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

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AHCA
AGENCY CLERK

2024 MAR -4 A 11: 57

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

CENTER FOR COMPREHENSIVE SERVICES
INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.
_______________________________________/

AHCA No. 2023015069
License No. 86
File No. 57000122
Provider Type: RTC
**RENDITION NO.: AHCA-24 - 174 -S-OLC**

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

CENTER FOR COMPREHENSIVE SERVICES
INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.
_______________________________________/

AHCA No. 2023016044

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

CENTER FOR COMPREHENSIVE SERVICES
INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.
_______________________________________/

AHCA Nos. 2024000871

# 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 Amended 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)

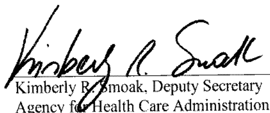
2. The Respondent shall pay the Agency $13,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 120 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

3. The Moratorium on Admissions entered on October 6, 2023, is lifted.

4. The Respondent shall comply with the licensure terms in the Settlement Agreement.

**ORDERED** at Tallahassee, Florida, on this 4th day of March, 2024.



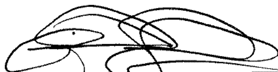
Kimberly R. Smoak, Deputy Secretary
Agency for Health Care Administration

## 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 4th day of March, 2024.



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<br>Agency for Health Care Administration<br>(Electronic Mail) | Central Intake Unit<br>Agency for Health Care Administration<br>(Electronic Mail) |
| Jack Plagge<br>Licensure Unit<br>Agency for Health Care Administration<br>(Electronic Mail) | Frances B. Lima, Field Office Manager<br>Field Office Manager<br>Agency for Health Care Administration<br>(Electronic Mail) |
| Gisela Iglesias, Senior Attorney<br>Office of the General Counsel<br>Agency for Health Care Administration<br>(Electronic Mail) | Jamie A. Klapholz, Esq.<br>Jessica A. Andrews, Esq.<br>Johnson, Pope et al<br>400 North Ashley Drive, Suite 3100<br>Tampa, Florida 33602<br>JamieK@jpfirm.com<br>(Electronic Mail) |
| Thomas M. Hoeler, Deputy General Counsel<br>Office of the General Counsel<br>Agency for Health Care Administration<br>(Electronic Mail) | |

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

STATE OF FLORIDA,
AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs.

CENTER FOR COMPREHENSIVE SERVICES,
INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.
_______________________________________/

AHCA No.: 2023016044
Provider Type: Residential Treatment Center for Children and Adolescents

## AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration (hereinafter "Agency"), by and through the undersigned counsel, and files this Administrative Complaint against the Center for Comprehensive Services, Inc. d/b/a Neurorestorative Florida (hereinafter "Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2023), and alleges:

## NATURE OF THE ACTION

This is an action to revoke the Respondent's license to operate a residential treatment center for children and adolescents pursuant to § 408.815, Florida Statutes (2023) and to impose an administrative fine in the amount of twelve thousand five hundred dollars ($12,500.00), pursuant to Sections 394.879(4) and 408.815(1), Florida Statutes (2023), based upon the citation of two (2) Class I, two (2) Class II, and eleven (11) Class III deficient practices in violation of law.

## JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to Sections 120.60, 394.875 and Chapter 408, Part II, Florida Statutes (2023).

**EXHIBIT 1**

2. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2023).

## PARTIES

3. The State of Florida, Agency for Health Care Administration ("the Agency"), is the licensure and regulatory authority that oversees residential treatment centers in Florida and enforces the applicable federal and state regulations, statutes and rules governing such facilities. Chs. 394, Part IV, and 408, Part II, Florida Statutes (2023); Ch. 65E-9, Florida Administrative Code.

4. Respondent was issued a license by the Agency (License No. 86) to operate a twelve (12) person capacity residential treatment center for children and adolescents, located at 2769 Whitney Road, Building 2, Clearwater, Florida 33760.

5. Respondent is currently, and had previously been, a licensed residential treatment center 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 (1) through (5) as if fully set forth herein.

7. Florida law provides that:

> (1) The provider shall protect children's rights under the federal and state constitutions and as specified in sections 394.459 and 394.4615, F.S. The provider shall also ensure that:
> (a) Physical punishment and treatment modalities that place the child at risk of physical injury or pain or death, including electroconvulsive or other convulsive therapy, "cocoon therapy," or other hazardous procedures shall never be used.
> (b) Children shall not be subjected to cruel, severe, unusual or unnecessary punishment or assigned excessive exercise or work duties, nor shall they be subjected to physical or mental abuse or corporal punishment.
> (c) The simultaneous use of seclusion and mechanical restraint is prohibited.
> (d) Children shall not be subjected to hazing, verbal abuse, coercion or remarks that ridicule them, their families or others.

(e) Children shall not be denied food, water, clothing, or medical care.
(f) Children shall not be exploited or required to make public statements to acknowledge gratitude to the provider program or perform at public gatherings.
(g) Identifiable pictures of children shall not be used without prior written consent of the parent or guardian. The signed consent form for any such usage shall be event-specific, indicate how the pictures will be used, and placed in the child's clinical record.
(2) Discipline. The provider shall have and implement written procedures on an ongoing basis regarding methods used for the discipline of children. The procedures shall include identification of staff authorized and trained to impose discipline, staff training requirements, methodology, monitoring, incident reporting, and quality improvement.
(3) Child abuse and neglect.
(a) The provider, as a mandated reporter, shall report to the department and the Abuse Registry all suspected cases of child abuse, neglect, and exploitation in accordance with chapter 39 and section 394.459, F.S.
(b) Each child shall have ready access to a telephone in order to report an alleged abuse, neglect or exploitation. The provider shall inform each child verbally and in writing of the procedure for reporting abuse. A written copy of that procedure, including the telephone number of the abuse hotline and reporting forms, shall be posted in plain view within eighteen inches of the telephone(s) designated for use by the children.
(c) The provider shall establish and implement a written procedure for the immediate protection of the alleged victim or any other potential victim and prevention of a recurrence of the alleged incident pending investigation by the department or law enforcement.
(d) The provider shall require each paid and volunteer staff member, upon hiring and every 12 months thereafter, to read and sign a statement summarizing the child abuse and neglect laws and outlining the staff member's responsibility to report all incidents of child abuse and neglect. Such signed statements shall be placed in each employee's personnel file.
(e) Residents' rights posters, including those with the telephone numbers for the Florida Abuse Hotline, Statewide Advocacy Council and the Advocacy Center for Persons with Disabilities, shall be legible, a minimum of 14 point font size, and shall be posted immediately next to telephones which are available for residents' use.
Rule 65E-9.012(1-3), Florida Administrative Code.

8. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

9. That based upon observation, interviews, and the review of records, Respondent failed to protect the rights of its clients to be free from physical abuse by inititating inappropriate and excessive restraints for one (1) of five (5) sampled clients (Client #1), the same being

contrary to the mandates of law.

10. A review of Respondent's Positive Behavioral Supports Philosophy, dated July 2020, provided:

> At the [facility], we recognize that many of the adults and children we serve encounter barriers and obstacles that impact their overall quality of life. We are committed to providing services for these adults and children and to supporting them in addressing the physical, intellectual, or behavioral challenges they may face. We acknowledge and appreciate the diversity of the individuals we serve and focus on creating safe environments, positive supports and cooperative relationships that will allow each individual to be successful in their home and community...

11. A review of Respondent' event log, event date September 16, 2023, stated that "[Client #1] was walking around in the back of the program of Whitney Acres. [Client #1] picked up a rock and threw it into a window. After the rock was thrown staff utilized improper CPI [Crisis Prevention Intervention] starting at 7:30 p.m. lasting until 7:44 p.m. Staff [B] initiated improper CPI ..."

12. A review of Client #1's clinical chart, including the Interim Behavior Plan, updated on August 9, 2023, reflected that Client #1 was admitted to Respondent's facility on February 27, 2023. Client #1's primary diagnosis was autistic disorder, and the secondary diagnoses included intellectual disability, disruptive mood dysregulation disorder, and psychosis (visual and auditory hallucinations).

13. A review of Crisis Prevention Intervention form, dated September 16, 2023, noted that the behavior creating risk and requiring physical intervention involved Client #1 throwing a brick/paver against the glass bedroom window of apartment #6. This caused loose glass to be in the area and presented unsafe risks/behavior.

14. The procedure used in response to Client #1's behavior was the implementation of physical restraint/manual (five (5) minutes or more) which was initiated at 7:30 p.m. upon

Client #1 and ceased at approximately 7:45 p.m.

15. Client #1's response to the physical intervention procedures included yelling, crying, and physical aggression. Client #1 calmed down after about fifteen (15) minutes and was transferred to a sensory room.

16. The description of the procedure implemented to restrain Client #1 consisted of grabbing Client #1 and transferring the client to the ground. Client #1 was on his/her side/stomach and one (1) hand was placed on Client #1's back by the person restraining the client to hold the client in place.

17. No injury to Client #1 was reported but injury to staff was reported.

18. The only chemical and physical restraint physician order for Client #1 was dated September 16, 2023. That order was for diphenhydramine, 50 mg to be taken orally, for behavior. An order for physical restraint was signed by the Director of Nursing (DON) on September 16, 2023, at 7:30 p.m. It reflected the duration of restraint was from 7:35 p.m. to 7:44 p.m. The seclusion area portion of the order was blank.

19. On October 2, 2023, at approximately 11:00 a.m., video footage of the September 16, 2023, event involving Client #1 was reviewed by the Agency's representative with Respondent's Program Director. The video had been recorded from the camera located on the rear of the gym building which viewed the back corner of the Whitney Acres apartment building. The start time of the video footage was 19:30 at which time Client #1 was observed standing in a grass area behind the Whitney Acres building. Staff B, a life skills trainer (LST), was observed facing Client #1. Staff B wrapped his arms around Client #1 in a bear hug-like motion and moved the client toward the ground. Staff C, a life skills trainer, was observed walking into view, bending over to pick up an object, tossing the object, and then walking out

of view while Staff B was restraining Client #1 who was on the ground.

20. Respondent's Program Director was interviewed during the observation of the video. She stated, "That was an improper hold," referring to the way Staff B was holding Client #1. Staff B was observed to place his hand on the side of the back of Client #1's head and face and push Client #1's face towards the ground.

21. At 19:31:36, Staff D, a life skills trainer, walked into camera view, around Staff B and Client #1, towards the broken window. Subsequently, Staff A, a life skills trainer, entered the area. She walked over to Client #1 who was struggling against Staff B on the ground and walked around them to the window. Staff D was observed leaving the area. Thereafter, Staff A was observed approaching Client #1 and kneeled on the lower torso of Client #1 with her knees positioned on one of the client's legs, and her hand on the client's other leg. The client's lower torso was prone (lying face down to the ground). Staff A was observed to adjust her knees to be directly on the back of the client's leg.

22. The Program Director commented during the review of the video that Staff A was inappropriately positioned on top of Client #1 as Staff A was using her body to hold the client down. She stated the client's face was to the side with his/her body partially prone, and the client should have been in a supine (facing up) position.

23. Client #1 was observed attempting to raise the leg that Staff A was holding with her hand at 19:34:10. Staff A caught the leg and slammed it into the ground. Staff D subsequently walked into view while talking on his cell phone. The Program Director stated that Staff D was calling Staff E, the Residential Supervisor.

24. At 19:34:30, Staff A rose and walked out of the area. Staff D who was still talking on the cell phone, lowered himself onto Client #1's lower torso with his knee on the

thigh of Client #1. Staff D did not follow through with the hold but stood and walked out of the video surveillance range while Staff B continued to hold the client on the ground.

25. Client #1 had struggled to a seated position at 19:34:58. Staff B was standing over the client with his hand on the client's shoulder. Staff C and A later walked back into view and were standing next to the seated client with Staff B standing over the client. Staff A subsequently walked closer to Client #1, and leaned into the client's side with her knee while the client was in a seated position. The client was trying to lean forward while Staff B was moving the client back and forward with his hands on Client #1's shoulders. Staff B later grabbed Client #1's left arm and moved it behind the client's back and upwards.

26. Client #1 was observed to struggle and Staff B placed his body on top of the client at 19:37:19. The client was sideways to the ground. Staff A and Staff C were standing next to them watching. Staff B held the client on the client's side and Staff A walked around Client #1 and kicked the client in the leg. Staff A backed up and Staff C lowered herself onto the client's lower legs. At 19:37:33, Staff D walked back into view. Staff C rose and stepped back from the client.

27. Staff B was seen rising to his feet at 19:38:24. No hands were placed on the client and Client #1 assumed a seated position on the ground while Staff A, B, C, and D were standing near the client. Shortly thereafter, Client #1 attempted to rise from the ground. Staff B and D placed their hands on the client's shoulders and the client returned to a seated position on the ground. Staff C and D walked out of view.

28. Client #1 attempted to rise again at 19:39:43. Staff B, who was standing behind the client, placed both of his hands on the client's shoulders and the client sat back on ground. Staff A walked around to the front of the client. Next, Client #1 rose to a standing position and

attempted to leave. Staff A and Staff B grabbed the client by the back of the client's shirt. Staff B held the client's left forearm and the back of the client's shirt. Staff A held and pulled the back of the client's shirt. Client #1leaned forward and sat on the ground against the gym building wall.

29. Client #1 rose to his/her feet and attempted to walk back towards the fence at 19:41:05. Staff A pulled on the back of the client's shirt. Staff B gripped the client's right wrist. The client attempted to break free from them but was later pushed toward the ground by Staff A. Staff A stood behind the client. Client #1's back fell against Staff A who pushed the client forward, placed her right hand around the back of Client #1's head, and held Client #1 with her left hand. Staff A pulled back her right arm and punched Client #1 in the nape of the neck with her right fist. The force of the punch caused Client #1's head to move upon impact. Staff A then used both of her hands on the back of Client #1's head and pushed the client's head down with the weight of her body. Client #1's face was facing forward into the ground. Staff A straddled the client's back and leaned into Client #1's head with pressure while Staff B stood and watched.

30. At 19:41:23, Client #1 turned his/her head to the side while Staff A continued to push repeatedly down on the client's head. Client #1's legs were kicking. Staff A continued pushing Client #1's head into the ground while the client was lying on his/her stomach as Staff B walked out of camera range. Next, Staff A, while still on top of the back of Client #1, used both of her hands to push the client's face into the ground. Client #1 struggled and turned his/her face to the side and up. Staff A, while still straddling Client #1, held the side of the client's face against the ground with her right hand, while her left hand was on the client's shoulder.

31. Client #1 struggled onto his/her side at 19:41:36. Staff A had positioned her knee on the client's shoulder and Staff B walked back into view. Client #1 later struggled to his/her

side and Staff A stood up from Client #1. Client #1 rolled over on his/her back, with his/her head tilted back while Staff A stood near the client's legs. Staff B was observed approximately three (3) feet from Client #1 who rolled back and forth on the ground.

32. Staff D returned into camera view, looked around at the ground, and then faced Client #1, Staff A, and Staff B at 19:42:28. Client #1 was later observed on the ground on his/her back while Staff A stood next to the client. Staff B and D were standing approximately three (3) feet away looking down at the client. Client #1 used his/her arm to hit Staff A. Staff A used her left leg to kick Client #1 in the back. Client #1 then attempted to hit Staff A again. Staff A lowered her body onto Client #1's side, grabbed the client's head with her right hand, pulled the client's head back, and with an outspread hand over the client's head, banged Client #1's head into the ground and held the head against the ground. Staff D crouched down at the side of the client's head and positioned himself towards Client #1's lower torso. Staff B stood and watched.

33. Staff A, using the force of her weight, pressed against the client's head, using both of her hands on the back of Client #1's head at 19:42:36. Client #1 was later observed attempting to turn his/her head to the side, but Staff A dragged the client's head against the ground. Staff A realigned her upper body and pushed down on the client's head again. Staff B lowered himself to the client's feet. Staff A lifted her left hand and brought it back down on the client's head.

34. At 19:42:53, Client #1 struggled and turned his/her face from the ground and subsequently attempted to turn on his/her side. Staff A had both of her hands on the client's left shoulder, attempting to turn the client to face the ground. Staff D was crouched in front of the client attempting to hold him/her while Staff B was at the client's feet.

35. Staff A stood up at 19:43:05 while Staff D continued to hold Client #1. The client was on his/her side with Staff B at the client's' feet. Client #2 subsequently walked into the camera range and looked at Client #1 on the ground. Staff D rose from Client #1 and approached Client #2 to redirect Client #2 away from the area. Staff B held Client #1's left leg with his right hand above the knee and used his left hand to hold the resident's ankle. Shortly thereafter, Client #1 raised his/her left leg and Staff B slammed it back to the ground. Staff D walked out of the camera range. Staff B continued to hold Client #1 by one (1) leg. Client #1's upper body moved back and forth while Staff A was positioned by Client #1's head.

36. Client #2 was observed being chased by Staff D while running towards Client #1 who was on the ground at 19:43:31. Client #2 ran towards Client #1 with running force and jumped on Client #1. Client #2 landed with his/her foot on Client #1's left shoulder/upper arm area. Staff D pulled Client #2 off Client #1. Staff A continued to lean by the head of Client #1 while Staff B continued to hold Client #1 by one (1) leg. Staff D walked back into camera range at 19:43:48, and was followed by Client #2 who made a throwing motion towards toward Client #1.

37. The Program Director advised that the leg hold that Staff B was using was not appropriate according to Crisis Prevention Intervention (CPI) guidelines. She stated that both legs should be held at the time of the hold. The Program Director further explained that the throwing motion made by Client #2 towards Client #1 was due to Client #2 throwing a rock at Client #1.

38. The video reflected that at 19:44:16, Staff B removed his hands from Client #1's legs and rose to his feet. Staff C subsequently entered the range of the surveillance camera. Client #1 was still on the ground and Staff B stood approximately two (2) feet from the client's

feet while Staff A stood next to the client's head.

39. Subsequently, Staff A, Staff B, and Staff C, were standing and talking while Client #1 remained on the ground. Client #2 then walked over to Client #1 to hand him/her a small bag.

40. The Program Director was asked why Client #2 was allowed to enter into the area where Client #1 was lying on the ground. She responded that Client #2 should not have been in that area. The Program Director could not confirm what Client #2 handed to client #1 in the bag but she assumed it may have been candy.

41. At 19:48:05, Staff I, the Activities Director, entered the camera range while Client #1 was still on the ground. Staff A was standing near Client #1's head, Staff B was standing at the client's feet, and Staff C was standing near the corner of the building. Shortly thereafter, Staff I reached down and grabbed Client #1's wrist while Staff A and Staff B assisted her. Staff I held the right wrist, Staff A held the left wrist, and Staff B held the client's ankles. They were observed attempting to pick the client up by his/her arms and ankles and then released the client back onto the ground.

