STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

SA-PG-VERO BEACH, LLC d/b/a PALM GARDEN OF VERO BEACH,

Respondent.
_____/

AHCA NO. 2013002508
DOAH NO. 13-2012
RENDITION NO.: AHCA-13 - 831 -S-OLC

FINAL ORDER

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

1. The Agency has jurisdiction over the above-named Respondent pursuant to Chapter 408, Part II, Florida Statutes, and the applicable authorizing statutes and administrative code provisions.

2. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The Election of Rights form advised of the right to an administrative hearing.

3. The parties have since entered into the attached Settlement Agreement. (Ex. 2)

Based upon the foregoing, it is **ORDERED:**

1. The Settlement Agreement is adopted and incorporated by reference into this Final Order. The parties shall comply with the terms of the Settlement Agreement.

2. The Respondent shall pay the Agency $5,000. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

3. Conditional licensure status is imposed on the Respondent beginning on February 15, 2013 and ending on March 15, 2013.

ORDERED at Tallahassee, Florida, on this 26 day of August, 2013.

Elizabeth Dudek, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 26 day of August, 2013.

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Bldg. #3, Mail Stop #3
Tallahassee, Florida 32308-5403
Telephone: (850) 412-3630

Jan Mills Facilities Intake Unit (Electronic Mail)	Finance & Accounting Revenue Management Unit (Electronic Mail)
Andrea M. Lang, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Margaret Chamberlain, Esq. Attorney for Respondent Kitch Drutchas Wagner Valitutti & Sherbrook 2379 Woodlake Drive, Suite 400 Okemos, Michigan 48864 (U.S. Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA,
AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case Nos. 2013002508

SA-PG - VERO BEACH LLC
d/b/a PALM GARDEN OF VERO BEACH
Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration (hereinafter "Agency"), by and through the undersigned counsel, and files this Administrative Complaint against SA-PG - VERO BEACH LLC d/b/a PALM GARDEN OF VERO BEACH (hereinafter "Respondent"), pursuant to Sections 120.569 and 120.57 Florida Statutes (2012), and alleges:

NATURE OF THE ACTION

This is an action against a skilled nursing facility to impose an administrative fine of FIVE THOUSAND DOLLARS ($5,000.00) pursuant to Section 400.23(8)(b), Florida Statutes (2012), based upon two (2) Class II deficiencies and to assign conditional licensure status beginning on February 15, 2013, and ending on March 15, 2013, pursuant to Section 400.23(7)(b), Florida Statutes (2012). The original certificate for the conditional license is attached as Exhibit A and is incorporated by reference. The original certificate for the standard license is attached as Exhibit B and is incorporated by reference.

JURISDICTION AND VENUE

1. The Court has jurisdiction over the subject matter pursuant to Sections 120.569 and 120.57, Florida Statutes (2012).

EXHIBIT 1

2. The Agency has jurisdiction over the Respondent pursuant to Section 20.42, Chapter 120, and Chapter 400, Part II, Florida Statutes (2012).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code.

PARTIES

4. The Agency is the regulatory authority responsible for the licensure of skilled nursing facilities and the enforcement of all applicable federal and state statutes, regulations and rules governing skilled nursing facilities pursuant to Chapter 400, Part II, Florida Statutes (2012) and Chapter 59A-4, Florida Administrative Code. The Agency is authorized to deny, suspend, or revoke a license, and impose administrative fines pursuant to Sections 400.121 and 400.23, Florida Statutes (2012); assign a conditional license pursuant to Section 400.23(2), Florida Statutes (2012); and assess costs related to the investigation and prosecution of this case pursuant to Section 400.121, Florida Statutes (2012).

5. Respondent operates a 180-bed nursing home, located at 1755 37th Street, Vero Beach, Florida 32960, and is licensed as a skilled nursing facility, license number 1415096. Respondent was at all times material hereto, a licensed skilled nursing facility under the licensing authority of the Agency, and was required to comply with all applicable state rules, regulations and statutes.

COUNT I
The Respondent Failed To Ensure Physician Orders Shall Be Followed As Prescribed in Violation Of Rule 59A-4.107(5), Florida Administrative Code

6. The Agency re-alleges and incorporates by reference paragraphs one (1) through five (5).

7. Pursuant to Florida law, all physician orders shall be followed as prescribed, and if not followed, the reason shall be recorded on the resident's medical record during that shift. Rule 59A-4.107(5), Florida Administrative Code.

