STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA No. 2016007836
License No. 11955
File No. 11967955
Provider Type : Assisted Living Facility

SNR 23 GRACE MANOR LEASING, LLC, d/b/a GRACE MANOR ASSISTED LIVING AND MEMORY CARE,

Respondent.
_____/

EMERGENCY SUSPENSION ORDER AND 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 careful review of the matter at hand and being otherwise fully advised, finds and concludes as follows:

THE PARTIES

1. The Agency for Health Care Administration (hereinafter "the Agency"), is the licensure and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state statutes and rules governing assisted living facilities. Chs. 408, Part II, and 429, Part I, Fla. Stat. (2015), Ch. 58A-5, Fla. Admin. Code. As part of its statutory oversight responsibilities, the Agency has the authority to impose emergency orders, including a limitation of license, a moratorium on admissions and an emergency suspension order, when circumstances dictate such action. §§ 120.60(6), 408.814, Fla. Stat. (2016).

2. The Respondent, SNR 23 Grace Manor Leasing LLC d/b/a Grace Manor Assisted Living and Memory Care (hereinafter "the Respondent"), was issued a license by the Agency

(License Number 11955) to operate a fifty-four (54) bed assisted living facility (hereinafter "Facility") located at 1321 Herbert Street, Port Orange, Florida 32129, and was at all material times required to comply with the applicable statutes and rules governing such facilities.

3. 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. (2016). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2015). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2015). § 408.803(11), Fla. Stat, (2016). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2016), and listed in Section 408.802, Florida Statutes (2015). § 408.802(13), Fla. Stat. (2016). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2016). The Respondent holds itself out to the public as an assisted living facility that fully complies with state laws governing such providers.

4. The Respondent holds itself out to the public as an assisted living facility that complies with the 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, these residents are entitled to receive the benefits and protections under Chapters 120, 408, Part II, and 429, Part I, Florida Statutes (2016), and Chapter 58A-5, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the census at the Respondent's Facility is fifty-two (52) residents/clients.

THE AGENCY'S EMERGENCY ORDER AUTHORITY

6. The Agency may impose an immediate moratorium or emergency suspension as defined in section 120.60, Florida Statutes (2016), 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. (2016). 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. (2016).

LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

7. Under Florida law, "No resident of a 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) [l]ive in a safe and decent living environment, free from abuse and neglect; (b) [b]e treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy; and . . . (j) [a]ccess to adequate and appropriate health care consistent with established and recognized standards within the community." § 429.28(1), Fla. Stat. (2016):

8. Under Florida law, all assisted living facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), Florida Statutes. Fla. Admin. Code R. 58A-5.023(3)(a).

9. Under Florida law, 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).

10. Under Florida law, every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Chapters 408, Part II, 429, Part I, F.S. and Rule Chapter 59A-35, F.A.C., and this rule chapter. Rule 58A-5.019(1), Florida Administrative Code.

FACTS JUSTIFYING EMERGENCY ACTION

11. On or about July 9, 2016, the Agency completed a survey of the Respondent's Facility.

12. Based upon this investigation, the Agency makes the following findings:

a. A male resident of the Facility was admitted on May 11, 2016, from another health care facility.

b. The Respondent's administrator indicates the transferring facility had informed her that the resident was "touchy feely with staff, not residents." Respondent's administrator also indicated that she, not a health care professional, completed the resident's Health Assessment, Form 1823, a document utilized by assisted living facilities to assess whether the facility has the services and personnel sufficient to meet the resident's needs. This form identified this resident as suffering from dementia and behavioral disturbances. The resident's cognitive status was identified as "Calm."

c. In late May or early June, 2016, this male resident was found in the room of a female resident. The male resident was in the bed with the female resident, the female resident unclothed from the waist down.

d. The female resident, who suffers from some cognitive deficits, nonetheless recalls the event. The female resident explains that the male resident had, prior to June 2, 2016, inappropriately touched the resident, exposed himself to the resident, and verbally invited the resident to engage in sexual activity. None of this activity was invited by the female resident who repeatedly declined the male resident's advances. On June 2, 2016, the male resident proceeded despite the female resident's declinations. The female resident described the event as "terrible."

e. Respondent's staff member who witnessed this event had responded to the female resident calling out. After addressing the immediate situation, this staff member informed Respondent's Assistant Health and Wellness Director (hereinafter "AHWD") of the event.

