No. 19-1400

In The
Supreme Court of the United States

REHABILITATION CENTER AT
HOLLYWOOD HILLS, LLC,

Petitioner,

v.

STATE OF FLORIDA,
AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

On Petition For Writ Of Certiorari
To The Fourth District Court Of Appeal
For The State Of Florida

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does the refusal to consider causation, substantial causes, and mitigating evidence—central to this licensure revocation—violate the Due Process Clause of the Constitution?

2. Does the imposition of strict liability without notice of this standard to The Licensee violate the Due Process Clause?

3. Does the denial of discovery into causation and mitigating circumstances preclude the Licensee's "opportunity to be heard" and violate the Due Process Clause?

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INTRODUCTION

Petitioner seeks review of a decision of the State of Florida, Fourth District Court of Appeal, which affirms, *per curiam*, a Final Order entered by the Agency for Health Care Administration ("Agency") determining that Petitioner's actions and/or inactions violated Florida law and led to or contributed to the deaths of multiple residents at the Rehabilitation Center at Hollywood Hills ("RCHH") following the loss of air conditioning ("A/C") in the wake of Hurricane Irma. [Pet. App. 2]

After several residents were discovered deceased in their rooms and many others were transported to the hospital by Hollywood Hills Fire Rescue, the first responders called a Mass Casualty Incident and the entire RCHH facility was evacuated. The Agency immediately commenced an investigation, which ultimately led to an evidentiary hearing before an independent administrative law judge ("ALJ") from the State of Florida, Division of Administrative Hearings ("DOAH"). At the conclusion of the multi-week hearing, the ALJ recommended the Agency revoke RCHH's nursing home license. RCHH filed exceptions to the ALJ's Recommended Order and ultimately appealed the Agency's Final Order, which adopted the ALJ's recommendation *in toto*, to Florida's Fourth District Court of Appeal, but lost. RCHH now requests this Court to overturn the ALJ's/Agency's detailed and well-supported factual findings, which established that RCHH failed to meet its obligations as a licensed

nursing home in Florida. This Court should reject those efforts and deny *certiorari*.

RCHH's claim that it has been denied due process ignores the voluminous record developed in the multi-week evidentiary hearing conducted to address the issue of whether RCHH met its obligations as a facility licensed to care for the frail elderly population. At the hearing, RCHH presented testimony from thirteen (13) witnesses, including an expert on nursing home evacuations, an expert on heat related illnesses, an expert on climatology, an expert on disaster preparedness, an expert in forensic pathology and medical examination, two experts on nursing home administration and an expert on facility assessment and physical plant diagnosis. [Pet. App. 29-30] RCHH also introduced into evidence the deposition transcripts of five (5) additional witnesses and extensive video recordings from RCHH's facility during the pertinent timeframe. [Pet. App. 29-30[1]]

After the evidentiary hearing concluded, both parties were afforded the opportunity to submit proposed findings of fact and conclusions of law for consideration by the ALJ. Subsequently, after careful consideration of the entire record, the ALJ entered a detailed Recommended Order setting forth specific findings of fact regarding the circumstances at the facility that led to the

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[1] All citations included herein to the Petitioner's Appendix are referred to as "Pet. App.," followed by page number(s). All citations herein to the Agency's Appendix are referred to as "Agency App.," followed by page number(s).

deaths of multiple residents. [Pet. App. 25-117] In the Recommended Order, the ALJ concluded that "the clear and convincing evidence established that [RCHH] committed 3 Class I [i.e., the most serious] deficiencies by violating provisions of Part II Chapter 400, Florida Statutes, as set forth in Counts 1 through III of the Administrative Complaint, including an intentional or negligent act materially affecting the health and safety of the facilities' residents." [Pet. App. 111]

In its Petition, RCHH claims a "strict liability" standard was imposed upon it, but its Petition does not contain a single citation to the record to support this accusation. *See* Pet. pp. 7, 16, 17, 33, 32, 35. As discussed in more detail below, neither the ALJ during the evidentiary proceeding or in her Recommended Order, nor the Agency in its Final Order imposed a "strict liability" standard on RCHH. In accordance with Florida law, the ALJ applied a clear and convincing evidence standard and explained in detail her determination that the Agency had met its burden to prove RCHH failed to meet the standards expected of a licensed facility and that its license should be revoked.

RCHH's Petition mischaracterizes and/or ignores the reasoned grounds for revocation thoughtfully articulated in the ALJ's findings of RCHH's failures based on the extensive evidence presented during the hearing. The Recommended Order confirms the ALJ correctly focused on the standards applicable to a licensed

nursing home facility and concluded RCHH had woefully failed to meet those standards.

COUNTER-STATEMENT OF THE CASE

RCHH's Statement of the Case is incomplete, one-sided and includes several incorrect statements. In order for this Court to have an accurate understanding of the sequence of events that occurred at the RCHH facility, the Agency sets forth its statement of the facts below followed by citation to the incorrect factual statements in the Petition which appear in the Petitioner's Statement of the Case and also in the arguments regarding review.

A. Statement of the Facts and Case

The Agency is the licensing and regulatory authority in Florida that oversees "skilled nursing facilities" or "nursing homes" pursuant to Chapters 400, Part II, and 408, Part II, Florida Statutes, and Florida Admin. Code, Chapters 59A-4 and 59A-35. *See* §408.802(12), Fla. Stat. Under Florida law, the Agency has discretionary authority to revoke a Florida nursing home's license when it established by clear and convincing evidence that the licensee failed to meet its statutory obligations to its residents, including the duty to provide a safe environment and access to necessary health care. *See* Fla. Stat. §§400.121 and 408.815.

