STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

HARBORCHASE OF VERO BEACH, LLC,

Respondent.
_____/

DOAH CASE NO. 17-3333

AHCA CASE NOs. 2016000331
2015010753

RENDITION NO.: AHCA- 17-052C-S-OLC

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 $12,000. 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

ORDERED at Tallahassee, Florida, on this 14 day of August, 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 16 day of August, 2017.

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403
Telephone: (850) 412-3630

Jan Mills Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Mail Stop #61 (Electronic Mail)
Antonio Lozada, Assistant General Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Deborah Hollenbach, Administrator Harborchase of Vero Beach 4150 Indian River Blvd. Vero Beach, FL 32967 (U.S. Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No.: 2016000331
2015010753
File No.: 11966908
License No.: 11030
Provider Type: Assisted Living Facility

HARBORCHASE OF VERO BEACH, LLC,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), by and through the undersigned counsel, and files this Administrative Complaint against the Respondent HARBORCHASE OF VERO BEACH, LLC ("the Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2016), and alleges:

NATURE OF THE ACTION

This is an action against an assisted living facility to impose an administrative fine of $14,500.00 and assess a survey fee of $500.

PARTIES

1. The Agency is the licensing and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state statutes and rules governing such facilities. Ch. 408, Part II, Ch. 429, Part I, Fla. Stat. (2016); Ch. 58A-5, Fla. Admin. Code. The Agency may deny, revoke, and suspend any license issued to an assisted living facility and impose an administrative fine for a violation of the Health Care Licensing Procedures Act, the authorizing

EXHIBIT "1"

statutes or applicable rules. §§ 408.813, 408.815, 429.14, 429.19, Fla. Stat. (2016). In addition to licensure denial, revocation or suspension, or any administrative fine imposed, the Agency may assess a survey fee against an assisted living facility. § 429.19(7), Fla. Stat. (2016).

2. The Respondent was issued a license by the Agency to operate an assisted living facility ("the Facility") located at 4150 WEST INDIAN RIVER BOULEVARD VERO BEACH, FL 32967, and was at all times material required to comply with the applicable statutes and rules governing assisted living facilities.

COUNTS I & II
Resident Care—Supervision

3. 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 that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

Rule 58A-5.0182(1), F.A.C. (2016).

4. Additionally, Florida law provides:

> (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

§ 429.26(7) Fla. Stat. (2016).

Facts
Survey of July 9, 2015 through July 16, 2015

5. On or about July 9, 2015 through July 16, 2015, the Agency conducted an unannounced complaint survey of the Respondent.

6. Based on observation, interview and record review, the Respondent failed to adequately provide care and services to meet the needs of 4 out of 10 sampled residents (Residents 1, 2, 3 and 10). The Respondent failed to assist or supervise the residents with their activities of daily living (ADLs) and not overseeing their specialized safety precaution requirements.

Resident 1

7. On or about July 9, 2015, the Agency surveyor observed Resident 1 transferred from sitting to standing and walking independently, without any staff assistance or supervision, from the north-end memory care unit (MCU) living area to his bedroom, a distance of approximately 50 feet. In an interview with Resident, he stated that he did not receive any assistance or supervision from the staff while walking and transferring in the Respondent's MCU.

8. In an interview with Nurse A on or about July 9, 2015, she stated that Resident 1 walked and transferred independently, did not require assistance or direct supervision with

walking and transferring, and did not have any specialized precautions that the direct care staff needed to observe.

9. In another interview with Nurse A on or about July 9, 2015, she stated that it was common that Resident 1 ambulated independently, without any direct supervision, within the MCU common areas, including the common living areas not directly viewable from the nursing station. She stated that the MCU's north and south-end common living areas were not viewable from the MCU nursing station and that she would spend the majority of her time in the nursing station while in the MCU.

10. In an interview with the Administrator on or about July 9, 2015, she stated that Caregiver B found Resident 1 when he broke out of the facility on May 5, 2015, and that the resident was found after falling on the courtyard floor on July 6, 2015. She stated that the Respondent did not have an established fall or accident prevention policy and procedure. She stated that the Respondent did not implement any additional fall or accident prevention measures after this resident's fall on July 6, 2015, and she did not know if the resident previously had any unidentified problems which may have adversely affected his mobility.

11. In an interview with Resident 1's family members on or about July 9, 2015, they stated that the resident had previously tried to get out of the facility. Resident 1's family members stated that the Respondent notified them that, when he was found in the MCU's courtyard, no staff member witnessed this fall. Resident 1's family members stated that, based on their numerous previous visits to see the resident in the facility, they had not seen the facility staff assist or supervise Resident 1 with his ambulation or transfers. Resident 1's family stated that the resident was sometimes unshaven and not properly groomed, even though he was supposed to receive staff assistance for shaving and grooming.

12. In an interview with Caregiver A on or about July 9, 2015, she stated that while she was working in the facility's 2nd floor on July 6, 2015, from a window facing the MCU's courtyard, she noticed that Resident 1 was lying supine on the floor. She stated that she immediately went downstairs and, as she was going to the MCU's courtyard, she notified Caregiver B. Caregiver A stated that when she arrived to the resident, she noticed that his skin was very warm and red in color, as if he had been outdoors for an extended period of time. She stated that the resident told her that he fell and he was going in and out of consciousness. She stated that she initially looked for other staff members nearby to assist with the resident, but no other staff members were around. She stated that she waited for Nurse B to arrive to assist with the resident approximately one hour later.

13. In an interview with Nurse B on or about July 9, 2015, she stated that she responded to Resident #1 on when Caregiver A informed her that he was found on the courtyard floor earlier that day. She stated that she was not aware of any specialized precautions implemented for the resident after the event on July 6, 2015.

