STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SANTA BARBARA BH, INC., d/b/a VILLA SERENA VIII,

Respondent.
_____/

DOAH No.: 19-5514
AHCA No.: 2019008816
Facility Type: ALF
License No. 5059

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SANTA BARBARA BH, INC., d/b/a VILLA SERENA VIII,

Respondent.
_____/

DOAH No. 19-5560
AHCA No.: 2019011132
Facility Type: ALF
License No. 5059

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SANTA BARBARA BH, INC., d/b/a VILLA SERENA VIII,

Respondent.
_____/

AHCA No.: 2019017727
Facility Type: ALF
License No. 5059

RENDITION NO.: AHCA- 20 - 437**-S-OLC**

FINAL ORDER

THIS CAUSE came on for consideration before the Agency for Health Care Administration ("the

ORDERED at Tallahassee, Florida, on this 11th day of June, 2019.

Mary C. Mayhew, 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 11th day of Jan, 2019.

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)	Keisha Wood, Unit Manager Licensure Unit Agency for Health Care Administration (Electronic Mail)
Central Intake Unit Agency for Health Care Administration (Electronic Mail)	Arlene Mayo-Davis, Field Office Manager Local Field Office Agency for Health Care Administration (Electronic Mail)
Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Gisela Iglesias, Assistant General Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)

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

(5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of $1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation.

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

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

facilities and enforcement of all applicable federal regulations, state statutes, and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code, respectively.

4. Respondent operates a twelve (12) bed assisted living facility located at 3321 SW 24th Terrace #23, Miami, Florida 33145-3139, and is licensed as an assisted living facility, license number 5059.

5. Respondent was at all times material hereto a licensed facility under the licensing authority of the Agency and was required to comply with all applicable rules and statutes.

COUNT 1

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

7. Florida law provides:

> That Florida law provides:
> (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.
> § 429.26(7), Florida Statutes (2018).

8. Florida law also provides:

> (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:
> (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C.
> (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

14. A review of records by the Agency's representative revealed Respondent failed to document Residents #1 and #2's report to Staff D that Staff I allegedly touched them inappropriately. Respondent also did not report this to Residents #1 and #2's representatives or doctors for further evaluations. Respondent also failed to report the incidents to law enforcement to investigate. There were no notes that the Department of Children and Families was contacted to investigate Residents #1 and #2's claims or that Respondent investigated the claims or if any action was taken by Respondent's administration.

15. Respondent did not have any documentation that its staff received additional training regarding residents' rights, and how to prevent and report abuse after the incidents, and how to prevent similar incidents in the future.

16. On March 12, 2019, at 1:30 p.m., Respondent's Administrator and Owner acknowledged that Respondent failed to have written documentation about the incidents and the investigation conducted after Residents #1 and #2 informed that were improperly touched by Staff I. They also stated that neither the doctor was called to further evaluate the residents nor was the police department called to investigate the incidents.

17. The Administrator and the Owner stated on March 12, 2019, that there was a meeting with staff to discuss the incidents but there was no documentation regarding this meeting. They stated Respondent did not provide any additional training regarding residents' rights and how to avoid and report abuse. They admitted Respondent had no policies and procedures in place to avoid abuse incidents in the future.

18. That the above reflects Respondent's failure to have written documentation or documentation that an investigation was completed after two (2) out of twelve (12) sampled residents alleged that a staff member sexually abused them (Residents #1 and #2). Respondent

Resident #1 was admitted to another hospital on May 8, 2019, for an arm fracture.

26. In an interview with Staff O on May 15, 2019, at 3:34 p.m., Staff O stated, "a doctor came and he checked Resident #1. He noticed that something was not right. [Resident #1] was in a lot of pain. They came to do an x-ray the same day. The bone was broken and still the same way as before, [the bone] was not healed. The person who did the x-ray told us the broken bone was near a vein that [Resident #1] was in danger of dying if that bone cut anything as [he/she] was moving around. I am the one who called the rescue and they transferred [Resident #1] to the hospital."

27. A review of Resident #1's hospital records performed by the Agency's representative on May 16, 2019, showed that the resident was admitted on March 10, 2019, and discharged on March 14, 2019. The hospital record stated, "The resident stated that [he/she] slipped and fell while walking in the ALF, hitting [his/her] left shoulder, associated with severe swelling, inability to move the shoulder and [he/she] was brought to the trauma center due to Left Upper Extremity (LUE) deformity." The physical exam stated "Left Upper Extremity with fracture brace, LUE edema improving, no edema in the rest of extremities." The radiology findings were "comminuted displaced fracture of the ulnar styloid with mild displacement of the distal fracture fragment age- indeterminate. Acute highly comminuted fractures of the proximal to mid left humeral diaphysis with foreshortening and apex lateral angulation. There is a posterior displacement of additional fracture fragments."