RCHH was licensed to operate a two-story, 152-bed nursing home in Hollywood Hills, Florida. [Pet. App. 31 ¶2] RCHH lost A/C but not power to the remainder of its facility in the aftermath of Hurricane Irma. [Pet. App. 35 ¶12] After multiple residents were found dead or suffering from heat stroke as a result of sweltering conditions in the facility, first responders declared a Level 3 Mass Casualty Incident ("MCI") due to the immediate harm and threat to human life. [Pet. App. 51-54] First responders and staff from a nearby hospital, Memorial Regional Hospital ("MRH"), evacuated the facility. Because of the multiple deaths at the facility, the City of Hollywood Hills Police Department ("HPD") was called to the scene. [Pet. App. 51-54] The evacuation was completed at 9:40 a.m. and the facility was sealed as a potential crime scene. [Pet. App. 53 ¶66; 56 ¶72; R. 953-54]

The Agency sent surveyors to the scene who found an immediate danger to the public health, safety and welfare as a result of RCHH's inadequate practices, policies and/or response to the loss of A/C. The Agency entered three emergency orders including an Immediate Moratorium on Admissions, an Immediate Suspension Final Order and an Emergency Suspension Order ("ESO"). RCHH sought review of all three of the orders from Florida's First District Court of Appeal, which affirmed all three orders. *See Rehabilitation Center at Hollywood Hills, LLC v. AHCA*, 250 So. 3d 737 (Fla. 1st DCA 2020).

As required by Florida law, the Agency initiated administrative proceedings within twenty (20) days of

entry of the ESO by serving a four-count Administrative Complaint on RCHH on October 3, 2017, seeking permanent revocation of RCHH's license. *See* Fla. Admin. Code R. 28-106.501. RCHH requested a formal administrative hearing to contest the allegations. On October 16, 2017, RCHH's Petition was transmitted to DOAH for assignment to an ALJ. Subsequently, the Agency amended the Administrative Complaint to include additional resident deaths based on the results of an investigation by independent medical examiners from the Broward County Medical Examiner's Office ("IMEs"). After extensive discovery was conducted, a multi-week evidentiary hearing commenced on January 29, 2018. [Pet. App. 27]

The ALJ, after considering all of the evidence presented and post-hearing submittals from the parties, entered a detailed Recommended Order finding that the Agency had met its burden of proving by clear and convincing evidence that RCHH's "actions and inactions in the wake of Hurricane Irma violated Florida law and led to or contributed to the death of multiple residents." [Pet. App. 25] The Agency adopted the Recommended Order *in toto* and revoked RCHH's license. [Pet. App. 2]

The evidence adduced at the lengthy evidentiary hearing established that the tragic deaths of multiple RCHH residents were preventable. RCHH's actions and inactions after the loss of its A/C led to the unprecedented declaration of an MCI and evacuation of the facility by first responders and hospital staff. Markedly, no declaration of an MCI was made and no

evacuation by first responders occurred at any other nursing home in the state. RCHH's abject failure to meet its legal obligations as a licensed facility and the tragic consequences justify the Agency's decision to revoke its license.

The evidence presented at the hearing included testimony from numerous first responders who went inside the excessively hot RCHH facility and from the IMEs who were charged with investigating the cause and manner of death for the deceased residents. The IMEs were part of the investigation that began shortly after the MCI declaration. [Pet. App. 58 ¶76] The IMEs are physicians tasked with review of the evidence and circumstances to determine the cause and manner of deaths that occur from particular types of events or conditions. [Pet. App. 58 ¶76 n.7; T. 726-27, 731-32, 927, 1213] "Cause of death" refers to the medical condition, disease, or injury that leads to death. 'Manner of death' refers to whether the death is classified natural, homicide, suicide, accidental (unforeseen), or undetermined." [Pet. App. 58 ¶76 n.7; T. 719, 720-21, 1115-17]. To declare the manner of death as a "homicide" means the IME has determined the actions or inactions of others contributed to and precipitated the death, including situations where the deceased did not get appropriate supervision or care. [Pet. App. 60 ¶81; 75 ¶128; T. 844][2]

[2] Ultimately, the classification is the IMEs best professional judgment based on the totality of the facts and circumstances. [Pet. App. 72 ¶120; T. 720-21, 725-27, 731-32, 794, 846, 848, 927, 1120, 1211, 1232, 1228-31, 3623-26]

The IMEs' classifications of the cause and manner of death confirm RCHH's failures.[3] The IMEs determined the cause death for Residents 1, 2, 7 and 8 to be heat stroke due to environmental heat exposure and the manner of death to be homicide. [Pet. App. 75 ¶¶81, 88; 65 ¶95; 66-67 ¶¶100-01; R. 15755, 16405, 4392-94, 19190; T. 749, 756, 774, 777, 1158, 111-62] The IMEs also found the cause of death for Residents 4, 5, 6 and 11 to be environmental heat exposure and the manner of death to be homicide. [Pet. App. 69 ¶107-08; 71 ¶114; 72 ¶119; 79 ¶¶142-43; R. 17216, 17613, 17939, 21405; T. 785, 810-14, 818, 825-28, 1189] The IMEs further concluded the deaths of Residents 9, 10, 12 and 3 were complicated by environmental heat exposure and classified the manner of the deaths as homicides. [Pet. App. 75 ¶128; 76-77 ¶¶134- 36; 80 ¶¶145-46; 81 ¶150; R. 16806, 19750, 20372, 22478; T. 1176-79, 1197-99, 1201-02, 3653] The IMEs explained at the hearing that the manner of the deaths were determined to be "homicides" because RCHH's actions or inactions resulted in the residents remaining in an unsafe environment without proper care and monitoring. [Pet. App. 58 ¶76; T. 844, 851, 853-56, 1143-44]

The ALJ found the clear and convincing evidence established "that nine of the twelve residents referenced in the Amended Complaint suffered greatly from the exposure to unsafe heat in the facility . . . provide compelling evidence of the consequences of Hollywood Hills' failure to provide its residents with a safe

[3] In the proceeding below, the residents were referred to by number in order to protect their identity.

environment and appropriate access to health care." [Pet. App. 58 ¶76] After the Agency adopted *in toto* the ALJ's findings and recommendation of termination, RCHH appealed to the state's appellate court raising many of the same arguments set forth in the Petition. Florida's Fourth District Court of Appeal affirmed the Agency's Final Order and rejected RCHH's motion for rehearing. [Pet. App. 1; Agency App. 27]

B. Incorrect Statements of Fact Included in the Petition's Statement of the Case and Arguments on the Merits.

1. Facts Regarding Discovery in the Underlying Proceeding

RCHH's blanket statement on page 11 of the Petition that discovery from the Executive Office of the Governor ("EOG") and from Florida Power and Light ("FP&L") was refused is an overstatement. RCHH was allowed to conduct extensive discovery from the aforementioned third party entities, but the scope of that discovery was appropriately limited to the issues before the tribunal.

