

In The Matter Of:

*SOF v
REHAB*

MCKINSTRY

November 30, 2017

*Accurate Stenotype Reporters
2894-A Remington Green Lane
Tallahassee, Florida*

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,
Petitioner,
vs. DOAH CASE NO. 17-005769
REHABILITATION CENTER AT
HOLLYWOOD HILLS, LLC,
Respondent.

DEPOSITION OF: MOLLY McKINSTRY

TAKEN AT INSTANCE OF: The Respondent

DATE: November 30, 2017

TIME: Commenced at 10:00 a.m.
Concluded at 12:45 p.m.

LOCATION: 2727 Mahan Drive
Tallahassee, Florida

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1 STIPULATIONS

2 The following deposition of MOLLY McKINSTRY

3 was taken on oral examination, pursuant to notice, for

4 purposes of discovery, and for use as evidence, and for

5 other uses and purposes as may be permitted by the

6 applicable and governing rules. Reading and signing is

7 not waived.

8 * * *

9 **THE COURT REPORTER:** Do you swear or affirm to

10 tell the truth, the whole truth, and nothing but

11 the truth?

12 **THE WITNESS:** I do.

13 Thereupon,

14 was called as a witness, having been first duly sworn,

15 was examined and testified as follows:

16 **DIRECT EXAMINATION**

17 **BY MR. SMITH:**

18 Q Would you state your name?

19 A Molly McKinstry.

20 Q Ms. McKinstry, we know each other. I am Geoff

21 Smith. I represent Rehabilitation Center of Hollywood

22 Hills, and we're here today on a license revocation

23 proceedings. My purpose in being here is just to find

24 out what you may know, what facts you have. If you

25 intend to offer any kind of expert opinions in the

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1 proceeding, I'd want to find those out and find out what
2 are the bases of those.

3 Does that seem like a fair process to you?

4 **A Yes.**

5 **Q** You don't mind providing that information to
6 me today?

7 **A No, I don't.**

8 **MR. MENTON:** We'll be honest. You have to be
9 honest on that one.

10 **THE WITNESS:** I am willing.

11 **BY MR. SMITH:**

12 **Q** Can you just take a couple minutes and give me
13 for our record just a brief overview of your education
14 and career, your professional background.

15 **A Sure. I have a bachelor's degree from Florida
16 State University in business. I have worked with the
17 Agency -- well, with the state of Florida for close to
18 25 years. My career here with the Agency, I began in
19 January 2000 in the long-term care unit, had previously
20 worked with the Medicaid program as well as the
21 long-term care unit; left for a few years and came back
22 in 2000, managed the long-term care unit, and then
23 became a bureau chief for long-term care services;
24 ultimately promoted to deputy secretary for the division
25 of health quality assurance.**

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1 **Q** Okay. And deputy secretary reports directly
2 to the Secretary?

3 **A Yes.**

4 **Q** And so as far as issues pertaining to the
5 licensure of facilities, you would be the Agency person
6 that's most -- at a senior management level, that's
7 directly involved and you report up to Justin Senior as
8 the Secretary?

9 **A Yes.**

10 **Q** In preparation for your deposition today, did
11 you review any documents or information?

12 **A Yes, I did.**

13 **Q** And what did you review?

14 **A I reviewed the emergency orders, the
15 administrative complaint for revocation, I reviewed
16 several of the press releases that were prepared during
17 the events of Hurricane Irma, I reviewed the materials I
18 presented to the House and Senate.**

19 **That's probably the gist of it.**

20 **Q** And you testified before the House and Senate
21 committees in Florida, correct?

22 **A Yes.**

23 **Q** Have you provided any federal testimony --

24 **A No.**

25 **Q** -- regarding Hurricane Irma?

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1 One thing that you and I do, I sometimes talk
2 slow, but if you will bear with me and just let me get
3 the whole question out because it just makes a better
4 record.

5 Could you tell me who in the Agency, if
6 anyone, did you use to help assemble the information for
7 the presentations that you made to the House and Senate?

8 **A I am not certain I could recall exactly who I
9 used. I work frequently with all of our bureau chiefs
10 and staff on materials, so probably a wide variety of
11 staff.**

12 **Q** You don't recall any specific individuals that
13 you would have gathered information from, Laura
14 MacLafferty?

15 **A Sure. I am certain that I probably would have
16 worked with the bureau chiefs: Kim Smoak, Laura
17 MacLafferty, Ryan Fitch, perhaps Scott Waltz, several
18 other staff that report to me.**

19 **Q** We are here today to talk about the emergency
20 management and the issues surrounding the intended
21 license revocation at Hollywood Hills. Can you start by
22 just giving me an overview of AHCA's role in emergency
23 management in Florida?

24 **A Yes. Our role related to emergency operations
25 is generally under the coordination of the Department of**

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1 **Health.**

2 **The emergency operations center is divided
3 into special function areas, and the health and medical
4 section is led by the Department of Health as emergency
5 response is often a public health matter.**

6 **Our role is to remain in contact with any
7 facility issues that may come up in concert with the
8 Department of Health.**

9 **In Florida, emergencies are local, so the
10 local emergency operation centers have the lead in terms
11 of emergency preparation and response activities. And
12 the state emergency operations center operates in a
13 supporting role to locals, providing assistance when
14 needed.**

15 **Q** In terms of -- I have seen the acronym EFS-8.
16 What is ESF-8?

17 **A ESF-8 is --**

18 **Q** ESF-8.

19 **A -- the emergency special function branch, and
20 my understanding of the state emergency operations
21 center is that it is organized in the special function
22 branches that have different roles and responsibilities
23 during emergencies.**

24 **The ESF-8 is the health and medical section
25 that I mentioned that Department of Health leads.**

1 Q What role does the Agency for Health Care
2 Administration have, by statute, in review of
3 comprehensive emergency management plans for licensed
4 facilities?

5 A **Comprehensive emergency management plans are
6 required to be prepared by facilities to address their
7 response, their potential response and consider a
8 variety of approaches to deal with emergencies that may
9 come up. It is intended to be an all-hazards approach
10 that facilities consider a variety of ways to meet their
11 needs and have mechanisms in place to effect various
12 activities, including evacuation, emergency power,
13 sufficient food and water, sufficient staffing.**

14 **The plans are prepared and are to be submitted
15 and approved by local emergency management officials.
16 Those officials review them, they are the emergency
17 management experts. If they have questions or have
18 concerns, they may reach out to the Agency if a facility
19 is in -- is not in compliance, they may report that to
20 us.**

21 **It is a condition of licensure that they have
22 those plans in place. And so our role would not be in
23 reviewing those plans. We may be asked if there is an
24 issue, but the review and approval is a local emergency
25 management official role.**

1 I don't believe the statute requires us to review
2 it. I think the emergency officials can share it
3 with us for review.

4 **BY MR. SMITH:**

5 Q In fact, it directs that the emergency
6 management official, the local officials will share it,
7 shall share it with the Agency, correct?

8 **MR. MENTON:** Object to the form.

9 **THE WITNESS:** I would like to look at the
10 statute.

11 **BY MR. SMITH:**

12 Q Well, the statute will say what it says and we
13 can get it on a break or something. But would it be the
14 case that the Agency has not reviewed comprehensive
15 emergency management plans?

16 **MR. MENTON:** Object to the form.

17 **A The -- it's certainly possible that if the
18 plan is not shared with the Agency for review, the
19 Agency will not have reviewed it.**

20 **BY MR. SMITH:**

21 Q And is it possible that the plans that have
22 been shared with the Agency have not been reviewed?

23 **A I am not aware of that.**

24 Q Are you aware of ever providing testimony in
25 any legislative committee hearing where you would have

1 Q And under statute, am I correct that the role
2 of the agency as defined in Chapter 400 actually
3 includes review of comprehensive emergency management
4 plans?

5 **MR. MENTON:** Object to the form.

6 **THE WITNESS:** Do you have the statute with
7 you?

8 **BY MR. SMITH:**

9 Q In the rule challenge proceeding that -- you
10 testified in the rule challenge proceeding, correct?

11 **A Uh-huh, yes.**

12 Q Do you recall Mr. Frazier had asked you about
13 this area -- I think it's section 400.23, somewhere
14 thereabouts in the statute -- and you at that time, at
15 least what I recall in your testimony, had stated that
16 there was a requirement in the statute that the local
17 emergency management planning agency share with state
18 agencies, including Agency for Healthcare
19 Administration, Department of Health, the comprehensive
20 emergency management plans for their review, is that
21 your recollection?

22 **MR. MENTON:** Object to the form.

23 **THE WITNESS:** That's why I would like to look
24 at the statute because I think the question that
25 you asked me is are we required to review it. And

1 testified that it would be impossible for the Agency to
2 review all of these comprehensive emergency management
3 plans?

4 **A I did speak in the House committee that it has
5 not been our experience that many plans are shared for
6 review; that when the legislation was originally
7 created, I believe in 2006, there was likely more
8 activity involving multiagency reviews, but that it was
9 not our experience that the plans were shared for the
10 most part at this time for review by the Agency; and the
11 workload associated with the volume of plans that would
12 be required for review would be significant, yes.**

13 Q So that's not something that's occurring, the
14 review of comprehensive emergency management plans by
15 the Agency?

16 **MR. MENTON:** Object to the form.

17 **THE WITNESS:** My understanding, it is not
18 occurring in the majority of cases.

19 **BY MR. SMITH:**

20 Q Okay. With respect to Rehabilitation Center
21 at Hollywood Hills, have you reviewed their
22 comprehensive emergency management plan?

23 **A No.**

24 Q And since you have not reviewed it, would
25 you -- would I be correct you don't intend to offer any

1 kind of testimony in this proceeding that there is
2 anything deficient in the comprehensive emergency
3 management plan of Hollywood Hills?

4 **A I can't speak to their plan.**

5 Q When a hurricane is approaching the state of
6 Florida, is there an activation process that takes place
7 to activate the Agency's role in hurricane preparedness
8 and response operations?

9 **A Our role with respect to emergency response is
10 directed through the state emergency operations center
11 and the Department of Health, who is the lead, as I
12 mentioned, for ESF-8. So if we are asked to activate by
13 Department of Health or the state EOC, we would do so.**

14 Q Is there a process in which there's alert
15 levels or something similar to that where at some point
16 the Agency is put on notice that, yes, we are now going
17 to implement our emergency preparedness as an agency?

18 **A We would be alerted to activation of the state
19 emergency operations center, but we would not initiate
20 any actions unless directed to do so by the Department
21 of Health.**

22 Q And how are you notified that there is a need
23 to activate your emergency preparedness actions as a
24 state agency? Who notifies you?

