STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA NO. 2014003053

ST. PETERSBURG NURSING HOME LLC d/b/a JACARANDA MANOR,

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 has jurisdiction over the above-named Respondent pursuant to Chapter 408, Part II, Florida Statutes, and the applicable authorizing statutes and administrative code provisions.

2. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The Election of Rights form advised of the right to an administrative hearing. The Respondent returned the Election of Rights form selecting "Option 1." (Ex. 2) The Respondent thus waived the right to a hearing to contest the allegations and sanction sought in the Administrative Complaint.

Based upon the foregoing, it is **ORDERED:**

1. The findings of fact and conclusions of law set forth in the Administrative Complaint are adopted and incorporated by reference into this Final Order.

2. The Respondent shall pay the Agency $16,000.00 in administrative fines and survey fees. 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:

Office of Finance and Accounting
Revenue Management Unit
Agency for Health Care Administration
2727 Mahan Drive, MS 14
Tallahassee, Florida 32308

3. Conditional licensure status is imposed on the Respondent beginning on March 4, 2014, and ending on April 1, 2014.

ORDERED at Tallahassee, Florida, on this 3 day of June, 2014.

Elizabeth Dudek, 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 3rd day of June, 2014.

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)	Finance & Accounting Revenue Management Unit (Electronic Mail)
Thomas J. Walsh II Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Katherine Sherrill-Hager Administrator St. Petersburg Nursing Home LLC d/b/a Jacaranda Manor 4250 66th Street North St. Petersburg, Florida 33709 (U.S. Mail)

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d/b/a JACARANDA MANOR,

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 St. Petersburg Nursing Home LLC d/b/a Jacaranda Manor (hereinafter "Respondent"), pursuant to §§120.569 and 120.57 Florida Statutes (2013), and alleges:

NATURE OF THE ACTION

This is an action to change Respondent's licensure status from Standard to Conditional commencing March 4, 2014, and ending April 1, 2014, to impose administrative fines in the amount of ten thousand dollars ($10,000.00), and to impose survey fees of six thousand dollars ($6,000.00) with a two (2) year survey cycle based upon Respondent being cited for one (1) isolated State Class I deficiency.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60 and 400.062, Florida Statutes (2013).

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

PARTIES

3. The Agency is the regulatory authority responsible for licensure of nursing homes and

EXHIBIT "1"

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

4. Respondent operates a two hundred ninety-nine (299) bed nursing home, located at 4250 66th Street North, St. Petersburg, Florida 33709, and is licensed as a skilled nursing facility license number 1252096.

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 eight (8), as if fully set forth herein.

7. That pursuant to Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. § 400.022(1)(l), Fla. Stat. (2013).

8. That Florida law provides the following: "'Practice of practical nursing' means the performance of selected acts, including the administration of treatments and medications, in the

care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist. A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing." § 464.003(19), Fla. Stat. (2013).

9. That on May 18, 2013, the Agency completed a relicensure survey of the Respondent facility.

10. That based upon 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 provide care and services necessary to implement end of life decisions, including but not limited to "Do Not Resuscitate Orders," according to the requirements of facility policy and procedure and law.

11. That Petitioner's representative interviewed on February 27, 2014 at 10:48 a.m., Respondent's administrator, director of nursing, and risk manager, who indicated as follows related to an incident involving resident number twenty-four (24):

a. On February 23, 2014, at around 6:30 p.m., the resident was in the dining room at the time and was not responsive.

b. A certified nursing assistant, employee "A," was sitting at the dinner table with the resident and feeding another resident.

c. Employee "A" noticed that the resident wasn't eating and shook the resident to get the resident to respond.

d. When the resident was unresponsive, employee "A" called for the licensed practical nurse, employee "B," who was present in the dining room to assist.

e. Employee "B" quickly assessed the resident who was pale, had no response to sternal rub, and no pulse.

f. A mouth sweep was done with nothing found and cardiopulmonary resuscitation was initiated.

g. Paramedics arrived and took the resident to the hospital.

h. The resident was discovered to be a "Do Not Resuscitate."

i. The administrative staff described this resident as being alert with confusion, able to follow simple commands, and would ambulate throughout the facility using a merry walker.

j. The resident was at the local hospital in stable condition where the resident was found to have a pneumothorax with the insertion of a chest tube.

k. The director if nurses stated she received a phone call from employee "B" on the night the incident to inform her that the resident was found unresponsive in the dining room.

l. Employee "B" was a weekend supervisor for the 2nd floor of the facility.

m. They started cardiopulmonary resuscitation and the resident was doing well when transported to the hospital.

n. Employee "B" told her the code went well and when the resident left the building the resident had a pulse.

o. Employee "B" later discovered that the resident was a "Do Not Resuscitate."

p. The director advised employee "B" to complete a report and to contact the

resident's responsible party and tell them exactly what was done and then report back. She also explained to employee "B" that the employee needed to notify the risk manager.

