IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT
STATE OF FLORIDA

195 MATTIE M. KELLY BOULEVARD OPERATIONS, LLC d/b/a DESTIN HEALTHCARE AND REHABILITATION CENTER,

Petitioner,

v.

CASE NO: 1D22-1254
L.T. NO: 2022005525

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

RESPONSE IN OPPOSITION TO PETITIONER'S EXPEDITED MOTION FOR STAY OF EMERGENCY ORDER

Pursuant to Florida Rules of Appellate Procedure 9.190(e)(2)(B) and 9.300, Respondent Agency for Health Care Administration ("AHCA" or "the Agency") hereby responds to Petitioner 195 Mattie M. Kelly Boulevard Operations, LLC d/b/a Destin Healthcare and Rehabilitation Center's ("Destin Healthcare" or "the facility") Expedited Motion for Stay of Emergency Order ("Motion for Stay") and this Court's April 27, 2022, Order to Show Cause. AHCA strongly opposes a stay.

Summary of Argument/Statement of AHCA's Position

Destin Healthcare is a nursing home facility that has demonstrated egregious violations of its frail and vulnerable residents' care needs and rights, of the laws governing nursing home staffing standards, and of the statutory requirement that a nursing home must self-impose a moratorium on new resident admissions when short-staffed for two (2) consecutive days. These conditions, along with corporate managements' demonstrated preference for putting corporate financial health over resident care and services and the resultant harm to residents, constitute an immediate and serious threat and danger to the health, safety, and welfare of the public, including residents/clients, and potential residents, warranting both AHCA's imposition of the Immediate Moratorium on Admissions and Emergency Suspension Order ("Emergency Order") and this Court's denial of the instant Motion for Stay.

As detailed in the Emergency Order, when AHCA's surveyors visited Destin Healthcare beginning on April 10, 2022, they reviewed nine (9) weeks of records and discovered the facility had been operating with staffing below the minimum statutorily-mandated levels for this entire period, yet had failed to self-impose the statutorily-mandated moratorium on resident admissions. In paragraph 4 of the Affidavit included in the

Appendix to the Motion for Stay, Destin Healthcare's Regional Vice President of Operations admits the facility had actually been operating short-staffed for even longer – some four (4) months. (Revised Appendix to Expedited Motion for Stay of Emergency Order p.1, ¶ 4/Bates 21). During this extended period of understaffing, the facility's administration repeatedly informed corporate management of the inadequate staffing levels and of the law requiring the self-imposition of a moratorium on resident admissions, but corporate management chose to violate the legislative moratorium mandate and compelled the facility to accept new resident admissions.

Destin Healthcare's records showed an average daily census of between 112 and 114 residents. The vast majority of these residents required assistance with activities of daily living, including dressing (77% of residents), bathing (97% of residents), transfer (81% of residents), eating (91% of residents), and toileting (83% of residents). Additionally, some 17 residents required a two (2)-person assist with transfers, and 4 residents were entirely dependent on staff for eating.

The existent staff at the facility were doing their best to cope with the staffing situation and ensure residents received care, working overtime and double shifts and prioritizing care needs, but they were tired and fighting an

uphill battle. All staff members that AHCA interviewed were concerned about the severe staffing shortages and their resultant inability to meet residents' care needs, particularly with regard to showers/baths, the regular checking/changing for incontinence episodes, and weighing residents.

Regarding the severity of the shortages, the Medical Director described the staffing levels as "unacceptable" and the nursing levels as "dire." He said, "there is not enough staff to take care of residents" and the residents' "basic needs are being met minimally, but not as well as they should be." Staff F, a Registered Nurse, said she had once worked two (2) wings with a combined 54 residents for the length of a shift by herself. Staff D, a Certified Nursing Assistant, told surveyors that "tonight will be a good night because the Facility has four [(4)] staff members, which is very unusual." To put this in context, a nursing home is statutorily prohibited from staffing below one certified nursing assistant per 20 residents, and one licensed nurse per 40 residents.

Regarding corporate management's failure to adequately respond to the staffing shortages at the facility and its choice to violate the law requiring a moratorium on admissions, Destin Healthcare's Medical Director said he first spoke with the Regional Vice President about the staffing issues on February 23, 2022, and the Regional Vice President told

him “the Facility must have 112 residents in order to meet financial needs”; the company had not otherwise responded to his concerns about staffing. The Administrator said he had “many conversations with corporate office regarding the continued admission of residents.” Even the Regional Vice President admitted having regular conversations with the Administrator regarding the staffing shortages but there was no stop to admissions.

Destin Healthcare’s admission/discharge reports show the facility admitted 17 new residents in January 2022, 19 new residents in February 2022, 19 new residents in March 2022, and 2 new residents in April 2022 – all despite the lack of sufficient staff to adequately care for its current residents, much less to care for the new residents. There is nothing in the facility’s records indicating the new residents were informed of the inadequate staffing levels. The corporate decision to, in knowing violation of the law, continue resident admissions when the facility was already experiencing severe staff shortages exacerbated an inadequate staffing problem into a resident crisis.

Contrary to Destin Healthcare’s claims, facility residents have suffered harm, including both physical harm and the violation of their rights, due to the severe staffing shortages and the facility’s illegal decision to continue admitting residents. In the Emergency Order, AHCA documented

that Resident #2 said the facility lacked the staff to assist him with putting on a brace and a splint, at times he has waited for over an hour for assistance, the staffing situation had been getting worse, and at times there was only one certified nursing assistant per floor. Resident #3 stated things had gotten bad at the facility over the last few months, she could not remember when she was last bathed, and she had once laid in urine for 16 hours. Resident #4, who was observed in a hospital gown, said residents were not receiving needed care, that she had not been receiving baths regularly, that she has a severe injury but was not receiving needed care to treat it, that she has had to stay in bed all day because the facility lacked enough staff to operate the mechanical lift required to help her out of bed, and she has waited two (2) hours for her call light to be answered and lain in her own feces for four (4) hours. Resident #5 was observed lying in bed with a dark brown substance under his fingernails, while Resident #6 had greasy hair, and Resident #7 had not been showered in a while. Resident #8 was supposed to wear a splint, but there was not enough staff available to help him put it on. He had not received his scheduled bath for at least a week, he wanted to go to other locations in the facility but had to stay in bed because there was not enough staff to operate the mechanical lift needed to help him up, and this was a frequent enough occurrence that he

had ordered a large TV so that he had something to do all day. Resident #9 could not remember when she last received a shower and was observed in a hospital gown. Resident #10 said things were very bad at the facility and she had asked a family member to find her another facility. The previous Saturday, a visiting family member had found her lying in feces from a bowel movement on Friday evening and observed feces on the floor. Resident #10 said the visiting family member had helped to clean her but could not lift her from the bed, and there was no staff member available to help as there was only one (1) certified nursing assistant for 60 residents that day. The family member was so disgusted with conditions at the facility that she called law enforcement. Further, Resident #10 said she must go to bed at 4:00 p.m. or wait until 10:00 p.m. because there is not enough staff to assist her between times, that she had once laid in bed from 4:00 p.m. on Friday until Sunday morning, and when in bed she is stuck in one position because she cannot move herself (thus, putting her at risk of pressure sores). Resident #11 stated she had only been receiving one bath per month and had not had a bath in a long time, probably because two (2) staff members were needed to bathe her.

These findings constitute clear resident harm, including the blatant violation of residents' rights to receive adequate and appropriate care and

to be treated courteously, fairly, and with the fullest measure of dignity. The fact that the facility – particularly its corporate management – neither seems to realize it nor consider it to be significant for residents' health and well-being is highly disturbing to the Agency and should be equally disturbing to this Court.

The residents of the facility are vulnerable and frail. They are within the sole care and custody of the facility and are, therefore, at its mercy. The severe staffing shortages, failure to impose the admissions moratorium, and the grossly inadequate patient care conditions have persisted for months. Yet Destin Healthcare's corporate management did not see fit to hire additional staff, at whatever cost, or decline new admissions, as required by law, until the Agency issued the Emergency Order. Corporate management's knowing and intentional actions and inactions, in light of the facility's ongoing staffing crisis, constitute a flagrant disregard of the law and of the care needs and rights of its residents warranting emergency action by the Agency, including the immediate moratorium on admissions and emergency suspension order. It is not necessary that AHCA be able to show that residents have died or suffered horrific injury resulting in a higher level of care for the conditions at the facility to warrant emergency action.

In the Order Extending Effective Date of Emergency Suspension (Immediate Moratorium on Admissions Remains in Place) ("Order Extending Suspension Date"), AHCA extended the period prior to the suspension of the facility's license. AHCA did this simply because it had no other reasonable alternative; since the issuance of the Emergency Order the facility dragged its feet in arranging for resident transfer such that residents could not be safely removed by the original suspension date of April 25, 2022. It is important that residents are removed safely to appropriate alternative placements. As stated in the Order Extending Suspension Date, AHCA has placed conditions on the extension and is conducting daily monitoring visits pending the new suspension date of May 2, 2022.

