STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA NO.: 2015001159
DOAH NO.: 15-2179
RENDITION NO.: AHCA-15-0645-S-OLC

FRUITVILLE HOLDINGS-OPPIDAN, INC.,

Respondent.
_____/

FINAL ORDER

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

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The parties have since entered into the attached Settlement Agreement, which is adopted and incorporated by reference into this Final Order. (Ex. 2)

2. The Respondent shall pay the Agency $10,500. 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:

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

ORDERED at Tallahassee, Florida, on this 3 day of November, 2015.

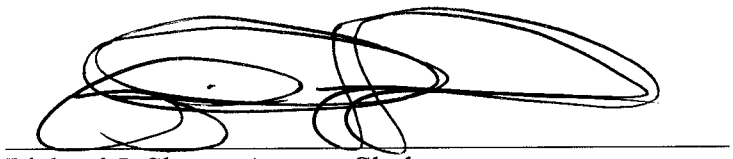
Elizabeth Dudek, Secretary
Agency for Health Care Administration

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 3rd day of November, 2015.



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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Andrea Lang, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Jay Adams, Esq. Attorney for Respondent Broad and Cassel 215 South Monroe Street Tallahassee, Florida 32301 (U.S. Mail)
Linzie Bogan Administrative Law Judge Division of Administrative Hearings (Electronic Mail)	

STATE OF FLORIDA
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FRUITVILLE HOLDINGS-OPPIDAN, INC.,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration (hereinafter "the Agency"), by and through its undersigned counsel, and files this Administrative Complaint against the Respondent, FRUITVILLE HOLDINGS-OPPIDAN, INC. (hereinafter "the Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2014), and states:

NATURE OF THE ACTION

This is an action to impose an administrative fine against an assisted living facility in the sum of TEN THOUSAND DOLLARS ($10,000.00) based upon two (2) Class II violations pursuant to Section 429.19(2)(b), Florida Statutes (2014) and FIVE HUNDRED DOLLARS for one (1) Class III violation.

JURISDICTION AND VENUE

1. The Court has jurisdiction over the subject matter pursuant to Sections 120.569 and 120.57, Florida Statutes (2014).

2. The Agency has jurisdiction over the Respondent pursuant to Sections 20.42 and 120.60, and Chapters 408, Part II, and 429, Part I, Florida Statutes (2014).

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

EXHIBIT 1

PARTIES

4. The Agency is the licensing and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state regulations, statutes and rules governing such facilities. Chapters 408, Part II, and 429, Part I, Florida Statutes (2014); Chapter 58A-5, Florida Administrative Code. The Agency may deny, revoke, or suspend any license issued to an assisted living facility, or impose an administrative fine in the manner provided in Chapter 120, Florida Statutes (2014). Sections 408.815 and 429.14, Florida Statutes (2014).

5. The Respondent was issued a license by the Agency (License Number 10999) to operate a 2-bed assisted living facility located at 4038 Fruitville Road, Sarasota, Florida 34232, and was at all times material required to comply with the applicable state regulations, statutes and rules governing assisted living facilities.

COUNT I
The Respondent Failed To Ensure Services Of Residents In Meeting Criteria For Continued Residency In Violation Of Rule 58A-5.0181(5), Florida Administrative Code

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

7. Pursuant to Florida law, if the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with Section 429.28, Florida Satatutes. Rule 58A-5.0181(5), Florida Administrative Code.

8. On or about January 14, 2015, the Agency conducted a Follow-up Survey of the November 5, 2014 Biennial Survey of the Respondent's facility.

9. Based on observation, record review and interview, the Respondent failed to ensure 1 of 2 sampled residents, specifically Resident #2, met residency criteria and failed to meet the needs of the resident for continued residency at the assisted living facility. Resident #2 was documented as requiring total assistance with Activities of Daily Living and is totally

dependent on staff for transfers; staff are using improper technique while transferring Resident #2 causing pain to the resident during transfers; and in spite of implementing a close visual supervision protocol, staff failed to consistently implement the protocol and Resident #2 continues to burn him/herself while smoking.