14. In an interview with Caregiver B on or about July 20, 2015, she stated that she and Caregiver A responded when Resident 1 fell and assisted the resident when they found him on the MCU's courtyard floor. She stated that Resident 1 had previously walked away from the facility on May 5, 2015, when she found him wandering around her own apartment complex. She stated that she did not know how the resident arrived to her apartment complex, approximately one mile from the facility. She stated that she immediately went to the resident and led him into her apartment so she could call the Respondent to inform them. She stated that the resident was somewhat disoriented, so she immediately notified the Respondent and they came to pick up the resident shortly thereafter. She stated that she had seen the resident walk

about the Respondent's MCU independently, without any direct supervision.

15. In an interview with Nurse C on or about July 16, 2015, she stated that she was aware that Resident 1 fell in the courtyard about a week prior, that this resident was not considered a fall risk, and that no specialized precautions were in place for him. She stated that she was not able to visually supervise this resident if he walked outside of the MCU common areas not viewable from inside the MCU nursing station. She acknowledged that the resident walked independently all around the MCU common areas.

Resident 2

16. On or about July 9, 2015, an Agency surveyor observed Resident 2 transferred from sitting to standing in the dining room. Resident 2 started to walk using a rolling walker without any supervision. The resident then walked towards the front lobby and then continued to walk, without supervision, to her bedroom for a total length of approximately 120 feet.

17. In an interview with Resident 2 on or about July 9, 2015, she stated that she was used to walking and transferring without any supervision from the facility staff. She stated that she sometimes felt unstable doing these tasks, especially when she had to maneuver around the furniture inside her bedroom. She further stated that she fractured her pelvis when she fell in the facility's beauty salon about 6 months ago. She said that she walked to the beauty salon independently, fell when she tried to get into the salon chair, and there was no direct care staff member supervising her at that time. She also stated that she received no fall-risk precautions by the facility staff.

18. Review of Resident 2's health assessment dated April 23, 2015, indicated that she was diagnosed with a history of falls, paralysis agitans, abnormal gait, hypertension, backache, involuntary movements, and previous pelvic fracture. It indicated that she was a fall risk due to

loss of balance with obstacles. Review of the resident's health assessment indicated that she required supervision with her ambulation, with standby assist for 200 feet, and transferring with standby or contact guard assist.

19. In an interview with the Resident Care Director on or about July 9, 2015, she stated that Resident 2 did not receive direct staff supervision for ambulation or transfers and that the resident did not have any special precautions implemented by the Respondent.

20. In an interview with the receptionist on or about July 9, 2015, she stated that, over the prior months, she had repeatedly seen Resident 2 walking and transferring independently without any caregiver supervision throughout the facility common areas.

Resident 3

21. On or about July 9, 2015, Resident 3 was observed walking independently in the MCU hallway without any direct supervision.

22. In an interview with Resident 3 on or about July 9, 2015, she stated that she usually walked around the Respondent's MCU common areas without any direct supervision from the staff.

23. Review of Resident 3's health assessment dated February 25, 2015, indicated that she was diagnosed with breast cancer, coronary artery disease, osteoarthrosis, dementia, and had decreased mobility. Review of this health assessment indicated that the resident needed supervision with ambulation and needed assistance with bathing, dressing, grooming and toileting.

24. In an interview with Nurse B on or about July 9, 2015, she stated that Resident 3 ambulated independently without any direct supervision or assistive devices. Nurse B stated that she was not completely aware of the resident's documented activities of daily living

requirements.

Resident 10

25. On or about the afternoon of July 16, 2015, Resident 10 was observed sleeping inside his bedroom.

26. In an interview with Caregiver C on July 16, 2015, she stated that she did not know if Resident 10 received his required physical therapy, scheduled for that afternoon. She stated that she was not aware that the resident had been in his bedroom sleeping for the past couple of hours.

Survey of September 4 through 9, 2015

27. On or about September 4 through 9, 2015, the Agency conducted an unannounced follow-up survey to the July 2015 complaint survey.

28. Based on observation, interview and record review, the Respondent failed to adequately provide care and services to meet the needs of 2 out of 13 sampled residents (Residents 1 and 11) by not assisting or supervising the residents with their activities of daily living (ADLs).

Resident 1

29. Resident 1's health assessment dated August 12, 2015, indicated that he was diagnosed with Alzheimer's disease, shoulder surgery, thrombocytopenia and stent, and needed special fall precautions. Further review of the resident 's health assessment indicated that the resident was forgetful, unsure of his location, and needed supervision with dressing by facility staff.

30. The Respondent's incident report from August 18, 2015, indicated that Resident 1 fell inside his bedroom during a dizzy spell, suffering lacerations on his head and left forearm.

Review of the report indicated that the resident was hospitalized and returned to the facility.

31. In an interview with Resident 1's daughter in-law on or about September 4, 2015, she stated that the level of care extended to Resident 1 had not changed in the preceding 6 weeks. She stated that she was contacted earlier that morning by Nurse D to inform her that Resident 1 had just been found on the floor inside his bedroom. She stated that the nurse explained to her that a caregiver went into Resident 1's room and saw him sleeping, so the caregiver decided to let him sleep a little longer, but when the caregiver returned to the resident's room she found him on the floor. She stated that the nurse told her that Resident 1 was not able to get up from the floor by himself, but was without injuries and did not need to go to the hospital.

32. In an interview with Resident 1's son on or about September 4, 2015, he stated that, on August 18, 2015, he was informed that caregivers found lacerations on Resident 1's head and forearm while showering him. Resident 1's son stated that the facility staff told him that they did not know when or how the resident fell. They also told him that the facility sent the resident to the hospital for evaluation. Resident 1's son stated that, while the resident was in the hospital, no adverse medical condition causing the fall could be determined and that he believed that the resident was not being adequately supervised in the facility. He also stated that he was not informed of the resident's changes described in the health assessment dated August 12, 2015.

33. On or about the afternoon of September 4, 2015, before interviewing the Administrator, the Agency surveyor found Resident 1's bedroom door was locked and received no answer upon repeatedly knocking on the bedroom door.