This Court should not construe the increase in current staffing levels at the facility, AHCA's decision to extend the suspension date, or AHCA's monitoring visits to the facility as proof that conditions that resulted in the Emergency Order have been remedied; they have not.

The underlying cause of all the facility's problems – corporate management's profound disregard for the governing law and for the care needs and rights of vulnerable and frail residents – has not been corrected or alleviated. Corporate management's continued disregard for the

residents' health, safety, and welfare is apparent from the arguments in the Petition for Review and Expedited Motion for Stay, which portray the harms and indignities the residents have suffered as insignificant and inconsequential.

The same corporate management for Destin Healthcare is also the corporate management for several other Florida health care facilities. AHCA has learned that it has been pressuring the Administrators of those facilities to violate statutory staffing and self-moratoria requirements at those facilities. Additionally, seven of the nursing homes that AHCA has cited since the beginning of 2021 for violating the requirement to impose a moratorium on admissions when staffing levels are below the statutory minimum are managed by the same management company. The management company, thus, has a pattern of illegal and unsafe conduct that cannot be condoned.

Also, the AHCA has yet to determine if Destin Healthcare staffing issues have been permanently solved and/or if the facility's staff are providing adequate care to meet residents' needs. Destin Healthcare only obtained the additional staff **after** AHCA issued the Emergency Order imposing the moratorium and suspending its license. If the facility has sufficient staffing now (and it was done so quickly), then it clearly could

have been obtained earlier. It appears the primary reason sufficient staff were not hired earlier was the expense, which is inexcusable because the facility should be putting its residents' welfare first. The staff the facility has hired are temporary staff supplied by an agency and are unfamiliar with residents' needs. As documented in the survey notes, Regional Vice President is still has complaining to Agency surveyors about the cost of hiring the temporary staff, which is another red flag. And some of the permanent staff have notified the Administrator that they are leaving for jobs elsewhere. In short, AHCA is not satisfied the facility will continue to meet the minimum staffing levels required by law and necessary to adequately protect and care for its residents if the Emergency Order is stayed.

For all these reasons, conditions at the facility remain equally as immediate, serious, dangerous, and threatening to the health, safety, and welfare of the public, including residents/clients and potential residents, as they were when AHCA conducted its survey and issued the Emergency Order. The Emergency Order, therefore, remains necessary to protect the public from the immediate and serious dangers to health, safety, and welfare posed by the facility. As such, AHCA strongly urges this Court to deny the requested stay.

AHCA points out that nowhere in the Motion for Stay does Destin Healthcare challenge the moratorium on admissions. As such, this Court need not address the moratorium in its Order on the Motion for Stay.

Legal and Factual Background Supporting AHCA's Position

A. Summary of the Relevant Laws Governing Florida Nursing Home Facilities.

Licensure. In Florida, nursing homes are licensed and regulated by AHCA pursuant to chapters 400, part II, and 408, part II, Florida Statutes, and chapters 59A-4 and 59A-35, Florida Administrative Code. See generally §§ 400.011, 400.21(2), (7), (12), 400.23, 408.801, 408.802(10), 408.803(1), 408.819, Fla. Stat.[1] It is unlawful to operate a nursing home without obtaining and maintaining a license issued by AHCA. §§ 400.062(1), 408.802(10), 408.804(1), Fla. Stat.

The holder of a license to operate a nursing home is termed the "licensee." § 408.803(9), Fla. Stat. (defining "licensee" as "an individual corporation, partnership, firm association, governmental entity, or other entity that is issued a … license by the agency. …" The licensee is legally responsible for all aspects of the provider operation." Id. Additionally, "[t]he licensee must have full legal authority and responsibility for the operation of

the facility." Fla. Admin. Code R. 59A-4.103(4)(a). "Provider" includes "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802[,]" including nursing homes, which are listed at subsection (10). §§ 408.802(10), 408.803(1), (12), Fla. Stat.

Administration and Management. Florida law provides that "[e]very [nursing home] facility shall comply with all standards and rules of the agency and shall: (a) Be under the administrative direction and charge of a licensed administrator." § 400.141(1)(a), Fla. Stat. "No nursing home shall operate except under the supervision of a licensed nursing home administrator, and no person shall be a nursing home administrator unless he or she is the holder of a current license as provided in chapter 468." § 400.20, Fla. Stat. "The licensee of each facility must designate one person, who is licensed by the Florida Department of Health, Board of Nursing Home Administrators under Chapter 468, Part II, F.S., as the Administrator who oversees the day to day administration and operation of the facility." Fla. Admin. Code R. 59A-4.103(4)(b).

[1] All references in this Response are to the 2021 version of the Florida Statutes and the 2021 through current versions of the Florida Administrative Code.

Staffing. Section 400.23(3)(a)-(c) sets forth the minimum staffing requirements for nursing homes prescribed by the Legislature, including that each facility must have:

> [(3)(a)1.]a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.
>
> b. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.
>
> c. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.

§ 400.23(3)(a)1.a.-c., Fla. Stat. Rule 59A-4.108(4) adds that:

> In accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Fla. Admin. Code R. 59A-4.108(4).

Section 400.141(1)(n) mandates that "[a] facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for 6 consecutive days. …" Thus, a facility

that fails to meet staffing standards for two (2) consecutive days is required to self-impose a moratorium on admissions. Id.

Residents' Rights. Section 400.022(1), Florida Statutes, requires every nursing home to "adopt and make public a statement of the rights and responsibilities of residents" and to "treat such residents in accordance with the provisions of that statement." The "statement shall assure each resident the following:

> [(1)](l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with the rules adopted by the Agency.
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> * * *
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> (n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

§ 400.022(1)(l), (1)(n), Fla. Stat.

Surveys and Actions Resulting from Surveys. As part of its regulatory duties, AHCA conducts periodic unannounced surveys, including both licensure and complaint surveys, of nursing home facilities to determine their compliance with the law. See §§ 400.19, 400.23(7),

400.241(1), 408.811, Fla. Stat.; Fla. Admin. Code R. 59A-35.120. After a survey, AHCA must provide a nursing home with a report or "statement of deficiencies" containing its findings and listing any identified "deficiencies" or violations. § 408.811(4), Fla. Stat.; Fla. Admin. Code R. 59A-35.120(1)(a). A nursing home that receives a statement of deficiencies must submit a detailed plan of correction to AHCA for approval and must correct within 30 days, or such other period identified by AHCA, except Class I deficiencies must be corrected within 24 hours. § 408.811(4)-(5), Fla. Stat.; Fla. Admin. Code R. 59A-35.120(1)(a). AHCA may conduct follow-up surveys to verify correction has occurred. § 408.811, Fla. Stat.; Fla. Admin. Code R. 59A-35.120(1)(b). In addition to requiring correction, AHCA may charge the nursing home with deficiencies or violations of the law identified through a survey by administrative complaint and may seek to impose penalties ranging from fines to license suspension or revocation. See §§ 120.60(6), 400.121, 400.23(8), 408.811, 408.813-408.815, Fla. Stat.; Fla. Admin. Code R. 28-106.2015, 28-106.501.

B. Statement of the Case and Facts.

At all times relevant, Destin Healthcare has held a license from AHCA, license number 16210961, to operate a 119-bed nursing home

facility in Destin, Florida. (App. A at Bates 3; App. B at Bates 20).[2] Destin Healthcare is owned by Epsilon Healthcare Properties, LLC, of which Michael Campbell is a Board Member/Officer (App. E, Exh. A at Bates 47). It is managed by Josera, LLC d/b/a Independency Living Centers. (App. E, Exh. A at Bates 37, 47).

Beginning on April 10, 2022, an AHCA survey team conducted a survey of Destin Healthcare that lasted several days and included a review of facility records, interviews with staff and residents, and observation. (App. A at Bates 7-13). Based on the survey, AHCA determined it was necessary and appropriate to place an immediate moratorium on admissions to the facility and to suspend its operating license. (App. A at Bates 3-19).

On April 16, 2022, AHCA issued the Immediate Moratorium on Admissions and Emergency Suspension Order (again, "Emergency Order"). (App. A at Bates 3-19). The Emergency Order: (1) imposed an immediate moratorium on admissions to Destin Healthcare, prohibiting both new admissions and the readmission of residents after discharge; (2) suspended the facility's license to operate as a nursing home, effective April 25, 2022 at 5:00 p.m.; (3) required the facility to "immediately take the

[2] This Response has an Appendix, which will be referenced herein as

appropriate steps to safely discharge the nursing home residents, notify any guardians and family members that are responsible for the residents and record the residents' new locations"; and (4) stated, "[a]s of the effective date and time of the emergency suspension, the Respondent shall no longer operate this nursing home." (App. A at Bates 18). The facts and law supporting the Emergency Order were stated therein. (App. A at Bates 3-15). They are also largely repeated in this Response.

