STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC,

Respondent.
_____/

DOAH CASE NO. 17-5769
AHCA NO. 2017011570
FILE NO. 100611
LICENSE NO. 1238096
PROVIDER TYPE : NURSING HOME
RENDITION NO.: AHCA-19-0038-FOF-OLC

FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where the assigned Administrative Law Judge (ALJ), Mary Li Creasy, conducted a formal administrative hearing. At issue in this proceeding is whether Respondent, Rehabilitation Center at Hollywood Hills, LLC ("Hollywood Hills"), violated Florida law as alleged in the Amended Administrative Complaint issued by the Agency for Health Care Administration ("AHCA" or "Agency"); and, if so, what sanctions should be imposed. The Recommended Order entered on November 30, 2018 is attached to this final order and incorporated herein by reference.

RULINGS ON EXCEPTIONS

Respondent filed exceptions to the Recommended Order, and Petitioner filed a response to Respondent's exceptions.

In determining how to rule upon Respondent's exceptions and whether to adopt the ALJ's Recommended Order in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over

> which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

§ 120.57(1)(*l*), Fla. Stat. Additionally, "[t]he final order shall include an explicit ruling on each exception, but an agency need not rule on an exception that does not clearly identify the disputed portion of the recommended order by page number or paragraph, that does not identify the legal basis for the exception, or that does not include appropriate and specific citations to the record." § 120.57(1)(k), Fla. Stat. In accordance with these legal standards, the Agency makes the following rulings on Respondent's exceptions:

In Exception 1, Respondent takes exception to the ALJ's evidentiary rulings in this matter, arguing they took away its legal defenses. An ALJ's rulings on evidentiary issues are clearly outside of the Agency's substantive jurisdiction. See Barfield v. Dep't of Health, 805 So. 2d 1008, 1011 (Fla. 1st DCA 2002). Thus, the Agency cannot disturb them. § 120.57(1)(*l*), Fla. Stat. Therefore, the Agency denies Exception 1.

In Exception 2, Respondent takes exception to Paragraph 51 of the Recommended Order, arguing the findings of fact contained therein are not based on competent, substantial evidence. Respondent's argument is incorrect. The findings of fact in Paragraph 51 of the Recommended Order are based on competent, substantial record evidence. See Transcript at Pages 412-413, 504, 505-506, 537; Petitioner's Exhibit 25 at 05:24:20; Respondent's Exhibit 35, Item 60, 2017-

09-13, CH02 from 10:13:33 to 04:56:40. Thus, the Agency cannot reject or modify them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz v. Dep't of Bus. Reg., 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there is no competent, substantial evidence from which the finding could reasonably be inferred"). While there might be contradictory evidence in the record, it is the job of the ALJ to weigh the evidence, and make the resulting findings of fact. The Agency cannot re-weigh the evidence, or second-guess the ALJ's determination on what weight should be given to the evidence. See Heifetz, 475 So. 2d at 1281. Furthermore, to the extent Respondent's exception takes issue with the ALJ's ruling on an evidentiary issue, the Agency does not have substantive jurisdiction over that ruling. See § 120.57(1)(*l*), Fla. Stat.; Barfield, 805 So. 2d at 1011. Therefore, the Agency denies Exception 2.

In Exception 3, Respondent takes exception to the findings of fact in Paragraphs 50, 104 and 105 of the Recommended Order, arguing the paragraphs are not supported by competent, substantial evidence. Contrary to Respondent's argument, the findings of fact in Paragraphs 50, 104 and 105 of the Recommended Order are all supported by competent, substantial record evidence. See Transcript at Pages 412-413, 504-506, 537, 542, 655-657, 661-662, 665-666, 1191-1193; Petitioner's Exhibit 52, #24 at 05:44:48; Respondent's Exhibit 195 at #7737, #7739, #7779. Thus, the Agency is prohibited from rejecting or modifying them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception 3.

In Exception 4, Respondent takes exception to Paragraph 21 of the Recommended Order, arguing the findings of fact contained therein are not based on competent, substantial evidence. Specifically, Respondent takes exceptions to the ALJ's finding that "no temperature logs were discovered by the police, casting serious doubt on the credibility and accuracy of Mr. Williams'

testimony regarding monitoring temperatures." The finding at issue is the direct result of the ALJ's weighing of witness testimony. See Transcript at Pages 2639, 2644-2646, 2649, 3729-3733, 3768-3769, 3773-3775. The Agency is prohibited from re-weighing the testimony, or second-guessing the ALJ's weighing of testimony. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281 ("The agency is not authorized to weigh the evidence presented, judge credibility of witnesses, or otherwise interpret the evidence to fit its desired ultimate conclusion."). Therefore, the Agency denies Exception 4.

In Exceptions 5 and 6, Respondent takes exception to Paragraphs 152, 166-169, 212, 220, 228 and Endnote 9 of the Recommended Order, arguing the findings of fact and conclusions of law contained therein are not supported by competent, substantial evidence, and should not be grounds for revocation of Respondent's license. The Agency disagrees. The findings of fact in Paragraphs 152, 166-169 and Endnote 9 of the Recommended Order are supported by competent, substantial record evidence. See Transcript at Pages 2098-2099, 2108, 2128-2129, 2145, 2148-2149, 2155-2156. Thus, the Agency is not at liberty to reject or modify them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Based on the findings of fact in Paragraphs 152, 166-169 and Endnote 9, the ALJ correctly concludes in Paragraphs 212, 220 and 228 of the Recommended Order that Respondent created an unsafe environment for its residents, and thus "negatively affected the health and safety of its residents and led or contributed to the death of multiple residents." See Paragraph 220 of the Recommended Order. The Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraphs 212, 220 and 228 of the Recommended Order because it is the state agency charged with the licensure and regulation of nursing homes in Florida. However, the Agency is unable to substitute conclusions of law that are as or more reasonable than those reached by the ALJ in Paragraphs 212, 220 and 228 of the

Recommended Order. § 120.57(1)(*l*), Fla. Stat. Additionally, Respondent is essentially asking the Agency to re-weigh witness testimony in this matter. However, the Agency cannot lawfully engage in such an exercise. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, based on the foregoing reasons, the Agency denies Exceptions 5 and 6.

In Exception 7, Respondent takes exception to Paragraphs 21, 64, 66, 71, 73, 74 and 176 of the Recommended Order, arguing the findings of fact contained therein should be stricken because of the witness testimony from which they are derived. Respondent's argument is based on its January 5, 2018 Motion in Limine, which the ALJ denied. The Agency does not have substantive jurisdiction to review the ALJ's ruling on Respondent's Motion in Limine. See § 120.57(1)(*l*), Fla. Stat.; Barfield, 805 So. 2d 1008. Therefore, the Agency denies Exception 7.

In Exception 8, Respondent takes exception to Paragraphs 33, 34, 35, 41, 42, 43, 45, 46, 47, 49, 50, 51, 52, 53, 54, 57, 59, 60, 61, 63, 67, 68, 69, 78, 79, 80, 85, 86, 93, 98, 99, 104, 110, 112, 116, 138, 139 and 140 of the Recommended Order, using the same argument from its Exception 7. Based upon the Agency's ruling on Exception 7 supra, which is hereby incorporated by reference, the Agency denies Exception 8.

In Exception 9, Respondent takes exception to what it deems was the ALJ's improper refusal to allow Respondent to conduct discovery on mitigating evidence. As was the case with Respondent's Exceptions 7 and 8, Exception 9 concerns evidentiary rulings by the ALJ that are clearly outside of the Agency's substantive jurisdiction. See § 120.57(1)(*l*), Fla. Stat.; Barfield, 805 So. 2d at 1011. Therefore, the Agency denies Exception 9.

In Exception 10, Respondent takes exception to what it deems was the Agency's improper collusion with the Hialeah Police Department to obtain Respondent's alleged attorney-client information. Exception 10 fails to clearly identify the disputed portion of the

Recommended Order to which the exception pertains by page number or paragraph. Thus, the Agency does not need to rule on it. See § 120.57(1)(k), Fla. Stat. Alternatively, Exception 10 concerns the ALJ's ruling on an evidentiary issue that is clearly outside of the Agency's substantive jurisdiction. See § 120.57(1)(*l*), Fla. Stat.; Barfield, 805 So. 2d at 1011. Therefore, the Agency denies Exception 10.

In Exception 11, Respondent takes exception to Paragraphs 6, 7, 14, 15, 40, 41, 192, 195, 196 and 228 of the Recommended Order, arguing

> [t]he ALJ, through her ruling on pre-hearing motions as discussed elsewhere herein, specifically prevented Hollywood Hills from developing, discovering and presenting evidence concerning the facts and circumstances regarding this deficit in the emergency management system from lack of any rules for alternate power or alternative cooling systems, and subsequent measures taken by state officials to try to remedy a deficient system.

See Page 69 of Hollywood Hills' Exceptions to the Recommended Order. Respondent once again takes exception to evidentiary rulings that the Agency cannot address because they are outside its substantive jurisdiction. See § 120.57(1)(*l*), Fla. Stat.; Barfield, 805 So. 2d at 1011. Additionally, Respondent is asking the Agency to re-weigh the evidence presented and make findings and conclusions that differ from the ALJ. However, the Agency cannot engage in such an exercise. See Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception 11.

In Exception 12, Respondent takes exception to Paragraphs 23, 40, 51, 84, 90, 96, 97, 115, 135, 184, 186, 187, 199, 216, 220 and 221 of the Recommended Order, arguing the findings of fact and conclusions of law in these paragraphs are not supported by competent, substantial evidence and should be rejected by the Agency. The findings of fact contained in Paragraphs 23, 40, 51, 84, 90, 96, 97, 115, 135, 184, 186, 187 and 199 of the Recommended Order are all supported by competent, substantial record evidence. See Transcript at Pages 413, 645, 648-649,

1051-1052, 1922-1924, 2221-2222, 2315-2316, 2325-2326, 3174, 3190-3197, 3203, 3290-3291, 3786-3787, 3792-3793, 4018, 4032-4033; Petitioner's Exhibit 52, at #3, #21-#24, #25 at 05:24:20; Respondent's Exhibit 35, Item 60, 2017-09-13, CH02 from 10:13:33 to 04:56:40, CH10, from 18:59:58 to 23:58:17, and from 00:00:08 to 02:54:36; Respondent's Exhibit 193 at #6703; Respondent's Exhibit 196 at #8465, #8475; Respondent's Exhibit 198 at #8883-8884, #8925, #8964; Respondent's Exhibit 199 at #9425, #9428, #9853. Thus, the Agency is prohibited from rejecting or modifying them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. The findings of fact, in turn, led the ALJ to correctly conclude in Paragraphs 216, 220 and 221 of the Recommended Order that Respondent violated the law. The Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraphs 216, 220 and 221 of the Recommended Order because it is the state agency charged with the licensure and regulation of nursing homes in Florida. However, the Agency cannot substitute conclusions of law that are as or more reasonable than those reached by the ALJ in Paragraphs 216, 220 and 221 of the Recommended Order. § 120.57(1)(*l*), Fla. Stat. Therefore, the Agency denies Exception 12.

In Exception 13, Respondent takes exception to Paragraphs 34, 41, 43, 45, 47, 48, 64 and 140 of the Recommended Order, arguing Petitioner did not produce any direct evidence regarding the temperature in Respondent's facility during the events at issue. The findings of fact in Paragraphs 34, 41, 43, 45, 47, 48, 64 and 140 of the Recommended Order are all supported by competent, substantial record evidence. See Transcript at Pages 111-112, 114-115, 116-117, 128, 175, 238, 243-244, 248, 249, 317, 392, 398-399, 402, 403, 405, 406-407, 424-425, 497-498, 501, 502, 510-511, 531-533, 694, 816, 825-826, 1306-1307 and 1465; Respondent's Exhibit 193 at #6715; and Respondent's Exhibit 202 at #11586. Thus, the Agency is not

permitted to reject or modify them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception 13.

In Exception 14, Respondent takes exception to the alleged "unconstitutional vagueness" of the statutes and rules the ALJ concluded it violated. Since there is no express authority given to the Agency by section 120.57(1), Florida Statutes, to address and rule on constitutional issues in administrative proceedings, the Agency will not rule on Exception 14. See also Gulf Pines Mem'l Park, Inc. v. Oakland Mem'l Park, Inc., 361 So. 2d 695 (Fla. 1978).

In Exception 15, Respondent accuses the ALJ of basing her findings of fact on "inferences stacked upon inferences." See Page 90 of Hollywood Hills' Exceptions to the Recommended Order. The Agency does not need to rule on Exception 15 because it is not a valid exception since Respondent fails to clearly identify the disputed portion of the Recommended Order that it is taking exception to by page number or paragraph. See § 120.57(1)(k), Fla. Stat.

In Exception 16, Respondent takes exception to the Agency's denial of its motion for an extension of time to file exceptions to the Recommended Order. This too is also not a valid exception to the Recommended Order since Respondent fails to clearly identify the disputed portion of the Recommended Order by page number or paragraph. See § 120.57(1)(k), Fla. Stat. Therefore, the Agency need not rule on it.

In Exception 17, Respondent takes exception to the lack of a proper record in this matter. Once again, Respondent fails to clearly identify the disputed portion of the Recommended Order to which it is taking exception by page number or paragraph. Thus, the Agency need not rule on it. § 120.57(1)(k), Fla. Stat. Alternatively, Respondent's argument concerns an issue that is clearly outside of the Agency's substantive jurisdiction. See, e.g., § 120.57(1)(*l*), Fla. Stat.;

Deep Lagoon Boat Club, Ltd. v. Sheridan, 784 So. 2d 1140, 1142 (Fla. 2d DCA 2001) (stating an agency does not have substantive jurisdiction to decide whether the doctrine of collateral estoppel applies to a particular case); Barfield, 805 So. 2d at 1011 (stating a licensing board lacked substantive jurisdiction to reject an ALJ's conclusion of law on an evidentiary issue). Therefore, the Agency denies Exception 17.

In Exception 18, Respondent takes exception to the ALJ's alleged improper burden shifting in this matter, and specifically mentions Paragraph 15 of the Recommended Order. Paragraph 15 of the Recommended Order contains findings of fact that are based on competent, substantial record evidence. See Transcript at Pages 1859 and 2727; Respondent's Exhibit 78. Thus, the Agency cannot reject or modify them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Additionally, Respondent's argument is unfounded. The Recommended Order clearly states Petitioner had the burden of proof by clear and convincing evidence in this matter (See Paragraph 203 of the Recommended Order), and met its burden of proof (See Paragraph 205 of the Recommended Order). Therefore, the Agency denies Exception 18.

In Exception 19, Respondent takes exception to Paragraphs 32 and 37 of the Recommended Order, arguing the findings of fact in these paragraphs are not based on competent, substantial evidence. Contrary to Respondent's argument, the findings of fact in Paragraphs 32 and 37 of the Recommended Order are based on competent, substantial record evidence. See Transcript at Pages 2532-2536, 3789-3791; Respondent's Exhibits 2, 3, 21. Thus, the Agency cannot disturb them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception 19.

In Exception 20, Respondent takes exception to Paragraphs 36 of the Recommended Order, arguing the findings of fact contained therein are not based on competent, substantial

evidence. Contrary to Respondent's assertion, the findings of fact in Paragraph 36 of the Recommended Order are based on competent, substantial record evidence. See Transcript at Pages 152, 157 and 162-163; and Respondent's Exhibit 202 at #11331-11333. Thus, the Agency is prohibited from rejecting or modifying them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception 20.

