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AHCA
AGENCY CLERK

2018 NOV 14 A 10: 43

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

Case No.: 18-554PH
AHCA Case No.: 2018006576
Facility Type: Assisted Living

RENDITION NO.: AHCA- 18 -0838 -S-OLC

SENIOR LIVING PROPERTIES V, LLC
d/b/a SAVANNAH COURT OF THE PALM BEACHES,

Respondent.
_______________________________________/

FINAL ORDER

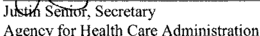
Having reviewed the Administrative Complaint, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

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

2. The Respondent shall pay the Agency fifteen thousand dollars ($15,000.00). If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 60 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 November, 2018.



Justin 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 14 day of November, 2018.

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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Nicola L. C. Brown Assistant General Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Allyn C. McKinney Risk Manager Senior Living Properties V, LLC d/b/a Savannah Court of the Palm Beaches 9660 W. Bay Harbor Drive, #2C Bay Harbor Island, FL 33154

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

AHCA No.: 2018006576

Petitioner,

Facility Type: Assisted Living

v.

SENIOR LIVING PROPERTIES V, LLC
d/b/a SAVANNAH COURT OF THE PALM BEACHES,

Respondent.

_______________________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), by and through its undersigned counsel, and files this Administrative Complaint against Respondent, Senior Living Properties V, LLC d/b/a Savannah Court of the Palm Beaches ("the Respondent"), pursuant to §§ 120.569 and 120.57, Florida Statutes (2017), and alleges:

NATURE OF THE ACTION

This is an action against an assisted living facility to impose an administrative fine in the amount of fifteen thousand dollars ($15,000.00) based upon three (3) Class II deficient practices.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 20.42, 120.60, and Chapters 408, Part II, and 429, Part I, Florida Statutes (2017).
2. Venue lies pursuant to Florida Administrative Code R. 28-106.207.

EXHIBIT 1

PARTIES

3. The Agency is the regulatory authority responsible for licensure of assisted living facilities and enforcement of all applicable federal regulations, state statutes and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code, respectively.

4. Respondent operates a one hundred and fourteen (114) bed assisted living facility located at 2090 N. Congress Avenue, West Palm Beach, FL 33401, and is licensed as an assisted living facility, license number 8367.

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

COUNT I

6. The Agency re-alleges and incorporates paragraphs one (1) through five (5) as if fully set forth herein.

7. That 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.
>
> Section 429.26, Florida Statutes (2017).

8. That Florida law provides:

> 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), Florida Administrative Code.

9. That between November 22, 2016 and December 8, 2016, the Agency conducted a complaint survey of Respondent and its facility.

10. That based on record review and interview, Respondent failed to provide care and services appropriate to the needs of residents, including medication assistance and monitoring of residents well-being for 1 out of 3 sampled residents (Resident #1).

11. That Petitioner's representative review of Resident #1's progress notes dated November 17, 2016, revealed the following:

- A third party Physical Therapist Assistant reported to Staff "D" that the resident had a blood pressure of over 200 systolic.
- Staff "D" re-measured the blood pressure and it was found to be 200/98 mmHg.
- The Advanced Registered Nurse Practitioner (ARNP) was made aware and orders received.
- The resident was later taken to a local area hospital by his/her family at 2:40 PM on November 17, 2016 and was discharged and returned to the facility on November 18, 2016.

- Resident #1 was again taken to the emergency room by his/her family on November 20, 2016, with high blood pressure and returned to the facility the same day.
- The resident's health care practitioner increased the dosages of Amlodipine/Benazepril 5-20mg to 10-20mg daily (blood pressure medication) and Hydrochlorothiazide 12.5 mg (diuretic used to treat high blood pressure and fluid retention) was increased to 25mg daily.

12. That on or about November 22, 2016 at approximately 10:35AM, during an interview with Resident #1, the resident confirmed that he/she went to the hospital twice for high blood pressure.

13. That on or about November 28, 2016, at or approximately 5:30 PM, during an interview with Resident #1' s family member, she stated that she was made aware that Resident #1's blood pressure was high. When she arrived at the facility to transport Resident #1 to the hospital on November 17, 2016, she was told by the nurse on duty that Resident #1 had not received his/her blood pressure medication for four (4) days.