On page 12, RCHH confusingly links testimony from the HPD to the limitations on discovery from the EOG and FP&L. The issues related to the ongoing criminal investigation by the HPD were discussed at length prior to and during the evidentiary hearing. [Pet. App. 56 ¶72, 58 ¶76; R .849, 891; T. 959-60, 984-85] The ALJ's balanced and well-reasoned rulings are documented in the record but avoided in the Petition.

The ALJ's handling of the discovery issues was one of the primary arguments advanced by RCHH in its appeal to Florida's Fourth District Court of Appeal, which did not accept RCHH's interpretations of the applicable state law and legal precedents. [Pet. App. 1; Agency App. 8]

Contrary to the suggestion on page 5 of the Petition, the ALJ did not protect law enforcement officials from giving certain testimony or producing documents. Subpoenas were directed by RCHH to the police department regarding an ongoing criminal investigation. The ALJ ruled on the scope of what she deemed relevant to the proceedings she was conducting. [T. 960-62] DOAH, as an administrative tribunal, does not have authority to enforce subpoenas. Fla. Stat. §120.569(2)(k)2. To the extent RCHH believed it was entitled to more information, RCHH was required to seek enforcement of its subpoenas in a Florida circuit court, but it never did so. [R. 1686] *See*, *e.g.*, *Fla. Industrial Power Users Grp. v. Graham*, 209 So. 3d 1142, 1144-45 (Fla. 2017) (quoting *Agner v. Smith*, 167 So. 2d 86, 91 (Fla. 1st DCA 1964)). RCHH was given the same access to the police records as the Agency. [R. 1678] RCHH also had ample opportunity to depose and cross-examine Lt. Devlin, the officer in charge of HPD's criminal investigation. [T. 977, 979, 984; R. 1609, 5207, 5236; T. 956-59, 960-63, 967-83] RCHH fails to note that it insisted upon an expedited hearing. Consequently, it cannot reasonably complain about its inability to timely seek appropriate relief in circuit

court to enforce any of the subpoenas it believes were necessary prior to the evidentiary proceeding.

The description in RCHH's Petition regarding the testimony of Lt. Jeff Devlin is incomplete and inaccurate. The claim on page 12 of the Petition that HPD Lt. Devlin made "strategic choices" about what information to disclose and what to withhold is not supported by competent substantial evidence in the record. At the time of the license revocation hearing, there was an ongoing criminal investigation. [T. 959-60] Because of the on-going investigation, HPD was both legally and justifiably cautious about taking any action which could potentially compromise that investigation.

On page 16, RCHH asserts a due process violation as a result of the denial of discovery. RCHH fails to discuss the extensive discovery conducted, including dozens of depositions and the production of thousands of pages of documents and video recordings. [Pet. App. 29-30] Contrary to the claim on page 16, RCCH never sought to introduce rebuttal evidence.

2. Facts Relative to the Role of the ALJ

RCHH's argument on page 17 does not accurately explain the due process accorded to licensees in Florida and incorrectly implies the Agency was the arbiter of the entire process. Under Florida's Administrative Procedures Act ("APA"), Chapter 120, Florida Statutes, the matter was assigned to an independent ALJ with no affiliation to the Agency. The Agency was a party to

the independent adjudicatory process, but the Agency did not, and could not, exercise any control over it. Fla. Stat. § 120.569(2)(a). The ALJ conducted evidentiary proceedings in accordance with Sections 120.569 and 120.57(1), Florida Statutes, which enabled all parties to introduce evidence, cross-examine witnesses and present legal argument. When the Agency issued its Final Order, it was constrained by the APA regarding the changes it could make to the ALJ's findings. Fla. Stat. §120.57(1)(l).

3. Facts Relative to the Evidentiary Proceeding

While the Petition includes extensive citations to authorities regarding the right to "meaningful" discovery and a "meaningful" hearing [Petition p. 8], the Petition fails to note that a 20-day evidentiary hearing was conducted with dozens of depositions taken before the evidentiary hearing even began. [Agency App. 1-7]

RCHH erroneously claims on page 13 of the Petition that the Agency rejected any consideration of mitigating evidence of whether RCHH's conduct was reasonable under the circumstances. In paragraphs 191 through 197 of the Recommended Order, the ALJ expressly addressed RCHH's arguments that its responsibility and any penalty should be mitigated by third party actions. [Pet. App. 96-97] Petitioner erroneously claims on page 26 that RCHH was precluded from discovery and that no consideration was given to its claims that the actions of third parties were

actually responsible for the deaths at the facility. A similar claim is made on page 29 that RCHH was prevented from having the issue of causation presented and considered at the hearing. The ALJ considered RCHH's mitigation arguments but did not deem them persuasive. As set forth in paragraph 230 of the Recommended Order, the ALJ explained her conclusion that "the gravity of the harm done to multiple residents strongly outweighs any mitigating factors that might be considered against revocation." [Pet. App. 112]

Detailed testimony from the IMEs established the cause of the residents' deaths. RCHH had a full opportunity to conduct discovery of those witnesses prior to their testimony and to cross-examine them at the hearing. RCHH also called its own experts to address the cause of the deaths and to challenge the testimony of the IMEs. Thus, RCHH had a full and fair opportunity to address the causation issues.

Contrary to the claim on page 13, the ALJ did not reject all consideration of third-party conduct. The ALJ simply ruled that the culpability or negligence of third parties was not a matter within her jurisdiction to resolve. In other words, the ALJ considered RCHH's arguments within the context of the case pending before her. [Pet. App. 96-99 ¶¶191-99] She recognized the third parties were not licensees and were not parties to the proceeding, but she did not preclude RCHH from making its arguments, she just did not accept RCHH's efforts to shift responsibility for the residents in its care to others who were not licensed by the Agency. In

reaching her recommendation, the ALJ appropriately focused on the actions of RCHH and whether it complied with its statutory obligations. [Pet. App. 96-99 ¶¶191-99, 106, ¶216, 107-08, ¶¶ 220-21, 111-12 ¶238] This is not the same as applying a "strict liability" standard on the licensee as asserted by RCHH on page 33.