q. The director stated that employee "B" informed her that she immediately felt compelled to do cardiopulmonary resuscitation and "... to do the right thing."

r. Employee "B" called the resident's guardian and explained in detail what had occurred three times and employee "B" told the director that the guardian said that she understood that the resident received cardiopulmonary resuscitation and was okay with it.

s. The doctor was also made aware.

t. The director then instructed Employee "B" to go ahead and start education with the other staff in the facility along with the nursing supervisor on the first floor of the facility. The education consisted of verifying whether a resident was a "Do Not Resuscitate" status or a full code.

u. The risk manager stated she was also called by employee "B" on the night of the incident and informed of the events which took place in regards to the resident.

v. The risk manager told employee "B" to go ahead and start the education as directed by the director of nursing.

w. The administrator, director of nursing, and risk manager all indicated that they did not come in on the night of the incident.

12. That Petitioner's representative telephonically interviewed the legal guardian for resident number twenty-four (24), on February 27, 2014, who indicated as follows;

a. The resident was still in the Intensive Care Unit (ICU) at the hospital with chest tubes in both lungs.

b. The resident has been kept in ICU because there is still fluid on the lungs.

c. The guardian remembered receiving a phone call to tell her that the resident was in the dining room and became unresponsive.

d. They told the guardian that they performed cardiopulmonary resuscitation and that the resident had a pulse when the resident left.

e. They obviously did not have the chart with them when this happened.

f. The resident has become unresponsive in the past and usually comes right back.

g. They did explain to the guardian that they did not know the resident was a Do Not Resuscitate at the time and I didn't have a problem with what they did because they didn't know at the time.

13. That Petitioner's representative telephonically interviewed Respondent's employee "A," a certified nursing assistant, regarding the incident with resident number twenty-four (24), on February 27, 2014, who indicated as follows:

a. He had been a certified nursing assistant for the past eleven (11) years.

b. He worked in the restorative department on the weekends from 7:00 a.m. - 11:00 p.m.

c. He was familiar with the resident and stated the resident was always walking around in a merry walker, was not very talkative, but liked to read things like your name tag and things like that.

d. On February 23, 2014, he was sitting next to the resident at the table in the 2nd

floor dining room.

e. Everyone was eating at the table and when he looked back at the resident he noticed the resident wasn't eating.

f. He called out the resident's name and said "it's time to eat."

g. He then touched the resident's arm and again said the resident's name and told the resident to eat.

h. The resident did not respond.

i. He noticed the resident was not breathing right. "Like it wasn't regular it wasn't normal. I don't know if [the resident] was hardly breathing but it just didn't look right so I called the nurse over."

j. The nurse, employee "B," was in the dining room and came over and looked at the resident. She said call 911 and page code 99.

k. At that point, he started moving other residents out of the way because he knew the ambulance was coming.

l. He then came back over to the resident and awaited further instructions on what to do.

m. Other staff were present but he could not recall exactly who.

n. Employee "B" said "let's lay [the resident] down," and they put the gait belt around the resident and lowered the resident to the floor.

o. He stood there and was trying to keep the other residents out of the way while employee "B" started doing cardiopulmonary resuscitation.

p. He recalled employee "B" performing chest compressions and using the AED (automated external defibrillator) machine.

q. He did not recall the resident receiving a shock from the AED machine and also could not recall any breaths being given but stated, "... they probably did, but I don't recall that."

r. He could not recall if anyone looked for the resident's code status in the resident's chart or in the computer kiosk located in the dining room. He stated "I don't recall if anyone did. I just know what I was doing at the time and that was keeping the patients away."

14. That Petitioner's representative interviewed Respondent's employee "B," a licensed practical nurse, regarding the incident with resident number twenty-four (24), on February 24, 2014, who indicated as follows:

a. She was directly involved in the occurrence with the resident on February 23, 2014.

b. She had been a licensed practical nurse for the past eleven (11) years and has worked in the facility for seventeen (17) years, first starting out as a certified nursing assistant.

c. Her assigned position at the time of the event was second floor weekend supervisor on Saturday and Sunday from 7:00 a.m. - 11:00 p.m.

d. She stated she used to take care of the resident when the resident lived on the second floor but at the time of the event the resident was living downstairs.

e. She would recognize the resident if she saw the resident, but was not familiar with the resident hands on.

f. She recalled the resident walking all over the building in a merry walker.

g. The resident also liked to read and write, would hang out by the nurses'

stations, and would pick up a book if it was sitting there and read it.

h. The resident did not speak much.

i. The resident ate in the restorative program which was held in the 2nd floor dining room.

j. On February 23, 2014, at dinner time, she was present in the 2nd floor dining room and remembered being called over by employee "A" who said the patient does not look right.