34. In an interview with the Administrator on or about the afternoon of September 4, 2015, several hours after Resident 1 was found on the floor, she stated that she was only aware of the resident falling on August 18, 2015.

35. During the interview, the Administrator was asked to unlock the resident's door to see if the resident was inside his bedroom. She unlocked and opened the resident's bedroom door. The Agency surveyor observed resident alone inside his bedroom, wearing undergarments and attempting to dress or undress without any staff supervision. The resident appeared confused.

36. In an interview with Resident 1's physician on September 9, 2015, he stated that he evaluated Resident 1 in August 2015 and that, due to his advanced dementia and decreased mental capacity, the resident needed physical assistance with all of his activities of daily living (ADLs) (including ambulation, toileting, dressing and transferring).

Resident 11

37. On or about September 4, 2015, and Agency surveyor observed Resident 11 eating her meal with her bare hands and without any assistance in the MCU dining room. In an interview with Nurse B at the time of the observation, she stated that Resident 11 ate independently, without any staff assistance, and that it was okay for the resident to use her bare hands to eat her meals.

38. Review of Resident 11's health assessment dated August 27, 2015, indicated that the resident was diagnosed with dementia, urinary incontinence, hypothyroidism, hyperlipidemia and severe memory loss. Further review of the resident's assessment indicated that the resident needed physical assistance with all of her activities of daily living (ADLs), including eating with verbal cuing and prompting.

Survey of October 26 through November 2, 2015

39. On or about October 26 through November 2, 2015, the Agency conducted an unannounced follow-up survey to the September 2015 complaint survey.

40. Based on record review and interview, the facility failed to adequately provide care and services to meet the needs of 2 out of 15 sampled residents (Residents 13 and 15) by not assisting the residents with their assessed activities of daily living (ADLs).

Resident 13

41. The Respondent's incident report log indicated that Resident 13 suffered unwitnessed falls on September 11, 12, 14, 17, and 21, 2015, and suffered a witnessed fall on September 20, 2015.

42. In an interview with Nurse D on October 26, 2015, she stated that Resident 13 did not have any fall or accident precautions in place and provided a facility generated form titled "Memory Care Fall Precaution." Review of the form indicated that Resident 13 was not included in the resident list to have any fall or accident precautions in place.

43. Resident 13's records indicated that she was admitted to the facility on August 24, 2015. Her health assessment from the admission date indicated that she was diagnosed with urinary tract infection, altered mental status, convulsions, paralysis, atrial fibrillation, orthostatic hypotension, depressive disorder, anxiety and osteoporosis. Further review of the health assessment indicated that the resident needed special precautions for poor safety awareness, assistance with transferring and ambulation, specifically the use of a wheelchair and escort. The health assessment dated October 26, 2015, contained all the diagnoses of the previous assessment, but further indicated that the resident had physical limitations involving gait and ambulation difficulty. The assessment indicated that she needed fall precautions as well as assistance with transferring and ambulation (wheelchair and escort).

44. Review of the Respondent's incident report from the afternoon of September 11, 2015, indicated that Resident 13 was found sitting on the floor in the MCU hallway next to the

MCU director's office and the resident was without her wheelchair. Another incident report from the same date, later that evening, indicated that the resident was found next to her wheelchair on the floor in the MCU activity room after hitting her head. The incident report indicated that the resident was transported to the hospital for evaluation of her injury and no additional measures were implemented by the facility to prevent future similar events.

45. The Respondent's incident report from the morning of September 12, 2015, indicated that Resident 13 was found on the floor in the MCU hallway next to the nursing station and she injured her left wrist with a skin tear. The incident report indicated that the no additional measures were implemented by the facility to prevent future similar events.

46. The Respondent's incident report from the afternoon of September 14, 2015, indicated that Resident 13 was found sitting on the floor in the MCU hallway and she was found without injury.

47. The Respondent's incident report from the night of September 17, 2015, indicated that Resident 13 was found on the floor in the resident's bedroom living room area, that the resident injured her right wrist and forehead (skin tears), and that her wheelchair was found not near her. The incident report indicated that the resident was transported to the hospital for evaluation of her injuries and that the resident needed one on one attention to prevent future similar events.

48. The Respondent's incident report from the morning of September 20, 2015, indicated that Resident 13 was observed by a facility staff member transferring out from her wheelchair and subsequently falling on her head in the MCU activity room. The incident report indicated that the resident was transported to the hospital for evaluation of her injury and that the facility did not implement any additional measures (beyond those previously established) to

prevent future similar events.

49. In an interview with Resident 13's daughter on or about October 28, 2015, she stated that her mother suffered several falls while in the facility since September 11, 2015, and that she felt that the facility was not properly assisting the resident with her activities of daily living, including ambulation, transferring and toileting. She stated that her mother recently suffered a few injuries due to the accidents in the facility, including bruises on her upper extremities, and that her mother did not receive continual one on one care from the facility direct care staff. She stated that her mother told her that she had to continually have to hold her urine because the facility direct care staff would not assist her to go to the bathroom often enough. She stated that she asked a direct care nurse to assist her mother with toileting more frequently and the nurse indicated that the facility was not able to provide toileting assistance more than every 2 to 3 hours.

50. The Respondent's actions or inactions constituted a violation of Section 429.26(7), Florida Statutes (2016), and Rule 58A-5.0182(1), Florida Administrative Code (2016).

Sanction

51. Under Florida law, the Respondent as the licensee is legally responsible for all aspects of the provider operation. § 408.803(9), Fla. Stat. (2016).

52. Under Florida law, in addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, for the actions of any person subject to level 2 background screening under

s. 408.809, or for the actions of any facility employee: an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility. § 429.14(1)(a), Fla. Stat. (2016).

53. Under Florida law, "Class II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. § 408.813(2)(b), Fla. Stat. (2016).

54. Under Florida law, the Agency shall impose an administrative fine for a cited Class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. § 429.19(2)(b), Fla. Stat. (2016).