Strict liability was never imposed on RCHH. The Petition does not cite to any specific portion of the Recommended Order or Final Order that expressly applies a strict liability standard. RCHH's argument is premised on a distorted, incomplete analysis of the ALJ's findings and conclusions. The Recommended Order refelcts the ALJ's careful review of the obligations of a licensed facility. The ALJ reasonably concluded that RCHH's claims of third party responsibility did not relieve the licensee from meeting its statutory obligations. [Pet. App. 96-99 ¶¶191-99, 106, ¶216, 107-08, ¶¶ 220-21, 111-12 ¶238] The ALJ found the licensee's actions and inactions under the circumstances were woefully deficient.

Contrary to the suggestion on page 23, all the evidence that the ALJ relied upon in her Recommended Order was disclosed in advance of the hearing to RCHH. Pages 14 through 28 include a lengthy academic discussion of due process rights in general, but the argument presented is based on an incomplete and slanted discussion of the extensive discovery and lengthy evidentiary proceedings that were conducted as part of the meaningful license revocation proceedings accorded to RCHH.

The Agency does not contest the general legal principle set forth on pages 15 and 16 of the Petition that a licensee is entitled to a fair trial in a fair tribunal. As demonstrated by the record, RCHH received a fair trial before a fair tribunal.

4. Facts Related to the Actions of the First Responders

As set forth in the Recommended Order, several entities were involved in the events at RCHH in the wake of numerous 911 calls and the discovery of distressed and deceased residents at RCHH's facility. These first responders included emergency medical service providers from HFR, staff from MRH, and officers from HPD. [Pet. App. 42-43, ¶¶33-36; 45-58 ¶¶41-75; 59-62 ¶¶ 77-80, 87; 64, ¶¶ 93-94; 67 ¶¶98-99; 68 ¶104; 70 ¶¶110-112; 71, ¶116; 73, ¶122; 76 ¶131; 77-78 ¶¶138-39] The Petition contains several incorrect statements of fact relative to the actions of the first responders at the facility and the discovery related to their actions.

On pages 9-10, without record citation, RCHH incorrectly claims that the nursing home staff initiated the movement of the residents on the second floor "to the cooler, first floor." The ALJ specifically found that it was the First Responders who actually moved the second floor residents from the RCHH facility following the discovery of multiple deaths and the declaration of an MCI. [Pet. App. 51-52 ¶¶60-64]

RCHH discussion on page 10 of the evacuation of the facility fails to mention the evacuation occurred because HFR and MRH determined the facility was an unsafe environment and an MCI event had been declared. [Pet. App. 51 ¶60]

RCHH provides a sanitized version of the tragic circumstances that occurred at the facility and resulted in the avoidable loss of multiple lives. For example, RCHH's Petition fails to mention the multiple deaths were reviewed by the IMEs, who determined at least 9 of the residents died as the result of exposure to unsafe environmental conditions and the deaths were classified by the IME's as homicides due to the actions or inactions of RCHH. [See detailed record cites below as to each resident.]

5. Facts Relative to RCHH's Inactions/Actions

The Petition includes a lengthy recitation of actions purportedly taken by RCHH before and during the hurricane. *See* Petition pp. 7-10. All of these factors were presented to the ALJ, who nonetheless concluded that RCHH failed to meet the obligations expected of a facility licensed to care for the frail elderly population. [Pet. App. 96-99 ¶¶ 191-99; 104-05 ¶211]

On pages 6, 7 and 13, RCHH asserts that it should be immune from penalty for its actions because a natural disaster, Hurricane Irma, had occurred. The ALJ analyzed RCHH's actions in context of the natural disaster. She concluded that RCHH failed to take the

steps reasonably expected of a licensed facility. [Pet. App. 96-99 ¶¶ 191-99; 104-05 ¶211]

RCHH's claim on page 9 that there is an accepted standard of care related to the "shelter-in-place" concept is simply incorrect. This issue is addressed in more detail in the Reasons for Denial section below.

On page 17, RCHH claims it followed established industry procedures and practices under the circumstances, but RCHH fails to note or address the testimony of the multiple expert witnesses who testified at the hearing and directly disputed that claim. The Petition fails to acknowledge the competing evidence that was presented to the ALJ. Ultimately, the ALJ determined that the witnesses and evidence presented by the Agency were more persuasive than that presented by RCHH. As discussed below, RCHH's argument was expressly rejected in the Recommended Order wherein the ALJ concluded that the facility did not meet the standards expected.

REASONS TO DENY THE PETITION

As set forth above, RCHH was accorded meaningful due process prior to the revocation of its license, including extensive prehearing discovery and a 20-day evidentiary hearing before an independent ALJ. The ALJ thoughtfully and reasonably addressed the numerous discovery and evidentiary issues raised during the proceedings and fully explained her rulings. Contrary to RCHH's assertions, each party had the same

information available to it and ample opportunity to conduct discovery. RCHH's challenges to the ALJ's discovery and evidentiary rulings are unsupported and were correctly rejected by the Florida appellate court.

As a licensed nursing home, RCHH had a duty and responsibility to ensure the safety of the residents, even following the loss of power to its A/C. *See* Fla. Stat. §§ 400.022, 400.102, 400.121, 400.141 and 408.815; Fla. Admin. Code R. 59A-4.122 and 59A-4.103(4)(a). The demonstrated failure of RCHH to meet its responsibilities warranted AHCA's decision to revoke RCHH's license to operate a nursing home in Florida for the care of frail elders and disabled persons. [R. 61, 1018]

I. The Fourth District Court of Appeal Decision Does Not Conflict With Due Process Precedent and Laws of the United States—Acceptance of Jurisdiction is Not Warranted.

Contrary to RCHH's assertion, the Florida Fourth District Court of Appeal's decision does not conflict with established due process precedent or the laws of the United States. There is no due process violation here. RCHH was accorded a meaningful 20- day evidentiary hearing with a full and fair opportunity to present evidence, cross-examine witnesses and present legal argument. The applicable legal processes set forth in Florida's APA were assiduously followed. The Final Order was reviewed by the Fourth District Court

of Appeal and affirmed. There is no conflict with federal due process precedents to support this Court's jurisdiction.

Furthermore, it is unclear from the Petition what relief RCHH seeks from this Court. The revocation of the license is final under state law and no stay has been entered. There is no explanation in the Petition as to what relief this Court could grant RCHH since its license has been finally revoked.

