurological status, c. Current level of pain, and any recent changes in pain level, d. Level of consciousness, e. Cognitive and emotional status, g. Onset, duration, severity, h. Recent labs, j. All active diagnoses, k. All current medications.

96. A review of the policy and procedure titled, "Physician Medication Orders," revised April 2010, read: Policy Statement: Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Physician's Orders - Policy Interpretation and Implementation: 1. No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. 2. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used.

97. A review of the policy and procedure titled, "Administering Medications," revised December 2012, read: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 2. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. 3. Medications must be administered in accordance with the orders, including any required time frame. 5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering

the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 25. If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. 27. The Charge Nurse must accompany new nursing personnel on their medication rounds for minimum of three (3) days to ensure established procedures are followed and proper resident identification methods are learned.

98. A review of the policy and procedure titled, "CPR/Code Blue" creation date 11-2016 read: Policy: Cardiopulmonary Resuscitation (CPR) will be provided to residents who are identified to be in cardiac arrest unless such resident has DNR order. CPR is performed only by individuals certified in CPR. Licensed Nurses are to maintain CPR certification. Procedure: When a Resident is found without respirations and/or without pulse, the individual finding the resident will identify the Resident's code status. 2. In the event that the Resident is identified as a Full Code and the person finding the Resident is trained in CPR, they will: a. Call for help by stating "Code Blue; b. Initiate CPR. 3. The individual responding to the call for help will call "Code Blue" over the intercom 3 times and identify: a. Floor and Unit; b. Room Number or area in which Resident is located. 5. Clinical Staff will respond to the announced location of the "Code Blue" with facility AED and closet crash cart. 6. The Nurse Manager/Supervisor/Licensed Nurse will assume the responsibility for the code and delegate the following: a. Calling 911; b. Assign staff to document the ongoing event using the "code blue documentation" form; c. Notify the MD i. Obtain MD order to transfer to hospital; d. Completion of transfer form i. Call receiving ER

with report of resident and event; f. Complete the necessary documentation in the Resident's medical record; g. Restock Crash Cart.

Relief

99. The Facility's actions and/or inactions constituted a class I deficiency.

100. Under Florida law, 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 correction. 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).

101. Under Florida law, the Agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the Agency shall assign a licensure status of standard or conditional to each nursing home. § 400.23(7), Fla. Stat. (2019).

102. A conditional licensure status means that 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, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the Agency. § 400.23(7)(b), Fla. Stat. (2019).

103. Due to the presence of a class I deficiency at the time of the survey, the Agency assigned the Respondent conditional licensure status for the period alleged above in the nature of the action.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks an administrative fine of $12,500.00 and the assignment of conditional licensure status against the Respondent.

COUNT II
Director of Nursing

104. Under Florida law:

> **59A-4.108 Nursing Services.**
> (1) The Administrator of each nursing home must designate one registered nurse as a Director of Nursing (DON) who shall be responsible and accountable for the supervision and administration of the total nursing services program. When a Director of Nursing is delegated institutional responsibilities, a full time qualified registered nurse (RN), as defined in Chapter 464, F.S., must be designated to serve as Assistant Director of Nursing. In a facility with a census of 121 or more residents, an RN must be designated as an Assistant Director of Nursing.

Fla. Admin. Code R. 59A-4.108(1).

Survey Findings

105. On or about August 27, 2019, through August 29, 2019, an announced complaint survey was conducted at the Facility.

106. The Agency re-alleges and incorporates by reference the allegations in Count I as set forth above.

107. A review of the job description for job title Administrator read: Job Summary: Contributes to the physical, mental, emotional and spiritual well being of the residents by coordination, supervision, and directing of all facility personnel. Works with all facility

departments to provide overall care and comfort for each resident. Job Duties: 2. Employees an adequate number of appropriately trained professional and auxiliary personnel including the appropriate delegation of duties to ensure the needs of the residents are met. 4. ensures each resident's right to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights. 8. Ensures the implementation of established resident care policies, personnel policies, preparation of budget, etc. Responsible For: 2. Knowing and protecting all residents rights.

108. A review of the job description for job title DON read: Job Summary: Contributes to the physical, mental, emotional, & spiritual well-being of the residents by coordination, supervision & directing all nursing personnel; collaborates with the other facility department to provide overall care & comfort for each resident. Job Duties: Developing & implementing policies & procedures related to all resident care provided by the nursing department. 4. Instructing, demonstrating & supervising nursing personnel on all aspects of resident care including restorative & rehabilitative nursing. 5. Making daily rounds to oversee the nursing care provided by nursing staff. 6. Supervising the orientation of newly employed nursing staff for their specific job duties. 11. .... Assures that resident's needs are assessed timely at admission & during stay to determine care required & that a Care Plan is developed to meet those needs, with implementation of same. 12. Assuring all medication, treatments, diets, rehabilitative & restorative care is provided all residents in accordance with physician's written orders & the resident's individual needs. Responsible For: 2. Knowing & protecting all residents' rights. 3. Organizing & directing the operations of the Nursing Department. 5. Responsible for employing, training, supervising, evaluating & terminating personnel.