42. The Program Director advised that the method used by Staff I, A, and B to transport Client #1 was not appropriate.

43. Respondent's Clinical Director also reviewed the video. He stated that "In the definition, a transport is not considered a restraint." He stated that if a client is "dead weight and flopped," the client should not be transported and should be left where he/she is.

44. The video later shows Client #1 in a seated position on the ground at 19:53:09. Subsequently, Client #1 stood on his/her own and walked with staff (Staff I, Staff B, and Staff A) out of the view of the camera between two buildings. Client #1 was subsequently placed in

a sensory room.

45. On October 2, 2023, at approximately 10:25 a.m., the Agency's representative observed the sensory room with the Director of Nursing. The area where the sensory room is located was formerly an apartment. The exterior door to the room opens into a room with a table and heavy weighted chairs. There is a bathroom at the back with a door. A second room in the back has a door that can be closed. No lock was observed on the door. That door opens outward towards the larger room and not into the sensory room. A two (2) way mirror window was in the wall between the outside room and the sensory room, which provided the ability for visualization from the outside into the sensory room.

46. A sign on the door of the second room noted the Seclusion Guidelines for the sensory room which included that a "staff member must have eyes on participant at all times when they are in [the] quiet room," that the door not be barricaded and that items not be placed in front of the door to prevent it from opening, and that the door must be held shut manually so that the participant is able to exit if staff is not present.

47. On October 2, 2023, at approximately 3:12 p.m., the review of video surveillance was continued with the Program Director.

48. The video showed that at 19:54:08, Staff C opened the outer door to the apartment in which sensory room was located. Staff I and Staff B held Client #1 on each side. Client #1 was observed to drop to the floor at the entrance. Staff A was behind the client on the outside of the apartment.

49. Staff C subsequently dragged Client #1 by his/her feet while Staff B and Staff I held the client's arms. The staff dragged Client #1 into the sensory room, left the client on the floor, exited the room, and closed the door. Client #1 proceeded to kick the door and reached

up and attempted to turn the door handle.

50. The Program Director commented that the door to the seclusion room does not lock and that there was probably a staff member holding the door so that Client #1 could not leave.

51. At 19:56:39, Staff B, Staff C, and Staff A were present in the room in front of the sensory room. Staff D was observed entering that room while on his cell phone. Thereafter, Staff C left that room and Staff B moved a weighted chair towards the door of the sensory room. In the sensory room, Client #1 was observed on the floor. Between the sensory room and the front room, an observation window was present but no staff member was positioned at the window to observe the client.

52. When the Program Director was asked who was observing Client #1 while the client was in the seclusion room, she responded, "That is a great question."

53. At 20:11:14, Staff C entered the sensory room and stood over Client #1. Staff B subsequently entered the sensory room. Client #1 rose to a standing position and Staff B handed the client a snack. Staff B, Staff C, and Client #1 later walked out of the sensory room.

54. An interview was conducted on October 2, 2023, at 9:50 a.m. with the Director of Nursing. The Director of Nursing confirmed that a client had been restrained on September 16, 2023, during the evening. The Director of Nursing confirmed she was not at the facility at the time of the restraint. The Director of Nursing was asked about the time the restraint occurred and she answered, "I want to say, it was between 6:30 p.m. and 7:00 p.m." The Director of Nursing stated she spoke with Staff J, the Direct Staff Lead at Respondent's sister facility, around 7:10 p.m., and Staff J said something about Client #1 being in a hold with dirt on his/her face. The Director of Nursing said she arrived at the facility about ten (10) minutes after her

conversation with Staff J. When she arrived at the facility, she went to check on Client #1, and did her assessment of Client #1 which revealed no injuries or red marks. Client #1 was sitting on the couch watching television, with no dirt on his/her face, and nothing to suggest that anything improper had happened.

55. Staff J was interviewed on October 3, 2023, at approximately 10:15 a.m. Staff J confirmed she worked the 3:00 p.m. to 11:00 p.m. shift on September 16, 2023, at Respondent's sister facility. Staff J stated she had gone over to the main building (attached to Whitney Acres) to return a receipt. Around 7:20 p.m. or 7:30 p.m., she saw Client #1 with bricks in his/her hand. Client #1 was coming from the courtyard and was going towards the back of the building between the gym and the apartment building. Client #1 shattered an apartment window and Staff J saw Staff B take Client #1 down using a one (1) person hold. Staff B was on the top. It looked like Client #1's face was definitely in the dirt but the client was not lying completely on his/her stomach. Staff J said she spoke to Staff D and told her the procedures used by the staff to restrain Client #1 were improper. She added that they need to "separate all of them" and do a proper three (3) person transfer and put the client in the sensory room. Staff J added that Staff D told her she was not sure what Staff J could do, and he was on the phone with his Resident Supervisor. After speaking with Staff D, Staff J returned to the sister facility. She did not want to get in trouble for what was happening. It was improper Crisis Prevention Intervention.

56. Staff J was asked who she would call if she witnessed abuse, and she responded that she would call the nurse and then the residential supervisor. She advised that as team leaders, they have authorization to call 911. Staff J confirmed she had received Abuse & Neglect training within the past two (2) weeks. When asked if she was aware of anyone else or an agency she could call to report abuse, she stated she was not aware of anyone else. She stated she was

not aware of the abuse hotline, or that she could call and report abuse.

57. Staff B was interviewed by telephone on October 3, 2023, at 3:30 p.m. He stated Client #1 and Client #2 had come from an apartment. He did not remember Client #1 grabbing the rock or brick or little pavers, but he thinks the client had two (2). Client #1 broke the window with them and the shards were hanging out of the frame. Staff B said that was when he wrapped his arms around Client #1 and Client #1 went down to the ground and Staff B fell with the client. He did not see Staff A kick the client until he viewed the video. Staff B added that when Client #1 broke the window and he and Client #1 were down on the ground, Client #2 was inside the room looking through a window. Staff B confirmed that when a client is let go, that ends the restraint.

58. Staff B was asked why Client #1 was taken to the sensory room and responded, "Ma'am, I agree. Not sure why [he/she] had to go there. [He/She] was calm. It is protocol there. It is standard at the facility to have a ten (10) minute calm. I have asked, they say it is protocol. Once the girl came over [Staff I] she mentioned the sensory room, and that was when [Client #1] got agitated. Staff B confirmed he had placed a chair in front of the sensory room door as the door to that room does not lock. He put the chair in front of the door so the client could not get out. Staff B said he thought the chair was there "for two minutes, could be longer, closer to ten minutes." He added he had not had a lot of sensory room use experience. Staff B stated his most recent Crisis Prevention Intervention training had been in January 2023 and he was scheduled to take the Abuse training on Friday, October 6, 2023. Staff B stated he had been suspended on September 16, 2023, until last Friday, September 29, 2023. When asked if management had talked to him about restraints, Staff B stated, "I do not think that it was super bad." Staff B confirmed there had been issues with clients getting items from the yard and

management was aware of it. He said some of the staff are small and it would be hard for them to perform the Crisis Prevention Interventions they are expected to use.

59. On October 3, 2023, at 2:45 p.m., The Program Director was interviewed, and she stated that Staff B was current with his Crisis Prevention Intervention training. Staff B had not received additional training.

60. Personnel records were reviewed on September 29, 2023, at 2:00 p.m. with the Program Director. Staff A's personnel records indicated that Staff A had been hired on February 16, 2021, but worked for a separate program until August 15, 2023. Staff A transferred to Respondent's facility on August 15, 2023. Staff A's Crisis Prevention Intervention certification expired on January 28, 2022. The Program Director confirmed that Staff A did not have current Crisis Prevention Intervention certification. Staff A's most recent Abuse, Neglect and Exploitation training was on January 18, 2021, which was more than one (1) year ago. Staff D's personnel records reflected a hire date of January 21, 2014. Staff D's Crisis Prevention Intervention certification expired on April 29, 2023. The Program Director confirmed Staff D did not have a current Crisis Prevention Intervention certification.

61. On October 3, 2023, at 4:17 p.m., the Program Director was interviewed. The Program Director stated she had to ask the trainers what the six (6) month Crisis Prevention Intervention certification consisted of, and she was unaware that with the child clients, the Crisis Prevention Intervention certification had to be completed every six (6) months.

62. On October 4, 2023, at 10:46 a.m., Staff C was interviewed. When asked what had happened prior to Client #1 going to the back of the building, Staff C stated that other clients (Clients #2, #4, and #5) were trying to beat up Client #1 in the courtyard. Clients #2, #4, and #5 had a toaster, broomstick, branches, mop, and bricks. When asked what were the staff were

doing to separate the clients, Staff C, stated that they were trying to verbally redirect the clients but the clients had weapons. The staff present were Staff A, Staff B, and Staff D. When asked if she felt the staff had control of the situation, Staff C said, "No. At that point, they had weapons. You are hoping they will listen to you." When asked if there was anyone to call when this happens, she stated, "I believe we are supposed to call our Residential Supervisor and she will instruct us. "We have protocol. For de-escalation, sometimes it is hard, [the clients] will go from 0-100 with agitation so, then we put in a CPI hold. The duration depends."

63. Staff C was asked what causes a client to be placed in the sensory room and she responded, "If they are destructive." Staff C stated she did not feel there was enough help that night and she did not think there was a Residential Supervisor there that night. When asked if she had received any additional education pertaining to the use of the sensory room and when to use it, or additional education regarding restraints, Staff C said, "No. I saw they had a refresher last week, and again this week. I asked them if I could attend. I have not heard anything."

64. On October 4, 2023, at 12:50 p.m., an interview was conducted with Respondent's Crisis Prevention Intervention Trainer. The trainer confirmed she had reviewed the September 16, 2023, video. She confirmed that when the staff let go of Client #1, the restraint is stopped. She said that during the restraint, the client should not be prone and staff should flip the client over. They would want to try to get the client on his/her back for health and safety reasons. The trainer added that there should be "no forcing down." Dragging a client was not a technique that was taught and neither was picking a client up by the limbs. She said that Crisis Prevention Intervention does not teach seclusion, but instead teaches de-escalation. Physical restraint is the last resort.

65. On October 3, 2023, 12:18 p.m., Respondent's Quality Improvement Specialist (QIS) was interviewed by telephone. The Quality Improvement Specialist stated her role was to ensure the facility is doing what it is supposed to do under the regulation. She stated that the incident report regarding the September 16, 2023 event was electronic and she went to the facility to complete interviews of the staff and clients on September 18, 2023, September 20, 203, and September 21, 2023. The Qualified Improvement Specialist confirmed she had watched the video involving the incident from beginning to end. She stated she "did have findings that supported the allegation of abuse. The CPI restraints that were utilized were not appropriate. I did see where [Staff A] appeared, where she kicked [Client #1]. I did see where she pushed [Client #1's] face into the ground. I found [Staff D] and [Staff A] were not current with their CPI training. Also, [Staff D] was not current on his annual Abuse & Neglect Training. Guardians were not notified until Monday evening, 9/18/2023." When asked if there were any other findings, the Quality Improvement Specialist stated that the only other thing was when Client #2 was able to walk up and kick Client #1.

66. The Quality Improvement Specialist stated that the Director of Nursing completed the skin assessment of Client #1 on September 16, 2023, and September 19, 2023. Staff N, a registered nurse, also completed a skin assessment of Client #1 on September 21, 2023, which referenced multiple medium sized scars. When the Quality Improvement Specialist was asked if she thought assessments completed on September 16, 2023, and September 19, 2023, by the Director of Nursing were accurate, she stated, "No, based on the duration, the dragging on the ground, and the aggression from staff. No." The Quality Improvement Specialist confirmed that an alleged inappropriate restraint process was an allegation of abuse.

67. A review of Respondent's Child Abuse Prevention Policies & Procedures, A(12), effective May 2021, provided:

> NeuroRestorative prohibits the mistreatment, neglect, and abuse of individuals and misappropriation of child's property by anyone including but not limited to: staff, family, friends, or fellow children. Employees are appropriately screened and trained to prevent abuse. Each employee is responsible to report any suspected abuse. Each incident will be investigated, and required reporting completed. FL Statute: 400.9978.
>
> Definitions:
> NeuroRestorative acknowledges the following definitions as guidelines. All state & federal regulations are followed.
> Abuse: includes verbal, physical, sexual, or emotional abuse. Willful infliction of injury. Unreasonable confinement. Intimidation with resulting physical harm/pain/ mental anguish. Punishment with resulting physical harm/ pain/ mental anguish. Deprivation of goods or services that are necessary to attain or maintain well-being.

68. That the above reflects Respondent's failure to protect the rights of its clients to be free from physical abuse by inititating inappropriate and excessive restraints for one (1) of five (5) sampled clients (Client #1), the same being contrary to the mandates of law.

69. That the Agency cited the Respondent for a violation of the minimum requirements of law.

70. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statute (2023).

71. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

72. That the foregoing constitute a Class I offense as defined in in § 408.813(2)(a), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

**COUNT II**

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

74. Florida Law provides:

(1) General requirements.
(a) Providers shall comply with guidelines for the use of restraint, seclusion and time-out as specified in Chapter 394, F.S., in addition to the guidelines specified in this rule.
(b) Restraint or seclusion shall not result in harm or injury to the child and shall be used only:
1. To ensure the safety of the child or others during an emergency safety situation; and
2. Until the emergency safety situation has ceased and the child's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(c) Restraint or seclusion shall not be used for purposes of punishment, coercion, discipline, convenience, or retaliation by staff or to compensate for inadequate staffing.
(d) An order for restraint or seclusion shall not be issued as a standing order or on an as-needed basis.
(e) Restraint or seclusion shall be used in a manner that is safe and proportionate to the severity of the behavior and the child's chronological and developmental age; size; gender; physical, medical and psychiatric condition, including current medications; and personal history, including history of physical or sexual abuse.
(f) Only staff who have completed a competency-based training program that prepares them to properly use restraint or seclusion shall apply these procedures to children.
(g) Restraint that impedes respiration (e.g., choke hold or basket hold), places weight on the child's upper torso, neck, chest or back, or restricts blood flow to the head is prohibited.
(h) Ambulatory or walking restraints (e.g., shackles that bind the ankles and waist-wrist shackles) may only be used during transportation under the supervision of trained staff. The use of ambulatory or walking restraints is prohibited except for purposes of off-premise transportation.
(i) The provider's medical or clinical director shall be responsible for providing oversight of ongoing monitoring, quality improvement and staff training in the use of restraint and seclusion and in the use of less intrusive, alternative interventions.
Rule 65E-9.013(1), Florida Administrative Code.

75. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

76. That based upon observation, interviews, and the review of records, Respondent failed to comply with guidelines regarding the use of restraint and seclusion for two (2) of five (5) sampled clients (Client #1 and Client #2), the same being contrary to the mandates of law.

77. A review of Client #1's clinical chart, including the Interim Behavior Plan, updated August 9, 2023, reflected that Client #1 was admitted to Respondent's facility on February 27, 2023. Client #1's primary diagnosis was autistic disorder, and the secondary diagnoses included intellectual disability, disruptive mood dysregulation disorder, and psychosis (visual and auditory hallucinations).

78. On October 2, 2023, at approximately 11:00 a.m., video footage of the September 16, 2023, event involving Client #1 was reviewed by the Agency's representative

with Respondent's Program Director. The video had been recorded from the camera located on the rear of the gym building which viewed the back corner of the Whitney Acres apartment building. The start time of the video footage was 19:30 at which time Client #1 was observed standing in a grass area behind the Whitney Acres building. Staff B, a life skills trainer, was observed facing Client #1. Staff B wrapped his arms around Client #1 in a bear hug-like motion and moved the client toward the ground.

79. Respondent's Program Director was interviewed during the observation of the video. She stated, "That was an improper hold," referring to the way Staff B was holding Client #1. Staff B was observed to place his hand on the side of the back of Client #1's head and face and push Client #1's face towards the ground.

80. At 19:32:09, Staff A was observed approaching Client #1 and then kneeling on the lower torso of Client #1. Her knees were positioned on the client's leg, and her hand was on the client's other leg. The client's lower torso was prone. Staff A was observed to adjust her knees to be directly on the back of the client's leg.

81. The Program Director commented during the review of the video that Staff A was inappropriately positioned on top of Client #1 as Staff A was using her body to hold the client down. She stated the client's face was to the side with his/her body partially prone, and the client should have been in a supine position.

82. Client #1 was later seen on the video 19:34:10 attempting to raise the leg that Staff A was holding with her hand. Staff A caught the leg and slammed it into the ground. Shortly thereafter, Staff A rose from the client and walked out of the area, out of video surveillance. Staff D then lowered himself onto the client's lower torso and placed his knee on the thigh of Client #1. Staff D was talking on the cell phone during this time. Staff D did not

follow through with the hold but stood and walked out of the video area while still on the phone. Staff B was still holding the client on the ground.

83. Client #1 had struggled to a seated position at 19:34:58. Staff B was standing over the client with his hand on the client's shoulder. Staff C and A later walked back into view and were standing next to the seated client with Staff B standing over the client. Staff A subsequently walked closer to Client #1, and leaned into the client's side with her knee while the client was in a seated position. The client was trying to lean forward while Staff B was moving the client back and forward with his hands on Client #1's shoulders. Staff B later grabbed Client #1's left arm and moved it behind the client's back and upwards.

84. Client #1 was observed to struggle and Staff B placed his body on top of the client at 19:37:19. The client was sideways to the ground. While Staff B held client on the client's side, Staff A walked around Client #1 and kicked the client in the leg. Staff A backed up and Staff C lowered herself onto the client's lower legs.

85. Staff B was seen rising to his feet at 19:38:24. No hands were placed on the client and Client #1 assumed a seated position on the ground while Staff A, B, C, and D stood near the client. Shortly thereafter, Client #1 attempted to rise from the ground. Staff B and D placed their hands on the client's shoulders and the client returned to a seated position on the ground. Staff C and D walked out of view.

86. Client #1 attempted to rise again at 19:39:43. Staff B, who was standing behind the client, placed both of his hands on the client's shoulders and the client sat back on ground. Staff A walked around to the front of the client. Next, Client #1 rose to a standing position and attempted to leave. Staff A and Staff B grabbed the client by the back of the client's shirt. Staff B held the client's left forearm and the back of the client's shirt. Staff A was holding and pulling

the back of the client's shirt. Client #1 was leaning forward and sat on the ground against the gym building wall.