28. Additional review of Resident #1's hospital records from his second admission showed that the resident was admitted on May 8, 2019, transported via ambulance. History of present illness stated "the patient presents following fall. The onset was unknown. The fall was described as tripped. Location: Left upper extremity. 73 years old … patient presents to the emergency

30. In an interview on May 16, 2019, at 11:45 a.m., Resident #1's family member stated that Resident #1 "had an elbow fracture. They sent [him/her] to a local hospital, then a rehabilitation. [Resident #1] spent a month at the rehab and went back to the [Respondent's] facility. After a week, the facility called us and we learned that [he/she] had another fracture and they sent [him/her] to the hospital again. The first fracture was in the elbow. The second one was in [his/her] upper arm. [He/she] had surgery on Sunday and now [he/she] is in rehab. We thought the second fracture was related to the first one, but the orthopedist told us it was a new fracture."

31. On May 15, 2019, at 1:04 p.m., Resident #2 was observed bumping his/her head on the common area corner wall while trying to go to his/her room. Staff O was sitting on the recliner and shouted to Resident #2 "Que pasa [what happened]?" but did not check on the resident. Resident #2's health assessment dated November 24, 2018, stated that the resident was legally blind and noted fall precautions. Resident #2's medical history and diagnoses were: acute kidney injury (AKI), urinary retention, hypertension, and dehydration. There were no progress notes on file.

32. On May 15, 2019, at 11:59 a.m., the Agency's representative observed Resident #3 with a cut in the middle of the forehead between the eyes. Resident #3 was in respite care according to Staff O.

33. A review of Resident #3's health assessment dated May 2, 2019, reflected the resident's medical history and diagnoses as: dementia with behavioral changes, major depression, and malnutrition due to decrease intake. Special precautions were not completed. However, the physician wrote "patient is needing constant supervision in a safe environment." The resident was independent with ambulation; needed supervision with transferring; needed assistance with

of the night and fell."

37. In an interview on May 21, 2019, after 4:00 p.m., Respondent's Owner stated Resident #3 was seen by the doctor who visits the facility but did not provide any documentation.

38. A review of Respondent's admission and discharge log on May 15, 2019, showed that eleven (11) residents were listed there. The entries for Resident #4 did not have a date/reason and place of discharge. A health assessment dated February 27, 2018, for Resident #4 showed a diagnosis of Alzheimer's disease and no allergies. There were no physical or sensory limitations and no nursing/treatment/therapy service requirements specified in the health assessment. Nothing was noted regarding special precautions and the resident was not identified as an elopement risk. With respect to activities of daily living, the form indicated Resident #4 was independent with ambulation, eating, grooming, toileting and transferring. Supervision was required with bathing and dressing. Resident #4's progress notes for 2017 showed no significant changes. Progress notes for 2018 showed that in February 2018, the resident went to hospital for knee pain and the resident's family was notified. Progress notes for April 2018, state that Resident #4 refused to go to the doctor. An observation log for the resident showed that on February 7, 2018, the Resident fell in the bathroom and felt pain in the knee. An ambulance was called and the resident was taken to the doctor. There was no documentation of the resident's multiple falls.

39. In an interview on May 16, 2019, at 12:28 a.m., Resident #4's family member stated "[Resident #4] fell and went to a local hospital and the hospital recommended a rehab place. At the facility, [he/she] walked and got weaker. [Resident #4] falls every 6 months. I would say that [he/she] fell at the facility maybe on April 20th. It has happened 3 times but [he/she] had not suffered any fractures."

45. A review of the hospital log for Resident #9 showed an admission to a local hospital on April 1, 2019, for hematuria and a discharge date of April 2, 2019. A health assessment dated November 9, 2018, listed a medical history and diagnoses of dementia and hypertension. There were no progress notes.

46. That the above reflects Respondent's failure to provide care and services appropriate to the needs of residents, and to offer personal supervision as appropriate for each resident to ensure awareness of the general health, safety, and physical and emotional well-being for seven (7) out of seventeen (17) sampled residents (Residents #1, #2, #3, #4, #5, #6, and #9). Resident #1 experienced two (2) falls with broken bones and was transferred to the hospital within the last two (2) months. Respondent also failed to have any interventions in place to prevent falls and failed to have written documentation after a resident fell or was transferred to the hospital. The foregoing are contrary to law.

47. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of a provider or to the care of clients which directly threatens the physical or emotional health, safety, or security of the clients, other than class I violations.

48. That the same constitutes a Class II offense as defined in § 408.813(2)(b), Florida Statutes, (2018).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five thousand dollars ($5,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(b), Florida Statutes (2018).

COUNT II

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

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida.
§ 429.28(1) and (2), Florida Statutes (2018).