f. On June 2, 2016, the advanced registered nurse practitioner (hereinafter "ARNP") for the male resident visited the Facility and the resident. The ARNP was told of the above referenced event by a Facility nurse. The ARNP consulted with Respondent's AHWD regarding the event, directing that the families of the involved be notified. The AHWD indicated to the ARNP that the incident had been reported.

g. The ARNP noted in the male resident's records that the resident had a diagnosis of "Sex addiction."

h. Respondent's records for these two involved resident records are silent as to the events of late May or early June 2016. There is no indication that any services, including but not limited to physical or psychological assessment of the female resident after suffering this event, was sought or occurred. There is no indication that the family members of the residents were notified of the event. There is no indication that law enforcement was notified of the event. There is no indication that Florida's Department of Children and Families, Adult Protective Services, was notified of the event.

i. Respondent's administrator, who admits learning of the event on June 3, 2016, confirms that no internal investigation was conducted by Respondent regarding this event, that there was no documentation regarding the event, and that she had not reported the event to third parties.

j. On June 3, 2015, the physician for the male resident visited the resident for the first time. The physician was told of the events of late May or early June, 2016. The physician informed Respondent's AHWD that the male resident

needed close monitoring and a psychiatric evaluation.

k. Respondent's staff, including Respondent's administrator and AHWD, do not report that any intervention was devised or implemented to address the male resident's behaviors or to protect other residents from those behaviors. There is no indication that the psychiatric services directed by the physician were sought for the resident.

l. A second female resident reported that this same male resident had started entering her room soon after the male resident's admission to the Facility. The male resident inappropriately touched the resident, including reaching into her garment to touch her breast. Cupping his genitals, the male resident verbally propositioned the female resident, who declined and demanded the male resident leave.

m. This female resident reported the event to her family members, who on turn reported the event to Facility personnel. In response, the family members were informed that the male resident had been moved and therefor their concerns were calmed.

n. In fact, the male resident was moved to another room on June 4, 2016. Respondent's administrator denies knowledge of this event and asserts the male resident was moved for financial purposes. Similar to the June 2, 2016, event, respondent's records lack any documentation of the event reported by the female resident's family member, any investigation of the allegation, or any reporting to state or local authorities.

o. On June 20, 2016, a staff member of Respondent responded to the yell of a

third female resident. The staff member found the male resident unclothed in the bed of this female resident, the female unclothed below the waist.

p. The staff member, after addressing the immediate situation, informed Respondent's AHWD of the event the staff member had just witnessed. This staff member reports that in response to the staff member's actions to redirect the male resident, he responded "I am a man and I have needs."

q. Respondent's AHWD reports she sought explanation from the male resident, but he was not responsive. The AHWD documented in the male resident's records that the male resident had been found in a female resident's room after staff responded to the female resident's yell. The note indicated the female resident was watching television and that there was no indication of "contact or inappropriate behavior." The note continues that the male resident's relative was contacted to tell the family to pick up the male resident as his "behavior was alarming." The note omits any indication of the state of undress by either of the residents or the facts recited by the witnessing staff member.

r. Respondent's AHWD did not immediately report this event to the physician or family members of the individuals involved. The female resident's family member was told several days later, during the family member's visit to the Facility, that another resident had exposed himself to the female resident, though no physical contact was made. The family member was further informed the resident had been discharged from the Facility, which assuaged the family member's immediate concerns.

s. Staff members of the Facility report several incidents when this male resident was observed inappropriately kissing or touching residents. The staff members further report that these incidents were reported by the staff members to Respondent's administrator or AHWD.

t. Respondent's administrator and AHWD confirm that they had heard complaints of the inappropriate behaviors of this male resident, but no documentation of the complaints was made, no investigation conducted, no family or physicians notified, and no interventions designed or implemented.

u. After having been removed from the Facility by his sister on June 20, 2016, the resident returned to the Facility. The date is unclear, though medication records reflect the resident received his prescribed medications on June 28, 2016.

v. Respondent's staff report that they were told to lock residents in their rooms at night beginning sometime during the week of June 28, 2016. The purpose announced by Respondent's administrator was to keep this male resident out of other residents' rooms.