87. Client #1 rose to his/her feet and attempted to walk back towards the fence at 19:41:05. Staff A pulled on the back of the client's shirt. Staff B gripped the client's right wrist. The client attempted to break free from them but was later pushed toward the ground by Staff A. Staff A stood behind the client. Client #1's back fell against Staff A who pushed the client forward, placed her right hand around the back of Client #1's head, and held Client #1 with her left hand. Staff A pulled back her right arm and punched Client #1 in the nape of the neck with her right fist. The force of the punch caused Client #1's head to move upon impact. Staff A then used both of her hands on the back of Client #1's head and pushed the client's head down with the weight of her body. Client #1's face was facing forward into the ground. Staff A straddled the client's back and leaned into Client #1's head with pressure while Staff B stood and watched.

88. At 19:41:23, Client #1 turned his/her head to the side while Staff A continued to push repeatedly down on the client's head. Client #1's legs were kicking. Staff A then continued pushing Client #1's head into the ground while the client was lying on his/her stomach as Staff B walked out of camera range. Next, Staff A, while still on top of the back of Client #1, used both of her hands to push the client's face into the ground. Client #1 struggled, turn his/her face to the side and up. Staff A, while still straddling Client #1, held the side of the client's face against the ground with her right hand, while her left hand was on the client's shoulder.

89. Client #1 struggled onto his/her side at 19:41:36. Staff A had positioned her knee on the client's shoulder and Staff B walked back into view. Client #1 later struggled to his/her side and Staff A stood up from Client #1. Client #1 rolled over on his/her back, with his/her head tilted back while Staff A stood near the client's legs. Staff B was observed approximately

three (3) feet from Client #1 who rolled back and forth on the ground.

90. Client #1 was later observed on the ground on his/her back while Staff A was standing next to the client. Staff B and D were standing approximately three (3) feet away looking down at the client. Client #1 used his/her arm to hit Staff A. Staff A used her left leg to kick Client #1 in the back. Client #1 then attempted to hit Staff A again. Staff A lowered her body onto Client #1's side, grabbed the client's head with her right hand, pulled the client's head back, and with an outspread hand over the client's head, banged Client #1's head into the ground and held the head against the ground. Staff D crouched down at the side of the client's head and positioned himself towards Client #1's lower torso. Staff B stood and watched.

91. Staff A, using the force of her weight, pressed against the client's head using both of her hands on the back of Client #1's head at 19:42:36. Client #1 was later observed attempting to turn his/her head to the side, but Staff A dragged the client's head against the ground. Staff A realigned her upper body and pushed down on the client's head again. Staff B lowered himself to the client's feet. Staff A lifted her left hand and brought it back down on the client's head.

92. At 19:42:53, Client #1 struggled and turned his/her face from the ground and subsequently attempted to turn on his/her side. Staff A had both of her hands on the client's left shoulder, attempting to turn the client to face the ground. Staff D was crouched in front of the client attempting to hold him/her while Staff B was at the client's feet

93. Staff A stood up at 19:43:05 while Staff D continued to hold Client #1. The client was on his/her side with Staff B at the client's feet. Client #2 subsequently walked into the camera range and looked at Client #1 on the ground. Staff D rose from Client #1 and approached Client #2 to redirect Client #2 away from the area. Staff B held Client #1's left leg with his right

hand above the knee and used his left hand to hold the resident's ankle. Shortly thereafter, Client #1 raised his/her left leg and Staff B slammed it back to the ground and Staff D walked out of the camera range. Staff B continued to hold Client #1 by one (1) leg. Client #1's upper body moved back and forth while Staff A was positioned by Client #1's head.

94. The Program Director advised that the leg hold that Staff B was using was not appropriate according to Crisis Prevention Intervention guidelines. She stated that both legs should be held at the time of the hold.

95. The video reflected that at 19:44:16, Staff B removed his hands from Client #1's legs and rose to his feet. Staff C subsequently entered the range of the surveillance camera. Client #1 was still on the ground and Staff B stood approximately two (2) feet from the client's feet while Staff A stood next to the client's head. Subsequently, Staff A, Staff B, and Staff C, were standing and talking while Client #1 remained on the ground.

96. At 19:48:05, Staff I, the Activities Director, entered the camera range while Client #1 was still on the ground. Staff A was standing near Client #1's head, Staff B was standing at the client's feet, and Staff C was standing near the corner of the building. Shortly thereafter, Client #1 was observed in a seated position on the ground and later stood on his/her own and walked with Staff I, B, and A out of the view of the camera between the two (2) buildings.

97. On October 2, 2023, at approximately 3:12 p.m., the review of video surveillance was continued with the Program Director. The video showed that at 19:54:08, Staff C opened the outer door to the apartment in which sensory room was located. Staff I and Staff B held Client #1 on each side. Client #1 was observed to drop to the floor at the entrance. Staff A was behind the client on the outside of the apartment.

98. Staff C subsequently dragged Client #1 by his/her feet while Staff B and Staff I held the client's arms. The staff dragged Client #1 into the sensory room, left the client on the floor, exited the room, and closed the door. Client #1 proceeded to kick the door and reached up and attempted to turn the door handle.

99. The Program Director commented that the door to the seclusion room does not lock and that there was probably a staff member holding the door so that Client #1 could not leave.

100. At 19:56:39, Staff B, Staff C, and Staff A were present the room in front of the sensory room. Staff D was observed entering that room while on his cell phone. Thereafter, Staff C left that room and Staff B moved a weighted chair towards the door of the sensory room. In the sensory room, Client #1 was observed on the floor. Between the sensory room and the front room, an observation window was present but no staff member was positioned at the window to observe the client.

101. When the Program Director was asked who was observing Client #1 while the client was in the seclusion room, she responded, "That is a great question."

102. Staff C was observed at 20:11:08 returning through the front room door. Staff B moved the chair back to the center of the room.

103. At 20:11:14, Staff C entered the sensory room and stood over Client #1. Staff B subsequently entered the sensory room. Client #1 rose to a standing position and Staff B handed the client a snack. Staff B, Staff C, and Client #1 later walked out of the sensory room.

104. The video footage reflected that while Client #1 was in the sensory room, no staff member was observed to continually visually monitor the client.

105. During the survey conducted on September 29, 2023, through October 4, 2023,

Respondent was asked to provide a policy and procedure for the use of seclusion. Respondent did not provide one.

106. The video tape involving Client #1 which started at 19:30 and ended at 20:11 reflected that no licensed staff member (*i.e.*, physician or nurse) was observed to assess or monitor Client #1 and no staff documentation was presented during the survey that would indicate staff had documented monitoring Client #1 during the use of restraints or during the seclusion.

107. On October 2, 2023, Respondent provided a physician's order dated September 16, 2023, which indicated a continuous restraint had occurred from 7:30 p.m. until 7:44 p.m. (19:30 until 19:44).

108. During an interview conducted on October 2, 2023, at 9:50 a.m. with the Director of Nursing, she confirmed she was not at the facility during Client #1's restraint or seclusion. She also confirmed no other nurse was at the facility on September 16, 2023, from 3:00 p.m. until the time she arrived (approximately 7:20 p.m.). The Director of Nursing also confirmed she was not up to date with her Crisis Prevention Intervention Training. A review of her personnel record reflected that her Crisis Prevention Intervention certification had expired on April 30, 2020.

109. Staff B was interviewed by telephone on October 3, 2023, at 3:30 p.m. He stated Client #1 and Client #2 had come from an apartment. He did not remember Client #1 grabbing the rock or brick or little pavers, but he thinks the client had two (2). Client #1 broke the window with them and the shards were hanging out of the frame. Staff B said that was when he wrapped his arms around Client #1 and Client #1 went down to the ground and Staff B fell with the client. He did not see Staff A kick the client until he viewed the video. Staff B added that when

Client #1 broke the window and he and Client #1 were down on the ground, Client #2 was inside the room looking through a window. Staff B confirmed that when a client is let go, that ends the restraint.

110. Staff B was asked why Client #1 was taken to the sensory room and responded, "Ma'am, I agree. Not sure why [he/she] had to go there. [He/She] was calm. It is protocol there. It is standard at the facility to have a ten (10) minute calm. I have asked, they say it is protocol. Once the girl came over [Staff I] she mentioned the sensory room, and that was when [Client #1] got agitated. Staff B confirmed he had placed a chair in front of the sensory room door as the door to that room does not lock. He put the chair in front of the door so the client could not get out. Staff B said he thought the chair was there "for two minutes, could be longer, closer to ten minutes." He added he had not had a lot of sensory room use experience. Staff B stated his most recent Crisis Prevention Intervention training had been in January 2023 and he was scheduled to take the Abuse training on Friday, October 6, 2023. Staff B stated he had been suspended on September 16, 2023, until last Friday, September 29, 2023. When asked if management had talked to him about restraints, Staff B stated, "I do not think that it was super bad." Staff B confirmed there had been issues with clients getting items from the yard and management was aware of it. He said some of the staff are small and it would be hard for them to perform the Crisis Prevention Interventions they are expected to use.

111. On October 3, 2023, at 2:45 p.m., The Program Director was interviewed, and she stated that Staff B was current with his Crisis Prevention Intervention training. Staff B had not received additional training.

112. On October 3, 2023, at 4:17 p.m., the Program Director was interviewed. The Program Director stated she had to ask the trainers what the six (6) month Crisis Prevention

Intervention certification consisted of, and she was unaware that with the child clients, the Crisis Prevention Intervention certification had to be completed every six (6) months.

113. Clinical records regarding Client #2 were also reviewed. The records indicated that Client #2 was admitted to Respondent's facility on June 12, 2023. Client #2's Interim Behavior Plan which was last updated on August 9, 2023, reflected diagnoses of attention deficit hyperactivity disorder (ADHD), disruptive mood dysregulation disorder, personality disorder, and bipolar disorder.

114. Respondent's event report regarding the incident on September 16, 2023, at 8:44 stated that staff were asked to come help to assist Client #2 inside the café due to him/her having glass shards in his/her hands. Staff prompted Client #2 to hand over the shards. When Client #2 refused, he/she was transported to the sensory room and outside the sensory room, a four (4) person Crisis Prevention Intervention was performed. Client #2 was also given a "PRN" (as needed). Client #2 was then redirected to the sensory room with one (1) staff, and when Client #2 started hitting his/her head continuously against the window with force, staff implemented another Crisis Prevention Intervention and a five (5) person hold was performed. Client #2 was calm for a while and was asked to stay inside the sensory room for another two (2) minutes and the client then appeared to be calm.

115. Respondent's September 16, 2023, Crisis Prevention Intervention Form was reviewed on October 2, 2023. The form indicated that physical restraint was initiated at 8:00 p.m. and that the restraint was released at 9:45 pm. The specific criteria for release from restraint was documented as "10 minutes calm/safe behavior." The name of the staff who completed the form is illegible.

116. A second Crisis Prevention Intervention form was also reviewed on October 2, 2023, regarding the same incident on September 16, 2023. This form was completed by Staff Q

and documented a physical restraint was initiated at 8:44 p.m. and that the restraint was released at 9:50 p.m. There was only one (1) physician order for the time period of 8:00 p.m. to 9:50 p.m., despite three (3) separate Crisis Prevention Intervention holds having been conducted as confirmed by the Program Director in an interview on October 2, 2023, at 10:29 a.m.

117. The Physician Order Restraint/Seclusion form regarding the September 16, 2023 event reflected no date and time of form completion but documented a verbal order obtained by the Director of Nursing at 8:20 p.m. for chemical restraint and physical restraint. The chemical restraint was documented as diphenhydramine, 50 mg/1ml IM (intramuscular) plus diphenhydramine, 50 mg PO (by mouth). The duration of the physical restraint was documented as occurring from 8:40 p.m. to 9: 25 p.m.

118. A Post Restraint Nursing Assessment form reviewed on October 2, 2023, indicated that it was completed on September 16, 2023, at 10:00 p.m., by the Director of Nursing and appeared to have "chemical restraint" crossed through and "physical restraint" circled.

119. Video footage related to the restraint and seclusion for Client #2 on September 26, 2023, was reviewed with the Clinical Director on October 4, 2023, at approximately 10:45 a.m.

120. The video footage reflected Client #2 being transported from Client #2's apartment to the sensory room. At 18:31:46, Client #2 was observed being made to stand by Staff E, F, G, and H. Client #2 then went back down to the floor. Staff E, F, G and H were observed grabbing Client #2's arms and legs and carrying the client while supine out of the apartment with a mesh type hood which had been placed over the entirety of the client's head down to the client's shoulders. The Clinical Director stated that the mesh hood was a spit mask.

121. Staff E, F, G, H were still carrying Client #2 supine by Client #2's arms and legs

into the outer room of apartment housing the sensory room at 18:32:08. Client #2's spit mask was still in place.

122. Client #2 was subsequently carried into sensory room by Staff E, F, G, and H who appeared to struggle to put Client #2 down on the floor from a carrying position. The spit mask worn by Client #2 fell onto the floor.

123. On October 4, 2023, a nursing progress note dated September 26, 2023, at 18:44 p.m., written by Staff K, a registered nurse, stated:

> Participant [Client #2] was being CPI for agitation on the floor at Apt ...by Acres staff. ... After entering room ... again, I noticed that participant was picked up by [his/her] arms and legs by staff. This writer immediately told them to stop and put the participant down and Acres RS [Resident Supervisor - Staff E] said and [sic] quote 'We are allowed to pick [him/her] up as long as we are not dragging the participant' and [they] continued taking [the] participant to the sensory room. Acres RS [Staff E] was asked again about the way PBS [person being served] was taken to the sensory room and she responded the same again. DON was contacted and notified of the incident immediately by this writer. Participant completed [his/her] time in the sensory room and was brough to [his/her] room. Post restraint assessment was completed. Participant had 2 small scratches in right forearm, a scratch in back of right knee and multiple dry scratches in lower back, no blood present. Participant said no to being in pain or any kind of discomfort at the moment. Nursing to follow.

124. While viewing the above described footage, the Clinical Director stated that this was not an appropriate transport and that "We told them many times not to pick them up and carry them."

125. Review of the Crisis Prevention Intervention documentation for the incident on September 16, 2023, involving Client #1, and the incidents involving Client #2 on September 16, 2023, and September 26, 2023, revealed no documentation of a debriefing with the child after each episode of Crisis Prevention Intervention.

126. The Program Director was interviewed on October 2, 2023, at 10:04 a.m. The Program Director stated that child debriefings are not done.

127. On October 2, 2023, at approximately 10:25 a.m., the Agency's representative observed the sensory room with the Director of Nursing. The area where the sensory room is located was formerly an apartment. The exterior door to the room opens into a room with a table and heavy weighted chairs. There is a bathroom at the back with a door. A second room in the back has a door that can be closed. No lock was observed on the door. That door opens outward towards the larger room and not into the sensory room. A two (2) way mirror window was in the wall between the outside room and the sensory room, which provided the ability for visualization from the outside into the sensory room.

128. A sign on the door of the second room noted the Seclusion Guidelines for the sensory room which included that a "staff member must have eyes on participant at all times when they are in [the] quiet room," that the door not be barricaded and that items not be placed in front of the door to prevent it from opening, and that the door must be held shut manually so that the participant is able to exit if staff is not present.

129. On October 4, 2023, at 12:50 p.m., an interview was conducted with Respondent's Crisis Prevention Intervention Trainer. The trainer confirmed she had reviewed the September 16, 2023, video. She confirmed when the staff let go of Client #1, the restraint is stopped. She said that during the restraint, the client should not be prone and staff should flip the client over. They would want to try to get the client on his/her back for health and safety reasons. The trainer added that there should be "no forcing down." Dragging a client was not a technique that was taught and neither was picking a client up by the limbs. She said that Crisis Prevention Intervention does not teach seclusion, but instead teaches de-escalation. Physical restraint is the last resort.

130. Personnel records were reviewed on September 29, 2023, at 2:00 p.m. with the

Program Director. Staff A's personnel records indicated that Staff A had been hired on February 16, 2021, but worked for a separate program until August 15, 2023. Staff A transferred to Respondent's facility on August 15, 2923. Staff A's Crisis Prevention Intervention certification expired on January 28, 2022. The Program Director confirmed that Staff A did not have current Crisis Prevention Intervention certification. Staff A's most recent Abuse, Neglect and Exploitation training was on January 18, 2021, which was more than one (1) year ago. Staff D's personnel records reflected a hire date of January 21, 2014. Staff D's Crisis Prevention Intervention certification expired on April 29, 2023. The Program Director confirmed Staff D did not have a current Crisis Prevention Intervention certification.

131. A review of personnel records was again conducted on October 4, 2023, at 12:30 p.m., with the Program Director. The review showed that Staff F, a life style trainer, was hired by Respondent on January 21, 2022, and her Crisis Prevention Intervention certification expired on May 27, 2023. Staff F's personnel file contained a new certification document reflecting that she attended a seven (7) hour Crisis Prevention Intervention Training on September 28, 2023.

132. Personnel records regarding Staff G, a life style trainer lead, indicated that Staff G was hired on January 8, 2018. Staff G's Crisis Prevention Intervention certification expired on May 27, 2022. Staff G had a new certification document which indicated he had attended Crisis Prevention Intervention training on September 28, 2023.

133. Staff K, a registered nurse, had a date of hire of October 22, 2021. His Crisis Prevention Intervention certification expired on August 26, 2023.

134. The Director of Nursing had a hire date of December 13, 2012. Her Crisis Prevention Intervention Training expired on April 30, 2020.

135. Respondent's Crisis Management Planning and the Use of Emergency

Procedures and Physical Intervention Policy and Procedure, effective February 2021, stated:

> The Network recognizes the importance of treating an individual in crisis with dignity and respect throughout the encounter. This policy provides direction on the use of emergency physical interventions that are only to be utilized as instructed if/ when imminent danger is presented by the individual, and there are no other means to stop, prevent, or deter harm from occurring.
> Specific Standards:
> A. Individualized Crisis Management Plans (action plans based on an individual's demonstrated need and/ or regulatory requirements) are developed to identify how to effectively respond and support an individual at specific times when he or she may be at risk of harm to self or others related to mental health or behavioral health needs. The plans identify techniques to calm, contain and deescalate in a volatile situation and include:
> 1. Identification of event (s) demonstrating need;
> 2. Identification of events or situations that have or may trigger the individual;
> 3. Consideration of a history of trauma and any medical/ physical conditions;
> 4. Age and developmentally appropriate strategies;
> 5. De-escalation techniques and alternatives to physical interventions;
> 6. Strategies designed in accordance with licensing, regulatory requirements
> and Network Policies; and identify that.
> 7. Individuals providing direct support receive education and training on the
> crisis management plan and the strategies for effective implementation prior to working unsupervised.
> B. In an Emergency, interventions may include physical restraint or other restrictive procedures, in compliance with state and local regulations as well as Network Policy:
> 1. Those providing emergency interventions are to use the least restrictive intervention possible to ensure the health and safety of the individuals involved:
> 2. Physical restraint is only used to address situations where the individual is
> posing an immediate risk of danger to him/herself, or others and other safe
> and effective intervention is not possible;
> 3. The restraint must be the least restrictive needed to mitigate the immediate
> risk of harm and for the shortest amount of time needed.
> 4. The following restraints are prohibited in all situations:
> **a. Restraining an individual in a prone position (face down);**
> b. Choke holds or other types of holds that may restrict airway access or compromise respiration (e.g., sitting on, laying on, kneeling on the

individual);

c. **Any position in which a person is bent over in such a way that it is difficult for the person to breathe (e.g., a seated or kneeling position in which a person being restrained is bent over at the waist);**

d. Those that cause the intentional infliction of pain.