8. On or about February 11, 2013 through February 15, 2013, the Agency conducted a Licensure Survey of the Respondent's facility.

9. Based on observation, interview and record review, it was determined the facility failed to

follow physician orders for catheter placement, pain medication and skin sweeps for one (1) of twenty eight (28) residents, specifically Resident number ninety six (96), which resulted in significant pain for the resident.

10. Resident number ninety six (96) was admitted on January 7, 2013 with diagnoses to include urinary retention and urethral erosion. An observation was made of Resident number ninety six (96) on February 13, 2013 at 8:30 a.m. and Resident number ninety six (96) was holding his/her hands over his/her genital area.

11. A review of the medical record documented a physician order dated January 25, 2013 for Keflex 250mg by mouth four (4) times daily for seven (7) days for urethral erosion and lidocaine jelly 2% to the urethra as needed four (4) times a day. The February Physician Order Sheet documented; keep the catheter up and taped to abdomen and positioned out of top of pants. There is an order on the Physician Order Sheet for weekly skin assessment due Friday on the 3:00 p.m. to 11:00 a.m. shift.

12. Catheter care was observed on February 13, 2013 at 8:33 a.m. As the Certified Nursing Assistant started to perform the catheter care, Resident number ninety six (96) moved into the fetal position and started moaning and grunting. The Certified Nursing Assistant stated this is normal for Resident number ninety six (96). As the Certified Nursing Assistant moved the resident's scrotum, the left groin area was noted to be bright red and patchy. Resident number ninety six (96) yelled out and tried crossing his/her legs. Resident number ninety six (96) was not asked if he/she was in pain. The Certified Nursing Assistant drew back the foreskin of the penis and it appeared to be bright red and excoriated. The resident was moaning when touched, mumbling "Oh God ". Resident number ninety six (96) kept crossing his/her legs and trying to get back into the fetal position and the Certified Nursing Assistant would reposition the resident onto his/her back to wash the catheter and genital area. At one point, Resident number ninety six (96) lifted his/her head and groaned loudly with a grimace on his/her face and his/her eyes bulging. At this point the

Certified Nursing Assistant asked Resident number ninety six (96) if he/she was in pain. The resident stated "a little ". Lidocaine Jelly 2% was not applied to the urethra. The catheter was then brought out the bottom of the adult brief, not anchored to any anatomical site.

13. In an interview with the Registered Nurse who was providing care for Resident number ninety six (96) on February 13, 2013 at 9:01 a.m., the Registered Nurse stated that she would check the catheter to make sure it is patent and positioned properly. The Registered Nurse checked for exudate on the penis and checked the indwelling catheter to make sure it was draining properly. The Registered Nurse stated that the catheter was positioned properly. The catheter was still threaded through the bottom of the adult brief and not taped to Resident number ninety six's (96) abdomen.

14. A review of the February Medication Administration Record revealed no lidocaine jelly 2% listed. The Treatment Administration Record documented "keep Foley catheter taped to abdomen and position out of top of pants." The last skin sweep documented is February 1, 2013 and did not document anything about redness to the groin area.

15. In an interview with the Unit Manager at 9:28 a.m. on February 13, 2013, the Unit Manager acknowledged that there is an order written for lidocaine jelly 2% that was not transcribed onto the Medication Administration Record. The Unit Manager also verified that there was nothing in the chart to indicate a rash or redness to the groin of Resident number ninety six (96) nor was the weekly skin sweep done as ordered on February 8, 2013.

16. The Unit Manager went with the surveyor to assess Resident number ninety six (96) at 9:35 a.m. The Unit Manager acknowledged that the catheter tubing was not taped to Resident number ninety six's (96) abdomen, nor was it up and over the top of the adult brief. The Unit Manager also acknowledged excoriation in the left groin and penis. Resident number ninety six (96) would still flinch and moan when touched, and the Unit Manager stated he/she was in pain.

17. Resident number ninety six (96) was observed with the Licensed Practical Nurse on February 14, 2013 at 11:03 a.m. Resident number ninety six (96) was fidgeting in the wheelchair. When asked, Resident number ninety six (96) stated the catheter did not feel okay. The catheter was angled downwards through the leg of the brief and not taped to the abdomen as ordered. The Licensed Practical Nurse acknowledged the catheter tubing was incorrectly placed and not taped to the abdomen as ordered.

18. The Agency determined that this deficient practice compromised the 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. The Agency cited Respondent for a Class II deficiency as set forth in Section 400.23(8)(b), Florida Statutes (2012).