51. Florida law further provides:

(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.
(a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C.
(b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Disability Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800)96-ABUSE or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;

expendable for their account, which are received by a facility. Any facility whose owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility as principal and a licensed surety company. The bond shall be conditioned upon the faithful compliance of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection.

(3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $500 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500.

(4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident.

(5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an

my balls [testicles]."

56. On March 7, 2019, at 11:00 a.m., Resident #2 reported that Staff I touched [him/her] when changing the resident's incontinence brief. Resident #2 stated, "He did it many times."

57. On March 7, 2019, at 11:10, a.m., Staff D stated Resident #2 reported to her that Staff I touched the resident when the resident was showering. However, Staff D also said that Resident #2 showers himself/herself. Staff D stated that Resident #2 also stated that Staff I touched him/her when putting briefs on the resident. When another staff asked Resident #2 why [he/she] did not want to shower, he/she answered that it was because Staff I touched him/her. Resident #2 stated that he/she did not want to use briefs because Staff I touched him.

58. On March 7, 2019, at 10:55 a.m., Respondent's Owner was interviewed. The Owner stated that when Residents #1 and #2 told staff they were improperly touched by Staff I, she immediately separated Staff I and removed him from the schedule. She said she also called the Department of Children and Families to report the incidents.

59. The Agency's representative reviewed Respondent's grievance policy in Residents' #1 and #2 file. The policy stated that "[a]ll resident grievance (complaints) will be notified to the ALF Administrator, Assistant Administrator or Staff in charge." Respondent's complaint procedure required that it:

> 1. Investigate if resident's statement is true with Staff and family. Also find out if there is any Staff involved in this grievance.
> 2. Give a solution to this grievance with the resident, family and Staff in a period of 30 days.
> 3. Meetings will take place as needed with the resident, family and the ALF, administrative Staff, leading to resolving the situation to the resident's satisfaction.
> 4. Complete the Complaint form, explain the solution and place a copy in the resident's file.

The policy further stated that, "[a] suggestion box is placed in the ALF (where most appropriate) accessible for resident to write their suggestions. The Administrator, staff will check the

66. That Florida law requires that cited deficient practice be corrected within thirty (30) days. *See,* § 408.811(4), Florida Statutes (2018).

67. On or about May 21, 2019, a revisit to the March 12, 2019 complaint survey was completed.

68. That based upon observation, interviews, and the review of records, Respondent failed to provide a forty-five (45) day written notice of relocation or termination of residency to one (1) of seventeen (17) sampled residents (Resident #16), the same being contrary to law.

69. A review of records by the Agency's representative showed that Resident #16 was admitted to Respondent's facility on May 21, 2017 and discharged on May 1, 2019. Resident #16's monthly assisted living facility rent was $800.00.

70. On May 20, 2019, at 10:00 a.m., the Agency's representative interviewed a family member of Resident #16. The family member stated, "They told me to take [Resident #16] when we told them we could not pay the new amount of $1900. We used to pay $800. They told me they were going to send me a letter to sign but never did. I called a few times and they said they sent it by email but I never received it. Then they asked me to write a statement saying that I was going to take [Resident #16] within 30 days but I thought it was too much pressure and took him as soon as possible. We took [Resident #16] out of there in April."

71. A review of Respondent's records by the Agency's representative showed that Respondent did not provide a forty-five (45) day written termination notice to Resident #16.

72. The above reflects Respondent's failure to provide a forty-five (45) day written notice of relocation or termination of residency to one (1) of seventeen (17) sampled residents (Resident #16), the same being contrary to law.

73. The Agency determined that this deficient practice was a condition or occurrence related

NOTICE

The Respondent is notified that it/he/she has the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If the Respondent wants to hire an attorney, it/he/she has the right to be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights form.

The Respondent is further notified if the Election of Rights form is not received by the Agency for Health Care Administration within twenty-one (21) days of the receipt of this Administrative Complaint, a final order will be entered.

The Election of Rights form shall be made to the Agency for Health Care Administration and delivered to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Mail Stop 3, Tallahassee, FL 32308; Telephone (850) 412-3630.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7018 2290 0001 4174 2336 on July 9, 2019 to Claudia Rizo, Administrator for Santa Barbara BH Inc., d/b/a Villa Serena VIII, at 3321 SW 24th Terrace #23, Miami, Florida 33145-3139, and by Regular U.S. Mail to Roxana, Solano, Registered Agent for Santa Barbara BH Inc., d/b/a Villa Serena VIII, at 3317 S.W. 24th Terrace, Miami, Florida 33145.

Gisela Iglesias, Esq.

Copy furnished to:
Arlene Mayo Davis
Field Office Manager
Agency for Health Care Administration

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

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

Licensee Name: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (Optional) _____

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

Signed: _____ Date: _____

Print Name: _____ Title: _____

3. The Agency is the regulatory authority responsible for licensure of assisted living facilities and enforcement of all applicable federal regulations, state statutes, and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 59A-36, Florida Administrative Code, respectively.