RCHH's argument for review, although set forth in three sections, is repetitive. While the Agency attempts to answer the argument set forth in each section below, all of the below arguments are equally applicable to all of the issues raised by the Petitioner.

A. RCHH Was Not Denied Due Process—RCHH Was Not Denied the Right to Discovery, Was Not Prohibited From Submitting Rebuttal Evidence and Was Not Prevented From Preparing its Case.

RCHH unjustifiably claims that it was denied discovery and prevented from presenting evidence to support its claims regarding the responsibilities and/or failures of third parties. The Appendix to this Brief in Opposition includes a copy of the docket from the lengthy proceeding conducted before the Florida DOAH, which evidences RCHH was afforded full and fair due process. [Agency App. 1-26] While RCHH cites to several cases in its Petition as supporting its

position, none of those address a circumstance similar to this case where there were more than two dozen depositions taken and extensive written discovery exchanged in advance of a 20–day evidentiary hearing involving multiple witnesses, including multiple experts called by both parties who were subject to extensive cross-examination.

From the outset of this proceeding, RCHH has attempted to shift responsibility for the horrific events at its facility. During prehearing proceedings and at the evidentiary hearing, the ALJ patiently and thoughtfully considered RCHH's rampant speculation about the actions of third parties, but consistently and correctly ruled that the only issues before her to resolve centered on the actions or inactions of RCHH and whether *its* license should be revoked. Rule 1.280(b), Florida Rules of Civil Procedure, requires discovery requests to be "relevant to the subject matter of the pending action." *See Allstate Ins. Co. v. Langston*, 655 So. 2d 91, 94 (Fla. 1995). Thus, in order for evidence to be discoverable, it had to be *relevant* to the issues pending before the ALJ as well as potentially admissible in the proceeding. The ALJ did not preclude discovery, but reasonably and appropriately limited discovery from third-party entities to issues relevant to the pending case. [R. 686, 431-33, 682]

1. Legal Issues Before the ALJ

The issue pending before the ALJ was whether the Agency established by clear and convincing evidence

that RCHH failed to provide the care expected of a licensed facility. While extensive discovery was conducted in advance of the evidentiary hearing, some of the discovery sought by RCHH from the third-party entities was far afield from the counts in the Administrative Complaint and not relevant to the proceeding. RCHH served the EOG and FP&L with extremely broad discovery requests. Both entities filed motions for protective orders to quash the subpoenas duces tecum served by RCHH asserting the information sought was irrelevant to RCHH's duty to protect its residents and that the requests were overbroad. [R. 551-72, 622-46, 664, 672] The ALJ allowed RCHH considerable leeway, but deemed certain of RCHH's requests to be overly broad and beyond the scope of the legal issues to be resolved by her.

The legal issues before the ALJ were delineated by the Administrative Complaint, which alleged:

- **Count I**: "Hollywood Hills violated section 400.141(1)(h), Florida Statutes, by failing to maintain the facility premises and equipment and by failing to conduct its operations in a safe and sanitary manner," and/or Rule 59A-4.122, "by failing to provide a safe, clean, comfortable, and homelike environment, including comfortable and safe room temperatures." [Pet. App. 102 ¶207; R. 63, 1020, 1722-23]

- **Count II**: "Hollywood Hills violated section 400.022(1)(l), by failing to ensure its residents received adequate and appropriate health care and protective and support services consistent with the resident care

plan, and with established and recognized practice standards within the community." [Pet. App. 105 ¶214; R. 73-74, 1034, 1722-23]

- **Count III**: "Hollywood Hills' intentional and/or negligent acts materially affected the health and safety of its residents resulting in the death of multiple residents and placing many other residents in harm's way in violation of section 400.102(1) and (4)." [Pet. App. 107 ¶218; R. 91, 1070-71, 1722-23]

- **Count IV**: "Hollywood Hills: (1) violated part II, chapter 400, and Part II of Chapter 408, Florida Statutes, or the applicable rules, because it was cited for two class I deficiencies arising from unrelated circumstances during the survey or investigation and (3) committed an intentional or negligent act materially affecting the health or safety of a client of the provider." (endnotes omitted). [Pet. App 110 ¶226; R. 116-17, 1100-01, 1722-23]

The ALJ correctly determined that the issues before her for resolution were RCHH's compliance with its obligations as a licensed facility. Discovery directed to third parties was allowed and RCHH was permitted to present evidence regarding third parties and arguments regarding same at the hearing. But, the ALJ appropriately ruled that the third parties were not licensees and were not on trial before her. She focused the case on whether RCHH met its obligations as a licensed facility. [Pet. App. 96-98 ¶¶ 191-97] The ALJ's rulings on discovery and evidentiary matters fell

exclusively within her purview and discretion as the fact finder under Florida law.

2. The ALJ Properly Determined Certain Discovery Requests to Third Parties Were Not Relevant.

Contrary to RCHH's broad and non-specific assertions in its Petition, the ALJ did not blanketly preclude RCHH from conducting discovery. In order to place the discovery and evidentiary rulings in proper perspective, it is necessary to review some of the specific prehearing rulings made by the ALJ. With respect to FP&L's Motion, the ALJ only limited discovery related to certain irrelevant issues, but otherwise required FP&L to produce a corporate representative for deposition to address several areas of RCHH's inquiry. FP&L was also required to produce documents responsive to 9 out of 14 of RCHH's document requests. [R. 668, 504-06]

In ruling on FP&L's Motion, the ALJ addressed the nature and scope of the documentation and information sought. The ALJ granted FP&L's Motion in part and denied it in part explaining:

> Certainly, communications between FP&L and Hollywood Hills in the aftermath of the hurricane, regarding the timing of adequate power restoration, is relevant to whether Hollywood Hills' actions were intentional or negligent in the failing to timely relocate its patients. However, information on how FP&L identified "critical facilities" or power

> restoration priorities in general is irrelevant to the issue of whether Hollywood Hills committed the violations alleged in the Administrative Complaint.
>
> While purported systemic failures understandably may be of critical interest to the nursing home industry and the focus of legislative investigations, the inquiry before this tribunal is very narrow. It is not whether Broward County and/or FP&L failed to adequately prioritize power restoration. The question is whether Hollywood Hills provided its residents a safe environment in the aftermath of the hurricane, or did its actions result in the deaths of eight patients? Whether in hindsight FP&L should have given nursing homes a different prioritization for power restoration and repairs is a matter of grave public concern. But, it is not relevant to the factual inquiry of how the staff at Hollywood Hills reacted to the situation in which they found their patients after the air conditioning failed. Nor do the actions or alleged inactions of FP&L mitigate the responsibility which Hollywood Hills had to maintain a safe environment for its patients. [Emphasis added.]