10. During the entrance conference on 1/14/15 at 9:00 a.m., the Director of Maintenance and Staff B (who is a certified nursing assistant) said Resident #2 continues to unsafely smoke at the facility. Staff B said as a result of the biennial survey when it was identified Resident #2 was burning him/herself from smoking, the facility offered Resident #2 a smoking apron and special glove in an effort to prevent further burns from smoking. Staff B said two days after trialing the smoking apron, the resident refused the apron and the glove. Staff B said because of the way the resident holds his/her hand, the resident couldn't use the glove. The Director of Maintenance said Resident #2 is noncompliant with transfers and the facility is in the process of working on obtaining a Transitional Living Facility license because Resident #2 remains a total lift. Staff B said after the biennial survey (11/5/14), Resident #2 started to be a two man pivot transfer. Staff B stated, "Resident #2's testicles swelled and the transfer type was hurting Resident #2's testicles so they had to go back to the two man lift. Resident #2 went to the hospital and after Christmas, Resident #2 has been a total two person lift." Staff B said that Resident #2 was on antibiotics and cream. Staff B further indicated Resident #2 is still receiving the cream, and the resident is still sore.

11. A record review on 1/14/15 revealed that the record documents Resident #2 was admitted to the facility on 2/2/2007 with diagnoses of traumatic brain injury, quadriplegia and limited use of the left arm. A review of the health assessment dated 2/2/07 revealed that it indicated that Resident #2 required total help with ambulation, bathing, and dressing and assistance with toileting, grooming and transferring.

12. A review of the current health assessment, dated 2/19/14, revealed that it

indicated that Resident #2 requires assistance with ambulation, bathing, dressing, grooming, toileting and transferring. The assessment documents the resident is a 2 person assist pivot transfer. The assessment also documents the resident requires total care with Activities of Daily Living.

13. The 2/19/14 Health Assessment shows conflicting information (total vs. assistance with Activities of Daily Living).

14. In an interview on 1/14/15 at 9:36 a.m., the Administrator said she called the Occupational Therapist to come out and assess Resident #2 for safe smoking and the Occupational Therapist recommended the apron. Because the resident refused the apron, they tried a safety glove and the resident refused that. The Administrator said they decided to place the resident on close visual supervision. The Administrator explained that staff were to remain within 3 feet of the resident and visually supervise the resident for safe smoking. She said no one informed her that Resident #2 was dependent on 2 people for transfers.

15. In an interview and observation in the presence of Staff B on 1/14/15 9:45 a.m., Resident #2 held up his/her left hand and showed two cigarette burns to the left thumb and scabs and peeling skin to the left middle finger. A cigarette burn the size of a pencil eraser tip to the web space between the left thumb and forefinger was observed. The area was deep red and the wound was moist with a small amount of yellow tissue on the wound base. A second burn the same size was observed along the side and middle of the thumb. The wound was reddish brown. Resident #2 said the burns to his/her left thumb and middle finger were from ashes from cigarettes.

16. During this same interview and observation, Resident #2 said an infection of the testicles had developed from improper transfers. Resident #2 said he/she ended up in the hospital twice around the holidays and after he/she came back, which was about 5 weeks ago, Resident #2 wouldn't let the staff pivot transfer him/her anymore. Resident #2 said he/she gets lifted out of

bed by two staff members and Resident #2 said my testicles were still tender. An observation of the testicles showed no acute redness or swelling.

17. A telephone interview was conducted with the Occupational Therapist on 1/14/15 at 10:15 a.m. The Occupational Therapist said he received a referral from the facility to do a smoking evaluation for Resident #2. The Occupational Therapist said the facility told him Resident #2 was having more difficulties managing cigarettes. The Occupational Therapist did a smoking safety evaluation and recommended a flame retardant smoking apron. The Occupational Therapist was not aware Resident #2 refused to wear the apron. The Occupational Therapist was not aware Resident #2 was still burning his/her fingers. The Occupational Therapist said he had been out to the facility several times to assess the resident for transfers because the physical therapist was out on maternity leave. The Occupational Therapist stated, "every time I've been out here Resident #2's either refused or had a medical issue at the time where they couldn't do it. This has been an ongoing issue with the resident refusing. I have not worked with Resident #2 regarding transfers."

18. The Administrator provided a document entitled, "Protocol Form", completed by the Occupational Therapist and dated 11/2014. The form included the following information: "... Resident #2 is to be under close visual supervision during smoking breaks. This supervision must continue throughout the full smoking break, from when the cigarette is lit until it is extinguished. Staff will be required to document each smoking break with provided form. The resident must wear a flame retardant smoking apron during all smoking breaks."

19. In an interview on 1/14/15 at 10:20 a.m., the Licensed Practical Nurse said she was not aware of the 2 cigarette burns to the resident's left thumb or scabbed burn areas to Resident #2's middle finger. The Licensed Practical Nurse was aware the resident requires close visual supervision while smoking, but said she did not know staff were required to document each smoking break on a form provided by the Occupational Therapist. The Licensed Practical

Nurse said no one told her Resident #2 was a total lift of two people for transfers.

