STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC,

Respondent.
_____/

AHCA NO. 2017010728
License No. 1238096
File No. 100611
Provider Type: Nursing Home

EMERGENCY SUSPENSION ORDER

THIS CAUSE came before the Secretary of the Agency for Health Care Administration, or his duly appointed designee, who after careful review of the record and being otherwise fully advised, finds and concludes, as more fully described herein, that Respondent's licensure to operate a nursing home in the State of Florida should be suspended immediately.

SUMMARY

Respondent failed to maintain safe conditions in its Facility; failed to timely evacuate its Facility once conditions were no longer safe for residents; and failed to timely contact "911" during a medical emergency. These failures resulted in the deaths of at least eight (8) residents of the Facility, one resident having a body temperature of one hundred nine point nine (109.9) degrees Fahrenheit recorded at the hospital. Respondent's records related to the deceased residents contain multiple "late entries," meaning the entries were non-contemporaneous and recorded after the fact under dubious circumstances. Emergency planning and preparedness cannot prevent the gross negligence or criminal negligence of a licensed health care provider.

THE PARTIES

1. The Agency for Health Care Administration (hereinafter "the Agency") is the licensure and regulatory authority that oversees nursing homes in Florida and enforces the applicable state statutes and rules governing nursing homes. Chs. 408, Part II, and 400, Part II, Fla. Stat. (2017), Ch. 59A-4, Fla. Admin. Code. As part of its statutory oversight responsibilities, the Agency has the authority to impose emergency orders, including a limitation of license, a moratorium on admissions and an emergency suspension order, when circumstances dictate such action. §§ 120.60(6), 408.814, Fla. Stat. (2017).

2. The Respondent, Rehabilitation Center at Hollywood Hills, LLC (hereinafter "the Respondent"), was issued a license by the Agency (License Number 1238096) to operate a nursing home (hereinafter "the Facility") located at 1200 North 35th Avenue, Hollywood, Florida 33021. The licensed capacity of the Facility is one hundred fifty-two (152) residents.

3. As the holder of such a license, the Respondent is a licensee. "Licensee" means "an individual, corporation, partnership, firm, association, or governmental entity, that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2017). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2017). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2017). § 408.803(11), Fla. Stat. (2017). Nursing homes are regulated by the Agency under Chapter 400, Part II, Florida Statutes (2017), and listed in Section 408.802, Florida Statutes (2017). § 408.802(12), Fla. Stat. (2017). Nursing home residents are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2017). The Respondent holds itself out to the public as a nursing home that fully complies with state laws governing such providers.

4. The current census of the Respondent as of this date is zero (0) residents.

THE AGENCY'S IMMEDIATE SUSPENSION ORDER AUTHORITY

5. Under Florida law, the Agency may impose an emergency suspension order or immediate moratorium on admissions as defined in section 120.60, Florida Statutes (2017), on any provider if the Agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client. § 408.814(1), Fla. Stat. (2017).

6. Under Florida law, if the Agency finds that an immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license, the Agency may take such action by any procedure that is fair under the circumstances. § 120.60(6), Fla. Stat. (2017).

LEGAL DUTIES OF A NURSING HOME

7. Under Florida law: "Every licensed facility shall comply with all applicable standards and rules of the agency and shall ... Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner." § 400.141(1)(h), Fla. Stat. (2017).

8. Under Florida law: "In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee ... (1) An intentional or negligent act materially affecting the health or safety of residents of the facility." § 400.102(1), Fla. Stat. (2017).

FACTS JUSTIFYING AN EMERGENCY SUSPENSION OF LICENSURE

9. On September 13, 2017, the Agency commenced a survey of the Respondent and its Facility.

10. As a result of preliminary results of that survey, the Agency issued an Immediate Moratorium on Admissions dated September 13, 2017. Since that time, additional facts have

been gleaned by the Agency in its ongoing survey activity.

11. Based upon the above referenced survey activity, the Agency makes the following findings:

a. On September 10, 2017, Respondent became aware that its air conditioning equipment had ceased to operate effectively.

b. In addition to contacting the local electrical power provider, Respondent situated eight (8) portable air coolers somewhere in the facility and equipped the halls with fans.

c. Between 1:30 AM and 5:00 AM on September 13, 2017, several residents suffered respiratory or cardiac distress. At least eight (8) of those residents ultimately expired.

d. Emergency personnel and law enforcement responding to these multiple emergency medical events directed Respondent, as a result of the heat in the building, to evacuate the second floor of the Facility.

e. Respondent ultimately evacuated the entire building.

f. Due to the active state of emergency of Hurricane Irma, the Florida Emergency Operations Center was actively staffed to assist with critical incidents. Additional emergency resources through several state and local government agencies were also available. This includes potential assistance with a timely evacuation, which the Facility never requested.

g. Agency officials have reviewed records pertaining to the operational status of Memorial Regional Hospital, the hospital located directly across the street from the Respondent Facility, and have

confirmed that at all times relevant to this matter, the hospital was open, air-conditioned, and available to receive patients.