109. A review of the job description for job title Assistant Director of Nursing read: Job Summary: Co-ordinates & supervises the nursing care of all residents to ensure that the therapeutic

regimen is implemented & documented according to federal, state & local regulations.

110. A review of the job description for job title Unit Manager read: Job Summary: Coordinate and supervise the day-to-day nursing care of all residents, emphasizing the implementation and documentation of all therapeutic regimens. Job Duties: Making daily and as needed rounds on residents to evaluate, receive comments, review care and ensure their safety and comfort. Observation of medication passes and treatment procedures, to ensure proper nursing practices plus adherence to Federal, State, Local regulations, policies and procedures of facility. Assist in investigations and process improvement initiatives as assigned. Responsible for: Knowing and protecting all residents' rights. Knowing and enforcing the facility policies and procedures.

111. During an interview on 8/28/2019, at 9:43 AM, the Human Resources/Payroll Director (HRD) the personnel records are listed were reviewed.

112. The HRD stated: "There are no competencies for the nurses or for the CNA's. This was something that was discussed with the DON but never implemented. The nurses and CNA's are paired with another nurse or CNA for four to five days, then if they feel confident, they are scheduled their own shifts."

113. A review of personnel records revealed:

A. Staff P, CNA (suspended on 8/17/19 returned to work on 8/19/19) DOH (Date of hire) 5/15/17, Competency: None.

B. Staff Q, LPN (Licensed Practical Nurse), DOH 1/28/16, Competency: None.

C. Staff R, CNA, DOH: 3/9/16, Competency: None.

D. Staff S, CNA, DOH 8/12/11, Competency: None.

E. Staff G, CNA, DOH: 10/29/18, Competency: None, Annual performance reviews: None.

F. Staff E, CNA, DOH: 7/1/98, Competency: None.

G. Staff B, LPN, DOH: 3/9/17, Competency: None.

H. Staff T, LPN, DOH 7/17/19, Competency: None, Annual performance reviews: None.

I. Staff F, DOH: 10/29/18, Competency: None. Annual performance reviews: None.

J. Staff U, RN/Unit Manager, DOH 6/19/19, resignation date: On file 8/18/19. Competency: None.

K. Staff V, CNA, Transferred date: 6/24/19, DOH, 3/19/19, Competency: None.

L. Staff J, LPN, DOH: 2/21/18, Competency: None.

M. Staff AA, LPN, DOH, 10/1/18, Abuse Training: None, Competency: None. CPR: None.

N. Staff BB, LPN, DOH: 3/25/13, Competency: None.

O. Staff CC, PN, DOH: 10/11/13, Abuse Training: None. Competency: None. Annual performance reviews: None.

P. RN/DON, DOH: 1/29/19, Abuse Training: None. Competency: None. CPR Certification; None,

Q. RN/ADON, DOH 2/19, Abuse training: None. CPR Certification: None.

Relief

114. The Facility's actions and/or inactions constituted a class I deficiency.

115. Under Florida law, 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 correction. 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).

116. Under Florida law, the Agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the Agency shall assign a licensure status of standard or conditional to each nursing home. § 400.23(7), Fla. Stat. (2019).

117. A conditional licensure status means that 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, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the Agency. § 400.23(7)(b), Fla. Stat. (2019).

118. Due to the presence of a class I deficiency at the time of the survey, the Agency assigned the Respondent conditional licensure status for the period alleged above in the nature of the action.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks an administrative fine of $12,500.00 and the assignment of conditional licensure status against the Respondent.

COUNT III
Staff Knowledge – Access to Care Plan

119. Under Florida law:

59A-4.109 Resident Assessment and Care Plan.
(1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of:
(a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.
(b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission.
(c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be:
1. Reviewed no less than once every 3 months;
2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and,
3. Revised as appropriate to assure the continued accuracy of the assessment.
(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.
(3) At the resident's option, every effort must be made to include the resident and family or responsible party, including private duty nurse or nursing assistant, in the development, implementation, maintenance and evaluation of the resident's plan of care.
(4) All staff personnel who provide care, and at the resident's option, private duty nurses or personnel who are not employees of the facility, must be knowledgeable of, and have access to, the resident's plan of care.
(5) A summary of the resident's plan of care and a copy of any advanced directives must accompany each resident discharged or transferred to another health care facility, licensed under Chapter 395 or 400, F.S., or must be forwarded to the receiving facility as soon as possible consistent with good medical practice.