k. She went over to the resident and saw that the head was down and the resident was pale.

l. She did a sternum rub and talked to the resident who did not respond.

m. She checked radial pulse and found the resident had no pulse and no respirations. "[The] chest wasn't rising."

n. She did not know the resident well because the resident lived downstairs and she called out for somebody go get the chart and to call downstairs so they could find out the code status.

o. She is unsure who she gave those instructions to and what other staff members were present in the dining room with the exception of employee "A."

p. After that, it seemed like too much time was going by so we placed the resident on the floor, and did a mouth sweep with no findings and no coughing.

q. When she wasn't receiving a response, she started cardiopulmonary resuscitation.

r. She put the AED machine on the resident and followed the directions given by

the machine.

s. She placed the two pads on to the resident - the machine says to stay away from patient because it will deliver a shock.

t. She could not recall if the AED shocked the resident, but did remember the message coming up.

u. She then did chest compressions.

v. The machine also gave messages to let her know if more pressure was needed with the compressions.

w. During this process, someone came up with the chart, she doesn't know who, who said the resident was a DNR and she continued CPR.

x. She continued CPR because once CPR was started "you do not stop."

y. An ambu bag was used during the code and the crash cart was brought in.

z. One of the certified nursing assistants used the ambu bag which was hooked up to oxygen, though she cannot recall who the assistant was

aa. Another unknown employee, possibly a nurse, had called 911 and when the paramedics arrived, they took over the situation.

bb. Code status can also be checked using the computer kiosk and one of the certified nursing assistants checked the kiosk, though she does not know who, but she felt too much time was passing so she used nursing judgment and started cardiopulmonary resuscitation.

cc. She could not recall exactly how much time had passed but "... it seemed like a lot of time passed by but I can't say if it was one minute or five minutes."

dd. After the event, she called the resident's guardian and told her what had

happened; that the resident was a "Do Not Resuscitate" and she did start cardiopulmonary resuscitation.

ee. She also called the on call doctor, not sure exactly who, and informed him that the resident was a Do Not Resuscitate and "we 911'd him and sent him out."

ff. She also called the director of nurses and the risk manager and told them exactly what had happened.

gg. The director of nurses in-serviced her over the phone on checking the residents' code status and instructed her to do an in-service with staff on code status, full code versus Do Not Resuscitate.

hh. She then in-serviced the nurses showing them to look on the chart or in the kiosk for the information.

15. That Petitioner's representative interviewed Respondent's medical director, regarding the incident with resident number twenty-four (24), on February 27, 2014, who indicated as follows:

a. He also served as the attending physician for the resident.

b. He was unsure who was on call on February 23, 2014, the night of this occurrence, as they have a team of eleven (11) physicians and practitioners who provide coverage.

c. He was certain that the facility called them as "... they call us like clockwork."

d. He had a meeting on Monday, February 24, 2014, with the nursing home administrator and was informed that they had instituted cardiopulmonary resuscitation on the resident when the resident was a "Do Not Resuscitate."

e. The doctor had been taking care of the resident for a long time and " ...

unfortunately, I think they started CPR. We can't change what happened unfortunately."

f. It was his expectation that if a resident was a full "Do Not Resuscitate," then they should just contact the physician and contact the family. If the family doesn't want anything done then we would follow protocol for a "Do Not Resuscitate."

16. That Petitioner's representative reviewed Respondent's records related to resident number twenty-four (24) during the survey and noted as follows:

a. The face sheet reflected a date of birth of November 11, 1938, or currently seventy-five (75) years old, and an original date of admission to the facility of July 22, 2008. .

b. The face sheet also documented that the resident was a widow who had previously worked as a Registered Nurse (RN).

c. The advanced directives section of the clinical record contained the following relevant documents:

i. Legal guardianship court documents for the resident, an incapacitated person, dated July 8th, 2008.

ii. A "State of Florida Do NOT RESUSCITATE ORDER" form printed on yellow goldenrod paper and signed by the resident's legal guardian on January 1, 2010, and the attending physician on January 19, 2010.

d. The resident had the following relevant diagnosis history: Diabetes Mellitus II, Hyperlipidemia, Dementia, Schizoaffective disorder, Encephalopathy, Cataract, Hypertension, Cerebrovascular Disease, Dysphagia, Hypotension,

Chronic Airway Obstruction, Esophageal Reflux, Chronic Kidney Disorder, Benign Prostatic Hypertrophy without obstruction, Osteoarthrosis, Arthropathy, Muscle and Respiratory Distress Syndrome.