20. During an interview on 1/14/15 at 10:33 a.m., Staff B said he was not aware of the burns on Resident #2's left thumb and left middle finger. Staff B said staff document Resident #2's activities of daily living on the ADL sheet and smoking is included, however, he is not familiar with any specific form provided by the Occupational Therapist. Staff B said he sits with Resident #2 and supervises the smoking.

21. An observation in the presence of the Licensed Practical Nurse on 1/14/15 at 11:18 a.m. showed Resident #2 seated in a wheelchair on the lanai smoking a cigarette. Staff B was observed outside of the lanai, approximately 6 feet away from Resident #2 talking on the phone with his back turned toward the resident. The resident opened his/her left hand which revealed one reddish brown area on the inside portion of the thumb and a reddened moist area on the top of the web space between the thumb and forefinger. This wound had a yellow center, and multiple small scabbed areas were observed on the top of the left middle finger. The Licensed Practical Nurse called Staff B back into the lanai, reminding Staff B to stay close to Resident #2 while she went inside to call the doctor.

22. A review of the Activities of Daily Living flow sheets from 11/2014 through 1/2015 failed to consistently document when Resident #2 was being supervised during smoke breaks. Incomplete documentation was observed during the weeks of 11/24/14, 12/1/14, 12/8/14, 12/22/14, 12/29/14, and 1/5/15.

23. During an observation on 1/14/15 at 10:10 a.m., the House Director, and Staff B entered Resident #2's room to transfer the resident out of bed to the wheelchair. Resident #2 was lying flat in bed with multipodus boots (orthotic braces) on the lower extremities. The House Director asked Staff B where Resident #2's gait belt was. Staff B pointed to the laundry basket and said it was wet. Without applying a gait belt, both staff assisted Resident #2 to a sitting position at the edge of the bed. The multipodus boots rested on the floor; however, the resident's

feet were not flat against the bottom of the inside of the boots. While both staff held the resident under the arms with one hand, they lifted the resident by the back of the pants and swung him/her into the wheelchair. The resident stated, "Ow, Ow, my crotch, my crotch."

24. A telephone interview was conducted with the Physical Therapy Assistant on 1/14/15 at 10:42 a.m. The Physical Therapy Assistant said the facility had asked him to come in and work on some sliding board transfers with the resident about a month or two ago. The Physical Therapy Assistant said Resident #2 preferred stand pivot transfers as opposed to sliding board transfers so he had staff present and showed both the staff and Resident #2 how to correctly do a stand pivot transfer. The Physical Therapy Assistant said staff were to rock the resident forward and have the resident push up with his/her hands from the wheelchair to help as much as possible and then get the resident to a standing position (feet flat on floor, knees locked). The Physical Therapy Assistant said after they get the resident to a standing position, staff are to encourage Resident #2 to take a couple steps and have the resident sit at the edge of the bed, bring the residents' legs up and lay the resident down. The Physical Therapy Assistant said a gait belt is to be used during the process. The Physical Therapy Assistant confirmed he was familiar with Resident #2 and did remember Resident #2 was a quadriplegic and had foot drop. The Physical Therapy Assistant re-stated Resident #2's knees should be locked while in a standing position. The Physical Therapy Assistant said there was no specific footwear necessary for this process. The Physical Therapy Assistant said there was no need for two people to assist Resident #2 with the process of the transfer.

25. A review of the "Transfer Protocol Form" dated 12/12/14 by the Occupational Therapist included the following: "...Client requires maximum assistance of one to two trained staff to perform sliding board or stand pivot transfer to and from wheelchair and bed. Client should be wearing a gait belt and slip resistant shoes during transfer. Staff is to maintain hands on assistance at all times including when client is seated in bed."

26. A record review on 1/14/15 documents physician's orders dated 12/16/14 which indicate, "physical therapy for lower (illegible)".

27. A review of the "Protocol Form", undated and signed by the Physical Therapy Assistant, included the following: "...Client is to transfer with use of stand pivot transfer. This is the safest transfer for this client. Make sure you use a gait belt. Scoot towards front of chair. If able, have client help as much as possible...it is easier to stand client up by grabbing buttocks for it initiates standing...Cheat Sheet: Wear gait belt...it is easier to lift client by buttocks which initiates stand."

28. The specific type of transfer technique to be used for Resident #2 conflicted between the Physical Therapy Assistant and Occupational Therapist.