Fla. Admin. Code R. 59A-4.109(4) (emphasis supplied).

Survey Findings

120. On or about August 27, 2019, through August 29, 2019, an announced complaint

survey was conducted at the Facility.

121. The Agency re-alleges and incorporates by reference the allegations in Count I and Count II set forth above.

Relief

122. The Facility's actions and/or inactions constituted a class I deficiency.

123. Under Florida law, 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 correction. 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).

124. Under Florida law, the Agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the Agency shall assign a licensure status of standard or conditional to each nursing home. § 400.23(7), Fla. Stat. (2019).

125. A conditional licensure status means that 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, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the Agency. § 400.23(7)(b), Fla. Stat. (2019).

126. Due to the presence of a class I deficiency at the time of the survey, the Agency assigned the Respondent conditional licensure status for the period alleged above in the nature of the action.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks an administrative fine of $10,000.00 and the assignment of conditional licensure status against the Respondent.

COUNT IV
Administrator Responsible for Risk Management

127. Under Florida law:

> **400.147 Internal risk management and quality assurance program.—**
> (1) Every facility shall, as part of its administrative functions, establish an internal risk management and quality assurance program, the purpose of which is to assess resident care practices; review facility quality indicators, facility incident reports, deficiencies cited by the agency, and resident grievances; and develop plans of action to correct and respond quickly to identified quality deficiencies. The program must include:
> (a) A designated person to serve as risk manager, who is responsible for implementation and oversight of the facility's risk management and quality assurance program as required by this section.
> (b) A risk management and quality assurance committee consisting of the facility risk manager, the administrator, the director of nursing, the medical director, and at least three other members of the facility staff. The risk management and quality assurance committee shall meet at least monthly.
> (c) Policies and procedures to implement the internal risk management and quality assurance program, which must include the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to residents.
> (d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.
> (e) The development of appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk

management and risk prevention for all nonphysician personnel, as follows:

1. Such education and training of all nonphysician personnel must be part of their initial orientation; and

2. At least 1 hour of such education and training must be provided annually for all nonphysician personnel of the licensed facility working in clinical areas and providing resident care.

(f) The analysis of resident grievances that relate to resident care and the quality of clinical services.

(2) The internal risk management and quality assurance program is the responsibility of the facility administrator.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of adverse incidents to residents and violations of residents' rights shall be encouraged and their implementation and operation facilitated.

§ 400.147(2), Fla. Stat. (2019) (emphasis supplied)

128. On or about August 27, 2019, through August 29, 2019, an announced complaint survey was conducted at the Facility.

Survey Findings

129. The Agency re-alleges and incorporates by reference the allegations in Count I as set forth above.

130. A review of the Retainer Agreement Medical Director, dated 03/22/2019, read: Medical Director's Responsibilities: Supervise the overall functions of the Facility's medical services in that the Medical Director shall: 1. Assist the facility in identifying, interpreting, and complying with relevant State and Federal Laws and regulations. 2. Advising the facility on policies and procedures for implementing medical services and assuming the administrative authority of the medical organization of the nursing home. 3. Ensure proper documentation of patient care and related information, participating in a review of the residents quality of care, including (but not limited to) areas covered by regulation (e.g., monitoring medications, laboratory and x-ray monitoring, pain management, and infection control). . . . 5. Assist the facility in educating and training its staff in areas that are relevant to providing high quality patient care. . . .

7. Participate in the following programs: Quality Assurance/Performance Improvement, Infection Control, Pharmacy, Risk Management/Incident/Accidents.

Relief

131. The Facility's actions and/or inactions constituted a class I deficiency.

132. Under Florida law, 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 correction. 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).

133. Under Florida law, the Agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. In addition to license categories authorized under part II of chapter 408, the Agency shall assign a licensure status of standard or conditional to each nursing home. § 400.23(7), Fla. Stat. (2019).

134. A conditional licensure status means that 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, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the Agency. § 400.23(7)(b), Fla. Stat. (2019).

135. Due to the presence of a class I deficiency at the time of the survey, the Agency assigned the Respondent conditional licensure status for the period alleged above in the nature of the action.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks an administrative fine of $12,500.00 and the assignment of conditional licensure status against the Respondent.

COUNT V
Six-Month Survey Cycle Fine

136. 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. § 400.019(3), Fla. Stat. (2019).

137. Due to the presence of one or more class I deficiencies at the time of the survey, the Facility is subject to a six-month survey cycle and its corresponding fine.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks a six-month survey cycle fine of $6,000 fine against the Respondent.