In Exception 21, Respondent takes exception to Paragraphs 81, 91, 95, 101, 107, 114, 128, 136, 143 and 146 of the Recommended Order, arguing "[t]he ALJ improperly relied on the testimony of the medical examiners despite the clear evidence that these examiners did not follow the National Association of Medical Examiner Guidelines." The findings of fact in Paragraphs 81, 91, 95, 101, 107, 114, 128, 136, 143 and 146 of the Recommended Order are all based on competent, substantial record evidence. See Transcript at Pages 622, 624, 625-626, 639-644, 648-649, 659, 661, 666, 682-684, 694-695, 701, 942, 953, 956, 964, 981, 986, 1000, 1051, 1085-1086; Respondent's Exhibit 192 at #5902; Respondent's Exhibit 193 at #6703; Respondent's Exhibit 195 at #7778-7779; Respondent's Exhibit 196 at #8163-#8164; Respondent's Exhibit 198 at #8884; Respondent's Exhibit 199 at #9466, #9467, #9611; Respondent's Exhibit 200 at #10116; Respondent's Exhibit 201 at #10685; Respondent's Exhibit 202 at #11333; Respondent's Exhibit 203 at #12358. Thus, the Agency is not at liberty to reject or modify them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. In addition, to the extent Respondent's argument involves the ALJ's determination of the credibility of witnesses, the Agency cannot second-guess the ALJ's determination on that issue. See Heifetz, 475 So. 2d at 1281 ("The agency is not authorized to weigh the evidence presented, judge credibility of witnesses, or otherwise interpret the evidence to fit its desired ultimate conclusion."). Therefore, the Agency denies Exception 21.

In Exception 22, Respondent takes exception to Paragraphs 153, 154, 155, 156, 157, 158, 159, 160, 162, 163, 164, 173, 175 and 177 of the Recommended Order, arguing the findings of fact in these paragraphs are not supported by competent, substantial evidence. Contrary to Respondent's assertion, the findings of fact in Paragraphs 153, 154, 155, 156, 157, 158, 159, 160, 162, 163, 164, 173, 175 and 177 of the Recommended Order are all supported by competent, substantial record evidence. See Transcript at Pages 2097-2099, 2101-2102, 2108, 2113, 2117, 2121, 2123, 2130-2132, 2133, 2136-2140, 2142, 2143, 2144, 2147, 2148-2149, 2150-2151, 2154, 2155-2156, 3336-3338, 3372, 3402-3403, 3417-3418, 4097; and Deposition Composite Exhibits 175, 177, 178, 179, 185. Thus, the Agency is not permitted to reject or modify them. See §120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. In addition, to the extent Respondent's argument involves the ALJ's determination of the credibility of witnesses, the Agency cannot second-guess the ALJ's determination on that issue. See Heifetz, 475 So. 2d at 1281 ("The agency is not authorized to weigh the evidence presented, judge credibility of witnesses, or otherwise interpret the evidence to fit its desired ultimate conclusion."). Therefore, the Agency denies Exception 22.

In Exception 23, Respondent does not take exception to anything in the Recommended Order. Instead, it incorporates by reference its Proposed Recommended Order and "all written motions filed in this matter, including the arguments contained therein." The Agency does not need to rule on Exception 23 because it is not a valid exception since Respondent fails to clearly identify the disputed portion of the Recommended Order that it is taking exception to by page number or paragraph. See § 120.57(1)(k), Fla. Stat.

FINDINGS OF FACT

The Agency hereby adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency hereby adopts the conclusions of law set forth in the Recommended Order.

ORDER

1. Respondent's nursing home license is hereby revoked, and an administrative fine of $37,500 is hereby imposed on Respondent. Unless payment has already been made, payment in the amount of $37,500 is now due from Respondent. Such payment shall be made in full within 30 days of the filing of this Final Order unless other payment arrangements have been made. The payment shall be made by check payable to Agency for Health Care Administration, and shall be mailed to the Agency for Health Care Administration, Attn. Central Intake Unit, 2727 Mahan Drive, Mail Stop 61, Tallahassee, Florida 32308.

2. Respondent shall also pay the costs of the investigation and prosecution of the case to the Agency pursuant to section 400.121(8), Florida Statutes. The parties shall attempt to agree to amount of the costs of the investigation and prosecution of this matter. If the parties are unable to reach such agreement, either party may file a request for hearing with the Division of Administrative Hearings under this case style within 30 days of the date of rendition of this Final Order, and the Administrative Law Judge who presided over this matter shall determine the amount of such costs.

3. In accordance with Florida law, Petitioner is responsible for retaining and appropriately distributing all client records within the timeframes prescribed in the authorizing statutes and applicable administrative code provisions. Petitioner is advised of Section 408.810, Florida Statutes.

4. In accordance with Florida law, Petitioner is responsible for any refunds that may have to be made to the clients.

5. Petitioner is given notice of Florida law regarding unlicensed activity. It is

advised of Section 408.804 and Section 408.812, Florida Statutes. Petitioner should also consult the applicable authorizing statutes and administrative code provisions. Petitioner is notified that the revocation of its registration may have ramifications potentially affecting accrediting, third party billing including but not limited to the Florida Medicaid program, and private contracts.

DONE AND ORDERED in Tallahassee, Florida, on this 4th day of January, 2019.

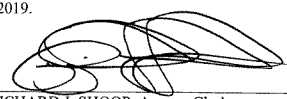
JUSTIN M. SENIOR, Secretary
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE 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 PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE 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 January, 2019.



RICHARD J. SHOOP, Agency Clerk
AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Copies furnished to:

Jan Mills Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Keisha Woods, Unit Manager Assisted Living Unit Agency for Health Care Administration (Electronic Mail)
Finance & Accounting Revenue Management Unit Agency for Health Care Administration (Electronic Mail)	Arlene Mayo-Davis, Field Office Manager Area 10 Field Office (Electronic Mail)
Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Stephen A. Ecenia, Esquire J. Stephen Menton, Esquire Gabriel F. V. Warren, Esquire Tana D. Storey, Esquire Jennifer F. Hinson, Esquire David Mark Maloney, Esquire Rutledge Ecenia, P.A. 119 South Monroe Street, Suite 202 Tallahassee, Florida 32301 (via electronic mail to Steve@rutledge-ecenia.com, smenton@rutledge-ecenia.com, gwarren@rutledge-ecenia.com, tana@rutledge-ecenia.com, Jennifer@ rutledge-ecenia.com, and dmaloney@rutledge-ecenia.com)

Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Geoffrey D. Smith, Esquire Susan C. Smith, Esquire Timothy B. Elliott, Esquire Corinne T. Porcher, Esquire Smith & Associates 3301 Thomasville Road, Suite 201 Tallahassee, Florida 32303 (via electronic mail to geoff@smithlawtlh.com, susan@smithlawtlh.com, tim@smithlawtlh.com, and corinne@smithlawtlh.com)
Honorable Mary Li Creasy Administrative Law Judge Division of Administrative Hearings The DeSoto Building 1230 Apalachee Parkway Tallahassee, Florida 32399-3060 (Electronic Filing)	Stephen B. Burch, Esquire Smith & Associates 1499 South Harbor City Boulevard, Suite 202 Melbourne, Florida 32901 (via electronic mail to stephen@smithlawtlh.com)
	Julie W. Allison, Esquire Julie W. Allison, P.A. 225 South 21st Avenue Hollywood, Florida 33020 (via electronic mail to julie@allisonlaw.net)

NOTICE OF FLORIDA LAW

408.804 License required; display.--

(1) It is unlawful to provide services that require licensure, or operate or maintain a provider that offers or provides services that require licensure, without first obtaining from the agency a license authorizing the provision of such services or the operation or maintenance of such provider.

(2) A license must be displayed in a conspicuous place readily visible to clients who enter at the address that appears on the license and is valid only in the hands of the licensee to whom it is issued and may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily. The

license is valid only for the licensee, provider, and location for which the license is issued.

408.812 Unlicensed activity. --

(1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license.

(2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency.

(3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense.

(4) Any person or entity that fails to cease operation after agency notification may be fined $1,000 for each day of noncompliance.

(5) When a controlling interest or licensee has an interest in more than one provider and fails to

license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

(6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules.

(7) Any person aware of the operation of an unlicensed provider must report that provider to the agency.

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 17-5769

REHABILITATION CENTER AT HOLLYWOOD HILLS, LLC,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held on January 29 through February 1; March 1, 2, 5 through 9, 19 through 22, 26, 28 and 29; and May 24 and 25, 2018, before Mary Li Creasy, a duly-designated Administrative Law Judge of the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner: Stephen A. Ecenia, Esquire
J. Stephen Menton, Esquire
Gabriel F. V. Warren, Esquire
Tana D. Storey, Esquire
Jennifer F. Hinson, Esquire
David Mark Maloney, Esquire
Rutledge Ecenia P.A.
119 South Monroe Street, Suite 202
Post Office Box 551
Tallahassee, Florida 32301

For Respondent: Geoffrey D. Smith, Esquire
Susan Crystal Smith, Esquire
Corrine T. Porcher, Esquire
Timothy Bruce Elliott, Esquire
Smith & Associates
3301 Thomasville Road, Suite 201
Tallahassee, Florida 32308

Stephen B. Burch, Esquire
Smith & Associates
1499 South Harbor City Boulevard, Suite 202
Melbourne, Florida 32901

Julie W. Allison, Esquire
Julie W. Allison, P.A.
225 South 21st Avenue
Hollywood, Florida 33020

STATEMENT OF THE ISSUES

The issues to be determined in this case are whether Respondent, Rehabilitation Center at Hollywood Hills, LLC ("Hollywood Hills"), violated Florida law as alleged in the Amended Administrative Complaint filed by the Agency for Health Care Administration ("AHCA" or "Agency"); and, if so, what sanctions should be imposed.

PRELIMINARY STATEMENT

On October 3, 2017, AHCA issued a four-count Administrative Complaint charging Hollywood Hills with multiple violations of Florida law and seeking permanent revocation of its nursing home license. The allegations arose from the alleged failure by Hollywood Hills, after an air conditioning ("A/C") outage caused by Hurricane Irma, to comply with its duty to protect its residents and provide a safe environment, which AHCA asserts led

to the deaths of at least eight residents, the evacuation of the facility, and the declaration of a mass casualty incident ("MCI").

Hollywood Hills requested a formal administrative hearing and AHCA forwarded this case to DOAH on, or about, October 16, 2017. By agreement of the parties, the final hearing was initially scheduled for January 2 through 5 and 8 through 12, 2018. Without objection, the hearing was rescheduled for January 29 through February 2; March 1, 2, 5 through 9, 19 through 22, 26, 28 and 29, and May 24 and 25 2018.

On December 22, 2017, AHCA filed a Motion for Leave to Amend Administrative Complaint ("Motion") to include four additional resident deaths as a result of the investigation conducted by the Broward County Medical Examiner's ("ME") Office. AHCA also sought to add allegations related to patients who had not passed away in the aftermath of the storm, but were nonetheless adversely affected by the conditions in the facility. The four additional deaths arose from the same underlying conditions and events as the eight deaths referenced in the original Administrative Complaint. On January 5, 2018, the undersigned granted the Motion, in part, and allowed the additional allegations related to deceased residents 9 through 12 be added to the Administrative Complaint (hereinafter referred to as the

"Amended Complaint"). The remainder of the requested amendments were denied.

At hearing, AHCA presented the testimony of the following witnesses from the Hollywood Hills Fire Rescue and Beach Safety Department ("HFR"): Lieutenant ("Lt.") Amy Parrinello; Captain Andrew Holtfreter; Battalion Chief Robert Ladwig; Lieutenant Brian Ettinger; Lieutenant Christopher Sullivan; Lieutenant Sidney Doret; Firefighter Luis Santana; and Firefighter Craig Wohlitka; from the City of Hollywood Police Department ("HPD"): Lieutenant Jeff Devlin; and the deposition of Detective Robert Knapp; from the Palm Beach County Sheriff's Office: Deputy Officer Xavier Pastrana; from Memorial Regional Hospital ("MRH"): Judy Frum, Chief Nursing Officer; Tracy Meltzer, Director of Nursing of Trauma Services and Critical Care; Randy Katz, MD, Medical Director for MRH Adult Emergency Room Department and Medical Director for HFR; from Joe Dimaggio Children's Hospital: Doug Lamendola, Director of Emergency Services; from Broward County Medical Examiner's Office: Dr. Wendolyn Sneed, Associate Medical Examiner; Dr. Marlon S. Osbourne, Associate Medical Examiner; and Investigator Orlando Portillo; from AHCA: Arlene Mayo-Davis, Field Office Manager; Anne Sosiak, RN, Surveyor; and Kathy Allen, RN, Surveyor. AHCA also presented the testimony of the following expert witnesses: Terry Goodman, who was accepted as an expert on nursing home administration and management;

Dr. Nanette Hoffman, expert in geriatrics; W. Scott Crawford, who was accepted as an expert in mechanical engineering and Heating, Ventilation, and Air Conditioning ("HVAC") systems; and Kathryn Hyer, PhD, MPP, who was accepted as an expert on nursing home quality of care and nursing home disaster preparedness, planning and evacuations.

Hollywood Hills presented the testimony of the following witnesses: Natasha Anderson, CEO of Larkin; James Williams, building maintenance supervisor; Maria Castro, Director of Nursing ("DON"); Jorge Carballo, Nursing Home Administrator; and Sergio Colon, RN, night shift supervisor. Hollywood Hills also presented testimony from the following experts: David Dosa, MD, who was accepted as an expert on nursing home evacuations; Douglas Casa, who was accepted as an expert on heat-related illnesses; Andrew Grundstein, who was accepted as an expert on climatology; Dennis Mileti, PhD, who was accepted as an expert on disaster preparedness; Jeffrey Jentzen, MD, who was accepted as an expert in forensic pathology and medical examination to determine cause of death; Connie Cheren, who was accepted as an expert on nursing home administration; David Deveraux, who was accepted as an expert on health care administration; and Nick Ganick, who was accepted as an expert on facility assessment and physical plant diagnosis. Hollywood Hills submitted the deposition testimony of Orlando Suarez, corporate representative

for the surveillance cameras at Hollywood Hills; and the video depositions of Sylvia Pistoia, a former resident; Richie Pistoia, Ms. Pistoia's son; and Loretta Lynn, a former resident.

AHCA exhibits 5, 7, 13, 15, 16, 31, 32, 34, and 52 through 56 were admitted into evidence. Exhibits 2 and 3 were proffered, but not admitted.

Hollywood Hills offered the following exhibits which were admitted into evidence: 1, 2 (partial), 3, 7, 8, 15 through 17, 21, 24 through 26, 28 through 31, 35, 40, 42, 45 through 48, 74, 76 through 81, 89, 91, 93 through 95, 97 (list only), 98, 99, 111 (except page 31), 112 through 117, 119, 121 through 126, 139, 156, 186 through 188, 190, 192 through 203, 226 through 228, 230, 232, 233, 241, 243 (only Exhibit 17 from deposition transcript), 245, 246, 248, 254 through 256, 266, 279, 324, 327, and 329 through 331. Hollywood Hills' Exhibits 6, 32 through 34, 43, 96, 105, and 183 were proffered, but not admitted.

The Transcript of the hearing consisted of 21 volumes and was filed on June 15 and 28, July 18, and August 6, 2018. Both parties requested and were provided an extended period in which to file their proposed recommended orders. The proposed recommended orders were considered in the preparation of this Recommended Order.

Except as otherwise indicated, citations to Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect at the time of the alleged violations.

FINDINGS OF FACT

The Parties

1. AHCA is the licensing and regulatory authority that oversees skilled nursing facilities (also known as nursing homes) and enforces the state statutes and rules governing such facilities. See Ch. 408, Part II; and Ch. 400, Part II, Fla. Stat.; Fla. Admin. Code Ch. 59A-4.

2. Hollywood Hills is a nursing home located in Hollywood, Florida, with a licensed capacity of 152 beds. It shares a building with Larkin, a mental health facility. The facilities are separated by locked hallway corridor doors. They share an A/C chiller. Hollywood Hills currently holds AHCA nursing home license number 1238096. Hollywood Hills is located across a parking lot from MRH. As a licensed nursing home, Hollywood Hills has an obligation to provide a safe environment and reasonable access to care to the residents who reside in the facility.

Hurricane Irma

3. On September 4, 2017, Florida Governor Rick Scott declared a state of emergency due to the approach of Hurricane Irma. As the hurricane intensified and landfall was anticipated

in Florida, an estimated 6.5 million Floridians were ordered to evacuate, mostly those living on barrier islands, in coastal areas, and in low-lying or flood-prone areas.