14. That later in the family member's communication with staff, it was determined Resident #1 had missed several doses of his/her anti-anxiety medication. Resident #1's family member stated that when Resident #1 returned from the hospital on November 18, 2016, the facility still did not have the medications available. As a result, Resident #1 did not receive his/her blood pressure medications on November 19 and 20, 2016. This caused Resident #1's blood pressure to become high again resulting in another emergency room visit on November 20, 2016.

15. That a review of Resident #1's Medication Observation Record (MOR), confirmed the resident was prescribed two medications to control his/her blood pressure; Amlodipine/Benazepril 5-20mg daily and Hydrochlorothiazide 12.5mg (diuretic) every

other day.

16. Petitioner's representative review of hospital records revealed that Resident #1 was admitted on November 17, 2016, with Hypertensive Urgency complaining of fatigue, malaise, dizziness and headache.

17. That Hypertensive Urgency refers to "a blood pressure reading of 180/110 or greater which could be accompanied by severe headache, nose bleed, shortness of breath and sever anxiety." The American Heart Association.

18. That Resident #1's blood pressure was documented as 200/98 mmHg at 3:05 PM and the resident was given two blood pressure medications; Hydralazine 5mg intravenously and Clonidine 0.2mg tablet by mouth.

19. That the resident's blood pressure was re-evaluated at 4:00 PM and had decreased to 150/68 mmHg. Resident #1 was discharged from the hospital on November 18, 2016, at 2:30 PM with orders to be continued which included two medications, Hydrochlorothiazide 12.5 mg every other day and Amlodipine / Benazepril 5-10mg daily.

20. That review of additional hospital records dated November 20, 2016, revealed Resident #1 was seen again in the emergency room on that date with a complaint of high blood pressure and a documented blood pressure of 191/181 mmHg. Resident #1 was treated with one dose of Clonidine 0.1 mg tablet by mouth. The resident's blood pressure was re-evaluated and decreased to 133/62. Resident #1 was discharged that same evening with a prescription for Clonidine 0.1mg as needed (PRN) for elevated blood pressure.

21. That on or about November 30, 2016 at approximately 10:25 AM, during an interview with the Physical Therapy Assistant, she stated she normally took Resident #1's blood pressure when she came to see him/her. She stated that during her visit with Resident #1 on

November 17, 2016, the resident stated he/she was not feeling well and he/she was lightheaded. The Physical Therapist Assistant stated that she routinely checked blood pressure before working with a resident. However, since Resident #1 complained of feeling lightheaded she remembered she checked the resident's blood pressure.

22. That although the Physical Therapist Assistant could not recall Resident #1's blood pressure reading, she remembered it was high and went to get the nurse.

23. That the nurse took Resident #1's blood pressure two more times and it remained elevated. The Physical Therapist Assistant stated that the nurse said she would take care of the matter.

24. That the Physical Therapist Assistant stated that she was later informed by Resident #1's family that the resident was admitted to the hospital.

25. That on or about November 30, 2016, at approximately 9:30 AM, during an interview with Resident #1's ARNP (Advanced Registered Nurse Practitioner), she stated that she was informed on November 17, 2016 that Resident #1's blood pressure was about 180 systolic and the diastolic in the 90's, which was high enough for her to give the resident an extra dose of blood pressure medication.

26. That the ARNP stated she increased Resident #1's blood pressure medications under the assumption that Resident #1 was receiving the appropriate medication but that the dosage was not effective.

27. That the ARNP stated that she later found out that Resident #1 had not been receiving the prescribed order.

28. That the ARNP confirmed that the facility informed her of Resident #1's hospitalization the same day but she was never informed that the resident's blood pressure was 200 mmHg

systolic. If she knew that she would have immediately sent Resident #1 to the Emergency Room.

29. That the ARNP stated that she was under the impression that the extra dose did not work and that was what led Resident #1's family to take him/her to the emergency room. The ARNP continued to state that she was made aware of the missed medications by the resident's family.

30. That the ARNP confirmed that prior to the resident's hospitalization, Resident #1 was stable for some time. She further confirmed that if Resident #1 missed a dosage of his/her anti-anxiety or blood pressure medications, the resident became unstable.

