

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
ARCA
AGENCY CLERK

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

2017 JUN -6 A 9:35

Petitioner,

vs.

2916 HABANA WAY OPERATIONS, LLC d/b/a
HABANA HEALTH CARE CENTER,

Case Nos. 2016006807
License No. 15500962
File No. 62914

RENDITION NO.: AHCA-17 - 04 03-S-0LC

Respondent.

FINAL ORDER

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

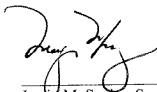
1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1). The parties have since entered into the attached Settlement Agreement, which is adopted and incorporated by reference into this Final Order. (Ex. 2)

2. The Respondent shall pay the Agency \$1,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

3. Conditional licensure status is imposed on the Respondent beginning May 12, 2016, and ending June 12, 2016.

ORDERED at Tallahassee, Florida, on this 5 day of June, 2017.



Justin M. Senior, Secretary

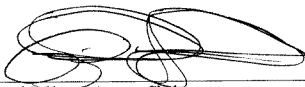
Agency for Health Care Administration

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 6 day of June, 2017.



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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Thomas J. Walsh II, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Carly M. Bradlow, Esq. 5102 West Laurel Street, Suite 700 Tampa, FL, 33607 (U.S. Mail)

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION**

**STATE OF FLORIDA AGENCY FOR
HEALTH CARE ADMINISTRATION,**

Petitioner,

AHCA CASE NO.: 2016006807

License No.: 15500962

vs.

**2916 HABANA WAY OPERATIONS, LLC d/b/a
HABANA HEALTH CARE CENTER,**

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 2916 Habana Way Operations, LLC d/b/a Habana Health Care Center (hereinafter Respondent), pursuant to Section 120.569, and 120.57, Florida Statutes, (2016), and alleges:

NATURE OF THE ACTION

This is an action to change Respondent's licensure status from Standard to Conditional commencing May 12, 2016 and ending June 12, 2016 and to impose an administrative fine of one thousand dollars (\$1,000.00), based upon one uncorrected cited State Class III deficiency.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60 and 400.062, Fla. Stat. (2016).
2. Venue lies pursuant to Fla. Admin. Code R. 28-106.207.

PARTIES

3. The Agency is the regulatory authority responsible for licensure of nursing homes and enforcement of applicable federal regulations, state statutes and rules governing skilled

EXHIBIT 1

nursing facilities pursuant to the Omnibus Reconciliation Act of 1987, Title IV, Subtitle C (as amended); Chapter 400, Part II, Fla. Stat. (2016), and Fla. Admin. Code R. 59A-4, respectively.

4. Respondent operates a one hundred fifty (150) bed nursing home located at 2916 Habana Way, Tampa, Florida, and is licensed as a skilled nursing facility, license number 15500962.

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

COUNT I

6. 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. (2016).

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. (2016).

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

10. That on March 24, 2016, the Agency completed a survey of the Respondent facility.

11. That based upon the review of records, observation, and interview, Respondent failed to ensure the provision of adequate and appropriate health care consistent with established and recognized practice standards within the community, and or failed to follow physician's orders, related to related to wound care and infection control, the same being contrary to the mandates of law.

12. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted a physician's interim order, dated March 15, 2016, prescribing Bactroban 2% topical ointment apply 1 applicatorful by topical route 2 times per day N/S (normal saline) cleanse sacral wound apply bactroban bid and cover with dcd (dry clean dressing).

13. That Petitioner's representative reviewed on March 24, 2016 at 11:30 a.m. wound care provided to resident number one (1) and noted as follows:

- a. The nurse, Respondent's staff member "A," had already set up a cart with a barrier and supplies, prior to the start of the scheduled observation.
- b. The nurse washed her hands secured a red bag for discarded waste onto the end of the table.
- c. She stated she gave the resident a pain medication 30 minutes ago, so the resident would not be in pain during the dressing change.
- d. The Director of Nurses (DON) came into the room to assist.