On April 22, 2022, AHCA issued the Order Extending Effective Date of Emergency Suspension (Immediate Moratorium on Admissions Remains In Place) (again, "Order Extending Suspension Date") extending the licensure suspension date until May 2, 2022 at 5:00 p.m. (App. B at Bates 20-24). As AHCA explained in the text of the Order Extending Suspension Date, which is hereby incorporated by reference, the extension was necessary because the facility had dragged its feet in arranging for resident discharge or transfer, and AHCA was concerned the residents could not be safely discharged by the previous April 25, 2022 at 5:00 p.m. suspension date. (App. B at Bates 20-23). AHCA recognized in the Order Extending Suspension Date that the facility had, at least temporarily, obtained sufficient staff to meet minimum requirements of law, but it remained to be

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"App.," followed by any appropriate appendix letters and Bates numbers.

determined if there had been any permanent correction of the issues that resulted in the Emergency Order. (App. B at Bates 21-22). The Order Extending Suspension Date pointed out that the new staff was temporary and that AHCA was conducting daily monitoring visits to monitor the situation. (App. B at Bates 21-23). The Order Extending Suspension date imposed conditions on the extension, including: (1) "[t]he Facility must act with great urgency and expediate the discharge process"; (2) the Facility must "provide the Agency with status reports on a daily basis," forward them "in a secured manner directly to the Agency's local Field Office Manager," and "include the identity of the resident, the name and place of the entity where the resident is being discharged, the date and time of discharge, the name and contact information of the resident's treating health care practitioner and caretaker"; and (3) the Facility must "maintain a log on all residents noting all actions the Facility has taken to discharge each resident," including "any communications with residents' family member, caretaker, and managed care plan." (App. B at Bates 22-23).

On April 26, 2022, Destin Healthcare filed; (1) the Petition for Review of Emergency Suspension of License Order; (2) an Appendix consisting of the Emergency Order, an Affidavit of its Regional Vice President of Operations, Michael D. Campbell, and the Order Extending Suspension

Date; and (3) an Expedited Motion for Stay of Emergency Order (again, "Motion to Stay").

On April 27, 2022, this Court issued an Order directing AHCA to: (1) respond to the Motion for Stay by April 29, 2022 at noon and show cause why it should not be granted; and (2) to respond to the Petition for Review within 20 days. (App. C at Bates 25).

Agency surveyors have visited the facility every day since the issuance of the Emergency Order and redacted versions of their status reports and the facility's closure logs are available in the Appendix to this Response. (App. D at Bates 26-36). Markedly, the survey notes show:

- The facility only discharged one (1) resident to another placement during the period from April 17 through 24, 2022, with that discharge occurring on April 23, 2022; all other residents who were discharged were deceased, hospitalized, or pre-scheduled to be discharged after therapy (App. D at Bates 26-33).

- The facility was fully staffed by April 17, 2022, i.e. the day after AHCA issued the Emergency Order, despite being short-staffed for months. (App. D at Bates 26).

- Most (perhaps all) of new staff were temporary staff supplied by a temporary agency and were being trained by the permanent staff. (App. D at Bates 27-32).

- Some of the permanent staff have "turned in their notices" to the facility Administrator, indicating they are leaving the facility's employment for jobs elsewhere. (App. D at Bates 35).

- On April 24, 2022, the Regional Vice President complained to AHCA survey staff about the cost of obtaining the temporary staff for the facility, stating the agency was charging $110 per hour for a certified nursing assistant. (App. D at Bates 32).

C. Affidavit of Karla Beasley, AHCA Field Office Manager

Included as Appendix E to this Response is the Affidavit of Karla Beasley, a Registered Nurse and AHCA's Field Office Manager for Areas 1 and 2, consisting of counties ranging from Escambia County through Madison and Taylor Counties. (App. E at Bates 37). She is also the Records Custodian for AHCA for these Field Offices. (App. E at Bates 38). She has been employed with AHCA since September 2006. (App. E at Bates 37).

In her Affidavit, Ms. Beasley states that, prior to the survey of Destin Healthcare, several nursing home administrators had reached out to her

about being pressured or forced to accept new resident admissions when nursing home staffing was an issue. (App. E at Bates 38, 49). More specifically:

- The Administrator for Tallahassee Living Center, called in December 2021 and informed Ms. Beasley that he was terminated for refusing to take new admissions when facility staffing was low. (App. E at Bates 38). Like Destin Healthcare, Tallahassee Living Center is managed by Josera, LLC, d/b/a Independent Living Centers. (App. E, Exh. B, at Bates 38, 49). AHCA conducted surveys of the facility in February 2021, determined the facility had been operating without sufficient staffing and had not self-imposed the required moratorium on admissions, and issued a statement of deficiencies to the facility. (App. E, Exh. C, at Bates 38-39, 51-70).

- The Administrator for nursing home University Hills Health and Rehabilitation Center contacted Ms. Beasley to tell her she had resigned over resident admission pressure; she was beginning work at another facility that week. (App. E at Bates 39-40). Like Destin Healthcare, University Hills Health and Rehabilitation Center is managed by Josera, LLC d/b/a Independence Living Centers. (App. E, Exh. D, at Bates 40, 71). AHCA conducted surveys of the facility in January and February 2022,

determined the facility had been operating without sufficient staffing and had not self-imposed the required moratorium on admissions, and issued a statement of deficiencies to the facility. (App. E, Exh. E, at Bates 40-41, 73-79).

- The Administrator of nursing home Perry Oaks Health Care (formerly Marshall Health and Rehabilitation Center) informed an Agency surveyor that corporate management was aware that facility was below minimum staffing levels but wanted the facility to continue to admit new residents. (App. E at Bates 41). Like Destin Healthcare and University Hills Health and Rehabilitation Center, Perry Oaks Health Care is managed by Josera, LLC d/b/a Independence Living Centers. (App. E, Exh. F, at Bates 41, 80). AHCA conducted surveys of the facility in March 2022, determined the facility had been operating without sufficient staffing and had not self-imposed the required moratorium on admissions, and issued a statement of deficiencies to the facility. (App. E, Exh. G, at Bates 41-42, 82-96).

- The Administrator of nursing home Living Center of Pensacola resigned due to pressure to admit residents when the facility was understaffed. (App. E at Bates 42). Like Destin Healthcare, University Hills Health and Rehabilitation Center, and Perry Oaks Health Care, Living

Center of Pensacola is managed by Josera, LLC d/b/a Independence Living Centers. (App. E, Exh. H, at Bates 42, 97).

- The Administrator of Shoal Creek Rehabilitation Center was experiencing the same issues with corporate management regarding short staffing and the admission of new residents. (App. E, Exh. H, at Bates 42). Like Destin Healthcare, University Hills Health and Rehabilitation Center, Perry Oaks Health Care, and Living Center of Pensacola, Shoal Creek Rehabilitation Center is managed by Josera, LLC d/b/a Independence Living Centers. (App. E, Exh. I, at Bates 43, 99). AHCA conducted a survey of the facility in February 2022, determined the facility had been operating without sufficient staffing and had not self-imposed the required moratorium on admissions, and issued a statement of deficiencies to the facility. (App. E, Exh. J, at Bates 43-44, 99-112).

Ms. Beasley stated in the Affidavit:

> 38. In my professional opinion, grossly inadequate nursing home staffing over a prolonged period of time negatively impacts the overall care and wellbeing of nursing home residents. As nurses and other nursing home staff are severely overworked and overburdened, they become physically tired and rushed. This increases the risk of errors and resident harm. Nurses and staff that are well-rested and ready to provide the quality care will lead to better patient outcomes. As residents wait longer times for a response to their call lights and get less face-to-face time with nursing staff, patient perceptions of care worsen. When nurses and other caregivers do not have the support and resources they need,

> burnout can occur. This may lead to more resignations and retirements. Facilities may ultimately find themselves in the position of spiraling staff losses and revolving door hiring. To compound matters, if a facility is already short on staff, callouts heighten the stress of the work environment. Grossly inadequate nursing home staffing over a prolonged period of time creates an imminent risk of harm that will ultimately lead to resident tragedies, including medical errors, contractions, resident falls and pressure injuries. This may lead to unnecessary resident hospitalizations and ultimately deaths.

(App. E at Bates 45).

Ms. Beasley stated that, based on Agency's survey, Destin Healthcare is being cited for multiple Class I (most severe) violations of the nursing home laws, including for failure to impose the required moratorium after two (2) days of understaffing and the failure to honor Florida's nursing home residents' rights. (App. E at Bates 45-46). In the past, AHCA has cited nursing homes for violating the requirement to self-impose a moratorium, but "[i]n all my time as a surveyor and field office manager, I do not recall a nursing home violating this legal requirement to this extent. (App. E at Bates 46). Other nursing homes are experiencing staffing shortages but, for the most part, they have self-imposed the moratorium on admissions in compliance with Florida law. (App. E at Bates 46).

Argument

A. Summary of the Law Governing Agency Emergency Orders and Moratoriums.

AHCA may take emergency action against a nursing home's license, pursuant to Sections 120.60(6), 408.814(1), or 400.121(1), Florida Statutes, and Rule 28-106.501, Florida Administrative Code, "if the agency finds [an] immediate serious danger to the public health, safety or welfare" or "if the agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client."