4. Hurricane Irma first made landfall in the Florida Keys on September 10, 2017, as a Category 4 hurricane[1/] with winds of 130 miles per hour. Irma weakened to Category 3 intensity before making its final landfall later that day in Marco Island, Florida, with sustained winds of 115 miles per hour. Irma continued to weaken as it passed east of Tampa and moved northeast across the state, although it retained a large wind field with most of Florida experiencing gale force winds. More than 7.7 million homes and business in Florida were left without electricity in the wake of the storm.

5. AHCA's Deputy Secretary Molly McKinstry testified the power outages were the most extreme she had ever seen, leaving more than 245 Florida nursing homes without power. Nursing homes without power and with inadequate cooling was a "pervasive" problem.

Hollywood Hills' Pre-Storm Preparation

6. Hollywood Hills had a Comprehensive Emergency Management Plan ("CEMP"), approved by the Broward County Division of Emergency Management. AHCA was provided an opportunity to review and comment on Hollywood Hills' CEMP prior to its approval, but did not review it or seek any changes to it.

7. There are no allegations in the Statement of Deficiencies or Amended Complaint that Hollywood Hills did not follow its CEMP, which provided, "Patient relocation and evacuation is inherently dangerous to patients and staff and is to be undertaken only when conditions of the environment cannot support care, treatment, and/or services." Throughout the year, Hollywood Hills' staff conducted emergency training drills in accordance with its CEMP and provided monthly and quarterly training to staff, including drills on hurricanes. The CEMP was approved through August 6, 2018. Notably absent from the CEMP was any plan of action for an extended loss of A/C.

8. On September 4, 2017, Hollywood Hills activated its emergency plan per its CEMP after Governor Scott declared the state of emergency. From September 5 through 9, 2017, Hollywood Hills' staff participated in the nursing home industry's hurricane preparedness calls hosted by AHCA and coordinated with State and local emergency management officials, the Florida Health Care Association, and Governor Scott. On these calls, nursing homes were given emergency contact numbers, including Florida emergency management telephone numbers, AHCA emergency telephone numbers, and cell phone numbers of key AHCA employees. Governor Scott also gave his personal cell phone number, encouraging nursing homes experiencing problems to call him for help.

9. Hollywood Hills staff took action to prepare for the storm, including: (a) securing a sufficient supply of food, water, and patient care supplies; (b) stocking up on common hurricane supplies; (c) physically preparing the facility by taping and boarding up doors and windows; (d) renting ten spot coolers[2/] and purchasing fans; (e) ensuring the generator was working properly and had adequate fuel for seven days; (f) initiating an Alpha/Bravo team schedule with staffing ratios above all federal and state requirements; (g) lowering the A/C; and (h) monitoring evacuation orders.[3/]

10. On Friday, September 8, 2017, as the storm approached, Hollywood Hills staff activated its Alpha team, which was designated to shelter with the residents until Monday after the storm passed.

Hollywood Hills' Actions September 9 and 10, 2017

11. On Saturday, September 9, 2017, Broward County started to feel the effects of Hurricane Irma. The Alpha team, consisting of Hollywood Hills' Administrator, DON, Building Supervisor, Director of Patient Care Services, Activities Director, and other supervising directors, as well as full nursing care teams, continued to shelter in place with residents.

12. On Sunday, September 10, 2017, at about 3:30 p.m., a fuse to the transformer on a power pole that provided power to the A/C was dislodged. Hollywood Hills never lost electrical

power. Jorge Carballo, Administrator, and James Williams, Building Supervisor, immediately notified Florida Power & Light ("FP&L") and requested priority restoration. In a recorded call at 3:40 p.m., Mr. Williams advised FP&L this was an "emergency." He notified FP&L they just needed to put the fuse back in place. The tropical storm force winds subsided early Sunday evening in Broward County. Hollywood Hills had no damage, other than the loss of A/C.

13. Because the Building Supervisor lowered the temperature in the building prior to the storm as a precaution against the loss of A/C, the facility reportedly remained in the lower 70s throughout Sunday night. Multiple witnesses testified there was no observable difference in temperatures until after midnight. However, due to the lack of A/C, the DON, Maria Castro, instructed staff to monitor residents closely, make continuous hydration rounds, and notify the nursing supervisor immediately if residents had changes in conditions. Her personal observation was that the facility remained cool throughout Sunday.

14. Nursing home patients are generally very vulnerable and it is well known that a disruption to their normal daily routine, such as by an evacuation, results in a higher risk of mortality. The clinical literature shows nursing home residents may double their risks of dying and quadruple their risks of hospitalization by evacuating. However, at no time did the administration of

Hollywood Hills discuss the possible evacuation or selective evacuation of residents due to the loss of power to the A/C.

15. Although multiple experts testified at the final hearing that "shelter in place until it is no longer safe to do so" is the standard of care in the nursing home industry during a hurricane, no testimony was presented to show that Hollywood Hills undertook an evaluation at any time after the loss of A/C whether it was more dangerous to relocate or evacuate patients versus continuing to stay in place indefinitely while waiting on restoration of power to the A/C.

Hollywood Hills' Actions on September 11, 2017

16. Shortly after midnight on Monday, September 11, 2017, when the A/C lost residual cooling capacity, spot coolers and fans were deployed. Initially, there were ten spot coolers. Mr. Williams put three on the second floor of Larkin, three on the second floor of Hollywood Hills, and four on the first floor of Hollywood Hills. Staff and patients were directed to keep the windows closed to maintain the cooling effect in the building.

17. The spot coolers on the first floor were set up to blow cooled air into the common hallways. The spot coolers on the first floor were vented into the ceiling above the first floor to discharge hot air. This space was essentially a closed fire-proofed box, trapping the heated air between the first and second floors, heating the second floor slab, and allowing some

discharge of hot air back into the first floor through porous ceiling tiles. The spot coolers on the second floor were also placed to cool the nursing stations and hallways. The heated air generated by the second floor spot coolers was vented into the plenum between the second floor and roof which had minimal ventilation to the outside.

18. Hollywood Hills occupied more of the first floor than the second floor. However, the first floor of Hollywood Hills primarily consisted of short-term rehabilitation patients. The second floor consisted of long-term nursing home patients, many of whom were bed-bound or had significant difficulty ambulating, and difficulty verbalizing their needs.

19. On Monday, September 11, 2017, Administrator Carballo told Mr. Williams to monitor the facility temperatures and let him know if any exceeded 80 degrees. Mr. Williams used an infrared surface temperature gun to take temperatures throughout the facility, primarily in the common areas. He also observed the ambient air temperatures displayed on the spot coolers. Mr. Carballo observed Mr. Williams taking temperatures and he never reported any temperatures exceeded 80 degrees. During Monday, the temperatures Mr. Williams observed were in the mid to upper 70s, and his perception was the facility felt comfortable, despite him wearing long pants and doing physically demanding work.

20. Mr. Carballo remained in the facility until around 7:00 p.m. on Monday. Throughout the day, he was also personally monitoring ambient air temperatures in the facility with a handheld thermometer and observing the ambient air temperatures reflected on the spot coolers. The temperatures he observed never exceeded 80 degrees. His perception was the facility was a little bit warm, but comfortable.

21. Mr. Carballo was not recording his temperature readings, but Mr. Williams testified he was recording the readings he personally took. Mr. Williams testified his temperature logs disappeared when police confiscated multiple items from his office. However, no temperature logs were discovered by the police, casting serious doubt on the credibility and accuracy of Mr. Williams' testimony regarding monitoring temperatures.

22. At 11:00 a.m. on Monday, Broward County issued the "all clear" alert. Hollywood Hills reopened its facility to families and visitors. Multiple health care providers, including physicians, nurses, other clinical staff, and EMS personnel, were in the facility on Monday. There were no complaints to AHCA or the Department of Children and Families ("DCF") regarding the climbing temperatures within Hollywood Hills. This is significant because licensed health care providers, including physicians, nurses, and paramedics, are required by Florida law

to report any dangerous conditions potentially affecting nursing home residents.

23. On Monday afternoon, the Alpha team began to be relieved by the Bravo team. Each Alpha team clinician had to be replaced with a Bravo team clinician. Instructions about monitoring patients closely, continuously offering hydration, and reporting any changes to the nursing supervisor were given to the Bravo team. However, the nursing notes are devoid of any confirmation that these instructions were actually followed.

24. The Bravo team had day and night shift nursing supervisors. Milina Tellechea, an Advanced Registered Nurse Practitioner ("ARNP"), who had worked at Hollywood Hills for over ten years, was the daytime nursing supervisor. Sergo Colin, the night shift nursing supervisor, was employed at the facility for only a few weeks when Hurricane Irma hit. Although Mr. Colin had 17 prior years of experience as a licensed paramedic, and 11 years as an RN, as of September 11, 2017, he had little to no familiarity with the patients or the staff of Hollywood Hills.

25. Hollywood Hills continued its efforts to get the A/C restored. Staff contacted FP&L multiple times on Monday. Staff also contacted multiple state and local emergency call lines, AHCA, and called the Governor's cell phone, without receiving a response.

26. On Monday evening, at 5:36 p.m., Natasha Anderson, the CEO of Larkin, called the Florida 1-800 emergency number she had been provided on the pre-storm industry calls. The person she spoke with gave her the Tallahassee emergency management number to call, which she did at 5:39 p.m. She spoke with a person named "George" who assured her he would make sure the A/C restoration was escalated. Ms. Anderson conveyed this information to Mr. Carballo.

27. Ms. Anderson followed up with the state emergency operations center at 6:57 p.m. and spoke to "George" again, who assured her the matter had been made a priority and the restoration was being escalated. She spoke with the emergency operations center three more times that evening at 7:29 p.m., 9:24 p.m., and 9:57 p.m. Each time, she emphasized the urgency of getting the A/C restored, and each time she was assured they understood and were working on it.

28. Beyond calling FP&L and others, Hollywood Hills' staff also tried unsuccessfully to pursue other means of getting the A/C restored, including: physically chasing a FP&L truck seen driving by, trying to hire an independent electrician to fix the fuse, and contacting an engineer to see if the facility's generator could be configured to operate the chiller or another generator could power the A/C.

Hollywood Hills' Actions and the Events of September 12, 2017

29. Hollywood Hills staff members communicated with each other before, during, and after the storm on a group messaging service, "WhatsApp," which included key members of the Hollywood Hills management and staff, including Mr. Carballo, DON Castro, Mr. Williams, and others. These messages reveal there were increasing concerns about the impact of the conditions in the facility by at least the morning of Tuesday, September 12, 2017. At 9:40 a.m. on Tuesday morning, Mr. Carballo ordered no more resident admissions until the A/C was restored and asked the staff to secure more fans.

30. Shortly thereafter at 9:58 a.m., Jocelyn Rosario, director of housekeeping and building services, informed the messaging group that the "patients don't look good" and "we need fans." Despite this alarming message, Hollywood Hills' management and supervisors did not follow up with staff present at the facility to determine which patients showed signs of distress from the heat.

31. Mr. Carballo also asked the affiliated corporate entities to use their purchasing officers to assist in finding more spot coolers to rent. They also contacted the "Broward Coalition" made up of multiple hospitals and health care entities in the nearby area to borrow spot coolers. Hollywood Hills staff was able to purchase six large industrial fans (three round

orange ones and three five-foot pedestal ones) and 20 box fans. Larkin borrowed four additional spot coolers from MRH, allowing one of the spot coolers it already had to be relocated to the Hollywood Hills' side of the building. By 7:00 p.m. on Tuesday, the multiple additional fans and spot coolers had been assembled and deployed.

32. Later that morning, Ms. Tellechea, nursing supervisor for the day shift, notified the group that the residents "had a difficult night." She advised that the facility continued to be without A/C and ice, and suggested that staff try to buy ice for the residents.[4/] Ms. Tellechea also stated that it was too hot in the facility to conduct normal therapy operations. Again, no Hollywood Hills management or supervisors responded to this warning or directed specific actions be taken to protect the patients.

33. Only minutes after Ms. Tellechea sent this warning to the Hollywood Hills staff, HFR was dispatched to Hollywood Hills for Resident 11. HFR Crew 31 was dispatched to Hollywood Hills in response to a call regarding a resident with a breathing problem. HFR Crew 31, consisting of Lieutenant Amy Parrinello, Luis Santana, and Craig Wohlitka, arrived at the scene shortly before 1:00 p.m. Upon arrival, they found Resident 11, a 93-year-old man, unresponsive and in serious condition with labored

breathing. EMS noted Resident 11's skin temperature at the scene was hot to the touch.

34. While in the building, the HFR crew noticed the temperature inside the facility was hot. Lt. Parrinello and her team asked the Hollywood Hills staff about the temperature and were told the A/C was down, but Hollywood Hills was working on it.

35. HFR promptly brought Resident 11 to MRH where he was treated by Dr. Randy Katz, an emergency room physician and the HFR Medical Director. MRH is directly across the street from Hollywood Hills. When he arrived at the MRH emergency room, Resident 11's core body temperature was measured at 106.5 degrees. HFR expressed their concerns about the lack of A/C in the facility to medical personnel at MRH, including Dr. Katz.

36. Dr. Katz diagnosed Resident 11 with heatstroke and severe sepsis based on the lack of A/C within the facility and the high outside environmental temperature. Resident 11's condition prompted Dr. Katz to direct MRH's social worker to reach out to Hollywood Hills and determine if the facility had similar issues with other residents. Resident 11 ultimately died five days later after the initial treatment he received on September 12, 2017.

37. At 1:53 p.m. on September 12, 2017, DON Castro issued another warning to the message group that "the residents upstairs

are having a really hard time." Efforts to get FP&L to restore the A/C were intensified on Tuesday, including multiple calls to FP&L, AHCA, and state and local emergency management centers. Collectively, Mr. Carballo, Ms. Anderson, and Mr. Early called the Governor's cell phone four times on Tuesday between 9:00 a.m. and 5:00 p.m., leaving voicemails asking for help.

38. In contrast to the increasing concerns expressed in the WhatsApp messages, Mr. Carballo testified, no one expressed concerns about the facility temperature or suggested evacuation on Tuesday. He was aware multiple physicians were there throughout the day. He observed Brian James, the physician's assistant to Dr. Ibraham, Hollywood Hills' Medical Director, rounding on patients as late as 9:30 p.m. that night. He was also aware Dr. Wayne Evancho, Dr. Frances Cadogan, and another physician assistant for Optum had rounded on their patients that day as well. Mr. Carballo testified if these physicians had concerns about their patients' safety, they would have contacted him.

39. When Mr. Carballo left at about 11:00 p.m., the outside air temperature was about 83 degrees. He assumed the facility would continue to cool because it was nighttime. He planned to come back to the facility early in the morning to reassess the situation with the clinical staff. Mr. Carballo's testimony, that he had no reason to suspect the temperature in the facility

would increase or that anyone was in danger, is not credible in light of the WhatsApp messages, and the fact that no air temperatures were apparently being taken after Mr. Williams left the facility at 6:30 p.m. on September 12.[5/]

40. By Tuesday, September 12, 2017, Hollywood Hills was aware of the rising temperature and the potential dangers posed to the residents--some of whom had already been identified as impacted by the conditions in the facility. Despite clear evidence that the heat was affecting the residents, Hollywood Hills failed to document any efforts to provide extra care or monitoring to the residents, nor was the staff instructed on how to monitor and care for the residents more effectively, or to prepare for possible evacuation of the facility.

September 13, 2017, Events Prior to the Evacuation

41. HFR Crew 31 returned to Hollywood Hills in the early morning of September 13, 2017, responding at 3:07 a.m. to a report of a resident with cardiac arrest who was not breathing and did not have a pulse. Additional HFR backup also responded to assist. The HFR crews vividly testified about the hot conditions in the facility. One first responder described the temperature inside the facility as "ungodly hot." When the staff at Hollywood Hills was questioned about the heat, they again replied they were working on the A/C.

