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AGENCY CLERK

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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case No: 2020013726

RENDITION NO.: AHCA- 21 - 323 -S-OLC

ISLF DEERWOOD PLACE JACKSONVILLE, LLC d/b/a REGENTS PARK OF JACKSONVILLE,

Respondent.
_____/

FINAL ORDER

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

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

2. The Respondent shall pay the Agency $22,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

3. Conditional licensure status is imposed on the Respondent beginning July 22, 2020 and ending September 5, 2020.

ORDERED at Tallahassee, Florida, on this 24 day of March, 2021.

Molly McKinstry, Deputy 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 25th day of March, 2021.

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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Thomas J. Walsh II, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Peter A. Lewis, Attorney Law Offices of Peter A. Lewis, P.L. Counsel for Respondent 3023 N. Shannon Lakes Drive, Suite 101 Tallahassee, Florida 32309 palewis@petelewislaw.com (Electronic Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case Nos: 2020013726
Facility Type: Nursing Home
License No.: 1467096

ISLF DEERWOOD PLACE JACKSONVILLE, LLC d/b/a REGENTS PARK OF JACKSONVILLE,

Respondent.

_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration (hereinafter "Agency"), by and through the undersigned counsel, and files this Administrative Complaint against ISLF Deerwood Place Jacksonville, LLC d/b/a Regents Park of Jacksonville (hereinafter "Respondent"), pursuant to §§120.569 and 120.57 Florida Statutes (2020). and alleges:

NATURE OF THE ACTION

This is an action to change Respondent's licensure status from Standard to Conditional commencing July 22, 2020 and ending September 5, 2020, to impose administrative fines in the amount of twenty thousand dollars ($20,000.00), and the imposition of a two (2) year survey cycle and its six thousand dollar ($6,000.00) fee, for a total assessment of twenty-six thousand dollars ($26,000.00) based upon Respondent being cited for two (2) State Class I deficiencies.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60 and 400.062, Florida Statutes (2020).

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

EXHIBIT 1

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

4. Respondent operates a one hundred twenty (120) bed nursing home, located at 8700 A C Skinner Parkway, Jacksonville, Florida 32256, and is licensed as a skilled nursing facility license number 1467096.

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

COUNT I

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

7. That pursuant to Florida law, All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. Rule 59A-4.107(5), Florida Administrative Code.

8. That Petitioner completed a survey of Respondent and its operations on July 22, 2020.

9. That based upon observation, the review of records, and interview, Respondent failed to follow all physician orders as prescribed, and if not followed, the reason recorded on the resident's medical record during that shift, as represented by Respondent's failure to timely transfer a resident to a higher level of care after a physician's order to do so, the same being contrary to the mandates of law.

10. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted the following:

a. The resident's admission date was July 25, 2019.

b. Diagnoses included chronic obstructive pulmonary disease (COPD), unspecified convulsions, atrial fibrillation (AFib), hypertension (HTN), heart failure and metabolic encephalopathy (diffuse disorder of brain function that often impairs cognition).

c. The resident had documented wishes to be resuscitated in the event of a cardiac arrest (full code).

d. The resident's most recent Minimum Data Set (MDS) assessment (quarterly), with an assessment reference date of April 30, 2020, revealed:

i. The resident had a Brief Interview for Mental Status (BIMS) score of three (3) out of a possible fifteen (15) possible points, indicating severe cognitive impairment.

ii. The resident required extensive assistance of one staff member with most activities of daily living (ADLs), except for meals, for which the resident only required supervision.

e. A nursing progress note dated July 8, 2020 at 4:44 p.m. by staff member "A," a licensed practical nurse, documented:

i. She went to assess the resident with the two other nurses, staff member "B" and staff member "C," registered nurses, and the resident's oxygen saturation dropped to 89% on room air with a RR of 26.

ii. "The resident was rechecked and had a temperature of 99.2 (F) and RR26

with slight twitching from head to toe."

iii. She noted that the resident was placed on oxygen via face mask at 10 liters per minute and the oxygen saturation came up to 99%.

f. A nursing progress note dated July 8, 2020 at 4:54 p.m. by staff member "A," a licensed practical nurse, documented that a telephone order was received from the physician instructing staff to, "Send resident to ER for seizure/uncontrolled Phenytoin levels."

11. That based on a review of the resident's clinical record and a review of the facility's investigation documentation, on July 8, 2020, staff member "A," a licensed practical nurse was working the day shift, from 7:00 a.m. to 3:00 p.m., providing care on the unit where resident number one (1) lived, while staff member "B," a registered nurse, was also working on that shift, and at 3:00 p.m., staff member "C," a registered nurse, came on duty to work the evening shift, 3:00 p.m. to 11:00 p.m., and to care for the resident.

12. That Petitioner's representative reviewed the written statement, dated July 8, 2020 at 3:30 p.m., of Respondent's staff member "C," a registered nurse, related to resident number one (1) and noted the following:

a. During change of shift rounds, he found the resident with a respiratory rate (RR) of 26, "twitching" activity, and resident was not responding to painful stimulation.

b. He documented that oxygen was started at 2 liters per minute.

c. He called staff member "A," a licensed practical nurse, and staff member "B," a registered nurse, to assess the resident and documented that an order was

d. received from the physician to send the resident to the emergency room (ER) for evaluation.