Section 120.60(6) states:

> (6) If the agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license, the agency may take such action by any procedure that is fair under the circumstances if:
>
> (a) The procedure provides at least the same procedural protection as is given by other statutes, the State Constitution, or the United States Constitution;
>
> (b) The agency takes only that action necessary to protect the public interest under the emergency procedure; and
>
> (c) The agency states in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety, or welfare and its reasons for concluding that the procedure used is fair under the circumstances. The agency's findings of immediate danger, necessity, and procedural fairness are judicially reviewable. Summary suspension, restriction, or limitation may be ordered, but a suspension or revocation proceeding pursuant to ss. 120.569 and 120.57 shall also be promptly instituted and acted upon.

§ 120.60(6)(a)–(c), Fla. Stat.

Similarly, Section 408.814(1) states:

> (1) The agency may impose an immediate moratorium or emergency suspension as defined in s. 120.60 on any provider if the agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client.

§ 408.814(1), Fla. Stat.

Section 400.121(1)(a) adds:

> (1) The agency may deny an application, revoke or suspend a license, and impose an administrative fine, not to exceed $500 per violation per day for the violation of any provision of [part II of chapter 400], part II of chapter 408, or applicable rules, against any applicant or licensee for the following violations by the applicant, licensee, or other controlling interest:
>
> (a) A violation of any provision of [part II of chapter 400], part II of chapter 408, or applicable rules; …

§ 400.121(1)(a), Fla. Stat.

Finally, Rule 28-106.501 states:

> (1) If the agency finds that immediate serious danger to the public health, safety, or welfare requires emergency action, the agency shall enter an emergency order summarily suspending, limiting, or restricting a license, or taking such other emergency action as is authorized by law.
>
> (2) The agency's emergency order shall include a notice of the licensee's (or person or entity subject to the agency's jurisdiction) right to an immediate appeal of the emergency final order pursuant to Section 120.569(2)(n) or 120.60(6), F.S.
>
> (3) In the case of the emergency suspension, limitation, or

> restriction of a license, unless otherwise provided by law, within 20 days after emergency action taken pursuant to subsection (1) of this rule, the agency shall initiate administrative proceedings in compliance with Sections 120.569, 120.57 and 120.60, F.S. and Rule 28-106.2015, F.A.C.

Fla. Admin. Code R. 28-106.501(1)-(3).

When a non-final emergency order limiting or restricting a license is rendered by an agency without a hearing, appellate review is limited to the "four corners" of the order, and every element essential to the emergency order's validity must appear on its face. E.g., Rehab. Ctr. at Hollywood Hills v. Ag. for Health Care Admin., 250 So. 3d 737, 743 (Fla. 1st DCA 2018); Valls v. Dep't of Health, 255 So. 3d 515, 517 (Fla. 3d DCA 2018); Nath v. Dep't of Health, 100 So. 3d 1273, 1276 (Fla. 1st DCA 2012); Bio-Med Plus v. Dep't of Health, 915 So. 2d 669, 673 n.3 (Fla. 1st DCA 2005). It is not enough for an emergency order to merely allege statutory violations. Kaplan v. Dep't of Health, 45 So. 3d 19, 20 (Fla. 1st DCA 2010); Bio-Med Plus, 915 So. 2d at 672. To satisfy due process, the emergency order must contain particularized allegations of fact that demonstrate: (1) the circumstances or conduct of the facility constitute(s) "an immediate serious danger to the public health, safety, or welfare" ***or*** "a threat to the health, safety, or welfare of a client"; (2) the complained of circumstances or conduct are likely to continue or be repeated; (3) the order is necessary to

stop the emergency or prevent its likely repetition; ***and*** (4) the order is sufficiently narrowly-tailored to be fair. See, e.g., §§ 120.60(6), 408.814(1), Fla. Stat.; Valls, 255 So. 3d at 517; Sanchez, 225 So. 3d at 966; Omulepu v. Dep't of Health, 198 So. 3d 1046, 1047 (Fla. 1st DCA 2016); Webber v. Dep't of Bus. & Prof'l Reg., 198 So. 3d 922, 922-23 (Fla. 1st DCA 2016); Nath, 100 So. 3d at 1275-76; Kaplan v, 45 So. 3d at 20-21; All State Floridian Ins. Co. v. Off. of Ins. Reg., 981 So. 2d 617, 623 (Fla. 1st DCA 2008); Kodsy v. Dep't of Fin. Servs., 972 So. 2d 999, 1002 (Fla. 4th DCA 2008); St. Michael's Acad., Inc. v. Dep't of Child. & Fams., 965 So. 2d 169, 172 (Fla. 3d DCA 2007); Bio-Med, Plus, 915 So. 2d at 671-74. If the facts alleged in the order demonstrate the four (4) elements above, no hearing was required prior to the emergency action and the emergency action should be upheld on review. Kodsy, 972 So. 2d at 1002.

Case law states that, where an agency enters a non-final emergency order under section 120.60(6), allegations of "sufficiently serious" or "egregious" past acts which are of a nature likely to be repeated may substitute for claims of immediate harm. Omulepu, 198 So. 3d at 1047; Kodsy, 972 So. 2d at 2001; St. Michael's Acad., 965 So. 2d at 172; Bio-Med, Plus, 915 So. 2d at 673. "While … emergency orders cannot be used to discipline prior conduct, prior conduct is relevant to determining future

risk. 'There is ample precedent supporting the suspension of a license upon [a] showing of past harm when the harm is sufficiently serious and of a nature likely to be repeated." Rehab. Ctr. at Hollywood Hills, 250 So. 3d at 744 (quoting Stock v. Dep't of Banking & Fin., 584 So. 2d 112, 115-16 (Fla. 5th DCA 1991)). However, "general conclusory predictions of harm" are insufficient to support an emergency order; there must be allegations showing risk to the public or clients of the facility. See, e.g., Webber, 198 So. 3d at 922-23; Kodsy, 972 So. 2d at 1002; St. Michael's Acad., 965 So. 2d at 172; Field v. Dep't of Health, 902 So. 2d 893, 895 (Fla. 1st DCA 2005); Daube v. Dep't of Health, 897 So. 2d 493, 495 (Fla. 1st DCA 2005).

Further, for a non-final emergency order to be sufficiently narrowly-tailored to be fair, the order must be the "least restrictive reasonable means" of protecting the public or facility residents/clients available to the Agency. § 120.60(6)(b), Fla. Stat.; Yalamanchi v. Dep't of Health, 909 So. 2d 395, 395 (Fla. 1st DCA 2005). Accord Henson v. Dep't of Health, 922 So. 2d 376, 377 (Fla. 1st DCA 2006); Daube v. Dep't of Health, 902 So. 2d 269, 270 (Fla. 1st DCA 2005); Field, 902 So. 2d at 895. In other words, the agency must show why less restrictive alternatives would have been insufficient to stop the harm alleged. Burton v. Dep't of Health, 116 So. 3d 1285, 1286 (Fla. 1st DCA 2013); Nath v, 100 So. 3d at 1276.

The above standards apply to this Court's review of the instant Emergency Order and Order Extending Suspension Date and, thus, in determining whether the Motion for Stay should be denied.

B. Summary of the Law Governing Stays of Emergency Orders.

AHCA agrees with Destin Healthcare's summary of the applicable law governing stays, as set forth in the Motion for Stay at pages 3-4. AHCA reiterates the standards here to aid the reader.

When seeking to obtain a stay of an emergency order on a license issued pursuant to Section 120.60(6), a party affected by an agency's emergency order suspending its license may apply to the District Court of Appeal, which may grant a stay on appropriate terms. Fla. R. App. P. 9.310. Rule 9.190(e)(2)(B) sets forth the following governing procedures:

> (e) Stay Pending Review.
>
> (2) Application for Stay Under the Administrative Procedure Act.
>
> (B) When an agency has ordered emergency suspension, restriction, or limitations of a license under section 120.60(6), Florida Statutes, . . . the affected party may file with the reviewing court a motion for stay on an expedited basis. The court may issue an order to show cause and, after considering the agency's response, if timely filed, grant a stay upon appropriate terms.

Fla. R. App. P. 9.190(e)(2)(B).

