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

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

LANGHAM HEALTHCARE, LLC d/b/a THE WOODLANDS,

Respondent.
_____/

AHCA No: 2023016272
License No. 6601
File No. 11932487
Provider Type: Assisted Living Facility

# EMERGENCY SUSPENSION ORDER

THIS CAUSE came on for consideration before the Secretary of the Agency for Health Care Administration, or his duly appointed designee, who after careful review of the matter at hand and being otherwise fully advised, finds and concludes as follows:

## THE PARTIES

1. The Agency for Health Care Administration ("the Agency"), is the licensure and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state statutes and rules governing assisted living facilities. Chs. 408, Part II, and 429, Part I, Fla. Stat. (2023), Ch. 59A-36, Fla. Admin. Code. As part of its statutory oversight responsibilities, the Agency has the authority to impose emergency orders, including a moratorium on admissions and an emergency suspension order, when circumstances dictate such action. §§ 120.60(6), 408.814, Fla. Stat. (2023).

2. The Respondent, Langham Healthcare, LLC d/b/a The Woodlands ("the Respondent"), was issued a license (License Number 6601) by the Agency to operate a one hundred ten (110) bed assisted living facility ("the Facility") located at 825 Santa Barbara

Boulevard, Cape Coral, Florida 33991, and was at all material times required to comply with the statutes and rules governing such facilities.

3. As the holder of such a license, the Respondent is a licensee. "Licensee" means "an individual, corporation, partnership, firm, association, or governmental entity, or other entity that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2023). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2023). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2023). § 408.803(11), Fla. Stat, (2023). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2023), and listed in Section 408.802, Florida Statutes (2023). § 408.802(11), Fla. Stat. (2023). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2023).

4. The Respondent holds itself out to the public as an assisted living facility that complies with the laws governing assisted living facilities. These laws exist to protect the health, safety, and welfare of the residents of assisted living facilities. As individuals receiving services from an assisted living facility, these residents are entitled to receive the benefits and protections under Chapters 120, 408, Part II, and 429, Part I, Florida Statutes (2023), and Chapter 59A-36, Florida Administrative Code.

5. As of the date of this Emergency Suspension Order the total census at the Facility is ninety-nine (99) residents/clients.

## THE AGENCY'S EMERGENCY ORDER AUTHORITY

6. The Agency may impose an immediate moratorium or emergency suspension as defined in section 120.60, Florida Statutes (2023), 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. (2023). If the Agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license, the Agency may take such action by any procedure that is fair under the circumstances. § 120.60(6), Fla. Stat. (2023).

## LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

### Resident Rights

7. Under Florida law, "No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) [l]ive in a safe and decent living environment, free from abuse and neglect; (b) [b]e treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy; and . . . (j) [a]ssistance with obtaining access to adequate and appropriate health care..." § 429.28(1), Fla. Stat. (2023).

### Supervision

8. 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 59A-36.012, 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.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) 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.

Fla. Admin. Code R. 59A-36.007(1).

**Physical Plant**

9. Florida law provides:

(3) OTHER REQUIREMENTS.
(a) All facilities must:
1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.
2. Be maintained free of hazards; and,
3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.
(b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:
1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident,
2. A closet or wardrobe space for hanging clothes,
3. A dresser, chest or other furniture designed for storage of clothing or personal effects,
4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,
5. A comfortable chair, if requested.
(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.
(d) Residents who use portable bedside commodes must be provided with privacy during use.
(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be threadbare.

Fla. Admin. Code R. 59A-36.014(3).

**Administrator's Responsibility**

(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility

including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.

...

Fla. Admin. Code R. 59A-36.010(1).

**Financial Ability to Operate**

10. Florida law provides:

(1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.

Fla. Admin. Code R. 59A-36.013(1).

