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AGENCY CLERK
2009 OCT 20 A II: 08

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

OAKWOOD NURSING CENTER, INC.,

Respondent.
_______________________________/

DOAH No. 09-0931

AHCA No. 2008012947
2008012950

RENDITION NO.: AHCA-09-1055-S-OLC

FINAL ORDER

Having reviewed the first amended administrative complaint dated March 3, 2009, attached hereto and incorporated herein (Ex. 1), and all other matters of record, the Agency for Health Care Administration ("Agency") has entered into a Settlement Agreement (Ex. 2) with the other party to these proceedings, and being otherwise well-advised in the premises, finds and concludes as follows:

ORDERED:

1. The attached Settlement Agreement is approved and adopted as part of this Final Order, and the parties are directed to comply with the terms of the Settlement Agreement.

2. The Respondent shall pay the Agency an administrative fine of ten thousand dollars ($10,000.00). The administrative fine is due and payable within thirty (30) days of the date of rendition of this Order.

Filed October 20, 2009 3:15 PM Division of Administrative Hearings.

3. Checks should be made payable to the "Agency for Health Care Administration." The check, along with a reference to this case number should be sent directly to:

Agency for Health Care Administration
Office of Finance and Accounting
Revenue Management Unit
2727 Mahan Drive, MS# 14
Tallahassee, Florida 32308

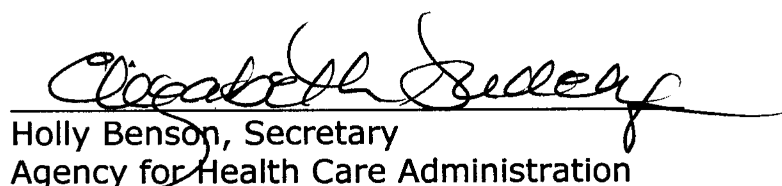
4. Unpaid amounts pursuant to this Order are subject to statutory interest and may be collected by all methods legally available.

5. The Respondent accepts conditional licensure status beginning on October 31, 2009, and ending on November 6, 2009.

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

7. The above-styled cases are hereby closed.

DONE and **ORDERED** this 19 day of October, 2009, in Tallahassee, Leon County, Florida.



Holly Benson, Secretary
Agency for Health Care Administration

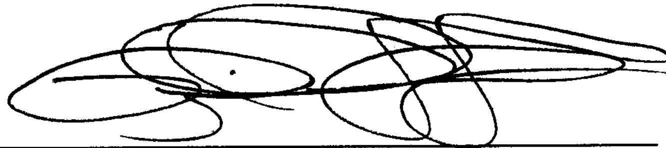
A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY, ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW OF PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

Robert Hagan, President Oakwood Nursing Center, Inc. 2021 SW 1st Avenue Ocala, Florida 344741 (U. S. Mail)	John E. Terrel, Esquire Law Offices of John Gilroy, III, P.A. 1695 Metropolitan Circle Suite 2 Tallahassee, Florida, 32308
Finance & Accounting Agency for Health Care Administration Revenue Management Unit 2727 Mahan Drive, MS #14 Tallahassee, Florida 32308 (Interoffice Mail)	MaryAlice H. David Assistant General Counsel Agency for Health Care Administration 2727 Mahan Drive, Bldg #3, MS #3 Tallahassee, Florida 32308 (Interoffice Mail)
Jan Mills Agency for Health Care Administration 2727 Mahan Drive, Bldg #3, MS #3 Tallahassee, Florida 32308 (Interoffice Mail)	Kriste Mennella Agency for Health Care Administration 14101 NW Hwy 141, Suite #800 Alachua, Florida 32615 (Interoffice Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of this Final Order was served on the above-named person(s) and entities by U.S. Mail, or the method designated, on this the 20th day of October, 2009.



Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Building #3
Tallahassee, Florida 32308-5403
(850) 922-5873

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

OAKWOOD NURSING CENTER, INC.,

Respondent.
_______________________________/

Case No. 09-931
FRAES Nos. 2008012947 (Fine)
2008012950 (Cond.)

FIRST AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration (the "Agency") and files this First Amended Administrative Complaint against OAKWOOD NURSING CENTER, INC. (the "Respondent" or "Respondent Facility"), pursuant to §§120.569 and 120.57, Florida Statutes (2008), and alleges:

NATURE OF THE ACTION

This is an action to change Respondent's licensure status from Standard to Conditional commencing October 31, 2008, and ending November 5, 2008, and to impose an administrative fine in the amount of $20,000.00, based upon Respondent being cited for two State Class II widespread deficiencies and a violation of residents' rights. Specifically, all 62 residents of the Respondent facility were improperly discharged or transferred, in violation of applicable Florida law, and in doing so Respondent intentionally or negligently acted to materially

Filed March 3, 2009 2:20 PM Division of Administrative Hearings.

affect the health or safety of Respondent facility's residents.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60, 400.062, and 408.802(3), Florida Statutes (2008).