"The purpose of an appellate stay is to maintain the status quo in the lower tribunal while an appeal proceeds." QBE Ins. Corp. v. Chalfonte Condo. Apartment Ass'n, Inc., 94 So. 3d 541, 555 (Fla. 2012). The "[f]actors which are considered ... in deciding whether to grant a stay include the moving party's likelihood of success on the merits, and the likelihood of [irreparable] harm should a stay not be granted." Perez v. Perez, 769 So. 2d 389, 391 n.4 (Fla. 3d DCA 1999). Accord Mitchell v. State, 911 So. 2d 1211, 1219 (Fla. 2005) (employing the same "principle considerations" in deciding whether to vacate a stay and specifying that the harm must be both likely and irreparable). Where the requested stay will enjoin an agency action, the court should also consider whether the moving party has demonstrated: (1) an irreparable harm, or likelihood of irreparable harm, if the injunction is not granted; (2) a clear legal right to the requested relief; (3) unavailability of an adequate remedy at law; and (4) whether considerations of public interest or public policy support the injunction. E.g., Liberty Counsel v. Fla. Bd. of Governors, 12 So. 3d 183, 185 n.7 (Fla. 2009); Reform Party of Fla. v. Black, 885 So. 2d 303, 305 (Fla. 2004); Grove Isle Ass'n, Inc. v. Grove Isle Assoc., LLLP, 137 So. 3d 1081, 1092 (Fla. 3d DCA 2014); Miami-Dade Cnty. ex rel. Walthour v. Malibu Lodging

Invs., LLC, 64 So. 3d 716, 722 (Fla. 3d DCA 2011). Weekley v. Pace Assembly Ministries, Inc., 671 So. 2d 220, 220 (Fla. 1st DCA 1996).

C. Destin Healthcare Has Not Demonstrated That A Stay Should Be Granted Pursuant to the Factors Prescribed by Caselaw.

In this case, all the case-law stay factors described above apply since a stay would have the effect of enjoining AHCA's enforcement of the Emergency Order and Order Extending Suspension Date. However, as explained further below, the case law factors do not support granting a stay under the facts and circumstances of this case. As such, this Court should deny the Motion for Stay. AHCA points out that nowhere in the Motion for Stay does Destin Healthcare challenge the moratorium on admissions. As such, this Court need not address the moratorium in its Order on the Motion for Stay.

1. Destin Healthcare Is Unlikely to Succeed on the Merits of Its Petition for Review.

Destin Healthcare is unlikely to succeed on the merits of its Petition for Review.

As set forth in detail at Argument, Section A, AHCA has discretionary authority to issue emergency orders, including the instant Emergency Order and Order Extending Suspension Date imposing the immediate moratorium on admissions and suspending Destin Healthcare's operating license, pursuant to Sections 120.60(6), 408.814(1), and 400.121(1), and Rule 28-106.501. Since emergency orders must be followed by an

administrative complaint per Section 120.60(6)(c) and Rule 38-106.501(3)'s procedures, this Court's review of the instant Emergency Order and Order Extending Suspension Date is limited to the documents' "four corners." E.g., Rehab. Ctr. at Hollywood Hills, 250 So. 3d at 743; Valls, 255 So. 3d at 517; Sanchez, 225 So. 3d at 966; Nath, 100 So. 3d at 1276; Bio-Med Plus, 915 So. 2d at 673 n.3. Thus, this Court **is not** permitted to consider any other information – including the Affidavit at Appendix B of the Petition for Review or the additional information that AHCA has included in the Appendix to this Response to Motion for Stay – when reviewing the sufficiency of the Emergency Order and Order Extending Suspension Date.

Here, the Emergency Order is legally sufficient within its four corners because it contains particularized allegations of fact that demonstrate: (1) the circumstances or conduct of the facility constitute "an immediate serious danger to the public health, safety, or welfare" and/or "a threat to the health, safety, or welfare of a client"; (2) the complained of circumstances or conduct are likely to continue or be repeated; (3) the order is necessary to stop the emergency or prevent its likely repetition; and (4) the order is sufficiently narrowly-tailored to be fair. See, e.g., §§ 120.60(6), 400.121(1), 408.814(1), Fla. Stat.; Valls, 255 So. 3d at 517; Sanchez, 225 So. 3d at 966; Omulepu, 198 So. 3d at 1047; Webber, 198

So. 3d at 922-23; Nath, 100 So. 3d at 1275-76; Kaplan, 45 So. 3d at 20-21; All State Floridian Ins. Co., 981 So. 2d at 623; Kodsy, 972 So. 2d at 1002; St. Michael's Acad., 965 So. 2d at 172; Bio-Med, Plus, 915 So. 2d at 671-74.

Indeed, the particularized allegations of fact set forth in the Emergency Order are as follows:

> **FACTS JUSTIFYING AN IMMEDIATE MORATORIUM ON ADMISSIONS AND EMERGENCY SUSPENSION OF LICENSE**
>
> 12. On April 10, 2022, the Agency commenced a survey of the Facility.
>
> 13. A review of the Facility records revealed an average daily census of 112-114.
>
> 14. Based upon this census, the Facility identified residents requiring assistance with activities of daily living ("ADL") from assistance of 1-2 staff members to total dependence, make up a large percentage of its resident population. ADLs include dressing (77%), bathing (97%), transfer (81 %), eating (91 %), and toileting (83%). The Facility has 17 residents who require a 2-person assist with transfers and 4 residents who are dependent on staff for eating.
>
> 15. The survey team conducted 19 staff interviews, all of which revealed concerns with inadequate staffing. The survey team conducted interviews with 12 interviewable residents, all of which voiced concerns with inadequate staffing. Two non-interviewable residents had visible ADL needs. One Quality Assurance Committee group interview revealed "dire" staffing concerns. A total of 9 weeks of Facility staffing records were reviewed. The Facility failed to meet minimum state staffing guidelines for 58 out of 63 days reviewed. By law, the Facility

was required to self-impose a moratorium on resident admissions. § 400.14l(l)(n), Fla. Stat. (2021).

16. The survey team found that all of the residents were at immediate risk due to the continual short staffing of nurses and certified nurse assistants ("CNA"). Multiple staff interviews revealed that the Facility staff are working extra shifts frequently and have very heavy patient assignments during work. The staff expressed feelings of being very tired and frustrated because they could not provide the care that the residents require. Multiple resident interviews revealed complaints about excessive waits after incontinent episodes as well as the lack of showers due to the inadequate staff level. In fact, some residents were concerned for the staff and one resident actually became tearful when describing how hard the staff are working. Many residents stated that they are reluctant to call for assistance because the staff are working so hard. One resident stated he would like to go outside and smoke, or just sit in the courtyard, but cannot on a regular basis due to the inadequate staffing level. Another resident has to go to bed at 4:00 p.m. depending on the staffing levels. As a result [of] the grossly inadequate staff levels, all of the residents are at immediate increased risk for poor outcomes.

17. Most disturbing, after the Facility's administration repeatedly informed corporate management of the inadequate staff levels over an extended period of time and the law requiring the self-imposition of a moratorium on resident admissions, corporate management overrode the legislative moratorium mandate and compelled the Facility to accept new resident admissions. The admissions/discharge reports revealed that the Facility admitted 17 new residents during January 2022, 19 new residents during February 2022; 19 new residents in March 2022, and 2 new residents during April 2022. There is nothing in the Facility records indicating that these new residents were informed of the Facility's inadequate staffing levels. The corporate decision to continue resident admissions when the Facility was experiencing a severe staffing shortage exacerbated an inadequate staffing problem into a resident crisis.

18. The Agency's findings as a result of the resident interviews mirrored each other in large part. They [sic] resident interviews revealed as follows:

a. Resident #2 stated that he can shower himself, but needed help getting his brace on his right arm. The Resident showed the surveyor his arm revealing a contracted wrist. The Resident stated it is getting worse, that he cannot put the brace on himself, and that the Facility does not have enough CNAs to help. He states the staffing has gotten worse. The surveyor observed the Resident's arm splint in the resident's wheelchair beside the bed. The resident is unable to reach it. He stated something has to be done about the staff. At times, he stated he has waited over an hour for staff assistance. He stated there are times there is only one CNA on the floor.

b. Resident #3 stated that the last couple of months things have gotten bad at the Facility. She stated the staff are working hard, but they do not have enough staff to take care of the residents. She did not remember when she had a bath last, and stated she laid in urine for 16 hours one day. She could not remember when it was, she thinks it was about one month ago. Resident #3 was observed in a hospital gown. She stated the food is terrible, but she has to eat it, or go hungry. Later, Resident #3 was observed awake, sitting up in bed, and wearing a night gown. The Resident stated that she has lived at the Facility for 3 years. When asked about any concerns, Resident #3 stated that the Facility is short-handed. The staff was doing its best, but that it is not enough.

c. Resident #4 stated the Facility is short-staffed and that the residents are not receiving the care they need. She stated that she has had a severe injury and needs help getting out of bed. She stated she could change herself, but the facility won't let her do that. She stated she was supposed to have a bath last Saturday,

but the staff does not give baths because they do not have enough CNAs. Resident #4 stated she has waited for 2 hours for the call light to be answered and stated she has laid in feces for 4 hours in the recent past, though unable to provide an exact date. She stated she does not have any skin breakdown yet. She is supposed to receive a specific type of care regularly because of her severe injury, but has not received the care. She stated she has had to stay in bed all day because the Facility does not have enough CNAs to assist her getting out of bed. The resident requires a mechanical lift. Resident #4 was observed in a hospital gown.

d. Resident #5 was observed and noted to be confused. The resident was observed lying in bed, in a hospital gown. Notably, a dark brown substance was observed under all of the residents' fingernails.

e. Resident #6 was observed with greasy hair.

f. An interview with Resident #7 revealed that the Resident has not had a shower in a while.