55. The Agency cited the Respondent for two Class II violations arising from the facts alleged in Counts I and II of this administrative complaint.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $7,500.00 against the Respondent.

COUNT III
Staffing Standards—Administrator

56. Under Florida law, "[e]very 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), F.A.C., (2016).

Facts

57. The Agency re-alleges and incorporates by reference all of the facts listed in Count I and II of this complaint.

Survey of July 9, 2015 through July 16, 2015

58. On or about July 9, 2015 through July 16, 2015, the Agency conducted an unannounced complaint survey of the Respondent.

59. Based on observation, interview and record review, the facility Administrator failed to provide adequate supervision of the facility and did not manage the staff to ensure appropriate care and services for 5 out of 10 residents (Residents 1, 2, 3, 7 and 10).

Resident 1

60. Review of Resident 1's record indicated that on the morning of May 5, 2015, the resident was unaccounted for and the window in his bedroom was found open. Record review further indicated that the resident was found by a staff member outside of the facility and the resident returned safely to the facility.

61. An observation record from May 11, 2015, indicated that the resident was standing on a bench in the courtyard, attempting to climb up the fence. Records further indicated that the resident later cracked the window inside his bedroom while attempting to get out of the facility's MCU.

62. An observation record from May 20, 2015, indicated that the resident was found bleeding from the back of his head when he came outside his bedroom and he was transported to the hospital for evaluation.

63. An observation record from May 25, 2015, indicated that the resident was found in the courtyard tampering with the fence gate's lock.

64. An observation record from July 6, 2015, indicated that the resident was found lying on the courtyard's ground by a caregiver at approximately 2:00 PM.

65. In an interview with the Administrator on or about July 9, 2015, she stated that

Caregiver B found Resident 1 when he broke out of the facility on May 5, 2015, but she did not recollect the details of the event involving the same resident attempting to break out of the MCU on May 11, 2015. She stated that she was not aware that Resident 1 tampered with the lock on the courtyard doors on May 25, 2015, as per the attached resident records, and she did not know if any staff member ever communicated this event to her. She stated that she was aware of the resident's event on July 6, 2015, which she learned of from Nurse B's documentation in the resident's record. She stated that none of the staff in the facility was able to provide her more information relating to the aforementioned events involving Resident 1. She stated that she did not recall who notified her or when she was notified of the events relating to Resident 1 and she currently knew about these events solely from the documentation in the resident's record.

66. In an interview with Resident 1's family members on or about July 9, 2015, they stated that it was very difficult to receive objective information from the facility staff and administration about any events relating to the resident. They stated that they tried to contact the Administrator several times when the resident was previously hospitalized, but the Administrator did not return their phone calls. They said they had to go onsite and piece information together from individual staff sources.

Resident 2

67. In an interview with the Administrator on or about July 9, 2015, she stated that Resident 2 did not require any supervision with her mobility, including ambulation and transferring.

68. In an interview with the Resident Care Director on or about July 9, 2015, she stated that she was aware that Resident 2 walked and transferred independently and that the staff members "tried" to supervise her while she walked about the facility as required in the resident's

health assessment.

Resident 3

69. In an interview with the Administrator on or about July 9, 2015, she stated that the facility did not have a dedicated resident fall/accident prevention policy. She declined to provide any other procedures, protocols or efforts to guide the facility's direct care staff regarding additional care for residents with an elevated risk for falls or accidents.

Resident 7

70. In an interview with the Administrator on or about July 16, 2015, she stated that Resident 7's family visited on her June 28, 2015, and took the resident to their home that day. She stated that the resident's family took the resident to the hospital. She stated that she was aware that the resident leaving the facility with her family was not documented in detail to reflect that the resident was actually discharged from the facility that day.

Survey of September 4 through 9, 2015

71. On or about September 4 through 9, 2015, the Agency conducted an unannounced follow-up survey to the July 2015 complaint survey.

72. Based on observation, interview and record review, the Administrator failed to provide adequate supervision of the facility and did not manage the facility staff to ensure appropriate care and services for 3 out of 13 residents (Residents 1, 11 and 13).

Resident 1

73. In an interview with the MCU activity coordinator on or about September 4, 2015, she stated that during her activity routines with the residents on that day, the activities were interrupted at least 15 times by residents requiring extra assistance or supervision. She stated that, even if she could redirect a particular resident to their own bedroom and leave the

activity room for a moment, she would not be able to unlock a resident's bedroom door because the facility recently established a practice to lock each resident room during the daytime hours. She stated that she was not provided any keys for access into the resident rooms, and she believed that the nurses and caregivers only had keys with access to the resident rooms.

74. In an interview with Nurse D on or about September 4, 2015, she stated that earlier in the day, Resident 1 was found on the floor by the caregiver and she suspected that the resident had fallen. She stated that this resident had a history of falls and he suffered an injury from a suspected fall in August 2015. She stated that she immediately evaluated the resident on, found that he was not injured, and she did not notify the facility administration of the incident.

Resident 13

75. In an interview with the Administrator on or about September 4, 2015, she stated that the resident bedroom doors inside the MCU were supposed to remain locked during the daytime so that no resident would wander into their rooms without direct care staff supervision. She stated that every direct care staff was supposed to have a key to provide access into the MCU resident rooms and did not know why any MCU direct care staff would not have a key.

76. In an interview with Caregiver G on September 4, 2015, she stated that Resident 13 requested to go to the bathroom inside her bedroom, but she was not able to take the resident into her bedroom because it was locked and she was not given a key to unlock the resident bedrooms in the MCU.

Generally

77. Review of the facility staff time sheets dated September 4, 2015, indicated that Caregiver E, who was scheduled to work until 3:00 PM, clocked out at 2:53 PM; and Caregiver F, who was scheduled to work until 3:00 PM, clocked out at 2:43 PM. Further review of the

employee time sheets indicated that no scheduled MCU caregiver scheduled to begin working at 3:00 clocked in before 2:58 PM.