29. In an interview with the Administrator, Licensed Practical Nurse and House Director on 1/14/15 at 11:00 a.m., they were unaware of the 12/16/14 physician's order for physical therapy. The Administrator said she called the rehab department associated with their facility because that's who'd been working with Resident #2 in the past, but the physical therapist was on maternity leave. The Administrator was unable to produce documentation the resident was appropriately evaluated by a physical therapist for the stand pivot transfers. The Administrator did not know why the Occupational Therapist came out to assess the resident for transfers when the order was for Physical Therapy but figured it was because the original Physical Therapist was out on maternity leave. The Administrator, Licensed Practical Nurse and House Director confirmed Resident #2 cannot walk and cannot stand upright with knees locked and did not know why the Physical Therapy Assistant said the resident could. The Licensed Practical Nurse stated, "He didn't remember the resident" despite the repeat affirmation by the Physical Therapy Assistant that he did remember Resident #2. The Administrator confirmed she did not give Resident #2 the choice of which therapy center the resident would prefer. The Administrator said the orders must have been missed and she would call the physician for

clarification.

30. In spite of the facility implementing a close visual supervision protocol, Resident #2 has continued to burn his/her fingers while smoking. Staff has failed to ensure Resident #2 is adequately supervised as evidenced by inadequate safe smoking documentation on the Activities of Daily Living flow sheets. The Licensed Practical Nurse, Administrator and House Director said they did not know Resident #2 was continuing to burn him/herself while supervised by staff and unaware of the status of the burns on Resident #2's left thumb and middle finger, and acknowledged Staff B's failure to closely visualize Resident #2 while smoking. Resident #2 and Staff B confirmed the resident is a total lift of two people for transfers. Staff B and the House Director used improper technique while transferring Resident #2 out of bed causing Resident #2 to yell out in pain during the process.

31. The Respondent's deficient practice constituted a Class II violation in that it related to the operation and maintenance of a provider or to the care of clients which the Agency determined directly threatened the physical or emotional health, safety, or security of the clients, other than a Class I violation. Section 429.19(2)(b), Florida Statutes (2014).

32. The Agency shall impose an administrative fine for a cited Class II violation in an amount not less than one thousand dollars ($1,000.00) and not exceeding five thousand dollars ($5,000.00) for each violation as set forth in Section 429.19(2)(b), Florida Statutes (2014). A fine shall be levied notwithstanding the correction of the violation.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of FIVE THOUSAND DOLLARS ($5,000.00) pursuant to Section 429.19(2)(b), Florida Statutes (2014).

COUNT II
The Respondent Failed To Ensure Appropriate Care and Services Of Residents In Violation Of Rule 58A-5.0182(1), Florida Administrative Code

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

five (5).

34. Pursuant to Florida law, an assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.

(1) Facilities must offer personal supervision, as appropriate for each resident, including the following:

(a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, Florida Administrative Code.

(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.

(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.

(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.

(e) Maintaining a written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), Florida Administrative Code, any illnesses that resulted in medical attention, major incidents, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

Rule 58A-5.0182(1), Florida Administrative Code.

35. On or about November 5, 2014, the Agency conducted a Biennial Survey of the Respondent's facility.

36. Based on observation, record review, and interviews, the Respondent failed to adequately supervise 1 of 2 sampled residents, specifically Resident #2, for safe smoking. This

failure contributed to Resident #2 repeatedly receiving burns from hot ashes while smoking, causing blisters and scabs to the fingers.

37. During an observation on 11/5/14 at 9:30 a.m., Resident #2 was observed sitting outside in an electric wheelchair smoking a cigarette. A blue jacket covered with numerous burn holes from cigarettes ashes was across the front of the resident's chest. Small scabbed areas were observed on the inside of the left and middle fingers. As Resident #2 was speaking, ashes accumulated at the end of the cigarette, dropping onto the blue jacket and down the side of the wheelchair. The resident's shoulder and upper arm did not move. The resident's elbow was fixed alongside the upper body. Resident #2 used an elbow to bend his/her lower arm and bent his/her head toward the fingers in order to inhale the cigarette. Staff C, who is a licensed practical nurse, walked up to the resident, wiped ashes off of the front of the jacket, informed the resident of going to the doctor, and walked back into the building.

38. A record review on 11/5/14 documented Resident #2 was admitted to the facility on 2/2/07 with diagnoses of traumatic brain injury, quadriplegia, and limited use of the left arm.

39. A review of the current health assessment, dated 2/19/14, showed Resident #2 required assistance with ambulation, bathing, dressing, grooming, toileting, and transferring. The assessment documented the resident was a 2 person assist pivot transfer. The assessment also documented the resident required total care with Activities of Daily Living.