2. Venue lies pursuant to Florida Administrative Code R. 28-106.207.

PARTIES

3. The Agency is the regulatory authority responsible for licensure of nursing homes and enforcement of applicable federal regulations, state statutes and rules governing skilled nursing facilities pursuant to the Omnibus Reconciliation Act of 1987, Title IV, Subtitle C (as amended), Chapter 400, Part II, and Chapter 408, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

4. Respondent operates a 133-bed nursing home, located at 2021 SW 1st Avenue, Ocala, Florida 34474 and is licensed as a skilled nursing facility license number 1524096.

5. At all times material to the allegations of this administrative complaint, Respondent was a licensed nursing facility under the licensing authority of the Agency and was required to comply with all applicable rules and statutes.

6. On November 6, 2008, all residents were gone from the Respondent's facility and pursuant to the Respondent's request, Respondent was given an inactive license by the Agency.

COUNT I

7. The Agency re-alleges and incorporates paragraphs one (1) through six (6), as if fully set forth in this count.

8. Section 400.0255, Florida Statutes, requires:

> (1) As used in this section, the term:
> (a) . . .
> (b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.
> (2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.
> (3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.
> (4)(a) Each facility must notify the agency of any proposed discharge or transfer of a resident when such discharge or transfer is necessitated by changes in the physical plant of the facility that make the facility unsafe for the resident.
> (b) Upon receipt of such a notice, the agency shall conduct an onsite inspection of the facility to verify the necessity of the discharge or transfer.
> (5) A resident of any Medicaid or Medicare certified facility may challenge a decision by the facility to discharge or transfer the resident.
> (6) . . .
> (7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's

legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or

(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

(8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department's Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. Further, the form shall state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form shall clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council to review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.

(9) A resident may request that the local ombudsman council review any notice of discharge or transfer given to the resident. When requested by a resident to review a notice of discharge or transfer, the local ombudsman council shall do so within 7 days after

receipt of the request. The nursing home administrator, or the administrator's designee, must forward the request for review contained in the notice to the local ombudsman council within 24 hours after such request is submitted. Failure to forward the request within 24 hours after the request is submitted shall toll the running of the 30-day advance notice period until the request has been forwarded.

(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.

(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.

(c) If the resident fails to request a hearing within 10 days after receipt of the facility notice of the proposed discharge or transfer, the facility may transfer or discharge the resident after 30 days from the date the resident received the notice.

(11) Notwithstanding paragraph (10)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the period of time after the notice is given and before the time a hearing decision is rendered. Notice of an emergency discharge or transfer to the resident, the resident's legal guardian or representative, and the local ombudsman council if requested pursuant to subsection (9) must be by telephone or in person. This notice shall be given before the transfer, if possible, or as soon thereafter as practicable. A local ombudsman council conducting a review under this subsection shall do so within 24 hours after receipt of the request. The resident's file must be documented to show who was contacted, whether the contact was by telephone or in person, and the date and time of the contact. If the notice is not given in writing, written notice meeting the requirements of subsection (8) must be given the next working day.

(12) After receipt of any notice required under this

section, the local ombudsman council may request a private informal conversation with a resident to whom the notice is directed, and, if known, a family member or the resident's legal guardian or designee, to ensure that the facility is proceeding with the discharge or transfer in accordance with the requirements of this section. If requested, the local ombudsman council shall assist the resident with filing an appeal of the proposed discharge or transfer.

(13) The following persons must be present at all hearings authorized under this section:

(a) The resident, or the resident's legal representative or designee.

(b) The facility administrator, or the facility's legal representative or designee.

A representative of the local long-term care ombudsman council may be present at all hearings authorized by this section.

(14) . . .

(15)(a) The department's Office of Appeals Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.

(b) The department shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for fair hearings for other Medicaid cases, chapter 10-2, part VI, Florida Administrative Code. The burden of proof must be clear and convincing evidence. A hearing decision must be rendered within 90 days after receipt of the request for hearing.

(c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed.

(d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

(16) The department may adopt rules necessary to administer this section.

(17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and not by the resident or by

the resident's physician or legal guardian or representative.