13. That Petitioner's representative reviewed the written statement, dated July 9, 2020, of Respondent's staff member "B," a registered nurse, related to resident number one (1) and noted the following:

a. She had been called to the resident's room to "take a look" at the resident, but at no time did she "put a stethoscope to the resident or a blood pressure cuff."

b. She observed the other nurses, staff member "A," a licensed practical nurse, and staff member "C," a registered nurse, and the resident.

c. She saw the resident "twitching" and verified through conversations with the nurses, staff "A" and "C," that the resident had a history of seizures.

d. She reviewed the resident's record to confirm a history of seizures.

e. After confirming the seizure history, she reminded staff members "A" and "C" to call the physician, then she went to her office leaving the other two nurses to continue assessing the resident.

f. Once she reached her office, she called the medical director's clinical nurse liaison about another matter.

g. While she was speaking with the clinical nurse liaison, she called out to staff member "A," a licensed practical nurse, and staff member "C," a registered nurse, asking whether the physician had been called.

h. They had not called the resident's physician, so she mentioned the resident's condition to the clinical nurse liaison during the call.

i. The clinical nurse liaison stated, "[The resident] should go ahead and go out.

[The resident] will probably need an IV (intravenous administration) of Phenytoin. If the resident is having seizures it would be a risk to give [the resident] anything by mouth."

j. A photograph of a text message sent by staff member "B" to the clinical nurse liaison on July 8, 2020 at 3:54 p.m. revealed, "Hey, [resident] isn't responding to painful stimuli, [is] lethargic and [nurses "A" and "C"] are still assessing [resident]. I am in here now."

k. The clinical nurse liaison replied, "If [] is unresponsive, send [resident] out."

l. Staff member "B" messaged, "[Resident] is not unresponsive, just lethargic, but staff are in there now."

14. That Petitioner's representative reviewed Respondent's notes of a July 10, 2020 facility-initiated interview, no time recorded, conducted as part of Respondent's investigation regarding resident number one (1), with staff member "B," a registered nurse and noted:

a. When asked how she assessed the resident, she replied that she "just visualized [the resident]."

b. Staff member "B" thought the resident was stable, and she asked staff members "A" and "C" if the resident would be sent out emergently via 911.

c. Staff members "A" and "C" replied, "No," the resident was stable, so staff member "B" returned to her office.

d. As she was preparing to leave the facility for the day, staff member "B" overheard staff member "A" tell staff member "C," "If transport does not arrive in an hour, call 911."

e. Staff member "B" then left the facility.

15. That Petitioner's representative interviewed Respondent's staff member "B," a registered nurse on July 21, 2020 at 10:50 a.m. regarding resident number one (1) and noted:

a. When asked how she determined that the resident was stable on July 8, 2020 before she left for the day, she replied that she "visualized [the resident]."

b. When asked whether a respiratory rate of 25-26 was normal or stable, she did not answer.

16. That Petitioner's representative reviewed the written statements, dated July 10, 2020 and an unknown date, of Respondent's staff member "A," a licensed practical nurse, related to resident number one (1) and noted the following:

a. At 4:00 p.m. on July 8, 2020, she was called to the resident's room by registered nurse "C."

b. There she found the resident with an elevated temperature and not responding to a rigorous sternal rub (Using the knuckles of a closed fist to rub the center chest of a patient who is not alert and does not respond to verbal stimuli. Source - EMS1.com at www.ems1.com, accessed on 7/22/20 at 11:56 a.m.).

c. She described the resident as "twitching with abnormal vital signs" including a BP 158/98 (blood pressure), P63 (pulse), RR 26 (respiratory rate), Temp 99 degrees Fahrenheit (F), Oxygen Saturation (O2sats) of 89% and mouth breathing."

d. An undated and untimed statement made during the facility's investigation documented that staff member "A" informed the resident's relative of possible seizure and non-therapeutic Phenytoin levels. A call was placed to a non-emergency transport company, but they were unavailable, so a second call

was placed to another non-emergency transport company, who informed staff member "A" that there would be a one-hour wait.

e. Staff member "A" then left the facility.

17. That Petitioner's representative reviewed the written statement, dated July 8, 2020, of Respondent's staff member "C," a registered nurse, related to resident number one (1) and noted the following:

a. July 8, 2020 at 4:00 p.m. - [The resident's] respirations were 26. [] was receiving oxygen at 2 liters per minute via nasal cannula.

b. July 8, 2020 at 5:00 p.m. - Rechecked resident, no signs of pain or distress noted, RR25, oxygen at 2 liters per minute, resident stable, will continue to monitor.

c. July 8, 2020 at 5:30 p.m. - No "twitching," but RR25 and resident continues on oxygen at 2 liters to keep [] sats (blood oxygen saturation) at 97%. Resident stable, will continue to monitor.

d. July 8, 2020 6:00 p.m. - Temp 99.3 F, RR26, continues on oxygen at 2 liters per minute to keep oxygen saturation at 97%. Resident stable. Will continue to monitor.