- e. The nurse washed her hands, gloved, shut the curtain then re-gloved without washing her hands. The DON put gloves on.
 - f. The resident was lying on the right side.
 - g. When the sheet was removed, the resident's buttocks was exposed with an open wound in the sacral area with undermining.
 - h. There was no dressing in place.
 - i. The nurse stated that when she and the certified nursing assistant put the resident back to bed to prepare for the dressing change, the resident had a bowel movement (BM) resulting in the soiling of the gauze dressing therefore the dressing was removed.
 - j. The nurse proceeded to cleanse the wound with normal saline and gauze three times.
 - k. The nurse then washed her hands, re-gloved, and used an applicator to apply ointment, from a med cup (prepared prior to dressing change), to the undermining area of the wound.
 - l. The nurse then picked up the border gauze, which was out of its packaging, peeled off the backing to expose the tape and gauze.
 - m. While doing this the nurse touched the middle part of the gauze.
 - n. The nurse continued to cover the wound with the border gauze, secured the call light in place, and discarded the waste in the red bag.
9. That Petitioner's representative interviewed nurse "A" at 11:45 a.m., after the wound care was completed, and the nurse stated she did not realize she touched the gauze.
10. That Petitioner's representative reviewed Respondent's policy and procedure entitled "The Dressing Change policy, N-1310," with an effective date of 11/30/2014, which recited: "A clean dressing will be applied to an open wound as ordered to promote healing."

11. That the above reflects Respondent's failure to ensure the provision of adequate and appropriate health care consistent with established and recognized practice standards within the community, and or failed to follow physician's orders, related to wound care and infection control.

12. That the Agency determined that this deficient practice will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services and cited Respondent for a patterned State Class III deficiency.

13. That Florida law requires the correction of a cited deficiency within thirty (30) days. *See*, § 408.811(4), Florida Statutes (2016).

14. That on May 12, 2016, the Agency completed a re-visit to the March 2016 survey of the Respondent facility.

15. That based upon the review of records, observation, and interview, Respondent failed to ensure the provision of adequate and appropriate health care consistent with established and recognized practice standards within the community, and or failed to follow physician's orders, related to related to wound care and infection control, the same being contrary to the mandates of law.

16. That Petitioner's representative reviewed Respondent's records related to resident number two (2) during the survey and noted as follows:

- a. The resident is eighty-nine (89) years old and has resided at the facility for four (4) years.

- b. A progress note dated May 10, 2016, by an advanced registered nurse practitioner documented the reason for the appointment was to follow up on wound healing and comorbidities.
- c. Under the history of present illness, the record reflects: "The patient is being followed routinely for wound healing. The patient's wound appears to have worsened - treatment adjusted accordingly. We will continue to make adjustments pending the progress of the wound. The patient has multiple comorbid conditions affecting wound healing."
- d. Treatment: Pressure ulcer of sacral region stage 3. Stop BACTROBAN, apply to wound bed, BID Start Collagen dressing, as directed, apply to affected area, daily. 2. Incontinent without sensory awareness. Notes: Keep skin clean and dry to prevent further skin breakdown as the facility does.
- e. The Wound Form dated May 10, 2016, under the heading peri-wound, documented "maceration." Progress: "Worse."

17. That Petitioner's representative observed wound care provided to resident number two (2) on May 12, 2016 at 10:45 a.m. and noted as follows:

- a. Respondent's staff member "A," a certified nursing assistant, was observed providing care.
- b. Staff member "A" indicated she has cared for the resident for some time and was preparing the resident for wound treatment.
- c. She had checked the resident's brief and added that she had already provided perineal care earlier in her shift.