9. Rule 59A-4.106(1)(f), Florida Administrative Code, requires:

> (1) Admission, retention, transfer, and discharge policies:
>
> . . .
>
> (f) All resident transfers and discharges shall be in accordance with the facility's policies and procedures, provisions of Sections 400.022 and 400.0255, F.S., this rule, and other applicable state and federal laws and will include notices provided to residents which are incorporated by reference by using AHCA Form 3120-0002, 3120-0002A, Revised, May, 2001, "Nursing Home Transfer and Discharge Notice," and 3120-0003, Revised, May, 2001, "Fair Hearing Request for Transfer or Discharge From a Nursing Home," and 3120-0004, Revised, May, 2001, "Long-Term Care Ombudsman Council Request for Review of Nursing Home Discharge and Transfer." These forms may be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, MS 33, Tallahassee, FL 32308. The Department of Children and Family Services will assist in the arrangement for appropriate continued care, when requested.

10. On or about October 27-31, 2008, the Agency conducted an unannounced Complaint Survey (CCR# 2008011798) at Respondent Facility.

11. Based on record review and interview, the facility failed to provide a 30 day notice of transfer to 62 of 62 residents when facility management decided to close the building. The facility's failure to provide appropriate notice of closure caused widespread and significant psychosocial harm, confusion and grief to both the residents and families.

12. Clinical record reviews of the sampled charts were conducted on 10/17/08 at approximately 12:45 PM. The following were discovered in the records:

12.1. Resident #13's clinical record has a social service note dated 9/24/08 that states "received notice from administrator that resident is transferring to another SNF. Administrator made all the discharge arrangements". A nurse's note on 9/23/08 at 1:30 PM states "Spoke with resident concerning transfer to nursing center in Crescent City. Resident began getting tearful and talking about (unrelated issues) and then (his/her) comments became non-coherent. A call placed to (sibling) left message for (him/her) to call this writer to discuss (his/her sibling)." There are no further entries as to whether or not the facility reached the family member. The MDS assessment dated 9/3/08 coded Resident #13's memory as a problem, and cognitive skills for daily decision making as moderately impaired. There is no 30 day notice in Resident #13's chart. The resident was discharged on 9/24/08.

12.2. In Resident #14's clinical record is a social service note dated 9/26/08 "Received notice that res (resident) transferred to other SNF (nursing home) this date. This SW (social worker) did not participate in (his/her) transfer. Administrator made all the D/C

(discharge) arrangements". There are no nursing notes regarding the transfer. The MDS assessment dated 9/3/08 reports that Resident #14's memory is coded as short term, and long term memory is a problem. The memory recall section is coded as "e," none are recalled, and the ability to understand others is coded as a "3" rarely/never understands. On a Department of Children and Families form required for skilled nursing home placement, there is a note that the family is agreeable to placement of the resident at Respondent Oakwood. The signature on the form is the Director of Nursing's (DON) from a facility in Jacksonville, where the interim administrator for Respondent facility at this time, is also the administrator. There are no notes of the family contact anywhere in the record about this move from Oakwood. A doctor's telephone order dated 9/25/08 states "Discharge to (XYZ nursing center)". The resident's discharge was on 9/26/08. There is no 30 day notice in Resident #14's chart.

12.3. Resident #16's clinical record contains the memorialization of a verbal doctor's order dated 9/19/08 stating "may discharge to (LNC) [nursing home] with meds per family request". A nurse's note of the same date states assisted with transfer to another facility. A

social service note dated 9/16/08 stated "offered Res (resident) & res (sibling) transfer to other SNF per Administrator directive. Res and (sibling) agreed to transfer. DC/ transfer arrangements being made by administrator". The resident was discharged to another facility on 9/19/08. There is no 30 day notice in Resident #16's chart.

12.4. In Resident #17's clinical record there is a social service progress note signed by the social worker dated 9/24/08 that states "received notice from the administrator that Res transferring to another SNF. This SW did not participate in this Res D/C plan. Administrator made all the D/C arrangements." The MDS Quarterly assessment form dated 7/23/08 under cognitive skills for daily decision making is coded as a "1," modified independence and some difficulty in new situations. Under ability to understand others, he/she is coded as a "1," that he/she usually understands, may miss some part or intent of the message. A nurse's note dated 9/24/08 at 12:30 PM states resident transferred to (LNC) via van and (LNC) staff." Again, the Department of Children's and Families form (3008) required for skilled nursing home placement is signed by the DON from the Jacksonville facility. This form has checked that the resident is

confused, wanders, and is disoriented under the section of mental and behavior status. On the face sheet of this record, a family member and a phone number are listed. There is no mention of any attempts to contact the family member or prepare this resident for discharge. This resident was transferred on 9/24/08. There is no 30 day notice in Resident #17's chart.

12.5. The Assistant Director of Nursing (ADON) was interviewed on 10/17/08 at 2:00 PM about why the above residents were transferred to a different facility. She explained that she knew nothing of the reason for transfer, just that they were moving to another facility.