**FACTS JUSTIFYING EMERGENCY ACTION**

11. On October 25, 2023, the Agency commenced a survey of the Facility.

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

**Sexual Assault of Resident**

a. On July 24, 2023, a resident sexually assaulted another resident:

b. The aggressor had masturbated on another resident, whose shirt had been removed. The victim suffers from dementia and is unable to answer simple questions.

c. The Facility's sole response was to shower the victim. No further medical or mental health assessments were conducted.

d. The residents' respective rooms were located on the same hallway, diagonally across from one another. Neither resident was relocated within the Facility.

e. The Facility undertook no investigation of the event, and did not notify the residents' physicians, family, or law enforcement of the event.

f. Subsequent to this event, the aggressor resident was noted on August 13 and 14,

2023 exposing genitals within the Facility.

g. There are no documented interventions considered or undertaken to address the aggressor's continuing inappropriate sexual behaviors.

**Fallen Resident**

h. On October 3, 2023, a resident fell through a glass window in the entrance lobby:

i. The resident suffered injuries and was sent to a local emergency department for treatment.

j. The Facility undertook no internal investigation of the event and did not complete, or file adverse incident reports related to the event as required by Section 429.23, Florida Statutes (2023).

k. The resident had suffered two (2) falls on October 6, 2023, and a total of nine (9) falls since July 13, 2023.

l. There are no documented interventions considered or undertaken to address the resident's falls.

**Resident Elopement**

m. On October 3, 3023, a resident eloped from the Facility at approximately 7:00 p.m. by exiting the front door when staff had released an electronic lock to allow a pizza delivery.

n. The Facility was unaware that the resident had eloped until approximately 9:00 p.m.

o. Neither law enforcement nor the resident's family were notified of the event. The Facility's Administrator was contacted at approximately 10:00 p.m.

p. Emergency medical services located the resident approximately one point four

(1.4) miles from the Facility on a sidewalk aside a busy four (4) lane highway.

q. The resident was transported to a local hospital. The Administrator was notified by hospital personnel of the resident's hospitalization before the Facility staff notified the Administrator of the elopement.

r. The Facility undertook no internal investigation of the event and did not complete, or file adverse incident reports related to the event as required by Section 429.23, Florida Statutes (2023).

s. The Facility's sole response to the elopement was to give an employee warning to the staff member allowing the pizza delivery, the warning reading, "Will make sure to pay attention at all times who goes in or out."

**Physical Plant**

t. Water pipes located in the ceiling of the 100 hall are dripping in resident rooms and the hallway. The Facility Maintenance Director acknowledged the leaking pipes and indicated they were being repaired as leaks appear, and that there is suspected bio-growth in the area above the ceilings as a result of the leaks.

u. Ceiling damage noted included: (1) The ceiling of room 111 fell due to water damage on October 24, 2023, and was patched with drywall. (2) The ceiling of room 110 reflects extensive water damage with water evident stains and bio-growth on the ceiling panels.

**Hot Water Systems**

v. There is no hot water available on three (3) of the five (5) resident halls, and the laundry.

w. The hot water boiler serving these areas broke on October 14, 2023.

x. The water on the 400 hall is one hundred thirty-nine (139) degrees Fahrenheit, an unsafe temperature. The water on the 500 hall is one hundred twenty (120) degrees Fahrenheit.

y. Ninety-eight (98) residents are forced to either take cold showers or utilize two (2) communal showers on the 500 hallway.

z. Residents report foregoing showers due to the lack of hot water. A staff member reports showering three (3) residents in cold water without the residents' complaint, however the three (3) identified residents suffer from dementia and were unable to answer questions regarding their care appropriately.

aa. The Facility has no policy or procedure to address the lack of hot water in its laundry systems and has not addressed any health and safety risks presented by the lack of hot water and its potential effect on effective infection control.

bb. The Administrator asserts that two (2) companies have come to the Facility to address the lack of hot water issues, but one (1) did not submit a quote and the other submitted a quote for repairs on October 24, 2023. The Facility's corporate office has yet to approve the repair expenses.