40. A record review on 11/5/14 documented a "Monthly Client Service Plan/Assessment Report" completed by the Administrator for the date of 9/20/14. Documentation included: "There was one reported injury during this reporting period. On 8/24/14 it was noted that (Resident #2) had a blister on the right thumb and a scabbed blister area on the left little finger. Resident #2 stated that when smoking, the hot ashes off the cigarette fell off onto the residents' fingers. This has since been resolved."

41. An incident report dated 8/24/14 at 4:30 p.m. documented an intact blister to

Resident #2's right thumb, measuring 1 cm x ½ cm. A pencil sized scabbed area is documented to the left hand. Documentation included "Client has 2 blisters on the left hand on the thumb and pointer finger stated cigarette burn. Staff found at 4:45 while client was smoking out back."

42. There was no documentation to support any staff intervention after cigarette burns to the resident's fingers were observed. There was no documentation to support the physician was notified.

43. A second incident report completed on 10/1/14 at 10:20 p.m. documented, "While putting client in noticed left hand burn above thumb area. Also on right shoulder looks just like a sore. Client states that they been there awhile." Documentation includes, "Burn above the right thumb, 1 cm x 1 cm scab with pink at area right thumb, above. No discharge noted."

44. There was no documentation to support staff intervention to ensure Resident #2 was safe to smoke. There was no documentation to support the physician was notified.

45. During an interview on 11/5/14 at 1:39 p.m., Staff C stated, "Staff don't have to sit outside with the resident." She stated, "There's not too much I can do except ask the resident to be careful. Smoking is all the resident's got." There was no documentation to support staff were monitoring the affected areas. Staff D said she usually doesn't notify the physician about the blisters, "Only if there is an infection. The doctor would have my butt in a sling if I called him."

46. In an interview on 11/5/14 at 4:00 p.m., the Administrator and House Director were unaware Resident #2's fingers were currently scabbed from burns by cigarettes. The Administrator admitted they had not considered any interventions to assist Resident #2 to safely smoke. She stated, "What are we supposed to do? Resident #2 is not going to quit smoking."

47. The Respondent's deficient practice constituted a Class II violation in that it related to the operation and maintenance of a provider or to the care of clients which the Agency determined directly threatened the physical or emotional health, safety, or security of the clients, other than a Class I violation. Section 429.19(2)(b), Florida Statutes (2014).

48. On or about January 14, 2015, the Agency conducted a Follow-up Survey of the November 5, 2014 Biennial Survey of the Respondent's facility.

49. Based on observation, record review and interviews, the Respondent failed to adequately supervise 1 of 2 sampled residents, specifically Resident #2, for safe smoking. This failure contributed to Resident #2 continuing to burn him/herself from hot ashes while smoking.

50. During the entrance conference on 1/14/15 at 9:00 a.m., the Director of Maintenance and Staff B (who is a certified nursing assistant) said Resident #2 continues to unsafely smoke at the facility. Staff B said as a result of the biennial survey when it was identified Resident #2 was burning him/herself from smoking, the facility offered the resident a smoking apron and special glove in an effort to prevent Resident #2 from further burns from smoking. Staff B said two days after trialing the smoking apron, the resident refused the apron and the glove. Staff B said because of the way the resident holds his/her hand, the resident couldn't use the glove.

51. In an interview on 1/14/15 at 9:36 a.m., the Administrator said she called the Occupational Therapist, who recommended the apron, to come out and assess Resident #2 for safe smoking. Because the resident refused the apron, they tried a safety glove and the resident refused that. The Administrator said they decided to place the resident on close visual supervision. The Administrator explained staff are to remain within 3 feet of the resident and visually supervise the resident for safe smoking.

52. In an interview and observation on 1/14/15 9:45 a.m., Resident #2 held up his/her left hand and showed two cigarette burns to the left thumb and scabs and peeling skin to the left middle finger. A cigarette burn the size of a pencil eraser tip to the web space between the left thumb and forefinger was observed. The area was deep red and the wound was moist with a small amount of yellow tissue on the wound base. A second burn the same size was observed along the side and middle of the thumb. The wound was reddish brown. Resident #2 said the

burns to the left thumb and middle finger were from ashes from cigarettes.

53. A telephone interview was conducted with the Occupational Therapist on 1/14/15 at 10:15 a.m. The Occupational Therapist said he received a referral from the facility to do a smoking evaluation for Resident #2. The Occupational Therapist said the facility told him Resident #2 was having more difficulties managing cigarettes. The Occupational Therapist did a smoking safety evaluation and recommended a flame retardant smoking apron. The Occupational Therapist was not aware Resident #2 refused to wear the apron and was still burning his/her fingers.