78. In an observation in the vacant MCU activities room on or about the evening of September 4, 2015, there were two sets of shoes left on the floor. In an interview with the Resident Care Director at the time of the observation, she stated that the two residents' shoes were left behind in the MCU activities room before the residents were transported into the dining room for dinner. She stated that she was not aware of the reason why the residents took their shoes off their feet and left them behind in the activities room.

79. In an interview with the Administrator on the evening of September 4, 2015, she stated that it was the facility's expectation for every caregiver to work their complete shift or to notify administration if they were to deviate from that scheduled shift. She stated that she or the Resident Care Director were not aware that MCU caregivers E and F, who were scheduled to work until 3:00 PM on September 4, 2015, clocked out before 3:00 PM and left a significant time gap in resident direct care coverage until the caregivers scheduled to begin their shifts at 3:00 PM clocked in for work.

80. The Respondent's actions or inactions constituted a violation of Rule 58A-5.019(1), F.A.C., (2016).

Sanction

81. Under Florida law, the Respondent as the licensee is legally responsible for all aspects of the provider operation. § 408.803(9), Fla. Stat. (2016).

82. Under Florida law, in addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any

provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee: an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility. § 429.14(1)(a), Fla. Stat. (2016).

83. Under Florida law, "Class II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. § 408.813(2)(b), Fla. Stat. (2016).

84. Under Florida law, the Agency shall impose an administrative fine for a cited Class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. § 429.19(2)(b), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $2,500 against the Respondent.

COUNT IV
Staffing Standards

85. Under Florida law,

> (3) STAFFING STANDARDS.
> (a) Minimum staffing:
> 1. Facilities must maintain the following minimum staff hours per week:
> Number of Residents Staff Hours/Week
> 0-5 168
> 6-15 212
> 16- 25 253
> 26-35 294
> 36-45 335
> 46-55 375
> **56- 65 416**
> 66-75 457

76-85 498
86-95 539
For every 20 residents over 95 add 42 staff hours per week.
2. Independent living residents as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility and who receive no personal, limited nursing, or extended congregate care services, are not counted as a resident for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and Cardiopulmonary Resuscitation (CPR) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or CPR courses offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Heart Association, or National Safety Council; or a provider approved by the Department of Health, satisfies this requirement. b. A nurse is considered as having met the course requirements for both First Aid and CPR. In addition, an emergency medical technician or paramedic currently certified under Chapter 401, Part III, F.S., is considered as having met the course requirements for both First Aid and CPR. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least 21 years of age must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.

(b) **Notwithstanding the minimum staffing requirements**

specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or representatives, for that resident's care.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a) if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41(1)(a), F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if the plan increases the staff to needed levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.

Rule 58A-5.0185(2), F.A.C. (2016) (emphasis added).

Facts

86. The Agency re-alleges and incorporates by reference all of the facts listed in Counts I through III of this complaint.

Survey of July 9, 2015 through July 16, 2015

87. Based on observation, record review, and interview, the facility failed to provide

enough qualified staff to provide adequate resident direct care for 4 out of 10 residents (Residents 1, 2, 3 and 10).

Generally

88. The facility census list dated July 9, 2015 indicated that there were 18 residents in the MCU area and 43 residents in the standard assisted living area of the facility.

89. The facility staffing hours for July 6, 2015 indicated that Caregiver B was scheduled to work from 7:00 AM to 2:00 PM, Nurse C was scheduled to work from 7:00 AM to 1:00PM, and Nurse B was scheduled to work from 3:00 PM to 8:00 PM.

90. Review of the administrative work schedule for July 6, 2015, indicated that the Administrator was scheduled to work, but the resident care director was not scheduled to work that day.

91. In an interview with Nurse A on or about July 9, 2015, she stated that if the two caregivers who were commonly scheduled to be on shift in the MCU were inside individual resident rooms assisting those residents, other residents who were assessed to require assistance or supervision with their ambulation and transfers would walk about the MCU independently without direct supervision (in the north and south-end MCU common living areas).

Resident 1

92. In an interview with Caregiver A on or about July 9, 2015, she stated that she initially looked for other staff members to assist with the resident that fell in the courtyard on July 6, 2015, (Resident 1), but no staff members were around because a nurse had left early that day and the MCU had only one other caregiver assisting the rest of the MCU residents. She stated that she was scheduled to work in the standard assisted living area of the facility that day and there were only two other caregivers working in the area, along with caregivers working the

MCU area. Caregiver A said she did not see the administrator onsite that day either.

93. In an interview with Nurse B on or about July 9, 2015, she stated that she was scheduled to begin work at 3:00 PM on July 6, 2015, and there was no nurse on shift when she arrived to work that day.

94. In an interview with Residents 4 and 5 on or about July 9, 2015, they stated that they had been living in the facility for approximately four months and felt that there were not enough staff members to care for the MCU residents.

95. In an interview with Caregiver B on or about July 10, 2015, she stated that she was ordered by the facility administration prior to adjust her schedule from 7:00 AM to 3:00 PM to 7:00 AM to 2:00PM to save on the hours paid by the facility. She stated that she felt that the facility's reduction of direct care staffing hours was not commensurate to the level of care needed by the residents in the facility, especially the increased level of care that the MCU residents required. She stated that she worked past her scheduled time to assist Caregiver A with Resident 1 that day. She that she worked from 7:00 AM to 8:00 AM on May 5, 2015 (the day Resident 1 wandered into her apartment complex), because she was asked to leave early. She stated that the facility administration determined that there was enough staff onsite that day.

96. In an interview with the Administrator on July 16, 2015, she stated that the Resident Care Director did not work (but was on-call) on July 6, 2015. The Administrator stated that she worked in the facility on that day, but she did not remember the specific circumstances surrounding Resident 1's fall; however, she said that she did not feel any urgency to contact the Resident Care Director to respond to the event. She stated that she did not encourage any caregiver to contact the Resident Care Director because she thought that Nurse B was supposed to come in at 2:00 PM. She acknowledged that Nurse B was actually scheduled to start work at

3:00 PM on July 6, 2015.