**Bed Bug Infestation**

cc. On September 11, 2023, Florida's Department of Health identified an infestation of bed bugs within the Facility and directed the Facility to address the infection within thirty (30) days.

dd. Upon the return of Department personnel on October 16, 2023, they discovered that the Facility did not contract with a pest control company, but instead treated the infestation by an over-the-counter pesticide applied only when bed bugs are

visually observed.

ee. Active bed bug infestation was identified in ten (10) resident rooms and the activity room.

ff. Four (4) residents confirmed the presence of bed bugs in their rooms, with one (1) identifying a bite on the resident's body.

gg. The Administrator asserts that two (2) companies have submitted quotes for pest control, which were forwarded to the corporate office on September 28, 2023. The corporate office has yet to approve the pest control service expenses.

**Emergency Generator**

hh. On October 25, 2023, the control panel of the Facility's emergency generator displayed the following: "STOPPED – WARNING Service Schedule A."

ii. The Facility has no procedures on how to start the generator should it not start automatically. The Administrator was unaware of the generator's self-generated service warning until notified by Agency personnel.

jj. There is no regular service or monitoring of the generator by the Facility or a third-party service provider, though the equipment was serviced in August 2023.

kk. The only Facility personnel who have been trained to start the generator are the Administrator and Maintenance Director.

**Financial Ability to Operate**

ll. The Facility provided an Income Statement for (1) one month, September 2023, with income by source and expense by category and income documented room and board $179,159.87 for the month, and Medicaid revenue of $89,859.60 for the month. Total income listed is $269,019.47.

mm. The Administrator indicates that the Facility operates at a loss; however reported

numbers do not reflect that assertion as follows:

1. April 2023 – Total income $271,286.00 – Total Expenses $244,000.00 – Net Income $27,286.00.
2. May 2023 – Total income $245,116.00 – Total Expenses $245,046.00 – Net Income $70.00.
3. June 2023 – Total income $259,285.00 – Total Expenses $232,533.00 – Net Income $26, 752.00.
4. July 2023 – Total income $252,007.00 – Total Expenses $232,151.00 – Net Income $19, 866.00.
5. August 2023 – Total income $258,404.00 – Total Expenses $253,776.00 – Net Income $4,628.00.

nn. The total net income for the six (6) month period is $94,770.00.

oo. Outstanding invoices include:

1. A Perfect Choice Home Care - owed $116,912.60 since August 2023.
2. An identified dietician – owed $250.00 since May 2023.
3. Naples Fire Protection – owed $9,291.72 since March 2023.
4. Scripts Pharmacy - owed $5,879.05 since March 2023.
5. Gulf Shore Cooling - owed $11,979.24 after last payment of October 9, 2023.
6. Xfinity - owed $1,719.19 since September 2023.
7. LCEC - owed $5,680.31 since September 26, 2023.
8. Gordon Foods - owed $13,568.95 – current bill September and October 2023.
9. Cape Coral Utilities - owed $6,593.65 for September 2023.

pp. The total identified sum owed to vendors is $171,632.71.

qq. A third-party provider who supplied propane fuel informed Agency personnel that it had removed a two hundred (200) gallon tank from the Facility on October 23, 2023 due to non-payment and also terminated the contract with Facility due to multiple insufficient funds. The vendor loaned the Facility temporary tanks until another provider could be identified.

**NECESSITY FOR EMERGENCY ACTION**

13. The Agency is charged with the responsibility of enforcing the laws enacted to protect the health, safety and welfare of residents and clients in Florida's assisted living facilities. Ch. 429, Part I, Fla. Stat. (2023), Ch. 408, Part II, Fla. Stat. (2023); Ch. 59A-36, Fla. Admin.

Code. In those instances where the health, safety or welfare of an assisted living facility resident is at risk, the Agency will take prompt and appropriate action.

14. Residents of assisted living facilities possess the right to live in a safe and decent living environment, free from abuse and neglect, to be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. § 429.28(1), Fla. Stat. (2023). Assisted living residents must receive care and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 59A-36.010(1). The Facility Administrator 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. Fla. Admin. Code R. 59A-36.010(1).

15. In addition, licensees must provide a safe living environment, maintained free of hazards, and ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. Fla. Admin. Code R. 59A-36.014(3). The licensee must also assure its operations are administered on a sound financial basis in order to ensure adequate resources to meet resident needs. Fla. Admin. Code R. 59A-36.013(1).