19. A Class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 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 shall be levied notwithstanding the correction of the deficiency.

20. Based upon the above findings, the Respondent's actions, inactions or conduct constituted an isolated Class II deficiency pursuant to Section 400.23(8)(b), Florida Statutes (2012).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of TWO THOUSAND FIVE HUNDRED DOLLARS ($2,500.00) against the Respondent pursuant to Sections 400.23(8)(b), and 400.102, Florida Statutes (2012).

COUNT II

The Respondent Failed To Ensure The Right To Receive Adequate And Appropriate Health Care in Violation of Section 400.022(1)(l), Florida Statutes (2012)

21. The Agency re-alleges and incorporates by reference paragraphs one (1) through five (5).

22. Pursuant to Florida law, 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: 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. Section 400.022(1)(l), Florida Statutes (2012).

23. On or about February 11, 2013 through February 15, 2013, the Agency conducted a Licensure Survey of the Respondent's facility.

24. Based on observation, interview and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for three (3) of twenty eight (28) residents, specifically Resident number ninety six (96), Resident number three hundred five (305) and Resident number two hundred forty two (242), regarding failure to assess and manage pain for a resident with an urethral erosion and two (2) residents with no medical justification for their catheters respectively.

25. Resident number ninety six (96) was admitted on January 7, 2013 with diagnoses to include urinary retention and urethral erosion. An observation was made of Resident number ninety six (96) on February 13, 2013 at 8:30 a.m. to be holding his/her hands over his/her genital area.

26. Catheter care was observed on February 13, 2013 at 8:33 a.m. As the Certified Nursing Assistant started to perform the catheter care, Resident number ninety six (96) moved into the fetal position and started moaning and grunting. The Certified Nursing Assistant stated this is normal for the resident. As the Certified Nursing Assistant moved Resident number ninety six's (96) scrotum, the left groin area was noted to be bright red and patchy. Resident number ninety six (96) yelled out and tried crossing his/her legs. Resident number ninety six (96) was not asked if he/she

was in pain. The Certified Nursing Assistant drew back the foreskin of the penis and it appeared to be bright red and excoriated. The resident was moaning when touched, mumbling "Oh God ". Resident number ninety six (96) kept crossing his/her legs and trying to get back into the fetal position and the Certified Nursing Assistant would reposition the resident to wash the catheter and genital area. At one point, Resident number ninety six (96) lifted his/her head and groaned loudly, with a grimace on his/her face and the eyes bulging. At this point the Certified Nursing Assistant asked Resident number ninety six (96) if he/she was in pain. The resident stated "a little ". The catheter was then brought out the bottom of the adult brief, not anchored to any anatomical site.

27. There is a Pain Evaluation in Advanced Dementia sheet in Resident number ninety six's (96) chart that has the residents name on it but is not filled out. Based on the criteria listed on the form, the combination of "repeated calling out, loud moaning or groaning, crying", "facial grimacing" and "rigid, fists clenched, knees pulled up, pulling or pushing away" indicates distressing pain. On February 14, 2013 at 1:13 p.m., the Director of Nursing acknowledged the form was in the chart and should have been filled out.

28. In an interview with the Registered Nurse on February 13, 2013 at 9:01 a.m., the Registered Nurse stated that she would first give Resident number ninety six (96) medications, then she would check Resident number ninety six's (96) catheter to make sure it is patent and positioned properly. The Registered Nurse checked for exudate on the penis and checked the indwelling catheter to make sure it was draining properly. The Registered Nurse stated that the catheter was positioned properly and did not assess the groin or pull back the foreskin to properly assess the penis. Resident number ninety six (96) was still moaning and the nurse asked if he/she was in pain but the resident said no. Resident number ninety six (96) appeared more relaxed in bed, not grimacing. The Registered Nurse stated the Certified Nursing Assistant was supposed to tell the nurse when the resident stated he/she is in pain.

29. A review of the medical record documented a physician order dated January 25, 2013 for

Keflex 250mg by mouth four (4) times daily for seven (7) days for urethral erosion and lidocaine jelly 2% to the urethra as needed four (4) times a day. The February Physician Order Sheet documented keep the catheter up and taped to abdomen and positioned out of top of pants.

30. A review of the February Medication Administration Record revealed no lidocaine jelly 2% transcribed. The Treatment Administration Record documented "keep Foley catheter taped to abdomen and position out of top of pants. The last skin sweep found is February 1, 2013 and did not document anything about redness to the groin or penis.