e. July 8, 2020 6:30 p.m. - No "twitching," RR25, resident continues on oxygen at 2 liters per minute to help maintain saturation of 97%. Resident stable, continue to monitor closely.

f. July 8, 2020 7:00 p.m. - No "twitching," RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely.

g. July 8, 2020 7:30 p.m. - No "twitching," RR25, continues on oxygen at 2 liters

per minute. Stable, will continue to monitor closely.

h. July 8, 2020 8:00 p.m. - No "twitching," RR25, continues on oxygen at 2 liters per minute to maintain saturation at 97%. Called the non-emergency transport company again and they stated they would be available in 2 hours. Will continue to monitor closely.

i. July 8, 2020 8:30 p.m. - Respiratory rate increased to RR26, resident still requires oxygen at 2 liters per minute to maintain oxygen sats of 97%. Resident stable, continue to monitor.

j. July 8, 2020 9:00 p.m. - RR26 breaths per minute. Continues to require oxygen at 2 liters per minute to maintain sats at 97%. Stable, continue to monitor.

k. July 8, 2020 9:30 p.m. - RR27 breaths per minute, oxygen saturation 94 %. Stable, will continue to monitor closely.

l. July 8, 2020 10:00 p.m. - Called non-emergency transport, and they reported they would probably arrive at midnight or 1:00 a.m. Went to the resident's room to recheck and found the resident using accessory muscles to breathe. Asked another nurse, not identified in his note, to call 911. Monitored the resident at bedside and at 10:14 p.m. he documented that the resident had a respiratory arrest and a code blue was called.

18. That Petitioner's representative reviewed Respondent's Code Blue worksheet related to resident number one (1) and noted:

a. At 10:14 p.m., the resident became unconscious.

b. Cardiopulmonary resuscitation (CPR) was started at 10:14 p.m.

c. Emergency medical services arrived at 10:20 p.m., took over cardiopulmonary resuscitation, and transported the resident to the emergency room at 10:30 p.m.

d. Resident did not survive.

19. That Petitioner's representative interviewed Respondent's director of nursing on July 22, 2020 at 2:42 p.m. regarding resident number one (1) and noted:

a. When asked to clarify what "no response to pain stimulation" meant, she stated it meant the resident was not responsive.

b. When asked what the significance of a respiratory rate of 25 - 27 was, she replied it meant the resident was in distress.

c. When asked for her expectation of the nursing staff on July 8, 2020 between 3:30 p.m. and 10:14 p.m. regarding the resident, she stated, "They should have just sent [the resident] out 911."

d. When the resident's care plan for seizure activity was reviewed with the director, noting that during seizure activity the staff should document the seizure location, activity and level of consciousness after seizure activity, the director confirmed that no documentation was available verifying this was done for the resident on July 8, 2020.

20. That Petitioner's representative interviewed Respondent's medical director's clinical nurse liaison on July 21, 2020 at 11:02 a.m. regarding resident number one (1) and noted:

a. Respondent's staff member "B," a registered nurse, called her on July 8, 2020, time not remembered, and reported that the resident was "... not []self, respirations were up, the resident was 'twitching' and staff were unable to get

an oxygen saturation reading, because the resident's hands were 'twitching and jerking.'"

b. She asked staff member "B" about the resident's seizure medication and whether the resident had received it the night before. July 7, 2020, and staff member "B" stated the resident had not received the correct dosage.

c. She advised staff member "B" that the resident would need to go to the hospital.

d. She reached out to the resident's physician who also said, "Send [the resident] to the hospital."

e. The expectation was that the facility would summons emergency transport for any respirations over 20, as this would be considered respiratory distress, especially for this resident with a typical RR of 17-20 per minute.

f. When asked for her expectation of what would happen to a resident in respiratory distress for an extended period of time, she replied, "I would expect them to die."

21. That Petitioner's representative interviewed on July 21, 2020 at 11:36 a.m. the physician for resident number one (1) and noted:

a. When asked to recount what he recalled of the events of July 8, 2020 and the resident. he reported he remembered that the resident had problems with the Phenytoin level being low, so he increased the medication.

b. When he learned that the resident was having a seizure, he said he stated, "This is not something we're going to mess with, especially in a nursing home where bad things do happen."

c. He asked that the resident be sent to the hospital and then, "When I say to send the resident to the hospital, I mean go now."

d. When asked about the resident's RR of 25-27 and the expected result of a prolonged period of respiratory distress, he stated, "Bad stuff happens when someone is in distress. Sometimes someone can hang in there for a while, but they need a higher level of care, so they need to be sent to the ER immediately."

22. That Petitioner's representative interviewed Respondent's director of nursing on July 22, 2020 at 2:04 p.m. regarding resident number one (1) and noted:

a. She stated that staff member "C," a registered nurse, "did not use the best clinical judgement."

b. She further stated that respirations of 25-27 were not normal for any resident and required emergency intervention.

c. She could not understand why staff member "C," a registered nurse, did not call her for guidance.

23. That Petitioner's representative interviewed Respondent's administrator on July 22, 2020 at 5:00 p.m. regarding resident number one (1) and the administrator stated that the delay in provision of care and transportation to a higher level of care "should never have happened."