16. As the facts reflect, the Facility failed to meet these minimum licensure standards and these failures are not isolated events, but operational and management system deficiencies affecting the health, safety, and well-being of the current or future residents.

17. Residents who reside in assisted living facilities oftentimes suffer from disease or disability. They typically consist of the frail, elderly or vulnerable. By law, the Facility has been licensed and entrusted to provide care and services to this class of people, and as such, must comply with the statutes and rules that have been enacted for the special needs of these residents.

18. In this instance, the Facility has demonstrated an inability or unwillingness to comply with the regulatory scheme. These failures include significant shortcomings in the

physical plant, the provision of adequate water temperatures to promote resident health and sanitary conditions, the provision of care and services appropriate to resident needs, and the prevention of resident abuse or neglect.

19. The current and ongoing threat to Facility residents and potential residents posed by the Facility's ongoing deficiencies is vividly illustrated by the Facility's failure to take action to address an apparent assault, battery, abuse, or sexual assault. No action to investigate the incident, to address the ongoing safety of the victim resident, or to address the behavior of the apparent aggressor to protect Facility residents and staff was undertaken by the Facility. This inaction continued even though the aggressor resident continued to exhibit inappropriate sexual behavior after the initial incident of sexual assault. In each of the identified instances of resident abuse and neglect, including the elopement event, the Facility administration failed to take risk management actions, including the failure to file adverse incident reports required by law.

20. This inaction constitutes a clear violation of the laws governing assisted living facilities and is per se an unsafe condition for residents and potential residents. No concept of assisted living facility services could encompass a total lack of diligence to address conditions where assaultive actions took place between residents and the Facility took no action to assure the physical and emotional safety of its residents were protected.

21. The Facility physical plant is in severe disrepair. The majority of the Facility lacks a hot water supply. This condition has existed for an extended period of time and correction is not in the foreseeable future. Meanwhile residents face risks to their health by the Hobson's choice of bathing in cold water or foregoing cleanliness. The lack of hot water for clothes and linen washing adds to the risk of spreading infection and deprives the Facility of the ability to control pest infestation. Appropriate water temperatures are essential to resident health

and well-being ranging from the maintenance of internal facility temperatures at a level to promote comfort and prevent physical or emotional stress, to the maintenance of personal hygiene of both residents and staff to minimize infection and promote personal dignity.

22. Pipes are leaking water into the ceiling above the residents. Though the Facility knows of the inadequacy of the pipes, it has chosen to address the issue only when the underlying ceilings reflect damage or direct water seepage. This ongoing issue presents a danger to resident health and wellbeing by the resultant development of mold or other bio-growth. Additionally, collapse of ceiling panels occur without warning as a result of water intrusion, a result the Facility has actually experienced.

23. The Facility has suffered an infestation of bed bugs since at least September 11, 2023. Though directed by Florida's Department of Health to contract with a pest control service to eradicate the infestation, the Facility has failed to do so, opting instead to utilize a handheld over-the -counter spray when infestation is noted. This approach demonstrates an economic blind eye to the nature of the infestation and its spread. It is not a pest infestation eradication plan, but a series of band-aids on an ongoing threat to the health and dignity of the residents.

24. Last, the diversity of the Facility's outstanding invoices, both in the sums due and the length of time the balances have been outstanding, present immediate concerns of the Facility's ability to maintain operations without presenting risks to resident health, safety and welfare. Foreseeable risks exist in ongoing services by food vendors and home health care services, the loss of either presenting immediate peril to resident health and well-being.

25. The Administrator is the individual statutorily charged with the responsibility of assuring the Facility's operations are administered on a sound financial basis in order to ensure adequate resources to meet resident needs. The facts of this cause, in their entirety, reflect that

the Administrator has not ensured that the Facility is administered ina manner to meet resident needs. Bed bugs, the lack of hot water, leaking pipes, dysfunctional emergency equipment, and inadequate resident supervision to prevent assault, falls, or elopement, all vividly reflect gross failures in administration.