31. In an interview with the Unit Manager at 9:28 a.m. on February 13, 2013, the Unit Manager acknowledged that there is an order written for lidocaine jelly 2% that is not listed in the Medication Administration Record. The Unit Manager also verified that there was nothing in the chart to indicate a rash or redness to the groin of Resident number ninety six (96).

32. The Unit Manager went with the surveyor to assess the resident at 9:35 a.m. The Unit Manager acknowledged that the catheter tubing was not taped to Resident number ninety six's (96) abdomen, nor was it up and over the top of the residents' adult brief. The Unit Manager also acknowledged excoriation in the left groin and penis. The Unit Manager acknowledged Resident number ninety six (96) was acting as if he/she was in pain, groaning and guarding his/her genitals when touched.

33. In an interview with the Director of Nursing on February 13, 2013 at 2:42 p.m., the Director of Nursing stated Resident number ninety six (96) was transferred to the Reflections unit for behaviors of yelling and screaming and was given a care plan to reflect the behaviors. The Director of Nursing stated Resident number ninety six (96) is not necessarily in pain; this is just how the resident acts. In a subsequent interview with the Director of Nursing on February 14, 2013 at 1:13 p.m., she acknowledged the care plan indicates Resident number ninety six (96) had behaviors of resisting care, not yelling and screaming. The Director of Nursing also stated she was unable to find any documentation in the chart that indicates Resident number ninety six (96) had

yelling behaviors.

34. A nurse's note dated January 22, 2013 documented that Resident number ninety six (96) had pain which was manifested by fidgeting and shouting out intermittently. Routine pain medication was given and the effect was good with decreased fidgeting and decreased shouting.

35. The pain assessment dated January 7, 2013 documented under the question "Does the patient/resident exhibit any non-verbal signs that would indicate pain?" Moaning is checked off. Under nursing interventions, no evidence of pain is checked off. The monthly summary dated February 12, 2013 indicated Resident number ninety six (96) is alert and confused, quiet and cooperative with a flat affect. Resident number ninety six's (96) speech is listed as difficult.

36. A review of the fourteen (14) day Minimum Data Set assessment with an Assessment Reference Date of January 24, 2013 revealed Resident number ninety six (96) was severely impaired with cognition. No behavioral symptoms are exhibited, including screaming and disruptive sounds. The Minimum Data Set identified Resident number ninety six (96) as having pain occasionally in five (5) of the seven (7) previous days with a level of five (5) out of ten (10).

37. In an interview with Resident number ninety six (96), the Licensed Practical Nurse on February 14, 2013 at 11:03 a.m. stated the catheter is to be positioned up over the brief and taped to the abdomen to prevent further irritation to the urethra. Resident number ninety six (96) has had a catheter for a long time. Because Resident number ninety six (96) is confused, the Licensed Practical Nurse stated she would watch for grimacing or fidgeting as signs of pain and that Resident number ninety six (96) tried to stand on his/her own if the catheter is placed incorrectly. The Licensed Practical Nurse stated that the staff does not use yelling as an indicator for pain because Resident number ninety six (96) often yells. Because Resident number ninety six (96) was trying to stand up in the activity room, the Licensed Practical Nurse brought him/her back into the room to check on the catheter. The resident stated to the nurse that the catheter "does not feel ok". Resident number ninety six (96) kept crossing his/her legs and fidgeting in the chair. A Certified

Nursing Assistant came into the room to assist the Licensed Practical Nurse stand up Resident number ninety six (96). Resident number ninety six (96) stood to have his/her pants pulled down and his/her brief opened. The catheter was angled down and not taped to the abdomen as ordered. This was acknowledged by the Licensed Practical Nurse. When the nurse touched Resident number ninety six (96) he/she would yell out. There was also tape tangled in the pubic hair and as the nurse tried to remove it, Resident number ninety six (96) yelled out "It hurts a lot ". Resident number ninety six (96) kept trying to grab the nurse to make her stop but the Certified Nursing Assistant held his/her hands still. The catheter was then placed correctly. Resident number ninety six (96) stated he/she felt much better when the catheter was properly positioned.

38. An observation on February 12, 2013 at 3:25 p.m. revealed Resident number two hundred forty two (242) lying in bed. A Foley catheter (indwelling urinary drainage devise) was observed at bedside draining.