[R. 667]

The EOG also filed a Motion for Protective Order seeking to limit the broad discovery requests RCHH served on it. The ALJ's ruling on EOG's Motion was similar to the ruling on FP&L's motion. The ALJ concluded:

Certainly communications between EOG and Hollywood Hills in the aftermath of the hurricane, regarding the timing of adequate power restoration and assistance, is relevant to whether Hollywood Hills' actions were intentional or negligent in failing to timely relocate its patients. Information in the possession, custody, or control of EOG that demonstrates Hollywood Hills was responsible for the death of eight patients is relevant.

However, information on how the EOG issued evacuation orders, nursing home deaths statewide after the hurricanes, the state's inventory of generators, and the Governor's direction to AHCA and DOH to institute emergency rules pertaining to nursing homes and the basis for said direction is irrelevant to the issue of whether Hollywood Hills committed the violations alleged in the Administrative Complaint.

. . . Whether in hindsight EOG should or could have done more to respond to purported calls for help from nursing homes after Hurricane Irma is a matter of grave public concern. But, it is not relevant to the factual inquiry of how the staff at Hollywood Hills reacted to the situation in which they found their patients after the air-conditioning failed. Nor do the actions or alleged inactions of the EOG mitigate the responsibility which Hollywood Hills had to maintain a safe environment for its patients. [Emphasis added.]

[R. 675] The EOG was ordered to produce for deposition a representative knowledgeable about a host of issues listed in the Order and to produce documents responsive to 29 out of the 49 categories requested by RCHH. [R. 676-77]

At the hearing, the ALJ appropriately exercised her discretion to allow evidence relevant to RCHH's actions, while limiting evidence related to the irrelevant actions of third parties. [T. 3668-70, 3692, 3696-97, 3701, 3723]

The Recommended Order and Final Order correctly conclude that the actions or inactions of third parties, including the EOG and FP&L, did not obviate RCHH's statutory duty to maintain a safe environment. The ALJ expressly rejected the claim that RCHH acted reasonably in the context of a natural disaster. [Pet. App. 96-98 ¶¶ 191-97; 104-05 ¶211; R. 3067-70]; *see also* Fla. Stat. §§ 400.141, 400.022, 400.102.

RCHH challenged the ALJ's discovery and evidentiary rulings on appeal and had a meaningful and fair opportunity to present its arguments to the appropriate Florida appellate court. The Florida appellate court found no basis to overturn or disturb the ALJ's rulings under the applicable Florida precedents. [Pet. App. 1; Agency App. 8] *See Jones Total Health Care Pharmacy, LLC v. Drug Enforcement Administration*, 881 F.3d 823 (11th Cir. 2018).

Nursing homes in Florida are licensed to provide care to those in need. As a licensee, RCHH bore the responsibility to provide a safe and secure living

environment for its residents and, when it was unable to do so, to take action to protect the residents from the unsafe conditions at its facility per Florida law. *See* §400.102(1) and (4), Fla. Stat. The actions or inactions of third parties and events occurring outside RCHH's facility had minimal, if any, relevance to whether RCHH's actions violated the cited statutes.

Unlike the situation in *NLRB v Rex Disposables, Division of DHJ industries, Inc.* 494 F.2d 588, 592 (5th Cir. 1974), *Firestone Synthetic Fibers Company v. NLRB*, 374 F.2d 211, 214 (4th Cir. 1967) and *Shively v Stewart*, 421 P.2d 65 (Cal 1966), the limitations on discovery imposed by the ALJ in this case were only granted with respect to third parties who had filed objections to the scope of the discovery. There was no limitation on the discovery that RCHH was allowed to conduct from the Agency, the adverse party in the proceeding.

3. The ALJ Did Not Abuse Her Discretion in Ruling on Evidence Presented by Law Enforcement Personnel.

On page 28, RCHH makes the unsupported contention that it was "defenseless against the attacks lodged through law enforcement." There were no "attacks" by law enforcement; both sides sought factual information from the first responders and both sides received the same information. RCHH unjustifiably suggests the Agency had control over the HPD and directed it to withhold unknown exculpatory evidence.

This characterization is a gross distortion of events and wholly unsupported by the record. [R. 1687; T. 960-62; 984-85] The ALJ assiduously ensured no evidence was admitted at the evidentiary hearing that was not available during discovery. The record confirms that the Agency and RCHH received the same information from law enforcement. [R. 1687]

As explained at the evidentiary hearing by HPD's Lt. Devlin, it is highly unusual for the HPD to provide to non-law enforcement personnel (including regulatory agencies) any evidence gathered in an ongoing criminal investigation when no arrests had yet been made.[4] [T. 959] The HPD initially refused to provide any documents or testimony to either the Agency or RCHH due to concerns that any such production could hinder the ongoing criminal investigation. [R. 1324; T. 959] After multiple requests were made and motions were threatened, or filed, HPD agreed to produce the same information to both parties which did not hinder the ongoing criminal investigation. [T. 984-85]

There is nothing in the record to support RCHH's suggestions of improper or unfair dissemination of the information ultimately provided by HPD. After the facility was closed and while the police investigation was underway, RCHH sought discovery from HPD. At the outset of discovery, RCHH sent several subpoenas duces tecum to HFR and HPD officers,

[4] The criminal investigation is ongoing.

including Lt. Devlin. [R. 847; 891] HPD, after acceptance of duly issued subpoenas as part of the administrative proceeding, determined that it would provide to all parties in the administrative proceeding factual information that would not jeopardize the ongoing criminal investigation. [T. 959-60, 984-985] This Court should defer to the ALJ's superior vantage point on discovery and evidentiary matters.