COUNT VI
License Revocation

138. Under Florida law:

> **400.121 Denial, suspension, revocation of license; administrative fines; procedure; order to increase staffing.—**
> (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; or**
>
> (3) The agency shall revoke or deny a nursing home license if the licensee or controlling interest operates a facility in this state that:
> (a) Has had two moratoria issued pursuant to this part or part II of chapter 408 which are imposed by final order for substandard quality of care, as defined by 42 C.F.R. part 483, within any 30-month period;
> (b) Is conditionally licensed for 180 or more continuous days;
> **(c) Is cited for two class I deficiencies arising from unrelated circumstances during the same survey or investigation; or**
> (d) Is cited for two class I deficiencies arising from separate surveys or investigations within a 30-month period.

§ 400.121(1), (3), Fla. Stat. (2019) (emphasis supplied).

139. The Agency re-alleges and incorporates by reference Count I through Count IV set forth above.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks the revocation of the Respondent's license to operate this nursing home.

CLAIM FOR RELIEF

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

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

2. Grants the relief set forth above.

Respectfully Submitted,

Doyle Carlton Enfinger II, Senior Attorney
Florida Bar No. 793450
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #7
Tallahassee, Florida 32303
Telephone: 850-412-3681
Facsimile: 850-922-9634
Carlton.Enfinger@ahca.myflorida.com

NOTICE OF RIGHTS

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. In order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), F.S., however, a party must file a request for an administrative hearing that complies with the requirements of Rule 28-106.2015, Florida Administrative Code. Specific options for administrative action are set out in the attached Election of Rights form.

The Election of Rights form 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.

CERTIFICATE OF SERVICE

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 19th day of September, 2019.

Doyle Carlton Enfinger II, Senior Attorney
Florida Bar No. 793450
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #7
Tallahassee, Florida 32303
Telephone: 850-412-3681
Facsimile: 850-922-9634
Carlton.Enfinger@ahca.myflorida.com

Administrator Crestwood Nursing Center, Inc. 501 South Palm Avenue Palatka, FL 32177 (U.S. Certified Mail)	

9489 0090 0027 6049 2038 42

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: Crestwood Nursing Center, Inc. **ACHA No. 2019014456**

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 Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your Election of Rights form to this address:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, 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 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: _____

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 form to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____ Date: _____

Printed Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA NO.: 2019014456
(Moratorium) 2019013677

CRESTWOOD NURSING CENTER, INC., d/b/a CRESTWOOD NURSING CENTER

Respondent.
_____/

SETTLEMENT AGREEMENT

The State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Crestwood Nursing Center, Inc. d/b/a Crestwood Nursing Center, (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, The Agency has jurisdiction by virtue of being the licensing and regulatory authority that oversees skilled nursing facilities (also called nursing homes) and enforces the state statutes and rules governing such facilities pursuant to Chapter 408, Part II, Chapter 400, Part II, Fla. Stat. and Chapter 59A-4, Fla. Admin. Code; and

WHEREAS, Respondent is skilled nursing facility licensed pursuant to Chapter 408, Part II, Chapter 400, Part II, Fla. Stat. and Chapter 59A-4, Fla. Admin. Code; and

WHEREAS, an Immediate Moratorium on Admissions to Respondent's facility was entered on August 30, 2019; and

WHEREAS, the Agency served Respondent with an Administrative Complaint seeking fines, imposition of conditional license and revocation of licensure; and

EXHIBIT "2"

WHEREAS, Respondent requested a formal administrative proceeding; and

WHEREAS, the parties have negotiated and agreed that the best interest of all the parties will be served by a settlement of these proceedings; and

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

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

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

3. Respondent waives any and all appeals and proceedings relating to this complaint 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 waives 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. Respondent shall to pay the Agency an administrative fine of $53,500.00. Said payment shall be made within thirty (30) days of entry of the Final Order in this matter.

5. Respondent shall have 120 days from the date of the final order to pursue a change of ownership of the facility. Respondent shall not be eligible to renew their current nursing home license and, in the event that a change of ownership does not take place, will initiate the orderly transfer and relocation of their residents to be completed on or before Junes 30, 2020.

6. The Agency will not seek revocation of Respondent's license and the Immediate

Moratorium on Admissions (AHCA Case No. 2019013677) shall be lifted effective the date of the entry of the Final Order in this case.

7. 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.

8. By executing this Agreement, the Respondent does not admit to any of the facts and legal conclusions raised in the administrative complaint referenced herein, and the Agency continues to assert the validity thereof. 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 the 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 the Respondent based solely on the allegations in the 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.

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 cases.

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 parties.

12. 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.

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

14. In the event that the Respondent was a Medicaid provider at the time of the occurrences alleged in the Notice of Intent to Deny Renewal Application, 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 the Respondent. This Agreement does not prohibit the Agency from taking any action regarding the Respondent's Medicaid provider status, conditions, requirements or contract, if applicable.

15. 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.

16. 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.

17. 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, Building #3
Tallahassee, Florida 32308

DATED: 1/8/20

Robert W Hagan
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