97. In an interview with Nurse C on July 16, 2015, she stated that during the daytime shifts, there were two caregivers normally scheduled to work in the MCU and two to three caregivers scheduled to work in the standard assisted living area of the facility. She stated that the daytime nurses were supposed to split their time between the MCU and the standard assisted living areas, performing tasks involving mostly resident medication. The nurses would cover for any caregivers who would not come to work. She stated that the Resident Care Director was supposed to cover the nurses during the weekday scheduling gaps between 1pm and 3pm, but the Resident Care Director was sometimes off during those days, so there would not be any direct care nursing coverage during those times. She stated that administration had asked her to work the additional 2 hours between 1:00 PM to 3:00 PM this past week, because there were no nurses scheduled during those times. She stated that she felt that the facility direct care staffing was not adequate in relation to the resident care needs, especially in the MCU. She stated that she had brought this staffing concern to the administration's attention and they responded by telling her that they were "working on it." She stated that she was not able to visually supervise any MCU resident if they walked outside of the MCU common areas not viewable from inside the MCU nursing station, such as the north and south-end common living areas.

Resident 10

98. In an interview with Caregiver C on July 16, 2015, she stated that she was not aware that the resident had been in his bedroom sleeping for the past couple of hours. She stated that this was an example of how she felt that there were not enough direct care staff members scheduled to adequately care for and monitor the MCU residents to meet their specific needs.

Survey of September 4 through 9, 2015

99. On or about September 4 through 9, 2015, the Agency conducted an unannounced follow-up survey to the July 2015 complaint survey.

100. Based on observation, record review, and interview, the facility failed to provide enough qualified staff to provide adequate resident direct care for 3 out of 13 residents (Residents 1, 11 and 13).

Generally

101. Review of the facility census roster dated September 4, 2015, indicated that there were 17 residents in the MCU and 43 residents in the standard side of the facility. Review of the facility staffing schedule from the same date indicated that there was one caregiver scheduled to work in the MCU from 6:00 AM to 2:00 PM, 7:00 AM to 3:00 PM, and 6:00 AM to 10:00 AM. Review of the schedule indicated that there was one dedicated caregiver scheduled to work in the MCU from 3:00 PM to 11:00PM and one caregiver working mixed duty between the MCU and the standard side of the facility from 3:00 PM to 11:00PM.

102. The two nurses originally scheduled to work from 7:00AM to 1:00PM (Nurse D) and from 3:00 PM to 11:00 PM (Nurse B) predominantly worked inside the MCU nursing station and the residents were not allowed to remain inside the nursing station.

103. In an interview with Resident 12 on or about the afternoon of September 4, 2015, she stated that she felt that the facility did not provide enough coverage in the MCU because there were a few residents who "acted up" during the activity sessions and brought the activities to halt until the activity coordinator found help to assist the disrupting residents.

Resident 13

104. On or about the afternoon of September 4, 2015, in the MCU activity room, an Agency surveyor observed Resident 13 yelling and attempting to ambulate independently while

the activity coordinator attempted to calm the resident down. There was no other direct care staff member in the activity room at this time.

105. Moments later, in an interview with Caregiver G on or about September 4, 2015, she stated that she was told to come to the MCU about five minutes prior to cover for another caregiver and that the standard side of the facility currently had one caregiver. Caregiver G was observed assisting Resident 13 in the living room, Caregiver I was observed delivering medications to MCU residents, and Nurse B was observed alongside Caregiver D in the MCU nursing station.

106. In an interview with Caregiver I, shortly after the interview with Caregiver G, she stated that she felt that the facility, particularly in the MCU, was understaffed and that the "more hands to help with the residents, the better."

107. In an interview with Caregiver D on or about the afternoon of September 4, 2015, she stated that she was responsible to extend direct care services in the standard side of the facility that day and that she had to go to the MCU from about 3:50 PM to 4:00 PM. She stated that she thought that Caregiver G was working on the standard side of the facility while she was in the MCU.

108. In an interview with the MCU Activity Coordinator on or about the afternoon of September 4, 2015, she stated that during her activity routines with the residents on that day, the activities were interrupted at least 15 times by residents requiring extra assistance or supervision. She stated that most of those times, she had to individually assist each of the residents and was not able to redirect the residents to another area because she was the only person in the activity area. She stated that she felt it was her responsibility to handle each and every resident not wanting to participate in the activities when there was no other caregiver available to assist those

residents and that it was difficult to do so while attempting to maintain the other residents engaged in the activities already in progress. She stated that, most of the time, there are no other caregivers in the MCU to assist in the activity room because there are only one or two caregivers working in the MCU and these caregivers would sometimes be assisting residents inside their rooms or on the other side of the MCU. She stated that the staff nurse would often be busy inside the MCU nursing station or on the standard side of the facility, making it difficult to extend physical resident assistance during the daytime hours.

109. She stated that, earlier that afternoon, Resident #13 was brought by a caregiver to participate in the activities in the MCU activity room, but the resident had been extremely anxious and disruptive to the other residents. The Activity Coordinator tried to engage the resident to participate, but she ended up trying to pacify the resident while she waited for a caregiver to assist her. The Activity Coordinator stated that she assisted and supervised the resident for approximately 30 minutes before she could continue the ongoing resident activities and prepare the resident snacks. She stated that she was over 45 minutes late to bake the residents' cookies that afternoon because of the interruptions. She further stated that the participating residents sometimes become uneasy when the disrupting residents cause the activities to stop.

110. The Activity Coordinator stated that Resident 13 normally needed at least one caregiver for assistance, but probably needed two caregivers on that day because the resident was really anxious and needed a lot of stimulation. The Activity Coordinator said that her shift for that day was scheduled for 10:00 AM through 6:00 PM, but her schedule was constantly changing. She stated that she had expressed to her supervisor that there was not enough direct care staff in the MCU, but her supervisor could not do anything to increase the staffing.