42. When HFR arrived, Resident 1 was completely undressed, not wearing any clothes, and had a fan blowing on her. HFR measured Resident 1 to have a tympanic temperature of 107.5 degrees. Lt. Parrinello and Firefighter Wohlitka testified that they had never seen a patient with a temperature that high. HFR categorized Resident 1 as a sepsis alert--the same alert noted for Resident 11, who was transported to the emergency room in the early afternoon of September 12, 2017. A "sepsis alert" is not a medical diagnosis. HFR protocol for initiating a severe sepsis alert is a temperature greater than 104 degrees, a heart rate greater than 90, a respiratory rate greater than 20, a history of urinary tract infection, an altered level of consciousness, and acute change in mental status. Resident 1 met all of these criteria.

43. HFR documented, in this and subsequent run reports, the lack of A/C and hot conditions in the facility. Lt. Parrinello explained, "I noted it because it was unusual and it was ongoing; it was hot in the facility. I wanted to document that they didn't have air conditioning." HFR accepted the representations of the Hollywood Hills staff members, including the nursing supervisor at the time for Hollywood Hills, that the A/C was being worked on and adequate steps had been taken to protect the patients.

44. After transport to and treatment at MRH Emergency Room, Resident 1 ultimately expired several hours later.

45. Less than thirty minutes after transporting Resident 1 and leaving MRH, HFR Crew 31 was dispatched back to Hollywood Hills. Shortly after HFR arrived back at Hollywood Hills at 4:00 a.m., Resident 2 went into cardiac arrest. HFR noted the A/C was still not functioning and "the facility was still hot."

46. When HFR found Resident 2, she was nonverbal, had labored breathing, was hot to the touch, had vomit in her mouth, and had a tympanic temperature of 107.5 degrees. The credible testimony and documentation from HFR contrast sharply with Hollywood Hills staff notes that Resident 2 was "awake and alert" without any vomiting or other signs of distress. Despite their many years of experience, the members of HFR Crew 31 had never seen two patients in the same facility with temperatures at this level within such a brief period of time. Resident 2 was immediately transported to MRH, where she died later that day.

47. The first responders present at the facility in the early morning hours of September 13, 2017, universally confirmed it was hotter inside the facility than outside. They explained that they felt extreme heat upon entering the Hollywood Hills facility, and testified that the heat within the facility was unbearable and uncomfortable. This is consistent with video of the staff during the same hours (late September 12, 2017, and

early September 13, 2017), who are seen visibly sweating through their scrubs. All but one of the 12 deceased residents delineated in the Amended Complaint resided on the second floor of the facility, which was described by the first responders as noticeably hotter than the first floor.

48. After transporting Resident 2 to MRH and noting the unprecedentedly high patient temperatures, Lt. Parrinello contacted DCF to report the facility conditions and the impact on the residents. Lt. Parrinello reported to DCF the residents were exposed to hot conditions "like a sauna" at Hollywood Hills, with no A/C and only limited fans to cool the residents.

49. While Lt. Parrinello was alerting DCF, HFR received another dispatch call to respond to Hollywood Hills. HFR Crew 31 returned to Hollywood Hills, where they found the night charge nurse, Sergo Colin, administering cardiopulmonary resuscitation ("CPR") to Resident 4 in Room 226.

50. HFR immediately determined that Resident 4 was already deceased. Resident 4 was in a state of rigor mortis when HFR arrived. Firefighter Wohlitka determined Resident 4 was dead upon his entry to the room after finding no pulse and attempting to move the resident's left arm, which did not move due to stiffness. It typically takes at least several hours for rigor mortis to set in within the body. This strongly suggests that

the staff was not rounding on patients regularly and providing water and ice.

51. HFR's observations overwhelmingly contradict the claims by Hollywood Hills' staff that Resident 4 was awake or alert in a normal capacity approximately an hour prior to EMS arriving. The clear video evidence shows Hollywood Hills was not monitoring Resident 4. No one entered Room 226 for nearly seven hours between approximately 10:00 p.m. on September 12, 2017, and 5:00 a.m. on September 13, 2017, when he was found by housekeeping staff during routine housekeeping operations.

52. HFR Captain Andrew Holtfreter responded to the facility shortly before 6:00 a.m. As he arrived on the second floor, a Hollywood Hills staff member frantically waved for EMS assistance. When he entered Room 226 on the second floor of the facility, Captain Holtfreter discovered Resident 5 deceased in his bed. Captain Holtfreter immediately issued a Signal 7 code over the HFR radio system to alert other crew members, signifying contact with a deceased resident.

53. At 6:21 a.m., another HFR crew arrived at the Hollywood Hills facility in response to a distress call for Resident 8. Resident 8 had a tympanic temperature so high that the thermometer commonly used by EMS did not display an actual temperature, but instead simply read "HI." According to the thermometer manual, this meant the tympanic temperature of

Resident 8 was higher than 108 degrees, which the HFR crew had never before seen.

54. While HFR Crew 31 was attempting to treat and stabilize Resident 8, another resident in the facility was discovered in serious respiratory distress. Resident 8 was transported to MRH. HFR Crew 105 attended to the resident with respiratory distress while HFR Crew 31 transported Resident 8, who had gone into cardiac arrest. Additional HFR units were dispatched to Hollywood Hills to assist with the residents.

55. At 6:30 a.m. on September 13, 2017, MRH nurses Judy Frum and Tracy Meltzer learned that a third Hollywood Hills resident had presented to MRH's emergency room with an extremely high temperature. The experienced MRH staff had never seen multiple patients with temperatures in excess of 105 degrees, like those at Hollywood Hills. In light of the escalating situation, the nurses became extremely concerned for the safety of the residents and walked over to the Hollywood Hills facility to assess the situation firsthand.

56. Ms. Meltzer credibly described the conditions in Hollywood Hills facility when she exited the elevator to the second floor as, "there was like a blast of heat like when you open your car door at the end of the day after it's been sitting out."

57. MRH staff and HFR vividly described the scene at Hollywood Hills on September 13, 2017, to include Hollywood Hills staff visibly sweating from the heat and overwhelmed by the number of critical patients. Staff was heard shouting, "they are dropping like flies." Patients were disoriented and visibly uncomfortable inside the facility. One resident was found in a fetal position on a mattress with no sheet, in a diaper "saturated with urine and feces," hot and visibly sweating.

58. HFR and MRH first responders quickly recognized that the residents were in extreme distress and it was not safe for them to remain inside the facility. After Resident 4 was found deceased, HFR and MRH staff concluded that other patients were potentially in danger.

59. Earlier that morning, Hollywood Hills staff members had discouraged HFR from checking on other residents. Staff members told HFR that they conducted rounds and every resident was within normal limits. However, given the unfolding events, Lt. Parrinello rejected the contention by Mr. Colin, night shift supervisor, that the staff had already checked on the other patients and that everyone was okay, telling him, "you told me that before and now we have multiple deceased patients so with all due respect I don't trust your judgment and we're going to check on everyone ourselves."

60. HFR and MRH staff all agreed that evacuation of the Hollywood Hills facility was necessary to protect the residents. HFR Battalion Chief Robert Ladwig assumed command and was in charge of operations at the commencement of the evacuation. After assuming command and assessing the totality of the situation, Chief Ladwig determined the situation to be a Level 3 MCI involving immediate harm or threat to human life. Chief Ladwig had never before in his career experienced a single facility that had endangered patients as he witnessed at Hollywood Hills.

61. Captain Holtfreter was put in charge of the second floor, and he reported his findings via radio to Chief Ladwig. Captain Holtfreter also had never seen a situation like this before. He remained on the second floor until all of the residents were evacuated from the facility. No other facility in Florida experienced a MCI after Hurricane Irma.

62. MRH's DON Meltzer initiated a "green alert" at MRH to notify staff that multiple critical patients from Hollywood Hills would be arriving for immediate care. MRH staff immediately prepared and organized the emergency department with equipment, supplies, intravenous solutions, lab tools, and other supplies to treat the arriving residents. From what she had personally observed, Nurse Meltzer determined a majority of the residents on the second floor needed medical attention. Nurse Meltzer alerted

MRH that approximately 50 Hollywood Hills residents would be transported to the hospital for care and treatment of heat-related illnesses.

September 13, 2017--The Evacuation Process

63. Dozens of MRH staff members arrived at the facility to assist with the evacuation of the residents. HFR and MRH staff went room to room on the second floor of the facility to check on each resident. Based on what they discovered regarding the condition of the residents, they made the immediate decision to evacuate all residents from the hot environment. First responders credibly testified that the only appropriate action was to remove the residents from the life-threatening heat in the facility.

64. The second-floor residents were evacuated first because of the extremely high temperatures. HPD officers arrived at the facility to assist with transport of critical patients out of the hot building. Hollywood Hills staff also worked with first responders to move the patients out of the building. Lt. Jeff Devlin, as well as Dr. Katz, testified that upon their arrival at 7:30 a.m. during the evacuation of the facility, it was hotter inside than outside of the facility.

65. Many MRH staff members ran to the nursing home to assess critical patients as quickly as possible, including Dr. Katz. Residents were triaged and moved from the facility to

MRH if they needed critical care. Residents who did not need immediate acute care were taken outside in front of the facility where numerous medical personnel triaged and attended to them.

66. Homicide detectives from HPD soon arrived at the facility to begin investigating the deaths of the residents and the conditions of the facility. As explained by Lt. Devlin, "in this instance multiple deaths under suspicious circumstances, there is always a potential for a crime scene." After the evacuation was completed, the facility was quickly designated a crime scene and sealed off.

67. Lt. Parrinello explained that "the conditions in the facility were contributing to the seriousness of the patients." Captain Sullivan described the conditions inside Hollywood Hills as being comparable to "toxic gas" inside the building, "it was an unsafe, dangerous environment for the people who were there, and they needed to be removed." The first responders relied on their training to handle the critical situation and moved quickly to save the residents. Firefighter Wohlitka tearfully and credibly testified that, "the lack of care that [the residents] were experiencing, in all honesty, this call still very much haunts me. Fourteen people had to die to see the lack of care these people were receiving and just frustration over trying to do as much as we could for as many as we could."

68. The first responders who assisted with the evacuation of the facility provided convincing testimony of the need to evacuate the facility, and established that the evacuation and triaging of the residents was handled appropriately and in an organized manner, given the size of the facility and the number of patients.

69. Contrary to the position asserted by some of Hollywood Hills' witnesses, there was a very systematic approach utilized by the first responders to coordinate the evacuation and triage of all of the residents in the facility. The overall scene was described as "controlled chaos." There had been no decisions or efforts to evacuate the building or provide needed care to the residents prior to the arrival of the first responders. Hollywood Hills staff did not object to the evacuation of the residents.[6/]

70. Undoubtedly, the swift and efficient actions of the first responders and MRH staff, particularly Nurses Frum and Meltzer, and Dr. Katz, saved lives and avoided further catastrophe that day. Any insinuation to the contrary is preposterous.

September 13, 2017--the Initial Investigation

71. By 9:40 a.m. on September 13, 2017, the evacuation of the facility was complete. Pursuant to normal HPD protocol for active crime scenes, Hollywood Hills was sealed off by HPD for

further investigation. HPD seized numerous medical records and computers, as well as logs and records from the nurse's station and desks.

72. At approximately noon on September 13, 2017, AHCA surveyors Anne Sosiak and Kathy Allen arrived at Hollywood Hills to inspect the premises and observe the conditions of the facility. HPD did not allow the surveyors inside the building, because it was an active crime scene and part of an ongoing criminal investigation. HPD also directed the surveyors not to contact Hollywood Hills' patients or their family members.

73. Lt. Devlin of HPD directed detectives and crime scene technicians to immediately document the temperatures and placement of the spot coolers within the facility after the evacuation was over. HPD recorded surface temperatures between 11:00 a.m. and 11:30 a.m. on September 13, 2017, at 11 separate locations on the first and second floors of the facility to get an overall gauge of the conditions inside the facility. The facility was noticeably cooler when these temperature readings were taken compared to when HPD first arrived in the midst of the evacuation of the facility around 7:30 a.m.

74. HPD recorded surface temperatures in excess of 100 degrees on the second floor of the facility, including in the patient rooms. The temperature outside Room 226, where three deceased residents resided, measured 99 degrees. The first floor

was also hot, with temperatures in excess of 96 degrees. Surface temperature readings are a more stable measure of temperature than ambient air readings because surface temperature takes longer to heat or cool. Although direct sunlight or other radiant heat can impact surface temperature readings, none of the temperatures taken by HPD appeared to be impacted by those factors. The HPD surface temperature readings are a good proxy for the conditions in the facility because there were no heating elements in the walls, meaning the surface temperature was based on the air temperature.

75. Hollywood Hills argues that the outside temperature during the early morning of September 13, 2017, contributed to the high temperatures recorded by the police. The ambient outside air temperature was only 79 degrees when the evacuation began at 7:00 a.m. The outside air temperature would actually have relieved heat in the building when the doors were opened. The suggestion that the HPD temperature readings can be disregarded because of the number of people in the facility during the evacuation is not supported by credible evidence. While the exact temperature in the facility at the time the evacuation took place cannot be established with certainty, the police readings and the observations of the first responders provide a sufficient basis to conclude that the facility was not safe for the frail, elderly residents.

Hollywood Hills' Patient Deaths

76. The Amended Complaint includes specific allegations related to the deaths of twelve residents in the facility and general allegations as to the failure of the facility to provide a safe environment for the other residents. Clear and convincing evidence was presented in this proceeding to establish that nine of the twelve residents referenced in the Amended Complaint suffered greatly from the exposure to unsafe heat in the facility. The ME was called upon, as part of an ongoing criminal investigation, to conduct an independent review of the deaths of residents from the facility in the aftermath of the loss of its A/C. The results of the autopsies and investigations by the Assistant MEs, who testified regarding the cause and manner of death of the 12 patients identified in this proceeding,[7/] provide compelling evidence of the consequences of Hollywood Hills' failure to provide its residents with a safe environment and appropriate access to health care.

77. The MEs' conclusions confirm, in many instances, the testimony from AHCA's expert witness, Dr. Nannette Hoffman. However, Hollywood Hill's expert pathologist, Dr. Jeffrey Jentzen,[8/] credibly and convincingly explained that several patient deaths were too attenuated in time and lacked sufficient evidence that their deaths were attributable to, or hastened by, environmental heat exposure at Hollywood Hills. Specific factual

findings related to each of the 12 residents named in the Amended Complaint, presented in this proceeding, are set forth below.

Resident 1

78. Resident 1 was an 84-year-old female with multiple medical conditions, which caused her to be bedridden and entirely dependent upon nursing staff for attention and care. On September 13, 2017, HFR was dispatched to Hollywood Hills at 3:01 a.m. to respond to Resident 1 for cardiac arrest. Upon arrival, HFR found Resident 1 supine in bed unconscious with shallow, labored breathing. HFR measured her tympanic temperature to be 107.5 degrees and observed that her skin was pale, moist, and hot.

79. A temperature of 107.5 is reflective of heatstroke or hyperthermia. It is very unusual for individuals with infections to have body temperatures in that range. Neither HFR nor Dr. Marlon Osbourne, the Assistant ME, had ever seen a body temperature that high in individuals with infections. To lower her body temperature, HFR immediately started a chilled intravenous ("IV") saline infusion and applied cold packs to the axilla and groin.

80. HFR transported Resident 1 to the MRH emergency department, where her axillary temperature was measured at 105.3 degrees. At MRH, Resident 1 was put on a ventilator and admitted to the intensive care unit ("ICU") for hyperthermia and

respiratory failure. She died 12 hours after transport to the hospital.

81. The ME's Office asserted jurisdiction due to the circumstances surrounding her death and conducted an autopsy. Dr. Osbourne conducted the autopsy and based upon review of the hospital and available nursing home records, determined the cause of death for Resident 1 to be heatstroke due to environmental heat exposure. He attributed the manner of death as homicide, which means the actions or inactions of others contributed to her death. He concluded that environmental heat was a significant factor to her high body temperatures. Dr. Osbourne concluded the patient was not timely removed from unsafe environmental conditions and other measures to alleviate her elevated temperature were not taken until it was too late.

82. Dr. Osbourne did not find Resident 1 to have any conditions or immediate lethal injury at the time of her death--other than the conditions at the facility. Resident 1 did not have any illnesses or disease that would explain her elevated temperature or her death. She had natural underlying issues consistent with her age, but there was nothing acutely lethal that would have led to her death, but for the elevated temperature and documented diagnosis of hyperthermia.