5. The following types of interventions are prohibited in all situations:

a. Unattended, locked isolation;

b. Use of non-prescribed medication intended to impair the individual's freedom of movement;

c. Use of a mechanical device for the sole purpose of restraining tan individual (e.g., handcuffs or zip ties), that is outside of the device's intended purpose (e.g., seat belts in vehicular transport) and/or ways that are not approved in the individual treatment plan are also prohibited.

C. Anyone providing direct support will receive initial education as part of orientation and additional in-service education on crisis Management using a competency-based curriculum in accordance with local regulations and licensing requirements, which will also include:

1. Understanding behavior as communication;
2. Recognizing the signs and proactively addressing stress;
3. How and when to implement a crisis intervention plan;
4. Emergency Interventions including:

a. Prohibited procedures or interventions;

b. Verbal de-escalation techniques;

c. Utilizing environmental modifications (in accordance with local regulations and Network policy);

d. Risk assessment to determine the least restrictive interventions appropriate to various situations;

e. Oversight and reporting requirements.

5. CPR (Cardiopulmonary Resuscitation) training:
6. Network Policy on Positive Behavioral Supports and Human Rights.

D. The use of any emergency restraints or restrictive interventions not authorized in the individual's plan is reported through The Network's internal incident reporting process and to local authorities in accordance with licensing or other applicable regulations.

E. The use of restrictive procedures, seclusion or restraints is reviewed by the individual's Treatment team and documented in the individual's record and includes:

1. Debriefing session with all individuals involved in the event;
2. Discussion of what preceded the restrictive intervention including what was implemented to deescalate the situation;
3. Determination if the intervention followed approved protocols according to local licensing and regulations, as well as Network policy and

4. Review of the individual's Positive Behavioral Support and Crisis Management Plan, as indicated.

(Emphasis supplied)

136. That the above reflects Respondent's failure to comply with guidelines regarding the use of restraint and seclusion for two (2) of five (5) sampled clients (Client #1 and Client #2), the same being contrary to the mandates of law.

137. That the Agency cited the Respondent for a violation of the minimum requirements of law.

138. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

139. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

140. That the foregoing constitute a Class I offense as defined in in § 408.813(2)(a), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand dollars ($1,000.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT III

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

142. Florida law provides:

(e) Restraint or seclusion shall be used in a manner that is safe and proportionate to the severity of the behavior and the child's chronological and developmental age; size; gender; physical, medical and psychiatric condition, including current medications; and personal history, including history of physical or sexual abuse.
Rule 65E.9013(1)(e), Florida Administrative Code.

143. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

144. That based upon observation, interviews, and the review of records, Respondent failed to ensure that restraint and seclusion were used in a safe manner for one of (1) of two (2) sampled clients (Client #2 ), the same being contrary to the mandates of law.

145. Clinical records regarding Client #2 indicated that Client #2 was admitted to Respondent's facility on June 12, 2023. Client #2's Interim Behavior Plan which was last updated on August 9, 2023, reflected diagnoses of attention deficit hyperactivity disorder (ADHD), disruptive mood dysregulation disorder, personality disorder, and bipolar disorder.

146. Client #2's Interim Behavior Plan noted the following:

Reactive Strategies:
1. If [Client #2] engages in physical aggression/ property destruction/self-

injurious behavior

a. Block any continued attempts of aggression, property destruction, or self- injurious behavior.
b. Clear the area of any potentially hazardous items, i.e., heavy or sharp items, items that could be easily thrown, anything that could be used
to
choke or strike.
c. Create distance between [Client #2] and any clients from the area.
d. Should [Client #2] engage in continuous high magnitude aggression, property destruction, or self- injurious behavior, or behavior that poses an imminent risk to self or others that cannot be blocked or redirected, utilize a CPI transport to the nearest "quiet room". [sic]
    i. Once inside the quiet room, release [Client #2] and exit the room.
    ii. Staff should maintain eyes-on at all times using the mirror if necessary.
    iii. Mats will be outside of the quiet room available to take in if needed for CPI. They should not be in the quiet room with [Client #2] if [he/she] is in there by [himself/herself].
    iv. [Client #2] will stay in the quiet room until [he/she] is calm.

147. Video footage related to the restraint and seclusion of Client #2 on September 26, 2023, was reviewed with the Clinical Director on October 4, 2023, at approximately 10:30 am. The video footage commences at 18:06 with staff and Client #2 in Client #2's apartment living area and ends at 19:03 with staff and Client #2 exiting the sensory room.

148. At 18:31:46, the video tape reflects Client #2 being restrained by Staff E, F, G, and H. The staff released Client #2 from their hold and stood [him/her] up. Client #2 went back down to the floor. Staff E, F, G, and H grabbed Client #2's arms and legs and carried Client #2 while supine out of the apartment with a mesh type hood which had been placed over the entirety of the client's head down to the client's shoulders. While viewing this footage, the Clinical Director indicated that the mesh hood was a spit mask.

149. The video later depicts the staff to still be carrying Client #2 by the client's arms and legs while the client is in a supine position into the outer room of the apartment housing the sensory room. Client #2's spit mask was still in place. Shortly thereafter, Client #2 is carried

into the sensory room in the same manner. Staff struggled to put Client #2 down on the floor of the sensory room and the spit mask fell off onto the floor.

150. While viewing the foregoing footage, the Clinical Director stated that this was not an appropriate method of transport and "We told them many times not to pick them up and carry them." The Clinical Director stated that it could have caused harm to Client #2 if they dropped the client while carrying him/her.

151. From 18:33 until 19:03, the video showed Client #2 in the sensory room with the door closed and a black mat on the floor. A male staff member in the outer room is seen holding the door to the sensory room shut. The Clinical Director commented that someone was holding the door handle.

152. On October 2, 2023, at approximately 10:25 a.m., the Agency's representative observed the sensory room with the Director of Nursing. The area where the sensory room is located was formerly an apartment. The exterior door to the room opens into a room with a table and heavy weighted chairs. There is a bathroom at the back with a door. A second room in the back has a door that can be closed. No lock was observed on the door. That door opens outward towards the larger room and not into the sensory room. The sensory room had a mirror window approximately mid room, where a person could look into the room without being seen from the person on the inside.

153. A sign on the door of the second room read:

> Seclusion Guidelines:
> -A staff member must have eyes on participant at all times when they are in quiet room.
> -DO NOT barricade the door or place items in front of the door to prevent it from opening. Door must be held shut manually such that the participant would be able to exit if staff were not present.
> -Nothing may be in the room with participant if they are in the room alone. This includes mats, masks, etc.

-If participant engages in high magnitude SIB or begins to hurt themselves, enter the room and utilize the least restrictive form of CPI necessary to keep them safe.
-Mats will stay outside of the seclusion room until needed for CPI. Once CPI is complete, mats must be removed from quiet room.
Refer to participant behavior plan for criteria for exiting the room.

154. Continued observation of the video showed that Client #2, while in the sensory room, threw a soft clog-type shoe at the ceiling, kicked the door, attempted to open the door, punched the door with the shoe, punched the mirror that was located in the top corner where the wall and ceiling met, hit himself/herself on the side of the head and the face with the shoe, hit his/her head against the wall three (3) times, and took the folded up black mat and held it up over the observation window.

155. During an interview with the Clinical Director on October 4, 2023, at 11:18 a.m., the Clinical Director stated the mat should not have been in the room.

156. The video of the outer room of the building that housed the sensory room reflected that no staff were continuously monitoring Client #2 during the time the client was in the seclusion room.

157. On October 4, 2023, a nursing progress note dated September 26, 2023, at 18:44 p.m., written by Staff K, stated:

> Participant [Client #2] was being CPI for agitation on the floor at Apt ...by Acres staff. ... After entering room ... again, I noticed that participant was picked up by [his/her] arms and legs by staff. This writer immediately told them to stop and put the participant down and Acres RS [Resident Supervisor - Staff E] said and [sic] quote 'We are allowed to pick [him/her] up as long as we are not dragging the participant' and [they] continued taking [the] participant to the sensory room. Acres RS [Staff E] was asked again about the way PBS [person being served] was taken to the sensory room and she responded the same again. DON was contacted and notified of the incident immediately by this writer. Participant completed [his/her] time in the sensory room and was brough to [his/her] room. Post restraint assessment was completed. Participant had 2 small scratches in right forearm, a scratch in back of right knee and multiple dry scratches in lower back, no blood present. Participant said ["N]o[",] to being in pain or any kind of discomfort at the moment. Nursing to follow.

158. That the above reflects that Respondent failed to ensure that restraint and seclusion were used in a safe manner for one of (1) of two (2) sampled clients (Client #2 ), the same being contrary to the mandates of law.

159. That the Agency cited the Respondent for a violation of the minimum requirements of law.

160. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

161. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

162. That the foregoing constitutes a Class II violation pursuant to § 408.813(2)(b), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT IV

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

164. Florida law provides:

> (11) Time-out.
> (a) Time-out shall be used only for the purpose of providing a child with the opportunity to regain self-control and not as a consequence or punishment.
> (b) If time-out is used with a child, child-specific guidelines for the use and duration of time-out, based on the professional judgment of the child's treatment team, shall be specified in the child's treatment plan, upon consideration of the child's age, maturity, health, and other factors. In addition, the child's parent or guardian shall sign an informed consent form detailing the circumstances under which time-out will be used and how the procedure is to be implemented.
> (c) Time-out shall be initiated only by staff who have completed competency-based training in the use of time-out and such training shall be documented in their personnel record.
> (d) Time-out may take place either in or away from the area of activity or other children, such as in the child's room.
> (e) The designated area shall be a room or area that is part of the living environment the child normally inhabits or has access to during routinely scheduled activities and from which the child is not physically prevented from leaving.
> (f) If the child requires physical contact in order to move to the area or room, staff shall end the contact immediately once the child is in the designated area.
> (g) The child shall not be physically prevented from leaving the time-out area.
> (h) The criterion for being able to end time-out without further intervention shall be specified to the child at this time in a neutral manner.
> (i) Time-out shall be terminated after the child meets the behavioral criterion for the specified time period, which shall not exceed 5 minutes at a time. If the child meets the criterion earlier, staff shall end the procedure immediately.
> (j) If the child has not been able to meet the criterion for exiting time-out within 30 minutes, staff shall notify the ranking clinician on duty or on-call, who shall assess how the procedure was implemented, assess the child's condition, and determine whether to end the procedure, reduce the exit criterion, or continue the procedure.
> (k) When time-out is imposed, staff shall directly and continuously observe the child.
> (l) The child's treatment team shall review the use of time-out during that child's treatment team meetings, but no less frequently than two times per month. This review

shall consist of assessing the frequency, patterns and trends, questioning the function(s) of the behavior(s) that resulted in the use of time-out, possible ways to prevent the behavior(s) and the appropriateness of the exit criteria used.
(m) For each instance that time-out is used, staff who initiate the procedure shall document in the child's record:
1. The circumstances leading to the use of time-out;
2. The specific behavior criteria explained to the child that would allow for discontinuation of time-out;
3. When and how the child was informed of the behavior criteria;
4. The time the procedure started and ended; and
5. Any injuries sustained and treatment provided for those injuries.
(n) A separate time-out log shall be maintained that records:
1. The shift;
2. The staff who initiated the process;
3. The time the procedure started and ended;
4. The date and day of the week of each episode;
5. The age and gender of the child; and
6. Client ID.
Rule 65E-9.013(11), Florida Administrative Code.

165. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

166. That based upon observation, interviews, and the review of records, Respondent failed to ensure that prohibited restraints that impeded respiration or placed weight on a child's upper torso, neck, chest, or back were not conducted on one (1) of five (5) sampled clients (Client #1), the same being contrary to the mandates of law.

167. A review of Client #1's clinical chart, including the Interim Behavior Plan, updated August 9, 2023, reflected that Client #1 was admitted to Respondent's facility on February 27, 2023. Client #1's primary diagnosis was autistic disorder, and the secondary diagnoses included intellectual disability, disruptive mood dysregulation disorder, and psychosis (visual and auditory hallucinations).

168. On October 2, 2023, at approximately 11:00 a.m., video footage of the September 16, 2023, event involving Client #1 was reviewed by the Agency's representative

with Respondent's Program Director. The video had been recorded from the camera located on the rear of the gym building which viewed the back corner of the Whitney Acres apartment building. The start time of the video footage was 19:30 at which time Client #1 was observed standing in a grass area behind the Whitney Acres building. Staff B, a life skills trainer, was observed facing Client #1. Staff B wrapped his arms around Client #1 in a bear hug-like motion and moved the client toward the ground. Staff C, a life skills trainer, was observed walking into view, bending over to pick up an object, tossing the object, and then walking out of view while Staff B was restraining Client #1 who was on the ground.

169. Respondent's Program Director was interviewed during the observation of the video. She stated, "That was an improper hold," referring to the way Staff B was holding Client #1. Staff B was observed to place his hand on the side of the back of Client #1's head and face and push Client #1's face towards the ground.

170. At 19:32:09, Staff A was observed approaching Client #1 and kneeled on the lower torso of Client #1 with her knees positioned on one of the client's legs, and her hand on the client's other leg. The client's lower torso was prone. Staff A was observed to adjust her knees to be directly on the back of the client's leg.

171. The Program Director commented during the review of the video that Staff A was inappropriately positioned on top of Client #1 as Staff A was using her body to hold the client down. She stated the client's face was to the side with his/her body partially prone, and the client should have been in a supine position.

172. At 19:34:10, Client #1 was observed attempting to raise the leg Staff A was holding with her hand. Staff A caught the leg and slammed it into the ground.

173. At 19:34:30, Staff A rose and walked out of the area. Staff D who was still

talking on the cell phone, lowered himself onto Client #1's lower torso with his knee on the thigh of Client #1. Staff D did not follow through with the hold but stood and walked out of the video surveillance range while Staff B continued to hold the client on the ground.

174. Staff A subsequently walked closer to Client #1, and leaned into the client's side with her knee while the client was in a seated position. The client was trying to lean forward while Staff B was moving the client back and forward with his hands on Client #1's shoulders. Staff B later grabbed Client #1's left arm and moved it behind the client's back and upwards.

175. Client #1 was observed to struggle and Staff B placed his body on top of the client at 19:37:19. The client was sideways to the ground. While Staff B held client on the client's side, Staff A walked around Client #1 and kicked the client in the leg. Staff A backed up and Staff C lowered herself onto the client's lower legs.

176. Staff B was seen rising to his feet at 19:38:24. No hands were placed on the client and Client #1 assumed a seated position on the ground. Shortly thereafter, Client #1 was pushed toward the ground by Staff A. Staff A stood behind the client. Client #1's back fell against Staff A who pushed the client forward, placed her right hand around the back of Client #1's head, and held Client #1 with her left hand. Staff A pulled back her right arm and punched Client #1 in the nape of the neck with her right fist. The force of the punch caused Client #1's head to move upon impact. Staff A then used both of her hands on the back of Client #1's head and pushed the client's head down with the weight of her body. Client #1's face was facing forward into the ground. Staff A straddled the client's back and leaned into Client #1's head with pressure while Staff B stood and watched.

177. At 19:41:23, Client #1 turned his/her head to the side while Staff A continued to push repeatedly down on the client's head. Client #1's legs were kicking. Staff A continued

pushing Client #1's head into the ground while the client was lying on his/her stomach as Staff B walked out of camera range. Next, Staff A, while still on top of the back of Client #1, used both of her hands to push the client's face into the ground. Client #1 struggled, turned his/her face to the side and up. Staff A, while still straddling Client #1, held the side of the client's face against the ground with her right hand, while her left hand was on the client's shoulder.

178. Client #1 struggled onto his/her side at 19:41:36. Staff A had positioned her knee on the client's shoulder and Staff B walked back into view. Client #1 later struggled to his/her side and Staff A stood up from Client #1. Client #1 rolled over on his/her back, with his/her head tilted back while Staff A stood near the client's legs. Staff B was observed approximately three (3) feet from Client #1 who rolled back and forth on the ground.

179. Staff D returned into camera view looking around at the ground and facing Client #1, Staff A, and Staff B at 19:42:28. Client #1 was later observed on the ground on his/her back while Staff A was standing next to the client. Staff B and D were standing approximately three (3) feet away looking down at the client. Client #1 used his/her arm to hit Staff A. Staff A used her left leg to kick Client #1 in the back. Client #1 then attempted to hit Staff A again. Staff A lowered her body onto Client #1's side, grabbed the client's head with her right hand, pulled the client's head back, and with an outspread hand over the client's head, banged Client #1's head into the ground and held the head against the ground. Staff D crouched down at the side of the client's head and positioned himself towards Client #1's lower torso. Staff B stood and watched.

180. Staff A, using the force of her weight, pressed against the client's head using both of her hands on the back of Client #1's head at 19:42:36. Client #1 was later observed attempting to turn his/her head to the side, but Staff A dragged the client's head against the

ground. Staff A realigned her upper body and pushed down on the client's head again. Staff B lowered himself to the client's feet. Staff A lifted her left hand and brought it back down on the client's head.

181. At 19:42:53, Client #1 struggled and turned his/her face from the ground and subsequently attempted to turn on his/her side. Staff A had both of her hands on the client's left shoulder, attempting to turn the client to face the ground. Staff D was crouched in front of the client attempting to hold him/her while Staff B was at the client's feet.

182. Staff A stood up at 19:43:05 while Staff D continued to hold Client #1. The client was on his/her side with Staff B at the client's feet. Staff D rose from Client #1 and Staff B held Client #1's left leg with his right hand above the knee and used his left hand to hold the resident's ankle. Shortly thereafter, Client #1 raised his/her left leg and Staff B slammed it back to the ground and Staff D walked out of the camera range. Staff B continued to hold Client #1 by one (1) leg. Client #1's upper body moved back and forth while Staff A was positioned by Client #1's head.

183. The Program Director advised that the leg hold that Staff B was using was not appropriate according to Crisis Prevention Intervention guidelines. She stated that both legs should be held at the time of the hold.