g. Resident #8 was interviewed in the Resident's room. The Resident stated that he is supposed to wear a splint, but there is not enough staff to help him put it on. He stated he is scheduled for a bath on Sundays and Thursdays, but has not had a bath for at least a week. He stated he wants to get up out of bed, but he has to be lifted with a mechanical lift and the Facility does not have enough staff to assist him out of bed. He stated he wants to get up and go sit outside in the courtyard. He ordered a big television so that he can at least watch television since he has to lay in bed all the time.

h. Resident #9 was interviewed and stated that she did not remember when she last received a shower. The resident was observed in a hospital gown.

i. Resident #10 was interviewed and stated that things are very bad at the Facility. In fact, she asked a family member to find a better facility for her. The Resident stated that on this past Saturday, there was one 1 CNA for 60 residents. She stated on Saturday, her family member came to visit and found feces on the floor. She stated that her family member helped clean her, but could not lift her to get her out of bed. There was no staff to help. She stated she has to go to bed at 4:00 p.m. because if the staff does not put her down before they leave, she will not be able to go to bed until after 10:00 p.m. She stated she had to stay up until 10:00 p.m. last Sunday night. She stated she was in bed from Friday evening at 4:00 until Sunday morning. She stated she was in one position because she could not move herself. She stated she had a bowel movement sometime after she went to bed on Friday at 4:00 p.m. and that her family member had to clean her up when she visited on Saturday. She stated her family member called law enforcement because the family member was so disgusted with the Resident's care at the Facility.

j. Resident #11 was interviewed and stated she has not had a bath in a long time. She stated that she has been receiving a bath only one time per month. She stated she requires two staff to bathe her, so she wondered if that was why she is not receiving her baths.

19. Similarly, the Agency's findings as a result of the staff interviews mirrored each other in large part. The staff interviews revealed as follows:

a. An interview with Staff A, Licensed Practical Nurse ("LPN"), revealed that Staff A has worked at the Facility almost 5 years. She stated that for the past few months, the Facility has been short staffed. The staff is supposed to work 8-hour shifts, but some of the staff work double shifts. Some nurses are doing 12-hour shifts to cover the resident care needs. Staff A stated that she tries to pick up at least 1 or 2 double shifts per week, but

is very tired. Some other staff work more double shifts, but she does only one or two. The Facility is advertising positions, trying to hire, but is not getting staff. She added that the Facility has had some home health agency help, and everyone is working hard and getting tired. Some staff simply quit. The Facility does not have a Director of Nursing or an Assistant Director of Nursing. When asked whether resident care needs were being met, Staff A stated that the staff is doing the best it can, everyone is really working extra hard. Staff A admitted that the CNAs are so busy, that bathes and showers are behind.

b. An interview with Staff D, CNA, revealed that she is tired. She stated that the Facility works short every shift and she cannot provide the type of care she wants to provide to the residents. Staff D stated she just tries to do her best. She stated tonight will be a good night because the Facility has four staff members, which is very unusual. She is concerned about speaking up.

c. An interview with Staff D, CNA, revealed that she works evenings and tries to help out by picking up extra shifts. The Facility just called and asked if she could come in today. She picks up where she can, works a double shift now and again, and stays late to help the next shift. The Facility has been short-staffed for few months now and that the Facility needs more staff who want to work. The Facility has a great team that helps each other, but it is tiring. When asked whether any services are not being met, she stated that the Facility is behind on showers and bathes. It is trying to get caught up, but the C wing has a lot of mechanical lift patients. It is trying to get 2-3 done each shift, but it is not easy when it is short-staffed. She makes sure she rounds as often as she can and tries to keep everyone clean, dry and comfortable. She helps with hydration and meals, and also makes sure that the residents are safe.

d. An interview with Staff F, a registered nurse ("RN"), revealed that she was a night shift nurse. She

stated the staffing is pitiful. She works the A wing frequently. She stated she has worked the A wing on the night shift as the only staff member and that she had covered the residents on Serenity wing as well. The census of both units is 54. She could not remember the date, but thinks it was a couple of weeks ago. She stated she cannot check and change residents every two hours, but she made sure every resident was changed at least 2 times in her shift. She stated the staff at this Facility work their tails off, do not complain and have an amazing attitude. She stated when she was working by herself, the residents were trying to take care of her. She stated they kept asking her if she needed anything, offered her snacks and kept telling her to sit down and rest.

e. An interview was conducted with Staff K, CNA, who has been employed at the Facility for almost a year. When asked how the residents' care needs are being met, she stated that the staff is trying to get showers done and catch up on that. Management does not help much, the nurses help. The Facility is short-staffed and overworked. She wishes that management could just hire more staff because "we need them." When asked whether any services were not being met, she stated that the showers were behind. She rounds often on her patients, makes sure they get what they need, tries to keep them clean, dry and comfortable. She stated that the CNAs shower the residents, but some are not documenting their care with showers and bathes because they just do not have the time.

f. Interviews with Staff L, LPN, and Staff P, RN, echoed the same concerns and sentiments. Staff P stated the unit is well staffed for the first time in a long time. She stated it is not often that they have that much staff. She stated the weekends are usually very short staffed, and since they have more staff on this shift, they will try to make up some of the showers that have been missed.

g. On April 12, 2022, at 2:55 p.m., an interview was conducted with the Activities Director. She had just been promoted from the Assistant Activities Director two weeks prior. She stated that the Facility has been short staffed for a while and that she helps out wherever she can. The Facility needs more help in the laundry and with showers. The Facility used to have a grievance committee, but not any longer. The Facility has been understaffed for weeks.

h. On April 13, 2022, at 4:15 p.m., a telephone interview was conducted with the Medical Director with the QAPI team. The Medical Director stated that he spoke with the Regional Vice President back on February 23, 2022, at 2:23 p.m., to discuss the staffing concerns. The Medical Director stated that the nursing levels are at a dire level and there is not enough staff to take care of the residents. The Medical Director stated the staffing levels are not acceptable and the company has not responded to concerns. He stated no harm from a medical perspective has happened with the residents because he rounds with the nurses every Friday, that the staff is on top of everything, and that they do not hesitate to call him. He also stated the Regional Vice President stated that the Facility must have 112 residents in order to meet financial needs. The Medical Director stated the staff have done a commendable job, but with less and less nursing, it is becoming more and more difficult every day. He stated he is not sure how long the Facility could keep this going, and that corporate needs to understand the Facility could not keep going on forever. He stated basic needs are being met minimally, but not as well as they should be.

i. During the meeting, the performance improvement plan ("PIP") was discussed for missing residents' weights from October/November 2021 to February 2022. The Quality Assurance Performance Improvement ("QAPI") team identified resident weights were not being completed and discussed at the January 28, 2022, QAPI meeting. Staffing concerns were identified

as a reason for weights not being completed. The previous Director of Nursing ("DON") was responsible for implementing the PIP in February of 2022, but never did. When the Regional Nurse came in March, she found the PIP had not been initiated, so it was started on March 2022. 100% of the weights have been completed.

j. On April 11, 2022, at 1:24 p.m., an interview was conducted with the Administrator. The Administrator stated that he knows that the staffing is an issue. He stated that he is trying to hire staff, but is not getting applicants. Signs are posted in the front of the building offering a $1,500 as a sign on bonus. The Facility has raised the CNA pay. He stated he can offer up to 18.00 per hour and is offering to pay for tolls for staff who have to cross the Mid- Bay Bridge. He stated he has also offered gas money to staff. He stated he is not getting applicants. The Facility Administrator confirmed that he has had many conversations with the corporate office regarding continued admission of residents.

k. On April 13, 2022, at 5:08 p.m., an interview was conducted with the Regional Vice President. The vice president stated he has had regular conversations with the Administrator regarding the staffing issues. He stated they are working on hiring new staff, and are working on incentives. He stated they are offering a $10,000 sign on for nurses and new pay scale, trying to compete with the local market. He stated they are using more home health agency staff. He admitted that the Facility did not stop admissions until the first of April, and stated when he has been in the building it looked like things seem to be managed well, and the residents were receiving care. He was informed of the concerns we have identified and the VP responded with, "We have significant work to do."

* * *

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS AND EMERGENCY SUSPENSION OF LICENSE

21. The Agency is charged with the responsibility of enforcing the laws enacted to protect the health, safety and welfare of residents and clients in Florida's nursing homes. Ch. 400, Part II, Fla. Stat. (2021), Ch. 408, Part II, Fla. Stat. (2021); Ch. 59A-4, Fla. Admin. Code. In those instances where the health, safety or welfare of a nursing home resident is at risk, the Agency will take prompt and appropriate action.