39. A review of the record revealed Resident number two hundred forty two (242) was admitted to the facility on December 31, 2012 with diagnoses to include urinary tract infection, functional decline, hypertension, deep vein thrombosis, anemia, hyperlipidemia, and renal insufficiency. A review of the Nursing Evaluation dated December 31, 2012 documented the existence of the Foley catheter. A review of the admitting physician's orders documented, "Catheter Orders" and further documented the ordered care and treatment for the catheter. A further review of the physician orders revealed the next order related to the Foley was not until nine (9) days after admission. This order was dated January 8, 2013 for the discontinuing of the catheter. A final review of the record lacked any evidence of a diagnosis or medical justification for the Foley catheter.

40. During a review of the record and interview with the Director of Nursing on February 15, 2013 at 9:30 a.m., the Director of Nursing agreed there was no valid diagnosis or medical justification for the Foley catheter for Resident number two hundred forty two (242) upon

admission to the facility. When asked the standard procedure related to catheter use the Director of Nursing stated that they try to have the catheters discontinued within a few days of admission to their facility.

41. A review of the facility policy and procedure titled "Urinary Catheters" documents, "Procedure: 1. Eliminate indwelling urinary catheters when possible. 2. Use catheters only when they must be used, and only with documented medical justification by a physician."

42. During an interview on February 11, 2013 12:37 p.m., the Registered Nurse caring for Resident number three hundred five (305) was asked if the resident had a Foley catheter and the diagnosis or medical justification for the catheter. The Registered Nurse stated, "There is no valid reason for the catheter, Resident number three hundred five (305) came with it from the hospital. I'm going to call the doctor to see if it can be removed."

43. An observation of Resident number three hundred five (305) on February 12, 2013 at approximately 11:45 a.m. revealed the resident sitting in a wheel chair at the nurse's station. Although the bag that holds and covers the Foley catheter for dignity purposes was noted, the Foley catheter was not present.

44. A review of the record documented Resident number three hundred five (305) was admitted to the facility from an acute care hospital on January 31, 2013 having sustained a cerebral vascular accident/stroke and subdural hematoma. Admitting diagnoses included diabetes, hypertension, left ventricle thrombus, hyperlipidemia, and intermittent atrial fibrillation. The record documented the existence of the Foley catheter upon admission to the facility as per the nursing evaluation dated January 31, 2013, the plan of care and in daily nursing notes from admission through February 11, 2012. A review of the plan of care dated January 31, 2013 for the indwelling catheter specifically documented the intervention "Identify documentation in the medical record which substantiates use of indwelling catheter, if absent confer with MD". An order to discontinue the Foley catheter was obtained on February 11, 2013 after surveyor questioning. A

final review of the record lacked any diagnosis or medical justification for the catheter for Resident number three hundred five (305).

45. During an Interview on February 13, 2013 at approximately 4:00 p.m., the Unit Manager for the 300 unit was asked the procedure for residents admitted to the facility with a Foley catheter. The Unit Manger stated that the normal practice is to evaluate the resident and ask the physician for an order to discontinue the catheter within a few days of admission. The Unit Manager agreed that Resident number three hundred five (305) had a Foley catheter thirteen (13) days after admission to the facility with no appropriate diagnosis or medical justification.

46. A review of the facility policy and procedure titled "Urinary Catheters" documents, "Procedure: 1. Eliminate indwelling urinary catheters when possible. 2. Use catheters only when they must be used, and only with documented medical justification by a physician."

47. The Agency determined that this deficient practice compromised the 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. The Agency cited Respondent for a Class II deficiency as set forth in Section 400.23(8)(b), Florida Statutes (2012).

48. A Class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 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 shall be levied notwithstanding the correction of the deficiency.

49. Based upon the above findings, the Respondent's actions, inactions or conduct constituted an isolated Class II deficiency pursuant to Section 400.23(8)(b), Florida Statutes (2012).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of

TWO THOUSAND FIVE HUNDRED DOLLARS ($2,500.00) against the Respondent pursuant to Sections 400.23(8)(b), and 400.102, Florida Statutes (2012).

COUNT III
Assignment Of Conditional Licensure Status Pursuant To Section 400.23(7)(b), Florida Statutes (2012)

50. The Agency re-alleges and incorporates by reference the allegations in Count I.

51. The Agency is authorized to assign a conditional licensure status to nursing home facilities pursuant to Section 400.23(7), Florida Statutes (2012).