w. While some residents were capable of unlocking their room doors, many did not possess the physical or cognitive ability to do so. In addition to wrongly confining residents to their rooms, this practice could prove catastrophic in the event of an emergent situation.

x. On July 5, 2016, the male resident was issued a "Notice of Discharge," indicating the resident had forty-five (45) days to relocate from the Facility. The listed reason for this action was that the resident no longer meets

residency criteria for the assisted living facility. The document memorializes that the resident's inability to control his sexual urges place other residents at risk. The document further memorializes that should the male resident return to the Facility, a sitter would be required twenty-four (24) hours daily.

y. The male resident remained on site on July 7, 2016. No sitter was monitoring the resident. Respondent's staff were not maintaining one-to-one supervision of the resident. The resident candidly admitted to Agency personnel his behaviors directed toward female residents of the Facility.

z. During this same period, the spouse of another male resident reported that a female resident repeatedly entered the male resident's room, watch the resident in private acts, and inappropriately touch the male resident. The male resident lacks the cognitive capabilities to prevent such intrusions.

aa. The spouse of the male resident had reported this behavior by the female resident to Respondent's AHWD "about a dozen times."

bb. During the morning of July 8, 2016, the spouse found the female resident in her spouse's room, the female sitting on the toilet disrobed from the waist down. The spouse reported this event to Respondent's administrator. The spouse reports the administrator's response to her complaint was "I don't have a problem; you do."

cc. Respondent's policy and procedure entitled "Abuse, Fraud, and Wrongdoing" provides, inter alia, that "the community takes all reasonable steps to prevent resident abuse and neglect." Further, the policy requires that upon receipt of a report of abuse, fraud, or other wrongdoing, four steps will be undertaken.

First, the administrator is notified. Second, any urgent medical or safety issues are to be immediately addressed. Third, the administrator or designee initiates an investigation. And lastly, the resident's responsible party is notified.

dd. Though this policy was produced near the end of the Agency's on-site activity, Respondent's administrator, AHWD, and direct caregiving staff admit that they were unaware of the policy and its provisions.

ee. Respondent's direct care staff were trained on abuse and neglect via an automated training program. The curricula included definitions of the relevant terminology and directs that reporting of abuse or neglect must be done in accord with the individual facility's procedure.

ff. Respondent's caregiving staff appropriately verbalized definitions of abuse, neglect, etc., and continue to describe the only reporting mechanism is to notify Respondent's administrator or AHWD. All caregiving staff indicate that they have routinely reported all observed inappropriate behaviors of the sexual active male resident to the administrator or AHWD.

gg. The Facility lacked prominently displayed notifications containing phone numbers and information related to reporting abuse and neglect to state or local officials including the Ombudsman Program and Florida's Department of Children and Families, Adult Protective Services. The posting of this information is required by law. *See*, § 429.28(2), Fla. Stat. (2016).

NECESSITY FOR EMERGENCY ACTION

13. 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. (2016), Ch. 408, Part II, Fla. Stat. (2016); 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.

14. The residents of assisted living facilities enjoy a statutorily enacted Bill of Rights which mandates that assisted living facilities provide a safe and decent living environment, free from abuse and neglect. An assisted living facility must protect these resident rights, including the provision of a safe and decent living environment. § 429.28, Fla. Stat. (2016); Fla. Admin. Code R. 58A-5.023(3)(a). The residents that reside in assisted living facilities oftentimes suffer from disease or disability. They typically consist of the frail, elderly or vulnerable. By law, the Respondent has been licensed and entrusted to provide care and services to this class of people, and as such, must comply with the statutes and rules that have been enacted for the special needs of these residents.

15. In this instance, the Respondent has failed to ensure that these minimum requirements of law are being met. Respondent had actual knowledge of a resident who repeatedly engaged in inappropriate sexual behaviors with female residents of the Facility, yet took no action to address these behaviors. Despite this knowledge, Respondent took no action to ensure that these behaviors were treated and took no action to protect the remaining resident census from these ongoing behaviors.

16. As a result, the residents' right to be free from abuse or neglect in an assisted living facility has been violated. Respondent, rather than take action, knowingly allowed this individual to continue unmonitored and unsupervised, resulting in untold numbers of females being subject to inappropriate uninvited sexual behavior in their own homes. Particularly at risk

were those residents who lack the cognitive or physical capabilities to protest. The sole demonstrable action Respondent took was to move the male resident's room, and then, after numerous reported events, respond by locking these vulnerable residents in their own rooms, further depriving them of their rights and dignity, and placing them on harm's way should an emergent condition arise.