31. That the ARNP explained that if Resident #1 missed a dose of his/her thyroid medication Synthroid, the resident exhibited signs of increased depression and increased fatigue. If the resident missed a dose of Klonopin, he/she became anxious which increased his/her blood pressure.

32. That the ARNP stated that prescriptions were written for three months of refills and sometimes changed the doses of Klonopin (Clonazepam) and Hydrochlorothiazide but there was no reason Resident #1 should have missed the medications.

33. That in reviewing the November 2016 Medication Observation Record (MOR) for Resident #1, Petitioner's representative learned that Medication Technicians (MTs) were assisting with self-administration of medications. The initials of the MTs responsible for assisting with medications were either circled or documentation areas were left blank, which indicated that the medication was not taken/given to the resident on several days, including the following:

- Amlodipine/Benazepril 5-20 mg (hypertension), one capsule by mouth daily

scheduled for 9:00 AM was missed on November 14, 2016 through November 17, 2016, indicated by staff initials being circled.

- Levothyroxine 50 mcg (thyroid hormones), one tablet by mouth once daily scheduled for 6:00 AM was missed on November 10, 2016 through November 21, 2016, indicated by staff initials being circled.
- Memantine 10mg (anti-dementia), one tablet by mouth twice daily scheduled for twice a day. Doses scheduled for 9:00 AM were missed on November 2, 2016 through November 8, 2016, and November 19, 2016 through November 21, 2016, as indicated by staff initials being circled. Doses scheduled for 5:00 PM on November 1, 2016 through November 3, 2016, and November 8, 2016, were missed as indicated by blank spaces, and November 4, 2016 through November 7, 2016, were missed as indicated by staff initials being circled.
- Quetiapine 25mg (for anxiety), one tablet by mouth twice daily scheduled for 9:00 AM and 5:00 PM. The 9:00 AM doses were missed on November 2, 2016 through November 8, 2016, as indicated by staff initials being circled. Doses scheduled for 5:00 PM were missed on November 2, 2016, November 3, 2016, and November 8, 2016, as indicated by the documentation areas left blank, and on November 5, 2016 through November 7, 2016, as indicated by staff initials being circled.
- Aspirin 81 mg (chewable), one tablet by mouth once daily before meals scheduled for 9:00 AM was missed on November 14, 2016, as indicated by the box being left blank.
- Clonazepam 0.25mg tablet (for anxiety) by mouth three times a day was originally prescribed three times daily 9:00 AM, 1:00 PM, and 9:00 PM. Documentation was

left blank for the 9:00 AM doses on November 1, 2016, November 5, 2016, and November 8, 2016 through November 13, 2016. Documentation was left blank for the 1:00 PM doses scheduled for November 1, 2016, November 6, 2016, November 9, 2016 through November 14, 2016, and the 9:00 PM doses scheduled for November 3, 2016, November 11, 2016 through November 15, 2016. The staff initials were circled indicating the medication was not given on November 3, 2016 through November 5, 2016, November 7, 2016, November 14, 2016 and November 15, 2016 11/15/16. The 1:00 PM dose for November 8, 2016 and the 9:00 PM dose on November 4, 2016 through November 10, 2016. The medication times were changed on November 16, 2016 to 8:00 AM, 1:00 PM, and 6:00 PM. The medication documentation areas were left blank indicating it was not given to the resident on November 17, 2016 at 8:00 AM and November 18, 2016, at 1:00 PM.

34. That on or about November 22, 2016, at approximately 1:20 PM, during an interview with Staff "D," a Licensed Practical Nurse (LPN), he stated that on November 20, 2016, he discovered that Staff "F," a CNA/MT, had not given the blood pressure medication [Amlodipine/Benazepril 5-20mg] to Resident #1 that day but signed off as if she had.
35. That Staff "D" said the resident could not have been given the medication because it was not available at the facility.
36. That Petitioner's representative observed there were no documentation on the back of the MORs or in the progress notes to indicate why the aforementioned medications were not given.
37. That on or about November 23, 2016 at approximately 12 PM, upon further record review and interview with the Executive Director, Petitioner's representative learned there were

no MORs available for Resident #1 at the time of survey for the months of August and September of 2016.