54. The Administrator provided a document entitled, "Protocol Form", completed by the Occupational Therapist and dated 11/2014. The form included the following information: "... Resident #2 is to be under close visual supervision during smoking breaks. This supervision must continue throughout the full smoking break, from when the cigarette is lit until it is extinguished. Staff will be required to document each smoking break with provided form. Resident must wear a flame retardant smoking apron during all smoking breaks."

55. In an interview on 1/14/15 at 10:20 a.m., the Licensed Practical Nurse said she was not aware of the 2 cigarette burns to the resident's left thumb or scabbed burn areas to Resident #2's middle finger. The Licensed Practical Nurse was aware the resident requires close visual supervision while smoking, but said she did not know staff were required to document each smoking break on a form provided by the Occupational Therapist.

56. During an interview on 1/14/15 at 10:33 a.m., Staff B said he was not aware of the burns on Resident #2's left thumb and left middle finger. Staff B said staff document Resident #2's activities of daily living on the ADL sheet and smoking is included, however, he is not familiar with any specific form provided by the Occupational Therapist. Staff B said he sits with Resident #2 and supervises smoking.

57. An observation in the presence of the Licensed Practical Nurse on 1/14/15 at

11:18 a.m. showed Resident #2 seated in a wheelchair on the lanai smoking a cigarette. Staff B was observed outside of the lanai, approximately 6 feet away from Resident #2 talking on the phone with his back turned toward the resident. The resident opened his/her left hand which revealed one reddish brown area on the inside portion of the thumb and a reddened moist area on the top of the web space between the thumb and forefinger. This wound had a yellow center and multiple small scabbed areas were observed on top of the left middle finger. The Licensed Practical Nurse called Staff B back into the lanai, reminding Staff B to stay close to Resident #2 while she went inside to call the doctor.

58. A review of the nursing progress notes between 11/12/14 and 1/12/15 failed to show evidence of any monitoring of the burns to the resident's fingers.

59. A review of the Activities of Daily Living flow sheets from 11/2014 through 1/2015 failed to consistently document when Resident #2 was being supervised during smoke breaks. Incomplete documentation was observed during the weeks of 11/24/14, 12/1/14, 12/8/14, 12/22/14, 12/29/14, and 1/5/15.

60. In spite of the facility implementing a close visual supervision protocol, Resident #2 has continued to burn his/her fingers while smoking. Staff have failed to ensure Resident #2 is adequately supervised as evidenced by inadequate safe smoking documentation on the Activity of Daily Living flow sheets; Licensed Practical Nurse, Administrator and House Director unaware Resident #2 is continuing to burn him/herself when supervised by staff and unaware of the status of the burns on Resident #2's left thumb and middle finger; and Staff B's failure to closely visualize Resident #2 while smoking.

61. The Respondent's deficient practice constituted a Class II violation in that it related to the operation and maintenance of a provider or to the care of clients which the Agency determined directly threatened the physical or emotional health, safety, or security of the clients, other than a Class I violation. Section 429.19(2)(b), Florida Statutes (2014).

62. The Agency shall impose an administrative fine for a cited Class II violation in an amount not less than one thousand dollars ($1,000.00) and not exceeding five thousand dollars ($5,000.00) for each violation as set forth in Section 429.19(2)(b), Florida Statutes (2014). A fine shall be levied notwithstanding the correction of the violation.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of FIVE THOUSAND DOLLARS ($5,000.00) pursuant to Section 429.19(2)(b), Florida Statutes (2014).

COUNT III

The Respondent Failed To Ensure The Food Service Department Performed All Duties In A Safe And Sanitary Manner In Violation Of Rule 58A-5.020(1), Florida Administrative Code

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

64. Pursuant to Florida law, when food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply:

(a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices.

(b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule.

(c) An administrator or designee must perform his or her duties in a safe and

sanitary manner.

(d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets.

(e) An administrator or designee must comply with the food service continuing education requirements specified in Rule 58A-5.0191, Florida Administrative Code.

Rule 58A-5.020(1), Florida Administrative Code.

65. On or about November 5, 2014, the Agency conducted a Biennial Survey of the Respondent's facility.

66. Based on observation, record review and interview, the Respondent failed to provide food services within the facility; failed to have a separate approved menu by a Registered Dietitian; failed to ensure the food designee was current with food service training; and failed to ensure 1 of 2 sampled residents, specifically Resident #1, was provided the choice of eating at the facility or a facility of the residents' choice.