184. The video reflected that at 19:44:16, Staff B removed his hands from Client #1's legs and rose to his feet. Staff C subsequently entered the range of the surveillance camera. Client #1 was still on the ground and Staff B stood approximately two (2) feet from the client's feet while Staff A stood next to the client's head. Subsequently, Staff A, Staff B, and Staff C, were standing and talking while Client #1 remained on the ground.

185. On October 4, 2023, at 12:50 p.m., an interview was conducted with

Respondent's Crisis Prevention Intervention Trainer. The trainer confirmed she had reviewed the September 16, 2023, video. She confirmed that when the staff let go of Client #1, the restraint is stopped. She said that during the restraint, the client should not be prone and staff should flip the client over. They would want to try to get the client on his/her back for health and safety reasons. The trainer added that there should be "no forcing down." Dragging a client was not a technique that was taught and neither was picking a client up by the limbs. She said that Crisis Prevention Intervention does not teach seclusion, but instead teaches de-escalation. Physical restraint is the last resort.

186. Respondent's Crisis Management Planning and the Use of Emergency Procedures and Physical Intervention Policy and Procedure, effective February 2021, stated, in relevant part:

> The Network recognizes the importance of treating an individual in crisis with dignity and respect throughout the encounter. This policy provides direction on the use of emergency physical interventions that are only to be utilized as instructed if/ when imminent danger is presented by the individual, and there are no other means to stop, prevent, or deter harm from occurring.
> Specific Standards:
>
> ...
>
> B. In an Emergency, interventions may include physical restraint or other restrictive procedures, in compliance with state and local regulations as well as Network Policy:
>
> ...
>
> 4. The following restraints are prohibited in all situations:
>
> a. **Restraining an individual in a prone position (face down);**
>
> b. Choke holds or other types of holds that may restrict airway access or compromise respiration (e.g., sitting on, laying on, kneeling on the individual);
>
> c. **Any position in which a person is bent over in such a way that it is difficult for the person to breathe (e.g., a seated or kneeling position in which a person being restrained is bent over at the waist);**
>
> d. Those that cause the intentional infliction of pain ...
>
> (Emphasis supplied).

187. The above reflects Respondent's failure to ensure that prohibited restraints that

impeded respiration or placed weight on a child's upper torso, neck, chest, or back were not conducted on one (1) of five (5) sampled clients, the same being contrary to the mandates of law.

188. That the Agency cited the Respondent for a violation of the minimum requirements of law.

189. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

190. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

191. That the foregoing constitutes a Class II violation pursuant to § 408.813(2)(b), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

## COUNT V

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

193. Florida law provides:

> 2. Grounds shall have space for children's activities, which shall be designed based on the type of activities offered and age appropriateness. The grounds shall be maintained in a safe and reasonably attractive manner and kept free of standing water, debris, garbage, trash and other hazardous conditions.
> Rule 65E-9.005(5)(a)2, Florida Administrative Code.

194. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

195. That based upon observation, interviews, and the review of records, Respondent failed to ensure the facility grounds were maintained in a safe manner and free of hazardous conditions, the same being contrary to the mandates of law.

196. Respondent's facility event report reflected that Client #1 had an event on September 16, 2023, at approximately 7:30 p.m. which involved Client #1 breaking a window and subsequently being restrained.

197. On October 26, 2023, at 3:30 p.m., a phone interview was conducted with Staff B. Staff B was asked about an event which occurred on September 16, 2023, at approximately 7:30 p.m., involving Client #1 breaking a window. During the interview, Staff B stated he had seen Client #1 with a big slab of concrete in the client's hands which the client had been thrown down. Also, Client #1 had picked up a rock, brick, or little paver, and broke a window. Staff B

confirmed there had been issues with clients getting items from the yard and management was aware of it.

198. On October 4, 2023, at 10:46 a.m., an interview was conducted with Staff C. Staff C was asked what had occurred prior to the events involving Client #1 breaking a window and being restrained on September 16, 2023, at approximately 7:30 p.m. Staff C indicated that Clients #2, #4, and #5, were trying to beat Client #1 up. They were in the courtyard, they had a toaster, broomstick, tree branches, mop, and bricks. Staff C, stated, "At that point, they had weapons. You are hoping they will listen to you." Staff C indicated that earlier that evening, Clients #2, #4, and #5, had walked to the back area where the sheds and parking lot were located. Client #4 had grabbed a cart containing tree branches and threatened Client #1.

199. On October 4, 2023, at 10:30 a.m., a tour of Respondent's facility was conducted with the Clinical Director. A walk around the back of the apartment building was conducted. The apartment building was next to a building that was called "the gym." An employee parking lot and a maintenance area with sheds were observed. The Clinical Director stated they had been working on replacing the windows of the Whitney building with hurricane windows. A pickup truck near the fence was observed. The truck bed was full of broken window frames with broken glass. The Clinical Director was asked about the cart with branches and responded that clients are allowed to enter the maintenance area as part of a program to have clients help pick up sticks, branches, use the cart, and sweep.

200. A subsequent tour of the facility grounds was conducted on October 4, 2023, at 3:53 p.m. with the Clinical Director. During this tour, the common area outside of the clients' apartment building and the activity building was observed to have a patio area with walkways surrounded by rubber-like edging. The edging was observed to be held in place by exposed

rebar (metal pole) with the head of the rebar exposed approximately two (2) inches from the ground creating a trip/impalement hazard.

201. On October 4, 2023, at 3:53 p.m., three (3) cardboard boxes on the ground next to the trash receptacle were observed. The employee parking lot was also observed which indicated that a person could walk to the employee parking lot without restriction. There was a tree that had pavers and stones surrounding it and a yard cart containing branches. A shed with three (3) ladders hanging on it and surrounded by miscellaneous equipment was also seen. A pickup truck with an open bed was parked with the bed filled with broken window frames with broken glass.

202. That the above reflects that Respondent failed to ensure the facility grounds were maintained in a safe manner and free of hazardous conditions, the same being contrary to the mandates of law.

203. That the Agency cited the Respondent for a violation of the minimum requirements of law.

204. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

205. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or

applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

206. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT VI

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

208. Florida law provides:

> (7) Housekeeping.
> (a) The facility and its contents shall be kept free from dust, dirt, debris and noxious odors.
> (b) All rooms and corridors shall be maintained in a clean, safe, and orderly condition, and shall be properly ventilated to prevent condensation, mold growth, and noxious odors.
> (c) All walls and ceilings, including doors, windows, skylights, screens, and similar closures shall be kept clean.
> Rule 65E-9.005(7)(a-c), Florida Administrative Code.

209. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

210. That based upon observation, interviews, and the review of records, Respondent

failed to ensure that it maintained its facility in a clean, safe, and orderly condition, the same being contrary to the mandates of law.

211. On October 4, 2023, at approximately 9:55 a.m., a tour of Apartment #1 of Respondent's facility was conducted with the Clinical Director. The Clinical Director stated that two (2) clients reside in the apartment with each client having his/her own bedroom and sharing a bathroom. The commode tank in the bathroom had no lid thereby exposing the inner mechanism.

212. A review of the ceiling vent in each of the client's bedrooms revealed the presence of blackened material accumulated on the surface of the vents. The Clinical Director stated, "That is disgusting." He further stated that the housekeeper comes in five (5) times a week, does the floors, and the bathroom. Maintenance changes out the air filters and is supposed to clean the vents.

213. That the above reflects that Respondent failed to ensure that it maintained its facility in a clean, safe, and orderly condition, the same being contrary to the mandates of law.

214. That the Agency cited the Respondent for a violation of the minimum requirements of law.

215. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

216. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

217. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT VII

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

219. Florida law provides:

> (3) Staff composition. The provider shall have the following staffing, any of which may be part-time, if the required equivalent full-time coverage is provided, except for those positions with a required specified staffing ratio:
> ...
> (c) Registered nurse.
> 1. A registered nurse shall supervise the nursing staff during the times that the children are present in the facility and normally awake, the nursing staff to child ratio shall be no less than 1:30, and during normal sleeping hours, the nursing staff to child ratio shall be no less than 1:40.
> 2. For therapeutic group homes that do not use restraint or seclusion in their program,

the provider is not required to have a registered nurse or other nursing staff on duty, but shall have definitive written agreements for obtaining necessary nursing services. Rule 65E-9.007(3)(c), Florida Administrative Code.

220. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

221. That based upon observation, interviews, and the review of records, Respondent failed to ensure that it met the minimum required staff composition for nursing staff to children, the same being contrary to the mandates of law.

222. Respondent is licensed (License No. 86) to operate a twelve (12) person capacity residential treatment center for children and adolescents. At the time of the survey, the census was eight (8) clients.

223. A review of the Respondent's facility campus map reflected that the facility was located on property where a sister facility (issued License No. 80) was also located.

224. An interview was conducted on October 2, 2023, at 9:50 a.m. with the Director of Nursing. The Director of Nursing stated she had worked on Respondent's campus for thirteen (13) years. Her regular schedule was Monday through Friday, from 7:00 a.m. until approximately 3:00 p.m. The Director of Nursing stated that the nursing schedule was for the entire campus which included Respondent's facility as well as the separately licensed sister facility. The Director of Nursing stated she was unaware that campus had two (2) residential treatment centers with different licenses. The singular nurse schedule, one (1) nurse for each eight (8) hour shift, was for both of the facilities. The Director of Nursing stated that she arrived at campus on September 16, 2023, at approximately 7:20 p.m.

225. The Director of Nursing confirmed that on September 16, 2023, Staff K, a registered nurse, worked until 3:00 p.m. and then left the campus.

226. An interview was conducted on October 3, 2023, at approximately 10:15 a.m. with Staff J, a Direct Staff Lead for the sister facility on the campus. Staff J confirmed she worked on September 16, 2023, at the sister facility, but had gone to Whitney Acres at approximately 7:20 p.m. to 7:30 p.m. That was when she witnessed Client #1 being held in an inappropriate restraint by Staff B. Staff J stated she called the Director of Nursing at approximately 7:40 p.m., and then texted the Director of Nursing at 7:44 p.m. Staff J stated the Director of Nursing told her she would get to the facility as soon as possible. Staff J said that when the Director of Nursing arrived, she came to the sister facility first, around 8:15 p.m. or 8:30 p.m.

227. That the above reflects that Respondent failed ensure that it met the minimum required staff composition for nursing staff to children, the same being contrary to the mandates of law.

228. That the Agency cited the Respondent for a violation of the minimum requirements of law.

229. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

230. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or

applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

231. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT VIII

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

233. Florida law provides:

> (5) Staff orientation and training.
> ...
> (b) The provider shall implement orientation and training programs for all new employees and ongoing staff training to increase knowledge and skills and improve quality of care and treatment services.
> Rule 65E-9.007(5)(b), Florida Adminsitrative Code.

234. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

235. That based upon observation, interviews, and the review of records, Respondent failed to implement training programs and ongoing training for staff (Staff L, O, and P) to increase knowledge and skills and improve quality of care and treatment services, the same

being contrary to the mandates of law.

236. Respondent's direct care staff schedule for September 16, 2023, reflected that three (3) staff member time slots had no staff listed for the 3:00 p.m. to 11 p.m. shift.

237. The Program Director was interviewed on October 4, 2023, at 12:16 p.m. regarding the three (3) time slot entries on the September 16, 2023 schedule which had no staff listed. She stated the system does not put the names on the schedule for staff from an agency. She stated that the agency will provide certified nursing assistants and nurses and that the three (3) staff members who were not listed on the schedule were certified nursing assistants who were to provide direct care staff coverage. The Program Director stated that the agency staff working at Respondent's facility usually consist of four (4) to five (5) staff who are the same people. Respondent has used the agency for a long time and it knows that it provides certified nursing assistants. The agency does not provide staff that are Crisis Prevention Intervention trained. The certified nursing assistants provided by the agency are instructed not to go "hands on" with the clients.

238. The Program Director identified the agency staff who worked at Respondent's facility on September 16, 2023, during the 3:00 p.m. to 11:00 p.m. shift to be Staff L, Staff O, and Staff P, all who were certified nursing assistants.

239. Respondent's Crisis Management Planning and the Use of Emergency Procedures and Physical Intervention Policy and Procedure, effective February 2021, provided:

> The Network recognizes the importance of treating an individual in crisis with dignity and respect throughout the encounter. This policy provides direction on the use of emergency physical interventions that are only to be utilized as instructed if/ when imminent danger is presented by the individual, and there are not other means to stop, prevent, or deter harm from occurring.

240. The foregoing policy and procedure further provided:

Specific Standards:
A. Individualized Crisis Management Plans (action plans based on an individual's demonstrated need and/or regulatory requirements) are developed to identify how to effectively respond and support an individual at specific times when he or she may be at risk of harm to self or others related to mental health or behavioral health needs. The plans identify techniques to calm, contain and deescalate in a volatile situation and include:
1. Identification of event (s) demonstrating need;
2. Identification of events or situations that have or may trigger the individual;
3. Consideration of a history of trauma and any medical/ physical conditions;
4. Age and developmentally appropriate strategies;
5. De-escalation techniques and alternatives to physical interventions;
6. Strategies designed in accordance with licensing, regulatory requirements and Network Policies; and identify that
7. **Individuals providing direct support receive education and training on the crisis management plan and the strategies for effective implementation prior to working unsupervised.**
B. In an Emergency, interventions may include physical restraint or other restrictive procedures, in compliance with state and local regulations as well as Network Policy: ...
C. Anyone providing direct support will receive initial education as part of orientation and additional in-service education on crisis Management using a competency-based curriculum in accordance with local regulations and licensing requirements, which will also include:
1. Understanding behavior as communication;
2. Recognizing the signs and proactively addressing stress;
3. How and when to implement a crisis intervention plan;
4. Emergency Interventions including:
a. Prohibited procedures or interventions;
b. Verbal de-escalation techniques;
c. Utilizing environmental modifications (in accordance with local regulations and Network policy);
d. Risk assessment to determine the least restrictive interventions appropriate to various situations;
e. Oversight and reporting requirements.
5. CPR (Cardio Pulmonary Resuscitation) training:
6. Network Policy on Positive Behavioral Supports and Human Rights.

241. That the above reflects that Respondent failed to implement training programs and ongoing training for staff (Staff L, O, and P) to increase knowledge and skills and improve

quality of care and treatment services, the same being contrary to the mandates of law.

242. That the Agency cited the Respondent for a violation of the minimum requirements of law.

243. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

244. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

245. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand five hundred dollars ($1,500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT IX

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

247. Florida law provides:

(5) Staff orientation and training.

. . .

(e) The provider shall implement a minimum of 40 hours of in-service training annually for all staff and volunteers who work directly with children. Continuing education for professional licenses and certifications may count towards training hours if the training covers the appropriate areas. This training shall cover all policies and procedures relevant to each position and shall, at a minimum, include each of the following:
1. Administrative:
a. Administrative policies and procedures and overall program goals;
b. Federal and state laws and rules governing the program;
c. Identification and reporting of child abuse and neglect;
d. Protection of children's rights; and
e. Confidentiality.
2. Safety:
a. Disaster preparedness and evacuation procedures;
b. Fire safety;
c. Emergency procedures;
d. Violence prevention and suicide precautions; and
e. First aid and CPR, with competency demonstrated annually.
3. Child development:
a. Child supervision skills;
b. Children's physical and emotional needs;
c. Developmental stages of childhood and adolescence;
d. Family relationships and the impact of separation;
e. Substance abuse recognition and prevention; and
f. Principles and practices of child care.
4. Treatment services:
a. Individualized treatment that is culturally competent;
b. Treatment that addresses issues the child may have involving sexual or physical abuse, abandonment, domestic violence, separation, divorce, or adoption;
c. Behavior management techniques include, but are not limited to: preventing problem behavior, defining and teaching expectations, teaching and encouraging the child's long-term use of new skills as alternative behaviors, contingency management, teaching and promoting choice making and self-management skills, time-out, point systems or level systems, de-escalation procedures, and crisis prevention and intervention;
d. Treatment plan development and implementation;
e. Treatment that supports the child's permanency goals; and
f. The provider shall ensure ongoing training and be able to produce documentation of

such training on the use of restraint and seclusion, physical escort, time-out, de-escalation
procedures and crisis prevention and intervention.
(I) Before staff may participate in any use of restraint or seclusion, staff shall be competency trained to minimize the use of restraint and seclusion, to use alternative, non-physical, non-intrusive behavioral intervention techniques to handle agitated or potentially violent children, and to use restraints and seclusion safely.
(II) Staff shall complete a training course in the safe and appropriate use of seclusion and restraint and in the use of alternative non-intrusive behavior management techniques. The training course shall be provided by individuals qualified by education, training, and experience to provide such training. Competencies shall be demonstrated on a semiannual basis. Training requirements for all staff who participate in the use of restraint and seclusion shall include:
(A) An understanding of the underlying causes, e.g., medical, behavioral and environmental, of consequential behaviors exhibited by the children being served;
(B) How staff behaviors can affect the behaviors of others, especially children with a history of trauma;
(C) The use of non-physical interventions, such as de-escalation, mediation, active listening, self-protection and other techniques, such as time-out for the purpose of preventing potential and intervening in emergency safety situations;
(D) Recognizing signs of respiratory and cardiac distress in children;
(E) Recognizing signs of depression and potential suicidal behaviors;
(F) Certification in the use of cardiopulmonary resuscitation (CPR). Competency based re-certification in CPR is required annually;
(G) How to monitor children in restraint or seclusion; and
(H) The safe use of approved restraint techniques, including physical holding techniques, take-down procedures, and the proper application, monitoring and removal of restraints.
(III) Training requirements for staff who are authorized to monitor a child's condition and perform assessments while the child is in seclusion or restraint shall include:
(A) Taking vital signs and interpreting their relevance to the physical safety of the child;
(B) Tending to nutritional and hydration needs;
(C) Checking circulation and range of motion in the extremities;
(D) Addressing hydration, hygiene and elimination;
(E) Addressing physical and psychological status and comfort;
(F) Assisting children to de-escalate to a point that would allow for the discontinuation of restraint or seclusion;
(G) Recognizing when the emergency safety situation has ended and the safety of the child and others can be ensured so the restraint or seclusion can be discontinued; and
(H) Recognizing the need for and when to contact a medically trained licensed practitioner or emergency medical services in order to evaluate and treat the child's physical status.
Rule 65E-9.007(5)(e), Florida Administrative Code.

248. On October 4, 2023, the Agency completed a complaint survey (Complaint

#2023014628) of the Respondent and its facility.

249. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

250. That based upon observation, interviews, and the review of records, Respondent failed to ensure that staff who completed competency training in the use of restraints demonstrated competency on a semiannual basis for three (3) of three (3) sampled staff (Staff B, Staff H, and Staff I), the same being contrary to the mandates of law.