e. Nursing notes reflect the following relevant entries:

i. February 23, 2014 at 7:42 p.m. - "This writer was in the lifestyle 2 dining room at 6:45 p.m. when notified by staff member that something was wrong with the resident. Attended to resident at once who was sitting up in the chair with head leaning forward, skin color pale and not responsive to sternal rubs or to name calling. No coughing noted. Mouth sweep done and no food or foreign objects obtained. Unable to obtain a pulse. Resident than was placed on the floor. Code 99 was activated at 6:50 p.m. AED applied to chest and CPR was initiated at 6:54 p.m. 911 activated at 6:50 p.m. and paramedics arrived at scene at 6:57 p.m. and took over resident's state. Ok to send to hospital. Call placed to resident's responsible party at 7:13 p.m. and left message to call back at facility's number. Responsible party returned call at 7:30 p.m. and spoke with this writer who notified her of resident's state. She was made aware that resident was DNR and CPR was initiated. Responsible party stated that initiating CPR was fine that it was ok and that she did not have a problem with that. She also thanked writer for calling. Call placed to hospital at 8:25 p.m. regarding resident's state and spoke with staff member who stated that resident was stable, labs were pending and that he will be admitted. No diagnosis at this time. [Signed by Respondent's employee

"B"]."

f. February 23, 2014 at 9:18 p.m. - "Call placed to Emergency Room at 9:15 p.m., resident admitted with Diagnosis of respiratory distress."

17. That Petitioner's representative reviewed the hospital records for resident number twenty-four (24) and noted as follows:

a. February 23, 2014 at 7:18 p.m. - Rapid initial assessment from emergency room: "Nursing home reports patient turned blue while eating dinner and began having respiratory distress but did not appear to be choking. CPR was performed at nursing home prior to EMS arrival."

b. February 23, 2014 - Internal medicine progress note: "Foley catheter inserted."

c. History and Physical February 24, 2014 at 9:11 a.m.

i. Reason for admission: "Respiratory distress, right sided pneumothorax.

ii. History of present illness: resident from a nursing home brought to hospital with respiratory distress. The patient had a cardio-pulmonary arrest and had CPR. Chest x-ray revealed aspiration pneumonia and right side pneumothorax. Chest tube placed in ER and admitted to ICU.

iii. Assessment and Plan: 1. aspiration pneumonia, status post cardiac arrest; 2. Pneumothorax right side. Plan: Admit to ICU, will get in touch with Power of Attorney to find out how far one should be aggressive in the treatment."

d. Pulmonary Consult Note of February 4, 2014 at 9:10 a.m. "... per records the patient ambulated to the dining hall and had an unknown event for which CPR

was begun. Of note, pt is a DNR, but per records CPR was done at the nursing home. Per records, CPR was then completed with return of spontaneous circulation (ROSC) on this patient. Of great significance it is incredibly difficult to discern the actual occurrence of events prior to arrival in the ED: at this point it is unclear if the patient actually arrested at all. Patient had pulses when Emergency Medical Services (EMS) arrived, and he was subsequently brought to the hospital where significant subcutaneous of emphysema was noted on physical exam in the upper torso and Upper Extremities (UE's) and Chest X-Ray (CXR) revealed pneumothorax with subq air for which a chest tube was subsequently placed on the right. Pt currently on bipap...and chest tube was not seen in thorax on CXR this a.m. For this we replaced this right sided chest tube with a larger caliber."

e. .Diagnosis, Assessment, and Plan: Acute respiratory failure-stable right pneumothorax resolved s/p bedside chest tube insertion with remaining left sided pneumothorax, likely from traumatic chest compressions. Questionable concomitant Community Acquired Pneumonia (CAP) vs aspiration pneumonia. Questionable out of hospital cardiorespiratory arrest with CPR. Given patients guarded condition will place left sided chest tube tomorrow as doing two procedures in the same day could significantly worsen prognosis. Will continue broad spectrum antibiotic (ABT) coverage, check PCT with AM labs. Will monitor on BiPap and do all we can without intubation as patient is DNR."

f. February 25, 2014 - Critical Care Progress Note: "Assessment: Acute

respiratory failure right pneumothorax stable at 25%. ... Elevate PCT this a.m. consistent with concomitant health care acquired pneumonia vs. aspiration pneumonia. Will update ABT regimen to add vancomycin, zosyn, and Discontinue flagyl and rocephin. Pleural fluid consistent with exudiative/infectious etiology."

g. February 25, 2014 - Speech Therapy (ST) Clinical Dysphagia Evaluation: "Pt had increase work of breathing, mild decrease in oxygen sat, and mild increase in heart rate after by mouth (PO) trials. Pt had delayed cough after thin liquids. Recommend video swallow study to further assess swallow function."

h. February 26, 2014 – Speech Therapy: "Video swallow eval Comments: intermittently delayed bolus propultion ... Summary: Pt had pharyngeal stasis after all trials. Majority of pharyngeal stasis cleared with repeat swallow or liquid wash. No aspiration or penetration noted with any tested consistency. Chewing was mildly prolonged but adequate for mechanical soft trials."