12.6. At 2:30 PM on 10/17/2008, the Agency surveyor conducted an interview with the previous interim administrator, who explained he is also the regional supervisor for the management company's other facilities in this area, regarding the recent resident transfers. The interim administrator was asked when the anticipated change in ownership with the new company was expected to be completed. He said the target date was November 15 2008. When asked why the residents were selected to be moved, he replied that he was told the facility would be under construction, and therefore he instructed his staff to ask all the residents if they wanted to move to the other

facilities. The staff was to tell the residents that they were undergoing a change of ownership, and the staff were to ask each resident if they wanted to stay or transfer. He was asked if all families where involved in the transfer, and he responded he was told they were. He was unable to explain why there was no transfer planning, and why there were no discharge notices that could be reviewed by the Agency survey team.

13. In an interview on 10/28/2008 with the Agency surveyor the interim administrator at 1:10PM revealed that residents were being discharged, and she was not included in the plans. She indicated all discharges were being handled by another administrator from the management company and his Director of Nursing (DON) and Licensed Practical Nurse (LPN). She confirmed that the other administrator fired the Social Worker the prior night (10/27/2008), and no discharge planners were in the facility:

13.1. Interview with Resident #22 on 10/28/2008 at 1:20PM revealed that he/she had been notified Monday, 10/27/08, that the building was closing and he/she would have to move. He/She began to cry and indicated that his/her parent had been there and took the notice home, but were told they needed to move immediately by the administrator in a meeting that had occurred at 1:00 PM on

Monday, 10/27/2008. Resident #22 was very upset and crying. He/She expressed how he/she was unsure where he/she would go and stated that no one had provided him/her or his/her parent with discharge planning.

13.2. Interview with Resident #23's parent (88 years old) on 10/28/2008 revealed he/she had received a call from the LPN from the management company indicating that he/she had to have his/her adult child out of the facility by 12:30 PM that day (10/28/2008). Resident #23's parent became upset and began to cry indicating that he/she did not know what to do and was afraid the facility would put his/her child out on the street. He/She indicated that no one was assisting him/her to find another placement.

13.3. Interview with Resident #24 on 10/28/2008 at 1:45PM revealed that he/she never received written notice of discharge and that he/she was attempting to get in touch with family in California so they could contact his/her grandchildren in Florida to assist him/her since the facility was not providing assistance. He/She indicated he/she wanted to go to another city closer to his/her grandchildren, but had not been provided discharge planning or assistance.

13.4. Interview with Resident #20's spouse at 2:00

PM on 10/28/2008 revealed that his/her adult child, who is Resident #20's Power of Attorney (POA), received a letter that day indicting the facility was closing and that he/she had to come down to the facility and pick Resident #20 up that day. The spouse was very upset and confused and asked who could help him/her as he/she needed to take Resident #20 home, but that he/she could not care for him/her.

13.5. Interview with the Administrator from another Skilled Nursing Facility (SNF), at 2:25 PM on 10/28/2008 revealed that he/she had brought in his/her discharge planners to assist residents with moving as he/she had been told they had to be out of the facility in a "few days."

13.6. Interview with Resident #25 on 10/28/2008 at 2:30 PM revealed he/she received his/her notice for discharge on 10/24/08 and signed the form. At this time, he/she had requested to stay in the area and was told by the nursing home management staff that he/she would be going to another city. Observation on 10/28/2008 at 4:00 PM of a handmade discharge board in the office being utilized by the management company's staff confirmed that Resident #25 was going to be sent to a SNF in another city.

13.7. Telephone interview with the spouse of Resident #26's power of attorney (POA) on 10/28/2008 at

2:38 PM revealed they had just received a call from the facility indicating that it was being closed and that Resident #26 would be moved today or tomorrow. He/She expressed the shock and upset caused by the sudden news and the lack of prior notification and planning. He/She indicated he/she wanted Resident #26 to stay in the area to be close to them, but would move him/her wherever he/she would get the best care. He/She asked what their rights were and if they (the facility) could kick him/her out so quickly.

13.8. Interview with Resident #4's spouse on 10/28/2008 at 3:00PM revealed that he/she comes to the facility daily and that he/she was told Monday, 10/27/2008 that the facility was closing by a resident who greeted him/her on his/ her way into the building. He/She spoke with staff, who were very upset, and was notified about a meeting the management company was having at 1:00 PM that afternoon (10/27/2008). He/She indicated he/she had attended the meeting which had only 12 residents present, and he/she was the only family member and was conducted by the management company's staff (Administrator and LPN). Resident #4's spouse indicated that at this time he/she was told that the facility would try to help the alert and oriented residents find placement, but that everyone had to

be out before November 15, 2008. He/She indicated that they pressured the residents and him/her to move immediately. At this point, he/she began to cry and indicated that since he/she had visited his/her spouse in this facility everyday for 3 years that he/she felt as if they were being kicked out of their home. He/She stated that the facility always had problems, but that the staff treated people like family, and he/she had no idea why this discharge was conducted in this manner.

