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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

GV LAUDERHILL, LLC, d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

AHCA No. 2015000277
License No. 5113
File No. 11910377
Provider Type: Assisted Living Facility

IMMEDIATE MORATORIUM ON ADMISSIONS

THIS CAUSE came on for consideration before the Secretary of the Agency for Health Care Administration, or her duly appointed designee who, after a careful review of the matter at hand and being duly advised in the premises, finds and concludes as follows:

THE PARTIES

1. The Agency for Health Care Administration (hereinafter "the Agency"), is the governing authority responsible for the licensure and regulation of assisted living facilities in Florida and the enforcement of the applicable state statutes and rules governing assisted living facilities. Chs. 429, Part I, Fla. Stat., 408, Part II, Fla. Stat. (2014), Ch. 58A-5, Fla. Admin. Code. As part of its governing authority, the Agency may issue emergency orders when the circumstances dictate this type of action. §§ 120.60, 408.814, 429.14, Fla. Stat. (2014). The Agency has jurisdiction over the Respondent, GV Lauderhill, LLC d/b/a Grand Villa of Delray East (hereinafter "the Respondent"), an assisted living facility.

2. The Respondent was issued a standard license with extended congregate care specialty licensure by the Agency to operate a one hundred seventy (170) bed assisted living

facility located at 14555 Sims Road, Delray Beach, Florida, 33484 (hereinafter "the Facility"). § 429.11, Fla. Stat. (2014). As the holder of such a license, the Respondent is a licensee. "Licensee" means "an individual, corporation, partnership, firm, association, or governmental entity, that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2014). "The licensee is legally responsible for all aspects of the provider operation." Id. "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2014). § 408.803(11), Fla. Stat. (2014). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2014), and listed in Section 408.802, Florida Statutes (2014). § 408.802(13), Fla. Stat. (2014). Assisted living facility residents are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2014).

3. The Respondent holds itself out to the public as an assisted living facility that complies with the state laws governing assisted living facilities. These laws exist to protect the health, safety and welfare of the residents of assisted living facilities. As individuals receiving services from an assisted living facility, the residents are entitled to receive the benefits and protections under Chapters 120, 408, Part II, and 429, Part I, Florida Statutes (2014), and Chapter 58A-5, Florida Administrative Code.

4. As of the date of this Order, the census at the Respondent's Facility is one hundred sixty-six (166) residents/clients.

THE AGENCY'S EMERGENCY LICENSURE ACTION AUTHORITY

5. If the Agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license, the Agency may take such action by any procedure that is fair under the circumstances. § 120.60(6), Fla. Stat.

(2014).

6. The Agency may impose an immediate moratorium or emergency suspension of license order as defined in subsection 120.60, Florida Statutes, on any provider if the Agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client. § 408.814(1), Fla. Stat. (2014).

7. The Agency may deny, revoke, or suspend any license issued under Chapter 429, Part I, Florida Statutes, in the manner provided in Chapter 120, Florida Statutes, for any actions enumerated in Section 429.14, Florida Statues. § 429.14, Fla. Stat. (2014).

LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

Resident Rights

8. No resident of an assisted living facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from abuse and neglect … (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. § 429.28(1)(a), (j), Fla. Stat. (2014).

9. Rule 58A-5.023(3)(a), Florida Administrative Code, provides as follows:

> All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order

Resident Care Standards

10. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision, as appropriate for each resident, including the following: (a) Monitoring of

the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) Maintaining a written record, updated as needed, of any significant changes, any illnesses which resulted in medical attention, changes in the method of medication administration, or other changes which resulted in the provision of additional services. Fla. Admin. Code R. 58A-5.0182(1).

11. Florida law provides:

(1) ADMISSION CRITERIA.
(a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license:
1. Be at least 18 years of age.
2. Be free from signs and symptoms of any communicable disease that is likely to be transmitted to other residents or staff; however, an individual who has human immunodeficiency virus (HIV) infection may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule.
3. Be able to perform the activities of daily living, with supervision or assistance if necessary.
4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted.
5. Be capable of taking medication, by either self-administration, assistance with self-administration, or by administration of medication.
a. If the resident needs assistance with self-administration, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact.
b. The facility may accept a resident who requires the administration of