83. A temperature of 97 degrees on September 12, 2017, is the only temperature reading for Resident 1 in the Hollywood

Hills facility records. There is no time associated with the entry and nothing in the records indicates that additional temperatures were taken on September 13, 2017. As discussed below, there are serious questions as to the multiple temperature readings of 97 degrees for a number of Hollywood Hills' residents.

84. The video evidence shows Resident 1 was ignored by Hollywood Hills staff and not properly monitored given the dangerous conditions on the second floor. Resident 1 was never brought down to the first floor and remained on the second floor until HFR transported her to MRH.

Resident 2

85. Resident 2 was a 78-year-old female who was non-ambulatory and completely dependent on Hollywood Hills staff for all activities of daily living, including administration of fluids and food through a PEG tube. HFR was dispatched to Hollywood Hills on September 13, 2017, at 4:01 a.m. to respond to Resident 2 for a breathing problem. HFR recorded Resident 2's tympanic temperature at 107.5 degrees. Her skin was hot to the touch, and she had vomit in her mouth and on the pillow of her bed.

86. During initial treatment by HFR, Resident 2 became apneic and pulseless, and went into cardiac arrest. She was immediately transported to MRH for emergency treatment. At MRH,

she was documented to have a rectal temperature of 108.3 degrees. Rectal temperature is the most accurate measure of internal body temperature, since it measures the body's core temperature. A core body temperature of 108.3 degrees clearly indicates the patient suffered from heatstroke.

87. Resident 2 died at MRH at 5:00 a.m., shortly after transport. Prior to being exposed to the hot environment at the facility, Resident 2 was observed in her usual state of health. The ME's Office assumed jurisdiction over the case that morning.

88. Although Resident 2 had a number of conditions consistent with old age, such as arteriosclerosis and emphysema, Dr. Osbourne did not identify any acute or immediate lethal injury or natural disease that would have resulted in her death. Resident 2's liver enzymes and lactic acid levels were elevated, which is indicative of hyperthermia and heatstroke. There are many different signs of heatstroke. Some "soft signs" include hot skin, skin turgor, and low electrolytes. "Hard signs" include actual body temperature readings. Based on his autopsy and investigation, Dr. Osbourne determined the cause of death for Resident 2 was heatstroke due to environmental heat exposure. Dr. Osbourne concluded that Resident 2 clearly had demonstrable hyperthermia and was in a hazardous environment for too long.

89. Heat greatly exacerbates conditions, such as hypertension, heart disease, coronary disease, and edema. The

heat inside the facility likely contributed to Resident 2's heart failure because she already had underlying severe coronary disease. The stress of being in a hot environment, which makes it very difficult to breathe, would have put significant stress on her heart and may have sent her into cardiac arrest.

90. Dr. Osbourne concluded the lack of attention and failure to monitor contributed to Resident 2's death. As shown by the video footage from the facility, Resident 2 was seated in a wheel chair near a spot cooler, with the air from the cooler barely blowing on her on the evening of September 12, 2017. Hollywood Hills staff moved her to her room and at around 4:00 a.m. called 911 because she was in distress. Resident 2 was reported to have had shortness of breath and rhonchi bilaterally on auscultation.

91. Dr. Osbourne concluded that the manner of death for Resident 2 was homicide. His conclusion was based in part on what he deemed to be neglect by the individuals responsible for her care. Resident 2 was elderly and needed assistance with all basic daily activities, including ambulating and being removed from an unsafe environment.

92. Hollywood Hills suggests that, because Resident 2's temperature was reduced after Tylenol was administered, she did not die from heatstroke. This claim is not supported by the evidence. Whether Tylenol is effective in reducing temperature

depends on when it is administered in relation to the body's ability to thermo-regulate. Once a person's body loses the ability to thermo-regulate (i.e. loses the normal homeostasis processes), Tylenol will no longer lower body temperature because Tylenol depends on the body's ability to thermo-regulate. Tylenol can reduce body temperature for a person exposed to heat until such time as heatstroke occurs, which eliminates the body's ability to regulate temperature.

Resident 7

93. Resident 7 was a 71-year-old female. She had resided at Hollywood Hills since September 12, 2015. Since March 15, 2016, Resident 7 required assistance with her activities of daily living and required a wheelchair to get around. At 6:35 a.m. on September 13, 2017, HFR was dispatched to the Hollywood Hills facility for breathing problems associated with Resident 7. Upon arrival, HFR determined Resident 7 was in severe respiratory distress and a sepsis alert. She had a tympanic temperature recorded by HFR of 103.3 degrees, and her skin was hot to the touch.

94. Resident 7 was transported to MRH's emergency room at 7:06 a.m. MRH staff noted Resident 7 arrived with shortness of breath and the patient became unresponsive and asystolic shortly after arrival. At 7:50 a.m., Resident 7 had a core body temperature of 108.5 degrees. Hospital blood cultures showed no

growth after 72 hours. Despite medical intervention, Resident 7 was pronounced dead in the emergency room at 7:54 a.m.

95. Associate ME Dr. Wendolyn Sneed determined that the cause of Resident 7's death was heatstroke due to environmental heat exposure. Dr. Sneed did not find any source of inflammation that would suggest Resident 7 had an infection. Dr. Sneed determined the manner of death for Resident 7 to be homicide. Resident 7 was dependent upon staff for removal from the hot environment, and she could not vocalize that she was hot.

96. Dr. Sneed noted the facility records from Hollywood Hills did not reflect increased or continual monitoring of residents, or taking temperatures and vital signs despite the facility's loss of air conditioning. Dr. Sneed noted the highly unusual situation of multiple patients coming from the same facility within a short period of time with temperatures in excess of 108 degrees. There was no record of staff taking the steps expected of medical professionals under the circumstances to bring down temperatures.

97. While Hollywood Hills' records state Resident 7's temperature was taken on September 12, 2017, at 11:15 p.m., it is questionable whether this recording is reliable. There was no documentation of continual monitoring of her temperature or vital signs and Hollywood Hills' latest progress note for Resident 7 was dated September 7, 2017. Although Resident 7 was prescribed

two 325 mg tablets of aspirin every day by her physician, Hollywood Hills documentation does not show she was administered her prescribed medication between September 6 and 13, 2017, even during the loss of A/C.

Resident 8

98. Resident 8 was a 70-year-old female, who had been under the care of Hollywood Hills since September 8, 2010. On September 13, 2017, at 6:18 a.m., HFR was dispatched to Hollywood Hills for a breathing problem identified with Resident 8. At 6:23 a.m., HFR found Resident 8 to be in cardiac arrest. HFR tried to record a tympanic temperature for Resident 8, but the thermometer simply read "HI." None of the HFR crew had ever seen a temperature reading of "HI" before this encounter. HFR, after consulting the thermometer's manual, determined the "HI" meant Resident 8's temperature was 108 degrees or above.

99. HFR noted Resident 8 became apneic and pulseless during transfer and CPR was performed. Resident 8 arrived at MRH's emergency department at 6:35 a.m. Resident 8 was pronounced dead at 6:49 a.m. MRH staff took a rectal temperature of Resident 8 and recorded a core body temperature of 109.9 degrees at 7:04 a.m. 109.9 degrees is clearly within the range of a heatstroke.

100. Based on the autopsy results, Resident 8's records and symptoms, and the circumstances in the facility, Dr. Sneed

determined Resident 8's cause of death was heatstroke due to environmental heat exposure. Notably, nothing in Resident 8's autopsy provided any natural cause for a core body temperature of 109.9 degrees. Dr. Sneed did not find any acute natural condition to explain why Resident 8 would have died on September 13, 2017, other than the environmental heat.

101. Resident 8 was non-ambulatory and fully dependent on Hollywood Hills for all activities of daily living, including drinking adequate amounts of fluids to counteract the effects of the heat. During the autopsy, Dr. Sneed did not find any fluids in her stomach. Hollywood Hills last documented providing fluids to Resident 8 on September 12, 2017, at 8:05 p.m. Dr. Sneed determined Resident 8 was not adequately cared for. Consequently Dr. Sneed also determined the manner of death to be homicide.

102. The facility records of Resident 8's temperatures from September 4 to September 11, 2017, ranged from 97 to 98.3 degrees. On September 12, 2017, at 4:16 a.m., the facility records indicate she had a temperature of 102 degrees, which was not her normal baseline temperature. Resident 8 was purportedly provided with two tablets of Tylenol. A progress note in the facility records states on September 13, 2017, at 3:31 a.m., Resident 8 was alert, oriented with flushed and clammy skin. Her blood pressure was 148/76, heart rate was 79 beats per minute ("BPM") and respirations were 19 per minute. At that time,

Hollywood Hills recorded her temperature at 101 degrees and deemed her to be in "stable condition."

103. There are reasons to question the accuracy of this entry. This information was not documented in the treatment administration record. The day after Resident 8's death, "a late entry" was made to the facility records indicating that Resident 8 had a change in condition with labored breathing at 4:20 p.m. This "late entry" makes no sense. Even if it is assumed that this entry was intended to be for September 13, 2017, HFR was dispatched to the facility for Resident 8 more than ten hours before the time noted and Resident 8 died at 6:49 a.m. Furthermore, even if it is assumed that the "late entry" included a typo and meant to refer to 4:20 a.m., the entry is still problematic because 911 was not called until two hours later.

Resident 4

104. Resident 4 was a 96-year-old man. He was completely dependent on Hollywood Hills for all daily living activities and protection from unsafe conditions. HFR was dispatched to Hollywood Hills at 5:43 p.m. on September 13, 2017, in response to reports of chest pain for Resident 4. When HFR reached Resident 4 at 5:45 a.m., they immediately concluded that Resident 4 was already deceased and noted that rigor mortis had already set in. He was hot to the touch and his eyelids were fused closed.

105. Rigor mortis is the stiffening of the body after death. It is not present at or around the time of death. How long it takes for the body to stiffen depends on multiple factors, including the ambient temperature--in a hotter setting, the body will stiffen quicker. Even though heat accelerates the stiffening process, it takes some time for rigidity to set in.

106. Orlando Portillo, an investigator with the Broward County ME's Office, arrived at the facility around noon on September 13, 2017, and took core body temperatures of the deceased residents, including Resident 4. Resident 4's core body temperature was 104.6 degrees.

107. Dr. Sneed's autopsy did not show any acute natural conditions that would explain Resident 4's death. Based on her investigation, Dr. Sneed could not identify any logical explanation for his death other than heat exposure. Dr. Sneed determined his cause of death to be environmental heat exposure, and the manner of death to be homicide. This conclusion is supported by Mr. Portillo's post-mortem temperature recording.

108. Resident 4 was in the same room as two other residents who died on September 13, 2017, Residents 5 and 11, who were also deemed to have causes of death attributed to environmental heat exposure.

109. Prior to September 13, 2017, Hollywood Hills' records indicate that Resident 4 had a temperature range of 97 to

98.6 degrees between September 6 through 12, 2017. Resident 4 had not exhibited any change in condition prior to being exposure to the heat, which indicates that he did not die from his existing conditions.

110. As with Resident 8, there was a late entry made by Hollywood Hills on September 14, 2017, erroneously stating Resident 4 to be in cardiac arrest at 4:00 p.m. (no date specified); Resident 4 was actually pronounced dead by HFR at 5:45 a.m.

Resident 5

111. Resident 5 was an 84-year-old man, who was non-ambulatory and completely dependent upon Hollywood Hills' staff for all basic activities. He required a permanent feeding tube, which he needed for all nutrition, fluids, and medication. He resided in the same room as Residents 4 and 11, who also died.

112. There are conflicting accounts about the discovery of Resident 5's death. It is clear that Mr. Colin's claim that Resident 5 was found while HFR was assessing Resident 4 is not accurate. It appears Resident 5 was found deceased in his bed by HFR or Hollywood Hills staff around 6:30 a.m., about 45 minutes after Resident 4 was declared a Signal 7, and after HFR and Memorial staff began going room to room assessing patients.

113. Investigator Portillo took Resident 5's temperature when he arrived at the facility to conduct his investigation into

the deaths of Residents 4, 5, and 6. Resident 5's core body temperature taken shortly after noon on September 13, 2017, was measured at 104.1 degrees.

114. After conducting an autopsy, Dr. Sneed concluded Resident 5's cause of death was environmental heat exposure. Dr. Sneed's autopsy and investigation did not reveal any catastrophic disease that would explain why Resident 5 died on September 13, 2017, other than the unsafe conditions to which he was exposed. She attributed the manner of death to be homicide based on the condition of the other residents in the room and the circumstances in the facility.

115. Hollywood Hills recorded a late entry on September 14, 2017, indicating Resident 5 as resting in bed at 11:15 p.m., with unlabored breathing and percutaneous endoscopic gastrostomy ("PEG") tube intact. Staff also documented that vital signs were taken and safety and comfort were provided, however, there are no temperatures or vital signs actually recorded or an indication of the date to which this record pertains. The record does not support the claim that Hollywood Hills staff continually monitored Resident 5's temperature or conditions prior to his death.

Resident 6

116. Resident 6 was a 92-year-old man, who was non-ambulatory and required total assistance for all activities of

daily living. He was found deceased in the facility by HFR at approximately 6:30 a.m., around the same time HFR discovered Resident 5.

117. As part of his investigation into the deaths of Residents 4, 5, and 6, Investigator Portillo took photographs and assessed the ambient temperature in the facility around noon on September 13, 2017. He also took the body temperatures of the deceased residents. Investigator Portillo recorded Resident 6's core body temperature to be 105.9 degrees.

118. There is no apparent explanation for Resident 6's high body temperature other than environmental conditions. Body temperature does not rise naturally after death, unless the ambient air temperature is hotter than the body. Resident 6's post-mortem body temperature of 105.9 degrees indicates that the air temperature in his room at the facility was 105.9 degrees or higher when he died or shortly thereafter.

119. Dr. Osbourne conducted an autopsy and reasonably concluded that the cause of death for Resident 6 was environmental heat exposure. The autopsy conducted by Dr. Osbourne did not show any lethal or natural causes of death. Dr. Osbourne reasonably determined that heat exposure was the cause of death for Resident 6, irrespective of any natural diseases or conditions he had.

120. Dr. Osbourne credibly explained that a medical examiner cannot isolate a patient from the entirety of the circumstances surrounding the death. His knowledge of the other deceased residents reasonably led him to determine that the facility was a hazardous, hot environment that resulted in the deaths of these residents.

121. The last documented progress note for Resident 6 was on September 4, 2017, prior to the loss of the air conditioning to the facility, which indicated no signs of respiratory distress. Hollywood Hills' records indicate that Resident 4's temperature, but no other vital signs, was taken at 1:42 a.m. on September 13, 2017, however, the video evidence directly contradicts this note since there is no evidence that any staff entered Resident 6's room from midnight to almost 4:00 a.m.

Resident 9

122. Resident 9 was a 94-year-old female, who had been under the care of Hollywood Hills since August 29, 2017. Resident 9 was evacuated from Hollywood Hills on the morning of September 13, 2017, and was transported to MRH at 7:56 a.m. Initial medical assessment indicated that she had tachycardia and a change in mental status. After arrival at MRH, her blood pressure began to drop. She was suspected of a urinary tract infection ("UTI") and possible pneumonia.

123. Around 12:56 a.m. the next day, September 14, 2017, Resident 9 became lethargic, non-verbal and her blood pressure spiked to 150/111. Her blood pressure remained elevated until the afternoon of September 15, 2017. From September 14 to September 16, 2017, after the evacuation of Hollywood Hills, Resident 9 suffered acute delirium at MRH.

124. On September 20, 2017, Resident 9 was discharged to Seasons Hospice and Palliative Care. Upon discharge from MRH on September 20, 2017, Resident 9's blood pressure again spiked and she continued to decline. She subsequently went into cardiac arrest and died that evening.

125. Prior to Resident 9's admission to MRH, she was awake, alert, and able to hold a small conversation, including communicating by writing. Hospice records from September 20, 2017, reflect Resident 9 presented with altered mental status, was non-verbal, unable to follow commands, and was in need of continual monitoring.