251. On September 20, 2023, personnel records for Staff B, Staff H, and Staff L were reviewed. The records reflected that Crisis Prevention and Intervention training had been completed on January 10, 2023, by Staff B; on March 21, 2023, by Staff H; and on April 4, 2023, by Staff I. However, there was no documentation that Staff B, Staff H, and Staff I had demonstrated competency regarding Crisis Prevention and Intervention training on a semi-annual basis.

252. The Program Director was interviewed on September 29, 2023 at 2:58 p.m. regarding staff demonstrating competency on a semi-annual basis regarding the use of restraint. The Program Director advised that they were not having staff demonstrate competency on a semi-annual basis but were talking about it that morning.

253. The Program Director was subsequently interviewed on October 3, 2023, at 4:17 p.m. She stated she had to ask the trainers what the six (6) month Crisis Prevention Intervention training consisted of and she was unaware that with the child clients, the training had to be completed every six (6) months.

254. A review of the Respondent's Crisis Management Planning and the Use of Emergency Procedures and Physical Intervention Policy and Procedure, effective February 2021, provided:

> The Network recognizes the importance of treating an individual in crisis with dignity and respect throughout the encounter. This policy provides direction on the use of emergency physical interventions that are only to be utilized as instructed if/ when imminent danger is presented by the individual, and there are not other means to stop, prevent, or deter harm from occurring.

255. Respondent's policy and procedure mentioned above also provided for specific standards as follows:

A. Individualized Crisis Management Plans (action plans based on an individual's demonstrated need and/ or regulatory requirements) are developed to identify how to effectively respond and support an individual at specific times when he or she may be at risk of harm to self or others related to mental health or behavioral health needs. The plans identify techniques to calm, contain and deescalate in a volatile situation and include:
1. Identification of event (s) demonstrating need;
2. Identification of events or situations that have or may trigger the individual;
3. Consideration of a history of trauma and any medical/ physical conditions;
4. Age and developmentally appropriate strategies;
5. De-escalation techniques and alternatives to physical interventions;
6. Strategies designed in accordance with licensing, regulatory requirements and Network Policies; and identify that
7. Individuals providing direct support receive education and training on the crisis management plan and the strategies for effective implementation prior to working unsupervised.

B. In an Emergency, interventions may include physical restraint or other restrictive procedures, in compliance with state and local regulations as well as Network Policy:
...

C. Anyone providing direct support will receive initial education as part of orientation and additional in-service education on crisis Management using a competency-based curriculum in accordance with local regulations and licensing requirements, which will also include:
1. Understanding behavior as communication;
2. Recognizing the signs and proactively addressing stress;
3. How and when to implement a crisis intervention plan;
4. Emergency Interventions including:
a. Prohibited procedures or interventions;
b. Verbal de-escalation techniques;
c. Utilizing environmental modifications (in accordance with local regulations and Network policy);

d. Risk assessment to determine the least restrictive interventions appropriate to various situations;
e. Oversight and reporting requirements.
5. CPR (Cardio Pulmonary Resuscitation) training:
6. Network Policy on Positive Behavioral Supports and Human Rights.

256. That the above reflects that Respondent failed to ensure that staff who completed competency training in the use of restraints demonstrated competency on a semiannual basis for three (3) of three (3) sampled staff (Staff B, Staff H, and Staff I), the same being contrary to the mandates of law.

257. That the Agency cited the Respondent for a violation of the minimum requirements of law.

258. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

259. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay

the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

260. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand five hundred dollars ($1,500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT X

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

262. Florida law provides:

> (f) Only staff who have completed a competency-based training program that prepares them to properly use restraint or seclusion shall apply these procedures to children
> Rule 65E-9.013(1)(f), Florida Administrative Code.

263. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

264. That based upon observation, interviews, and the review of records, Respondent failed to ensure that staff completed a competency based training program regarding the proper uses of restraint or seclusion before applying these procedures to children, the same being contrary to the mandates of law.

265. On September 9, 2023, a review of documentation in Client #1's clinical records and video footage reflected that Staff A, B, C, and D participated in an incident involving the restraint and seclusion of Client #1 on September 16, 2023.

266. Personnel records regarding Staff A, B, C, and D were reviewed with the Program Director on September 29, 2023, at 2:00 p.m. The review reflected that Staff A's Crisis Prevention Intervention certification expired on January 28, 2022 and Staff D's Crisis Prevention Intervention certification expired on April 29, 2023. The Program Director confirmed that Staff A and Staff D did not have current Crisis Prevention Intervention certification.

267. On September 29, 2023, a review of documentation in Client #2's clinical record and video footage reflected that Staff E, F, G, and H participated in an incident involving the restraint and seclusion of Client #2 on September 26, 2023.

268. Personnel records regarding Staff E, F, G, and H were reviewed on October 4, 2023, at 12:30 p.m. with the Program Director. The review reflected that Staff F's Crisis Prevention Intervention certification expired on May 27, 2023. and Staff G's Crisis Prevention Intervention certification expired on May 27, 2022.

269. On October 4, 2023, at 12:50 p.m., an interview was conducted with Respondent's Crisis Prevention Intervention trainer. The trainer stated that seclusion is not taught in Crisis Prevention Intervention training.

270. The Program Director provided the Respondent's Restraint Guidelines policy but she stated on September 29, 2023, at 1:58 p.m. that Respondent did not have a seclusion policy.

271. That the above reflects that Respondent failed to ensure that staff completed a competency based training program regarding the proper uses of restraint or seclusion before applying these procedures to children, the same being contrary to the mandates of law.

272. That the Agency cited the Respondent for a violation of the minimum

requirements of law.

273. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

274. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

275. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of two thousand dollars ($2,000.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT XI

276. The Agency re-alleges and incorporates paragraphs (1) through (5) as if fully set

forth herein.

277. Florida law provides:

(2) Provider procedures. The provider's procedures shall address the use of restraint, seclusion and time-out. A copy of the procedures shall be provided to children and their parents or guardians, foster parents and guardian ad litem, if applicable, upon admission, to all staff, and to the department. The procedures shall include provisions for implementing the requirements of this section and the provider's strategies to:
(a) Reduce and strive to eliminate the need for and use of restraint and seclusion;
(b) Prevent situations that might lead to the use of restraint or seclusion;
(c) Use alternative, non-intrusive techniques in the prevention and management of challenging behavior;
(d) Train staff on how restraint and seclusion are experienced by children and the effect they have on children with a history of trauma; and
(e) Preserve the child's safety and dignity when restraint or seclusion is used.
Rule 65E-9.013(2), Florida Administrative Code.

278. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

279. That based upon observation, interviews, and the review of records, Respondent utilized seclusion for clients (Client #1 and Client #2) despite no policy or procedure in effect addressing seclusion, the same being contrary to the mandates of law.

280. On October 2, 2023, at approximately 10:25 a.m., the Respondent's sensory room was observed with the Director of Nursing. The area for the location of the room was formerly an apartment. The door from the outside opened into a room with a table and heavy weighted chairs and a bathroom at the back with a door. A second room in the back was present with a door that could be closed. No lock was observed on that door. The door opened towards the larger room and not into the sensory room. The sensory room had a mirror window present approximately in the middle of the room, where a person could look into the sensory room and observe it without being seen from a person inside the sensory room.

281. A sign was present on the door of the second room that read:

Seclusion Guidelines
A staff member must have eyes on participant at all times when they are in quiet room.
DO NOT barricade the door or place items in front of the door to prevent it from opening. Door must be held shut manually such that the participant would be able to exit if staff were not present.
Nothing may be in the room with participant if they are in the room alone. This include mats, masks, etc.
If participant engages in high magnitude SIB (self-injurious behavior) or begins to hurt themselves, enter the room and utilize least restrictive form of CPI necessary to keep them safe.
Mats will stay outside of the seclusion room until needed for CPI. Once CPI is complete, mats must be removed from quiet room.
Refer to participant behavior plan for criteria for exiting the room.

282. On October 2, 2023, at approximately 11:00 a.m., a review of video footage of the September 16, 2023 event involving Client #1 was conducted with the Program Director.

283. The video shows that at 19:54:08, Staff C opened the outer door to the apartment in which the sensory room was located. Shortly thereafter, Staff C is seen dragging Client #1 by the feet while Staff B and Staff I hold the client's arms. The staff dragged Client #1 into the sensory room, left the client on the floor, exited the room, and closed the door.

284. At 20:08:02, Staff B is observed on the video moving a weighted chair towards the door of the sensory room. In the sensory room, Client #1 was on the floor. No staff member was positioned at the observation window in the middle of the other room to observe the client.

285. On October 2, 2023, at approximately 11:00 a.m., the Program Director was interviewed. She stated that the door to the sensory room does not lock and that there was probably a staff member on the other side holding the door so the client could not get out.

286. On October 3, 2023, at 3:30 p.m., a telephone interview was conducted with Staff B. Staff B confirmed he had placed a chair in front of the sensory room door as the door to that room does not lock. He put the chair in front of the door so the client could not get out. Staff B said he thought the chair was there "for two minutes, could be longer, closer to ten

minutes." He added he had not had a lot of sensory room use experience.

287. On October 4, 2023, at approximately 10:30 a.m., video footage of the September 26, 2023, event involving Client #2 was conducted with the Clinical Director.

288. The video shows that at approximately 18:32, four (4) life skill trainers (Staff E, F, G and H) were observed carrying Client #2 in a supine position by the client's legs and arms into the sensory room then leaving the client alone in the room and shutting the door. An unidentified staff member was observed on the video on the outside of the sensory room holding the door shut to prevent Client #2 from leaving the room.

289. On October 4, 2023, at 12:50 p.m., an interview was conducted with Respondent's Crisis Prevention Intervention trainer. She stated seclusion is not taught in Crisis Prevention Intervention training.

290. The Program Director provided the Respondent's Restraint Guidelines policy but she stated on September 29, 2023, at 1:58 p.m. that Respondent did not have a seclusion policy. She later stated that the sensory room can be used to conduct a restraint or for a "calm down" period with staff and a client. She said that sometimes the door is open and sometimes it is closed during the "calm down" period. She stated this is part of the client's behavior plan.

291. On October 4, 2023, the Clinical Director stated that "any kid who is approved for seclusion, it is in their behavior plan."

292. That the above reflects that Respondent utilized seclusion for clients (Client #1 and Client #2) despite no policy or procedure in effect addressing seclusion, the same being contrary to the mandates of law.

293. That the Agency cited the Respondent for a violation of the minimum requirements of law.

294. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

295. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

296. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT XII

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

298. Florida law provides:

(3) Authorization of restraint or seclusion.
(j) Each order for restraint or seclusion shall include:
1. The ordering physician's name;
2. The date and time the order was obtained; and
3. The emergency safety intervention ordered, including the length of time for which the physician authorized its use, which length of time shall not exceed the time limits set forth in subsection 65E-9.013(3)(f)1.-.3, F.A.C.
Rule 65E-9.013(3)(j), Florida Administrative Code.

299. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

300. That based upon observation, interviews, and the review of records, Respondent failed to ensure physician orders for restraint and seclusion included the emergency safety interventions ordered, including the length of time for which the physician authorized the use of each emergency safety intervention, for two (2) of five (5) sampled clients (Clients #1 and #2), the same being contrary to the mandates of law.

301. Client #1's records included a Crisis Prevention Intervention Form dated September 16, 2023, that stated the situation, events, and interventions preceding physical intervention involved "Client #2 and Client #1 were verbally going at it with each other and threatening each other causing Client #1 to be agitated." The form reflected that Client #1's response to non-physical intervention was that "Client #1 ran to behind Apartment 6 and grabbed a brick/paver." The specific behavior identified as creating risk and requiring physical intervention was that "Client #1 threw the brick/paver through apartment 6 glass bedroom window causing loose glass to be in the area and presenting unsafe risk/behavior." The procedure used to address this behavior was "Physical Restraint/Manual (5 minutes or more)" which was initiated at 7:30 p.m. and terminated at approximately 7:44 p.m. Client #1's response to the physical intervention procedures consisted of yelling, crying, and physical aggression.

The form indicated that Client #1 calmed down after about fifteen (15) minutes and was transferred to the sensory room.

302. Crisis Prevention Intervention Form dated September 16, 2023, also stated that physical procedures used other than "classroom CPI" consisted of Client #1 being grabbed and transferred to the ground. Client #1 was on his/her side/stomach with one hand on [his/her] back holding [him/her] in place. The specific criteria for release from restraint identified in the form was "Calm body to transfer to the sensory room then 10 minutes of calm body/behavior to be released from the sensory room." There was no documentation of any less intrusive intervention by staff for the foregoing situation and event involving Client #1. The bottom of the form did not have a signature or time and date reflecting by whom and when it was reviewed. The form indicated it was to be reviewed by the Program Director or the Crisis Prevention Intervention instructor.

303. The Physician Order Restraint/Seclusion form indicated that the Director of Nursing obtained the physician's verbal order at 7:40 p.m. and the order was circled for chemical and physical restraint. It was not circled for seclusion. The sections on the form regarding participant risk factors and the reason for intervention were left blank. A verbal medication order for diphenhydramine, 50 mg oral for behavior, was documented.

304. The physical restraint duration was documented as 7:35 p.m. to 7:44 p.m. There was no documentation related to seclusion.

305. The video footage for this emergency safety situation commenced on September 16, 2023, at 19:30 and ended at 20:11.

306. The Post Restraint Nursing Assessment form was completed by the Director of Nursing on September 16, 2023, at 9:00 p.m. The interventions identified in the form were

chemical, physical, and seclusion.

307. Client #2's clinical records reflected that the client was admitted to Respondent's facility on June 12, 2023. Client #2's diagnoses contained in the Interim Behavior plan, last updated on August 9, 2023, included attention deficit hyperactivity disorder (ADHD), disruptive mood dysregulation disorder, personality disorder, and bipolar disorder.

308. Respondent's event report regarding the incident on September 16, 2023, at 8:44, stated that staff were asked to come help to assist Client #2 inside the café due to him/her having glass shards in his/her hands. Staff prompted Client #2 to hand over the shards. When Client #2 refused, he/she was transported to the sensory room and outside the sensory room, a four (4) person Crisis Prevention Intervention was performed. Client #2 was also given a "PRN" (as needed). Client #2 was then redirected to the sensory room with one (1) staff, and when Client #2 started hitting his/her head continuously against the window with force, staff implemented another Crisis Prevention Intervention and a five (5) person hold was performed. Client #2 was calm for a while and was asked to stay inside the sensory room for another two (2) minutes and the client then appeared to be calm. The client then tried to elope from the sensory room and the staff performed a third Crisis Prevention Intervention hold until the client was calm.

309. A September 16, 2023, Crisis Prevention Intervention Form was reviewed on October 2, 2023. The name of the staff who completed the form is illegible. The form indicated that physical restraint was initiated at 8:00 p.m. and that Client #2 was released at 9:45 pm. The specific criteria for release from restraint was documented as "10 minutes calm/safe behavior."

310. A second Crisis Prevention Intervention Form for the same September 16, 2023, Crisis Prevention Intervention hold completed by Staff Q was also reviewed on October 2, 2023. This form documented that physical restraint was initiated at 8:44 p.m. and tha the restraint was

released at 9:50 p.m.

311. There was only one (1) physician order for the time period of 8:00 p.m. to 9:50 p.m. despite three (3) separate Crisis Prevention Intervention holds conducted as confirmed by the Program Director on October 2, 2023, at 10:29 a.m.

312. The Physician Order Restraint/Seclusion form for Client #1's September 16, 2023 event (which was missing the date and time of the completion of that form) documented a verbal order obtained by the Director of Nursing at 8:20 p.m. for chemical restraint and physical restraint. The chemical restraint was documented as diphenhydramine, 50 mg/1ml IM (intramuscularly), plus diphenhydramine, 50 mg PO (by mouth). The duration of the physical restraint was documented as 8:40 p.m. to 9: 25 p.m.

313. Respondent's Behavioral Programming policy and procedure with an effective date of May 2021 stated:

> Procedures:
> 1. Level of Restriction: The following is a four-level procedural ranking in order to gauge treatment restrictiveness:
> ...
> Level II: These procedures are typically used within a more formal treatment program and may contain some features that are considered intrusive or restrictive. Although Level II procedures may require risk review, their use may be encouraged when other treatment selection concerns (e.g., relevance of target behavior) ...
> E. Brief (i.e.) less than five minutes) Physical interruption or prevention procedures used as part of a formal program to reduce unwanted and increase adaptive behavior (e.g., graduated guidance when a participant resists, " gentle teaching" procedures involving trainer blocking, brief interruption by manual holding on a response contingent basis, etc.) ...
> Level III: These procedures are generally considered to be highly restrictive or intrusive and their use requires review when employed on a regular basis. In such cases, staff shall refer to specific policies and procedures governing their use and approval. They should not be implemented without completion of training program including successful completion of competency testing. The following terms and definitions shall be used to distinguish between these types of interventions ...
> B. Physical Interruption - an emergency intervention in which staff

initiate the least amount of physical contact possible in order to reduce the likelihood of injury to the participant or others. Examples include ...a brief (less than 5 continuous minutes) implementation physical hold. Physical interruption is also involved when staff utilizes the least amount of physical contact necessary to ensure participant movement to or from a particular area (i.e., during escort)

C. Physical restraint - An emergency intervention that involves direct restriction of participant's limbs, head, or body through manual holding or use of restraint device. Physical restraint is considered to be highly intrusive intervention that is solely intended to protect a participant from producing injury to himself or others. It shall be considered to have been initiated whenever a manual method has been employed for longer than a five-minute continuous period of time.

D Medication solely for Behavior Management- Use of medication that is not part of a participant's regular medication regimen to control potentially dangerous behavior.

...

4. Physical Restraint

A. Rules Governing the use of Physical Restraint ...

2. A Physician's Order must be obtained prior to performing any type of restraint as defined in this policy...

D. Documentation: Each use of physical restraint shall be documented as a physical aggression in iServe. Qualified staff is responsible for descriptive documentation regarding the circumstances leading up to the use of restraint.

314. That the above reflects that Respondent failed to ensure physician orders for restraint and seclusion included the emergency safety interventions ordered, including the length of time for which the physician authorized the use of each emergency safety intervention for two (2) of five (5) sampled clients (Clients #1 and #2), the same being contrary to the mandates of law.