- d. The resident does not verbalize her needs to the staff.
 - e. She began repositioning the resident on the right side when the resident's coccyx wound was noted without a dressing in place.
 - f. When asked about the lack of dressing, staff member "A" stated that "[the resident] did not have a dressing on in the morning (at approximately 7:00 a.m.) when I first had checked []," and further stated, "It must have come off during the 11-7 shift."
 - g. During the time staff member "A" provided care, the resident appeared comfortable and in no distress.
18. That Petitioner's representative observed wound care provided to resident number two (2) on May 12, 2016 at 11:20 a.m. and noted as follows:
- a. Respondent's mini data collection nurse "B" (MDS B) placed a white piece of paper on top of the treatment cart and stated out loud that it was the Facility's policy and procedure on dressing changes.
 - b. She then proceeded to place the following supplies on top of the piece of paper: One sealed package of collagen, one 4 x 4 adhesive bordered gauze dressing, 5 pre-filled vials of normal saline, one red biohazard bag and a bulk stack of 4 x 4 gauze pads.
 - c. She entered the resident's bedroom and placed a barrier on top of the bed side table followed by treatment supplies.
 - d. The resident was still observed lying on the right side in the bed and appeared comfortable and in no distress.

- e. MDS B was observed washing her hands and applying clean gloves.
- f. She returned to the bedside where Respondent's assistant director of nursing (ADON) was present.
- g. "MDS B" removed the resident's brief and revealed the coccyx/sacral area which still remained without a dressing in place.
- h. "MDS B" was asked why the resident did not have a dressing in place and she replied that staff member "A" had told her that "the dressing came off during the brief change at 11:05 a.m."
- i. "MDS B" applied normal saline to one of the 4 x 4 gauze dressing and cleansed the coccyx/ sacral area with her right hand.
- j. She then picked up a clean gauze with her right hand and lightly pated the area dry.
- k. The wound bed was observed to be the size of a pencil eraser tip.
- l. The wound bed and the surrounding skin were observed white in color thus indicating maceration.
- m. The "MDS B" immediately picked up the collagen with her right gloved hand and applied it to the wound bed followed by the adhesive bordered gauze.
- n. She then picked up the red biohazard bag and tied it to close.
- o. The ADON the "MDS ZB" repositioned the resident in bed and re-attached the brief.
- p. After she had covered the resident with a blanket, "MDS" B removed her gloves and disposed of them in the garbage can.
- q. "MDS B" picked up the red biohazard bag and left the bed room.

- r. "MDS B" was observed outside of the soiled utility room using her right hand as she punched a code on the key pad.
- s. She then used her right hand and turned the door knob as she entered the soiled utility room.
- t. The red biohazard bag was placed into a red canister.
- u. "MDS B" was then observed going to the charting room, punching a code on the key pad, and entering the charting room.
- v. After entering the charting room, "MDS B" washed her hands.

19. That Petitioner's representative reviewed the electronic Treatment Administration Record (TAR) for resident number two (2) and noted it did not document that wound care had been provided to the resident on May 9, 10, or 11, 2016.

20. That Petitioner's representative interviewed Respondent's director of nursing regarding resident number two (2) on May 12, 2016, and the director indicated as follows:

- a. 4:00 p.m. - She reviewed the electronic TAR and confirmed that on May 9, 10, and 11, 2016, the TAR was not initialed that the treatment had been provided.
- b. 4:30 p.m. - She had spoken with Respondent's licensed practical nurse "J" who on May 11, 2016, had a family emergency, left the Facility early, and did not document care and treatment in the TAR.
- c. Staff member "J" also worked on May 9 and 10, 2016.
- d. Upon review of the resident's TAR, the director indicated that. "[LPN J] is a new nurse and she did not do the treatment because the wound had healed."

21. That this statement by Respondent's director of nursing is not supported by the medical records and observation of the wound care treatment for resident number two (2).