4. Respondent operates a twelve (12) bed assisted living facility located at 3321 SW 24th Terrace #23, Miami, Florida 33145-3139, and is licensed as an assisted living facility, license number 5059.

5. Respondent was at all times material hereto a licensed facility under the licensing authority of the Agency and was required to comply with all applicable rules and statutes.

COUNT 1

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

7. Florida law provides:

> That Florida law provides:
> (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.
> § 429.26(7), Florida Statutes (2018).

8. Florida law also provides:

> An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.
> (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:
> (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.
> (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-

(24) sampled residents (#22, #5, #23, #8, #10, #1, and #6), the same being contrary to the mandates of law.

11. A review of Respondent's admission and discharge log by the Agency's representative revealed that Resident #22 was admitted to Respondent's facility on June 7, 2019, after being discharged from the hospital. A health assessment dated May 23, 2019 showed that the resident was alert and disoriented but could follow simple instructions. Records showed that Resident #22 was discharged from Respondent's facility on June 10, 2019 (three (3) days later). The reason for discharge was written in Spanish and stated that the resident eloped from the villa.

12. Resident #22's health assessment completed on June 3, 2019, showed that the resident spent most of the time in bed and was alert and oriented x 2. There was a list of medications dated June 3, 2019, provided by the hospital to Respondent which listed levothyroxine 0.0265 mg tablet - one tablet by mouth before breakfast (to treat thyroid problems), mirtazapine 15 mg tablet - one tablet by mouth at bedtime (to treat depression), senna 8.6 mg tablet - one tablet by mouth at bedtime for 14 days (to treat constipation), escitalopram 10 mg tablet- one tablet by mouth every morning (to treat depression and anxiety), and thiamine 100 mg tablet - one tablet by mouth daily for 30 days (to treat Vitamin B1 deficiency). There were also copies of prescriptions for Percocet 5/325 mg tablet - one tablet by mouth every 12 hours for seven days (to treat moderate to severe pain), Ativan 1 mg tablet - one tablet by mouth every morning for seven days (to treat seizure and anxiety), Seroquel 25 mg tablet - one tablet by mouth twice a day, famotidine 20 mg tablet - one tablet by mouth twice a day (to treat stomach ulcers and heartburn), and levetiracetam 10 mg/ml oral solution - 10 ml per mouth twice a day (to treat seizures and bipolar disorder). However, Respondent did not provide any medication records to show that Resident #22 received the foregoing medications prescribed by the health care

16. On June 20, 2019 at 2:10 p.m., the Administrator stated that Resident #22 left Respondent's facility. The Administrator further stated that the resident was alert and oriented, and Respondent cannot retain any resident against his/her will.

17. Respondent did not have any documentation indicating that it informed Resident #22's guardian that Resident #22 left its facility on June 10, 2019.

18. On June 27, 2019 at 12:56 p.m., Resident #22's guardianship program representative advised that the resident was at a local hospital since June 12, 2019.

19. A review of hospital records for Resident #22 showed that an ambulance brought the resident to the emergency department of a local hospital on June 12, 2019 at 11:59 a.m. after the resident became dizzy and fell. Resident #22 was found unresponsive on the street. The resident suffered a head contusion with areas of skin discoloration on the right and frontal areas of head. The hospital identified the resident upon arrival with syncope, headache, dizziness, altered level of consciousness, suicidality, and hallucinations. The resident had abnormal/psychotic thoughts of suicidal and auditory hallucinations and received intravenous fluids due to dehydration.

20. Resident #22's health assessment was completed on June 20, 2019. It noted that the resident had a medical history and diagnoses of metabolic encephalopathy, gastroesophageal reflux disease, anemia, schizophrenia, and alcohol abuse. The resident had a slow cadence and was unsteady. The resident was confused, had impaired cognition, and required fall precautions. The resident needed assistance with ambulation, bathing, toileting, transferring and taking medications. The resident needed supervision for dressing, eating, and self-care. There were prescriptions dated July 1, 2019, for Resident #22 to take one tablet of clonazepam (1 mg) by mouth two times a day, and one capsule of temazepam (15 mg) at bedtime as needed for insomnia. There was a final active medication list in the record that included the clonazepam and

25. On July 3, 2019 at 1:08 p.m., Staff B stated that Resident #22 returned to Respondent's facility but left the day before (July 2, 2019) around 8 a.m. to 9 a.m. Staff looked for the resident in surrounding areas but did not find the resident. The staff was trained to look first inside Respondent's facility, then to look around in the neighborhood, and then call the administrator. The administrator should call the police, but she knew that the police would say to wait twenty-four (24) hours before declaring the resident missing.