126. The ME's autopsy found significant coronary artery disease in one vessel, blood pooling around her heart, and a tear or rupture in the wall of the left ventricle. These findings indicate she had an acute myocardial infarction (heart attack) that subsequently bled into the sac around her heart causing hemopericardium cardiac tamponade.

127. The ME concluded that the myocardial infarction began on September 13, 2017, the day Resident 9 was evacuated from Hollywood Hills, and then about seven days later, the rupture of the ventricle occurred. The ME concluded that the rupture on September 20, 2017, was the direct cause of her death. Specifically, the ME concluded her cause of death was atherosclerotic heart disease, complicated by environmental heat exposure, resulting in a ruptured acute and healing myocardial infarction. In other words, the hot environment caused Resident 9 stress, likely precipitating the initial myocardial infarction which led to the ventricle rupture from which she died.

128. The manner of death was found by the ME to be homicide due to exposure to the hot environment leading to the subsequent changes to her heart and classified her death as a homicide, meaning it was due to the action or inaction of others.

129. However, the evidence presented at the final hearing was insufficient to find that Resident 9's death was caused by environmental heat exposure. Her death came a week after evacuation. In light of her age, underlying coronary artery disease, and her diagnosis at admission to MRH of a UTI and pneumonia, there is insufficient evidence to find that Resident 9's death was caused or hastened by the action or inaction of Hollywood Hills staff. From the evidence presented

at final hearing, it is not possible to determine if her heart attack was attributable to the heat at Hollywood Hills, the evacuation, the care at MRH, the transfer to hospice, the care at hospice, or natural causes.

Resident 10

130. Resident 10 was a 57-year-old female, who had been under the care of Hollywood Hills since July 18, 2015. Resident 10 had neuronal ceroid lipofuscinosis--a genetic disorder where cells of the brain do not break down fatty acid. The human body needs fatty acids to make nerve functions work; without these acids, the body's cells cannot function. Because of this condition, Resident 10 had functional quadriplegia, dysphasia, and failure to thrive. Failure to thrive is defined as no impetus to eat or drink, requiring the external administration of feeding and intake of fluids. Resident 10 was completely dependent upon Hollywood Hills for all activities of daily living, including feeding, hydration, and all other basic life needs.

131. Resident 10 was evacuated from Hollywood Hills on the morning of September 13, 2017, and brought to MRH Emergency Department at 8:24 a.m. with dehydration, elevated white blood cell count, and hyperkinetic high potassium. She was ultimately admitted due to dehydration, electrolyte imbalance, and cachexia, which is wasting away.

132. MRH found bacteria in her blood culture which prevented them from regulating or correcting her electrolyte imbalance. Resident 10 was later discharged to hospice on September 19, 2017, and placed on comfort care. Resident 10 died 15 days after evacuation on September 29, 2017, while at hospice.

133. Because Resident 10 never returned to baseline after being exposed to the hot environment at Hollywood Hills, the ME conducted an autopsy. The autopsy revealed Resident 10 had extreme cachexia with contractures and had viral pneumonia. Her clinical signs revealed she had at least some physical changes associated with the exposure to the hot environment, namely dehydration.

134. The ME attributed Resident 10's death to the failure to thrive complications of well-known neuronal ceroid lipofuscinoses, complicated by environmental heat exposure. The only thing that changed for her from before the evacuation of the facility on September 13, 2017, was being in the hot environment inside Hollywood Hills. After that exposure, she never went back to her usual state of health.

135. Resident 10 was not in hospice before being exposed to heat. Only after being exposed to the heat was she placed at hospice, where she died. Exposure to the hot environment, and not being timely removed or continually monitored, affected her and likely hastened her death.

136. The ME found Resident 10's manner of death to be homicide. Resident 10 was 100 percent dependent upon caregivers to remove her from the hot environment and provide her any kind of basic needs, which Hollywood Hills failed to do.

Resident 11

137. Resident 11 was a 93-year-old male, who had been under the care of Hollywood Hills since January 24, 2016. He was completely dependent upon Hollywood Hills staff for activities of daily living and did not have the capability to remove himself from hazardous environments.

138. On September 12, 2017, at 12:50 p.m., HFR was dispatched to Hollywood Hills in response to a call that Resident 11 had a breathing problem. At 12:55 p.m., HFR determined Resident 11 had labored breathing and a tympanic temperature of 102 degrees. Hollywood Hills staff communicated to HFR that he had a rapid decline in mental status and oxygen saturation.

139. On September 12, 2017, Resident 11 was transported to the MRH Emergency Department at 1:11 p.m. HFR provided an intravenous fluid infusion and oxygen to him on route to the hospital. Upon arrival at MRH, Resident 11 was found to have altered mental status, acute respiratory distress, and fever. His axillary temperature was 103.2 degrees at this time. MRH staff subsequently took a rectal temperature, which is the most

accurate determination of core body temperature. Resident 11 was found to have a core body temperature of 106.5 degrees 20 minutes after his arrival at the emergency department. As discussed above, this temperature is indicative of heatstroke.

140. MRH records documented a conversation with HFR after the transfer of Resident 11. HFR reported Resident 11's room at Hollywood Hills was "very, very hot." Resident 11 was in Room 226, which he shared with Residents 4 and 5, who, as discussed above, passed away less than 18 hours later and were found to have extremely high body temperatures.

141. Resident 11's mental condition improved somewhat after initial treatment at MRH from September 13 to 14, 2017. However, his respiratory status continued to be compromised and he also developed non-sustained ventricular tachycardia. On September 15, 2017, Resident 11 was noncommunicative with respiratory congestion. He ultimately suffered with multiple organ failure and was pronounced dead on September 19, 2017.

142. The ME's Office investigated the death of Resident 11. Because of the temporal proximity of his death to other Hollywood Hills residents who died, the ME determined Resident 11's cause of death to be complications of environmental heat exposure with contributing atherosclerotic hypertensive cardiovascular disease.

143. The ME concluded that Resident 11 unequivocally had hyperthermia as confirmed by the rectal temperature of 106.5

degrees, which is indicative of heatstroke. Resident 11 experienced complications upon exposure to heat at Hollywood Hills and was never able to return to baseline prior to his death. Even though Resident 11 had several comorbidities and natural disease, his exposure to the stress of heat on his body severely complicated the effects of his natural disease and ultimately led to his elevated temperatures. The ME concluded that, given the circumstances, Resident 11's manner of death was properly classified as homicide.

Resident 12

144. Resident 12 was a 90-year-old female who had been under Hollywood Hills' care since August 18, 2009. Resident 12 was completely dependent upon Hollywood Hills staff for activities of daily living and was not able to remove herself from hazardous environments. Resident 12 was evacuated from Hollywood Hills on September 13, 2017, and taken to MRH at 7:54 a.m. Resident 12 was admitted for dehydration, elevated body temperature, and systemic inflammatory response syndrome. MRH's initial assessment revealed she was dry to the touch, with dry mucus membranes, and a change in mental status. Resident 12's vital signs, when she first presented, included blood pressure of 138/111 and an oral temperature of 99.3 degrees. A half hour after arrival, a second temperature was taken and revealed an elevated body temperature of 100.2 degrees.

145. After Resident 12 passed away on October 9, 2017, 28 days after evacuation, the ME investigated because of the close proximity to the deaths of other Hollywood Hills residents following the loss of A/C. Resident 12's cause of death, as determined by the ME, was hypertensive and arteriosclerosis cardiovascular disease, complicated by environmental heatexposure. Resident 12 never returned to baseline after being exposed to the hot environment at Hollywood Hills.

146. Because Resident 12 was 100 percent dependent upon Hollywood Hills to be removed from the unsafe hot environment, which had a deleterious effect on her conditions and in all likelihood led to her demise, the ME determined her manner of death to be homicide.

147. The evidence at final hearing was insufficient to find that Resident 12's death was caused by environmental heat exposure. Her death came almost a month after evacuation and she did not have a documented temperature consistent with hyperthermia. Her death was too attenuated from the evacuation to find that it was caused or hastened by the action or inaction of Hollywood Hills' staff.

Resident 3

148. Resident 3 was a 99-year-old woman. Resident 3 was a hospice patient who was terminally ill and was on "continuous

care" because as of September 12, 2017, her hospice doctor believed her death to be imminent.

149. Her underlying medical conditions included hypertension, aortic valve stenosis, and congestive heart failure, which can be exacerbated by the stress of a hot environment. She died at the facility at 1:55 a.m. on September 13, 2017, with a Vitas hospice nurse at her side, and was immediately transported to a local funeral home.

150. Dr. Osbourne conducted an autopsy and concluded that environmental heat exposure contributed to her death. Based on Dr. Osbourne's investigation, including an autopsy and analysis of her organs and tissues, there was nothing to suggest that death was imminent. The autopsy failed to uncover any other acute natural causes of death. However, this patient did not exhibit signs of heat stress and the testimony at final hearing was insufficient to demonstrate that her death was hastened by conditions at the facility.

The Spot Coolers Had Insufficient Cooling Capacity and Actually Heated the Building

151. Hollywood Hills failed to provide a safe environment for its residents after Hurricane Irma. The few steps the facility took to address the loss of A/C, such as obtaining spot coolers and fans, were woefully inadequate and exacerbated the

problem. The facility simply did not have nearly enough cooling capacity to replace the lost A/C chiller.

152. The evidence established that the steps Hollywood Hills took actually made the facility hotter. The facility installed the spot coolers inappropriately by venting them directly into the first and second floor ceilings, which had little to no venting to the outside. As a result, the exhaust from the spot coolers actually heated the inside of the facility, effectively turning the second floor into an oven.

153. The testimony of Scott Crawford, a mechanical engineer and expert in HVAC systems in nursing homes confirmed that the facility could not have maintained a temperature of 81 degrees for two primary reasons. First, Hollywood Hills did not have enough spot coolers to sufficiently cool the nursing home side of the facility to an ambient temperature at or below 81 degrees. Second, the spot coolers that were placed throughout the facility were not installed or used correctly, and as a result, added to the amount of heat inside the facility.

154. Hollywood Hills and the adjacent Larkin share an HVAC system, including a 125-ton chiller. Typically, 85 tons of this chiller is devoted entirely to the nursing home side of the building. After the loss of the chiller, Hollywood Hills and Larkin were only able to obtain portable A/C units (spot coolers) capable of 15 tons of cooling capacity. Of the nine tons

allocated for the nursing home, eight spot coolers were placed in the hallways--five on the first floor and three on the second floor.

155. This was far less than needed to maintain a safe temperature in the facility. The spot coolers are not designed to cool large areas; they do not have the capacity to replace a full HVAC system.

156. The patient areas on the second floor, where the critical residents in the facility were housed, totaled approximately 12,545 square feet. The manufacturer of the spot coolers used by Hollywood Hills identifies the cooling area for those units as 355 square feet, or approximately 18 by 18 feet. Using the manufacturer's recommendations, at least 35 spot coolers would be needed to maintain the second floor patient rooms at a temperature of 81 degrees or below.

157. Mr. Crawford conducted an independent load capacity analysis for the facility. Load capacity is the amount of refrigeration capacity required to maintain a particular temperature. If a facility does not have the appropriate load capacity, it is not possible to maintain that temperature.

158. In calculating load capacity, Mr. Crawford used the Carrier Hourly Analysis program, which is common in the mechanical engineering industry. The program considers a number of factors, such as the building construction and insulation, as

well as the amount of heat emitted from the people, lights, and equipment, to determine how much capacity is needed to cool a specific area. Mr. Crawford used values for each of the factors based on an inspection of the site. For undetermined values, Mr. Crawford used conservative estimates which generally reflected the best case scenario for the facility.

159. Mr. Crawford's load capacity analysis also considered the outside air temperature on September 11 and 12, 2017. Because load capacity analysis determines the cooling capacity needed to maintain the building at a specific temperature, Mr. Crawford used 81 degrees--the temperature Hollywood Hills' witnesses claimed was maintained in the building until the evacuation. Based on his analysis, Mr. Crawford concluded that on September 11, 2017, the first floor of the facility required over 12 tons of cooling capacity to maintain 81 degrees during the hottest part of the day, while the second floor separately required over 15 tons. During the hottest part of the day on September 12, 2017, the first floor of the facility required over 11 tons, while the second floor required nearly 17 tons.

160. Using this very conservative approach, Mr. Crawford persuasively explained that a minimum of 27 and 28 tons were needed to maintain a temperature of 81 degrees in the patient areas of the facility on September 11 and 12, 2017, respectively. Unfortunately, Hollywood Hills only had nine tons of portable

cooling capacity for the entire nursing home. Hollywood Hills simply did not have enough spot coolers to provide the load capacity needed to maintain the temperature at or below 81 degrees on either September 11 or 12, 2017.

161. Although Hollywood Hills made use of a limited number of fans in some areas of the hallways and patient rooms, those fans would not have any significant cooling effect--largely serving to just move the air around inside the facility.

162. Without the necessary load capacity, the temperature within the facility would unavoidably rise over time. While there may have been short periods at night when the facility had the necessary capacity to maintain the temperature on the first floor, this would only momentarily arrest the increasing temperature--not return it to 81 degrees.

163. The lack of the necessary load capacity was exacerbated by the venting of the exhaust from the spot coolers into the ceiling. A spot cooler cools the space around it, but actually gives off more heat than it cools. Thus, spot coolers must be vented away from the area being cooled. The hot air discharged by the spot coolers is typically 15 to 20 degrees above room temperature.

164. In this case, even if it is assumed the room temperature in the facility was 81 degrees, the heat discharged

from the spot coolers would have been approximately 95 to 100 degrees.

165. Online videos show spot coolers typically vented into drop ceilings with manufacturer-supplied venting kits. However, Weltem, the company that makes the spot coolers used by Hollywood Hills, and other spot cooler manufacturers warn that spot coolers should be vented into an area that is well-ventilated and large enough for the heat load to be absorbed, ideally outside the building. Routing the exhaust to a sufficiently ventilated area or directly outside prevents the discharged heat from simply being added back to the space being cooled.

166. Hollywood Hills did not vent the spot coolers into well-ventilated areas, but instead directed the exhaust into the ceilings on the first and second floors of the nursing home. The porous tiles of the first floor ceiling serve as the bottom of a confined space directly below the concrete slab of the second floor. The distance between the tiles and concrete slab is less than 24 inches. There is no ventilation to the outside of the building to release the heat from the spot coolers on the first floor nor is there any insulation between the floors of the building that could absorb the heat.

167. Consequently, the heat discharged from the spot coolers on the first floor went directly into the ceiling space, which was confined and not ventilated in any way. As a result,

the heat did not disappear or escape the facility; it remained in the facility and super-heated the concrete slab under the second floor and heated the air temperature on the second floor.

168. The second floor of the facility is divided into three smoke compartments, which are sealed off from each other for fire safety purposes. Two of the smoke compartments did not have any ventilation to the outside. Only one of the three spot coolers used on the second floor was located in the smoke compartment with ventilation. Other than this single ventilated smoke compartment in the second floor ceiling, there was nowhere else for the heat discharged from the three spot coolers to go upon entering the ceiling space on the second floor. The end result is that the installation and use of the spot coolers resulted in raising the air temperature in the facility, particularly on the second floor.[9/]

169. The unavoidable conclusion is that exhausting the spot coolers into the ceiling without proper ventilation was negligent and contributed to the unsafe conditions for the residents.

170. Hollywood Hills did not present any corresponding load capacity analysis to rebut Mr. Crawford's testimony. Instead, Hollywood Hills' HVAC expert, Nick Ganick, conducted an evaluation of the capacity of the spot coolers to cool the corridor areas of the facility. Mr. Ganick's analysis failed to account for the patient rooms, where the residents were primarily

housed, as well as the nurses' stations and other key areas. His analysis was not persuasive.

171. Mr. Ganick failed to support his conclusions with any calculations to show how the spot coolers could have cooled the air temperature in the corridors to 75 degrees. He also did not perform any analysis involving the impact of outside air temperatures on the temperature within the facility.