13.9. Interview with Licensed Practical Nurse (LPN) #1, on 10/28/2008 at 3:30 PM revealed that staff was being told by the management company staff to pack up residents belongings and get them onto vans. She indicated that 6 people had been discharged that morning alone to the other Nursing Homes in Florida owned by the same management company. She indicated that she had stopped the transfer of Resident #29 that morning as the resident was going to be transported to a SNF in another city owned by the management company, but had begun to cry and asked that his/her sibling be called first. The staff person indicated she called the sibling who knew nothing of the facility closing or where Resident #29 was being taken. As the resident was upset, LPN #1 held Resident #29 back from being moved and did not put him/her on the van.

14. Interview with the Administrator from the management company and his LPN on 10/28/2008 at 4:00 PM revealed that the 30 day closure notice was mailed October 24, 2008 to all responsible parties. Review of the discharge notice revealed it to indicate the discharge date to be November 23, 2008. The Administrator confirmed the lack of a social worker or discharge planners. He asked if the other facilities could just use their people to do the discharge planning. He was told the regulations indicate the facility itself is responsible to notice and to provide adequate discharge planning and social services. He indicated that a discharge planner from another of his facilities would be at the facility by 8:00 AM on 10/29/2008 to do the discharge planning. When questioned about the meeting on Monday, he indicated that he had determined the date of November 15, 2008, for everyone to be moved as the facility was scheduled for termination effective November 22, 2008. A second review of the discharge notice revealed that the facility could not be opened the required 30 days as they had indicated in the notices sent to residents and responsible parties as the notice indicates a discharge date of November 23, 2008, and the facility would be forced to close November 22, 2008. The Administrator confirmed that calls were made to families. Interview at this time with the LPN revealed she called several families and noticed them that the facility was closing, and

that if they asked for a few days she would agree. The Administrator and LPN were unable to provide any documentation that any discharge planning had been done in advance to prevent the confusion created by the sudden notice or that social services were provided to assist residents with transition.

14.1. At 9:20 am on 10/29/2008 a telephone call was received from Resident #23's parent. He/She indicated he/she was very upset. He/She stated that the facility management was sending his/her adult child to another SNF without his/her knowledge, and that he/she did not want the child to go there.

14.2. Interview with Resident #30 at 9:30AM on 10/29/2008 revealed that no one told him/her about being moved, where he/she would be moving to, or even asked where he/she would like to go. He/She indicated he/she very upset.

14.3. Interview on 10/29/2008 at 9:45 AM with Resident #3 revealed that he was willing to transfer to another facility, however, he/she stated he/she was on hospice, and that the chaos that was happening was making his/her blood pressure shoot up and he/she had to ask for an anti-anxiety pill to help calm him/her down.

14.4. A brief interview with Resident #31's family member on 10/29/2008 at 10:20 AM revealed that he/she had

just received the letter, and that, "they (facility management) aren't explaining anything". He/she indicated he/she was very upset and confused by the situation and how it was being handled.

14.5. During Interview with alert and oriented Resident #32 on 10/29/2008 at 11:00 AM, he/she revealed that at this time he/she had no idea where he/she was going to move and the facility had not provided assistance at this point to assist in his/her transfer.

14.6. Observation on 10/29/2008 at approximately 1:00 PM revealed Resident #2's parent seated at his/her bedside with a Certified Nursing Assistant (CNA) packing the resident's belongings. At this time, Resident #2's parent stated: "They were going to send (Resident #2) to south Florida without telling me." He/She stated a facility staff person made a sneak call to him/her, and he/she come over right away. The parent indicated that Resident #2 had 3 children and needed to remain in this area so that he/she and the children could visit. The parent appeared distraught, confused and upset.

14.7. Interview at 2:00 PM on 10/29/2008 with Resident #24's POA revealed that he had received a call from his/her parent indicating that he/she was moving to another city. Resident #24's POA stated that he/she knew

nothing of the move and had the resident removed from the van as the facility was attempting to transport his/her parent when he/she arrived. He/she indicated that facility management had said they obtained approval for the move from his/her sibling who lived in California. The POA indicated he/she was very upset and wanted answers about how this could happen without his/her knowledge.

14.8. Observation by an Agency surveyor on 10/30/2008 at 8:50 am revealed Resident #33 nude, in bed, with just a sheet covering him/her. Interview with Resident #33 at this time revealed that he/she was extremely upset about moving. He indicated that his/her child had made him/her the bookshelf observed in the room. The resident indicated that facility management had informed him/her that he/she could not bring the bookshelf with him/her as it did not fit into the van. He/she stated that he/she would not move without the bookshelf. When asked if he/she was aware he/she had up to 30 days to move, he/she indicated that he/she was not told that; but that he/she would then just "sit there" for 30 days and move with the bookshelf.