24. That the above reflects Respondent's failure to follow all physician orders as prescribed, and if not followed, the reason recorded on the resident's medical record during that shift, as represented by Respondent's failure to timely transfer a resident to a higher level of care after a physician's order to do so,

25. That the above described noncompliance caused or is likely to cause serious injury, harm,

impairment, or death to residents.

26. That the Agency determined that this deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility, and cited Respondent with an isolated Class I deficient practice.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(8)(a), Florida Statutes (2020).

COUNT II

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

28. That pursuant to Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. § 400.022(1)(l), Fla. Stat. (2020).

29. That Petitioner completed a survey of Respondent and its operations on July 22, 2020.

30. That based upon observation, the review of records, and interview, Respondent failed to provide adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and

therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, including but not limited to the failure to appropriately assess a resident's deteriorating condition and obtain appropriate treatment, the same being contrary to the mandates of law. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted the following:

a. The resident's admission date was July 25, 2019.

b. Diagnoses included chronic obstructive pulmonary disease (COPD), unspecified convulsions, atrial fibrillation (A-Fib), hypertension (HTN), heart failure and metabolic encephalopathy (diffuse disorder of brain function that often impairs cognition).

c. The resident had documented wishes to be resuscitated in the event of a cardiac arrest (full code).

d. The resident's most recent Minimum Data Set (MDS) assessment (quarterly), with an assessment reference date of April 30, 2020, revealed:

   i. The resident had a Brief Interview for Mental Status (BIMS) score of three (3) out of a possible fifteen (15) possible points, indicating severe cognitive impairment.

   ii. The resident required extensive assistance of one staff member with most activities of daily living (ADLs), except for meals, for which the resident only required supervision.

e. The record did not reflect that the resident had experienced any seizure type activity from the resident's date of admission on July 25, 2019 through July 7,

2020.

f. The resident's respiratory record history from January 2020 through June 2020, revealed an average respiratory rate (RR) of 17-20 breaths per minute.

g. The July 2020 Physician's Order Sheets (POS) revealed the resident was receiving Phenytoin (medication used to control and prevent seizures) 100 mg (milligrams) twice daily.

h. Laboratory work showed:

   i. On July 6, 2020, blood was drawn for a therapeutic level of Phenytoin, revealing suboptimal concentrations of the medication and a Phenytoin level of 6.7 ug/ml (micrograms per milliliter).

   ii. The normal range was noted as 10-20 ug/ml.

   iii. This left the resident more susceptible to seizure activity, and the resident's physician increased the Phenytoin dosage from 100 mg twice daily to 300 mg at bedtime on July 6, 2020.

i. A nursing progress note dated July 8, 2020 at 4:44 p.m. by staff member "A," a licensed practical nurse, documented:

   i. She went to assess the resident with the two other nurses, staff member "B" and staff member "C," registered nurses, and the resident's oxygen saturation dropped to 89% on room air with a RR of 26.

   ii. "The resident was rechecked and had a temperature of 99.2 (F) and RR26 with slight twitching from head to toe."

   iii. She noted that the resident was placed on oxygen via face mask at 10 liters per minute and the oxygen saturation came up to 99%.

j. Absent from the resident's current physician's orders were any orders for oxygen administration.

k. A nursing progress note dated July 8, 2020 at 4:54 p.m. by staff member "A," a licensed practical nurse, documented that a telephone order was received from the physician instructing staff to, "Send resident to ER for seizure/uncontrolled Phenytoin levels."

31. That based on a review of the resident's clinical record and a review of the facility's investigation documentation, on July 8, 2020, staff member "A," a licensed practical nurse was working the day shift, from 7:00 a.m. to 3:00 p.m., providing care on the unit where resident number one (1) lived, while staff member "B," a registered nurse, was also working on that shift, and at 3:00 p.m., staff member "C," a registered nurse, came on duty to work the evening shift, 3:00 p.m. to 11:00 p.m., and to care for the resident.

32. That Petitioner's representative reviewed the written statement, dated July 8, 2020 at 3:30 p.m., of Respondent's staff member "C," a registered nurse, related to resident number one (1) and noted the following:

a. During change of shift rounds, he found the resident with a respiratory rate (RR) of 26, "twitching" activity, and resident was not responding to painful stimulation.

b. He documented that oxygen was started at 2 liters per minute.

c. He called staff member "A," a licensed practical nurse, and staff member "B," a registered nurse, to assess the resident and documented that an order was received from the physician to send the resident to the emergency room (ER) for evaluation.