38. That on or about November 22, 2016, at approximately 1:40 PM, during an interview with Staff "A," an MT, she stated that if a medication was not given, she initialed and circled her initials and wrote on the back her explanation of why she did not give the medication. She confirmed that she did not write anything on the back of Resident #1 November 2016 MOR on the days her initials were circled. She further stated that if the medications were not available, staff completed the facility's Medication Request form and gave it to the nurse.

39. That on or about November 23, 2016, at approximately 10:45 AM, Petitioner's representative called the pharmacy in question.

40. That the pharmacy's staff confirmed that the pharmacy usually delivered the medications for the resident to the facility but lately the facility went to the pharmacy to retrieve the medications.

41. That the pharmacy's staff confirmed that a 30-day supply of Amlodipine/Benazepril was ordered for Resident #1 on November 21, 2016, and prior to that not since September 30, 2016 and August 25, 2016. The pharmacy confirmed that the medications were automatically paid for by insurance and a credit card on file, so there was no reason why they could not get the medication.

42. That on or about December 8, 2016, at approximately 8:45 AM, during a follow-up interview with Resident #1, the resident stated that subsequent to the hospital visits, the facility gave him/her the medications late and gave them without explaining to him/her what he/she was receiving. The resident hoped to get his/her blood pressure and anxiety

medications because he/she worried about his/her blood pressure.

43. That on or about November 22, 2016, at approximately 1:15 PM, during an interview with the interim DON (Director of Nursing), she confirmed that the MORs lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they had the pharmacy in the building today (11/22/16) to review everyone's medications and MORs.

44. That on or about November 22, 2016, at approximately 2:20 PM, during an interview with the Executive Director, he stated the previous Health and Wellness Director had not taken any measures to ensure the medications were timely received from the pharmacy. He confirmed there was no system in place to ensure the medications were ordered. He stated that the facility was aware it had a problem with medications not being ordered and available for the residents in a timely manner. A Medication Error Report was completed by the Administrator on November 18, 2016, regarding Resident #1, which indicated the error as Amlodipine/Benazepril cap 5-20mg was not re-ordered.

45. That the aforementioned facts reflect Respondent's failure to provide care and services appropriate to the needs of residents, including medication assistance and monitoring of residents' well-being.

46. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of a provider or to the care of clients which directly threatened the physical or emotional health, safety, or security of the clients, other than class I violations.

47. That the same constitutes a Class II offense as defined in Florida Statute 429.19(2)(b) (2017).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five thousand dollars ($5,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(b), Florida Statutes (2017).

COUNT II

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

49. That Florida law provides:

> (3) ASSISTANCE WITH SELF-ADMINISTRATION.
> (a) Any unlicensed person providing assistance with self administration of medication must be 18 years of age or older, trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.
> (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed.
> (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
> (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
> (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
> 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
> 2. The medication container may be given to the resident, a friend, or family

> member upon leaving the facility, with this fact noted in the resident's medication record,
> 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
> 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
> (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
> 1. As used in Section 429.256(4)(h), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
> 2. As used in Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.
>
> Rule 58A-5.0185(3), Florida Administrative Code.

50. That between November 22, 2016 and December 8, 2016, the Agency conducted a complaint survey of Respondent and its facility.

51. That based on record review and interview, Respondent failed to provide assistance with self-administration of medication(s) as ordered by residents' physicians, and failed to notify residents' physician of any concerns regarding the medications, including missed doses, for 3 of 3 sampled residents (Residents #1, #2 and #3).

52. That Petitioner's representative review of the October and November 2016 MOR for Resident #2 showed that Medication Technicians (MTs) were assisting with self-administration of medications. The initials of the MTs responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication were not taken/given to the resident on several days, including the following:

- Trazadone 50mg (sedative), one tab by mouth daily at bedtime, scheduled for 9:00 PM. The daily dose was missed November 1, 2016 through November 21, 2016, as

indicated by staff initials circled, and November 7, 2016 documentation area left blank.

- Gabapentin 300mg (anticonvulsant), one capsule by mouth once daily at 1 PM. A dose was missed on November 5, 2016, as indicated by documentation area left blank.
- APAP/Diphenhydramine 25-500mg (antihistamine), two tablets (50-1000mg) by mouth every night at bedtime, scheduled for 9:00 PM. A dose was missed on 11/18/16 as indicated by documentation area left blank.