i. Critical Care Progress Note of February 27, 2014: "Acute respiratory failure - improving. Chest tube out yesterday. CXR stable this am. Will continue on current ABT, keep on ventimask. .. From pulmonary standpoint, pt is stable to transfer to the floor."

j. Pulmonary Progress Note of February 28, 2014: "Chest X-ray 2/28/14 2:37 a.m. Impression: stable bilateral air space disease and enlargement cardiac silhouette suggesting Acute Respiratory Distress Syndrome."

k. Pulmonary Progress Note of March 2, 2014 at 7:04 a.m.: "Pt remains

nonverbal but does not appear in distress other than his paradoxical breathing. Nurse notes his oxygen sat has continued to drop overnight and increasing amount of oxygen was required to keep sat above 90%."

l. Pulmonary Progress Notes of March 2 and 3, 2014 indicated Respiratory/Chest Assessment: "Rales, wheezing, parodixical breathing, palpable rales on right anterior chest. Pectus Excavatum."

m. March 2, 2014 - Cardiology Consult: "Cardiology consult requested which I assume is to eval for possible CHF given patient's hypoxemia. The patient is DNR and with overall multiple comorbidities and very poor functional status. Therefore at first glance cardiology management will be conservative. Plan: ECHO and conservative care."

18. That Petitioner's representative reviewed Respondent's undated policy and procedure entitled "Code Arrest - Procedure and Protocol," which was in effect at the time of the February 23, 2014, incident with resident number twenty-four (24), and noted as follows:

a. Policy: Code protocol is established so that all residents will receive prompt specialized care in life threatening situations.

b. Purpose: Guidelines for code protocol to ensure that all residents receive prompt specialized care in life threatening situations.

c. General Guidelines:

i. SUPPORTIVE DATA - A. Definitions: 1. "Code 99" - Cardiac and/or respiratory arrest has occurred on an adult age 12 or above. It will be announced over facility intercom system. This will call all necessary members of the health care team to respond immediately to designated

area and assist with resuscitation.

ii. B. Initial Response:

(a) 1. Assess the resident for signs and symptoms of cardiopulmonary arrest:

a. Unconscious state.

b. Pulselessness.

c. Dilated Pupils.

d. Absent Respirations.

(b) 2. Assess need to call a code.

(c) 3. Call Code "99" Room ___ three times in succession on the intercom, nurse in charge of resident and other nursing unit staff will provide CPR, start IV's (per physician order) and bring resident's chart and code cart to the resident's room ..."

19. That Petitioner's representative reviewed Respondent's October 1, 2011, policy and procedure entitled " Abuse Prevention Policy & Procedure," which was in effect at the time of the February 23, 2014, incident with resident number twenty-four (24), and noted as follows:

a. Purpose: The purpose of this written Resident Abuse, Neglect, and Misappropriation Prevention Program 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. The scope of this program shall apply to the prevention of abuse committed by anyone, including but not limited to, staff ...

i. 1. Policy Statement: This facility shall not condone any acts of resident mistreatment, neglect, verbal, sexual, physical and/or mental abuse ...by any facility staff member ...

ii. 2. Definitions: The most common forms of abuse include: ... 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.

b. 6. 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.

c. Procedures: Immediate Response ... (2) Any employee suspected (alleged) of abuse will be suspended as the incident is reported; ... pending outcome of the investigation ...

d. 7. Prevention Through QA Policy: ... Reviewing and Disciplining - This facility will conduct a comprehensive review of any employee suspected of abuse, neglect or mistreatment of residents and will implement disciplinary action according to company policy. Any employee, who is accused or resident abuse ...will be suspended pending further investigation.

e. 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. Do not wait for the State Department of Human Services to

investigate."

20. That Petitioner's representative again interviewed on February 28, 2014 at 11:22 a.m., Respondent's administrator, director of nursing, and risk manager, joined by the assistant director of nursing and the staff development coordinator, who indicated as follows:

a. The facility conducted a root cause analysis for the February 23, 2014, event involving resident number twenty-four (24).

b. They determined that cardiopulmonary resuscitation was started without the code status having been verified.

c. They could not find any breakdown in the system at this time.

d. After speaking to the nurse involved, employee "B," she verified that she did not check the code status. She panicked and didn't want to lose valuable time waiting. She took action in case he was a full code.

e. Based on multiple interviews with staff, they were able to get the information on the resident's code status quickly, but by that time employee "B" had already started cardiopulmonary resuscitation. "It was a nursing judgment call."

f. Employee "B" never expressed concern that it was taking too long to get the information.

g. Employee "B" was currently in nursing school and she started thinking about what would happen if the resident's brain went too long without oxygen. "She basically said one minute could have been five minutes."

h. We honor advanced directives here. It is our expectation that if a resident experiences cardiac arrest and had a "Do Not Resuscitate" in place, the staff

do not resuscitate. Staff are trained according to the facility's philosophy to honor "Do Not Resuscitate" orders and it is incorporated into the code 99 process to check the resident's code status.