33. That Petitioner's representative reviewed the written statement. dated July 9, 2020, of Respondent's staff member "B," a registered nurse, related to resident number one (1) and noted the following:

a. She had been called to the resident's room to "take a look" at the resident, but at no time did she "put a stethoscope to the resident or a blood pressure cuff."

b. She observed the other nurses, staff member "A," a licensed practical nurse, and staff member "C," a registered nurse, and the resident.

c. She saw the resident "twitching" and verified through conversations with the nurses, staff "A" and "C," that the resident had a history of seizures.

d. She reviewed the resident's record to confirm a history of seizures.

e. After confirming the seizure history, she reminded staff members "A" and "C" to call the physician, then she went to her office leaving the other two nurses to continue assessing the resident.

f. Once she reached her office, she called the medical director's clinical nurse liaison about another matter.

g. While she was speaking with the clinical nurse liaison, she called out to staff member "A," a licensed practical nurse, and staff member "C," a registered nurse, asking whether the physician had been called.

h. They had not called the resident's physician, so she mentioned the resident's condition to the clinical nurse liaison during the call.

i. The clinical nurse liaison stated, "[The resident] should go ahead and go out. [The resident] will probably need an IV (intravenous administration) of Phenytoin. If the resident is having seizures it would be a risk to give [the

resident] anything by mouth."

j. A photograph of a text message sent by staff member "B" to the clinical nurse liaison on July 8, 2020 at 3:54 p.m. revealed, "Hey, [resident] isn't responding to painful stimuli, [is] lethargic and [nurses "A" and "C"] are still assessing [resident]. I am in here now."

k. The clinical nurse liaison replied, "If [] is unresponsive, send [resident] out."

l. Staff member "B" messaged, "[Resident] is not unresponsive, just lethargic, but staff are in there now."

34. That Petitioner's representative reviewed Respondent's notes of a July 10, 2020 facility-initiated interview, no time recorded, conducted as part of Respondent's investigation regarding resident number one (1), with staff member "B," a registered nurse and noted:

a. When asked how she assessed the resident, she replied that she "just visualized [the resident]."

b. Staff member "B" thought the resident was stable, and she asked staff members "A" and "C" if the resident would be sent out emergently via 911.

c. Staff members "A" and "C" replied, "No," the resident was stable, so staff member "B" returned to her office.

d. As she was preparing to leave the facility for the day, staff member "B" overheard staff member "A" tell staff member "C," "If transport does not arrive in an hour, call 911."

e. Staff member "B" then left the facility.

35. That Petitioner's representative interviewed Respondent's staff member "B," a registered nurse on July 21, 2020 at 10:50 a.m. regarding resident number one (1) and noted:

a. When asked how she determined that the resident was stable on July 8, 2020 before she left for the day, she replied that she "visualized [the resident]."

b. When asked whether a respiratory rate of 25-26 was normal or stable, she did not answer.

36. That Petitioner's representative reviewed the written statements, dated July 10, 2020 and an unknown date, of Respondent's staff member "A," a licensed practical nurse, related to resident number one (1) and noted the following:

a. At 4:00 p.m. on July 8, 2020, she was called to the resident's room by registered nurse "C."

b. There she found the resident with an elevated temperature and not responding to a rigorous sternal rub (Using the knuckles of a closed fist to rub the center chest of a patient who is not alert and does not respond to verbal stimuli. Source - EMS1.com at www.ems1.com, accessed on 7/22/20 at 11:56 a.m.).

c. She described the resident as "twitching with abnormal vital signs" including a BP 158/98 (blood pressure), P63 (pulse), RR 26 (respiratory rate), Temp 99 degrees Fahrenheit (F), Oxygen Saturation (O2sats) of 89% and mouth breathing."

d. An undated and untimed statement made during the facility's investigation documented that staff member "A" informed the resident's relative of possible seizure and non-therapeutic Phenytoin levels. A call was placed to a non-emergency transport company, but they were unavailable, so a second call was placed to another non-emergency transport company, who informed staff member "A" that there would be a one-hour wait.

e. Staff member "A" then left the facility.

37. That Petitioner's representative reviewed the written statement, dated July 8, 2020, of Respondent's staff member "C," a registered nurse, related to resident number one (1) and noted the following:

a. July 8, 2020 at 4:00 p.m. - [The resident's] respirations were 26. [] was receiving oxygen at 2 liters per minute via nasal cannula.

b. July 8, 2020 at 5:00 p.m. - Rechecked resident, no signs of pain or distress noted, RR25, oxygen at 2 liters per minute, resident stable, will continue to monitor.

c. July 8, 2020 at 5:30 p.m. - No "twitching," but RR25 and resident continues on oxygen at 2 liters to keep [] sats (blood oxygen saturation) at 97%. Resident stable, will continue to monitor.

d. July 8, 2020 6:00 p.m. - Temp 99.3 F, RR26, continues on oxygen at 2 liters per minute to keep oxygen saturation at 97%. Resident stable. Will continue to monitor.

e. July 8, 2020 6:30 p.m. - No "twitching," RR25, resident continues on oxygen at 2 liters per minute to help maintain saturation of 97%. Resident stable, continue to monitor closely.

f. July 8, 2020 7:00 p.m. - No "twitching," RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely.

g. July 8, 2020 7:30 p.m. - No "twitching," RR25, continues on oxygen at 2 liters per minute. Stable, will continue to monitor closely.

h. July 8, 2020 8:00 p.m. - No "twitching," RR25, continues on oxygen at 2 liters

per minute to maintain saturation at 97%. Called the non-emergency transport company again and they stated they would be available in 2 hours. Will continue to monitor closely.

i. July 8, 2020 8:30 p.m. - Respiratory rate increased to RR26, resident still requires oxygen at 2 liters per minute to maintain oxygen sats of 97%. Resident stable, continue to monitor.

j. July 8, 2020 9:00 p.m. - RR26 breaths per minute. Continues to require oxygen at 2 liters per minute to maintain sats at 97%. Stable, continue to monitor.

k. July 8, 2020 9:30 p.m. - RR27 breaths per minute, oxygen saturation 94 %. Stable, will continue to monitor closely.

l. July 8, 2020 10:00 p.m. - Called non-emergency transport, and they reported they would probably arrive at midnight or 1:00 a.m. Went to the resident's room to recheck and found the resident using accessory muscles to breathe. Asked another nurse, not identified in his note, to call 911. Monitored the resident at bedside and at 10:14 p.m. he documented that the resident had a respiratory arrest and a code blue was called.