53. That the only documentation that provided an explanation of missed doses were on November 18, 2016, at 9:00pm, which documented that the Trazadone was "On Order."
54. That upon further record review and interview with the Executive Director on or about November 23, 2016, at approximately 12:00 PM, Petitioner's representative learned that there were no MORs available at the time of survey for the months of August and September 2016.
55. That on or about November 22, 2016, at approximately 10:45 AM, during an interview with Resident #2, the resident stated that the facility ran out of his/her medications all the time, and that it happened too often. The resident stated either the facility forget to order it or they ordered it, it went downstairs, and never made it upstairs.
56. That Petitioner's representative review of the October and November 2016 MOR for Resident #3 showed that Medication Technicians (MTs) were assisting with self-administration of medications. The initials of the MTs responsible for assisting with medications were either circled or documentation areas were left blank, indicating that medication were not taken/given to the resident on several days, including the following:

- One-Daily Tab Multivitamin, one tablet by mouth once daily scheduled for 9:00 AM. The medication was not given on November 9, 2016 and November 10, 2016, as indicated by the documentation areas left blank.
- Losartan Potassium 100mg (for blood pressure), one tablet by mouth daily, scheduled for 9:00 PM. The medication was not given on November 7, 2016 through November 9, 2016, as indicated by the documentation areas left blank.
- Tramadol HCL 50mgTablet (pain medication), give two tablets (100mg) by mouth three times daily scheduled for 6:00 Am, 2:00 PM and 10:00 PM. The medication was not given on November 17, 2016, at 10:00 PM, as indicated by the documentation areas left blank.
- Citalopram Tab 10mg (anti-depressant), one tablet by mouth once daily, scheduled for 9:00 AM. The medication was not given on November 14, 2016, as indicated by the documentation areas left blank.
- Tamsulosin 0.4 mg Capsule (Prostate medication), one capsule by mouth every night at bedtime, scheduled for 9:00 PM. The medication was not given on November 2, 2016, November 14, 2016, November 19, 2016, and November 20, 2016, as indicated by staff initials being circled, and November 12, 2016, was missed as indicated by the documentation areas left blank. The back of the MOR indicated the resident refused the Tamsulosin on November 18, 2016, but there was no other documentation as to why the medication was not given the other days.
- Ciprofloxacin 500mg (antibiotic), one tab by mouth twice daily times one week scheduled for 9:00 AM and 5:00 PM. The transcriber indicated the medication was to be started on the morning of October 18, 2016. There was illegible writing in

the column for the 18th which did not coincide with staff signatures along with blank spaces on October 19, 2016, at 9:00 AM and November 24, 2016, at 5:00 PM. The MOR indicated only 10 of the 14 doses of antibiotics were documented as given. There was no indication on the back of the MOR's as to why the medications were missed.

- Limbrel 500/50 mg (analgesic), one cap by mouth twice daily, scheduled for 9:00 AM and 5:00 PM. The order was written twice on the October 2016 MOR. Staff initials were circled for the 9:00 AM dose on October 3, 2016, and documentation areas left blank from October 4, 2016 through October 22, 2016. The 5:00 PM doses were not given as evidenced by staff initials circled from October 2, 2016 through October 4, 2016, October 6, 2016 through October 14, 2016, and October 16, 2016. Documentation areas were left blank on October 5, 2016, October 15, 2016, October 17, 2016 through October 19, 2016, and October 21, 2016.

57. That there was no indication on the back of the MORs as to why the medications were missed.

58. That upon further record review and interview with the Executive Director on or about November 23, 2016, at approximately12 PM, Petitioner's representative learned there were no MOR's available for Resident #3 at the time of survey for the months of August and September 2016.

59. That on or about November 22, 2016, at approximately 11:15 AM, during an interview with Resident #3, the resident stated the facility had no checks and balances with the Med-Techs to ensure they were passing the medications correctly.

60. That Resident #3 informed Petitioner's representative that within the last month, on two

occasions, the facility failed to have the right meds, and on two other occasions, the facility missed giving the resident his/her Flomax (Tamsulosin).