22. That Petitioner's representative reviewed Respondent's records related to resident number eight (8) during the survey and noted as follows:

- a. The resident was ninety-four (94) years old and had been admitted to the Facility in 2015 for a short-term rehabilitation.
- b. The diagnosis sheet noted a pathological fracture, history of falling and pressure ulcer of left heel unstageable.
- c. A physician order dated May 11, 2016 provided: Cleanse left heel with normal saline, pat dry, then apply santyl cover with gauze and wrap with kerlix twice a day.
- d. The resident's medication administration record documented an order for antibiotic therapy for the left heel: administer doxycycline 100 mg tablet two times a day for 6 weeks. DX; Unspecified open wound, left foot, subsequent encounter.

23. That Petitioner's representative observed wound care provided to resident number eight (8) on May 12, 2016 at 11:35 a.m. and noted as follows:

- a. Respondent's registered nurse staff member "C" was outside of the resident's bedroom preparing the supplies that were needed for the dressing change and placing them on top of a barrier that was placed on the treatment cart.
- b. The supplies included a stack of 4 x 4 bulk gauze, normal saline, santyl ointment that was inserted into a soufflé cup and a red biohazard bag.

- c. The nurse then removed a pair of everyday scissors from the treatment cart and placed them on the right side of the carts surface (not on the barrier).
- d. Staff member "C" entered the resident's bedroom and placed a barrier on top of the over-the-bed side table and then placed the treatment supplies on the barrier.
- e. She then placed the pair of non-nursing scissors directly on top of the table.
- f. Nurse "C" went into the bathroom, washed her hands, and applied clean gloves.
- g. Respondent's assistant director of nursing (ADON) was present and assisted the nurse by picking up the resident's left ankle.
- h. Nurse "C" picked up the scissors from the table and cut off the kerlix on the left foot.
- i. The dressing to the foot was removed and it was placed inside of the red bag along with her gloves.
- j. Nurse "C" went to the bathroom and washed her hands and returned to the bedside donning clean gloves.
- k. The soiled dressing was observed to contained thick green tinged drainage that did not have an odor.
- l. The wound bed appeared the size of a large pear and, from 9 to 3 o'clock, was noted with pink tissue with scattered yellow tissue and from 4 to 8 o'clock firmly adherent necrotic tissue was present in a perfectly appearing cut straight line thus indicating a recent debridement.

- m. Nurse "C" applied normal saline to the gauze dressing and began to wash the wound bed in an invasive motion.
 - n. The resident that had been smiling and non-verbal now was heard stating aloud "ouch" with facial grimacing.
 - o. The nurse dropped the gauze in the red bag and picked up more normal saline and applied it to additional gauze and for a second time she washed the wound.
 - p. The resident again stated aloud "ouch" and was attempting to pull the leg away from the ADON that was still holding it.
 - q. Nurse "C" stated, "Am sure that's sore."
 - r. The wound bed was now bleeding as the nurse began drying the wound.
 - s. Nurse "C" picked up clean gauze and placed it inside of the soufflé cup that contained the santyl ointment.
 - t. The ointment was observed only on the 25 % top portion of the gauze and it was placed on the necrotic area followed by the kerlix dressing.
 - u. Nurse "C" disposed of her gloves in the red biohazard bag and tied the bag shut, left the bedroom, and was noted outside of the biohazard room using the key pad opening the door and disposing the bag into the biohazard container.
 - v. Nurse "C" returned to the resident's bedroom and washed her hands in the bathroom.
24. That on May 12, 2016 at 12:04 p.m., Respondent's assistant director of nursing indicated to Petitioner's representative that after being present during both wound care observations, two

of two nurses had left the bedrooms without washing their hands and that "The nurses were supposed to wash their hands before leaving the bedrooms."