38. That Petitioner's representative reviewed Respondent's Code Blue worksheet related to resident number one (1) and noted:

a. At 10:14 p.m., the resident became unconscious.

b. Cardiopulmonary resuscitation (CPR) was started at 10:14 p.m.

c. Emergency medical services arrived at 10:20 p.m., took over cardiopulmonary resuscitation, and transported the resident to the emergency room at 10:30

p.m.

d. Resident did not survive.

39. That Petitioner's representative reviewed Respondent's policy and procedure addressing a change in a resident's condition and could locate no instructions prioritizing or utilizing 911 in emergency situations, or when a resident experienced an acute change in condition, rather than non-emergency transportation.

40. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Standard Notification of Resident/Patient Change in Condition," effective February 2020, from the clinical guidelines manual 5.1.1 page 1 of 1 and noted in "Procedure:"

a. 1. Notify physician, resident/resident representative and case management when indicated, if there is a significant change in condition, regardless of the time of day ....

b. M. If the nurse responsible for the care of the resident is remaining with the resident and is unable to place the call, another nurse will place the call.

41. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Topic Significant Change in Resident Status," November 2013, Manual 5.3.1, page 1 of 1, and noted:

a. Staff will monitor for significant change in the resident's status and notify resident physician.

b. Procedure - Significant change is one of the following:

i. (a). Deterioration in 2 or more activities of daily living.

ii. (b). Change in the ability to walk or transfer.

iii. (c). Change in the ability to use one's hands or grasp small objects.

iv. (d). Deterioration in behavior or mood to the point where daily problems arise or relationships become problematic.

v. (e). Deterioration in health status that is permanent.

vi. (f). No response by the resident to the treatment for an identified problem.

vii. (g). Initial onset of unplanned weight loss or gain of 5% body weight with a 30-day period.

viii. (h). Threat to life such as stroke, heart condition or metastatic cancer.

ix. (i). A new diagnosis or a condition likely to affect the resident's physical, mental or psychosocial wellbeing over a prolonged period of time, such as an initial diagnosis of Alzheimer's or diabetes.

x. (j). Improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed.

xi. (k). New onset of impaired decision making.

xii. (l). Continence to incontinence or indwelling catheter.

xiii. (m). Use of a restraint when it was never used before.

42. That Petitioner's representative interviewed Respondent's director of nursing on July 22, 2020 at 2:42 p.m. regarding resident number one (1) and noted:

a. When asked to clarify what "no response to pain stimulation" meant, she stated it meant the resident was not responsive.

b. When asked what the significance of a respiratory rate of 25 - 27 was, she replied it meant the resident was in distress.

c. When asked for her expectation of the nursing staff on July 8, 2020 between 3:30 p.m. and 10:14 p.m. regarding the resident, she stated, "They should have

just sent [the resident] out 911."

d. When the resident's care plan for seizure activity was reviewed with the director, noting that during seizure activity the staff should document the seizure location, activity and level of consciousness after seizure activity, the director confirmed that no documentation was available verifying this was done for the resident on July 8, 2020.

43. That Petitioner's representative interviewed Respondent's medical director's clinical nurse liaison on July 21, 2020 at 11:02 a.m. regarding resident number one (1) and noted:

a. Respondent's staff member "B," a registered nurse, called her on July 8, 2020, time not remembered, and reported that the resident was "... not []self, respirations were up, the resident was 'twitching' and staff were unable to get an oxygen saturation reading, because the resident's hands were 'twitching and jerking.'"

b. She asked staff member "B" about the resident's seizure medication and whether the resident had received it the night before. July 7, 2020, and staff member "B" stated the resident had not received the correct dosage.

c. She advised staff member "B" that the resident would need to go to the hospital.

d. She reached out to the resident's physician who also said, "Send [the resident] to the hospital."

e. The expectation was that the facility would summons emergency transport for any respirations over 20, as this would be considered respiratory distress, especially for this resident with a typical RR of 17-20 per minute.

f. When asked for her expectation of what would happen to a resident in respiratory distress for an extended period of time, she replied, "I would expect them to die."

44. That Petitioner's representative interviewed on July 21, 2020 at 11:36 a.m. the physician for resident number one (1) and noted:

a. When asked to recount what he recalled of the events of July 8, 2020 and the resident, he reported he remembered that the resident had problems with the Phenytoin level being low, so he increased the medication.

b. When he learned that the resident was having a seizure, he said he stated, "This is not something we're going to mess with, especially in a nursing home where bad things do happen."

c. He asked that the resident be sent to the hospital and then, "When I say to send the resident to the hospital, I mean go now."

d. When asked about the resident's RR of 25-27 and the expected result of a prolonged period of respiratory distress, he stated, "Bad stuff happens when someone is in distress. Sometimes someone can hang in there for a while, but they need a higher level of care, so they need to be sent to the ER immediately."