medication, if the facility has a nurse to provide this service, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident.
6. Not have any special dietary needs that cannot be met by the facility.
7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapter 490 or 491, F.S.
8. Not require 24-hour licensed professional mental health treatment.
9. Not be bedridden.
10. Not have any stage 3 or 4 pressure sores. A resident requiring care of a stage 2 pressure sore may be admitted provided that:
a. Such resident either:
(I) Resides in a standard licensed facility and contracts directly with a licensed home health agency or a nurse to provide care, or
(II) Resides in a limited nursing services licensed facility and services are provided pursuant to a plan of care issued by a health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
b. The condition is documented in the resident's record and admission and discharge log; and
c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility.
11. Not require any of the following nursing services:
a. Oral, nasopharyngeal, or tracheotomy suctioning;
b. Assistance with tube feeding;
c. Monitoring of blood gases;
d. Intermittent positive pressure breathing therapy; or
e. Treatment of surgical incisions or wounds, unless the surgical incision or wound and the condition that caused it, has been stabilized and a plan of care developed.
12. Not require 24-hour nursing supervision.
13. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C.
14. Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator must base the decision on:
a. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule;
b. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and
c. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in Section 429.41, F.S. and Rule Chapter 69A-40, F.A.C.

* * *

(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. ...

Fla. Admin. Code R. 58A-5.0181(1)(a) and (4).

THE AGENCY'S SURVEY FINDINGS

12. On January 5, 2015, the Agency commenced a survey of Respondent and its Facility.

13. Based upon this survey, the Agency finds, as found and set forth more specifically below, that the Respondent is in substantial non-compliance with the statutes and rules governing assisted living facilities.

14. A resident of the Facility, who is currently seventy-seven (77) years old, was admitted to the Facility in May 2014.

15. The resident's admitting Health Assessment[1] specifically identified the resident needed supervision with observation with all activities of daily living[2] except eating. In addition, the Health Assessment required "Safety Precaution" without further definition. The Health Assessment further directed that the resident receive physical therapy and occupational therapy.[3] The fifth page of this Health Assessment was completed by the Respondent's administrator noting that the resident needs observation daily by staff with activities of daily living. Absent from the records was any indication that the Respondent had sought guidance from the health

[1] *See*, § 429.26(4), Fla. Stat. (2014); Rule 58A-5.0181(2), Florida Administrative Code.
[2] *See*, § 42902(1), Fla. Stat. (2014) .
[3] There is no indication that the directed occupational therapy was coordinated by the Respondent or otherwise provided.

care provider on the scope or character of the safety precautions directed in the Health Assessment.

16. This particular resident suffered the following:

a. August 29, 2014 – Resident found on the floor bleeding from the arm and leg. The resident was transported to a hospital emergency department.

b. September 10, 2014 - The resident was found on the floor and suffered a skin tear which required first aid treatment.

c. October 22, 2014 – The resident's hand was injured by an elevator door while ambulating in the hallway without supervision

d. October 27, 2014 – The resident was found on the floor, having fallen while dressing. No injuries were noted.

e. December 14, 2014 – The resident was found lying on the back on the floor. The resident's walker was found on top of the resident's face, and the resident was bleeding from the face and head. The resident was transported to a hospital emergency department.

17. The resident had received physical therapy from a third-party home health agency from August 7, 2014, through September 3, 2014. The initial evaluation noted that the resident required "contact guard assistance with transfers," a term explaining that manual assistance in direct contact with the resident was required. The tenth visit of September 3, 2014, noted the resident's functional capacities and further noted that the resident could ambulate eighty (80) feet with contact guard.

18. The home health agency staff completed a form summarizing each visit and noting the resident/patient's capabilities, progress, and needs. A copy of this form is left with the

Respondent Facility after each visit. In addition, home health agency staff personally met with the Respondent's staff on a weekly basis reporting on the status of residents treated by the home health agency.

19. Though requested, the Respondent failed to produce these home health agency treatment summaries and evaluations during the survey.

20. The home health agency was again ordered by the resident's physician to evaluate the resident for physical therapy on December 29, 2014, noting the resident had suffered two (2) falls within the previous week.[4] This evaluation, conducted on December 30, 2014, noted that the resident required contact guard for toileting, showering, and transfer, and stand-by assist for ambulation.

21. Despite these numerous events, the Respondent had not conducted investigations of the incidents, evaluated the resident for necessary interventions to provide care and services appropriate to the resident's demonstrated needs, completed required incident reports,[5] or evaluated the resident to determine the resident's continued appropriateness as an assisted living facility resident.

22. The Respondent could not demonstrate any mechanism by which it provided the care and services the resident required as documented in the resident's Health Assessment or periodic reports from the home health agency.