111. The Respondent's actions or inactions constituted a violation of Rule 58A-5.0185(2), F.A.C. (2016).

Sanction

112. Under Florida law, the Respondent as the licensee is legally responsible for all aspects of the provider operation. § 408.803(9), Fla. Stat. (2016).

113. Under Florida law, in addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee: an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility. § 429.14(1)(a), Fla. Stat. (2016).

114. Under Florida law, "Class II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. § 408.813(2)(b), Fla. Stat. (2016).

115. Under Florida law, the Agency shall impose an administrative fine for a cited Class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. § 429.19(2)(b), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $2,000.00 against the Respondent.

COUNT V
Resident Records

116. Under Florida law:

> Resident records; penalties for alteration.-
> (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.
> (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.

§ 429.49 Fla. Stat. (2016).

Facts

117. Based on record review and interview, the facility altered 1 out of 13 resident medical records (Resident 1's record).

118. Resident 1's health assessment dated August 12, 2015, indicated that he was diagnosed with Alzheimer's disease and thrombocytopenia with stent, had shoulder surgery, and needed special fall precautions. The resident's health assessment further indicated that the resident was forgetful; was unsure of his location; needed supervision with bathing, dressing and grooming; however, he was independent with ambulation, eating, toileting and transferring. Further review of this resident's record indicated that there were no additional entries to reflect any changes to the resident's health assessment.

119. In an interview with Resident 1's physician on or about September 9, 2015, he stated that he evaluated Resident 1 in August 2015 and the resident needed physical assistance with all of his activities of daily living (ADLs), including ambulation, toileting, dressing and transferring, due to his advanced dementia and decreased mental capacity. He stated that he performed Resident 1's examination and health assessment alone with the resident in the resident's room. He stated that no facility staff directly participated with the health assessment and he did not remember discussing the resident's physical ADL status with facility staff.

120. In an interview with the Administrator on or about the afternoon of September 9,

2015, she stated that she completed and recorded Resident 1's health assessment form dated August 12, 2015, and that she was present during this resident's examination with the resident's physician. She stated that she observed that the resident was able to walk, transfer, and eat independently without any supervision or assistance. She stated that, based on her observed resident ADL abilities and discussion with the resident's physician, she recorded that the resident was independent with ambulation, toileting and transferring on the resident's health assessment form.

Sanction

121. Under Florida law, the Respondent as the licensee is legally responsible for all aspects of the provider operation. § 408.803(9), Fla. Stat. (2016).

122. Under Florida law, in addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee: an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility. § 429.14(1)(a), Fla. Stat. (2016).

123. Under Florida law, "Class II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. § 408.813(2)(b), Fla. Stat. (2016).

124. Under Florida law, the Agency shall impose an administrative fine for a cited

Class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. § 429.19(2)(b), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $2,500.00 against the Respondent.

COUNT VI
Survey Fee

125. Under Florida law:

> (7) In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under s. 429.28(3)(c) to verify the correction of the violations.

§ 429.19(7) Fla. Stat. (2016).

126. The Agency re-alleges and incorporates by reference all of the facts listed in Counts I through V of this Administrative Complaint.

127. In response to a complaint, the Agency conducted a complaint survey of the Respondent's facility.

128. As a result of the complaint survey, the Respondent was cited for violations.

129. In addition to the original complaint survey, follow-up surveys were conducted to verify correction of the violations.

130. The basis for the violations alleged in this Administrative Complaint arise from the initial complaint and subsequent follow-up surveys.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to assess a survey fee of $500 against the Respondent.

CLAIM FOR RELIEF

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration,

seeks to enter a final order that:

1. Renders findings of fact and conclusions of law as set forth above.

2. Grants the relief set forth above.

Respectfully Submitted,

Antonio Lozada, Assistant General Counsel
Florida Bar No.: 112613
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 7
Tallahassee, Florida 32308
Telephone (850) 412-3699
Facsimile (850) 922-9634
Email: Antonio.Lozada@ahca.myflorida.com

NOTICE

Pursuant to Section 120.569, F.S., any party has the right to request an administrative hearing by filing a request with the Agency Clerk. In order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), F.S., however, a party must file a request for an administrative hearing that complies with the requirements of Rule 28-106.2015, Florida Administrative Code. Specific options for administrative action are set out in the attached Election of Rights form.

The Election of Rights form or request for hearing must be filed with the Agency Clerk for the Agency for Health Care Administration within 21 days of the day the Administrative Complaint was received. If the Election of Rights form or request for hearing is not timely received by the Agency Clerk by 5:00 p.m. Eastern Time on the 21st day, the right to a

hearing will be waived. A copy of the Election of Rights form or request for hearing must also be sent to the attorney who issued the Administrative Complaint at his or her address. The Election of Rights form shall be addressed to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 3, Tallahassee, FL 32308; Telephone (850) 412-3630, Facsimile (850) 921-0158.

Any party who appears in any agency proceeding has the right, at his or her own expense, to be accompanied, represented, and advised by counsel or other qualified representative. Mediation under Section 120.573, F.S., is available if the Agency agrees, and if available, the pursuit of mediation will not adversely affect the right to administrative proceedings in the event mediation does not result in a settlement.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form were served to the below named persons/entities by the method designated on this 24th day of March, 2017.