45. That Petitioner's representative interviewed Respondent's director of nursing on July 22, 2020 at 2:04 p.m. regarding resident number one (1) and noted:

a. She stated that staff member "C," a registered nurse, "did not use the best clinical judgement."

b. She further stated that respirations of 25-27 were not normal for any resident

and required emergency intervention.

c. She could not understand why staff member "C," a registered nurse, did not call her for guidance

46. That Petitioner's representative interviewed Respondent's administrator on July 22, 2020 at 5:00 p.m. regarding resident number one (1) and the administrator stated:

a. When asked how the facility confirmed the resident's cause of death, he stated, "Anytime a resident has a hospitalization or death, the very next day we call the hospital to determine the circumstances and to request a death certificate."

b. The facility called the hospital on July 9, 2020 at 8:00 a.m. and they were notified that the resident died from cardiac failure.

c. They requested a death certificate for the resident and were told the hospital thought the physician had it and he would ask the physician to send it to the facility.

d. No death certificate was provided for review.

e. The administrator stated that the delay in provision of care and transportation to a higher level of care "should never have happened."

47. That the above reflects Respondent's failure to provide adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, including but not limited to the failure to appropriately assess a resident's deteriorating condition and obtain appropriate treatment.

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

49. That the Agency determined that this deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility, and cited Respondent with an isolated Class I deficient practice.

50. WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(8)(a), Florida Statutes (2020).

COUNT III

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

52. That Respondent has been cited with for two (2) State Class I deficiencies and is therefore is subject to a six (6) month survey cycle for a period of two years and a survey fee of six thousand dollars ($6,000) pursuant to Section 400.19(3), Florida Statutes (2020).

WHEREFORE, the Agency intends to impose a six (6) month survey cycle for a period of two years and impose a survey fee in the amount of six thousand dollars ($6,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to Section 400.19(3), Florida Statutes (2020).

COUNT IV

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

54. Based upon Respondent's two (2) State Class I deficiencies, it was not in substantial

compliance at the time of the surveys with criteria established under Part II of Florida Statute 400, or the rules adopted by the Agency, a violation subjecting it to assignment of a conditional licensure status under § 400.23(7)(a), Florida Statutes (2020).

WHEREFORE, the Agency intends to assign a conditional licensure status to Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(7), Florida Statutes (2020) commencing on July 22, 2020 and ending September 5, 2020.

Respectfully submitted this 13 day of October 2020.

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

DISPLAY OF LICENSE

Pursuant to § 400.23(7)(e), Fla. Stat. (2020), Respondent shall post the most current license in a prominent place that is in clear and unobstructed public view, at or near, the place where residents are being admitted to the facility.

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

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

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

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7019 2970 0001 3240 7341 on October 7, 2020, to Larry Mann, Administrator, ISLF Deerwood Place Jacksonville, LLC d/b/a Regents Park of Jacksonville, 8700 A C Skinner Parkway, Jacksonville, Florida 32256, and by Regular U.S. Mail to CT Corporation System., Registered Agent for ISLF Deerwood Place Jacksonville, LLC, 1200 South Pine Island Road, Suite 1550, Plantation, Florida 33324.

Thomas J. Walsh II

Copy furnished to:
Robert Dickson
Field Office Manager
Agency for Health Care Admin.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: AHCA v. ISLF Deerwood Place Jacksonville, LLC d/b/a Regents Park of Jacksonville
AHCA No. 2020013726

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed agency action by the Agency for Health Care Administration (AHCA). The title may be Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint. Your Election of Rights may be returned by mail or by facsimile transmission, **but must be filed within 21 days** of the day that you receive the attached proposed agency action. **If your Election of Rights with your selected option is not received by AHCA within 21 days of the day that you received this proposed agency action, you will have waived your right to contest the proposed agency action and a Final Order will be issued.**

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _____ I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint and I waive my right to object and to have a hearing. I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) _____ I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I 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.

License Type: _____ (ALF? Nursing Home? Medical Equipment? Other Type?)

Licensee Name: _____ License Number: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (optional) _____

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

Signed: _____ Date: _____

Print Name: _____ Title: _____

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

August 13, 2020

Larry Mann, Administrator
Regents Park Of Jacksonville
8700 A C Skinner Parkway
Jacksonville, FL 32256

File Number: 41614
License Number: 1467096
Provider Type: Nursing Home

RE: 8700 A C Skinner Parkway, Jacksonville

Dear Mr. Mann:

The enclosed Nursing Home license with license number 1467096 and certificate number 24406 is issued for the above provider effective July 22, 2020 through August 29, 2021. The license is being issued for approval of the status change to Conditional.