12. Specific findings related to the residents who expired on September 13, 2017, are as follows:

a. Resident number two (2):

i. The resident was seventy-eight (78) years old and suffered from multiple disease processes including Peripheral Vascular disease, dementia, history of ischemic attack, and dysphagia.

ii. An entry in Respondent's nursing records for the resident indicated that on September 12, 2017 at 7:11 p.m. the resident's temperature was ninety-nine point eight (99.8) degrees Fahrenheit.

iii. A note of September 13, 2017 at 4:42 a.m., documented the resident with temperature of one hundred one point six (101.6) Fahrenheit; a heart rate of one hundred four (104); a respiratory rate of twenty-four (24); and blood pressure of one hundred twenty-six over seventy-eight (126/78). The resident was assessed to have seventy-seven percent (77%) oxygen saturation, oxygen was applied, emergency services called, and the resident was transferred to a hospital emergency department. **This nursing note, though not so designated by staff, is an apparent "late entry" as the resident had already been transported to the hospital at the time of the note's entry.**

iv. At 4:32 a.m. on September 13, 2017, the resident arrived at the emergency department in cardiac arrest and the resident's temperature

was documented at **one hundred eight point three (108.3) degrees Fahrenheit** at 4:33 a.m.

v. Resuscitative efforts failed and the resident was pronounced deceased at 5:00 a.m.

vi. It is extremely disturbing that the facility made a late entry claiming a temperature of 101.6. when the resident was already dying at the hospital with a temperature of 108.3.

b. Resident number one (1):

i. The resident was eighty-four (84) years old and suffered from multiple disease processes including Chronic Obstructive Pulmonary Disease (COPD), heart failure, and atrial fibrillation.

ii. A "Late Entry" in Respondent's nursing records for the resident indicated that on September 11, 2017 at 11:53 p.m. the resident's temperature was ninety-seven (97) degrees Fahrenheit; a heart rate of eighty (80); respiratory rate of nineteen (19); and blood pressure of one hundred thirty over seventy-two (130/72).

iii. The resident was discovered at 1:30 a.m. on September 13, 2017 in respiratory distress with "bluish" lips. Emergency services were contacted and the resident was transferred to a hospital emergency department.

iv. At 3:43 a.m. on September 13, 2017, the resident's temperature was documented at **one hundred seven (107) degrees Fahrenheit**.

v. The resident expired with a diagnosis of heat stroke.

c. Resident number eight (8):

i. The resident was seventy (70) years old and suffered from multiple disease processes including heart disease, hypertension, cardio-vascular accident, and atrial fibrillation.

ii. An entry in Respondent's nursing records for the resident indicated that on September 12, 2017 at 4:16 a.m., the resident's temperature was one hundred two (102) degrees Fahrenheit, and Tylenol was administered as ordered. That same day at 2:18 p.m., the resident's vital signs were documented at a temperature of ninety-eight point two (98.2); a heart rate of seventy (70); respiratory rate of sixteen (16); and blood pressure of one hundred thirty-four over seventy-six (134/76).

iii. A subsequent entry in Respondent's nursing records for the resident indicated that on September 13, 2017 at 3:31 a.m. the resident was alert with flushed skin. The resident's temperature was one hundred one (101) degrees Fahrenheit; a heart rate of seventy-nine (79); respiratory rate of nineteen (19); and blood pressure of one hundred forty-eight over seventy-six (148/76). The resident was provided oxygen and Tylenol for fever.

iv. A "late Entry" dated September 14, 2017 at 4:20 [no further description of time] noted the resident had a change of condition and was in respiratory distress. Respiratory rate was documented at twenty-eight (28) breaths per minute with rapid and labored breathing.