25 **A Typically, representatives of the Department**

1 **of Health and ESF-8 would contact us, most likely by
2 phone.**

3 Q And you described the role that the agency
4 plays in broad terms. What is the specific role that
5 the Agency for Healthcare Administration plays during
6 the hurricane event? What, if any?

7 **A We would communicate with providers through,
8 generally, the associations and messages by e-mail to
9 providers that are enrolled in the Florida Health STAT
10 system. That's a database that Department of Health
11 created that healthcare facilities use to enter
12 information related to their status. Providers are
13 generally directed to make entries based upon activation
14 of an event.**

15 **We would also potentially facilitate
16 conference calls; in some cases, make outreach calls to
17 providers. We generally, after an event, depending on
18 the severity of it, would make visits to facilities,
19 stay in contact with facilities through the state
20 emergency operations center and other partners at the
21 state ESF-8 to keep communication flowing between
22 providers and the state.**

23 Q How many hurricanes have you been personally
24 involved in doing those activities that you described on
25 behalf of the Agency for Healthcare Administration?

1 **A I don't know the number. I was involved in
2 the two hurricanes last year, certainly Hurricane Irma
3 and Nate this year, and I was also with the Agency in
4 2004, '5 and '6 when we had several hurricanes.**

5 Q Did you participate -- I am going to kind of
6 turn our attention a little bit towards Hurricane Irma
7 now.

8 Did you participate in conference calls with
9 the long-term care industry in Florida in preparation
10 for Hurricane Irma?

11 **A Yes.**

12 Q And do you know how many conference calls you
13 were on?

14 **A Yes, I believe we provided, as part of a press
15 release that was posted, a list of the calls that
16 occurred. (Examining Document.)**

17 **It looks like about 20 calls.**

18 Q And from what date to what date? You are
19 referring to a document. What's the document?

20 **A Yes, this is a document that was part of
21 documents that were posted with the press release on
22 September 25th, conference calls related to Hurricane
23 Irma.**

24 Q And is that the governor's press release or
25 AHCA's press release?

1 **A This was the governor's press release.**

2 Q Okay. During the conference calls --

3 **A I am sorry, I'm mistaken, a couple of those
4 calls were canceled at the end. So it looks like it's
5 shy of 20.**

6 Q During the calls, did the governor provide his
7 personal cell phone as a contact for industry members
8 that were having problems?

9 **A Yes.**

10 Q And did you provide your cell phone number?

11 **A Yes.**

12 Q And I understand there were a number of other
13 senior management staff that provided cell phone numbers
14 and they were posted, is that correct?

15 **A Yes.**

16 Q What was the -- I guess was there a structure
17 in place that you were trained on or people in the
18 Agency were trained on how to handle the calls that
19 would come in to the Governor's Office, the governor's
20 cell phone?

21 **A We were asked to assist with returning calls,
22 given the volume that was coming in, to assist in
23 finding out what concerns existed.**

24 Q And who asked you to do that?

25 **A I don't recall exactly. It probably was a**

1 **discussion I had with the Secretary.**

2 Q Did you have any correspondence, e-mail
3 correspondence, text messages, electronic correspondence
4 or paper correspondence with any representatives of the
5 executive Office of the Governor in advance of Hurricane
6 Irma?

7 A **It's possible that I had -- was copied on
8 e-mails related to staffing the Governor's Office.**

9 Q You say it's possible you were copied on
10 e-mails from the staff at the Governor's Office. Who
11 would be the staff at the Governor's Office that you
12 would interact with?

13 A **I didn't routinely interact with staff at the
14 Governor's Office. I -- we had several -- many folks on
15 deck, helping, given the scope of the storm that was
16 approaching. So I was routinely in communication with
17 our leadership staff, some of whom were speaking to
18 representatives from the Governor's Office, and we were
19 basically doing our best to keep everyone informed.**

20 Q And as far as those documents, any
21 communication between AHCA and the Governor's Office
22 concerning Hurricane Irma, have you undertaken any kind
23 of review to locate those e-mails and documents?

24 A **Those e-mails would have been pulled by our IT
25 department in response to document requests.**

1 personal cell phone number as a point of contact during
2 those phone conferences with industries?

3 A **I don't recall that he did, but I am sure we
4 gave other information as a point of contact.**

5 Q Did you provide personal cell phone numbers in
6 advance of Hurricane Nate for the Agency's staff?

7 A **I don't recall if I did, but I know that we
8 still had information available on our website that we
9 had shared statewide that was related to Hurricane Irma
10 that would still be available.**

11 Q Was there, to your knowledge, any discussion
12 that -- either with the Governor's Office or internally
13 at AHCA that perhaps the distribution of the personal
14 cell phone number had caused confusion and was maybe not
15 a good idea and don't do it going forward?

16 A **I was not aware of a discussion to that
17 effect.**

18 Q Do you believe that there was any confusion
19 caused by having multiple points of contact as opposed
20 to a central point of contact that everybody calls and
21 says this is where you contact if you are having a
22 problem?

23 A **I don't necessarily have concerns about that.
24 I think whenever we were dealing with the potential
25 impact of Hurricane Irma, there was a sense --**

1 Q Have you reviewed any of the correspondence
2 with the Governor's Office?

3 A **Not specifically. I am sure I would have been
4 involved in reviewing things as they were happening; but
5 given the volume of what we dealt with during the storm,
6 it was really the type of data pull that really could
7 only be handled by an IT.**

8 Q You mentioned a subsequent storm, Hurricane
9 Nate.

10 Was there anything different in the
11 preparation or response actions, to your knowledge, in
12 how the preparations and response for Hurricane Irma was
13 conducted versus Hurricane Nate? In other words, were
14 there any lessons learned where you maybe did things
15 differently with Hurricane Nate than what you did in
16 Hurricane Irma?

17 A **They were very different storms. Hurricane
18 Nate really had no significant impact to the state. So
19 there were many things that happened with Hurricane Irma
20 that were not relevant to Hurricane Nate.**

21 Q Do you know if there were industry phone
22 calls, phone conferences, scheduled in advance of
23 Hurricane Nate?

24 A **Yes, I believe there were.**

25 Q Do you know if the governor provided his

1 **especially given that, as a country, we had recently
2 seen the devastation in Houston, Texas -- there was a
3 sense that making sure that we provided as many points
4 of contact as possible was important.**

5 I think we were gearing up for the potential
6 of routine lines of communication being disrupted and
7 wanted to make sure that facilities had as many points
8 of contact as possible so they could get through to
9 someone if they needed assistance.

10 Q Does the Agency for Healthcare Administration
11 have any role in advising facilities whether to evacuate
12 or shelter in place in the approach of a major
13 hurricane?

14 **MR. MENTON:** Object to form.

15 **THE WITNESS:** We do not advise on that. Those
16 are emergency management matters. If we have
17 facilities that are asking questions about those
18 types of decisions, we refer them to contact the
19 local emergency management officials and, of
20 course, make sure that their responsibility to
21 protect the residents for whom they are licensed to
22 care are at the forefront of their decisions.

23 **BY MR. SMITH:**

24 Q Are you aware of any studies, literature that
25 would suggest that sheltering in place is a preferred

1 option if there is not an immediate threat that a
2 facility may suffer catastrophic damage from the storm,
3 that sheltering in place is a preferred option to
4 evacuation?

5 **A I am aware that there have been evaluations of**
6 **the impact of evacuation on long-term care residents,**
7 **and that there can be detriment to health long-term**
8 **because of the disruption of the home environment and**
9 **the logistics involved in moving.**

10 **However, those decisions to shelter in place**
11 **versus evacuate are important and challenging decisions**
12 **to be made by the leadership at the facility.**

13 **Certainly, the goal of making sure that patients are**
14 **protected should be the primary goal. In some cases,**
15 **evacuation is a better option than sheltering in place,**
16 **based upon the circumstances faced, and those decisions**
17 **are made on a case-by-case basis.**

18 **We did see several nursing homes evacuate**
19 **during Hurricane Irma: Some evacuated before the storm,**
20 **some evacuated after the storm due to deteriorating**
21 **conditions related to power outage; and those are**
22 **difficult decisions, but they are important decisions to**
23 **address and evaluate.**

24 **Q And you are aware of the difference between a**
25 **mandatory evacuation and a voluntary evacuation?**

1 prudent action that a nursing home operator would take?

2 **A I can't speak to the specifics of what they**
3 **should or should not have done. That's a decision that**
4 **needs to be made based upon the circumstances in the**
5 **facility.**

6 **I think one thing that was of concern related**
7 **to the facility is that measures did not -- were not in**
8 **place to protect people appropriately in response to the**
9 **concerns that occurred.**

10 **So whether it was evacuation or some other**
11 **measure that could have been considered, we worked with**
12 **many other facilities after the storm had passed that**
13 **were scrambling to find backup generators, to find**
14 **evacuation locations if their primary plans could not be**
15 **executed, to find assistance with transportation, to**
16 **obtain ice and water, things that we worked with other**
17 **facilities to accomplish because they were asking for**
18 **resources to carry them through until power could be**
19 **restored, and we did not see that same level of activity**
20 **in our discussions with Hollywood Hills.**

21 **Q Okay. And when you say -- did you undertake a**
22 **review to determine whether there were actions by**
23 **Hollywood Hills to obtain generators or to obtain spot**
24 **coolers or to do the things that you've just referenced?**

25 **A My understanding was there were spot coolers**

1 **A I am familiar with the concept of mandatory**
2 **evacuation, which typically is ordered by emergency**
3 **management officials when they feel there is a -- a**
4 **serious threat to -- generally geographically and most**
5 **often as a prestorm type of action for protection of a**
6 **facility if there is a risk of flooding or wind damage.**

7 **But yes, there are definitely circumstances**
8 **that don't fall under the emergency management mandatory**
9 **criteria when evacuation is considered by facilities to**
10 **protect patients.**

11 **Q Would I be correct that Hollywood Hills was**
12 **never placed under a mandatory evacuation order?**

13 **A I am not aware that they were placed under a**
14 **mandatory order.**

15 **Q And so Hollywood Hills, like nursing homes**
16 **around the state of Florida, had to decide: Should we**
17 **evacuate our residents or attempt to shelter in place,**
18 **is that true?**

19 **A That would have reasonably been part of their**
20 **decision-making, yes.**

21 **Q And the decision to shelter in place, do you**
22 **find to be a -- do you find fault with the decision in**
23 **the approach of Hurricane Irma that the facility,**
24 **Hollywood Hills, chose that they would shelter in place,**
25 **do you find fault that that was not a reasonable,**