61. That Resident #3 stated that he/she got a copy of his medication list and started keeping track of the amount of pills the facility gave to him/her versus what he/she was supposed to be getting.

62. That on or about November 22, 2016, at approximately 1:15 PM, during an interview with the interim DON (Director of Nursing), she confirmed that the MORs lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they had pharmacy in the building today (11/22/16) to review everyone's medications and MOR.

63. That the aforementioned facts reflect Respondent's failure to provide assistance with self-administration of medication(s) as ordered by residents' physicians, and failure to notify residents' physician of any concerns regarding the medications, including missed doses.

64. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of a provider or to the care of clients which directly threatened the physical or emotional health, safety, or security of the clients, other than class I violations.

65. That the same constitutes a Class II offense as defined in Florida Statute 429.19(2)(b) (2017).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five thousand dollars ($5,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(b), Florida Statutes (2017).

COUNT III

66. The Agency re-alleges and incorporates paragraphs one (1) through five (5) and Counts I and II, as if fully set forth herein.

67. That Florida law provides:

> (7) MEDICATION LABELING AND ORDERS.
> (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:
> 1. The resident's name; and,
> 2. Identification of each medicinal drug in the container.
> (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another.
> (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
> (d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident's health care provider, or a faxed or electronic copy of such order. The new directions must promptly be recorded in the resident's medication observation record. The facility may then place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record, or obtain a revised label from the pharmacist.
> (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The

facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.

Rule 58A-5.0182(1), Florida Administrative Code.

68. That between November 22, 2016 and December 8, 2016, the Agency conducted a complaint survey of Respondent and its facility.

69. That based on observation, record review, and interview, Respondent failed to make a reasonable effort to ensure that prescriptions for residents who received assistance with self-administration of medication or medication administration were filled or refilled in a timely manner.

70. That on or about November 22, 2016, Petitioner's representative requested to review a copy of the facility's policy and procedures related to medication assistance, administration, documenting, and ordering medications from the pharmacy.

71. That a copy of the Medication Management Lesson Plan was provided. However, it did not include any of the requested information.

72. That on or about November 23, 2016, at approximately 11:30 AM, during an interview with the facility's Executive Director, Petitioner's representative again requested to review a copy of the facility's policy and procedures related to medication assistance, administration, documenting, and ordering medications from the pharmacy. The Executive Director confirmed there was no such policy in place.

73. That on or about November 22, 2016, at approximately 1:15 PM, during an interview with the interim Director of Nursing (DON), she confirmed that the MORs lacked the appropriate documentation. She confirmed she was aware of everything going on with the medications including missed doses and lack of documentation. She stated that was why they had Pharmacy Consultants in the building today (11/22/16) to review everyone's medications and MOR.

74. That on or about November 22, 2016, at approximately 2:20 PM, during an interview with the Executive Director, he stated the previous Health and Wellness Director had not taken any measures to ensure the medications were timely received from the pharmacy. He confirmed there was no system in place to ensure the medications were ordered. He stated that the facility was aware it had a problem with medications not being ordered and available for the residents in a timely manner.

75. That on or about November 22, 2016, at approximately 2:00 PM, during an interview with Staff "C," she stated that med-techs notified the nurse when medications were needed. She explained that the med-techs took the sticker off the punch card, placed it on paper, and gave it to the nurse because they were not permitted to order medications. Staff "C" stated she was unsure which nurse she reported the matter to, but stated she verbally informed the nurse because there were no sticker there, so they should have long ordered it. She stated when the nurse faxed the orders, they were supposed to have a receipt that said "ok."

76. That Petitioner's representative conducted a confidential interview with a staff member. He/she stated there were residents whose medications had been missing for a month and nothing was done about it.

77. That the aforementioned facts reflect Respondent's failure to make a reasonable effort to ensure that prescriptions for residents who received assistance with self-administration of medication or medication administration were filled or refilled in a timely manner.

78. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of a provider or to the care of clients which directly threatened the physical or emotional health, safety, or security of the clients, other than class I violations.

79. That the same constitutes a Class II offense as defined in Florida Statute 429.19(2)(b) (2017).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five thousand dollars ($5,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(b), Florida Statutes (2017).