26. On July 3, 2019 at 1:17 p.m., Staff K said that the previous day, Resident #22 woke up, ate breakfast and sat on the back porch. When the staff looked for Resident #22, the resident was no longer on the back porch. The staff looked inside of the facility and checked all the rooms and bathrooms. Staff K informed Staff B that the resident eloped. Staff K called Respondent's owner and informed her that Resident #22 eloped from the facility. The staff from the other facility (located next door) went out and looked for the resident in the neighborhood but he did not find Resident #22. The staff did not know anything else.

27. On July 3, 2019 at 1:21 p.m., Staff B stated that Resident #22 did not inform any of the staff on duty that he/she was going to leave.

28. There was no evidence that Respondent called law enforcement on July 2, 2019, after finding Resident #22 was missing from its facility.

29. On July 3, 2019 at 1:42 p.m., the Owner said that Resident #22 took his/her medications when he/she left the last time. Respondent did not have any information written regarding Resident #22 leaving its facility as it happened the day before. Resident #22 came from the hospital with two (2) prescriptions but did not give Respondent time to send them to the pharmacy.

Staff did not provide any other assistance during the night unless the staff woke up from sleep for something. The Owner paid her employees per hour and they stopped providing those services around 10:30 p.m. The Owner added at 10:50 a.m. on June 20, 2019, that Respondent's staff did not reposition Resident #5 every two (2) hours during the night.

35. On June 20, 2019 at 11 a.m., the Owner told to Staff E and Staff I that they need to check the hospice documents. She explained that Respondent's staff cannot reposition the resident every two (2) hours during the night as the hospice documents indicated.

36. Resident #5's health assessment completed on November 8, 2018, was also reviewed. It noted the resident's physical or sensory limitations as non-ambulatory and bedbound. The resident required fall precautions. The resident needed assistance with eating, and total care for ambulation, bathing, dressing, self-care (grooming), toileting, and transferring.

37. Respondent maintained a separate folder with progress notes for all the residents. Staff wrote the notes in Spanish. The notes showed that on June 16, 2019, Resident #23 had diarrhea.

38. On July 3, 2019 at 1:55 p.m., Resident #23 advised the Agency's representative in an interview that he/she lived at Respondent's facility for months and the last two (2) weeks had feces on his/her bed at night due to his/her incontinence briefs not being changed at night.

39. On July 3, 2019 at 2:05 p.m., the Owner stated that Resident #23 liked to drink chocolate and milk products but refused a therapeutic order. Resident #23 had to be cleaned constantly.

40. A review of Resident #23's records showed that there was a health assessment completed on June 18, 2019, which noted the resident used a wheelchair and had an unsteady gait.

41. A review of Respondent's Staffing Pattern for July 2019 showed that staff were not required to work the entire night. Respondent allowed staff to sleep and they received pay for nighttime hours based on contract. The schedule showed Staff K working from 6 a.m. to 6 a.m.

precautions. The resident needed assistance for all activities of daily living including ambulation, bathing, dressing, eating, self-care, toileting, transferring and taking medications.

45. A review of a hospital record found in Resident #8's file showed that the resident was admitted to the hospital on June 3, 2019, with the diagnosis of acute sepsis. A review of progress notes showed that Respondent sent the resident to the hospital and the hospital informed Respondent that the resident had a urinary infection.

46. The Agency's representative also reviewed the records of Resident #10 which showed that the last health assessment was completed on September 17, 2018. The health assessment revealed a medical history and diagnoses of hypertension, diabetes type II, and osteoarthritis. It did not indicate if the resident had any cognitive or behavior diagnosis or problem identified.

47. Respondent's progress notes, completed by its staff, showed that Resident #10 brought a dead bird to the facility and put it next to the resident's bed on May 8, 2019. The resident also brought a lot of garbage and refused to shave. On May 14, 2019 around 7:00 p.m., the resident went in the kitchen and spat in the kitchen sink. When the staff redirected Resident #10, the resident became aggressive towards the staff. The staff from a neighboring facility was called to assist in containing the resident. On May 16, 2019 around 10:00 a.m., the staff was called by another resident because Resident #10 was threatening to kill him/her. Resident #10 changed his/her behavior and was very upset (out of control). Resident #10's roommate complained in the mornings that there was urine on the floor which could cause a fall. On May 28, 2019, Resident #10 attempted to get in the kitchen at lunch time. The staff redirected him as they were serving lunch. Resident #10 went over to one of the staff in an aggressive manner and held her by the arm causing some redness in the staff's arm. On June 6, 2019, Resident #10 was violent, and continued urinating in front of everyone and also continued bringing garbage to the facility. On

2019, because of the fall. On April 25, 2019, the resident went to an appointment and upon return to Respondent's facility, informed the staff that he/she fell on the street. Respondent sent the resident to the hospital. There was no documentation in the resident's record indicating the resident sustained any fracture or any physical problem due the fall on April 25, 2019. There was no documentation that the resident followed up with an orthopedic or that the facility put any interventions in place to prevent falls.