1 **in the facility. Based upon the reviews that we did and**
2 **the statement of deficiencies drafted, they were not**
3 **necessarily appropriately placed to provide protections**
4 **to all the patients in the facility.**

5 **Q Were there, to your knowledge -- how many**
6 **facilities in Florida lost power for a period of time**
7 **equal to or greater than the time that Hollywood Hills**
8 **was without power, AC power?**

9 **A I don't know the specific number. I know that**
10 **there were many facilities that were without power for**
11 **multiple days.**

12 **Q Would you describe that as a pervasive problem**
13 **that occurred in the state of Florida after Hurricane**
14 **Irma?**

15 **A There were a significant number of facilities**
16 **around the state and communities around the state that**
17 **were without power. I presented in my Senate testimony**
18 **information about the scope of power outages around the**
19 **state.**

20 **We did receive information through Florida**
21 **Health STAT, which we know doesn't represent all the**
22 **power outages, that there were a large number of**
23 **facilities without power in response to Hurricane Irma.**
24 **I am sure that's in my presentation.**

25 **Q And I show you a document and it has Bates**

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1 stamps. I believe it was from your rule challenge
 2 hearing. If I could just -- it starts at Bates stamp 1
 3 and continues through Bates stamp -- it looks like a 16.
 4 Can you just take a minute and look at that?
 5 **A (Examining Document.)**
 6 **Yes.**
 7 **Q** What is that document?
 8 **A This is a document of facilities that had**
 9 **reported power outages during Hurricane Irma. This**
 10 **would have been obtained from information entered into**
 11 **Florida Health STAT or communicated through the ESF-8,**
 12 **and it does show in some cases, the number of days power**
 13 **was out. It would be an estimate.**
 14 **We know that there were some facilities that**
 15 **were not reporting the duration of power outages, and in**
 16 **some cases, there are likely facilities that would not**
 17 **have been recorded here that were without power at some**
 18 **point.**
 19 **Q** Okay. So is the information on this document,
 20 again, Bates stamp 1 through 16 from the rule challenge
 21 exhibits, is that accurate information, to your
 22 knowledge, with the caveat it may understate the
 23 problem?
 24 **MR. MENTON:** Object to the form.
 25 **THE WITNESS:** I think it reflects some of the

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1 information that was relevant to the storm, based
 2 upon what was reported.
 3 **BY MR. SMITH:**
 4 **Q** I appreciate that but is it accurate, to your
 5 knowledge? Is the information here that is presented as
 6 to the number of facilities that lost power and the time
 7 periods reflected, would this be a baseline number?
 8 There may be more, there may be -- the days may be
 9 longer, but that's an accurate baseline?
 10 **MR. MENTON:** Object to the form.
 11 **THE WITNESS:** It's accurate based upon the
 12 information collected.
 13 **BY MR. SMITH:**
 14 **Q** I've looked that over and I will just tell
 15 you, it appeared to me that there were many facilities
 16 throughout the state of Florida that -- skilled nursing
 17 facilities that lost power to their air conditioning and
 18 they were without air conditioning for periods of time
 19 longer than Hollywood Hills. Would you agree?
 20 **A I have not analyzed it to that degree.**
 21 **Q** Do you think Hollywood Hills was unique among
 22 providers that lost air conditioning in terms of the
 23 length of time that they were without power before they
 24 either evacuated or had power restored?
 25 **MR. MENTON:** Object to the form.

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1 **THE WITNESS:** I think there were other
 2 facilities that lost power and were challenged with
 3 temperature issues as well.
 4 **BY MR. SMITH:**
 5 **Q** Is it your contention in this proceeding that
 6 Hollywood Hills is the only skilled nursing facility in
 7 the state of Florida at which there were deaths that
 8 occurred of residents, whether they occurred at a
 9 hospital, after being sent to a hospital under a 911
 10 call, or they occurred at the facility, that Hollywood
 11 Hills is unique in the state in the fact that there were
 12 deaths that may have been attributed to rising
 13 temperatures?
 14 **MR. MENTON:** Object to the form.
 15 **THE WITNESS:** I think what is unique with
 16 Hollywood Hills is the number and scope of the
 17 circumstances that occurred on the 13th and then
 18 shortly thereafter. We had not been aware of any
 19 situation where we had eight deaths on a single day
 20 with residents whose body temperatures -- multiple
 21 residents whose body temperatures registered at
 22 107, 108, 109.9-degrees and resulted in a mass
 23 casualty event in terms of another provider having
 24 to come in and assist with addressing patient
 25 decline, with being approached as a crime scene,

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1 with the information that ultimately we identified
 2 from emergency responders about the extreme
 3 temperatures in the building and the inappropriate
 4 location of cooling devices.
 5 **BY MR. SMITH:**
 6 **Q** What information are you referring to that you
 7 obtained from EMS responders that -- the rising
 8 temperature in the building and the inappropriate
 9 location of cooling devices?
 10 **A That's reflected in our statement of**
 11 **deficiencies from the survey, that the EMS records**
 12 **indicated the temperatures were untenable and that the**
 13 **location of coolers were -- let me refer to the**
 14 **document -- that the fans were inadequate in**
 15 **relationship to patients' whereabouts.**
 16 **Q** The fans or the spot coolers?
 17 **A This says fans.**
 18 **Q** Other than what's written in the survey, do
 19 you have any information that there was inappropriate
 20 location of either fans or spot coolers?
 21 **A I am not familiar with other information than**
 22 **what's available from our staff.**
 23 **Q** And do you know if there were numerous
 24 facilities throughout the state of Florida that lost
 25 power to their air conditioners and had no spot coolers

1 deployed in their building?
 2 **A I am not familiar with what each facility did.**
 3 **I know there were other facilities that were evaluated**
 4 **in all approaches to keeping residents cool and, in some**
 5 **cases, did choose to evacuate. But I am not familiar**
 6 **with what each facility did.**

7 Q With respect to the impacts to residents, have
 8 you undertaken any kind of investigation, as an agency,
 9 in conjunction with Department of Health to determine
 10 for each licensed facility that did lose power and did
 11 lose the air conditioning for their residents, whether
 12 residents were sent to area hospitals under 911 and
 13 whether those residents subsequently expired at area
 14 hospitals?

15 **MR. MENTON:** Object to the form.

16 **BY MR. SMITH:**

17 Q My question is just simply have you undertaken
 18 any kind of investigation to determine that information?

19 **A We have a number of post reviews that are**
 20 **being conducted to determine if there were concerns**
 21 **based upon complaints filed with the agency. We**
 22 **routinely investigate complaints that are filed with us**
 23 **and that process generally involves on-site inspection**
 24 **and review before we would determine the circumstances.**
 25 Q But I am probably asking a broader question.

1 **THE WITNESS:** There are always opportunities
 2 to look at circumstances in hindsight. I know
 3 sometimes that the Department of Health may be
 4 interested in looking at broader issues.

5 It's not something that we -- we just haven't
 6 made a decision at this time that we are pursuing
 7 anything like that. It is certainly something that
 8 might be considered in the future, but right now, I
 9 think we are looking at any specific issues that
 10 were addressed or were brought to our attention.

11 **BY MR. SMITH:**

12 Q I want to go back to the decision on whether
 13 to evacuate or shelter in place on the front end.

14 Is there any specific action or omission that
 15 you would point to in the approach of Hurricane Irma
 16 that Hollywood Hills took or didn't take that was
 17 deficient in terms of being prepared for the hurricane?
 18 In other words, did they do something or not do
 19 something that other facilities did, to your knowledge,
 20 in storm preparation?

21 **A I am not familiar with their preparation**
 22 **activities.**

23 Q So you don't know and don't have any
 24 information that there was something that they did
 25 deficient on the front end in terms of being prepared

1 Other than responding to a complaint that may be filed,
 2 has the Agency attempted in any way to secure data from
 3 the Department of Health, vital statistics, to say: We
 4 would like to take a look at the scope of deaths that
 5 may have occurred in Florida attributed to heat-related
 6 issues in nursing home and ALF facilities? In other
 7 words, let's look at the residents of those facilities
 8 that have -- that there is a record that they died
 9 during this time frame, September 9th, say, September 9
 10 through September 16, and try to get a grasp of what the
 11 scope of the number of deaths might have been across the
 12 state?

13 **MR. MENTON:** Object to the form.

14 **THE WITNESS:** We have not initiated a study to
 15 that effect, but I do feel that the complaints that
 16 I mentioned earlier would be information that we
 17 would look at on a statewide level over time.

18 **BY MR. SMITH:**

19 Q You would agree with me that would be
 20 something that -- regardless of what happens in the
 21 Hollywood Hills case, that it's something the State
 22 would want to do to determine were there nursing home
 23 deaths that might have been associated with loss of
 24 power and loss of AC?

25 **MR. MENTON:** Object to the form.

1 for the event, being prepared for the storm?

2 **A I don't know.**

3 Q Would you agree that actions that one might
 4 take that would be reasonable would be to consult your
 5 comprehensive emergency management plan and make sure
 6 you are doing the things that are in your CENP, that
 7 would be reasonable, correct?

8 **MR. MENTON:** Object to the form.

9 **THE WITNESS:** We would hope that an emergency
 10 management plan would serve as a roadmap for
 11 facilities to respond to emergencies. We did find
 12 that in talking to the facilities around the state
 13 that there were challenges in executing plans for
 14 many facilities for a variety of reasons. Some
 15 facilities had planned evacuation locations to
 16 which they could not go, either because they were
 17 promised to multiple parties and already occupied
 18 by another evacuating facility; in some cases they
 19 were too far away to move residents, given the gas
 20 shortages. In other cases, evacuation sites were
 21 in affected areas and also had to evacuate.

22 So we saw many facilities who could not
 23 execute their plans as written. But they also
 24 pursued other options because their plans could not
 25 necessarily be a single roadmap to an appropriate

1 response to protect their residents.
2 **BY MR. SMITH:**
3 Q And can you give me some of the examples of
4 those other options that other facilities would have
5 implemented that Hollywood Hills did not? That's what I
6 am after.