22. The Florida Legislature mandated that nursing homes self-impose a moratorium on resident admissions when staffing levels fall below minimum levels for two consecutive days. "A facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for 6 consecutive days." § 400.14l(1)(n)1, Fla. Stat. (2021). The purpose of the statute is clear. When nursing home staffing falls below minimum levels, it is virtually a certainty that patient harm and indignity will follow. In the instant case, residents have had to lie in their own feces and urine for extended periods of time. At least one family member called law enforcement when the family member found a resident in such a condition. The lack of personal hygiene care and attention over a lengthy period of time has the potential for adverse results such as skin breakdown, inflammatory skin conditions, secondary infections, and other preventable outcomes. At least one resident spent an excessive amount of time without being repositioned in bed. Ultimately, if continued, this lack of care will eventually lead to pressure injuries. One resident was observed with a dark brown substance under all of the resident's fingernails. All of the interviewed residents have complained about the lack of showers. They have had to endure the indignity of the personal body odor. The Facility staff readily admits that it simply cannot meet the resident needs due to lack of staffing.

23. The Administrator and Medical Director of the Facility repeated voiced their oncerns to corporate management about the lack of Facility staffing. In response, corporate management weighed their concerns and consciously decided to place

financial issues above that of resident care. The inappropriate response of corporate management was not only contrary to the standard of care for nursing home residents, it was directly contrary to Florida law. The self-imposition of a moratorium on resident admissions when staffing levels fall minimum levels for two consecutive days is mandated by Florida law. It is not discretionary on the part of the corporate management. It is not within the province of corporate management to disregard the Legislature's express direction. In fact, it is a circumstance in which the Legislature authorizes the imposition of an administrative fine regardless of correction by the nursing home. At the very least, the response of the Facility should have been to hire temporary staffing services to alleviate the immediate staffing shortcomings. Inexplicably, that was not done in this case. The disregard of this legal requirement is blatant.

24. In the case at hand, the Facility fell below the minimum staffing levels for nursing homes for at least two months. This violation is extraordinary. Under such circumstances, the propensity of Facility staff to make errors rises exponentially. Unless the condition is abated, the risk of serious physical harm to the residents is imminent.

24. The health, safety and welfare of residents is always the primary concern of the Agency. This applies to their physical health as well as their mental wellbeing. Resident rights include the right to receive adequate and appropriate health care and protective and support services as well as the right to be treated courteously, fairly, and with the fullest measure of dignity. Notwithstanding the best efforts of a truly dedicated staff, the facts set forth above show that the Facility did not fully honor those rights. While it understandable that nursing home residents will soil themselves, it is not acceptable to let them go for days and perhaps weeks on end without bathing. One resident was even observed with a dark brown substance under all of the resident's fingernails. All of the interviewed residents have complained about the lack of showers. They have had to endure the indignity of the personal body odor. The Facility staff, especially those who have worked

at this Facility for some time, seemed apologetic for not being able to provide better care and attention to the residents. Staff should not have to feel this way when they have gone over and above the call of service when they have worked double shifts, extended shifts, and after their shift has ended.

26. The corporate management of the [Facility] has prevented the administration of this Facility from performing its obligations. The Administrator repeatedly informed corporate management of the issues with staffing. Further, the Medical Director expressed his concerns to corporate management about the lack of staffing. These concerns and warnings occurred over a long period of time. This is not a case of inadvertent mistake or oversight. The decision to not self-impose a moratorium was a knowing decision. Far too many residents were admitted to the Facility at a time when the self-imposed moratorium should have been in place. The lack of care that those residents received was unwarranted. Had the moratorium on admissions been in place as required by Florida law, the existing residents in the Facility would have received better care and services from the limited staff in place. Hence, the point of the moratorium on admissions.

27. The [Facility's] deficient practice[s] exist presently[,] have existed in the past, and more likely than not will continue to exist if the Agency does not act promptly. The issue at hand is the corporate management of the facility and its approach towards resident care, staff and the local Facility administration. The misplaced weight on financial concerns over immediate resident care and the legal requirements of Florida law must be addressed.

(App. A at Bates 7-17).

Based on the law, as provided above and set forth at pages 1-5 of the Emergency Order (App. A at Bates 3-7), and the above-stated

particularized allegations of fact, AHCA concluded and expressly stated in the Emergency Order that:

- "[A]fter careful and due consideration" that practices and conditions at Destin Healthcare present a "threat to the health, safety and welfare of residents" and "clients," "an immediate serious danger to the public health, safety or welfare," and "an immediate or direct threat to the health, safety, or welfare of the residents." (App. A at Bates 13-14, 17).

- The Emergency Order "is necessary in order to protect residents from (1) the unsafe conditions and deficient practices that currently exist, (2) being placed at risk of living in an environment ill-equipped to provide for resident health, safety and welfare, and (3) being placed in a nursing home where the regulatory mechanisms enacted for resident protection have been disregarded." (App. A at Bates 17).

- The Facility's "deficient practices exist presently and will more likely than not continue to exist if the Agency does not act promptly." (App. A at Bates 17).

- "Less restrictive actions, such as the imposition of administrative fines, will not ensure that residents receive the appropriate care and services dictated by Florida law. The emergency action taken by the Agency in this particular instance is fair under the circumstances and

the least restrictive action that the Agency could take given the set of facts and circumstances of this particular matter. The remedy is narrowly tailored to address the specific harm in this instance." (App. A at Bates 17-18).

As such, AHCA's Emergency Order is facially sufficient and Destin Healthcare is unlikely to succeed on the merits of its appeal/petition for review. This case law stay factor, then, weighs against granting a stay of the Emergency Order.

Destin Healthcare complains the statements in the Emergency Order, particularly related to resident interviews, are "unverified." (Motion for Stay at p.7). However, there is no requirement in the law that AHCA provide proof of the veracity of residents' statements for an emergency order to withstand review; rather, all of that will be proven out during the administrative hearing to follow. See § 120.60(6)(c), Fla. Stat.; Fla. Admin. Code R. 28-106.501(3).

Destin Healthcare also inexplicably claims the Agency's particularized allegations of fact do not include any showing of harm to residents. In fact, the Emergency Order includes pages of facts showing residents have suffered violations of their rights, including their rights to receive adequate and appropriate care and to be treated courteously, fairly, and with the fullest measure of dignity. §§ 400.022(1)(l), (1)(n), 400.023(3)(a), Fla. Stat.;

Fla. Admin. Code R. 59A-4.108(4); (App. A p.3-15); (Motion to Stay at p.7). As detailed in the Emergency Order and in the Summary of Argument/Statement of AHCA's Position, above, residents have not been receiving adequate care. They have not been able to obtain staff assistance when needed. They have been confined to their beds and forced to lay in their own excrement for excessive periods, due to the lack of sufficient staffing. This is undoubtedly resident harm. The fact that the facility, particularly its corporate management, still does not seem to realize this or consider it to be significant is highly disturbing to the Agency and should be equally disturbing to this Court.

Again, the residents are frail and vulnerable. They are within the sole care and custody of the facility and are, therefore, at its mercy. The severe staffing shortages, the failure to impose the moratorium, and the inadequate patient care conditions persisted for months and yet the facility's corporate management did not see fit to hire additional staff – at whatever cost – or decline new admissions as required by law, until the Agency issued the Emergency Order. Corporate management's knowing and intentional inaction in light of the ongoing staffing crisis constitutes a flagrant disregard of the law and a total disregard of the care needs and rights of its residents that warrants emergency action by the Agency,

including an immediate moratorium on admissions and emergency suspension order. Clear harm to residents has been demonstrated. It is not necessary that AHCA be able to show that residents have died or suffered horrific injury resulting in hospitalization for the conditions at the facility to warrant emergency action.

Destin Healthcare has, for now, obtained sufficient temporary staffing **but this was only done since the Emergency Order was issued and only occurred because of the Agency's action**. Destin Healthcare's corporate management saw no need to hire staff to meet statutory requirements and residents' needs until the moratorium was imposed and the facility's license was to be suspended. As such, the current staffing levels are of no moment. Coerced compliance with statutory requirements does not necessarily remedy care and services deficiencies (among other things, the staff are temporary staff from an agency are not familiar with the residents or their service needs, and require training and some of the permanent staff are leaving), nor does it constitute continuing compliance. As noted, Agency monitoring continues for the purpose of determining compliance with staffing standards and if the care and services deficiencies are remedied, but there is no determination of compliance or guarantee of continuing compliance at this point.

The only reason that AHCA extended the suspension date until May 2, 2022 at 5:00 p.m. was that the facility had dragged its feet in arranging transfer such that the residents could not safely be relocated by the original suspension date of April 25, 2022 at 5:00 p.m. (App. B p.3-4). AHCA expressly stated in the Order Extending Suspension Date that it was continuing to monitor the situation at the facility, placed conditions on the extension, and retained the right to terminate the extension and modify the conditions at any time. (App. B p.3-4). Indeed, AHCA stated in the Order Extending Suspension Date:

> 3. On April 16, 2022, the Agency imposed an Immediate Moratorium on Admissions and Emergency Suspension Order on the Facility.
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> 4. The Agency found an immediate serious danger to the public health, safety, or welfare based upon findings of significant understaffing, resulting in various forms of danger to the nursing home residents. To compound matters, instead of self-imposing a moratorium on admissions in response to the understaffing, as mandated by law, corporate management made a business decision to continue the admission of new residents to its nursing home. This business decision was illegal. See § 400.141(1)(n), Fla. Stat. (2021). This business decision was also contrary to the multiple requests of the Facility Administrator and its Medical Director. Instead of alleviating the problems resulting from understaffing, corporate management exacerbated the danger to the residents.
>
> 5. Shortly after the imposition of the Emergency Order, a Manager of La Vie Care Centers, LLC, the ultimate parent in the ownership chain of the Facility, called the Agency and represented that immediate corrective action would be taken.