172. According to the manufacturer's specifications, the effective cooling area for a spot cooler is only 18 by 18 feet. Mr. Ganick conceded that his calculations of the area of the facility corridors (3,360 square feet) was more than double the cooling area stated in the manufacturer's specifications.

173. Hollywood Hills failed to rebut Mr. Crawford's load capacity analysis, which showed the facility did not have anywhere near the cooling capacity need to maintain 81 degrees in the facility.

174. Mr. Ganick admitted that heat cannot be discharged into a confined space in the ceiling or it would lead to temperature increase within the facility. He also confirmed that the first floor plenum area did not have ventilation to the outside of the building. Even though Mr. Ganick did not conduct his own heat load calculations, he speculated that the area above the first floor ceiling tiles and the facility walls had enough volume to absorb the heat discharged from the spot coolers.

However, the heat had nowhere to go. Moreover, the porous tiles in the ceilings would allow the heat discharged into the plenum area to flow back into the facility.

175. The suggestion by witnesses for Hollywood Hills that the outside temperature during the early morning of September 13, 2017, contributed to the high temperatures recorded by the police in the facility is not persuasive. The ambient outside air temperature was only 79 degrees when the evacuation began at 7:00 a.m. Thus, the outside air temperature would actually have relieved heat in the building when the doors were opened.

176. Similarly, the suggestion that the HPD temperature readings can be disregarded because of the number of people in the facility during the evacuation is not supported by credible evidence.

177. While the exact temperature in the facility at the time the evacuation took place cannot be established with certainty, the testimony of Mr. Crawford, coupled with the police readings and the observations of the first responders, provide a sufficient basis to conclude that the facility was not safe for the frail elderly residents.

Hollywood Hills Knew Conditions Were Unsafe But Failed to Take Appropriate Action to Protect Its Residents

178. Hollywood Hills argues that temperatures remained "comfortable" and that AHCA failed to present evidence of ambient

air temperatures in the facility at any time. Hollywood Hills relies on the testimony of Mr. Williams and Mr. Carballo that the temperatures they observed in the building from Sunday through Tuesday evening did not rise above 81 degrees.

179. Importantly, the temperatures observed by Mr. Williams and Mr. Carballo were taken in the common areas, near or on the spot coolers. They are not indicative of temperatures in the patient rooms, particularly on the second floor.

180. Further, the videotaped evidence shows Hollywood Hills staff profusely sweating and clearly uncomfortable as of Tuesday afternoon. As discussed above, by Tuesday at 10:00 a.m., staff documented through their WhatsApp messaging that "patients don't look good" and "we need more fans." By 2:00 p.m., DON Castro wrote, "the residents upstairs are having a really hard time."

181. Hollywood Hills also offered the expert testimony of Dr. Grundstein, a bio-climatologist, who explained that perceived temperatures by firefighters, staff, and residents were attributable to metabolic rates (activity levels).
Dr. Grundstein explained comfort is more than just temperature. It involves humidity, wind speed, metabolic rate, and the clothing a person is wearing. Altering humidity, wind speed, metabolic rate, and/or the clothing a person is wearing can significantly impact a person's perceived comfort. The model

takes all these into account. The model assumed a constant 81-degree temperature.

182. While firefighters would have perceived the temperatures as hot, the patients may have felt slightly cool to slightly warm, according to Dr. Grundstein. Dr. Grundstein's testimony is of little value. Although it shows perceptions can vary from hot to comfortable at 81 degrees, the model does not prove it was exactly 81 degrees or that temperatures in the facility did not exceed 81 degrees. If patients were "comfortable," why would staff be communicating by Tuesday about the patients having a difficult night, scrambling to find more fans, and stationing some patients in the hallways near the spot coolers?

183. According to Hollywood Hills, when the Bravo team took over on Monday, they were told to closely monitor the patients, continuously offer hydration, and report any changes to the nursing supervisor. Hollywood Hills offered the testimony of staff and third parties, including physicians, nurses, and family members, who testified that they personally observed the residents being monitored and provided hydration.

184. Unfortunately, the patient records, with the exception of a few unsupported late entries, are completely devoid of this purported monitoring and hydration. AHCA surveyors attempted to obtain from Hollywood Hills' administration all documentation

showing the care and monitoring of the residents within the facility. The very few vital signs recorded for the residents are not continuous, and there are no notes regarding their physiological systems or conditions. As acknowledged by Mr. Colin, a well-known axiom in medicine is, "If it's not documented in the records, it didn't happen."

185. Compounding this problem, in the immediate aftermath of the evacuation, the nursing staff was called back to create "late entry" notes that are unsupported by any contemporaneous documentation or corroborating testimony. These notes were clearly fabricated because some reflect the patients had normal body temperatures at a time when they were already dead or dying at MRH.[10/]

186. Similarly, the video relied upon by Hollywood Hills to show hydration only shows staff and family members carrying cups. It does not show distribution to patients. Because the cameras were pointed at nursing stations and common areas, no regular or heightened level of patient-monitoring is demonstrated. To the contrary, there are large periods of time on the video where there is little to no activity shown of staff entering patient rooms.[11/]

187. Contrary to his testimony, the video footage does not reflect that Sergo Colin, the night shift supervisor, made routine monitoring rounds with any of the attending nursing

assistants or nursing staff on September 12 or 13, 2017, to assess the condition of residents. The video only shows him responding in crisis situations to patients who had died or later expired shortly after evacuation.

188. The Hollywood Hills staff present during the storm through the evacuation of the facility were never instructed by the DON or the Facility Administrator to monitor patient temperatures. Hollywood Hills relied on staff members to monitor the patients and only take vital signs when they saw a change in condition in a patient. This was obviously an ineffective approach under the circumstances. The standard of care for dependent and immobilized residents of a nursing home during a precarious situation, such as the loss of A/C, does not depend simply upon physical symptoms staff can see. Temperatures within the body can rise without being visible to the human eye.

189. The medical experts uniformly testified that elderly patients cannot tolerate heat in the same fashion as younger people. As temperatures rise, the body tries to pump more blood and to sweat. The elderly do not have the same cardiac reserve as younger individuals. Their blood vessels do not dilate as well nor do they sweat as well to dissipate body heat. At high temperatures, proteins in the brain break down causing blood pressure to drop and the heart rate to increase. The kidneys

cannot get enough blood and the elderly are at risk of dehydration because their bodies cannot compensate.

190. An elderly person's ability to cope with excessive heat will obviously be impacted by their underlying medical conditions. Elderly patients are often on diuretics, which makes them particularly vulnerable to dehydration. If patients suffer from dementia, it may be impossible for them to communicate their needs for hydration. All of this was or should have been known to the staff at Hollywood Hills, yet there was no effort by staff to properly monitor their patients or move them to safety.

The Inaction of Others Did Not Mitigate the Responsibility of Hollywood Hills to Maintain a Safe and Comfortable Environment

191. Throughout this proceeding, Hollywood Hills argued that its responsibility, if any, for the patient deaths, should be mitigated by the inactions of others. As set forth in the Order entered in this proceeding on November 22, 2017, the focus of this proceeding is on whether Hollywood Hills met its obligation to provide a safe environment and appropriate health care to its residents. The efforts by Hollywood Hills to shift the blame by trying to point the finger at other entities is irrelevant to the issues before this tribunal.

192. Hollywood Hills highlights FP&L's inexplicable failure to timely respond to its requests for prioritization and the Governor's failure to return phone calls for assistance to his

cell phone. Apparently, Hollywood Hills incorrectly assumed that power restoration to its chiller was imminent, and it was therefore lulled into inaction. However, this is belied by the fact that Hollywood Hills staff never discussed the risks to the patients versus benefits of evacuation, or the timing of a possible evacuation if the A/C was not restored.

193. Hollywood Hills also points to the fact that several physicians and a physician assistant saw patients in the building on September 12, 2017, and none of them felt that it was dangerous for the residents or that an evacuation was necessary. The evidence showed that these physician interactions were limited and primarily on the first floor. The facility's responsibilities to the residents to provide a safe environment and reasonable access to health care cannot be delegated to providers who did not have direct and continuous responsibilities for all the second floor residents.

194. Hollywood Hills also claims the first responders should have called for an evacuation as soon as they arrived to treat the first patient on September 12, 2017, if the conditions were unsafe. This ignores the fact that the first responders were assured that the A/C was being fixed, that the nursing staff was continually monitoring the patients, and they were initially dissuaded by staff from checking the other residents.

195. In its defense, Hollywood Hills also argues that in response to the Hurricane, it followed its own CEMP, which was preapproved by the Broward County Division of Emergency Management. The appendix to Hollywood Hills' CEMP references a response plan for utility failures. However, the evidence revealed that there was no emergency response plan for utility or chiller failures within the facility. Hollywood Hills' CEMP is devoid of any emergency plan or guidance in the event of the loss of the A/C.

196. Hollywood Hills staff members apparently received some general disaster training when they were first hired but no additional training or direction was provided when a disaster became imminent or actually struck. The night shift supervisor on duty from September 12 to 13, 2017, Sergo Colin, did not attend any training or educational drills on how to care for the residents appropriately in the event of the loss of A/C. The second floor nurses, Tamika Miller and Althia Meggie, also are not documented to have ever participated in such training or drills. After the failure to the Hollywood Hills chiller on Sunday, September 10, 2017, it does not appear that any Hollywood Hills management or staff consulted the CEMP for guidance or direction on how to properly respond to the utility failure.

197. The lack of disaster training and education was apparent in the staff members' reactions and decisions leading up

to the evacuation of the Hollywood Hills facility. There was a lack of leadership providing effective guidance to staff members at the facility on September 12 and 13, 2017. Prior to the evacuation, the staff had no plan or course of conduct as to how to ensure the well-being of the patients in their care during the loss of A/C. Hollywood Hills left the most inexperienced staff in charge of the most vulnerable residents housed in the facility during the loss of A/C to the facility. Hollywood Hills management did not provide any written instructions to the staff on how to conduct rounds or monitor residents with respect to the loss of A/C.

Hollywood Hills Failed to Meet the Standard of Care

198. It is a nursing home's responsibility to ensure its residents are provided a safe and comfortable environment. Hollywood Hills failed to protect and ensure appropriate health care services to the residents in its care during the loss of A/C to the facility after Hurricane Irma.

199. Hollywood Hills management team failed to adequately coordinate and to discuss the situation, plan patient care, and evaluate the residents. The medical documentation shows that staff was not monitoring the effects of the heat on the vulnerable residents who were completely dependent on staff for daily living support and mobilization. Prolonged environmental heat exposure and heatstroke is preventable, and Hollywood Hills

failed to take the appropriate steps to prevent the numerous deaths and suffering of its residents.

CONCLUSIONS OF LAW

200. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. See §§ 120.60, 120.569 and 120.57, Fla. Stat.

201. As a licensed nursing home in the State of Florida, Hollywood Hills is subject to the requirements of part II, chapter 400, and part II, chapter 408, Florida Statutes.

202. Counts I through III of the four count Amended Complaint seek the imposition of administrative fines totaling $37,500.00 and assessment of costs related to the investigation and prosecution of the Amended Complaint. In Count IV, AHCA seeks to revoke Hollywood Hills' nursing home license.

203. AHCA bears the burden of proving the allegations in its Amended Complaint by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 933-34 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 29 (Fla. 1987).

204. Clear and convincing evidence requires that:

> [T]he evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and lacking in confusion as to the facts in issue. The evidence must be of such a weight that it produces in the mind of the trier of fact a

> firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005) (quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

205. AHCA met its burden of proving by clear and convincing evidence that Hollywood Hills' actions and inactions in the wake of Hurricane Irma violated Florida law and led to or contributed to the death of multiple residents.

206. The statutes regulating nursing homes provide for classification of deficiencies identified by the agency. Section 400.23 provides:

> (8) The agency shall adopt rules pursuant to this part and part II of chapter 408 to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency. The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the

deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency.

Count I

207. Count I of the Amended Complaint alleges that Hollywood Hills violated section 400.141(1)(h) by failing to maintain the facility premises and equipment and by failing to conduct its operations in a safe and sanitary manner. The agency also alleges that Hollywood Hills violated Florida Administrative Code Rule 59A-4.122, by failing to provide a safe, clean,

comfortable, and homelike environment, including comfortable and safe room temperatures.

208. Section 400.141(1)(h) provides that every licensed facility shall comply with all applicable standards and rules of the agency and shall maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.

209. Rule 59A-4.122, provides:

> (1) The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible.
>
> (2) The licensee must provide:
>
> (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
>
> * * *
>
> (e) Comfortable and safe room temperature levels in accordance with 42 CFR, Section 483.15(h)(6), which is effective October 1, 2014, and is incorporated by reference and available at http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/xml/CFR-2014-title42-vol5-sec483-15.xml; and,
>
> (3) Each nursing home licensee must establish written policies designed to maintain the physical plant and overall nursing home environment to assure the safety and well-being of residents.
> (4) The building and mechanical maintenance programs must be supervised by a person who is knowledgeable in the areas of building and mechanical maintenance as determined by the facility.

(5) All mechanical and electrical equipment must be maintained in working order and must be accessible for cleaning and inspection.

(6) All heating, ventilation and air conditioning (HVAC) systems must be maintained in accordance with the manufacturer's recommendation to ensure they are operating within specified parameters to meet manufacturers' specifications. Operation manuals and as-built drawings must be maintained for equipment installed after June 1, 2015.

210. The evidence established that Hollywood Hills failed to ensure a safe environment for its residents as required by Florida law and the failure to provide a safe environment caused serious injury, harm, impairment, and/or death to multiple residents receiving care in the Hollywood Hills facility. Further, Hollywood Hills violated section 400.141(1)(h) and rule 59A-4.122 by failing to maintain the facility premises and equipment and conduct its operations in a safe manner. AHCA met its burden of proof regarding the allegations in Count 1.

211. Without referencing any authority, Hollywood Hills contends that these are "general standards," which are not applicable in response to a natural disaster. It cites the corresponding rules, which require televisions and radios being tuned to stations of the residents' choosing; and that all mechanical and electrical equipment must be maintained and in working order. According to Hollywood Hills, "the question therefore, is whether Hollywood Hills acted reasonably in terms

of providing a safe and comfortable physical environment for its residents within the context of a natural disaster." As discussed in detail above, the answer is clearly "no."

212. AHCA did not cite Hollywood Hills for trivial matters, such as failure to meet radio or television operations standards. It cited the facility due to the unprecedented level of deaths and an MCI. Hollywood Hills created an unsafe environment by: (1) failing to have adequate cooling available; (2) failing to properly monitor the building temperature; and (3) venting the spot coolers in an unsafe manner.

213. The violation constitutes a Class I "patterned" deficiency pursuant to section 400.23(8)(a). The administrative fine of $12,500 sought in Count I of the Amended Complaint is appropriate for this violation. See § 400.23(8)(a), Fla. Stat.

Count II

214. Count II of the Amended Complaint alleges that Hollywood Hills violated section 400.022(1)(l) by failing to ensure that its residents received adequate and appropriate health care and protective and support services consistent with the resident care plan, and with established and recognized practice standards within the community.

215. Section 400.022(1)(l) provides:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the

> residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
>
> * * *
>
> (*l*) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

216. Hollywood Hills failed to comply with the above-quoted statutory mandate to provide adequate and appropriate health care and protective and support services. Hollywood Hills' actions violated the rights of numerous vulnerable and medically fragile residents, particularly those who resided on the second floor of its facility, by failing to provide a safe environment. The evidence clearly and convincingly demonstrates Hollywood Hills failed to properly monitor and hydrate its residents as temperatures continued to rise in the building, thus failing to provide appropriate health care and protective services. Hollywood Hills also failed to evacuate the premises when it became clearly uncomfortable and dangerous to the well-being of the patients.

217. This violation of section 400.022(1)(l) constitutes a Class I deficiency pursuant to section 400.23(8)(a) because

Hollywood Hills failed to ensure a safe environment for its residents and the noncompliance caused serious injury, harm, impairment, and/or death to multiple residents receiving care in the Hollywood Hills' facility. The administrative fine of $12,500 sought to be imposed by AHCA is appropriate for this violation.