7 **A I don't know all of the details of what**
8 **Hollywood Hills tried to implement. I do recall working**
9 **with facilities and being aware of facilities that**
10 **requested assistance in transportation, if their**
11 **transportation providers fell through.**

12 **In some cases, they asked for assistance in**
13 **finding evacuation locations and/or came up with**
14 **different strategies to do a partial evacuation if part**
15 **of the facility was affected, if they could move people**
16 **into an area that was appropriate and then move others**
17 **out.**

18 **In some cases, residents were divided up among**
19 **multiple locations to be able to move everyone out of a**
20 **facility.**

21 **There were cases where requests for generators**
22 **were made to bring in a way to run existing air cooling**
23 **equipment or bring in air cooling equipment.**

24 **And then I mentioned that there were cases**
25 **where requests for ice and water were also sought.**

1 **That request was made routinely.**
2 **What I am talking about in terms of**
3 **distinguishing between the type of help that they asked**
4 **for versus other facilities is making requests to keep**
5 **people comfortable while power was still out. So**
6 **whether it was -- what we saw from other facilities in**
7 **addition to requests for power restoration was cooling**
8 **devices, generators, consideration of evacuation, not**
9 **solely waiting for power to come back on, but making**
10 **sure that patients were kept safe during that outage**
11 **period.**

12 Q Things like trying to secure additional spot
13 coolers, would that qualify for that kind of action that
14 you are referencing?

15 **MR. MENTON:** Object to the form.

16 **BY MR. SMITH:**

17 Q That you saw other facilities do, the
18 attempting to go find more spot coolers for the
19 building?

20 **A I think whether it was spot coolers or**
21 **anything else, the expectation is that those avenues are**
22 **pursued to the point of people being safe while power is**
23 **out.**

24 Q Is that something they have to specifically
25 request from the emergency management officials; the

1 Q And did you find that Hollywood Hills was
2 deficient in exploring options?

3 **A I don't know which options they pursued. When**
4 **I looked at the types of assistance that was requested**
5 **for other facilities through the information that I saw**
6 **at the state level, I did not see requests from them**
7 **comparable to the types of requests that other**
8 **facilities had submitted.**

9 Q And by that, you mean -- can you be specific
10 for me? What requests would you have been looking for?

11 **MR. MENTON:** Object to the form.

12 **THE WITNESS:** Just the examples I just gave.

13 **BY MR. SMITH:**

14 Q Would this be the type of thing you were
15 looking for: Calling the Florida emergency line that
16 they were provided, that Hollywood Hills was provided
17 and leaving the -- or talking to the individual on the
18 emergency line that they need to be made a priority,
19 they are a hospital -- a nursing home with 162 patients,
20 many of them elderly and on oxygen, as well as adult
21 mental health and adolescent mental health patients,
22 that they needed assistance in making this a priority to
23 get their AC on, is that the type of thing --

24 **A The requests for power restoration was**
25 **certainly pervasive among long-term care facilities.**

1 emergency management officials wouldn't say to them:
2 Well, can we help you get a generator? Here's an
3 inventory of where we might have generators. Let us
4 know if we can help in that regard, or here's some
5 suggestions on where we might be able to get spot
6 coolers.

7 So is it your view that if there is not a
8 specific request, if the person calling doesn't say: I
9 need a generator or I need spot coolers, that it's not
10 something that the emergency management officials for
11 the state would know to volunteer and say: Let us help
12 you, you've got frail elderly patients without power?

13 **MR. MENTON:** Object to the form.

14 **THE WITNESS:** The -- I am not familiar with
15 how the mechanics of requesting resources locally
16 work. However, it is important to be able to
17 articulate and monitor what's happening with
18 individual residents and. If the situation is
19 declining, help articulate the types of services or
20 equipment that might assist the situation.

21 The emergency management officials are not in
22 the facility, they don't know specifically what is
23 going on with the individual residents or the
24 environment. And it's important for the leadership
25 at the nursing home, those staff that are there

1 whose job is to protect those residents, to be the
2 advocates for those residents and to help
3 articulate the level of assistance they need and
4 ways to help meet that need.

5 **BY MR. SMITH:**

6 Q Would you consider making 30 to 40 phone calls
7 to Florida Power and Light, to the governor of the
8 state, to the emergency, the Florida emergency
9 information line or Florida emergency line, I guess
10 (850)815-4925, that was provided to them as a number to
11 call for assistance, if they made just numerous calls
12 saying: Help, help, help, I've got frail elderly, you
13 think they needed to say: Well, help can be: Get my
14 power on, it could be get me an alternative source of
15 power, if they didn't specify, that wasn't enough?

16 **MR. MENTON:** Object to the form.

17 **THE WITNESS:** I think given the scope of the
18 emergency that we were all dealing with as a state,
19 that asking for help and not doing anything else to
20 keep people safe was not an appropriate response.

21 **BY MR. SMITH:**

22 Q Let's assume that they -- it's not what you
23 just said, that they didn't do anything else. Let's
24 assume that what they did is they explored every
25 possible avenue to obtain additional spot coolers, that

1 really at the heart of this? It's the Agency's view
2 that there was no other facility where there were
3 multiple resident deaths that occurred as a result of
4 rising temperatures in buildings, isn't that sort of at
5 the heart of what your -- your concern is with the
6 Agency -- I mean with the facility?

7 **MR. MENTON:** Object to the form.

8 **THE WITNESS:** I think the -- that
9 circumstance, in addition to the fact that the
10 gravity of the situation was identified by external
11 parties, from a hospital across the street from
12 this facility, that had to stand up mass casualty
13 response, that a police investigation immediately
14 was conducted and that the entire facility was
15 evacuated at the prompting of outside parties,
16 makes this case different than anything else we
17 saw.

18 **BY MR. SMITH:**

19 Q Okay. Do you know who ordered the mass
20 casualty evacuation of the building?

21 **A Not specifically.**

22 Q Do you know if I was to go down the list of
23 facilities from the spreadsheet on Bates stamps 1
24 through 16, facilities that were without power for days,
25 would you be able to identify for me whether or not they

1 they monitored their residents, that they hydrated their
2 residents, that they had third-party licensed medical
3 professionals in the building checking on their
4 residents, rounding on their residents, determining
5 whether or not to move their residents, they did all
6 those kinds of things, they provided hydration to their
7 patients, and they secured more fans, more spot coolers,
8 they explored trying to get their generator to power up
9 the AC if that was possible, explored that with
10 electricians, explored whether an electrician would
11 climb up there on the power pole to see if they could
12 fix the transformer. Would those all -- assume they did
13 all of that, would that affect your view that they
14 didn't respond appropriately?

15 **MR. MENTON:** Object to the form

16 **THE WITNESS:** Given that there were many other
17 facilities that were likely in similar situations,
18 struggling to keep people comfortable and making
19 very difficult decisions, but none of whom had
20 eight residents expire on a single day, with
21 dramatically high body temperatures, it does not
22 appear that they took appropriate measures to keep
23 their people safe.

24 **BY MR. SMITH:**

25 Q Isn't that -- what you just said, isn't that

1 had patients that were sent to the hospital via 911 and
2 how many and on what days?

3 **A Not specifically.**

4 Q Do you have any information that any of those
5 facilities did or did not send residents to hospitals on
6 the days that they were without power?

7 **A There may be information in some of the
8 investigations that we're pursuing, but I don't have
9 anything with me.**

10 Q Do you have any general information where you
11 could go down this list and say this -- can you tell me
12 how many 911 calls there were from this facility on this
13 day?

14 **A I don't have that specific information.**

15 Q And same thing with deaths, I couldn't -- you
16 couldn't tell me for any of the specific -- for the
17 facilities specifically did they send patients to the
18 hospital that died; you just don't know, isn't that
19 true?

20 **A I don't know. I do think that if there were a
21 significant number anywhere comparable to what we saw at
22 this facility, it would have been escalated.**

23 Q Did you receive any kind of training or
24 instruction on how to prioritize the requests that were
25 coming in for power restoration?

1 **MR. MENTON:** Object to the form.
2 **THE WITNESS:** No, we did not receive any
3 particular instruction. We did ask that if
4 facilities were without power, that they articulate
5 any other assistance they might need or share
6 anything about the gravity of their situation.

7 **BY MR. SMITH:**

8 Q Are there any documents, to your knowledge,
9 that are in the possession of the Agency for Healthcare
10 Administration that would address the issue of which
11 facilities should receive priority in power restoration?

12 **MR. MENTON:** Object to the form.

13 **BY MR. SMITH:**

14 Q Let me just give you an example.
15 Do hospitals have a greater priority for power
16 restoration than nursing homes?

17 **A I am not familiar with the details of how**
18 **power restoration is prioritized by power companies. It**
19 **is not within the Agency's jurisdiction to direct that.**

20 **I know that there have been efforts in the**
21 **past to make sure facilities are communicating with**
22 **their power companies to ask -- make sure that they**
23 **understand that their healthcare facilities -- and that**
24 **is something many facilities have done during kind of**
25 **nonemergency times to make sure that those circumstances**

1 **BY MR. SMITH:**

2 Q I think where we just left off, I was just
3 trying to affirm and make sure that you don't have any
4 kind of data or information for each of the facilities
5 that are located -- that are on your spreadsheet, the
6 facilities in Florida that lost power for days, whether
7 or not they sent patients by 911 to hospitals, you don't
8 have that data?

9 **A I am not aware of that data in any kind of**
10 **prescribed form. There may be information in individual**
11 **visits that we are conducting as part of follow-ups that**
12 **exist, but I don't --**

13 Q But you don't have -- you haven't reviewed
14 anything like that?

15 **A No.**

16 Q Okay. And same thing with data -- I think I
17 fully explored that and I don't want to beat a dead
18 horse, but you don't have death data for residents of
19 nursing homes that occurred during the storm time
20 period, and I will just put parameters from
21 September 9th, say, for the following two weeks?

22 **A Correct, I do not.**

23 Q Would you agree with me that the impact of
24 Hurricane Irma was considered to be widespread
25 throughout the state of Florida?

1 **are known. My understanding is that typically vital**
2 **infrastructures receives priority and that power**
3 **companies are making decisions about how to proceed**
4 **based upon many factors.**

5 Q Are there any documents at AHCA that address
6 the issue of priority for power restoration --

7 **A Not --**

8 Q -- whether they are documents of AHCA that it
9 prepared or documents of outside agencies or parties
10 that they prepared, do you have any such documents?

11 **MR. MENTON:** Object to the form.

12 **BY MR. SMITH:**

13 Q To your knowledge?

14 **A I can't think of any. I know that there**
15 **were -- at the agency, there were some efforts that the**
16 **Florida Healthcare Association participated in after the**
17 **storms in 2005 to help improve communication about power**
18 **issues, and I believe they might have conducted some**
19 **training of facilities in terms of how to have those**
20 **kinds of discussions with power companies, but I can't**
21 **think of anything that's in the Agency's purview.**

22 **MR. SMITH:** Can we take like a short break.
23 (A recess took place from 11:13 a.m. to
24 1:19 a.m.)
25

1 **A Yes.**

2 Q "Historic, unprecedented," would those be
3 reasonable terms to use in association with the impact
4 of Hurricane Irma on Florida?