52. A review of Resident #6's record showed that there was a health assessment completed on December 1, 2017. The health assessment indicated that the resident had a medical history and diagnoses of diabetes mellitus, hypertension, peripheral vascular disease, BHH, OSA (obstructive sleep apnea), CARB, CKD III (chronic kidney disease stage III), hyperemia, hypothyroid, right foot amputation. The resident had an unsteady gait and depression.

53. The above reflects Respondent's failure to provide adequate supervision as appropriate for each resident and ensure awareness of the general health, safety, and physical and emotional well-being of seven (7) out of twenty-four (24) sampled residents (#22, #5, #23, #8, #10, #1, and #6), the same being contrary to the mandates of law.

54. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of a provider or to the care of clients which the Agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom.

55. The Agency cited the Respondent for a Class I violation in accordance with applicable statutes and authorizing rules.

56. That the same constitutes a Class I offense as defined in § 429.19(2)(a), Florida Statutes (2018).

(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making appointments for health care services, the provision of or arrangement of transportation to health care appointments, and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida.
§ 429.28(1) and (2), Florida Statutes (2018).

59. That Florida law provides:

(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.
(a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full

60. Florida law additionally provides:

> (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated incompetent or incapacitated under state law, managing his or her own affairs.
> § 429.27(1)(a), Florida Statutes (2018).

61. On or about May 21, 2019, the Agency completed a revisit to a complaint investigation (Complaint No. 2019003384) of Respondent and its facility.

62. Based upon observation, interviews, and the review of records, Respondent failed to provide a forty-five (45) day notice of relocation or termination of residence to one (1) of seventeen (17) sampled residents (Resident #16), the same being contrary to the mandates of law.

63. A review of Resident #16's record showed the resident was admitted to Respondent's facility on May 21, 2017 and discharged on May 1, 2019. The resident's monthly rent was $800.00.

64. On May 20, 2019 at 10:00 a.m., a family member of the resident stated, "They told me to take him when we told them we could not pay the new amount of $1900. We used to pay $800. They told me they were going to send me a letter to sign but never did. I called few times and they said they sent it by email but I never received it. Then, they asked me to write a statement saying that I was going to take him within 30 days but I thought it was too much pressure and took him as soon as possible. We took him out of there in April."

65. Respondent's records did not contain and Respondent failed to provide proof that Resident #16 was given a 45 day notice of relocation or termination.

because there was no hot water in that bathroom.

74. On June 20, 2019 at 7:00 a.m., the thermometer showed that the water temperature of both faucets in the sink in the bathroom across room #4 was 70 degrees Fahrenheit. There were two (2) bathrooms close to the medication room and the water temperature reading was 110 degrees Fahrenheit in both of them.

75. The above reflects that Respondent failed to ensure that resident rights were honored including the right to live in a safe and decent living environment and the right to be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy, the same being contrary to the mandates of law. Specifically, Respondent failed to respond to resident complaints of not having hot water in one of its bathrooms and failed to give a resident an option to use hot water for bathing for one (1) out of twenty (20) sampled residents (#19).

76. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

77. That the same constitutes a Class III offense as defined in §429.19(2)(c), Florida Statutes (2018), and Respondent was cited with a Class III deficient practice.

78. That the same constitutes an uncorrected Class III deficient practice as defined by law.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand dollars ($1,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(c), Florida Statutes (2018).

COUNT III

action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.
§ 429.23, Florida Statutes (2018).

81. Florida law further provides:

(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting.
Rule 59A-36.016, Florida Administrative Code.[3]

82. On or about May 21, 2019, the Agency completed a revisit to a complaint investigation (Complaint No. 2019003384) of Respondent and its facility.

83. Based on observation, interviews, and the review of records, Respondent failed to ensure that it filed required adverse incident reports, the same being contrary to the mandates of law. Specifically, Respondent failed to submit a one (1) day adverse incident report and a fifteen (15) day full report to the Agency after one (1) resident (Resident #1) fell twice in two (2) months, sustained broken bones on each occasion, and was transferred to a higher level of care. Respondent also failed to submit a one (1) day adverse incident report and a fifteen (15) day full

[3] The predecessor of this rule, Rule 58A-5.0241, Florida Administrative Code, was renumbered and transferred to Chapter 59A effective July 1, 2019, without substantive changes from its prior version.

nursing home where [he/she] resides approximately 1-2 days ago. As a result of a fall [he /she] injured [his/her] left shoulder and arm.