B. RCHH Was Afforded the Right to Present Evidence of Causation and Such Evidence Was Considered.

As is evidenced by the above argument, as well as the record in this case, RCHH was afforded the opportunity to present evidence of causation and to have such evidence considered by the ALJ. The RCHH's arguments to the contrary are without merit and not supported by the record. For example, RCHH asserts that the ALJ rejected arguments regarding specific standards of care in a disaster situation such as the concept of "shelter in place." The ALJ, however, specifically considered and rejected RCHH's efforts to hide behind a unique interpretation of the "shelter in place" concept of resident care. [Pet. App. 36 ¶15] RCHH tries to hide behind testimony from its experts that "shelter in place" is the standard of care in the nursing home industry during a hurricane. [Pet. App. 36 ¶15; T. 2243-45, 2262-63, 2912] The ALJ heard testimony from multiple experts who explained the "shelter in place" concept usually refers to actions taken pre-storm and during a storm, not after the storm has passed by. [T.

2243] Perhaps more importantly, sheltering in place is appropriate only until it is no longer safe to do so. [T. 2245; 2262-63] The obligation of a licensed facility to continuously monitor the circumstances and the conditions of its residents is not eliminated simply by "sheltering in place." In the face of the rising heat in the facility, RCHH failed to adequately monitor its patients [see record citations above] and did not undertake any evaluation after the loss of its A/C to determine "whether it was more dangerous to relocate or evacuate patients versus continuing to stay in place indefinitely while waiting on restoration of power to the A/C." [Pet. App. 36 ¶15] The residents at RCHH were frail elderly and disabled who had a reduced capacity to tolerate heat and were dependent on RCHH for their care. [Pet. App. 95 ¶189; T. 936, 207, 2143-44, 2186-87, 2238] The ALJ determined, "[a]ll of this should have been known to the staff at Hollywood Hills, yet there was no effort by staff to properly monitor their patients or move them to safety." [Pet. App. 95 ¶190; T. 936, 1207, 2143-44, 2186-87, 2238, 2835] After considering conflicting expert testimony, the ALJ found that the principal of "shelter in place" did not excuse RCHH because "no testimony was presented to show that RCHH undertook an evaluation at any time after the loss of A/C whether it was more dangerous to relocate or evacuate patients versus continuing to stay in place indefinitely while waiting on restoration of power to the A/C." [Pet. App. 36 ¶15]

RCHH also makes a generic argument that the statutes lack specific standards or requirements that a

licensee must meet "during a hurricane or other natural disaster." The applicable statutes and rules impose a duty on a licensee to keep its residents safe. This is a non-delegable duty for which RCHH must account. AHCA did not charge RCHH with failure to be prepared for the hurricane. [Pet. App. 98-99 ¶¶198-99; 105 ¶212] RCHH's license was revoked because it failed to keep its residents safe and allowed an extremely unsafe environment to develop and continue, ultimately resulting in the deaths of at least nine (9) residents. The statutory language placed RCHH on notice that it was responsible for keeping its frail and vulnerable residents safe *at all times*. It is not up to the Legislature or AHCA to fully anticipate and delineate in statute or rule all actions a licensee must take when faced with every possible future scenario. *See Beverly Enterprises-Florida, Inc. v. McVey*, 739 So.2d 646, 648 (Fla. 2d DCA 1999).

Numerous findings of fact in the Recommended Order support the determination that RCHH failed to meet its statutory obligations because it:

- Failed to have adequate cooling available [Pet. App. 53-54 ¶67; 56-59 ¶¶73-74; 82 ¶151; 82-83 ¶¶153-164; 89 ¶173; 90 ¶177;105 ¶212; R. 5378, 5378, 5386; T. 114-17, 154, 175, 295-97, 306, 322, 369, 483-84, 491-92, 498, 510-11, 546, 583, 617-18, 652, 654, 978-79, 982-83, 1440, 1465, 1639, 1959, 2272, 2630-59, 2672-73, 2677, 2679-80, 2683, 2685, 2687, 2711, 4662, 4665, 4669, 4846, 4880];

- Failed to properly monitor the building temperatures [Pet. App. 41-42 ¶¶30-34; 43-44 ¶¶37-40; 50 ¶47; 50 ¶¶56-57; 51 ¶60; 53-54 ¶67; 57-58 ¶¶73-75; 89 ¶173; 90 ¶177; 90-91 ¶¶179-180; T. 2685-87];

- Vented the spot coolers in an unsafe manner [Pet. App. 82 ¶151-52; 86-88 ¶¶165-69; 90 ¶177; R. 5386-87, 5391, 5399, 5401, 5404, 5406; T. 2657, 2659-62, 2674, 2678-79, 2683, 2688-89]; and

- RCHH failed to properly monitor its residents [Pet. App. 35-36 ¶¶14-15; 38-39 ¶23; 41 ¶30; 41-42 ¶32-33; 42-43 ¶¶35-37; 45 ¶40; 45-46 ¶42; 46 ¶¶44-45; 48-49 ¶¶48-54; 50 ¶57-58; 51-52 ¶¶60-62; 58 ¶76; 61 ¶84; 62-63 ¶¶87-91; 65-66 ¶¶96-97; 66 ¶99; 68 ¶104; 72 ¶118; 73 ¶121; 77-78 ¶136-39; 92-93 ¶¶184-87; 94 ¶¶188-90; 98-99 ¶¶198-99];

- Nine (9) of the twelve deceased patients addressed in the Amended Complaint died as a result of heat related causes, which arose from unsafe environmental conditions at the facility. The IMEs, in the exercise of their independent professional judgment, classified the deaths as homicides [Pet. App. 59 ¶76; 60 ¶81; 63 ¶91; 65 ¶95; 66-67 ¶¶100-01; 69 ¶107-08; 72 ¶118; 77 ¶136; 79 ¶143];

- Three (3) residents found dead in their beds at the facility prior to the evacuation all evidenced signs of heat exposure [Pet. App. 48 ¶49-50; 49 ¶52; 68 ¶104; 70 ¶112; 71 ¶116; T. 7884-85, 8550-52, 8558-60, 8934-35, 8941-43, 9188-89, 9195-96]; and,

- RCHH left unqualified staff to care for the patients despite the extended loss of A/C beginning on September 10, 2017 [Pet. App. 39 ¶24; 98 ¶197; 48-49 ¶52; 50 ¶57; 54 ¶69; 61 ¶84; 65 ¶96; 71 ¶115; 73 ¶121; 75 ¶129; 98 ¶197]

Even considering RCHH's actions (and inactions) within the context of a natural disaster, the ALJ determined that RCHH did not act reasonably. [Pet. App. 104-05 ¶211] After reviewing and weighing the evidence presented, the ALJ determined that RCHH was negligent to such a degree that the health and safety of its residents was materially affected. These findings were supported by competent substantial evidence and were upheld on appeal.