25. That Petitioner's representative interviewed Respondent's registered nurse "C" regarding resident number eight (8) on May 12, 2016 at 12:10 p.m. and the nurse indicated as follows:

- a. When asked about the scissors that she had used during the treatment observation, she stated, "the scissors were clean" when she had removed them from the treatment cart.
- b. When asked if she had cleaned the scissors and put them in the treatment cart, she stated "No."
- c. When asked how she knew the scissors were clean, she stated, "We always clean the scissors before putting them back in the cart."
- d. She confirmed that she had not placed the scissors on the clean barrier on the treatment cart, and again, on entering the resident's bedroom, she had placed the scissors directly on top of over the bedside and not on the barrier.
- e. When asked why bandage scissors had not been utilized, she said that was the only scissors that she had.
- f. Respondent's assistant director of nursing interjected stating "I have a pair I keep in my office. Everyone should have bandage scissors," and said she thought that the central supply should have them.
- g. When staff member "C" was asked why she had only applied the santyl ointment to the top portion of the wound bed, she replied, "That is where the necrotic tissue is."

- h. When asked if that was the treatment orders, she then stated, "When I put the dressing on the ointment it squished out, you know when you put the ointment on, and you press it."

26. That the Facility provided its plan of correction that contained documents entitled: "Best Practice Steps on Treatments Listed from CMS Team," a document signed by licensed practical nurse "J" on April 21, 2016; staff member "B" on April 21, 2016, and registered nurse "C" on April 22, 2016, which provided:

- a. "Wipe scissors with alcohol swab, swab and leave open place on the barrier for at least one minute to dry.
- b. "Stop wound care of resident shows any S/S of pain-wincing, grimacing, guarding, saying ouch, yelling, tensing, or wiggling away from nurse.
- c. "Put on a set of gloves.
- d. "Remove old dressing and place in bag.
- e. "Remove gloves and wash hands.
- f. "Place towel under to prevent bed from getting wet.
- g. "Put on clean gloves, cleanse area as ordered and pat dry.
- h. "Remove gloves, wash hands, put on clean gloves and proceed with treatment as ordered.
- i. "Remove gloves.
- j. "Throw away barrier and extra treatment supplies.
- k. "Wash hands.
- l. "Take plastic bags with soiled treatment supplies to soiled utility room.
- m. "Discard and wash hands."

27. That Petitioner's representative interviewed Respondent's director of nursing regarding wound care on May 12, 2016 at 3:10 p.m. who indicated as follows:

- a. She confirmed licensed staff had been in-serviced on wound care.
- b. She used the "Best Practice Steps on Treatments Listed from CMS Team."
- c. The regional nurse had developed the Best Practice after reviewing the CMS web site and added that the facility's policy did not include all of the steps that were needed for wound treatments.
- d. She confirmed that all of the Licensed Nurses provided a return demonstration on the Best Practice.
- e. The nurses signed the form indicating the understanding of the procedure and that good performance had been observed on return demonstration.
- f. She had not watched the licensed nurse perform the treatments.
- g. That part of the plan of correction had been assigned to the ADON.
- h. She confirmed that it is her expectation that the licensed staff perform wound care treatments the way they had been in-serviced to follow the "Best Practice Steps on Treatments Listed from CMS Team."

28. That the above reflects Respondent's failure to ensure the provision of adequate and appropriate health care consistent with established and recognized practice standards within the community, and or failed to follow physician's orders, related to related to wound care and infection control.

29. That the Agency determined that this deficient practice will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical,

mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services and cited Respondent for a patterned State Class III deficiency.

30. That the same constitutes an uncorrected deficiency as defined by law.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of one thousand dollars (\$1,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to §§ 400.23(8)(c) and 400.102, Florida Statutes (2016).

COUNT II

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

32. Based upon Respondent's one (1) cited State uncorrected Class III 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 (2016).

33. 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 (2016) commencing May 12December 13, 2016

34. A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. § 400.23(8)(c), Fla. Stat. (2016).

35. The Agency cited the Respondent for an uncorrected class III violation.
36. A class III deficiency is subject to a civil penalty of \$1,000 for an isolated deficiency, \$2,000 for a patterned deficiency, and \$3,000 for a widespread deficiency.
- § 400.23(8)(c), Fla. Stat. (2016).