23. A second resident, who was eighty-eight (88) years of age, had a Health Assessment dated December 16, 2014, which specifically required as a special precaution "Fall Precautions." The Health Assessment further denoted that the resident required assistance with all activities of daily living except eating, must ambulate with a walker, and use a walker for

[4] The Facility records did not reflect that the resident has suffered two falls within two weeks prior to this order for physical therapy.
[5] *See*, § 429.23(2), Fla. Stat. (2014).

transfer. Absent from the records was any indication that the Respondent had sought guidance from the health care provider on the scope or character of the Fall Precautions directed in the Health Assessment.

24. Approximately two (2) months ago, the resident suffered a fall when the resident tripped over a chair during transfer. The fall exacerbated the resident's recovery from recent shoulder surgery.

25. The Respondent had not evaluated the resident for necessary interventions to provide care and services appropriate to the resident's demonstrated needs, or evaluated the resident to determine the resident's continued appropriateness as an assisted living facility resident.

26. The Respondent could not demonstrate any mechanism by which it provided the care and services the resident required as documented in the resident's Health Assessment.

27. A third resident, ninety-six (96) years of age, had a Health Assessment dated November 19, 2014, directing as special precautions "Precautions against falls." The assessment further required supervision with ambulation. Absent from the records was any indication that the Respondent had sought guidance from the health care provider on the scope or character of the fall precautions directed in the Health Assessment.

28. The Respondent could not demonstrate any fall precautions that it had instituted to meet the resident's specified care and service needs, or any mechanism to assure the resident received supervision while ambulating.

29. Another resident's Health Assessment noted a physical limitation requiring a walker for mobility. In addition, "Fall Precautions" were directed, and assistance was required for all activities of daily living except eating. Absent from the records was any indication that

the Respondent had sought guidance from the health care provider on the scope or character of the Fall Precautions directed in the Health Assessment.

30. Agency personnel observed this resident ambulating with a walker independently without any apparent staff assistance on both December 22, 2014, and January 6, 2015.

31. The Respondent could not demonstrate any fall precautions that it had instituted to meet the resident's specified care and service needs, on any mechanism to assure the resident received assistance while ambulating.

32. Last, a resident's Health Assessment noted that the resident had weakness and gait dysfunction. "Fall Precautions" were directed, and supervision was required for ambulation, dressing, and transfer. Absent from the records was any indication that the Respondent had sought guidance from the health care provider on the scope or character of either the Fall Precautions or supervision directed in the Health Assessment.

33. Agency personnel observed this resident ambulating with a walker independently without any apparent staff supervision on both December 22, 2014, and January 5, 2015.

34. The Respondent could not demonstrate any fall precautions it had instituted to meet the resident's specified care and service needs, on any mechanism to assure the resident received supervision while ambulating.

35. The Respondent was cited for deficient practice regarding the failure to provide care and services appropriate to the needs of residents accepted for admission to the facility[6] on March 14, 2014. In this cited deficient practice, the Respondent failed to implement its procedures related to every two hour checks of a resident and failed to implement its policy and procedure related to the contact of emergency services. The resident, who had a history of suffering from falls, was ultimately found on the floor of the resident's room and had passed.

[6] *See*, Rule 58A-5.0182(1), Florida Administrative Code.

36. Prior to the March 14, 2014, survey, the Respondent had received a directed plan of correction by the Agency as a result of a previous survey of the Facility on or about January 13-14, 2014. Accordingly, it appears that the Respondent had not successfully implemented correction action by the time of the March 14, 2014, survey.

37. On June 16, 2014, the Agency determined that the Respondent had corrected this deficient practice.

38. The Respondent was again cited for deficient practice regarding the failure to provide care and services appropriate to the needs of residents accepted for admission to the facility[7] on September 19, 2014. Though identifying deficient practice related to a total of five (5) identified residents, two (2) factual findings illustrate the scope of the identified non-compliance. For the resident who had been admitted to the Facility on March 31, 2014, the admitting Health Assessment specifically required fall precautions. By September 17, 2014, the resident had suffered four (4) separate documented falls, three (3) of which required a transfer to a hospital emergency department for evaluation and or treatment. Despite this series of events, the Respondent could not identify any methodology or interventions implemented to provide fall precautions for the resident. Similarly, for a second resident who had been admitted to the Respondent facility on August 20, 2104, the admitting Health Assessment specifically required assistance with ambulation, bathing, and dressing, and further required supervision with toileting and transfers. By September 17, 2014, the resident had suffered four (4) separate documented falls. Despite this series of events, the Respondent could not identify any methodology or interventions implemented to provide additional supervision or assistance to address the resident's frequent falls.