52. Due to the presence of one (1) Class II deficiency, the Respondent was not in substantial compliance at the time of the survey with criteria established under Chapter 400, Part II, Florida Statutes (2012), or the rules adopted by the Agency.

53. The Agency assigned the Respondent conditional licensure status with an action effective date of February 15, 2013. The original certificate for the conditional license is attached as Exhibit A and is incorporated by reference.

54. The Agency assigned the Respondent standard licensure status with an action effective date of March 15, 2013. The original certificate for the standard license is attached as Exhibit B and is incorporated by reference.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, respectfully requests the Court to enter a final order granting the Respondent conditional licensure status for the period beginning February 15, 2013 and ending on March 15, 2013 pursuant to Section 400.23(7)(b), Florida Statutes (2012).

CLAIM FOR RELIEF

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, respectfully requests the Court to enter a final order granting the following relief against the Respondent as follows:

1. Make findings of fact and conclusions of law in favor of the Agency.

2. Impose an administrative fine against the Respondent in the amount of FIVE THOUSAND DOLLARS ($5,000.00.).

3. Assign conditional licensure status to the Respondent for the period beginning on February 15, 2013, and ending on March 15, 2013.

4. Assess costs related to the investigation and prosecution of this case.

5. Enter any other relief that this Court deems just and appropriate.

Respectfully submitted this 3rd day of May, 2013.

Andrea M. Lang, Assistant General Counsel
Florida Bar No. 0364568
Agency for Health Care Administration
Office of the General Counsel
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901
(239) 335-1253

NOTICE

RESPONDENT IS NOTIFIED THAT IT/HE/SHE HAS A RIGHT TO REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO SECTIONS 120.569 AND 120.57, FLORIDA STATUTES. THE RESPONDENT IS FURTHER NOTIFIED THAT IT/HE/SHE 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 AND DELIVERED TO THE ATTENTION OF: *THE AGENCY CLERK, AGENCY FOR HEALTH CARE ADMINISTRATION, 2727 MAHAN DRIVE, BLDG #3, MS #3, TALLAHASSEE, FLORIDA 32308; TELEPHONE (850) 412-3630.*

THE RESPONDENT IS FURTHER NOTIFIED THAT IF A REQUEST FOR HEARING IS NOT RECEIVED BY THE AGENCY FOR HEALTH CARE ADMINISTRATION WITHIN TWENTY-ONE (21) DAYS OF THE RECEIPT OF THIS ADMINISTRATIVE COMPLAINT, A FINAL ORDER WILL BE ENTERED BY THE AGENCY.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form were served to: Anthony Brunicardi, Administrator, SA-PG - Vero Beach LLC d/b/a Palm Garden of Vero Beach, 1755 37th Street, Vero Beach, Florida 32960, by United States Certified Mail, Return Receipt No. 7011 1570 0002 1695 8511 and to Capitol Corporate Services, Inc., Registered Agent, SA-PG - Vero Beach LLC d/b/a Palm Garden of Vero Beach, 155 Office Plaza Drive, Suite A, Tallahassee, Florida 32301, by United States Certified Mail, Return Receipt No. 7011 1570 0002 1695 8528 on this 3rd day of May, 2013.

Andrea M. Lang

Andrea M. Lang, Assistant General Counsel
Florida Bar No. 0364568
Agency for Health Care Administration
Office of the General Counsel
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901
(239) 335-1253

Copies furnished to:

Anthony Brunicardi, Administrator SA-PG - Vero Beach LLC d/b/a Palm Garden of Vero Beach 1755 37th Street Vero Beach, Florida 32960 (U.S. Certified Mail)	Andrea M. Lang, Assistant General Counsel Agency for Health Care Administration Office of the General Counsel 2295 Victoria Avenue, Room 346C Fort Myers, Florida 33901
Capitol Corporate Services, Inc. Registered Agent for SA-PG - Vero Beach LLC d/b/a Palm Garden of Vero Beach 155 Office Plaza Drive, Suite A Tallahassee, Florida 32301 (U.S. Certified Mail)	Bernard Hudson, Health Services and Facilities Consultant Supervisor Bureau of Long Term Care Services Long Term Care Unit Agency for Health Care Administration 2727 Mahan Drive, Building #3, Room 1213B Tallahassee, Florida 32308 (Electronic Mail)
Arlene Mayo-Davis Field Office Manager Agency for Health Care Administration 5150 Linton Boulevard, Suite 500 Delray Beach, Florida 33484 (Electronic Mail)	