Respectfully submitted this 20th day of July, 2018.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION

By: [signature]

Nicola L. C. Brown
Assistant General Counsel
Fla. Bar. No. 0492507
Agency for Health Care Administration
525 Mirror Lake Drive, 330H
St. Petersburg, FL 33701
727.552.1946 (office)
Nicola.Brown@ahca.myflorida.com

NOTICE

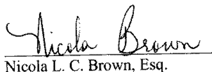
The Respondent is notified that it/he/she has the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If the Respondent wants to hire an attorney, it/he/she has the right to be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights form.

The Respondent is further notified if the Election of Rights form is not received by the Agency for Health Care Administration within twenty-one (21) days of the receipt of this Administrative Complaint, a final order will be entered.

The Election of Rights form shall be made to the Agency for Health Care Administration and delivered to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Mail Stop 3, Tallahassee, FL 32308; Telephone (850) 412-3630.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7013 2250 0001 4950 3400 on July 20, 2018, to Frances Scogna, Administrator for Senior Living Properties V, LLC, d/b/a Savannah Court of the Palm Beaches., 2090 N. Congress Avenue, West Palm Beach, FL 33401, and to Dennis Wagner, Registered Agent for Senior Living Properties V, LLC, d/b/a Savannah Court of the Palm Beaches, 4611 Johnson Road, Suite 1, Coconut Creek, FL 33073.



Nicola L. C. Brown, Esq.

Copy furnished to: Jon Seehawer
Field Office Manager

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: SENIOR LIVING PROPERTIES V, LLC d/b/a SAVANNAH COURT OF THE PALM BEACHES **AHCA No.: 2018006576**

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed agency action by the Agency for Health Care Administration (AHCA). The title may be Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint. Your Election of Rights may be returned by mail or by facsimile transmission, **but must be filed with the Agency Clerk within 21 days by 5:00 p.m., Eastern Time,** of the day that you receive the attached proposed agency action. **If your Election of Rights with your selected option is not received by AHCA within 21 days of the day that you received this proposed agency action, you will have waived your right to contest the proposed agency action and a Final Order will be issued.**

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

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

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _______ I waive the right to a hearing to contest the allegations of fact and conclusions of law contained in the Administrative Complaint. I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the fine, sanction or other agency action.

OPTION TWO (2) _______ I admit the allegations of fact contained in the Administrative Complaint, but wish to be heard at an informal hearing (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the

proposed administrative action is too severe or that the fine, sanction or other agency action should be reduced.

OPTION THREE (3) ________ I dispute the allegations of fact contained 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.

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

Signed: ________________________________ Date: ______________

Print Name: ____________________________ Title: ______________

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

Case No.: 18-554PH
AHCA No.: 2018006576
Facility Type: Assisted Living

SENIOR LIVING PROPERTIES V, LLC
d/b/a SAVANNAH COURT OF THE PALM BEACHES,

Respondent.
_______________________________________/

SETTLEMENT AGREEMENT

The Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), and the Respondent, Senior Living Properties V, LLC d/b/a Savannah Court of the Palm Beaches, ("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 December 8, 2016, and later issued the Respondent an Administrative Complaint on July 20, 2018, notifying Respondent of the Agency's intent to impose an administrative fine in the amount of fifteen thousand dollars ($15,000.00); and

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

EXHIBIT 2

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 fifteen thousand dollars ($15,000.00) within 60 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 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 Administrative Complaint, 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.

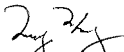
14. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. The Respondent has the legal capacity to execute this Agreement. The Respondent understands that it has the right to consult with its own independent counsel and has knowingly 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.

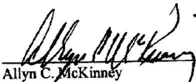
16. All parties agree that a facsimile signature suffices for an original signature.

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. #1
Tallahassee, Florida 32308

DATED: 11/14/18



Allyn C. McKinney
Risk Manager
Senior Living Properties V. LLC
d/b/a Savannah Court of the Palm Beaches
9660 West Bay Harbor Drive, #2C
Bay Harbor Island, FL 33154

DATED: 9/27/18

Stefan R. Grow, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 11/5/18

Nicola L. C. Brown
Assistant General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive North, Ste. 330H
St. Petersburg, Florida 33701

DATED: 9/27/18