Expert testimony established the standard of care for dependent and immobilized residents of a nursing home during a situation such as no A/C would include monitoring residents every two hours, offering fluids where appropriate, and checking for any temperature changes or other changes in condition, as well as to see if they are confused. [T. 1143, 1667, 1716, 2209-10, 2898, 4009] There was no persuasive evidence that the RCHH staff were properly instructed to continuously monitor patient temperatures. [T. 779, 781-82, 1716, 840-41, 2898, 4009] RCHH did not initiate any heat stroke protocols or evacuate the residents from the unsafe environment until told to do so by HFR and MRH. [Pet. 45-46 ¶42; 54 ¶¶ 68-71; 104-05 ¶211; 106 ¶216; T. 516-17, 529, 593, 631-33, 946, 1814-15, 1444, 1445-46, 2210]

In addition, the evidence established that RCHH negligently vented the spot coolers that were available. In this regard, its own actions contributed to the heat in the building by "directing the exhaust into the ceilings on the first and second floors of the nursing home," despite the lack of ventilation to the outside. [Pet. App. 86-87 ¶¶166-67; R. 386-87, 5391, 5399, 5401, 5404, 5406; T. 2657, 2659-52, 2674, 2678-79, 2683, 2688-89] The ALJ weighed the testimony of HVAC experts presented by both parties and found "[t]he unavoidable conclusion is that exhausting the spot coolers into the ceiling without proper ventilation was negligent and contributed to the unsafe conditions for the residents." [Pet. App. 87-89 ¶¶168-74] The competent substantial evidence supports the finding that, even if RCHH did not know it was unsafe to vent the spot coolers in this manner, they knew or should have known the temperatures in the facility were not safe for its residents. [Pet. App. 48-49 ¶52; 50 ¶57; 54 ¶69; 61 ¶84; 65 ¶96; 71 ¶115; 73 ¶121; 75 ¶129; T. 837-38, 1144-45, 2142-45]

Documentation of the care purportedly provided to residents was not only lacking, but it was also in many instances fabricated. [T. 761, 799-800] The ALJ determined numerous late entries in the RCHH records were not supported by contemporaneous documentation or corroborating testimony and further found that some of the facility notes were clearly fabricated. [Pet. App. 92 ¶185] Importantly, Section 400.102(4) prohibits a licensee from falsifying medical records and the evidence at the hearing established the industry standard is to document any care or monitoring right

away. If late entries are made, some contemporaneous record should exist to support any specific entries that are made. [T. 1606, 4018] That did not happen at RCHH.

Petitioner's reliance on page 29 of the Petition on the Florida Supreme Court decision in *Ferris v. Turlington*, 510 So 2d. 292 (Fla. 1987) is misplaced. The ALJ's findings and recommendation were based on clear and convincing evidence of substantial causes justifying the revocation. RCHH was provided extensive opportunity for discovery and a 20-day evidentiary hearing. Moreover, contrary to Petitioner's assertions, the mitigation factors that RCHH kept trying to advance were presented to the ALJ. As set forth in paragraph 230 of the Recommended Order, the ALJ explained her conclusion that "the gravity of the harm done to multiple residents strongly outweighs any mitigating factors that might be considered against revocation."[Pet. App. 112] The fact that the ALJ rejected RCHH's efforts to distract from its own conduct by citing to purported failure of others is not a denial of due process.

Despite the voluminous record and comprehensive hearing transcripts, RCHH claims on page 21 of the Petition that the hearing was a sham. As evidenced above, the multi-week hearing was anything but a sham.

C. RCHH Was Fully Informed as to the Issues on Which the Agency's Decision Was Based and the Standard on Which Those Issues Would be Reviewed.

From the outset, RCHH has sought to blame others for the tragic loss of life, including the EOG and FP&L. But, the actions of others were not at issue in the state license revocation case. Florida law places a non-delegable duty on nursing home licensees to provide appropriate care and keep residents safe. RCHH failed to take the steps necessary to prevent the numerous heat related deaths and the suffering of its residents after the loss of the facility's A/C. There is no basis for this Court to reweigh the extensive competent substantial evidence in the record, which the ALJ determined to be clear and convincing. *See* Fla. Stat. §120.68(7)(b).

Consistent with the Florida statutes and rules, RCHH was given an opportunity to contest the allegations that its own negligence, own intentional wrongdoing and own lack of due diligence was the cause of the residents' deaths. The extensive hearing fully satisfied all state and federal due process requirements. There is no conflict such that the Petition should be denied.

RCHH urges this Court to find that revocation of its license is too harsh. The results of a licensee's actions and/or inactions are relevant to determining the appropriate penalty. The horrific deaths of multiple residents cannot be ignored. Safety of the residents

is the most important consideration. Revocation of RCHH's license was within the permissible penalties outlined in statute and the Agency did not abuse its discretion in imposing that penalty, given the multiple preventable deaths that occurred. *See* Fla. Stat. §§120.68(7)(e) and 408.815. Florida law provides the Agency with discretion to determine when revocation is appropriate. *See Kale v. Dept. of Health*, 175 So. 3d 815, 817 (Fla. 1st DCA 2015) (when an agency "imposes a penalty within the permissible statutory range, an appellate court has no authority to review the penalty.") There is no reason for this Court to interfere with the sound exercise of that discretion.

CONCLUSION

RCHH was accorded a meaningful opportunity to conduct discovery and present evidence to an independent ALJ before its license was revoked. The record from the multi-week hearing confirms that AHCA met its burden to prove by clear and convincing evidence that RCHH's actions and inactions in the wake of Hurricane Irma violated Florida law and led to or contributed to the death of multiple residents. [Pet. App. ¶205] The Fourth District Court of Appeal affirmed the Agency's Final Order, *per curiam*. Petitioner has not, and cannot, set forth any colorable basis to support

review by this Court. The instant Petition should be denied.

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