17. In addition, the male resident was deprived of the care, services, supervision and medical services his physical or emotional conditions required. This failure is best illustrated by Respondent's failure to obtain the psychological evaluation and personal monitoring directed by the resident's physician. Respondent provided no services to this male resident which would have addressed his known inappropriate and dangerous behaviors.

18. This inaction not only did nothing to address an ongoing and known threat, Respondent further turned a blind eye to the health and well-being of those residents known to have been victimized by these inappropriate behaviors. Contrary to the requirements of law, Respondent failed to notify the responsible parties of and physicians of residents who suffered from the advances of this resident. No physical or psychological evaluation of the victimized residents was undertaken. Any aftercare needs these resident may have had have gone unfulfilled.

19. Respondent's inaction in the face of known sexually inappropriate or assaultive behaviors directed by residents toward other residents is not isolated. Similar behaviors between two residents was reported by a family member several times. Respondent could demonstrate no response to these allegations and Respondent's administrator expressed a callous disregard to the situation presented.

20. These events demonstrate Respondent's failure to understand and implement its

legal obligation to provide care and services, including personal supervision, appropriate to the needs of residents entrusted to Respondent's care. These events demonstrate Respondent's failure to understand and implement its obligation to ensure the living environment of its Facility be a safe and decent living environment including one where resident's entrusted to Respondent's care are not in danger from physical assault. These events demonstrate Respondent's failure to understand and implement its legal obligation to notify resident health care providers and family or responsible parties of significant events impacting a resident.

21. It is clear that the events described herein are merely a symptom of a Facility which lacks any substantive means by which it can identify, report, and prevent resident abuse, neglect, or exploitation. The Facility lacks a functional system for the reporting of abuse, neglect, or exploitation. The Facility lacks any understanding of the need to address physical or emotional impact on the victim of abuse, neglect, or exploitation, the failure of which may constitute neglect. The Facility lacks a cogent understanding of a resident's right to personal dignity, individuality, and privacy.

22. Residents are not provided a safe and decent living environment where these basic protections are not provided. This systemic failure is clearly demonstrated where, as in this Facility, no member of the staff, including its administrator an AHWD, were aware of Respondent's own policy and procedure related to abuse and neglect. While direct care staff identify and report incidents of abuse or neglect to Facility management, no further action is taken. When a family member reports allegations of abuse, management turns a blind eye. As such, the protections of Respondent's policy and procedure are rendered moot and are not being implemented within the Respondent Facility.

23. In each event identified, Respondent undertook no action to investigate,

undertook no action to notify resident responsible parties and physicians of these significant events, and undertook no action to investigate the report. As a result, no causation can be identified, no interventions to prevent recurrence could be weighed or implemented, no assessment for required medical or psychological services are completed, and resident families and physicians are robbed of the information they deserve to ensure the health, safety, and well-being of their family members and patients, respectively. Respondent has promulgated a policy and procedure on abuse which has been wholly ignored.

24. The administrator of an assisted living facility is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. *See*, Rule 58A-5.019(1), Florida Administrative Code. Respondent's administrator has clearly failed ensure its staff, including herself, has provided appropriate care, services, and supervision to residents. Resident rights, recognizing abuse, neglect, or exploitation, the reporting of violations, and systems to respond to incidents, are not evident at any level in Respondent's operations. The existence of this vacuum falls squarely within the purview of Respondent's Administrator.

25. The Respondent's deficient conduct is widespread and permeates the Facility thus placing in jeopardy the health, safety and welfare of all of the current residents and potential future residents. The Respondent has known or should have known about the existence of these deficient practices related to the assurance of a safe and decent living environment for all residents.

26. Individually and collectively, these facts reflect that the residents of this Facility are not currently residing in a safe and decent living environment free from abuse and neglect. § 429.28(1)(a) and (b), Fla. Stat. (2015). No resident of an assisted living facility should be placed

or maintained in such an environment. The Legislature created the Assisted Living Facilities Act. §§ 429.01, et seq., Fla. Stat. (2015). "The purpose of this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decision making ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state, . . . to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of several state agencies. § 429.01(2), Fla. Stat. (2015).