Oxygen was applied and emergency services called for transport to the hospital.

v. The resident arrived at the hospital on September 13, 2017 at 6:42 a.m. with complaints of cardiac arrest and severe hyperthermia.

vi. The resident expired on September 13, 2017 at 6:49 a.m. with post-mortem temperature of **one hundred nine point nine (109.9) degrees Fahrenheit.**

d. Resident number seven (7):

i. The resident was seventy-one (71) years old and suffered from multiple disease processes including hypertension, cardiovascular disease, dementia, and dysphagia.

ii. An entry in Respondent's nursing records for the resident indicated that on September 12, 2017 at 10:34 p.m. the resident's temperature was ninety-seven (97) degrees Fahrenheit; a heart rate of seventy (70); a respiratory rate of sixteen (16); and blood pressure of one hundred twenty-two over seventy-four (122/74).

iii. Emergency medical services records reflect contact with the resident at 6:55 a.m. on September 13, 2017, and describes the resident having altered mental status, hyperthermia, and respiratory distress. The resident's temperature was documented at one hundred three point three (103.3) degrees Fahrenheit and the skin was described as "hot."

iv. The resident arrived at the hospital emergency department on September 13, 2017 at 7:03 a.m. pulseless. Resuscitative efforts failed

and the resident was pronounced deceased at 7:54 a.m. with a documented temperature of **one hundred eight point five (108.5) degrees Fahrenheit** at 7:50 a.m.

e. Resident number five (5):

i. The resident was eighty-four (84) years old and suffered from multiple disease processes including hypertension, cardiac disease, dementia, and dysphagia. The resident was assessed at risk for aspiration, dehydration, falls, and skin breakdown.

ii. A "Late Entry" in Respondent's nursing records for the resident dated September 14, 2017, at 8:15, without further description, documented the resident resting in bed with respirations even and unlabored. **The resident had expired before this entry was made.** The previous nursing note was dated September 12, 2017 at 2:20 p.m. and documented the resident's temperature was ninety-eight point six (98.6) degrees Fahrenheit; a heart rate of seventy-six (76); respiratory rate of sixteen (16); and blood pressure of one hundred twenty-six over seventy (126/70).

iii. No additional documentation memorializing the resident's condition or hospitalization was available for review.

f. Resident number four (4):

i. The resident was ninety-six (96) years old and suffered from multiple disease processes including hypertension, congestive heart failure, and atherosclerotic heart disease.

ii. An entry in Respondent's nursing records for the resident indicated that on September 13, 2017 at 1:28 a.m. the resident's temperature was ninety-seven (97) degrees Fahrenheit; a heart rate of seventy-four (74); respiratory rate of eighteen (18); and blood pressure of one hundred twenty-eight over seventy-four (128/74).

iii. A subsequent entry in Respondent's nursing records for the resident indicated that on September 13, 2017 at 4:00 p.m. [sic], the resident was discovered in cardiac arrest with shallow breathing. Documented vital signs do not include temperature. Heart rate ceased. Cardiopulmonary resuscitation was commenced, emergency services were contacted and emergency services pronounced the resident expired upon emergency service's arrival.

g. Resident number six (6):

i. The resident suffered from multiple disease processes including hypertension, Chronic Obstructive Pulmonary Disease (COPD) with exacerbation, and bronchitis.

ii. An entry in Respondent's nursing records for the resident indicated that on September 13, 2017 at 1:42 a.m. the resident's temperature was ninety-seven (97) degrees Fahrenheit; a heart rate of sixty-nine (69); respiratory rate of eighteen (18); and blood pressure of one hundred twenty over seventy-six (120/76).

iii. No additional documentation memorializing the resident's condition, hospitalization, or condition was available for review.

iv. A staff member indicated the resident was found unresponsive and not breathing at approximately 4:30 a.m. on September 13, 2017. Emergency medical personnel were in the Facility and were unsuccessful in resuscitating the resident.

h. Resident number three (3):

i. The resident was ninety-nine (99) years old and suffered from multiple disease processes including congestive heart failure, peripheral vascular disease, and pulmonary hypertension. The resident was receiving Hospice care.

ii. An entry in Respondent's nursing records for the resident indicated that on September 12, 2017 at 12:00 a.m. the resident's temperature was ninety-seven (97) degrees Fahrenheit.

iii. The resident expired in the Facility at approximately 1:30 a.m. on September 13, 2017.

13. In this instance, after careful and due consideration, the Agency determines that the practices and conditions at the Respondent's Facility, as set forth more specifically above, present (1) a threat to the health, safety or welfare of residents of the Facility, (2) a threat to the health, safety or welfare of a client, (3) an immediate serious danger to the public health, safety or welfare, and (4) an immediate or direct threat to the health, safety, or welfare of the residents that constitutes sufficient factual and legal grounds justifying the imposition of an Emergency Suspension of Licensure to operate a nursing home in the State of Florida.