5 **A Yes.**

6 Q In that decision on the front end to evacuate
7 or shelter in place, would I be correct one of the
8 considerations that any operator has to put in the
9 equation is what the impacts, negative impacts of the
10 trauma of a transfer would have on the frail elderly
11 resident?

12 **MR. MENTON:** Object to the form.

13 **THE WITNESS:** Yes, we would expect the impact
14 of residents to be part of any possible options
15 that are considered.

16 **BY MR. SMITH:**

17 Q And as far as that decision to evacuate, would
18 you agree with me, Irma kind of demonstrated that it's a
19 very complicated decision because the facility to which
20 you would evacuate might also be impacted or the storm
21 may shift and a facility you thought wouldn't be
22 impacted ended up being impacted?

23 **A I would agree that that was something that we**
24 **actually saw with Hurricane Irma and saw many facilities**
25 **struggling with emergency management plans that fell**

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1 **through. But they also continued to pursue options**
 2 **until patients were in a safe setting.**
 3 Q Do you have any information -- I will just
 4 tell you to assume it -- if it's a wrong assumption,
 5 then it won't be worth anything to the judge -- but just
 6 assume there is going to be testimony that residents
 7 were being hydrated, that the spot coolers and fans were
 8 put throughout the building, that there was every effort
 9 made to ensure that residents were staying as
 10 comfortable as they could, and that there were
 11 temperatures being taken inside the building, monitoring
 12 of the temperature in the building.
 13 Do you have contrary information to that?
 14 **MR. MENTON:** Object to the form.
 15 **THE WITNESS:** Contrary information to?
 16 **BY MR. SMITH:**
 17 Q What I was just saying, that I can break it
 18 down.
 19 There's going to be testimony that residents
 20 were being monitored and hydrated by the facility's
 21 staff. Do you have any contrary information to that?
 22 **MR. MENTON:** Object to the form.
 23 **THE WITNESS:** The investigation that our staff
 24 was able to conduct was limited in that the
 25 facility had been roped off as a crime scene with a

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1 criminal investigation, so we had access to limited
 2 information.
 3 Our job as regulators is to make sure that
 4 people are safe and although, ideally, we would
 5 have been able to do a more extensive
 6 investigation, including review of clinical
 7 records, including interviews with residents and
 8 family members, including review of other records
 9 beyond the facility that have not been accessible
 10 due to the criminal investigation, the information
 11 we did ultimately review represented concerns that
 12 were -- that raised our concern that the
 13 circumstances in the facility related to
 14 heat-related detriment to residents with extremely
 15 high temperatures when they were treated at the
 16 hospital.
 17 So we don't have access to a lot of the
 18 records we typically would review. However, given
 19 the circumstances and the extreme nature and the
 20 volume of what we saw, we felt that our job as a
 21 regulatory agency required us to take action to
 22 protect other patients.
 23 We know that as those additional
 24 investigations are completed, both the criminal
 25 investigation, the medical examiner's reports and

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1 other records become available, those will further
 2 illustrate the circumstances at the facility; thus
 3 far the documents that have become available have
 4 not been contrary to our concerns as to what
 5 occurred at the facility.
 6 **BY MR. SMITH:**
 7 Q Do you have any information contrary to the
 8 assertion that the residents were being hydrated? That
 9 was my question.
 10 **MR. MENTON:** Object to the form.
 11 **THE WITNESS:** Given that we don't have access
 12 to all of the information, we can't comment on that
 13 matter.
 14 **BY MR. SMITH:**
 15 Q So you don't have any contrary information
 16 that you can share with me today on that issue:
 17 Hydration of residents?
 18 **MR. MENTON:** Object to the form.
 19 **THE WITNESS:** I have no additional information
 20 other than what's been part of our investigative
 21 reports.
 22 **BY MR. SMITH:**
 23 Q When you say part -- it's a wide-open issue.
 24 If you've got information, I need to know what it is.
 25 If you are saying what's in the survey document, that's

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1 fair game. You can tell me that's in the survey
 2 document and I will read that and whatever is there is
 3 there.
 4 But if there is other information, I just
 5 would like to know what specific information you would
 6 have that's contrary to the assertion that residents
 7 were being hydrated?
 8 **A I am not aware of any information that we**
 9 **have.**
 10 Q And do you have any information contrary to
 11 the assertion by the facility that it had deployed spot
 12 coolers?
 13 **A The information in the inspection report,**
 14 **which reflects notes from the emergency management**
 15 **officials indicating that the same expert I read**
 16 **earlier, that the fans were inadequate in relationship**
 17 **to the patient's location whereabouts.**
 18 Q That's a statement that some EMS provider had
 19 made?
 20 **A That's "EMS states they did note fans,**
 21 **however, were inadequate in relationship to patients'**
 22 **location whereabouts."**
 23 Q Do you know who said that?
 24 **A I don't personally know.**
 25 Q Are you aware that there were third-party

1 licensed medical professionals in the facility,
2 Hollywood Hills facility, on September 12 that ran --
3 that rounded on their patients?

4 **A I am not specifically aware of that.**

5 **Q** Do you have any information contrary to the
6 observation of those third-party medical professionals
7 that they -- their patients were not in distress or
8 showing any signs of developing an emergency medical
9 condition as of September 12 when they were in the
10 building?

11 **MR. MENTON:** Object to the form.

12 **THE WITNESS:** I am not aware of the specifics
13 of their reviews. This is a large facility. I
14 believe there were over 120 or more patients in the
15 facility. Given that it was a multistory building
16 and that temperatures can be different in different
17 rooms with different residents, I don't know that
18 information related to a portion of those residents
19 would be enough to address the needs of all the
20 residents in the facility.

21 (Discussion off record.)

22 **BY MR. SMITH:**

23 **Q** Ms. McKinstry, is there a standard of care
24 that you are aware of as to how long a facility can be
25 without power, AC power, before the facility needs to

1 rephrase it.

2 Do you believe that all of the caregivers in
3 the facility were negligent in their care for residents;
4 in other words, all the CNAs, the RNs, the physician
5 assistant, just everybody associated, it was a
6 collective failure of everybody to observe those
7 conditions and take other action?

8 **MR. ECENIA:** I will object to the form of the
9 question.

10 **THE WITNESS:** Our investigation of the case,
11 as I mentioned, was limited due to the
12 circumstances involving the criminal review. So
13 our review did not get down to individual
14 facility -- excuse me, individual practitioner
15 negligence.

16 It was, instead, focused on the extreme
17 conditions that were found with the residents that
18 were evacuated and ultimately died and that those
19 circumstances were unacceptable.

20 **BY MR. SMITH:**

21 **Q** When you say the extreme conditions, you mean
22 the body temperatures that were taken of some of the
23 residents at Memorial Regional?

24 **A That, and the clinical information indicated**
25 **they had appeared to have heat-related conditions,**

1 evacuate?

2 **MR. ECENIA:** I will object to the form of the
3 question.

4 **THE WITNESS:** I am not aware of any
5 proscriptive length of time. We would certainly
6 expect that every resident of long-term care
7 facilities' needs are met and their circumstances
8 are reviewed related to their illness. And part of
9 what we expect healthcare providers to do in a
10 long-term care setting is make sure that the needs
11 of every resident are met appropriately.

12 **BY MR. SMITH:**

13 **Q** But there is no standard, to your knowledge,
14 of if a facility is without power 24 hours or 48 hours
15 or 72 hours, then the facility needs to evacuate their
16 residents somewhere else?

17 **A I am not aware of a formula to make that**
18 **decision. Those are going to be complicated decisions**
19 **based upon the circumstances in a specific facility.**

20 **Q** Okay. And do you know, the assertion of the
21 agency appears to be that the facility did not
22 appropriately monitor or detect that there was -- that
23 patients would be in distress from the level of the
24 temperature in the building.

25 Did you consider in that decision -- let me

1 **hypothermia and other issues.**

2 **Q** Are you aware -- first of all, let me
3 establish you are not a -- you don't have any clinical
4 background?

5 **A Correct.**

6 **Q** Are you aware of any information as to the
7 onset of heat stroke and how rapidly it can occur?

8 **A No.**

9 **Q** Do you have any information on the ambient air
10 temperature and heat index at which hypothermia can
11 occur?

12 **A No.**

13 **Q** I want to go back to the issue of the priority
14 for power restoration.

15 Is there any system in place, to your
16 knowledge, in which a request for power restoration made
17 to the emergency operations center or the emergency
18 hotline, is there any guidance at all on how to seek
19 priority for power restoration internally?

20 **MR. ECENIA:** I will object to the form.

21 **BY MR. SMITH:**

22 **Q** Internally at AHCA.

23 **A Not at AHCA, no.**

24 **Q** To your knowledge, is there any such
25 documentation or guidance at any other state agency?

1 A The information that is collected through the
 2 emergency operations center is -- my understanding is
 3 that's shared with the different sections of the
 4 emergency operations center, one of which is related to
 5 power. So it provides a mechanism to note facilities
 6 that are without power, but requests for power
 7 restoration is not a substitute for taking measures to
 8 make sure people are safe until power has returned.

9 Q And the measures that one would take would be
 10 what specifically?

11 MR. ECENIA: Measures, I will object to the
 12 form.

13 MR. SMITH: To keep people safe. She said
 14 there would be the expectation to keep people safe,
 15 and it's not a substitute. So I am just wondering
 16 the specific measures that one would be expected to
 17 take.

18 MR. ECENIA: I will object to the form of the
 19 question.

20 THE WITNESS: It would depend on the
 21 circumstances of each facility and the residents
 22 there. But I have previously mentioned the types
 23 of measures we saw other facilities seeking to
 24 address issues while power was out, including
 25 assistance with additional cooling, potential

1 keep residents safe and protected while the power is out
 2 is part of what the facility should be doing in response
 3 to an emergency. The -- we have previously discussed
 4 the concept of asking for assistance outside of just
 5 power restoration and considering the safety of patients
 6 during the power outage.

7 911 would be a resource that we would expect
 8 be called if residents are in a situation that requires
 9 additional medical attention, but those calls should be
 10 made at a time -- health should be monitored in a way
 11 that -- prior to severe decline so that interventions
 12 that are needed are pursued prior to their death.

13 Q And my question is simple. If nobody in the
 14 building has what the medical professionals on site deem
 15 to be an emergency medical condition, there is nobody in
 16 distress, nobody is having what would -- appears to be
 17 an acute episode that is in need of emergency medical
 18 care, wouldn't I be correct that 911 is not an
 19 appropriate call to make to say we need to get our power
 20 back on and get our patients more comfortable, isn't
 21 that correct?