15. Interview on 10/30/2008 at 9:20 am with the two Social workers from the management company's other facilities revealed that they did not know the residents as they had never worked in

the building and that they did not have a current list of where and when residents were or would be transferred.

16. On 10/30/2008 at 3:30 pm, interview with the Interim Administrator revealed that another resident had informed her that Resident #20's spouse had the resident in his/her car and was taking him/her home. The Interim administrator indicated that the spouse was unable to care for Resident #20 as he/she would most likely require some personal assistance or placement very soon. She indicated she had to physically chase down the car and stop the spouse to have Resident #20 returned to the facility. She indicated that neither staff nor management could explain how Resident #20's spouse had been able to remove the resident from the building.

17. In an interview with the Advance Registered Nurse Practioner (ARNP) who provides services for the medical director on 10/30/2008 at 4:00 PM, the ARNP told the Agency surveyor that her residents were very upset and that the course chosen by facility management to transfer the residents was not an appropriate method or in the best interests of the residents as no preparations had been made. She indicated that staff members who provide care are being told very little by the management; therefore they are unable to assist the residents with the transfer process.

18. The Agency determined that Respondent's failure to

provide residents with adequate notice of discharge or transfer and failure to otherwise comply with the requirements of Florida law regarding resident transfer and discharge was widespread, effecting all 62 residents of Respondent's facility and compromised each resident's ability to maintain or reach his or her highest practicable physical, mental and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care and provision of services and cited this deficient practice as a widespread State Class II deficiency.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $7,500.00 against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23, Florida Statutes (2008).

COUNT II

19. The Agency re-alleges and incorporates paragraphs one (1) through six (6) and eleven (11) through seventeen (17), as if fully set forth in this count.

20. Section 400.022, Florida Statutes, requires:

> (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.

. . .

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) . . .

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice. A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes. Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable. Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

. . .

(3) Any violation of the resident's rights set forth in this section shall constitute grounds for action by the agency under the provisions of s. 400.102, s. 400.121, or part II of chapter 408. In order to

> determine whether the licensee is adequately protecting residents' rights, the licensure inspection of the facility shall include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards, and consultation with the ombudsman council in the local planning and service area of the Department of Elderly Affairs in which the nursing home is located.

21. On or about October 27-31, 2008, the Agency conducted an unannounced Complaint Survey (CCR# 2008011798) at Respondent Facility.

22. Based on record review and interview, the facility violated residents' rights by failing to provide at least 30 days prior notice of transfer to 62 of 62 residents, when facility management decided to close the building.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $5,000.00 against Respondent, a skilled nursing facility in the State of Florida, pursuant to §§ 400.121 and 400.102, Florida Statutes (2008).

COUNT III

23. The Agency re-alleges and incorporates paragraphs one (1) through six (6) and eight (8) through nineteen (19), as if fully set forth in this count.

24. Section 400.102(1)(a), Fla. Stat. (2008), provides: "(1) Any of the following conditions shall be grounds for action by the agency against a licensee: (a) An intentional or

negligent act materially affecting the health or safety of residents of the facility; . . ."

25. Rule 59A-4.122, Florida Administrative Code, requires:

> (1) The facility shall 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 facility shall provide:
> (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
> (b) Clean bed and bath linens that are in good condition;
> (c) Private closet space for each resident;
> (d) Furniture, such as a bed-side cabinet, drawer space;
> (e) Adequate and comfortable lighting levels in all areas;
> (f) Comfortable and safe temperature levels; and
> (g) The maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the residentwill be tuned to stations of the resident's choice.

26. On or about October 27-31, 2008, the Agency conducted an unannounced Complaint Survey (CCR# 2008011798) at Respondent Facility.

27. Based on observation, interview and review of facility documentation, the facility provided a substandard living environment and created an atmosphere of anxiety, confusion and emotional pain by failing to provide adequate, appropriate and required medically related social services, discharge planning and discharge notice to 62 of 62 residents. As a result of this widespread problem, residents and family member were confused,

expressed emotional grief and confusion due directly to the condition of the facility itself, lack of proper notice and lack of adequate, organized discharge planning after the facility determined to close the building.