315. That the Agency cited the Respondent for a violation of the minimum requirements of law.

316. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the

renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

317. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

318. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand dollars ($1,000.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

## COUNT XIII

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

320. Florida law provides:

> (4) Documentation. Staff shall document the intervention in the child's record, with documentation completed by the end of each shift during which the intervention begins and continues. Documentation shall include:
> (a) Each order for restraint or seclusion;

(b) The time the emergency safety intervention began and ended;
(c) The specific circumstances of the emergency safety situation, the rationale for the type of intervention selected, the less intrusive interventions that were considered or tried and the results of those interventions;
(d) Time-specific assessments of the child's physical and psychological condition;
(e) The name, position, and credentials of all staff involved in or witnessing the emergency safety intervention;
(f) Time and date of notification of the child's parent or guardian and guardian ad litem;
(g) The behavioral criteria and assistance provided by staff to help the child meet the criteria for discontinuation of restraint or seclusion;
(h) Summary of debriefing of the child with staff;
(i) Description of any injuries sustained by the child during or as a result of the restraint or emergency safety intervention and treatment received for those injuries;
(j) Review and revise, if necessary, the child's treatment plan, including a description of procedures designed to prevent the future need for and use of restraint or seclusion; and
(k) Before restraint or seclusion were ordered for the child, the ordering physician assessed whether there were pre-existing medical conditions or physical disabilities, history of sexual or physical abuse, or current use of psychotropic medication that could present a risk to the child and results of such review are documented in the order for restraint or seclusion and the child's record.
Rule 65E-9.013(4), Florida Administrative Code.

321. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

322. That based upon observation, interviews, and the review of records, Respondent failed to ensure accurate and complete documentation of restraint (including drugs used relating thereto) and seclusion conducted regarding two (2) of two (2) sampled clients (Client #1 and Client #2), the same being contrary to the mandates of law.

323. The Program Director was interviewed on October 2, 2023, at 1:15 p.m. The Program Director indicated that the Crisis Prevention Intervention Form, dated September 16, 2023, is used by life skills trainers to document what occurred during an emergency intervention. She indicated the Physician Order Restraint/Seclusion section is where the nurse documents the verbal orders she receives from the physician and the Post Restraint Nursing Assessment section is where the nurse documents the client's behavioral, physical, and

psychological status after the emergency safety intervention.

324. Client #1's records included a Crisis Prevention Intervention Form dated September 16, 2023, that stated the situation, events, and interventions preceding physical intervention involved "Client #2 and Client #1 were verbally going at it with each other and threatening each other causing Client #1 to be agitated." The form reflected that Client #1's response to non-physical intervention was that "Client #1 ran to behind Apartment 6 and grabbed a brick/paver." The specific behavior identified as creating risk and requiring physical intervention was that "Client #1 threw the brick/paver through apartment 6 glass bedroom window causing loose glass to be in the area and presenting unsafe risk/behavior." The procedure used to address this behavior was "Physical Restraint/Manual (5 minutes or more)" which was initiated at 7:30 p.m. and terminated at approximately 7:44 p.m. Client #1's response to the physical intervention procedures consisted of yelling, crying, and physical aggression. The form indicated that Client #1 calmed down after about fifteen (15) minutes and was transferred to the sensory room.

325. The Crisis Prevention Intervention Form dated September 16, 2023, also stated that physical procedures used other than "classroom CPI" consisted of Client #1 being grabbed and transferred to the ground. The client was on his/her side/stomach with one hand on [his/her] back holding [him/her] in place. The specific criteria for release from restraint identified in the form was "Calm body to transfer to the sensory room then 10 minutes of calm body/behavior to be released from the sensory room." There was no documentation of any less intrusive intervention by staff for the foregoing situation and event involving Client #1. The bottom of the form did not have a signature or time and date reflecting by whom and when it was reviewed. The form indicated it was to be reviewed by the Program Director or the Crisis Prevention

Intervention instructor.

326. The Physician Order Restraint Seclusion form indicated that the Director of nursing obtained the physician's verbal order at 7:40 p.m. and the order was circled for chemical and physical restraint. It was not circled for seclusion. The sections for noting participant risk factors and the reason for intervention were both left blank. A verbal medication order for diphenhydramine, 50 mg oral for behavior, was documented.

327. The duration of Client #1's physical restraint was documented as 7:35 p.m. to 7:44 p.m. There was no documentation related to seclusion.

328. The video footage regarding this emergency safety situation commenced at 19:30 and ended at 20:11.

329. A Post Restraint Nursing Assessment form completed by the Director of Nursing on September 16, 2023, at 9:00 p.m., had chemical, physical, and seclusion interventions circled.

330. There was no documentation produced by Respondent of a debriefing with Client #1.

331. Staff J was interviewed on October 3, 2023, at approximately 10:15 a.m. with Staff J. Staff J confirmed she worked on September 16, 2023, at Respondent's sister facility, but had gone to Whitney Acres at approximately 7:20 p.m. to 7:30 p.m. She had witnessed Client #1 being held in an inappropriate restraint by Staff B. Staff J stated she called the Director of Nursing at approximately 7:40 p.m., and then texted the Director of Nursing at 7:44 p.m. Staff J stated the Director of Nursing told her she would get to the facility as soon as possible. Staff J said that when the Director of Nursing arrived, she came to the sister facility first, around 8:15 p.m. or 8:30 p.m.

332. Client #2's clinical records indicated that the client was admitted to Respondent's facility on June 12, 2023. Client #2's Interim Behavior plan which was last updated on August 9, 2023, reflected diagnoses of attention deficit hyperactivity disorder (ADHD), disruptive mood dysregulation disorder, personality disorder and bipolar disorder.

333. Respondent's facility event report dated for an event on September 16, 2023, at 8: 44 p.m., documented that staff was asked to come help assist with Client #2 inside the café due to the client having glass shards in his/her hands. Staff prompted Client #2 to hand over the shards. When the client refused, the client was transported to the sensory room and outside the sensory room, a four (4) person Crisis Prevention Intervention was done. Client #2 was also given a "PRN" (as needed). The client was then redirected back to the sensory room with staff, when the client started hitting his/her head against the window with force continuously. Staff implemented Crisis Prevention Implementation immediately and a four (4) person Crisis Prevention Intervention hold was done. Client #2 appeared to be calm for a while and was asked to stay inside the sensory room for another two (2) minutes to calm down. Client #2 then tried to elope from the sensory room and staff performed a third Crisis Prevention Intervention hold until the client calmed down.

334. A Crisis Prevention Intervention Form dated September 16, 2023, was reviewed on October 2, 2023. The name of the staff who completed the form is illegible. The form indicated that physical restraint was initiated at 8:00 p.m. and that the restraint was released at 9:45 pm. The specific criteria for the release from restraint was documented as "10 minutes calm/safe behavior."

335. A second Crisis Prevention Intervention form was also reviewed on October 2, 2023, regarding the same incident on September 16, 2023. This form was completed by Staff Q

and documented a physical restraint was initiated at 8:44 p.m. and that the restraint was released at 9:50 p.m. There was only one (1) physician order for the time period of 8:00 p.m. to 9:50 p.m., despite three (3) separate Crisis Prevention Intervention holds having been conducted as confirmed by the Program Director in an interview on October 2, 2023, at 10:29 a.m.

336. The Physician Order Restraint/Seclusion form regarding the September 16, 2023 event reflected no date and time of form completion but documented a verbal order obtained by the Director of Nursing at 8:20 p.m. for chemical restraint and physical restraint. The chemical restraint was documented as diphenhydramine, 50 mg/1ml IM (intramuscular) plus diphenhydramine, 50 mg PO (by mouth). The duration of the physical restraint was documented as occurring from 8:40 p.m. to 9: 25 p.m.

337. Respondent's Behavioral Programming policy and procedure, with an effective date of May 2021 provides:

> Procedures:
> 1. Level of Restriction: The following is a four-level procedural ranking in order to gauge treatment restrictiveness:
> ...
> Level II: These procedures are typically used within a more formal treatment program and may contain some features that are considered intrusive or restrictive. Although Level II procedures may require risk review, their use may be encouraged when other treatment selection concerns (e.g., relevance of target behavior)
> E. Brief (i.e.) less than five minutes) Physical interruption or prevention procedures used as part of a formal program to reduce unwanted and increase adaptive behavior (e.g., graduated guidance when a participant resists, " gentle teaching" procedures involving trainer blocking, brief interruption by manual holding on a response contingent basis, etc.).
> Level III: These procedures are generally considered to be highly restrictive or intrusive and their use requires review when employed on a regular basis. In such cases, staff shall refer to specific policies and procedures governing their use and approval. They should not be implemented without the completion of training program including successful completion of competency testing. The following terms and definitions shall be used to distinguish between these types of interventions ...
> B. Physical Interruption - an emergency intervention in which staff

initiate the least amount of physical contact possible in order to reduce the likelihood of injury to the participant or others. Examples include ...a brief (less than 5 continuous minutes) implementation physical hold. Physical interruption is also involved when staff utilizes the least amount of physical contact necessary to ensure participant movement to or from a particular area (i.e., during escort)

C. Physical restraint - An emergency intervention that involves direct restriction of participant's limbs, head, or body through manual holding or use of restraint device. Physical restraint is considered to be highly intrusive intervention that is solely intended to protect a participant from producing injury to himself or others. It shall be considered to have been initiated whenever a manual method has been employed for longer than a five-minute continuous period of time.

D Medication solely for Behavior Management- Use of medication that is not part of a participant's regular medication regimen to control potentially dangerous behavior.

...

4. Physical Restraint

A. Rules Governing the use of Physical Restraint

...

2. A Physician's Order must be obtained prior to performing any type of restraint as defined in this policy ...

D. Documentation: Each use of physical restraint shall be documented as a physical aggression in iServe. Qualified staff is responsible for descriptive documentation regarding the circumstances leading up to the use of restraint.

338. That the above reflects Respondent failed to ensure accurate and complete documentation of restraint (including drugs used relating thereto) and seclusion conducted regarding two (2) of two (2) sampled clients (Client #1 and Client #2), the same being contrary to the mandates of law.

339. That the Agency cited the Respondent for a violation of the minimum requirements of law.

340. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the

severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

341. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

342. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT XIV

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

344. Florida law provides:

> (8) Monitoring of the child during and immediately after seclusion.
> (a) Staff trained in the use of emergency safety interventions and in assessment of suicide risk shall be physically present in or immediately outside the seclusion room, continually visually assessing, monitoring, and evaluating the physical and psychological well-being of the child in seclusion. Video or auditory monitoring shall not be used as substitutes for this requirement.

(b) If the emergency safety situation continues beyond the time limit of the physician's order for the use of seclusion, the staff person authorized to receive the verbal order, as identified in paragraph 65E-9.013(3)(c), F.A.C., shall immediately contact the ordering physician to receive further instructions or new orders for the use of seclusion and such notification shall be documented and maintained in the child's case file.
(c) A physician or other licensed staff member, as identified in paragraph 65E-9.013(3)(i), F.A.C., trained in the use of emergency safety interventions, shall evaluate the child's physical condition and psychological well-being immediately after the child is removed from seclusion and documentation of such evaluation shall be maintained in the child's case file.
(d) Staff shall immediately obtain medical treatment from qualified medical personnel for a child injured during or as a result of an emergency safety intervention.
Rule 65E-9.013(8), Florida Administrative Code.

345. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

346. That based upon observation, interviews, and the review of records, Respondent failed to continually visually assess, monitor, and evaluate the well-being of two (2) clients placed in seclusion (Clients #1 and #2) and also failed to ensure a physician or other licensed staff member documented an evaluation of one (1) client (Client #1) immediately after removal from seclusion, the same being contrary to the mandates of law.

347. On October 2, 2023, at approximately 10:25 a.m., the sensory room was observed with the Director of Nursing. The area for the location of the room was formerly an apartment. The door from the outside opened to a room with a table and heavy weighted chairs. There was a bathroom at the back with a door. A second room in the back was present with a door that could be closed. No lock was observed on the door. The door was observed to open towards the larger room and not into the sensory room. The sensory room had a mirror window present approximately mid-room, where a person could look into the room and observe it without being seen from the person on the inside.

348. A sign was present on the door of the second room that read:

Seclusion Guidelines:
-A staff member must have eyes on participant at all times when they are in quiet room.
-DO NOT barricade the door or place items in front of the door to prevent it from opening. Door must be held shut manually such that the participant would be able to exit if staff were not present.
-Nothing may be in the room with participant if they are in the room alone. This includes mats, masks, etc.
-If participant engages in high magnitude SIB or begins to hurt themselves, enter the room and utilize the least restrictive form of CPI necessary to keep them safe.
-Mats will stay outside of the seclusion room until needed for CPI. Once CPI is complete, mats must be removed from quiet room.
Refer to participant behavior plan for criteria for exiting the room.

349. On October 2, 2023, at approximately 11:00 a.m., video footage of the September 16, 2023 event involving Client #1 was conducted with the Program Director.

350. The video reflects that at 19:54:26, Staff C took Client #1 into the sensory room, left the client on the floor, exited the room, and closed the door.

351. The Program Director was interviewed during the review of the video and she stated that the sensory room door does not lock and there was probably a staff member on the other side holding the door so the client could not get out.

352. The video reflected that at 20:08:02, Staff C left the front room. Staff B moved a weighted chair towards the door of the sensory room. In the sensory room, Client #1 was observed on the floor. Between the sensory room and the front room, an observation window was present mid-wall. No staff member was positioned at the window to observe the client. The video footage did not reflect any staff member visually monitoring Client #1 continuously while the client was in the sensory room.

353. The Program Director was asked who was observing the client and she stated, "That is a great question."

354. Staff B was seen on the video at 20:11:33 at the door and the client rose to a

standing position. Staff B handed the client a snack bag and Staff B and the client walked out of the sensory room.

355. Client #1's clinical records contained a Post Restraint Nursing Assessment which was completed by the Director of Nursing on September 16, 2023, at 9:00 p.m. Nursing Progress notes regarding Client #1 for September 16, 2023, revealed no entries for that date. There was no documentation that Client #1 was evaluated by licensed staff related to his/her physical condition and psychological well-being immediately after being released from seclusion.

356. A review of video footage related to the restraint and seclusion of Client #2 on September 26, 2023, was conducted with the Clinical Director on October 4, 2023.

357. At 18:32:21 on the video, Client #2 is observed being brought into the sensory room by Staff E, F, G, and H and being placed on the floor.

358. The video depicts Client #2 in the sensory room with the door closed and a black mat on the floor from 18:33 until 19:03.

359. The video of the outer room of the apartment where the sensory room is located reflects that from 18:33, when the sensory room door was shut, until 19:03, a male staff member in the outer room is holding the door to the sensory room shut. The Clinical Director stated during the observation of the video that "someone is holding the door handle."

360. The video footage did not reflect any staff member visually monitoring Client #2 continuously while the client was in the sensory room. Instead from 18:33 to 19:03, staff intermittently, for periods of thirty (30) seconds to two (2) minutes looked through the observation window into the seclusion room approximately thirteen (13) times.

361. That the above reflects Respondent failed to continually visually assess, monitor,

and evaluate the well-being of two (2) clients placed in seclusion (Clients #1 and #2) and also failed to ensure a physician or other licensed staff member documented an evaluation of one (1) client (Client #1) immediately after removal from seclusion, the same being contrary to the mandates of law.

362. That the Agency cited the Respondent for a violation of the minimum requirements of law.

363. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

364. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

365. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand dollars ($1,000.00) against Respondent, a residential treatment center in the State of Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT XV

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

367. Florida law provides:

> (10) Post-restraint or seclusion practices.
> (a) After the use of restraint or seclusion, staff involved in an emergency safety intervention and the child shall have a face-to-face discussion, which is also known as a debriefing. Whenever possible, subject to staff scheduling, this discussion shall include all staff involved in the intervention. The child's parent or guardian shall be invited to participate in the discussion. The provider shall conduct the discussion in a language that is understood by the child and the child's parent or guardian. The discussion shall provide both the child and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the child, or others to prevent the need for the future use of restraint or seclusion. The discussion must occur within 24 hours of the emergency intervention, subject to the following exceptions:
> 1. Allowances may be made to accommodate the schedules of the parent(s) or legal guardian(s) of the child when they request an opportunity to participate in the debriefing and when staff deem their participation appropriate.
> 2. Allowances may be made to accommodate shift changes, vacation schedules, illnesses, and all applicable federal, state, and local labor laws and regulations.
> Rule 69E-9.013(10)(a), Florida Administrative Code.

368. On October 4, 2023, the Agency completed a complaint survey (Complaint #2023014628) of the Respondent and its facility.

369. That based upon observation, interviews, and the review of records, Respondent failed to ensure that a face-to-face discussion (debriefing) was held with two (2) clients (Clients #1 and #2) after the clients were subjected to restraint and/or seclusion, the same being contrary to the mandates of law.

370. The Program Director was interviewed on October 2, 2023, at 1:15 p.m. She

indicated that the Crisis Prevention Intervention Form dated September 16, 2023, is used by life skills trainers to document what occurred during an emergency intervention. She indicated the Physician Order Restraint/Seclusion section on that form is where the nurse documents the verbal orders she received from the physician and the Post Restraint Nursing Assessment is where the nurse documents the client's behavioral, physical, and psychological status after the emergency safety intervention. The Program Director stated that staff debriefing and follow-up forms are also completed by the staff involved in the Crisis Prevention Intervention.

371. Records regarding the Crisis Prevention Interventions conducted regarding Client #1 on September 16, 2023, and Client #2 on September 16, 2023, and September 26, 2023, revealed no documentation of a debriefing with Client #1 and Client #2 after each episode of Crisis Prevention Intervention.

372. On October 2, 2023, at 10:04 a.m., the Program Director said that child debriefings are not done.

373. Client #1's clinical records included a Crisis Prevention Intervention form dated September 16, 2023. In the section regarding the situation, events and interventions preceding the physical intervention, the form indicated that Client #1 and Client #2 were verbally going at it with each other and threatening each other which caused Client #1 to become agitated. However, there was no documentation of any less intrusive intervention by staff for this situation and event.

374. In the section of the Crisis Prevention Intervention form dated September 16, 2023, regarding the client's response to non-physical intervention, the form said that Client #1 ran behind Apartment 6 and grabbed a brick/paver. The form also noted that the specific behavior creating risk and requiring physical intervention was that Client #1 threw a

brick/paver through the glass bedroom window of apartment 6 causing loose glass to be in the area and presenting unsafe risk/behavior. The form specified that the procedure used in response to Client #1's actions consisted of "Physical Restraint/Manual (5 minutes or more)." The restraint was initiated at 7: 30 p.m. and the client was released at approximately 7:44 p.m. Client #1's response to the physical intervention procedures was yelling, crying, and physical aggression. Client #1 calmed down after about fifteen (15) minutes and was transferred to sensory room.

375. The Crisis Prevention Intervention form dated September 16, 2023, described that the physical procedures used other than "classroom CPI" consisted of Client #1 being grabbed and transferred to the ground. Client #1 was on his/her side/stomach and staff had one (1) hand on the client's back to hold the client in place. The criteria described to have the client released from restraint was "Calm body to transfer to the sensory room then 10 minutes of calm body/behavior to be released from the sensory room." The bottom of the form had no signature or time or date reflected to show by whom and when it was reviewed. The form indicated it was to be reviewed by the Program Director or the Crisis Prevention Intervention instructor and reflect the date and time of the review.