88. In an interview on May 16, 2019 at 11:45 a.m., Resident #1's family member stated, "[He/She] had an elbow fracture. They sent [him/her] to a local hospital, then a rehabilitation. [He/She] spent a month at the rehab and went back to the facility. After a week, the facility called us and we learned that [he/she] had another fracture and they sent [him/her] to the hospital again. The first fracture was in the elbow. The second one was in [his/her] upper arm. [He/She] had surgery on Sunday and now [he/she] is in rehab. We thought the second fracture was related to the first one, but the orthopedist told us it was a new fracture."

89. A review of records also revealed that the Department of Children and Families contacted law enforcement to investigate the allegations of sexual abuse regarding Residents #1 and #2. Respondent had no documentation that an incident report was submitted to the Agency in an incident that involved law enforcement.

90. The above reflects that Respondent failed to ensure that it filed required adverse incident reports, the same being contrary to the mandates of law.

91. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

92. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2018), and Respondent was cited with a Class III deficient practice.

93. Florida law requires that cited deficient practice be corrected within thirty (30) days. *See,* § 408.811(4), Florida Statutes (2018).

94. On or about July 5, 2019, the Agency completed a second revisit to a complaint

99. Progress notes for Resident #6 were also reviewed. The progress notes indicated that the resident slipped on the resident's own urine in the bathroom and fell in March 2019. That fall resulted in the resident being transferred to the hospital on March 23, 2019.

100. A further review of Resident #6's records showed that there was a health assessment completed on December 1, 2017 which showed the resident had a right foot amputation. The health assessment also noted that the resident had an unsteady gait and depression.

101. Records regarding resident # 22 were also reviewed and revealed that Resident # 22 eloped from Respondent's facility on June 10, 2019, and again on July 2, 2019. Respondent failed to report both these incidents to the Agency.

102. The above reflects Respondent's failure to file required adverse incident reports as required by law.

103. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

104. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2018), and Respondent was cited with a Class III deficient practice.

105. That the same constitutes an uncorrected Class III deficient practice as defined by law.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of one thousand dollars ($1,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(c), Florida Statutes (2016).

COUNT IV

106. The Agency re-alleges and incorporates paragraphs (1) through (5), and Counts I, II, and III, above as if fully set forth herein.

408.815(1)(b) and (c), Florida Statutes (2018).

110. That Respondent has been cited with one (a) Class I violation of law on a single survey which constitutes independent grounds for the revocation of Respondent's licensure as an assisted living facility.

111. That an Immediate Moratorium on Admissions was issued against Respondent on July 5, 2019, in the matter entitled *State of Florida, Agency for Health Care Administration v. Santa Barbara BH, Inc., d/b/a Villa Serena VIII,* AHCA No. 2019010390. That said Immediate Moratorium on Admissions constitutes grounds for denial of a license under § 429.14(3), Florida Statutes (2018). Under § 429.14(1)(k), Florida Statutes (2018), a license may be revoked for any act constituting a ground upon which a license may be denied. Accordingly, this constitutes independent grounds for the revocation of Respondent's licensure as an assisted living facility

112. That Respondent has violated the minimum requirements of law of Chapters 429, Part II, and Chapter 58A-5, Florida Administrative Code as described with particularity within this complaint.

113. That Respondent has a duty to maintain its operations in accord with the minimum requirements of law and to provide care and services at mandated minimum standards. That based thereon, individually and collectively, the Agency seeks the revocation of the Respondent's licensure.

WHEREFORE, the Agency intends to revoke the license of the Respondent to operate an assisted living facility in the State of Florida.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7018 2290 0001 4174 2367 on July 22, 2019 to Javier Talamo, Esquire, Counsel for Santa Barbara BH Inc., d/b/a Villa Serena VIII, at Kravitz and Talamo, 7600 W. 20th Avenue, Suite 213, Hialeah, Florida 33016.

Gisela Iglesias, Esq.

Copy furnished to:
Arlene Mayo Davis
Field Office Manager
Agency for Health Care Administration

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

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

Licensee Name: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (Optional) _____

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

Signed: _____ Date: _____

Print Name: _____ Title: _____

through its undersigned representatives, and Santa Barbara BH, Inc., d/b/a Villa Serena VIII (hereinafter "Villa Serena VIII"), and Roxana Solano, Individually, 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, the Agency issued an Administrative Complaint (hereinafter Complaint 1") dated July 9, 2019, seeking the imposition of administrative fines totaling five thousand five hundred dollars ($5,500.00) based upon one (1) Class II deficient practice and one (1) uncorrected Class III deficient practice; and

WHEREAS, Villa Serena VIII filed a petition for a formal hearing contesting the allegations in Complaint 1; and

WHEREAS, the Agency issued an Administrative Complaint (hereinafter "Complaint 2") dated July 22, 2019, seeking the revocation of Villa Serena VIII's license to operate an assisted living facility in the State of Florida and the imposition of administrative fines of twelve thousand dollars ($12,000.00) based upon one (1) Class I deficient practice and two (2) uncorrected Class III deficient practices; and