26. The Facility's failure to meet these requirements of law and the needs of its residents is not an isolated event, but a demonstrated pattern of non-compliance as illustrated by the long-standing conditions of the physical plant, the outstanding invoices, and the bed bug infestation. Whether this non-compliance is intentional or negligent in its ultimate genesis, it is clear that the Facility is unable or unwilling to correct its operations to comply with the minimum standards governing assisted living facilities in Florida. Additionally, the Facility has demonstrated that its financial management practices do not ensure adequate resources are available to meet resident needs pursuant to the requirements of law.

27. Altogether, the above-stated facts and circumstances present an immediate and serious risk and danger to the health, safety, and welfare of residents and the public. The deficient practices permeate Facility operations and will continue or be repeated absent the emergency suspension of the Facility's license.

28. Individually and collectively, these facts reflect that the residents of this Facility are not currently living in a safe and decent living environment, free from abuse and neglect, to be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy, *see*, § 429.28(1) Fla. Stat. (2023); receiving care and services, including supervision, appropriate to their needs, *see*, Fla. Admin. Code R. 59A-36.007; are not being provided a safe living environment, maintained free of hazards, and ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are

maintained in good working order, *see*, Fla. Admin. Code R. 59A-36.014(3); and are not receiving the services of an administrator to provide appropriate care to all residents by qualified personnel, *see,* Fla. Admin. Code R. 59A-36.010. No resident of an assisted living facility should be placed or maintained in such an environment.

29. The Legislature created the Assisted Living Facilities Act. §§ 429.01, *et seq*., Fla. Stat. (2023). "The purpose of this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decision-making ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state, . . . to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of" several state agencies. § 429.01(2), Fla. Stat. (2023).

30. Again, the Facility's deficient practices exist presently, have existed in the past, and will continue to exist if the Agency does not act promptly. If the Agency does not act, it is clear that the Facility's conduct will continue.

31. This remedy is narrowly tailored to address conditions at the Facility. No other remedy, such as the future imposition of administrative fines or a moratorium on admissions, will protect the residents in this particular circumstance.

## CONCLUSIONS OF LAW

32. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 429, Part I, Florida Statutes, and Chapter 59A-36, Florida Administrative Code.

33. Each resident of an assisted living facility has the statutory right to live in a safe

and decent living environment, § 429.28(1)(a), Fla. Stat. (2023), and to receive care and services, including supervision, appropriate to meet their needs, Fla. Admin. Code R. 59A-36.007.

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

35. 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 for resident health, safety and welfare, and (3) being placed in an assisted living facility where the regulatory mechanisms enacted for residents protection have been repeatedly overlooked.

36. The conditions at the Facility constitute an emergency that must be immediately addressed to protect residents and potential residents from the immediate threat and danger posed to their health, safety, and welfare. The deficient practices exist presently, have existed for an extended period in the past without corrective action, and will continue to exist if the Agency does not act promptly.

37. The emergency action taken by the Agency in this particular instance is fair under the circumstances and the least restrictive action that the Agency could take given the facts and circumstances. This remedy is narrowly tailored to address the specific harm in this instance. The Agency has considered less restrictive actions. However, less restrictive actions, such as

administrative fines or a moratorium on admissions, will not ensure that the current residents or future residents receive the appropriate care, services, and environment dictated by law.

**IT IS THEREFORE ORDERED THAT:**

38. The Facility's license to operate this assisted living facility is **SUSPENDED effective November 14, 2023 at 5:00 p.m.** During the interim period, the Agency will cooperate with other agencies to effectuate the safe and orderly discharge of the residents to other locations.

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

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

41. The Agency shall promptly file an administrative action against the Facility based upon the facts set out in this Emergency Suspension Order and provide notice of the right to a hearing under Section 120.57, Florida Statutes (2023), at the time that such action is taken.

**ORDERED** in Tallahassee, Florida, this 1st day of November, 2023.

Kimberly R. Smoak, Deputy 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.**