67. During an interview with Resident #1 on 11/5/14 at 9:01 a.m., Resident #1 said he/she eats meals in the facility "Next door." Resident #1 said he/she does not eat here; Resident #1 is to go over to the other facility for meals. Resident #1 was not aware of the daily menu and was not aware of a choice of eating meals where Resident #1 currently resided.

68. In an interview on 11/5/14 at 9:32 a.m., Resident #2 said he/she doesn't go over to the other facility to eat. Resident #2 said staff takes him/her out grocery shopping where he/she buys food and then meals are prepared when he/she gets back. During the tour of the facility on 11/5/14 at 9:00 a.m., no menu was posted and no in-house menu was available.

69. A review of the admission contracts for Residents #1 and Resident #2 confirmed the facility was to provide regular diets to both residents.

70. An interview was conducted with the Administrator and House Director on

11/5/14 at 2:00 p.m. The House Director said Resident #1 eats at the sister facility next door and confirmed it holds a separate license. The House Director said they could cook it over at the other facility and bring it over to this one. The House Director said there are no meals contracted or brought over to Fruitville Holdings. The House Director stated there is a menu approved by the Registered Dietitian, however, it is shared by both facilities and the menu is posted as well as available over at the other facility. The Administrator said the House Director is the person responsible for food service.

71. A personnel record review on 11/5/14 of the House Director's file failed to contain evidence of 2 hours of continuing food service education annually for the period of 2011-2013.

72. The Respondent's deficient practice was related to the operation and maintenance of a provider or to the care of clients which the Agency determined indirectly or potentially threatened the physical or emotional health, safety, or security of clients, other than Class I or Class II violations, and constituted a Class III deficiency as provided for in Section 429.19(2)(c), Florida Statutes (2014).

73. The Agency cited the Respondent for a Class III violation in accordance with Section 429.19(2)(c), Florida Statutes (2014).

74. On or about January 14, 2015, the Agency conducted a Follow-up Survey of the November 5, 2014 Biennial Survey of the Respondent's facility.

75. Based on record review and interview, the facility failed to ensure the designee responsible for food service obtained continuing education requirements specified in Rule 58A-5.0191, Florida Administrative Code.

76. During the biennial survey on 11/5/14, the House Director's personnel file was reviewed. (The House Director was designated responsible for food services.) At the time of the biennial survey, the House Director's personnel file failed to contain evidence of 2 hours of

continuing food service education annually for the period of 2011-2013.

77. A revisit survey was conducted on 1/14/15. During an interview on 1/14/15 at 12:26 p.m., the House Director admitted she had not obtained 2 hours of continuing education. The House Director said she had talked to the Registered Dietitian about coming to the facility to get the continuing food service education but hadn't received the training yet.

78. This remains an uncorrected deficiency.

79. The Respondent's deficient practice was related to the operation and maintenance of a provider or to the care of clients which the Agency determined indirectly or potentially threatened the physical or emotional health, safety, or security of clients, other than Class I or Class II violations, and constituted a Class III deficiency as provided for in Section 429.19(2)(c), Florida Statutes (2014).

80. The Agency cited the Respondent for an uncorrected Class III violation in accordance with Section 429.19(2)(c), Florida Statutes (2014).

81. The Respondent's deficient practice constituted an uncorrected Class III violation in accordance with Section 429.19(2)(c), Florida Statutes (2014).

82. The Agency shall impose an administrative fine for a cited Class III violation in an amount not less than five hundred dollars ($500.00) and not exceeding one thousand dollars ($1,000.00) for each violation. Section 429.19(2)(c), Florida Statutes (2014).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of FIVE HUNDRED DOLLARS ($500.00) pursuant to Section 429.19(2)(c), Florida Statutes (2014).

CLAIM FOR RELIEF

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, respectfully requests the Court to grant the following relief:

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

2. Impose an administrative fine against the Respondent in the amount of TEN THOUSAND FIVE HUNDRED DOLLARS ($10,500.00).

3. Order any other relief that the Court deems just and appropriate.

Respectfully submitted on this 25th day of March, 2015.

Deborah E. Leoci, Assistant General Counsel
Florida Bar No. 0814423
Agency for Health Care Administration
Office of the General Counsel
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901
Telephone: (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 has been served to: Kristina Marie Brennick, Administrator, Fruitville Holdings-Oppidan, Inc., 4038 Fruitville Road, Sarasota, Florida 34232, by U.S. Certified Mail, Return Receipt No. 7009 1680 0001 8776 0473 and to Joseph Brennick, Registered Agent, Fruitville Holdings-Oppidan, Inc., 1962 Vandolah Road, Wauchula, Florida 33873, by U.S. Certified Mail, Return Receipt No. 7009 1680 0001 8776 0480 on this 25th day of June, 2015.