6. Since the imposition of the Emergency Order, the Agency has monitored the Facility on a daily basis and will continue to conduct monitoring as appropriate.

7. On April 20, 2022, the Manager met with Agency management. He indicated that the Facility's Chief Executive Officer had been replaced. At that time, the new Interim Chief Executive Officer and the new Interim Chief Nursing Officer were presented. The Manager maintained that the Facility was addressing the issues of understaffing and was implementing a process to ensure that the understaffing issues at the Facility would not re-occur. The three representatives emphasized the difficulty the Facility was encountering with the relocation of more than 100 residents from the Okaloosa County area and the impact that the discharges would have on the residents and their family members. The information available to the Agency shows that there are approximately 40 to 50 nursing home beds currently available in this county.

8. Through its daily monitoring process, the Agency has confirmed the increase of temporary agency staff at the Facility. The Agency surveyors spoke with the Administrator, interviewed existing Facility staff and spoke with residents. The Agency surveyors observed the existing Facility staff being helpful and attentive with the training of the new temporary agency staff. At the moment of this Order, the Facility is no longer understaffed. Whether the staffing issue has been permanently corrected so that the Facility will be in compliance for the long term remains to be determined. At the current time, however, temporary protective measures have been put in place to at least address the present immediacy of the danger to the point where the suspension date of the license may be briefly extended in order to better accommodate the safe and orderly discharge of the nursing home residents.

9. In making this decision, the Agency has taken into consideration the nature and number of clients, the availability and location of acceptable alternative placements, and the ability of the licensee to continue providing care to the nursing

> home residents. Unfortunately, the Facility census has decreased little since the imposition of the Emergency Order. None of the decrease was due to the transfer of a resident to another nursing home. The Facility must act with great urgency and expedite the resident discharge process. As a condition of this extension, the Facility shall expedite the resident discharges and provide the Agency with status reports on a daily basis. The Facility shall maintain a log on all residents noting all actions the Facility has taken to discharge each resident. The log should include, where applicable, any communications with resident's family member, caretaker and managed care plan. In addition, the Facility shall forward daily status reports in a secured manner directly to the Agency's local Field Office Manager. The status reports shall include the identity of the resident, the name and place of the entity where resident is being discharged, the date and time of the discharge, the name and contact information of the resident's treating health care practitioner and caretaker.
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> 10. The Agency may terminate the extension or modify these conditions at any time.
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> 11. The Agency will continue to monitor the Facility on a regular basis to determine compliance with the regulations governing nursing homes.

(App. B at Bates 20-23).

2. Destin Healthcare Does Not Have a Clear Legal Right to a Stay.

As explained previously at Argument, Section B, the decision whether to grant a stay of the Emergency Order and/or Order Extending Suspension Date is discretionary with this Court. As such, Destin Healthcare does not have a clear legal right to a stay under Florida law.

3. Public Policy Considerations Support Denying the Requested Stay.

It is clear and unequivocal that the protection of vulnerable adults, and the protection of vulnerable adults from abuse, neglect, and exploitation, is a priority of Florida's statutory scheme. See § 415.101 Fla. Stat. et seq. (The Adult Protective Services Act). These provisions are supplemented with legislative provisions regulating residential care providers, ensuring that the residents thereof are provided with certain rights protecting their health, welfare, and safety. See, for example, §§ 400.022(1), 429.28 Fla. Stat. Vulnerable adults in nursing homes must not only receive adequate and appropriate health care and protective and supportive services, they must be treated with courtesy, fairness, and the fullest measure of dignity while receiving health care services in a nursing home. § 400.022(1)(l), (1)(n), Fla. Stat. These protections set forth Florida's mandate that those entrusted with the care of Florida's vulnerable population must not allow conditions to develop or continue where persons are subjected to physical or emotional discomfort as a direct result of the acts or omissions of those charges with providing care. No reasonable reading of these provisions would accommodate the failure to provide qualified personnel to assure that nursing home residents receive required assistance with activities of daily living on a timely basis, that prescribed

interventions for medical conditions are not timely administered, or that residents be subjected involuntarily to a lack of regular bathing, the ability to socialize and access the facility rather than to be left isolated in bed, and certainly not being left for hours lying in bodily wastes. When medical conditions require a person to receive care in a nursing home facility, the individual's rights to be treated with dignity, to be provided care in a timely manner, and to exercise individual expressions as a social animal are not left at the admissions door.

Florida currently has 704 active nursing homes. Since the beginning of 2021, the Agency has cited 28 nursing homes for the failure to self-impose a moratorium on admissions after staffing levels dropped below minimum levels since the beginning of 2021. These violations are set forth in the Appendix F, which is public information, not yet including the pending citation of Destin Healthcare and Rehabilitation Center. (App. F at Bates 113). Seven of the cited nursing homes are operated by the same management company as Destin Healthcare, Josera, LLC, d/b/a Independence Living Centers. (App. E, at Bates 38-43; App. F at Bates 113). These seven are highlighted in red or yellow. The four red highlighted nursing homes are located in Area 1 or Area 2 of Florida. The three yellow highlighted nursing homes are located in other areas of the state. As

detailed by Ms. Beasley in her Affidavit, discussed previously, the understaffing at these four nursing homes (some very egregious) was not followed by a self-imposed moratorium on admissions as mandated by law.

Staffing shortages are a challenge that presents itself to nursing homes. The Legislature has recognized that this problem and mandated that nursing homes in this situation self-impose a brief moratorium on admissions. The steadfast refusal of Destin Healthcare, and its management company, to comply with the statutory mandate due to a business decision is unacceptable.

For these reasons, and for all the forestated reasons, public policy does not support a stay.

4. Destin Healthcare Has Other Remedies at Law Available to It.

If this Motion for Stay is denied, and AHCA believes it should be, the law provides Destin Healthcare with other remedies, including but not limited to the following:

- Destin Healthcare may pursue its Petition for Review, thus obtaining facial review of the sufficiency of the Suspension Order from this Court. §§ 120.569(2)(l), 120.60(6)(c), 120.68(3), Fla. Stat.

- AHCA is required to file an administrative complaint regarding the moratorium and suspension within 20 days of issuing the Emergency

Order, i.e. by May 6, 2022, and Destin Healthcare has the right to request and receive an administrative hearing to dispute that administrative complaint, including the factual allegations underlying the Agency's actions against it license. § 120.569, 120.57, 120.60(6)(c), Fla. Stat.; Fla. Admin. Code R. 28-106.2015, 28-106.501(3).

5. Any Irreparable Harm Destin Healthcare May Incur Is the Result of Its Own Actions and is Outweighed by the Immediate and Serious Danger and Threat to the Health, Safety, and Welfare of the Public and Residents/Clients.

Destin Healthcare may suffer certain irreparable harms absent a stay. However, these irreparable harms are the direct and proximate result of its corporate management's bad choices, including the failure to heed the Administrator and Medical Director's concerns, to ensure the law was followed, that the facility was properly staffed or no new patients were admitted, and that residents received the care and services they required. If Destin Healthcare had self-imposed the statutorily-required moratorium on admissions when its staffing levels became problematic, it would not be in the current situation. AHCA understands the realities of staffing shortage but cannot condone the intentional and unlawful acts that have been demonstrated by this facility over a period of months. Facilities must comply with the law and cannot simply choose to violate the Legislature's mandates when those mandates do not further its bottom-line. Any

irreparable harm the facility may suffer, furthermore, is outweighed by the immediate and serious threat and danger conditions at the facility pose to residents/clients, the public, and the State, as described above.

Finally, AHCA emphasizes the same corporate management for Destin Healthcare is also the corporate management for several other Florida health care facilities. AHCA has learned that it has been pressuring the Administrators of those facilities to violate statutory staffing and self-moratoria requirements at those facilities. Seven of the nursing homes that AHCA has cited since the beginning of 2021 for violating the requirement to impose a moratorium on admissions when staffing levels are below the statutory minimum are managed by the same management company. The management company, thus, has a pattern of illegal and unsafe conduct that cannot be condoned.

WHEREFORE, for all the above-stated reasons, the Agency hereby requests this Court deny the Motion to Stay. AHCA points out that nowhere in the Motion for Stay does Destin Healthcare challenge the moratorium on admissions. As such, this Court need not address the moratorium in its Order on the Motion for Stay.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I CERTIFY that the foregoing document has been furnished by Electronic Mail to counsel for Appellant, John E. Bradley, Esquire, JBradley@mdlegal.net, Dias & Associates, P.A., 5102 W. Laurel Street, Suite 700, Tampa, Florida 33607 on April 29, 2022.

/s/ Tracy Lee Cooper George
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