39. These findings constitute sufficient factual and legal grounds justifying the

[7] *See*, Id.

imposition of an Immediate Moratorium on Admissions on the Respondent.

THE NECESSITY FOR THE IMMEDIATE MORATORIUM ON ADMISSIONS

40. The Agency is charged with the responsibility of enforcing the laws enacted to protect the health, safety and welfare of residents and clients in Florida's assisted living facilities. Ch. 429, Part I, Fla. Stat. (2014), Ch. 408, Part II, Fla. Stat. (2014); Ch. 58A-5, Fla. Admin. Code. In those instances where the health, safety or welfare of an assisted living facility resident is at risk, the Agency will take prompt and appropriate action.

41. Oftentimes, residents of assisted living facilities suffer from physical and/or emotional limitations which necessitate the attentiveness to or assistance of others to ensure their safety and ongoing well-being. Florida's regulatory scheme recognizes this by requiring that residents receive care and services *as appropriate to the residents' individual needs*. (Emphasis added).

42. The Respondent has demonstrated a failure to provide the care and services required by its residents to minimize the risk of falls. The facts reflect numerous occasions where the Respondent was aware of the supervision or assistance needs of residents with ambulation and transfer, yet failed to demonstrate any methodology to assure that these care and service needs are being provided to the residents. The Respondent failed to undertake actions necessary to meet the identified needs associated with those individuals susceptible to suffering a fall and, potentially, injury resulting from falls.

43. The Respondent has actual knowledge of the residents under its care who are at increased risk of falls. The residents' Health Assessments particularly require precautionary care and service needs. In several instances, this knowledge was supplemented with numerous documented falls suffered by these residents with no mention of the residents being supervised or

assisted when the falls occurred. In one instance, this knowledge is reiterated by a third party provider which specifically documents the resident's need for heightened hands-on supervision and assistance for certain activities. This knowledge has not resulted, however, in increased or directed care and services which would minimize fall risk. Interventions typically undertaken include, but are not limited to, directed safety awareness work with residents, increased levels of staff supervision, increased frequency of monitoring, bed alarms, and the use of call pendants.

44. One of the residents discussed from the most recent survey illustrates how this deficient practice places residents at immediate risk. An elderly resident suffered four (4) separate documented incidents of falling, three (3) resulting in documented injury to the resident; two (2) of those necessitating care from a hospital emergency department. Three (3) of these incidents occurred during a period in which the resident was also undergoing periodic physical therapy, the physical therapy provider specifically documenting and communicating to the Respondent the need of the resident to have heightened, often hands-on, care and services, to ensure safety during activities of daily living. Despite this overwhelming knowledge of the risks presented to this resident, the Respondent took no concentrated actions to ensure the safety of the resident.

45. The Respondent is aware of, and has documented notification from health care providers, that other residents suffer from increased risk for falls. The Respondent cannot, however, identify any action it has taken to assure that care and services appropriate to meet the particular needs of these residents.

46. Residents of assisted living facilities enjoy a right to a safe and decent living environment, free from abuse and neglect, and access to adequate and appropriate health care consistent with established and recognized standards within the community. § 429.28(1), Fla.

Stat. (2014). Licensees who undertake to provide care and services to residents of assisted living facilities must be diligent to ensure that the Facility has both the capability to meet its residents' needs and to ensure services particular to a resident, such as interventions to protect from falls, are in fact provided.

47. The Respondent has demonstrated its failure to meet these requirements. The Respondent had previously been cited for the failures to its resident supervision capacity. Any corrective action that the Respondent may or may not have undertaken has proven unsuccessful. The Respondent has not demonstrated that is has undertaken action to ensure that adequate care and services appropriate to the needs of a resident at risk of falls reside in a safe living environment.

48. No resident of an assisted living facility must suffer from known risks to safety which are not addressed by the provider which has been entrusted to the resident's care.

49. It may be that the Respondent cannot meet the care and service needs appropriate to one or several of its residents. In such cases, the Respondent has an affirmative obligation to discharge these residents to an appropriate provider. Fla. Admin. Code R. 58A-5.0181(4). Here, the Respondent has failed to demonstrate that it has ensured its residents continue to meet the minimum requirements for residence in its assisted living facility when care and services appropriate to resident needs are not being provided.