Deborah E. Leoci, Assistant General Counsel
Florida Bar No. 0814423
Agency for Health Care Administration
Office of the General Counsel
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901
Telephone: (239) 335-1253

Copy furnished to:

Kristina Marie Brennick, Administrator Fruitville Holdings-Oppidan, Inc. 4038 Fruitville Road Sarasota, Florida 34232 (U.S. Certified Mail)	Deborah E. Leoci, Assistant General Counsel Office of the General Counsel Agency for Health Care Administration 2295 Victoria Avenue, Room 346C Fort Myers, Florida 33901
Joseph Brennick, Registered Agent Fruitville Holdings-Oppidan, Inc. 1962 Vandolah Road Wauchula, Florida 33873 (U.S. Certified Mail)	Jon Seehawer Acting Field Office Manager Agency for Health Care Administration 2295 Victoria Avenue, Room 340A Fort Myers, Florida 33901 (Electronic Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: Fruitville Holdings-Oppidan, Inc. **Case No. 2015001159**

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be an **Administrative Complaint, Notice of Intent to Impose a Late Fee, or Notice of Intent to Impose a Late Fine.**

Your Election of Rights must be returned by mail or by fax within twenty-one (21) days of the date you receive the attached Administrative Complaint, Notice of Intent to Impose a Late Fee, or Notice of Intent to Impose a Late Fine.

If your Election of Rights with your elected Option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a Final Order will be issued.**

Please use this form unless you, your attorney or your representative prefer to reply in accordance with Chapter 120, Florida Statutes (2014) and Rule 28, Florida Administrative Code.

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308
Phone: 850-412-3630 Fax: 850-921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

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

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

OPTION THREE (3) ____ **I dispute the allegations of fact and law contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

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

1. Your name, address, telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License Type: _____(Assisted Living Facility, Nursing Home, Medical Equipment, Other)

Licensee Name: _____License Number:_____

Contact Person: _____
Name Title

Address: _____
Street and Number City State Zip Code

Telephone No. _____Fax No. _____E-Mail (optional)_____

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

Signature: _____ Date: _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA,
AGENCY FOR HEALTH
CARE ADMINISTRATION,

Petitioner,

vs.

DOAH Case No(s): 15-2179
AHCA Case No(s): 2015001159

FRUITVILLE HOLDINGS-OPPIDAN, INC.,

Respondent.

_____/

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondent, Fruitville Holdings-Oppidan, 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 an Assisted Living Facility licensed pursuant to Chapters 408, Part II, and 429, Part I, Florida Statutes, Section 20.42, Florida Statutes and Chapter 58A-5, Florida Administrative Code; and

EXHIBIT 2

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondent, pursuant to Chapter 429, Florida Statutes; and

WHEREAS, the Agency served Respondent with an administrative complaint on or about March, 2015, notifying the Respondent of its intent to impose administrative fines in the amount of $10,500; and

WHEREAS, Respondent requested a formal administrative proceeding by filing a Petition for Formal Administrative Hearing; and

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

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

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

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

3. Upon full execution of this Agreement, 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 $10,500 to the Agency within thirty (30) days of the entry of the Final Order.

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 denies, and the Agency asserts the validity of the allegations raised in the administrative complaint referenced herein. No agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, pursuant to the provisions of Chapter 400, Part II, 408, Part II, Florida Statutes and Chapter 59A-4, Florida Administrative Code, including a "repeat" or "uncorrected" deficiency identified in the Survey. In said event, Respondent retains the right to challenge the factual allegations related to the deficient practices/violations alleged in the instant cause.

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 estop any other federal, state, or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the administrative complaint.

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.

Molly McKinstry
Deputy Secretary
Agency for Health Care Administration
2727 Mahan Drive, Bldg #1
Tallahassee, Florida 32308

DATED: 11/3/15

Kristina Marie Brennick, Administrator
Fruitville Holdings-Oppidan, Inc.
4038 Fruitville Road
Sarasota, Florida 34232

DATED: 8/26/2015

Stuart F. Williams, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 11/6/15

Jay Adams, Esq.
Broad and Cassel
Attorney for Respondent
215 South Monroe Street, Suite 400
Tallahassee, Florida 32302

DATED: 8-31-15

Andrea M. Lang, Senior Attorney
Agency for Health Care Administration
2295 Victoria Avenue
Fort Myers, Florida 33901

DATED: 9/22/15