NECESSITY FOR AN EMERGENCY SUSPENSION OF LICENSURE

14. The Agency is charged with the responsibility of enforcing the laws enacted to

protect the health, safety and welfare of residents and clients in Florida's nursing homes. Ch. 400, Part II, Fla. Stat. (2017), Ch. 408, Part II, Fla. Stat. (2017); Ch. 59A-4, Fla. Admin. Code. In those instances where the health, safety or welfare of a nursing home resident is at risk, the Agency will take prompt and appropriate action.

15. A nursing home must ensure it maintains facility premises and equipment and conduct its operations in a safe and sanitary manner." § 400.141(1)(h), Fla. Stat. (2017). Residents of nursing homes suffer from disease or disability, are frail, elderly, or vulnerable. By law, the Respondent has been licensed and entrusted to provide care and services to this special class of people, and as such, must comply with the regulations, statutes and rules that have been enacted for the special needs of these residents.

16. Licensed health care facilities are responsible for the care and safety of their residents at all times, including during an emergency.

17. All health care administrators and practitioners must know to immediately call "911" in a medical emergency. Respondent knew or should have known the danger presented to residents in its physical plant, yet failed to monitor, care for, and protect its residents. Respondent's sole identified response was to belatedly call "911" on an individual basis as its residents suffered, one after another, cardiac or respiratory arrest. In addition, Respondent was and is located across the street from a large, air-conditioned public hospital. This hospital was fully functional during the relevant period, yet Respondent failed to transfer its residents to that large, air-conditioned public hospital, or any other appropriate placement, in a timely fashion.

18. As a result of Respondent's failure to care for and protect its residents, at least eight (8) residents have died. The deceased residents arrived at the large air-conditioned hospital across the street with core body temperatures of, for example, one hundred nine point nine

(109.9) degrees Fahrenheit; one hundred eight point five (108.5) degrees Fahrenheit; one hundred seven (107) degrees Fahrenheit; and one hundred eight point three (108.3) degrees Fahrenheit – too far gone and far too late to be saved.

19. These core body temperatures are the product of the facility's failure to maintain a safe environment at the facility, failure to properly monitor its patients, and failure to timely report an ongoing medical emergency. Respondent's records are replete with late entries.

20. The Agency concludes that this facility's administrator and medical professionals did not know to call "911" in an ongoing emergency. As such, this facility presents a danger to every person on its premises – residents, visitors and staff – and cannot be permitted to treat any residents, at any time, under any circumstances.

21. The Respondent's deficient conduct is widespread and places all future residents at immediate threat to their health, safety and welfare. The Respondent has demonstrated that its physical plant and its management cannot provide an environment where residents can be provided care and services in a safe and sanitary manner.

22. The above-stated conditions present an immediate serious danger to public health, safety, or welfare and constitute a direct threat to the health, safety or welfare of residents and/or potential residents of the Facility. No resident of a nursing home should be placed in such a hazardous environment.

23. The Respondent's deficient practice exists presently; has existed in the past, and more likely than not will continue to exist if the Agency does not act promptly.

24. An Emergency Suspension of Licensure of this nursing home is necessary to protect the residents from (1) the unsafe conditions and deficient practices that currently exist in the facility, (2) being placed at risk of living in an environment ill-equipped to provide for

resident health, safety and welfare, and (3) being placed in a nursing home where the statutory and regulatory mechanisms enacted for their protection have been breached.

CONCLUSIONS OF LAW

25. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

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

27. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an Emergency Suspension of Licensure is necessary in order to protect the residents from (1) the unsafe conditions and deficient practices that currently exist, (2) being placed at risk of living in an environment ill-equipped to provide a safe and sanitary living environment, and (3) being placed in a nursing home where the regulatory mechanisms enacted for residents protection have been overlooked.

28. The Respondent's deficient practices exist presently and will more likely than not continue to exist if the Agency does not act promptly. Such deficient practices and conditions justify the imposition of an Emergency Suspension of licensure. Less restrictive actions, such as the assessment of administrative fines, will not ensure that future residents receive the appropriate care, services, and environment dictated by Florida law.

29. The emergency action taken by the Agency in this particular instance is fair under

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

IT IS THEREFORE ORDERED THAT:

1. Respondent's license to operate a nursing home in the State of Florida, license number 1238096, is hereby Immediately Suspended based upon the above-referenced provisions of law.

2. This Emergency Suspension Order shall be posted and visible to the public at the Respondent's nursing home. § 408.41(4), Fla. Sta. (2017).

3. During the Emergency Suspension Order, the Agency may regularly monitor the Respondent's Facility.

4. The Agency shall promptly proceed with the filing of an administrative action against the Respondent based upon the facts set out within this Order and any other facts that may be discovered during the Agency's continuing investigation. The Agency shall provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2017), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 20th day of September, 2017.

Justin M. Senior, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

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