28. During an in depth tour of the facility on 10/16/08 commencing at 10:00 AM and continuing throughout the day until 6:00 PM, the following interviews and observations were made:

28.1. Interview conducted with Resident #11 on 10/16/08 at 10:30 AM revealed that on 10/13/08, his/her bed was replaced with a bed that was not as comfortable as his/her prior bed. Continued interview with the resident revealed that he/she was not given a reason for the bed change. Further interview with the resident on the same date and time revealed that his/her air conditioner was removed and replaced with a different unit, and, again, Resident #11 was provided no explanation for the change. Observation of the air conditioning unit on the same date and time revealed an air conditioner with 3" gray duct tape apparently taping the unit to the surrounding wall area.

28.2. Continued interview with the resident on the same date and time revealed that on 10/13/08, the 3 comfortable chairs and settee that were in the television viewing area on the 200 wing had been removed and replaced with straight back chairs with no arms, which the resident

stated were uncomfortable and caused his/her back to hurt. Due to not being comfortable, the resident stated that he/she no longer spends time in the area.

28.3. Interview conducted with Resident #2 on 10/16/08 at 11:30 AM with the assistance of the unit LPN (Licensed Practical Nurse) the resident agreed that his/her bed had been replaced 2 days earlier and was given no explanation. Observation of the air conditioning unit in his/her room revealed an air conditioning unit in the wall that appeared to be anchored in place by 3" gray duct tape around the entire conditioning unit.

28.4. Interview conducted with Resident #6 on 10/16/08 at 2:00 PM revealed that the prior seating in the television viewing area had been moved out and straight back chairs moved in, in their place. Further interview with the resident revealed that he/she doesn't see residents watching television as much as they used to in the past.

28.5. Gray duct tape anchoring air conditioners into the resident's bedroom walls were identified in the following resident rooms: 204, 206, 220, and 230. Rooms 208, 210 and 226 had no air conditioning units in the area where units had previously been and had been replaced by plywood and duct tape securing the areas.

28.6. A chest of drawers in room 256 was missing large areas of the wood finishing and also missing a drawer knob.

28.7. Room 254, 2 stained bedroom ceiling tiles were observed.

28.8. The lavatory sink was not secured to the pedestal base in room 144.

28.9. The lavatory cabinet of room 228, was missing numerous areas of paint. The adjacent wall to the lavatory had a 6" area of missing sheet rock along the wall. The ceiling of the resident's room had 2 stained ceiling tiles. There was an area observed above the resident's room mirror with no paint measuring 12" X 18". The bathroom floor tiles were discolored with a brownish crusty substance.

28.10. The bathroom in room 204 had a broken ceiling light cover.

28.11. The baseboard in the bathroom of room 220 was loose from the wall. The baseboard and wall covering in the resident's bedroom area was buckled extending 8" from the floor.

29. The above listed failures to maintain the physical environment of the Respondent facility were part of a widespread practice throughout the facility to remove equipment and

furniture and not replace the equipment or furniture or to replace the equipment or furniture with substandard equipment or furniture in preparation for closing the facility.

30. The Agency determined Respondent Facility's failure to institute transfer and discharge procedures in accord with the requirements of Florida law and failure to maintain a safe, clean and homelike environment for residents were intentional or negligent acts which materially affect the health or safety of residents of the facility and compromised each resident's ability to maintain or reach his or her highest practicable physical, mental and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care and provision of services and cited this deficient practice as an widespread State Class II deficiency.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of $7,500.00 against Respondent, a skilled nursing facility in the State of Florida, pursuant to §§ 400.23 and 400.102, Florida Statutes (2008).

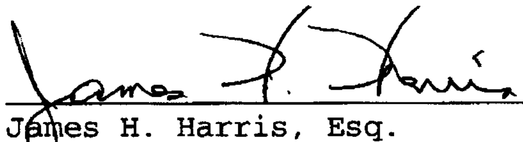
COUNT IV

31. The Agency re-alleges and incorporates paragraphs one (1) through six (6), and Counts I, II and III as if fully set forth in this count.

32. Based upon Respondent's two cited State Class II deficiencies and Respondent's violation of residents' rights,

Respondent was not in substantial compliance at the time of the survey with criteria established under Part II of Florida Statute 400, or the rules adopted by the Agency, a violation subjecting it to assignment of a conditional licensure status under § 400.23(7)(b), Florida Statutes (2008).

WHEREFORE, the Agency intends to assign a conditional licensure status to Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(7), Florida Statutes (2008) commencing October 31, 2008, and ending November 5, 2008.



James H. Harris, Esq.
Fla. Bar. No. 817775
Assistant General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive, 330H
St. Petersburg, FL 33701
727-552-1435

DISPLAY OF LICENSE

Pursuant to § 400.23(7)(e), Fla. Stat., Respondent shall post the most current license in a prominent place that is in clear and unobstructed public view, at or near, the place where residents are being admitted to the facility.