22 A The 911, I think, was brought up with respect
 23 to the clients that did decline and did expire at the
 24 facility.

25 Q But am I right about what I am saying, you

1 evacuation, things of that nature.

2 BY MR. SMITH:

3 Q On the issue of potential evacuation, it's
 4 been widely reported in press releases that Hollywood
 5 Hills, first of all, should have called 911 sooner.

6 What information, if any, do you have about
 7 using 911 as a means to advise that power had not been
 8 restored and that you had concerns that residents
 9 could -- if power is not restored, residents could
 10 develop problems?

11 A I think the concept of calling 911 relates to
 12 distress of individual residents and ideally, given that
 13 they are in a healthcare facility, their health should
 14 be monitored in a way that if they are declining,
 15 medical interventions are sought prior to their death.

16 Q So you would agree with me that 911 is not the
 17 mechanism that one would use to simply say: My
 18 residents do not appear to have any emergency medical
 19 condition, but they -- I need to get the power on before
 20 they do develop emergency medical conditions?

21 MR. ECENIA: I will object to form of the
 22 question.

23 BY MR. SMITH:

24 Q Would that be fair?

25 A I think the concept of seeking assistance to

1 don't use 911 to report that we still need to get our
 2 power back on because our residents need to be made more
 3 comfortable?

4 A Correct.

5 Q And are you aware that for each of the
 6 patients that were eventually transferred to Memorial or
 7 died at the facility, that 911 was called in each
 8 instance?

9 A I am not familiar with the details. I know
 10 that ultimately, there was a call for emergency medical
 11 assistance.

12 Q Were you aware that there were multiple calls
 13 for emergency medical assistance that were made on the
 14 night of September 13 -- or the early morning hours of
 15 September 13?

16 A Yes, my understanding is there were calls made
 17 on the 13th.

18 Q The second part of the issue of evacuating due
 19 to lack of power restoration, it's been widely reported
 20 that the facility should have evacuated to the hospital
 21 across the street, I think it's in the complaint. It's
 22 a large public hospital and it didn't lose power, so the
 23 facility should have evacuated its residents there.

24 Is that something that you have seen as a
 25 proper emergency response, to evacuate residents of a

1 nursing home to a nearby hospital because they have
2 power and you don't?

3 **MR. ECENIA:** I will object to the form of the
4 question.

5 **THE WITNESS:** We saw -- due to challenges in
6 evacuation locations, we did see facilities in
7 response to Hurricane Irma seek alternative
8 locations for residents.

9 I don't recall exactly if there were
10 individuals that went to hospitals, but I don't
11 think it would have been unreasonable. But in some
12 cases, individuals did go to hospitals as a part of
13 an evacuation.

14 **BY MR. SMITH:**

15 Q Would you agree with me that hospitals are
16 intended to be facilities for the care and treatment of
17 patients with either an emergency medical condition or
18 who are in need of inpatient hospitalization?

19 A **Typically that would be the case. However, we
20 did see many unusual circumstances related to locations
21 for evacuations in response to Hurricane Irma.**

22 **Basically in some cases, hospitals -- excuse me, nursing
23 homes had residents go to even schools in some
24 situations to set up situations where they could be in a
25 safe environment with the facility staff there with**

1 actually cited for inappropriate use of a hospital.

2 **A Yes, I am familiar with that.**

3 Q And so you would agree it's not appropriate to
4 take patients to -- nursing home residents to a hospital
5 simply because -- if they don't have an emergency
6 medical condition, simply because the hospital has
7 power?

8 **MR. ECENIA:** I will object to the form of the
9 question.

10 **THE WITNESS:** The situation that I am aware of
11 from last year involved what appeared to be an
12 assisted living facility that dropped their
13 residents off at a hospital emergency department
14 without making arrangements with the hospital to
15 care for those residents or seeking a collaborative
16 solution to their problem.

17 So I think that was a different scenario than
18 what could have been contemplated if there was a
19 discussion between this facility and a hospital or
20 any other location as a potential evacuation site.

21 Ideally evacuation sites are an agreed
22 situation where there is an outreach to a receiving
23 party and an agreement that the residents can be
24 transferred to that location. And we saw many
25 situations during Irma where unique circumstances

1 **them. So I think what's typical typical and what
2 happens in an emergency situation can be different.**

3 Q And the role of hospitals in an emergency
4 situation, to your knowledge, in Florida, is not to
5 serve as evacuation shelters for other licensed
6 healthcare facilities, is that true?

7 A **I think that would not be a typical
8 arrangement, but it certainly could be considered if
9 that were the best situation to deal with an emergency
10 situation.**

11 Q Have you reviewed the comprehensive emergency
12 management plan for Memorial Regional Hospital to
13 determine if its use as a hurricane evacuation
14 alternative for nursing homes that lose power was
15 contemplated?

16 A **I have not reviewed their plan.**

17 Q Did you have the opportunity to sit in
18 yesterday on Ms. Smoak's deposition?

19 A **I did listen to it, yes.**

20 Q Do you recall, I had asked her about
21 situations at the Agency where patients had been taken
22 to hospitals as part of an evacuation and left at
23 hospitals because the facility owner felt or operator
24 felt that was a safe place for the patient to be and
25 that in situations like that, facilities had been

1 had to be negotiated to provide those protections
2 and get people out of a facility when it was not an
3 appropriate location for them to be.

4 **BY MR. SMITH:**

5 Q Did you have any experience during Hurricane
6 Irma where hospitals discharged their residents to
7 nursing homes that had lost their power, lost AC power,
8 with the knowledge that the resident, the patient was
9 being discharged to a facility that did not have power?

10 A **I am not specifically aware of hospitals
11 discharging that. I know that there were some
12 situations where residents returned to facilities
13 without power, but they did that, the circumstances I am
14 familiar with, in conjunction with consultation with the
15 local emergency management officials to make sure that
16 if they returned, for example, from evacuation to a
17 facility without power, that there were circumstances
18 that provided for comfortable arrangements and that
19 emergency management officials were advised of the
20 circumstances, so that if they had to intervene later --**

21 **So, for example, if they came back on a
22 generator and the later emergency management officials
23 were called in to help with fuel to keep the generator
24 running, that the emergency management officials
25 understood the circumstances of reoccupation without**

1 power.

2 Q If a hospital was being reasonable and
3 prudent, they would be investigating to determine
4 whether the residents would be safe in a facility
5 without power?

6 MR. ECENIA: I will object to the form of the
7 question.

8 THE WITNESS: We would expect if a -- like I
9 said, I am not familiar with circumstances where
10 hospitals discharge people to nursing homes without
11 power, but I am familiar with some situations where
12 nursing homes went back without power and in that
13 case, we would expect the nursing home operator to
14 be aware of the situation, to inform local
15 emergency management officials and to make those
16 decisions in concert with those local officials.

17 BY MR. SMITH:

18 Q Are you aware if Memorial Hospital discharged
19 patients to Rehabilitation Center of Hollywood Hills
20 with knowledge that the nursing home did not have air
21 conditioning power?

22 A I am not aware of that.

23 Q Were you involved at all in the decision to
24 issue an immediate moratorium based upon the survey of
25 the facility that occurred on September 13th?

1 give me all of the players that were involved that made
2 that decision?

3 A Well, our staff who conducted the
4 investigation were involved, Kim Smoak, who was our
5 bureau chief for field operations and typically, they
6 are involved in these decisions. They are the ones on
7 the ground gathering the information. Kim and I were in
8 constant communication throughout the day as we had
9 been, frankly, every day since we had been responding to
10 this emergency.

11 And so she kept me briefed on what the
12 findings were. I shared that information with our
13 senior leadership, and we worked with legal to draft an
14 order of moratorium that was ultimately executed.

15 Q So were there conference calls between
16 yourself and Kim Smoak and Arlene Mayo Davis and the two
17 surveyors?

18 A I don't believe that I was on that conference
19 call with them. I think I just stayed in touch with Kim
20 Smoak.

21 Q And did you exchange any text messages or
22 e-mails with Kim Smoak on the decision to issue an
23 immediate moratorium?

24 A I don't recall there being any text or e-mail
25 messages about that. I wouldn't text Kim anyway. I

1 A I was aware of the situation at the facility
2 and the -- I stayed in contact with Kim Smoak, who was
3 in touch with our staff, who went on site to the
4 facility. And yes, I was aware of the moratorium.

5 Q Tell me to the best of your recollection what
6 transpired on September 13th in terms of AHCA's response
7 to the situation at Hollywood Hills?

8 A We became aware through -- really through
9 media reports that there appeared to be multiple deaths
10 at a facility. We had -- I believe there were some
11 initial conversations, contacting the facility to find
12 out what was transpiring. We sent staff on site that
13 day to determine what the circumstances were. Our staff
14 had limited access to the facility. As I mentioned
15 before, it was roped off as a crime scene. There was an
16 investigation going on.

17 We gathered information as best we could and
18 then evaluated our regulatory responsibility to make
19 sure people are protected and decided to implement a
20 moratorium on admissions to prevent any reoccupation of
21 the facility until additional information was known.

22 Q And who was involved in that decision-making
23 process, the decision to issue the immediate moratorium?
24 Specifically what calls were made? What e-mails were
25 exchanged, to the best of your recollection? Can you

1 think it was all just conversations.

2 Q Did you have any communication with the
3 Secretary about -- with Secretary Senior -- about
4 issuing the immediate moratorium?

5 A Yes, I was keeping him briefed.

6 Q Did you have any communications with the
7 executive office of the governor or any representative
8 of the Governor's Office regarding the issuance of the
9 immediate moratorium?

10 A I don't recall having any conversations with
11 the Governor's Office staff. They were likely briefed
12 by our staff, but I don't recall any conversations I
13 had.

14 Q And did Secretary Senior indicate to you that
15 he had been in discussions with the Governor's Office
16 about the immediate moratorium?

17 A He was likely keeping me briefed. I don't
18 recall specifically.

19 Q The reason I am asking all these questions is
20 because there is a press release in which the Governor's
21 Office says that the governor directed that the
22 immediate moratorium be issued.

23 Do you have any information as to why the
24 governor would indicate that it was the governor's
25 decision to issue the immediate moratorium on

1 admissions?

2 **MR. ECENIA:** I will object to the form of the
3 question.

4 **THE WITNESS:** I don't know that I recall
5 specifically information that he directed the
6 moratorium. I know there is -- can you point me to
7 some --

8 **BY MR. SMITH:**

9 Q Yes. It's this one. I will just read the
10 title for our record. "Governor Scott Directs AHCA" --
11 that's the Medicaid one, hold on. There is another one.