i. The code status of "Do Not Resuscitate" for resident number twenty-four (24) was determined very shortly after cardiopulmonary resuscitation was started and prior to the paramedics' arrival.

j. The facility's investigation was still on-going as of February 28, 2014, day five (5), and the facility had determined that this was an allegation of neglect on day one (1).

k. We did consider timeliness in the investigation.

l. We made sure all the information was at the front of chart to include the physician's telephone order with the goldenrod "Do Not Resuscitate" form.

m. The staff can check the chart, the computer, or the kiosk for the residents' code status.

n. Employee "B" "... panicked; it was human error. Thirty seconds must have seemed like ten (10) minutes."

o. Employee "B" had actually received training several hours before the incident with resident number twenty-four (24).

p. The staff development coordinator had come in over the weekend to do pre-survey education and covered a list of items to include Code 99 at 2:00 p.m. on February 23, 2014; this incident happened around 6:00 p.m.

q. Employee "B" received disciplinary action of a final written warning about a day or so after the event for not checking the "Do Not Resuscitate" status,

which was not in the employee's personnel file reviewed on February 27, 2014, because the disciplinary document was still awaiting review by the administrator.

r. When asked why employee "B," the individual who failed to honor the resident's Do Not Resuscitate, was selected as the person to begin training other staff members on-site that night, the director of nurses indicated that because employee "B" was the one who was incorrect in her response, she felt as though she should take ownership.

s. The director of nurses figured that if employee "B" was tasked with having to reiterate the correct process repeatedly then it would stick.

t. The administrator stated she asked the director of nurses the same question and when explained, it made sense.

21. That Petitioner's representative reviewed Respondent's personnel record for employee "B" during the survey and noted as follows:

a. She had current cardiopulmonary resuscitation certification by the American Heart Association with an issue date of January 18, 2013, and an expiration date of January 2015.

b. A Personnel Consultation Form with a date of counseling of February 25, 2014, and a date of occurrence of February 23, 2014, revealed the following:

i. Final Written Warning for a description of occurrence as follows: As per employment handbook page #25, line #9 stipulated unsatisfactory or careless work; page #25 line #13 stipulated violating facility rules or safety practices.

ii. Employee enacted code 99 protocols and started CPR and directed staff to do so prior to verifying actual code status of a resident.

iii. Corrective Action Taken: Employee was re-educated on the appropriate protocol and process to carryout Code 99 in the facility. Employee was re-educated on Emergency Response, verifying code status, and documentation components. Any further discrepancies/issues regarding this will result in immediate termination.

iv. The document was signed and dated by employee "B" and the director of nurses on February 25, 2014.

22. That Petitioner's representative again interviewed on February 27, 2014 at 10:48 a.m., Respondent's administrator, director of nursing, and risk manager, regarding facility action since the incident involving resident number twenty-four (24), and Respondent's staff indicated as follows:

a. The facility began education with the staff on the Code 99 process immediately after being informed of the event on February 23, 2014, by employee "B."

b. The following morning, February 24, 2014, the interdisciplinary team met and developed a Quality Assurance (QA) Action Plan, the QA Action Plan providing for an area identified as "Staff not verifying code status prior to initiating CPR" revealed the following actions to be taken (Process Change/Education):

i. One hundred percent (100%) education for all licensed nurses and certified nursing assistants regarding the Code 99 Policy and how to verify

code status. (Review of a list of all current licensed nurses and certified nursing assistants revealed a total of two hundred eighty-six (286) employees would need to receive this education.

ii. Validate Quality Education by interviewing randomly selected Nurses and certified nursing assistants using the post education questionnaire. Eight (8) nurses and eight (8) certified nursing assistants per shift; one hundred percent (100%) review of these will be completed by Respondent's administrator. This will be done daily for five (5) days and then weekly until one hundred percent (100%) accurate responses are provided to interviewer. This will continue for five (5) days then weekly until one hundred percent (100%) accurate responses are received for 4 consecutive weeks.

iii. Conduct Mock Code 99 drills once per shift for one week. The administrator will audit Code 99 drill participation sign in sheets. This will continue one time each week then once per week on each shift until the QA/PI Committee determines future duration.

iv. Conduct one hundred percent (100%) audit of all resident records including Kiosk, Physician Orders, Goldenrod/DNR forms and Care Plans on February 24, 2014, by social service staff. Post February 24, 2014, social services will do an additional audit of ten (10) per week for four (4) weeks on those residents with "Do Not Resuscitate" status. On February 27, 2014, medical records will conduct a second one hundred percent (100%) audit to verify accuracy of any corrections. The weekly audits of

ten (10) will continue until one hundred percent (100%) compliance is achieved for three (3) consecutive months.