Antonio Lozada, Assistant General Counsel
Florida Bar No.: 112613
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 7
Tallahassee, Florida 32308
Telephone (850) 412-3699
Facsimile (850) 922-9634
Email: Antonio.Lozada@ahca.myflorida.com

Arlene Mayo-Davis, Field Office Manager Agency for Health Care Administration Agency Field Office (Electronic Mail)	Administrator HarborChase of Vero Beach, LLC 4150 West Indian River Boulevard Vero Beach, FL 32967 Via Certified Mail: 91 7199 9991 7033 6372 8436
Laura Manville, Unit Manager Assisted Living Unit Agency for Health Care Administration (Electronic Mail)	

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: HARBORCHASE OF VERO BEACH, LLC **ACHA Nos. 2016000331**
2015010753

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. It may be returned by mail or facsimile transmission, but must be received by the Agency Clerk within 21 days, by 5:00 pm, Eastern Time, of the day you received the Administrative Complaint. If your Election of Rights form or request for hearing is not received by the Agency Clerk within 21 days of the day you received the Administrative Complaint, you will have waived your right to contest the proposed agency action and a Final Order will be issued imposing the sanction alleged in the Administrative Complaint.

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your Election of Rights form 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 fact and conclusions of law alleged in the Administrative Complaint and waive my right to object and to have a hearing. I understand that by giving up the right to object and have a hearing, a Final Order will be issued that adopts the allegations of fact and conclusions of law alleged in the Administrative Complaint and imposes the sanction alleged in the Administrative Complaint.

OPTION TWO (2) _____ I admit to the allegations of fact alleged in the Administrative Complaint, but 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 agency action is too severe or that the sanction should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact alleged in the Administrative Complaint and 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.

Licensee Name: _____

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 form to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____ Date: _____

Printed Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

DOAH CASE NO.:17-3333
AHCA CASE NOs.: 2016000331
2015010753

HARBORCHASE OF VERO BEACH, LLC,
Respondent.
_____/

SETTLEMENT AGREEMENT

The Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), and the Respondent, HARBORCHASE OF VERO BEACH, LLC, ("the Respondent"), pursuant to Section 120.57(4), Florida Statutes, enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, the Respondent is an assisted living facility licensed pursuant to Chapter 408, Part II, and Chapter 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code, and

WHEREAS, the Agency has jurisdiction by virtue of being the licensing and regulatory authority over the Respondent; and

WHEREAS, the Agency conducted a survey of the Respondent's assisted living facility on July 9 through 16, 2015, September 4 through 9, 2015, and October 26 through November 2, 2015; and

WHEREAS, the Agency issued the Respondent an Administrative Complaint on March 24, 2017, alleging five class II violations pertaining to resident care and supervision, administrator standards, staffing standards, and medical records; and

WHEREAS, the Agency's administrative complaint seeks the imposition of fifteen

EXHIBIT "2"

thousand dollars ($15,000.00) in fines and survey fees; and

WHEREAS, the Respondent requested an informal hearing by filing an election of rights form; and

WHEREAS, the parties have agreed that a fair, efficient, and cost effective resolution of this dispute would avoid the expenditure of substantial sums to litigate the dispute; and

WHEREAS, the parties stipulate to the adequacy of considerations exchanged; and

WHEREAS, the parties have negotiated in good faith 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. All parties agree that the above "whereas" clauses incorporated herein are binding findings of the parties.

3. Upon full execution of this Agreement, the Respondent agrees to waive service of an administrative complaint, any and all appeals and proceedings to which it may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that this agreement shall not be deemed a waiver by either party of its right to judicial enforcement of this Agreement.

4. Upon full execution of this Agreement, the Respondent agrees to pay the Agency twelve thousand dollars ($12,000.00) within 30 days of the entry of the Final Order as full and final payment required under this Agreement.

5. Venue for any action brought to interpret, enforce or challenge the terms of this Agreement and its corresponding Final Order shall lie solely in the Circuit Court of Florida, in and for Leon County, Florida.

6. By executing this Agreement, the Respondent neither admits nor denies the facts and legal conclusions raised in the Administrative Complaint referenced herein, and the Agency asserts the validity thereof. Nothing in this Agreement shall be deemed to preclude the Agency from using this assessment of fines in weighing future administrative actions regarding the Respondent including, but not limited to, decisions regarding the licensure of Respondent, including, but not limited to, licensure for limited mental health, limited nursing services, or extended congregate care. 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 Administrative Complaint.

7. 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.

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

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

10. The Respondent, for itself and its related or resulting organizations, successors, transferees, attorneys, heirs, and executors or administrators, discharges 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 the Respondent or its related or resulting organizations.

11. This Agreement is binding upon all parties and those persons and entities that are identified in the above paragraph.

12. In the event that the Respondent was a Medicaid provider at the time of the occurrences alleged in the Notice of Intent, this Agreement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any further sanctions pursuant to Rule 59G-9.070, Florida Administrative Code. This Agreement does not settle any pending or potential federal issues against the Respondent. This Agreement does not prohibit the Agency from taking any action regarding the Respondent's Medicaid provider status, conditions, requirements or contract, if applicable.

13. The Respondent agrees that if any funds to be paid under this Agreement to the Agency are not timely paid as set forth in this Agreement, the Agency may deduct the amounts assessed against the Respondent in the Final Order, or any portion thereof, owed by the Respondent to the Agency from any present or future funds owed to the Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to the Respondent by the Agency for said amounts until paid.

14. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. The Respondent has the legal capacity to execute this Agreement. The Respondent understands that it has the right to consult with its own independent counsel and has knowingly and freely entered into this Agreement. The Respondent understands that Agency counsel represents only the Agency and that Agency counsel has not provided any legal advice to, or influenced, the Respondent in its decision to enter into this Agreement.

15. This Agreement contains the entire understandings and agreements of the parties. This Agreement supersedes any prior oral or written agreements between the parties. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

16. All parties agree that a facsimile signature suffices for an original signature. The following representatives 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, Bldg. #3
Tallahassee, Florida 32308

DATED: 8/14/17

Deborah Hollenbach, Administrator
Harborchase of Vero Beach
4150 Indian River Blvd.
Vero Beach, FL 32967

DATED: 8/1/17

Stuart F. Williams,
General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 8/7/17

Antonio Lozada,
Assistant General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #7
Tallahassee, Florida 32308

DATED: 7/12/17