12 It's here, it's on -- "To interested media
13 from John Topps," and it says "On Wednesday,
14 September 13th, Governor Scott directed AHCA to issue an
15 emergency moratorium for the Rehabilitation Center at
16 Hollywood Hills that prevents the facility from
17 admitting any patients until it is lifted."

18 A Well, we conducted our review that, again, was
19 limited because of the criminal investigation, and we
20 felt that it was appropriate and actually our
21 responsibility to implement a moratorium on admissions.

22 Q But to your knowledge, you were not aware that
23 the governor had directed that the Agency issue the
24 moratorium?

25 A I am aware that the governor was very involved

1 in activities related to Hurricane Irma. His staff were
2 briefed, as I recall, not necessarily by me, but I do
3 believe they were briefed about what was going on, and
4 we pursued the moratorium. I kept the Secretary
5 informed as to the actions, and there was no concern
6 related to our pursuing that option expressed.

7 Q But you are not aware -- to your knowledge,
8 you haven't seen any information that the governor
9 directed that the moratorium be issued?

10 A We did what we needed to do in this situation.
11 It was an emergency situation. There was a lot going
12 on. It is not inconsistent that we were pursuing this
13 for the governor to have certainly been interested in
14 this, and -- but we carried out the moratorium based
15 upon the way that we normally do our business. We were
16 interested in putting it in place for the purposes of
17 protecting patients from harm.

18 Q Do you know if the governor directed that AHCA
19 terminate Hollywood Hills from the Medicaid program and
20 issued an immediate and final order to terminate the
21 Agency -- or terminate the facility, Hollywood Hills,
22 from the Medicaid program?

23 A As the regulatory agency, we looked at all of
24 the relationships that we had with the facility and
25 considered all options available. Termination of the

1 Medicaid treatment was one of those options available.
2 And it was -- I am sure there was probably some briefing
3 with the Governor's Office about other options and so
4 that avenue was also pursued.

5 Q But my question, do you know if Governor Scott
6 directed AHCA to terminate the Rehabilitation Center at
7 Hollywood Hills from the Medicaid program? Do you have
8 knowledge of that?

9 A That's the statement in this article.

10 Q But other than looking at what's in the press
11 release, did you have knowledge that it was the governor
12 that had directed the termination of Hollywood Hills
13 from the Medicaid program?

14 A I didn't speak directly to the governor.

15 Q Did you receive information indirectly that --
16 from the Secretary or anybody else that the Governor's
17 Office had directed the Agency to terminate the Medicaid
18 provider agreement for Hollywood Hills?

19 A I think that -- that I am aware that the
20 Governor's Office was being briefed, that we were
21 pursuing options that they were in agreement with,
22 that's my understanding.

23 Q Okay. But you don't have any specific
24 knowledge of the governor issuing a directive to the
25 Agency to terminate the facility from the Medicaid

1 program?

2 A Other than this press release.

3 Q I want to look just briefly at some documents
4 with you. If you could -- I will give you a copy of
5 this.

6 These were documents that we obtained from
7 your testimony in the rule challenge proceeding. We
8 already talked about the first tab behind tab 4. I am
9 just going to kind of go through these with you, and I
10 will call out Bates stamp numbers. Really, my exercise
11 here is to understand what the documents are.

12 If you could, starting -- the second tab
13 starts at Bates stamp 493 and this appears to be another
14 spreadsheet. Do you know what this document is?

15 A I am sorry, where are you?

16 Q It's tab 4A2.

17 A Yes.

18 Q What is this?

19 A This is a document that represents facilities
20 that reported evacuation either through Florida Health
21 STAT or based upon other information submitted at the
22 emergency operations center.

23 Q Okay. So these were facilities that
24 evacuated?

25 A Yes.

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1 Q And what is the -- is E and the R in the grid,
2 there is a capital E and capital R, is that evacuation
3 and return?
4 A **That's my understanding, yes.**
5 Q And what about the ones that don't have an E
6 or R and they just have like an X and a date, what does
7 that mean?
8 A **So the information was not always complete.**
9 **These were pieces of information that were gathered**
10 **during the event, and X would indicate there was an**
11 **indication that they were evacuated without necessarily**
12 **knowing when they initially evacuated or returned.**
13 Q We can go to the next tab. The next tab
14 starts on page 498 and continues to 513. Is that
15 essentially the same spreadsheet for assisted living
16 facilities?
17 A **Yes.**
18 Q And then the next tab it looks like it starts
19 on Bates stamp 516 and goes through 540. Can you just
20 tell me briefly what this spreadsheet is? It appears to
21 be generator information, but I am not sure what it
22 means. It has a column "Power Stat."
23 A **I would have to look into what this is. I am**
24 **not certain.**
25 Q Looking at the far column, "status: Closed or

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1 opened or null," does that mean anything to you?
2 A **I would have to look into what this means to**
3 **answer questions about this document.**
4 Q Do you know who prepared -- who was the author
5 of this document?
6 A **Not without looking into it with greater**
7 **detail.**
8 Q Let's go to the next tab beginning at Bates
9 stamps 542 and going over to Bates 566. Do you know --
10 A **Which tab?**
11 Q It was the next one in sequence. So it's 4A,
12 Roman Numeral V, B?
13 A **That's not the same Bates stamp I have. I**
14 **have 170.**
15 Q On this?
16 A **I'm sorry, 4A5?**
17 Q Uh-huh.
18 A **4A5, this is what the document I have looks**
19 **like.**
20 Q I wonder if it printed differently.
21 **MR. SMITH:** Off the record.
22 (Discussion off record.)
23 **BY MR. SMITH:**
24 Q There is a document that's titled "Nursing
25 Homes without a Permanent On-Site Generator." It's hard

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1 to read the Bates stamp, it looks like --
2 A **It's 175, could be 176.**
3 Q Yeah. Can you tell me what this is? Is it
4 self-explanatory? This is as of 9-25, these are nursing
5 homes that did not have a permanent generator on site?
6 A **Yes.**
7 Q And there is only 17 of them?
8 A **Yes.**
9 Q When you say a permanent generator, does that
10 mean that all the other nursing homes in the state have
11 a generator that would be capable of running AC power?
12 A **Not necessarily. The requirement for**
13 **generator support will vary by facility, based upon the**
14 **fire life safety code and building code in effect at the**
15 **time of construction or renovations. So these were**
16 **facilities without any generator, some of which either**
17 **had projects pending or had a quick-connect ability,**
18 **which meant they could bring in a generator to plug into**
19 **some of the electrical system.**
20 Q If you could go to -- hopefully, we are on the
21 same page. Can you go to the next tab?
22 A **Nothing.**
23 Q Let me just show you. Somehow our notebooks
24 are not identical.
25 A **This one?**

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1 Q There is an e-mail and the Bates stamp looks
2 like 43.
3 A **Yes.**
4 Q It's an e-mail from Celeste Philip to Wes Maul
5 and you are copied. Can you tell me about this e-mail.
6 What is the -- why did you receive a copy of this
7 e-mail?
8 A **Let me read it.**
9 **So this is an e-mail from Dr. Philip to Wes**
10 **Maul at the state EOC asking for power restoration**
11 **priority for a facility.**
12 Q Okay. And this is a facility, the Renaissance
13 at the Terraces, with over 200 clients, and it says they
14 have basic needs on generator but don't have capacity to
15 run AC, and some of their clients are deteriorating with
16 the higher temperature. And it's asking for -- to
17 create a mission since the CEO has been trying
18 unsuccessfully.
19 What was it that would prompt this response
20 from the Surgeon General and Secretary of the Department
21 of Health to get involved and say we need to make this a
22 priority?
23 A **So the Surgeon General was working at the**
24 **state EEOC and handling issues similar to really**
25 **everyone who was assisting with activities. This**

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1 appears to be a situation where she received information
 2 about a facility. We spoke at some point and as I
 3 mentioned earlier, the emergency response process is
 4 that the local emergency operations officials are the
 5 key responders and assisters in terms of any sort of
 6 emergency issues.
 7 The state EOC is available to assist if
 8 someone has difficulty reaching the local EOC or
 9 requires some other assistance. So it sounds like in
 10 this case, they have not been successful in reaching the
 11 local EOC and have asked that this be escalated at the
 12 state level.
 13 So this would be a mechanism to communicate at
 14 the state level the need for power restoration at this
 15 facility. This doesn't necessarily mean they weren't
 16 taking other measures as well as waiting on power
 17 restoration.
 18 Q Do you know if they were taking any other
 19 measures?
 20 A I don't know right off, no.
 21 Q Do you know if anybody had been -- said their
 22 clients were deteriorating with higher temperature, do
 23 you know if any of them were sent to the hospital?
 24 A I don't know.
 25 Q Do you know if any of them died?

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1 A I don't know.
 2 Q Can you flip over a couple of tabs and see if
 3 we can get on the same page with -- there is a 387 Bates
 4 stamp. It's an e-mail?
 5 A Yes.
 6 Q Okay. The top half is just an e-mail from you
 7 back. But I am looking at the bottom half.
 8 A Yes.
 9 Q It's from Gail Matillo on Wednesday,
 10 September 13, to AHCA EOC, and you are listed as one of
 11 the recipients. And down at the bottom, it says "Power
 12 Status: No power, no generator, have been without power
 13 for three days. Needs priority one FP&L for power
 14 restoration."
 15 And then if you flip over to the next page, it
 16 goes on, "Has spoken with FP&L with no success, have
 17 spoken with local EOC, concerned about heat stroke and
 18 hypothermia."
 19 Do you recall this particular facility and
 20 incident?
 21 A Not specifically.
 22 Q What does it mean to be needs priority one,
 23 what does that mean?
 24 A I don't know. That's a term that was written
 25 by Ms. Matillo.

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1 Q Who is Ms. Matillo?
 2 A She is with one of the associations.
 3 Q Which association?
 4 A Argentum, Florida Argentum.
 5 Q And do you know if this facility had any
 6 residents that were sent to the hospital by 911?
 7 A I don't know.
 8 Q And do you know if it had any residents that
 9 died?
 10 A I don't know.
 11 Q But it is a facility that apparently was
 12 without power for several days: No power, no generator,
 13 correct?
 14 A Based on this summary from Ms. Matillo.
 15 Q And patients that were -- they were concerned
 16 about heat stroke and hypothermia, correct?
 17 A That's what this says.
 18 Q Flip over to the next one, this is from you to
 19 Kim Smoak about a facility called Juniper Village. And
 20 I guess you had been copied previously on an e-mail from
 21 Lee Meadows to AHCA EOC regarding this facility?
 22 A Yes.
 23 Q And your e-mail to Kim Smoak, it just says,
 24 "Importance high, you may have already visited."
 25 What was it you were seeking to do here?