v. Ensure all Nursing Staff involved in February 23, 2014, Code 99 had valid cardiopulmonary resuscitation Certificate. In addition, fifteen (15) of all nursing staff will by audited for cardiopulmonary resuscitation certification monthly for three (3) months. This will be on-going until one hundred percent (100%) compliance is reported for three (3) consecutive months.

vi. The facility also had documentation of a meeting with the Medical Director on February 24, 2014, which discussed the circumstances of the Code 99 involving resident number twenty-four (24) on February 23, 2014, review of the QA Action Plan, and additional measures which could be instituted were also discussed.

vii. The Code 99 system to check a resident's code status was to utilize the resident's chart or check the computer or kiosk. This was the procedure in place when the event occurred on February 23, 2014, and it was the same today, February 27, 2014. However, upon review of the facility's Code Arrest Policy post the February 23, 2014, incident they decided to make it more specific and directive because the previous policy was "too vague." Review of the new policy revealed that the following items marked with an asterisk were added: "(2) Assess need to call a code: a. Review kiosk information for code status. b. May announce resident name overhead during code."

23. The following was reviewed by Petitioner's representatives by the exit on March 4, 2014, and noted as follows:

a. As of March 4, 2014, two hundred sixty-six (266) employees have signed in-service records indicating they have received this training. Interview with the DON and Staff Development Coordinator on March 4, 2014, revealed the twenty (20) remaining employees have not worked in the facility since the event due to various reasons to include scheduled vacation, medical leave, call in's, not scheduled, and PRN. The director had been calling them and leaving messages on their phones to inform them they need to come in to receive training. "In some cases, we can't get a hold of the people as the phone numbers are no longer working. If they have not worked in the past sixty (60) days we are going to terminate them from the system. Some work weekends only and have been on the schedule but called off this past weekend. We will be giving the staffing coordinator a list of the twenty (20) employees so she knows that they cannot be scheduled until they come in, receive the training, and sign off on it. The facility does not use agency staff." The director of nursing will hold ultimate responsibility to ensure that these twenty (20) employees will not be scheduled to work until the training has been received.

b. The facility's corrective action plan notebook revealed well over one hundred (100) questionnaires had been completed by nurses and certified nursing assistants. In-depth validation interviews were conducted by the survey team with thirty (30) employees representing all shifts as well as weekend staff with no negative results received.

c. Review of the facility's corrective action notebook revealed that the facility has far exceeded their stated number of mock drills for QA. Random interviews with the licensed nurses and certified nursing assistants revealed they have been participating in the drills where random scenarios are being utilized such as choking, diabetic, unresponsive, and cardiac arrest residents. The staff indicated that they are benefiting from the hands-on training and find it to be an effective educational tool.

d. The survey team reconciled the code status on the physician orders, goldenrod "DO Not Resuscitate" forms, and the computerized/kiosk system for sixty (60) randomly selected residents from six (6) of six (6) facility units. A slight discrepancy was found on one resident's record but it was quickly clarified and corrected.

e. The survey team reviewed thirty-one (31) licensed nurses and certified nursing assistant personnel files. This review revealed all had current cardiopulmonary resuscitation cards on hand: however, five (5) were on-line courses with no return demonstration requirement. This information was reported to the administrator on March 3, 2014, at approximately 10:30 a.m. As a result of this information the facility developed a second QA Action plan on March 3, 2014, for an area identified as "On-line C.P.R. class verified 5 of 31 Personnel Files checked for Licensed and Certified Staff." The five (5) staff members who only had documentation of on-line cardiopulmonary resuscitation training in their personnel file were immediately suspended. A one hundred percent (100%) audit will be conducted of Personnel Files to

determine if other staff members have inadequate documentation of their cardiopulmonary resuscitation Training. This may involve calling the numbers on the copies of the cards to verify a return demonstration of skills was conducted at the said class. Human resources director will immediately communicate names of staff who are verified through the above audit to not have had a return demonstration performed during cardiopulmonary resuscitation training to the Director of Nursing so that they may be removed from the schedule immediately. Immediately schedule training programs in the facility to train ant additional staff members whose cardiopulmonary resuscitation card indicates on-line course or upon calling training school, a return demonstration was not provided and passed by the staff member. These programs will be AHA approved. (Cardiopulmonary resuscitation classes were scheduled for March 4, 2014, at 4:00 p.m., March 5, 2014, at 1:00 p.m. and 4:00 p.m., and March 6, 2014, at 7:00 a.m.).

24. 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:

a. The failure to accurately implement a resident's "Do Not Resuscitate" order.

b. The failure to provide appropriate and qualified staff to implement resuscitation services.

c. The failure to follow physician's orders to not resuscitate.

d. The failure to follow facility practice and procedure related to end of life decisions.

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 (2013).

COUNT III

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

28. Based upon Respondent's cited State Class I deficiency, it was not in substantial compliance at the time of the survey 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 (2013).