Respondent is notified that it has a right to request an administrative hearing pursuant to Section 120.569, Florida Statutes. Respondent has the right to retain, and be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

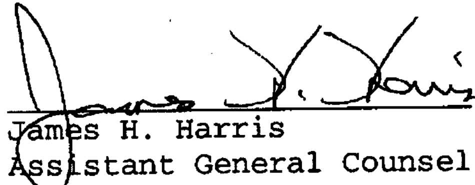
All requests for hearing shall be made to the attention of: ***The Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Bldg #3, MS #3, Tallahassee, Florida, 32308, (850) 922-***

5873.

RESPONDENT IS FURTHER NOTIFIED THAT A REQUEST FOR HEARING MUST BE RECEIVED WITHIN 21 DAYS OF RECEIPT OF THIS COMPLAINT OR WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by regular U.S. Mail to John F. Gilroy, III, P.A., 1695 Metropolitan Circle, Suite 2, Tallahassee, Florida 32308-8722, on March 3, 2009.



James H. Harris
Assistant General Counsel

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA,
AGENCY FOR HEALTH
CARE ADMINISTRATION,

Petitioner,

vs.

DOAH Case No.: 09-0931
Case No(s): 2008012947
2008012950

OAKWOOD NURSING CENTER, INC.,

Respondent.
_______________________________/

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondent, Oakwood Nursing Center, Inc. (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondent is a Skilled Nursing Facility licensed pursuant to Chapter 400, Part II, Florida Statutes, Section 20.42, Florida Statutes and Chapter 59A-4, Florida Administrative Code; and

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondent, pursuant to Chapter 400, Part II, Florida Statutes; and

WHEREAS, the Agency served Respondent with an administrative complaint on or about December 22, 2008, notifying the Respondent of its intent to impose administrative fines

in the amount of $15,000.00, later amended to fines of $20,000.00 and assigned a conditional licensure status commencing October 31, 2008 and ending November 06, 2008; and

WHEREAS, Respondent requested a formal administrative proceeding.

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

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

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

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

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

4. Upon full execution of this Agreement, Respondent agrees to pay $10,000.00 in administrative fines to the Agency within thirty (30) days of the entry of the Final Order. Respondent accepts the assignment of conditional licensure status commencing October 31, 2008 and ending November 06, 2008.

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

6. By executing this Agreement, Respondent neither admits nor denies, and the Agency asserts the validity of the allegations raised in the administrative complaint referenced herein. However, no agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, which constitutes a "repeat" or "uncorrected" deficiency from surveys identified in the administrative complaint. The parties agree that in such a "repeat" or "uncorrected" case, the deficiencies from the surveys identified in the administrative complaint shall be deemed found without further proof.

7. No agreement made herein shall preclude the Agency from using the deficiencies from the surveys identified in the administrative complaint in any decision regarding licensure of Respondent, including, but not limited to, licensure for limited mental health, limited nursing services, extended congregate care, or a demonstrated pattern of deficient performance. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Respondent acknowledges and agrees that this Agreement shall not preclude or stop any other federal, state, or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the administrative complaint. This agreement does not prohibit the Agency from taking action regarding Respondent's Medicaid provider status, conditions, requirements or contract.

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

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

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

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

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

13. In the event that Respondent was a Medicaid provider at the subject time of the occurrences alleged in the complaint herein, this settlement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any sanctions pursuant to Rule 59G-9.070, Florida Administrative Code.

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

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

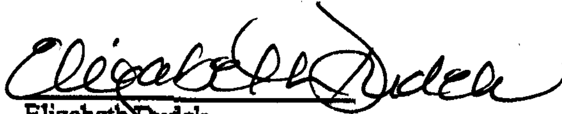
16. This Agreement contains and incorporates the entire understandings and agreements of the parties.

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

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

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

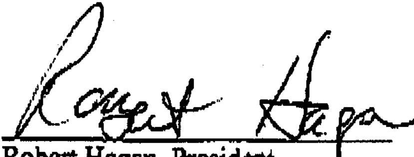
The following representatives hereby acknowledge that they are duly authorized to enter into this Agreement.



Elizabeth Dudek
Deputy Secretary
Agency for Health Care Administration
2727 Mahan Drive, Bldg #1
Tallahassee, Florida 32308
DATED: 10/19/2009

John E. Terrel, Esquire
Law Offices of John Gilroy, III, P.A.
1695 Metropolitan Circle Suite 2
Tallahassee, Florida 32308

DATED: 8/28/09



Robert Hagan, President
Oakwood Nursing Center, Inc.
2021 SW 1st Avenue
Ocala, Florida 344741

DATED: 8/27/09

Justin Senior, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308

DATED: 10/16/09

MaryAlice H. David, Esquire
Assistant General Counsel
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308

DATED: 10 Sept 09