Count III

218. Count III of the Amended Complaint alleges that Hollywood Hills' intentional and/or negligent acts materially affected the health and safety of its residents resulting in the death of multiple residents and placing many other residents in harm's way in violation of section 400.102(1) and (4).

219. Section 400.102 provides, in pertinent part:

> In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:
>
> (1) An intentional or negligent act materially affecting the health or safety of residents of the facility;
>
> * * *
>
> (4) Fraudulent altering, defacing, or falsifying any medical or nursing home records, or causing or procuring any of these offenses to be committed.

220. AHCA met its burden of proof regarding this allegation in Count III of the Amended Complaint. The evidence established that the staff of Hollywood Hills was negligent in failing to

maintain acceptable temperatures in the facility, negligently venting the spot coolers, failing to adequately monitor its residents given the conditions, and failing to timely evacuate its residents. These failures negatively affected the health and safety of its residents and led or contributed to the death of multiple residents.

221. The evidence also establishes that Hollywood Hills violated section 400.102(4) by virtue of the falsification of its nursing home records. The facility did not document the care the facility claims to have provided. Moreover, numerous entries in the nursing home records are clearly erroneous and not supported by video evidence. AHCA demonstrated that these entries by Hollywood Hills staff were falsified.

222. Pursuant to section 400.23(8)(a), Hollywood Hills' violations of section 400.102 constitute Class I deficiencies because of the serious injury, harm, impairment, and/or death to residents. The administrative fine of $12,500.00 sought to be imposed by AHCA is appropriate for these violations. See § 400.23(8)(a), Fla. Stat.

Count IV

223. In Count IV of the Amended Complaint, AHCA seeks revocation of the Hollywood Hills license pursuant to sections 400.121 and 408.815.

224. Section 400.121 provides authority for AHCA to revoke a license and states, in pertinent part:

> (1) The agency may deny an application, revoke or suspend a license, and impose an administrative fine, not to exceed $500 per violation per day for the violation of any provision of this part, part II of chapter 408, or applicable rules, against any applicant or licensee for the following violations by the applicant, licensee, or other controlling interest:
>
> (a) A violation of any provision of this part, part II of chapter 408, or applicable rules; or
>
> * * *
>
> (3) The agency shall revoke or deny a nursing home license if the licensee or controlling interest operates a facility in this state that:
>
> * * *
>
> (c) Is cited for two class I deficiencies arising from unrelated circumstances during the same survey or investigation; or
>
> * * *
>
> The licensee may present factors in mitigation of revocation, and the agency may make a determination not to revoke a license based upon a showing that revocation is inappropriate under the circumstances.

225. Section 408.815(1) provides, in pertinent part:

> (1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:

* * *

(b) An intentional or negligent act materially affecting the health or safety of a client of the provider.

(c) A violation of this part, authorizing statutes, or applicable rules.

226. In Count IV of the Amended Administrative Complaint, the Agency alleged that Hollywood Hills: (1) violated part II, chapter 400, and part II of chapter 408, Florida Statutes, or the applicable rules; (2) was cited for two class I deficiencies arising from unrelated circumstances during the survey or investigation;[12/] and (3) committed an intentional or negligent act materially affecting the health or safety of a client of the provider.[13/]

227. AHCA met its burden of proof with respect to the allegations in Count IV. The clear and convincing evidence established that Hollywood Hills committed three Class I deficiencies by violating provisions of part II, chapter 400, Florida Statutes, as set forth in Counts I through III, including an intentional or negligent act materially affecting the health and safety of the facility's residents.

Conclusion

228. A confluence of unfortunate circumstances resulted in the deteriorating conditions at Hollywood Hills on September 12 and 13, 2017. The unprecedented and widespread power outages

caused by Hurricane Irma, the lack of prioritization and a timely response by FP&L, an inexperienced Bravo team left on duty after the storm passed, inadequate backup cooling systems, and the improper venting of the spot coolers culminated in a crisis at Hollywood Hills. However, ultimately the patients were dependent on Hollywood Hills to recognize the danger and to keep them safe. The exacerbation of underlying medical conditions of extremely vulnerable patients by ongoing and increasing environmental heat exposure after the loss of A/C on September 10, 2017, was foreseeable and preventable. Properly monitoring of the patients' temperatures and a timely evacuation could have avoided this catastrophe.

229. Pursuant to section 400.121(1) and (3), and 408.815(1)(b), it is concluded that Hollywood Hills' nursing home license should be revoked.

230. The gravity of the harm done to multiple residents strongly outweighs any mitigating factors that might be considered against revocation. See Bayou Shores SNF, LLC, d/b/a Rehab. Ctr. of St. Petersburg v. AHCA, AHCA Case No. 2015000096 (AHCA Final Order, Aug. 30, 2016), aff'd, 240 So. 3d 666 (Fla. 2d DCA 2017)(per curiam)(revoking a nursing home's license after being cited for three Class I deficiencies, including the "failure to have end-of-life decisions as reflected in a signed [Do Not Resuscitate] order; failure to safeguard residents from a

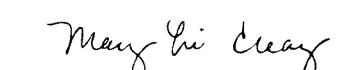
sexual offender; and failure to prevent a resident from leaving undetected and wandering outside the facility").

231. Because AHCA met its burden of proof relative to Counts I through III, administrative fines totaling $37,500.00, as well as an award of costs related to the investigation and prosecution of the case, are also appropriate. See §§ 400.23 and 400.121(8), Fla. Stat.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order revoking Hollywood Hills' license for its nursing home facility, and assessing fines totaling $37,500.00, as well as the costs of the investigation.

DONE AND ENTERED this 30th day of November, 2018, in Tallahassee, Leon County, Florida.



MARY LI CREASY
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of November, 2018.

ENDNOTES

[1/] The Saffir-Simpson Hurricane Wind Scale is a 1 to 5 rating based on a hurricane's sustained wind speed. This scale estimates potential property damage. Hurricanes reaching Category 3 and higher are considered major hurricanes because of their potential for significant loss of life and damage.

[2/] Hollywood Hills tried to rent 20 spot coolers but was only initially able to obtain ten spot coolers because supplies were limited.

[3/] Hollywood Hills was never under a mandatory evacuation order.

[4/] Although Hollywood Hills' ice-makers were operational, the facility was under a boil water precaution that precluded it from using the ice from the ice machines.

[5/] Hollywood Hills staff claim that temperatures were monitored in the facility throughout Tuesday, September 12, 2017, until 11:00 p.m. and that they believed the building was maintaining and had not exceeded 80 degrees. However, the testimony demonstrated that Mr. Carballo had no thermometer with him on Tuesday, and he only checked the temperatures displayed on the spot coolers. This location, directly on the machine, near the cooling vent, certainly is not a representation of what the temperatures in the patient's rooms must have been. Notably, the last temperatures purportedly taken by Mr. Williams on the second floor were at approximately 4:00 p.m. on September 12, 2017.

[6/] First responders triaged the residents based on signs of heat-related conditions, such as mental status, physical exam, and a quick assessment to decide who needed critical care. Medical personnel used color-coded bands to identify the condition of the patient. Red was used for patients in critical condition in need of immediate care. A yellow band indicated the patient did not have a life-threatening condition, but needed medical attention. Green bands meant the patient was stable and could wait for reassessment by medical personnel. A black band indicated the patient was deceased.

There were numerous residents identified as red by first responders. Dr. Katz, present during the triaging of the residents, testified that he observed approximately 20 residents identified in critical condition and given red bands. Any resident that was a red or a yellow code was immediately taken to MRH's emergency room to receive care. Over 100 residents

received care in the MRH emergency department after the triage process was complete. Of these residents, 34 were admitted to MRH Hospital. Roughly 70 residents had to be moved to other local hospitals to receive the care they needed.

First responders ensured that the residents triaged outside were stationed in areas shaded from the sun. Medical personnel from MRH performed a second triage of the green coded residents to assess vital signs, glucose, blood sugar, oxygen saturation, and other important data. This process continued until the building was completely evacuated. The green coded residents were ultimately moved to the shade of a nearby MRH parking garage, purposefully away from direct contact with the sun. The parking garage was equipped with fans and cold water, which were distributed to residents to mitigate the effects of the heat they had been exposed to inside the building. Later, the green coded residents were taken to MRH's air-conditioned auditorium until an appropriate transfer destination to another facility, or with family members, was determined.

Hollywood Hills' staff members did not provide initial documentation or medical records regarding patient assessments that they had been doing in the time leading up to the evacuation of the facility. Ultimately, the facility records were made available to the medical personnel at MRH.

[7/] As used by the ME, "cause of death" refers to the medical condition, disease, or injury that leads to death. "Manner of death" refers to whether the death is natural, homicide, suicide, accidental (unforeseen), or undetermined.

[8/] Dr. Jeffrey Jentzen is an expert pathologist and medical examiner, with over 30-years' professional experience. Dr. Jentzen is a co-author of the National Association of Medical Examiner Guidelines for Classification of Manner of Death in Heat Related Illnesses ("Guidelines") and has reviewed over 100 heat-related deaths.

[9/] Mr. Crawford conducted a separate load capacity analysis that accounted for the effect of the heat discharged from the spot coolers. This heat added to the load capacity necessary to maintain a temperature of 81 degrees, particularly on the second floor. Mr. Crawford's analysis was very conservative and did not account for any added heat from the spot coolers on the second floor--which were not all properly ventilated and also likely added some heat. Factoring in the heat from the first floor spot coolers, Mr. Crawford concluded that the cooling capacity needed

on the second floor during the hottest part of the day on September 11 and 12, 2017, was 23.6 and 24.9 tons, respectively.

For the first floor, Mr. Crawford's conservative analysis concluded that the cooling capacity needed to maintain 81 degrees during the hottest part of the day on September 11 and 12, 2017 was at least 12.9 and 11.8 tons, respectively. The clear and convincing evidence established that Hollywood Hills did not have anything close to enough cooling capacity to maintain 81 degrees on the second floor, particularly given the impact of the discharged heat from the first floor spot coolers.

Hollywood Hills' failure to reject the heat to non-confined space resulted in the discharged heat remaining in the confined space of the facility. The discharged heat eventually either recirculated into the first and second floors or, for the first floor spot coolers, traveled to the second floor.

[10/] Prior to September 13, 2017, there are no progress notes in the facility records regarding Resident 1's condition since August 29, 2017, at 12:33 p.m. An entry by Althia Meggie indicates that on September 13, 2017, Resident 1 was in respiratory distress at 4:25 a.m. However, HFR and MRH records document that Resident 1 arrived to MRH at 3:29 a.m. Thus, Resident 1 was not even in the Hollywood Hills facility at 4:25 a.m. as recorded by Hollywood Hills staff.

Moreover, after Ms. Meggie's initial entry on September 13, 2017, two more "late entries" were made for Resident 1 that are clearly copied and, in some aspects, inconsistent with the previous entry made for Resident 1. The two late entries for Resident 1 were made on September 14, 2017, at 7:43 p.m. and 8:17 p.m., the day after her death. The late entries on September 14, 2017, contain exact verbiage and typos from the progress notes for Resident 2. Clearly, somebody from Hollywood Hills inaccurately copied progress notes for one resident and replicated them as documentation of observations for another resident.

The late entry recorded for Resident 1 on September 14, 2017, at 8:17 p.m. stating Resident 1 was in "stable condition" when she was transported to MRH by HFR, is not consistent with the videos and HFR run reports that reveal Resident 1 was clearly in severe distress upon transfer. Video surveillance footage further shows that from 7:00 p.m. on September 12, 2017, to

3:09 a.m. on September 13, 2017, none of the Hollywood Hills staff members took vital signs or made any assessments of Resident 1.

Tamika Miller recorded a late entry for Resident 4 on September 14, 2017, at 7:42 p.m. and another late entry for Resident 4 on September 14, 2017, at 7:54 p.m. There is no specific date identified as to when the events delineated supposedly occurred. The late entry states that at 4:00 p.m. on some unspecified date, Resident 4 was noted to have cardiac arrest with shallow breathing. This entry is clearly inaccurate. Resident 4 was found dead at 5:45 a.m. on September 13, 2017. Neither the video footage nor the HFR records support a claim that he went into cardiac arrest at 4:00 a.m. and certainly not 4:00 p.m. on September 13, 2017, or any other date.

[11/] AHCA contends that the large gaps in the video are because the cameras were motion-activated and there was no activity on the hallways during the gap periods. However, the expert testimony of HPD Detective Robbie Knapp was not persuasive. He admitted that although the cameras were set to be motion-activated, he could not be certain. Detective Knapp admitted videos of this nature routinely have failures that could be attributable to overheating, a lost WiFi connection, or the camera just missing the motion. Accordingly, the video does not, standing alone, prove a failure to monitor residents. However, as discussed above, neither does it demonstrate active monitoring of the residents.

[12/] The Class 1 deficiency of Count I was premised on the physical environment. AHCA proved Hollywood Hills did not have adequate backup cooling, failed to monitor the building temperatures, and improperly vented the spot coolers.

The Class 1 deficiency of Count II was Hollywood Hills' violation of residents' rights by failing to provide adequate and appropriate health care. This was the result of the failure to monitor, hydrate, and evacuate. Accordingly, the deficiencies of Counts I and II arise from "unrelated circumstances."

[13/] The Agency further alleged that "[o]n September 14, 2017, the Agency issued an Immediate Suspension Final Order immediately suspending the Respondent from the state Medicaid program."

The Immediate Suspension Final Order ("ISFO") suspending Hollywood Hills from the state Medicaid program was affirmed on appeal by the First DCA. The First DCA determined in pertinent

part, that "The order sufficiently alleged an immediate, serious danger to the public health, safety, or welfare. AHCA was statutorily required to suspend the facility's Medicaid participation upon evidence of patient abuse or neglect." The evidence in this proceeding established the factual allegations that the First DCA found sufficient for the ISFO.

However, given the clear and convincing evidence presented by AHCA as to Counts I through III, including a negligent act materially affecting the health and safety of the facility's residents, it is unnecessary to rely on the emergency suspension order as a basis for license revocation.

COPIES FURNISHED:

Stephen A. Ecenia, Esquire
Rutledge Ecenia, P.A.
119 South Monroe Street, Suite 202
Post Office Box 551
Tallahassee, Florida 32301
(eServed)

Geoffrey D. Smith, Esquire
Smith & Associates
3301 Thomasville Road, Suite 201
Tallahassee, Florida 32308
(eServed)

Gabriel F.V. Warren, Esquire
Rutledge Ecenia, P.A.
119 South Monroe Street, Suite 202
Post Office Box 551
Tallahassee, Florida 32301
(eServed)

Tana D. Storey, Esquire
Rutledge Ecenia, P.A.
119 South Monroe Street, Suite 202
Tallahassee, Florida 32301
(eServed)

J. Stephen Menton, Esquire
Rutledge Ecenia, P.A.
119 South Monroe Street, Suite 202
Post Office Box 551
Tallahassee, Florida 32301
(eServed)

Corinne T. Porcher, Esquire
Smith & Associates
3301 Thomasville Road, Suite 201
Tallahassee, Florida 32308
(eServed)

Susan Crystal Smith, Esquire
Smith & Associates
3301 Thomasville Road, Suite 201
Tallahassee, Florida 32308
(eServed)

Stephen B. Burch, Esquire
Smith & Associates
1499 South Harbor City Boulevard, Suite 202
Melbourne, Florida 32901
(eServed)

Timothy Bruce Elliott, Esquire
Smith & Associates
3301 Thomasville Road, Suite 201
Tallahassee, Florida 32308
(eServed)

Jennifer F. Hinson, Esquire
Rutledge Ecenia, P.A.
119 South Monroe Street, Suite 202
Post Office Box 551
Tallahassee, Florida 32301
(eServed)

David Mark Maloney, Esquire
Rutledge Ecenia P.A.
119 South Monroe Street, Suite 202
Tallahassee, Florida 32301
(eServed)

Julie W. Allison, Esquire
Julie W. Allison, P.A.
225 South 21st Avenue
Hollywood, Florida 33020
(eServed)

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Stefan Grow, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Justin Senior, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 1
Tallahassee, Florida 32308
(eServed)

Shena Grantham, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Thomas M. Hoeler, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.