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

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

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

Sincerely,

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

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF1467096
CERTIFICATE #: 24406

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

CONDITIONAL

This is to confirm that ISLF DEERWOOD PLACE JACKSONVILLE, LLC has complied with the rules and regulations adopted by the State of Florida, Agency for Health Care Administration, authorized in Chapter 400, Part II, Florida Statutes, and is authorized to operate the following:

REGENTS PARK OF JACKSONVILLE
8700 A C Skinner Parkway
Jacksonville, FL 32256

Total: 120 Beds

STATUS CHANGE

EFFECTIVE DATE 07/22/2020

EXPIRATION DATE: 08/29/2021

Mary C. Mayhew

Secretary, Agency for Health Care Administration

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

September 22, 2020

Larry Mann, Administrator
Regents Park Of Jacksonville
8700 A C Skinner Parkway
Jacksonville, FL 32256

File Number: 41614
License Number: 1467096
Provider Type: Nursing Home

RE: 8700 A C Skinner Parkway, Jacksonville

Dear Mr. Mann:

The enclosed Nursing Home license with license number 1467096 and certificate number 24560 is issued for the above provider effective September 5, 2020 through August 29, 2021. The license is being issued for approval of the status change to Standard.

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

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

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

Sincerely,

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

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF1467096
CERTIFICATE #: 24560

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

STANDARD

This is to confirm that ISLF DEERWOOD PLACE JACKSONVILLE, LLC has complied with the rules and regulations adopted by the State of Florida, Agency for Health Care Administration, authorized in Chapter 400, Part II, Florida Statutes, and is authorized to operate the following:

REGENTS PARK OF JACKSONVILLE
8700 A C Skinner Parkway
Jacksonville, FL 32256

Total: 120 Beds

STATUS CHANGE

EFFECTIVE DATE 09/05/2020

EXPIRATION DATE: 08/29/2021

GREAT SEAL OF THE STATE OF FLORIDA
IN GOD WE TRUST

Mary C. Mayhew

Secretary, Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

ISLF DEERWOOD PLACE JACKSONVILLE, LLC d/b/a REGENTS PARK OF JACKSONVILLE,

Respondent.
_____/

Case Nos: 202001~~3726~~
Facility Type: Nursing Home
License No.: 1467096

SETTLEMENT AGREEMENT

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

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

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

WHEREAS, the Agency served Respondent with an administrative complaint dated October 13, 2020, notifying the Respondent of its intent to impose administrative fines in the amount of twenty thousand dollars ($20,000.00) and the imposition of a two (2) year survey

EXHIBIT 2

cycle and its six thousand dollar ($6,000.00) fee, for a total assessment of twenty-six thousand dollars ($26,000.00), and imposition of conditional licensure; and

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

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

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

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

3. Upon full execution of this Agreement, Respondent agrees to waive any and all appeals and proceedings to which it may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that no agreement herein shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement.

4. Upon full execution of this Agreement, Respondent agrees to pay sixteen thousand dollars ($16,000.00) in fines and six thousand dollars ($6,000.00) in survey fees for a total assessment of twenty-two thousand dollars ($22,000.00) to the Agency within thirty (30) days of the entry of the Final Order and accepts imposition of conditional licensure commencing July 22, 2020 and ending September 5, 2020.

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

6. By executing this Agreement, Respondent denies, and the Agency asserts the validity of the allegations raised in the survey referenced herein. No agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, pursuant to the provisions of Chapters 400, Part II, 408, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code, including a "repeat" or "uncorrected" deficiency identified in the Survey. In said event, Respondent retains the right to challenge the factual allegations related to the deficient practices/ violations alleged in the instant cause.

7. No agreement made herein shall preclude the Agency from using the deficiencies from the survey in any decision regarding licensure of Respondent, including, but not limited to, a demonstrated pattern of deficient performance. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Respondent acknowledges and agrees that this Agreement shall not preclude or estop any other federal, state, or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the Survey. This agreement does not prohibit the Agency from taking action regarding Respondent's Medicaid provider status, conditions, requirements or contract. In said event, Respondent retains the right to challenge the factual allegations related to the deficient practices/ violations alleged in the instant cause

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

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

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

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

12. This Agreement is binding upon all parties herein and those identified in paragraph eleven (11) of this Agreement.

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

14. Respondent agrees that if any funds to be paid under this agreement to the Agency are not paid within thirty-one (31) days of entry of the Final Order in this matter, the Agency may deduct the amounts assessed against Respondent in the Final Order, or any portion thereof, owed by Respondent to the Agency from any present or future funds owed to Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to Respondent by the Agency for said amounts until paid.

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

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

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

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

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

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

Molly McKinstry, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Building #1
Tallahassee, Florida 32308

DATED: 3/24/21

Peter A. Lewis, Attorney
Law Offices of Peter A. Lewis, P.L.
3023 N. Shannon Lakes Drive, Suite 101
Tallahassee, Florida 32309
Florida Bar No. 851639

DATED: 2-25-21

James D. Varnado, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Florida Bar No. 919070

DATED: 3/22/21

Name: Chris Green
Title: Administrator
ISLF Deerwood Place Jacksonville, LLC d/b/a
Regents Park of Jacksonville

DATED: 2-23-21

Thomas J. Walsh II, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive North, Suite 330G
St. Petersburg, Florida 33701
Florida Bar No. 566363

DATED: 9/3/24