WHEREAS, the Agency completed surveys of Villa Serena VIII on May 21, 2019 and August 6, 2019 (hereinafter "Surveys")[1] (Case number 2019017727), during which deficient practices were cited; and

WHEREAS, the citation of the above referenced deficient practices subject Villa Serena VIII to fines in the amount of one thousand dollars ($1,000.00);

WHEREAS, Roxana Solano is the controlling interest of Villa Serena VIII; and

NOW THEREFORE, for good and valuable consideration, the sufficiency of which is

[1] The findings of the Surveys were reduced to a State form 3020.

of any closing, leasehold, or purchase agreements between Villa Serena VIII and the CHOW applicant.

b. Should a CHOW application not be submitted to the Agency within ninety (90) days of the entry of a Final Order in accordance with the requirements set forth in subparagraph 4(a) above, Villa Serena VIII's application for license renewal (License number 5059) shall be deemed withdrawn effective as of the 90th day of the entry of the Final Order. In such case, all right, title or interest in Villa Serena VIII's license shall be deemed surrendered and canceled without further action required by the Agency as of the 90th day of the entry of the Final Order.

c. If the Agency receives a timely CHOW application as set forth above in subparagraph 4(a) above, but provisional licensure is not issued on or before one hundred twenty (120) days from the date of the Final Order adopting this Settlement Agreement, Villa Serena VIII's application for license renewal (License number 5059) shall be deemed withdrawn effective as of the 120th day of the date of the Final Order. In such case, all right, title or interest in Villa Serena VIII's license shall be deemed surrendered and canceled without further action required by the Agency as of the 120th day of the entry of the Final Order.

d. All residents in the Villa Serena VIII assisted living facility (License number 5059) shall be discharged within ninety (90) days of the entry of the Final Order unless a change of ownership application has been filed in accordance with subparagraph 4(a) by a third party applicant prior

h. Villa Serena VIII and Roxana Solano, Individually, further stipulate and agree that Villa Serena VIII and Roxana Solano, Individually, and any business entity in which Villa Serena VIII or Roxana Solano, Individually, hold an interest, shall not apply for future licensure, permits, or other authorization to conduct business under the color of law as administered by the Agency for Health Care Administration, including but not limited to, health facility licensure, registration, or Medicaid provider contracts; nor shall Villa Serena VIII or Roxana Solano, Individually, obtain any interest in any business entity which holds licensure or Medicaid provider contracts administered by law by the Agency for Health Care Administration, for a period of five (5) years from the entry of a Final Order adopting this Agreement. For the purposes of this paragraph, the term "business entity" shall not include any business entity publicly traded on a recognized stock exchange. Should Villa Serena VIII and Roxana Solano, Individually, apply for authorization to conduct business under the color of law as administered by the Agency for Health Care Administration including but not limited to health facility licensure, registration, or Medicaid provider contract, the application or other request of any type shall be summarily denied by the Agency. In said event, Villa Serena VIII and Roxana Solano, Individually, specifically waive any and all rights provided by law, including but not limited to, administrative review under Chapter 120, Florida Statutes, appellate rights, or injunctive or other actions in law or equity in any court or forum to challenge such

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, Villa Serena VIII denies the allegations set forth in Complaint 1, Complaint 2, and the Surveys, and the Agency asserts the validity of the allegations raised in Complaint 1, Complaint 2, and the Surveys. No agreement made herein shall preclude the Agency from imposing a penalty against Villa Serena VIII for any deficiency/violation of statute or rule identified in a future survey of Villa Serena VIII which constitutes a "repeat" or "uncorrected" deficiency from surveys identified in Complaint1, Complaint 2, and the Surveys. In said event, Villa Serena VIII 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 deficiencies from surveys involving Villa Serena I-VII regarding the licensure of Villa Serena I-VII, 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, Villa Serena VIII 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 above referenced Complaint 1, Complaint 2, and the Surveys. This agreement does not prohibit the Agency from taking action regarding Medicaid provider status, conditions, requirements or contract of Villa Serena VIII related to the allegations of the above referenced Complaint 1, Complaint 2, and the Surveys.

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.

the Agency shall hold a lien against present and future funds owed to Villa Serena 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. Villa Serena and Roxana Solano, Individually, have the capacity to execute this Agreement.

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

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

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

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

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

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

DATED: 6-11-20

Javier Talamo Esq.
Kravitz, Talamo & Leyton.
Counsel for Santa Barbara BH, Inc.,
d/b/a Villa Serena VIII and Roxana Solano
7600 W. 20th Avenue, Suite 213
Hialeah, Florida 33016
Florida Bar No. 721808

DATED: 12.9.19