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 (2011) commencing March 4, 2014, and ending April 1, 2014.

COUNT V

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

of this Complaint as if fully recited herein.

30. That Respondent has been cited with a State Class I deficiency and therefore is subject to a six (6) month survey cycle for a period of two years and a survey fee of six thousand dollars ($6,000) pursuant to Section 400.19(3), Florida Statutes (2013).

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 (2013).

Respectfully submitted this 6 day of May, 2014.

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

DISPLAY OF LICENSE

Pursuant to § 400.23(7)(e), Fla. Stat. (2011), 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: 7008 0500 0001 9503 9249 on May 7, 2014, to Katherine A. Sherrill-Hager, Administrator, St. Petersburg Nursing Home LLC d/b/a Jacaranda Manor, 4250 66th Street North, St. Petersburg, Florida 33709, and by Regular U.S. Mail to NRAI Services, Inc., Registered Agent for St. Petersburg Nursing Home LLC, 1200 South Pine Island Road, Plantation, Florida 33324.

Thomas J. Walsh, II, Esquire

Copy furnished to: Patricia R. Caufman, Field Office Manager, Agency for Health Care Admin.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: St. Petersburg Nursing Home LLC **CASE NO. 2014003053**
d/b/a Jacaranda Manor

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed 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 must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed 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 (2006) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308.
Phone: 850-412-3630 Fax: 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 Fine or Fee, 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, the 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, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____ Fax No. _____ Email(optional)_____

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

Signed: _____ Date:_____

Print Name:_____ Title:_____

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 4, 2014

Katherine A Sherrill-Hager, Administrator
Jacaranda Manor
4250 66th St N
Saint Petersburg, FL 33709

File Number: 55229
License Number: 1252096
Provider Type: Nursing Home

RE: 4250 66th St N, Saint Petersburg

Dear Administrator:

The enclosed Nursing Home license with license number 1252096 and certificate number 18805 is issued for the above provider effective March 4, 2014 through October 14, 2014. The license is being issued for a status change to Conditional effective March 4, 2014.

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 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 850-412-4427 or by email at Kathleen.Munn@ahca.myflorida.com.

Sincerely,

K. Munn

Kathy Munn
Health Services and Facilities Consultant
Long Term Care Unit
Division of Health Quality Assurance

CERTIFICATE #: 18805 LICENSE #: SNF1252096

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

CONDITIONAL

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

JACARANDA MANOR
4250 66th St N
Saint Petersburg, FL 33709

TOTAL: 299 BEDS

Status Change

EFFECTIVE DATE 03/04/2014

EXPIRATION DATE: 10/14/2014

Deputy Secretary/Division of Health Quality Assurance

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 4, 2014

Katherine A Sherrill-Hager, Administrator
Jacaranda Manor
4250 66th St N
Saint Petersburg, FL 33709

File Number: 55229
License Number: 1252096
Provider Type: Nursing Home

RE: 4250 66th St N, Saint Petersburg

Dear Administrator:

The enclosed Nursing Home license with license number 1252096 and certificate number 18806 is issued for the above provider effective April 1, 2014 through October 14, 2014. The license is being issued for a status change back to Standard effective April 2, 2014.

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 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 850-412-4427 or by email at Kathleen.Munn@ahca.myflorida.com.

Sincerely,

K. Munn

Kathy Munn
Health Services and Facilities Consultant
Long Term Care Unit
Division of Health Quality Assurance

CERTIFICATE #: 18806

LICENSE #: SNF1252096

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION

DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

STANDARD

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

JACARANDA MANOR
4250 66th St N
Saint Petersburg, FL 33709

TOTAL: 299 BEDS

Status Change

EFFECTIVE DATE 04/01/2014

EXPIRATION DATE: 10/14/2014

Molly McKinstry

Deputy Secretary, Division of Health Quality Assurance

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: St. Petersburg Nursing Home LLC **CASE NO. 2014003053**
d/b/a Jacaranda Manor

ELECTION OF RIGHTS

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If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed 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 (2006) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

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

FILED
2014 MAY 19 P 3:44
AHCA
AGENCY CLERK

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 Fine or Fee, 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, the 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, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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.

EXHIBIT 2

It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: SNF (ALF? nursing home? medical equipment? Other type?)

Licensee Name: St. Petersburg Nursing Home, LLC License number: SNF 1252096

Contact person: Katherine Sherrill-Hagen, Administrator
Name Title

Address: 4250 66th St. N. St. Petersburg, FL 33709
Street and number City Zip Code

Telephone No. 727-546-2405 Fax No. 727-541-5154 Email(optional) jaadmi@gracehc.com

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

Signed: _____ Date: 5-16-14

Print Name: Katherine Sherrill-Hagen Title: Administrator

Late fee/fine/AC