376. The Physician Order Restraint/Seclusion form indicated that the Director of Nursing obtained the physician's verbal order at 7:40 p.m. The order was circled to reflect chemical and physical restraint. It was not circled for seclusion. The sections in the form pertaining to participant risk factors and the reason for intervention were left blank. A verbal medication order for diphenhydramine, 50 mg oral for behavior, was indicated. The physical restraint duration was documented as 7:35 p.m. to 7:44 p.m. There was no documentation related to seclusion.

377. The Post Restraint Nursing Assessment form completed by the Director of Nursing on September 16, 2023, at 9:00 p.m. reflected the interventions employed as being chemical, physical and seclusion, which were circled.

378. Video footage regarding the emergency safety situation involving Client #1 commenced at 19:30 and ended at 20:11.

379. There was no proof provided of a debriefing with Client #1.

380. The Program Director was interviewed on September 29, 2023, at 2:00 p.m. She was asked about a face-to-face discussion (debriefing) with Client #1 after the emergency safety interventions of September 16, 2023. She stated that there were a lot of discussion with Client #1 the next day. However, she was not able to provide any documentation of a face-to-face assessment (debriefing) conducted with Client #1.

381. Respondent's facility event report regarding an event on September 16, 2023, at 8: 44 p.m. stated that Staff was asked to come help assist with Client #2 inside the café due to the client having glass shards in his/her hands. Staff prompted Client #2 to hand over the shards but when Client #2 refused, the client was transported to the sensory room. Outside the sensory room, a four (4) person Crisis Prevention Intervention was done. Client #2 was also given a "PRN" (as needed). Client #2 was then redirected back to the sensory room with one (1) staff. When Client #2 started hitting his/her head against the window with force continuously, staff implemented Criss Prevention Intervention procedures immediately and a four (4) person Crisis Prevention Intervention hold was performed. Client #2 appeared calm for a while and was asked to stay inside the sensory room for another two (2) minutes to continue to calm down. Client #2 then tried to elope from the sensory room and staff performed a third Crisis Prevention Intervention hold until the Client calmed down.

382. A September 16, 2023, Crisis Prevention Intervention form was reviewed on October 2, 2023. The name of the staff who completed this form is illegible. The form indicated that physical restraint was initiated at 8:00 p.m. and that the restraint was released at 9:45 pm. The specific criteria for release from the restraint was documented as "10 minutes calm/safe behavior."

383. A second Crisis Prevention Intervention Form for the same September 16, 2023, Crisis Prevention Intervention hold was completed by Staff Q and reviewed on October 2, 2023. This form documented that physical restraint was initiated at 8:44 p.m. and that the restraint was released at 9:50 p.m.

384. There was only one (1) physician order for the time period of 8:00 p.m. to 9:50 p.m., despite three (3) separate Crisis Prevention Intervention holds being conducted as confirmed by the Program Director on October 2, 2023, at 10:29 a.m.

385. The Physician Order Restraint/Seclusion form for Client #1's September 16, 2023 event (which did not indicate the date and time of form completion) reflected that a verbal order was obtained by the Director of Nursing at 8: 20 p.m. for chemical restraint and physical restraint. The chemical restraint was documented as diphenhydramine, 50 mg/1ml IM (intramuscularly), plus diphenhydramine, 50 mg PO (by mouth). The duration of the physical restraint was documented as being from 8:40 p.m. to 9:25 p.m.

386. Staff debriefing and follow-up forms were completed on September 19, 2023, and September 27, 2023, for the September 16, 2023 Crisis Prevention Intervention. However, there was no documentation reflecting that there was a face-to-face assessment (debriefing) with Client #2.

387. That the above reflects Respondent failed to ensure that a face-to-face discussion

(debriefing) was held with two (2) clients (Clients #1 and #2) after the clients were subjected to restraint and/or seclusion, the same being contrary to the mandates of law.

388. That the Agency cited the Respondent for a violation of the minimum requirements of law.

389. Under Florida law, in accordance with part II of chapter 408, the Agency may impose an administrative penalty of no more than $500 per day against any licensee that violates any rule adopted pursuant to this section and may suspend and revoke the license and deny the renewal application of such licensee. In imposing such penalty, the Agency shall consider the severity of the violation, actions taken by the licensee to correct the violation, and previous violations by the licensee. § 394.879(4), Florida Statutes (2023).

390. Under Florida law, as a penalty for any violation of Chapter 408, Part II, the authorizing statutes, or the applicable rules, the Agency may impose an administrative fine. Unless the amount or aggregate limitation of the fine is prescribed by authorizing statutes or applicable rules, the Agency may establish criteria by rule for the amount or aggregate limitation of administrative fines applicable to this part, authorizing statutes, and applicable rules. Each day of violation constitutes a separate violation and is subject to a separate fine. For fines imposed by final order of the Agency and not subject to further appeal, the violator shall pay the fine plus interest at the rate specified in Section 55.03, Florida Statutes, for each day beyond the date set by the Agency for payment of the fine. § 408.813, Florida Statutes (2023).

391. That the foregoing constitutes a Class III violation pursuant to § 408.813(2)(c), Florida Statutes (2023).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, a residential treatment center in the State of

Florida, pursuant to §§ 394.879 and 408.813, Florida Statutes (2023).

COUNT XVI

392. The Agency re-alleges and incorporates paragraphs (1) through (5) and Counts I – XV above as if fully set forth herein.

393. The Agency may deny or revoke the license of a residential treatment center based upon the facility's intentional or negligent act materially affecting the health or safety of a resident of the facility or a violation of the facility's authorizing statutes or applicable rules under § 408.815(1)(b-c), Florida Statutes (2023).

394. Florida law also provides that the license of any any licensee that violates any rule adopted pursuant to Section 394, Florida Statutes may be suspended and revoked. § 394.87(4), Florida Statutes (2023).

395. Respondent's actions as described with particularity hereinabove as described in:

- Count I involving Respondent's failure to protect the rights of its clients to be free from physical abuse
- Count II regarding Respondent's failure to comply with guidelines regarding the use of restraint and seclusion
- Count III detailing Respondent's failure to ensure that restraint and seclusion were used in a safe manner
- Count IV reflecting Respondent's failure to ensure that prohibited restraints that impeded respiration or weight on a child's upper torso, neck, chest or back were not conducted
- Count V relating to Respondent's failure to ensure the facility grounds were maintained in a safe manner and free of hazardous conditions
- Count VI pertaining to Respondent's failure to ensure that it maintained its facility in a clean, safe, and orderly condition
- Count VII involving Respondent's failure to ensure that it met the minimum required staff composition for nursing staff to children

- Count VIII regarding Respondent's failure to implement training programs and ongoing training for staff to increase knowledge and skills and improve quality of care and treatment services

- Count IX detailing Respondent's failure to ensure that staff who completed competency training in the use of restraints demonstrated competency on a semiannual basis

- Count X reflecting Respondent's failure to ensure that staff completed a competency based training program regarding the proper uses of restraint or seclusion before applying these procedures to children

- Count XI relating to Respondent's utilization of seclusion for clients despite no policy or procedure in effect addressing seclusion

- Count XII pertaining to Respondent's failure to ensure physician orders for restraint and seclusion included the emergency safety interventions ordered, including the length of time for which the physician authorized the use of each emergency safety intervention

- Count XIII involving Respondent's failure to ensure accurate and complete documentation of restraint (including drugs used relating thereto) and seclusion conducted

- Count XIV regarding Respondent's failure to continually visually assess, monitor, and evaluate the well-being of clients placed in seclusion, and Respondent's failure to ensure a physician or other licensed staff member documented an evaluation of a client immediately after removal from seclusion

- Count XV detailing Respondent's failure to ensure that face-to-face discussions (debriefings) were held with clients after the clients were subjected to restraint and/or seclusion

individually and collectively, constitute intentional or negligent acts materially affecting the health or safety of a client and/or a violation of the facility's authorizing statutes or applicable rules.

396. That Respondent has violated the minimum requirements of law of Chapters 408, Part II, as described with particularity within this complaint.

397. That Respondent has a duty to maintain its operations in accord with the

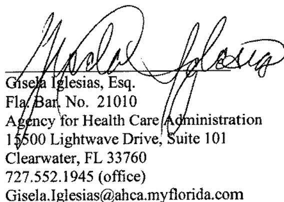
minimum requirements of law and to provide care and services at mandated minimum standards.

398. That the above reflect grounds for which the Agency may revoke Respondent's licensure to operate a residential treatment program for children and adolescents in the State of Florida.

399. That based thereon, individually and collectively, the Agency seeks the revocation of the Respondent's licensure.

WHEREFORE, the Agency intends to revoke the license of the Respondent to operate an residential treatment center in the State of Florida, pursuant to § 408.815 and § 394.87(4), Florida Statutes (2023).

Respectfully submitted on this 31st day of October 2023.



Gisela Iglesias, Esq.
Fla. Bar. No. 21010
Agency for Health Care Administration
15500 Lightwave Drive, Suite 101
Clearwater, FL 33760
727.552.1945 (office)
Gisela.Iglesias@ahca.myflorida.com

**NOTICE**

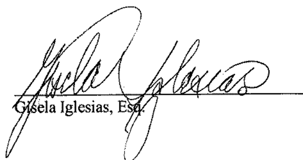
**The Respondent is notified that it/he/she has the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If the Respondent wants to hire an attorney, it/he/she has the right to be represented by an attorney in this matter. Specific options for administrative 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 against the Respondent.**

**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) 922-5873.**

## CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form have been served by U.S. Mail Delivery Confirmation No. 9114 9022 0078 9005 7651 37 to Kristy Bruna, Administrator, Center for Comprehensive Services, Inc. d/b/a Neurorestorative Florida, 2769 Whitney Road, Building 2, Clearwater, Florida 33760, and by U.S. Mail Delivery Confirmation No. 9114 9022 0078 9005 7651 13 to Corporation Service Company, Registered Agent for Center for Comprehensive Services, Inc. d/b/a Neurorestorative Florida, 1201 Hays Street, Tallahassee, Florida 32301-2525, on this 31st day of October 2023.



Gisela Iglesias, Esq.

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

**Re: AHCA v. CENTER FOR COMPREHENSIVE SERVICES, INC. d/b/a NEURORESTORATIVE FLORIDA**
**AHCA No.: 2023016044**

## AMENDED ELECTION OF RIGHTS

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

(Please use this form unless you, your attorney or your representative prefer to reply according to 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: 850-922-5873 Facsimile: 850-921-0158

**PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS**

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

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

**OPTION THREE (3) __________ I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Section 120.57(1), Florida Statutes)

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

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

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

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

Licensee Name: ________________________________ License Number: ________

Contact Person: ________________________________ Title: ________________

Address: ____________________________________________________________
Number and Street City Zip Code

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

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

Signed: ____________________________________________ Date: ______

Print Name: ________________________________________ Title: __________

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No.: 2023015069

CENTER FOR COMPREHENSIVE SERVICES, INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.

_________________________________________/

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No.: 2023016044

CENTER FOR COMPREHENSIVE SERVICES, INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.

_________________________________________/

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No.: 2024000871

CENTER FOR COMPREHENSIVE SERVICES, INC. d/b/a NEURORESTORATIVE FLORIDA,

Respondent.

_________________________________________/

## SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondent, Center for Comprehensive

**EXHIBIT 2**

Services, Inc. d/b/a Neurorestorative Florida (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

**WHEREAS,** Respondent was at all times relevant a residential treatment center for children and adolescents licensed, License Number 86, pursuant to Chapters 394, Part IV, and 408, Part II, Florida Statutes (2023); and Chapter 65E-9, Florida Administrative Code; and

**WHEREAS,** the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondent, pursuant to Chapters 394, Part IV, and 408, Part II, Florida Statutes; and

**WHEREAS,** the Agency issued a moratorium on admissions to the Respondent as a result of the alleged identified deficiencies through an Emergency Immediate Moratorium on Admissions dated October 6, 2023, in Case Number 2023015069; and

**WHEREAS,** the Agency served Respondent with an Amended Administrative Complaint dated October 31, 2023 in Case Number 2023016044, notifying the Respondent of the Agency's intent to revoke Respondent's licensure to operate a residential treatment center for children and adolescents in the State of Florida, and to impose administrative fines in the amount of twelve thousand five hundred dollars ($12,500.00); and

**WHEREAS,** Respondent filed a Petition for Formal Administrative hearing denying the allegations asserted in the Amended Administrative Complaint and requesting a formal hearing; and

**WHEREAS,** the Agency completed a survey of Respondent's facility on December 28, 2023 (hereinafter, the "Survey"), during which a deficient practice was cited and for which sanctions consisting of an administrative fine of five hundred dollars ($500.00) may be imposed;

and

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

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

1. All recitals herein are true and correct and are expressly incorporated herein.

2. Both parties agree that the "whereas" clauses incorporated herein are binding findings of the parties.

3. Upon full execution of this Agreement and the adoption of this Agreement into a Final Order of the Agency, Respondent agrees to waive any and all appeals and proceedings to which it may be entitled related to this state proceeding including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that no agreement herein shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement. Respondent specifically waives the necessity of the drafting of or service of an administrative complaint for the relief stipulated to in this Agreement as the same relates to the Survey.

4. Upon full execution of this Agreement and the adoption of this Agreement into a Final Order of the Agency:

   a. Respondent shall pay thirteen thousand ($13,000.00) in administrative fines to the Agency within thirty (30) days of the entry of the Final Order.

b. The Emergency Immediate Moratorium on Admissions dated October 6, 2023, in Case Number 2023015069 is lifted.

c. Count XVI of the Amended Administrative Complaint seeking the sanction of license revocation is voluntarily dismissed.

d. The internal reporting, analysis, and documentation requirements specified in subparagraphs (e) through (n) below shall remain in effect for a period of two (2) years from the date of the Final Order adopting this Agreement.

e. Respondent shall ensure that all staff who are involved in the implementation of restraints shall demonstrate competency in Crisis Prevention Intervention (CPI) on a semiannual basis. Documentation reflecting that such competency has been demonstrated on a semi-annual basis shall be maintained in the employee's record.

f. Respondent shall ensure that all staff are trained in the provider's "No Seclusion Policy" at least semiannually.

g. Respondent shall conduct twice weekly external grounds safety assessments and monthly interior environmental inspection, including the inspection and cleaning, if necessary, of air vents. Respondent's Florida Program Director(s) shall review these inspections no less than monthly to ensure the ongoing health and safety of clients.

h. Respondent's Board Certified Behavior Analyst and/or Residential Supervisor, Clinical Director, or Program Director will be present for all debriefings regarding all children for whom emergency safety interventions were implemented and, whenever possible and subject to staff scheduling, the debriefing shall include all staff

involved in the emergency safety intervention.

i. Parents or legal guardians of children for whom interventions were implemented by Respondent may participate in the debriefing when they request an opportunity to participate in the debriefing and when Respondent's staff deem their participation appropriate. This shall be documented by Respondent in the Emergency Procedures Checklist and a Family Debriefing Form will also be used to document the debriefing when the parents or legal guardians choose to participate in the debriefing.

j. Respondent's Medical Director, Clinical Director, and/or treating physician shall review all debriefing processes after the use of restraints and shall ensure interventions are implemented and the availability of a physician.

k. Respondent's Crisis Prevention Intervention (CPI) instructor or designee shall maintain a report of all active and expired CPI certifications. The report will be reviewed monthly with Respondent's Program Manager, Clinical Director, or Program Director or designees.

l. Respondent's Program Director or designee, will review the Monthly Status reports, including reports of staff training. The results of these reports will be also be reviewed monthly with the Program Manager, Clinical Director, Program Director or designee.

m. Respondent's Clinical Director, Board Certified Behavior Analyst, or designee shall track completion of training signatures to ensure that all staff are timely trained on the individual behavior plans.

n. Respondent's Governing Body shall meet at least monthly to address the effective implementation of Respondent's quality improvement program as defined in

Rule 65E-9.005 (1)(c)8, Florida Administrative Code. Respondent shall provide to the Clearwater Field Office of the Agency a summary of the Governing Body's quality improvement program activities, including identified quality indicators and directed interventions or monitoring for quality improvement, on a no less than a quarterly basis commencing May 2024.

o. Nothing in this Agreement estops or impedes the Agency from imposing administrative sanctions as a result of Respondent's future non-compliance with the minimum requirement of law, including, but not limited to, violations involving the use of restraint and seclusion.

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

6. By executing this Agreement, Respondent specifically denies, and the Agency asserts the validity of, the allegations raised in the Amended Administrative Complaint and Survey referenced herein. No agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, pursuant to the provisions of Chapters 394, Part IV, and 408, Part II, Florida Statutes (2023); and Chapter 65E-9, Florida Administrative Code, including a "repeat" or "uncorrected" deficiency identified in the Amended Administrative Complaint or Survey.

7. No agreement made herein shall preclude the Agency from using the deficiencies from the survey identified in the Administrative Complaint and the Survey in any decision regarding licensure of Respondent, including, but not limited to, a demonstrated pattern of deficient performance. Respondent reserves its right to contest any such actions. 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 and Survey. This agreement does not prohibit the Agency from taking action regarding Respondent's Medicaid provider status, conditions, requirements, or contract.

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

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

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

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

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

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

pursuant to Rule 59G-9.070, Florida Administrative Code.

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

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

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

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

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

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

[SIGNATURE PAGE FOLLOWS]

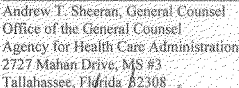
The following representatives hereby acknowledge that they are duly authorized to enter into this Agreement.

Kimberly R. Smoak, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Building #1
Tallahassee, Florida 32308

DATED: 2/14/2024

Jamie A. Klapholz, Esq.
Jessica K. Andrews, Esq.
Johnson, Pope, Bokor, Ruppel & Burns LLP
Counsel for Respondent, Center for Comprehensive Services, Inc. d/b/a Neurorestorative Florida
400 North Ashley Drive, Suite 3100
Tampa, Florida 33602

DATED: 2/14/24



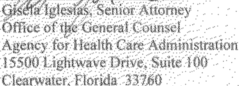
Andrew T. Sheeran, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308

DATED: 2/21/2024

Signed: 2/13/2024

Name: Jane Imboden
Title: Vice President of Operations
Center for Comprehensive Services, Inc. d/b/a Neurorestorative Florida

DATED: ______________



Gisela Iglesias, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
15500 Lightwave Drive, Suite 100
Clearwater, Florida 33760

DATED: 2/19/24