WHEREFORE, the Agency seeks to impose an administrative fine in the amount of one thousand dollars (\$1,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to §§ 400.23(8)(c) and 400.102, Florida Statutes (2016).

COUNT II

37. The Agency re-alleges and incorporates paragraphs one (1) through five (5) and Count I of this Complaint as if fully set forth herein.
38. Based upon Respondent's one (1) cited State uncorrected Class III 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 (2016).


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 (2016) commencing May 12, 2016.

Respectfully submitted this 20 day of April, 2017.



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 (Fax)
walsht@ahca.myflorida.com

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7013 2250 0001 4950 4827, to Woodie W. Lee, Jr., Administrator, 2916 Habana Way Operations, LLC d/b/a Habana Health Care Center, 2916 Habana Way, Tampa, Florida 33614, and by Regular U.S. Mail to Corporation Service Company, Registered Agent for 2916 Habana Way Operations, LLC, 1201 Hays Street, Tallahassee, Florida 32301-2525, this 20 day of April, 2017.



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)
walsht@ahca.myflorida.com

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: 2916 Habana Way Operations, LLC d/b/a
Habana Health Care Center

AHCA No. 2016006807
LICENSE No. 15500962

ELECTION OF RIGHTS

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

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your **Election of Rights** to this address:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

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

OPTION TWO (2) _____ I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I wish to be heard at an informal proceeding (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

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

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

Licensee Name: _____ License Number: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____ E-Mail (optional) _____

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

Signed: _____ Date: _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case Nos. 2016006807
License No. 15500962
File No. 62914

2916 HABANA WAY OPERATIONS, LLC d/b/a
HABANA HEALTH CARE CENTER,

Respondent.

_____ /

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondent, 2916 Habana Way Operations, LLC d/b/a Habana Health Care Center (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

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

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

EXHIBIT 2

WHEREAS, the Agency served Respondent with an administrative complaint on or about April 24, 2017, notifying the Respondent of its intent to impose administrative fines in the amount of one thousand dollars (\$1,000.00) and the imposition of conditional licensure; and

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

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

1. All recitals herein are true and correct and are expressly incorporated herein.
2. Both parties agree that the "whereas" clauses incorporated herein are binding findings of the parties.
3. Upon full execution of this Agreement, Respondent agrees to waive any and all appeals and proceedings to which it may be entitled related to this state proceeding including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that no agreement herein shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement.
4. Upon full execution of this Agreement, Respondent agrees to pay one thousand dollars (\$1,000.00) in fines to the Agency within thirty (30) days of the entry of the Final Order and accepts imposition of conditional licensure commencing May 12, 2016, and ending June 12, 2016.

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

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

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

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

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

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

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

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

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

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

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

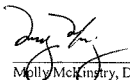
16. This Agreement contains and incorporates the entire understandings and agreements of the parties.

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

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

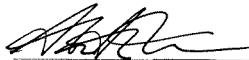
19. All parties agree that a facsimile signature suffices for an original signature.

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



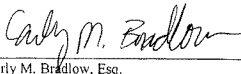
Molly McKinstry, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Building #1
Tallahassee, Florida 32308

DATED: 6/5/17



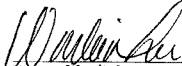
Stuart F. Williams, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Florida Bar No. 670731

DATED: 5/31/17




Carly M. Bradlow, Esq.
Counsel for Respondent
5102 West Laurel Street
Suite 700
Tampa, Florida 33607
Florida Bar No. 105523

DATED: 5/23/17



Name: Woodie Lee
Title: Executive Director
2916 Habana Way Operations, LLC d/b/a
Habana Health Care Center

DATED: 5/23/17



Thomas J. Walsh II, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive North, Suite 330G
St. Petersburg, Florida 33701
Florida Bar No. 560365

DATED: 5/23/12