50. The Respondent's deficient practices are not isolated incidents. These particular types of deficient practices have existed in the recent past, exist presently, and more likely than not will continue to exist if the Agency does not act promptly. In particular, the Respondent has been cited for deficient practice based on its failure to provide care and services appropriate to meet the needs of residents on three (3) separate occasions within the past ten (10) months. If

the Agency were to stand idly by, it is very likely that the Respondent's conduct will continue. The failure to implement mechanisms to ensure that resident care and service needs are met, and to ensure that appropriate action is taken in response to known resident dangers, such as increased risk of falls, place potential residents in unnecessary peril.

51. No successful efforts to resolve the conditions addressed have been demonstrated by the Respondent.

52. An Immediate Moratorium on Admissions is necessary to protect potential residents from (1) the unsafe conditions and deficient practices that currently exist in the facility, (2) being placed at risk of living in an environment ill-equipped to provide for resident health, safety and welfare, and (3) being placed in an assisted living facility where the statutory and regulatory mechanisms enacted for their protection have been repeatedly breached.

CONCLUSIONS OF LAW

53. The Agency has jurisdiction over the Respondent, an assisted living facility in the State of Florida, pursuant to Chapter 408, Part II, Florida Statutes (2014), Chapter 429, Part I, Florida Statutes (2014), and Chapter 58A-5, Florida Administrative Code.

54. Based upon the above stated provisions of law and findings of fact, the Secretary concludes that the current conditions existing in the Respondent's Facility present a direct and immediate threat to the health, safety or welfare of current or potential residents and warrants an immediate moratorium on admissions.

55. The Agency expressly finds that exigent circumstances exist in this instance that warrant emergency action. This Immediate Moratorium on Admissions is the least restrictive means that the Agency can take against the Respondent to ensure the protection of the health, safety and welfare of the residents. The Agency has other remedies at its disposal, such an

emergency suspension order or emergency injunctive relief, which it may impose upon facilities that are in violation of the rules to such a degree that they present a direct and immediate threat to the health, safety or welfare of the residents. These remedies are more drastic than a moratorium or admissions. In choosing this less severe action, the Agency has taken into consideration all of the facts and circumstances of this matter as well as overall risk to resident wellbeing.

56. In addition, alternative remedies will not ensure immediate corrective action by the Respondent. The imposition of fines will not remedy the immediate risks presented by these conditions, including but not limited to the failure to ensure a safe and decent living environment with care and services provided appropriate to resident needs.

57. The Agency notes that it retains the right to impose a greater remedy, and will do so without hesitation, should the Respondent fail to act accordingly or the circumstances change.

IT IS THEREFORE ORDERED THAT:

58. The Respondent is placed under an **IMMEDIATE MORATORIUM ON ALL ADMISSIONS.**

59. The Respondent shall promptly post this Emergency Order on its premises in a place that is conspicuous and visible to the public.

60. The Respondent shall not admit any residents or readmit any prior residents at this Facility.

61. The Agency may monitor the conditions at the Respondent's Facility as needed after the issuance of this Emergency Order.

62. This Emergency Order shall continue in effect without limitation or interruption until further order of the Agency and shall run concurrently with any administrative actions. *See*,

§ 408.814(2), Fla. Stat. (2014).

63. The Agency will promptly file an administrative action against the Respondent based upon the facts set out in this Emergency Order and provide notice to the Respondent of the right to an administrative hearing when such action is taken.

ORDERED in Tallahassee, Florida, on this 9th day of January, 2015.

Elizabeth Dudek, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

This emergency order is a non-final order subject to facial review for legal sufficiency. See Broyles v. State, 776 So.2d 340 (Fla. 1st DCA 2001). Such review is commenced by filing a petition for review in accordance with Florida Rules of Appellate Procedure 9.100(b) and (c). See Fla. R. App. P. 9.190(b)(2). In order to be timely, the petition for review must be filed within thirty (30) days of the rendition of this non-final emergency order.

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

DELEGATION OF AUTHORITY
To Execute
Immediate Orders of Moratorium

I specifically delegate the authority to execute Immediate Orders of Moratorium to Molly McKinstry, Deputy Secretary, Health Quality Assurance, or her delegate.

This delegation of authority shall be valid from date of October 1, 2010, until revoked by the Secretary.

Elizabeth Dudek
Elizabeth Dudek, Secretary

April 4, 2011
Date

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