27. The Respondent's deficient practices exist presently; have existed in the past, and more likely than not will continue to exist if the Agency does not act promptly. If the Agency does not act, it is likely that the Respondent's conduct will continue.

28. An Emergency Suspension of the Respondent's license to operate this facility and an Immediate Moratorium on Admissions during the interim period between the entry of this order and the effective date of the suspension is necessary in order to protect the 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 because of systemic failures intended to protect from abuse and neglect and resident care, service, and supervision deficiencies, 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

29. Based upon the above stated provisions of law and findings of fact, it is concluded

that the current conditions in the Respondent's Facility present a direct and immediate threat to the health, safety or welfare of the residents and warrants the suspension of the Respondent's license to operate this assisted living facility and an immediate moratorium on admissions.

30. The Agency expressly finds that exigent circumstances exist in this instance that warrant emergency action. The emergency action taken by the Agency in this particular instance is fair under the circumstances and the least restrictive action that the Agency could take given the set of facts and circumstances of this particular matter. The assessment of administrative fines or other administrative remedies would not protect the residents or potential residents of the Respondent facility from the immediate ongoing dangers existing in the Facility.

31. This Emergency Suspension Order is the least restrictive means that the Agency could take against the Respondent to ensure the protection of the health, safety and welfare of residents. The remedy of emergency license suspension is tailored to address the specific harm in this instance. A moratorium on admissions by itself would not alleviate the serious concerns presented with this Facility.

32. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code.

33. Each resident of an assisted living facility has the statutory right to live in a safe and decent living environment. § 429.28(1)(a), Fla. Stat. (2016).

34. Based upon the above stated provisions of law and findings of fact, the Agency concludes that: (1) an immediate serious danger to the public health, safety, or welfare presently exists at the Respondent's Facility which justifies an immediate moratorium on admissions to Respondent's Facility, and (2) the present conditions related to the Respondent and its Facility present a threat to the health, safety, or welfare of a resident, which requires an immediate

moratorium on admissions.

35. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an Immediate Moratorium on Admissions to Respondent's Facility is necessary in order to protect the residents from (1) the unsafe conditions and deficient practices that currently exist, (2) being placed at risk of living in an environment ill-equipped to provide for resident health, safety and welfare because of systemic failures intended to protect from abuse and neglect and care, services, and supervision deficiencies, and (3) being placed in an assisted living facility where the regulatory mechanisms enacted for residents protection have been repeatedly overlooked.

36. The Respondent's deficient practices exist presently and will more likely than not continue to exist if the Agency does not act promptly. If the Agency does not act, it is likely that the Respondent's conduct will continue. In addition to the failures in care, services and supervision identified, Respondent's subsequent inaction in failing to evaluate and address the events illustrate Respondent's inability or unwillingness to appreciate the potential dangers of its deficient practices, be they personnel or procedure related. Such deficient practices and conditions justify the imposition of an Emergency Suspension of Licensure and Immediate Moratorium on Admissions. Less restrictive actions, such as the assessment of administrative fines, will not ensure that the current residents or future residents receive the appropriate care, services, and environment dictated by Florida law.

37. The emergency action taken by the Agency in this particular instance is fair under the circumstances and the least restrictive action that the Agency could take given the set of facts and circumstances of this particular matter. This remedy is narrowly tailored to address the specific harm in this instance.

IT IS THEREFORE ORDERED THAT:

38. The Respondent's license to operate this assisted living facility is **SUSPENDED** effective July 26, 2016 at 5:00 p.m.

39. An **IMMEDIATE MORATORIUM ON ADMISSIONS** is imposed upon entry of this order.

40. Upon receipt of this order, the Respondent shall post this Order on its premises in a place that is conspicuous and visible to the public.

41. As of the effective date and time of the suspension, the Respondent shall not operate this assisted living facility.

42. The Agency shall promptly file an administrative action against the Respondent based upon the facts set out in this Emergency Suspension Order and provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2016), at the time that such action is taken.

ORDERED in Tallahassee, Florida, this 11 day of July, 2016.

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
Emergency Suspension Orders

I specifically delegate the authority to execute Emergency Suspension Orders 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

2727 Mahan Drive, MS#1
Tallahassee, Florida 32308

Visit AHCA online at
AHCA.MyFlorida.com

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