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1 A To make sure that we had stopped to visit at
 2 this facility.
 3 Q And this one, you know that there was at least
 4 one patient that was sent to the hospital for heat
 5 stroke?
 6 A That's what this says.
 7 Q Do you know if that patient died?
 8 A I don't know.
 9 Q Go to the next -- there is an e-mail from
 10 Justin Senior to you, at the bottom, and to you -- and
 11 actually to you and Celeste Philip, but then the
 12 salutation is Celeste. But it concerns a facility in
 13 Brooksville, Northbrook Health and Rehab. And it had to
 14 do with generator fuel.
 15 Above it, it looks like was urgent situation.
 16 Can you tell me about this? How is it determined when
 17 something is urgent, Level I, high priority, those kinds
 18 of terms that I see in a lot of these e-mails?
 19 A I think one of the things that is generally
 20 articulated in this is if residents are being affected.
 21 And so I don't know if it's -- let's see.
 22 So in this case, looking at the bottom of the
 23 second page, "Secretary received a text from Rose Garden
 24 the generator had just konked out. Extremely concerned
 25 that residents might not be able to make it without

1 **help. The locals have not been able to help yet."**
 2 **So these situations were addressing resident**
 3 **decline issues that required interventions.**
 4 Q Turn over the next -- there is a series of
 5 these from either Melody Selis -- am I saying her name
 6 right?
 7 A **I think so.**
 8 Q Bob --
 9 A **Asztalos.**
 10 Q -- Asztalos and Adam Hill. The first two
 11 Melody Selis and Bob Asztalos, are they representatives
 12 of the Florida Healthcare Administration?
 13 A **Yes, they were assisting with the emergency**
 14 **response activities.**
 15 **MR. ECENIA:** You said Florida healthcare
 16 administration.
 17 **MR. SMITH:** Florida healthcare Association is
 18 what I meant to say. I'm sorry. FHCA.
 19 **BY MR. SMITH:**
 20 Q Adam Hill, is he with the Public Service
 21 Commission?
 22 A **Where is he referenced?**
 23 Q The middle of the page, Adam Hill, it says
 24 "psc.state.dot.FL.US. Do you know Mr. Hill?
 25 A **I do not.**

1 Q The bottom of the page, there is another --
 2 there is an e-mail that says -- the subject is
 3 "Priority: Restoration of power." It lists out several
 4 nursing homes. Again, do you know how -- how is that
 5 determined that those three facilities were a priority
 6 restoration?
 7 A **I don't know.**
 8 Q Was it because they contacted FHCA and said we
 9 consider it a priority for our members and please try to
 10 get these back on?
 11 A **I don't know the circumstances related to**
 12 **these. I know that there were many people trying to**
 13 **assist on cases.**
 14 **This particular one, you can see, 11:30 at**
 15 **night. So folks are working kind of around the clock to**
 16 **help address any situations that they become aware of.**
 17 **The -- in many of these cases, some of them had to do**
 18 **with getting them other resources while power**
 19 **restoration was pending. In some cases, they needed**
 20 **more gas.**
 21 **I think if you go through these, there are**
 22 **probably some that do totally evacuate. For example,**
 23 **under 73, there is one where the "Generator is powering**
 24 **the nursing home but not operating the AC. Residents**
 25 **are overheating and dangers of high temp and will have**

1 **to evacuate if they cannot power the AC."**
 2 Q Do you know if they evacuated?
 3 A **In this case, they did get a generator hooked**
 4 **up and the central air was running, so the patients were**
 5 **stable. So I am not aware that they evacuated, at least**
 6 **based on this dialogue. But those were certainly part**
 7 **of some of the considerations.**
 8 Q I could go through all of these, but would you
 9 be able to tell me for any of the facilities represented
 10 in these e-mails and these mission reports whether or
 11 not they sent patients -- residents to the hospital via
 12 911 and whether or not any of those residents died?
 13 A **There may be some indications of patients**
 14 **being hospitalized in some of these. I can tell you I**
 15 **am not aware of any that had eight patients die on one**
 16 **day.**
 17 Q Was there some line of communication to
 18 Florida Power and Light which you could use to say:
 19 This is our highest priority, we need to get this
 20 facility back online?
 21 A **The AHCA EOC desk and the ESF-8 that were**
 22 **copied on these were responding to requests for**
 23 **information through the state EOC and facilitating lists**
 24 **of facilities without power to the emergency special**
 25 **function that handles power restoration of utilities.**

1 Q Going back to my question, is there any kind
 2 of a -- was there any kind of a system in place that
 3 there was a person, a point person at FP&L that you
 4 could call to say: This is a high priority, we need to
 5 get somebody out there to restore power?
 6 A **That was not done by agency staff. That would**
 7 **have been done at the emergency operations center if**
 8 **those requests had been made, but I am not aware.**
 9 **That's not something the Agency carries out.**
 10 Q Are you familiar with any information that
 11 Hollywood Hills actually requested and obtained some
 12 kind of effort to escalate their request?
 13 **MR. ECENIA:** I will object to the form of the
 14 question.
 15 **BY MR. SMITH:**
 16 Q It's a compound question. Let me -- are you
 17 aware if Hollywood Hills requested that they get
 18 priority?
 19 A **I think that they expressed the need for power**
 20 **in their communications, and my understanding is that**
 21 **they had contacted FP&L and had a ticket with FP&L.**
 22 Q Do you know if there were any efforts by the
 23 Agency to escalate the priority status for Hollywood
 24 Hills?
 25 A **The entries that were made in to Florida**

1 Health STAT were used to communicate at the state EOC
2 level nursing homes that didn't have power, and we had
3 conversations about the need for healthcare facilities
4 to have their power restored, if possible.

5 Q All these e-mails we're going through here, it
6 appears that they are coming to -- you are being copied,
7 they are coming to you, and then we need -- the
8 association is saying: Hey, we need help with these
9 three facilities. What would you do with those
10 requests? Obviously, there is a line of communication.
11 They said: Please, help us. Here's our priorities.

12 What would you do with that information?

13 A We would share that with the state emergency
14 operations center, who would share that. In some cases,
15 they shared information or requests for assistance with
16 local officials, who would facilitate resolution. In
17 some cases they would be entered into Florida Health
18 STAT and lists of facilities without power would be
19 shared. There were varieties of ways to share
20 communication.

21 Q And I just want to -- as fully as we can, I
22 want to know what the varieties were. You said: Okay,
23 well, you could share the information with EOC.

24 A Uh-huh. And we did. So that's the copying of
25 AHCA EOC and the state ESF-8 planning, these were all

1 If they needed specific assistance, now
2 everybody wanted power restored, absolutely, but if
3 they -- but they had to take care of people until the
4 power was restored. That was a big unknown, it was very
5 difficult, given the widespread power outage, to know
6 when power was going to be restored, so a lot of these
7 show requests for generators, for assistance with
8 cooling devices, for, in some cases, transportation if
9 they have to evacuate.

10 So it was a difficult situation, it was a
11 widespread situation. There was a lot of activity going
12 on, but it was all focused on keeping people safe until
13 their systems could come back to normal.

14 Q It's your view that Hollywood Hills, by virtue
15 of the fact they had the resident deaths, they were not
16 trying to keep residents safe?

17 A Whatever they were doing was not enough to
18 save the eight people who died that day.

19 Q Is that what this case kind of boils down to:
20 That eight people died, therefore, you must not have
21 been doing enough? Otherwise, they wouldn't have died?

22 Is there any information, specific facts that
23 you can point to and say: This facility, Hollywood
24 Hills, did not do X, Y, and Z, that they should have
25 done, or that Hollywood Hills did X, Y, and Z that

1 shared with the state EOC.

2 Q And you could update information on Florida
3 Health STAT?

4 A Yes.

5 Q What else -- is there anything else that you
6 would do in response to any of these requests that came
7 from the Florida Healthcare -- Florida Healthcare
8 Association for assistance in escalating the priority
9 for the facilities?

10 A This was -- so the way that the emergency
11 response works is that local officials are the frontline
12 in terms of responding to emergencies. The issues that
13 are circulated at the state EOC serve to provide
14 assistance when the locals can't meet needs.

15 It is incumbent upon the facilities to
16 escalate issues, if they feel that the situations are
17 deteriorating, and I think that's what some of these
18 e-mails articulate, is people having to make these
19 difficult decisions: I am going to have to evacuate if
20 I can't have power restoration; is there a way to get a
21 backup generator to run the air conditioning unit?

22 So these were examples of situations where
23 people were articulating the gravity and then making
24 decisions to protect their patients based upon the
25 circumstances they were faced with.

1 affirmatively contributed to the deaths of these
2 residents?

3 MR. ECENIA: Object to the form of the
4 question. It's still going on. It's a long
5 question.

6 MR. SMITH: It is a long question. It's more
7 of a discovery question than a question that I am
8 using at trial.

9 I am just trying to get your view, is that
10 what this boils down to, is that they had resident
11 deaths, multiple resident deaths, and the residents
12 had high temperatures and that, therefore, they
13 must have done something wrong?

14 MR. ECENIA: I will object to the form of the
15 question.

16 THE WITNESS: So our object as a regulatory
17 agency is to protect patients. We expect
18 facilities that have a license to operate as a
19 nursing home in the state of Florida to -- we
20 entrust them to care for people in their care.

21 Our job is not necessarily to prove a criminal
22 case and find every detail of information related
23 to what happened and why, but our job is to make
24 sure people are protected and safe.

25 In this case we could not conduct a thorough

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1 investigation because of the ongoing criminal case.
 2 My understanding is there was a homicide
 3 investigation underway. There were medical
 4 examiner reports that would take some time to
 5 become available. There were clinical records we
 6 could not obtain access to because of the nature of
 7 the criminal investigation.
 8 We were able to obtain enough information to
 9 raise concerns about the ability for people to be
 10 safely maintained in this facility. We initially
 11 imposed the moratorium and, then as additional
 12 facts were available that indicated that the
 13 temperatures in the facility were extreme, that
 14 proper protections were not in place to keep people
 15 safe, that eight people died on that single day,
 16 and ultimately more people died, and that the
 17 temperatures of those individuals was so extreme,
 18 that we are very concerned that people would be
 19 safe to be in this facility in the future.
 20 **BY MR. SMITH:**
 21 Q Is there any specific actions you can say,
 22 like they weren't providing sufficient water, they
 23 weren't -- they should have had 14 spot coolers instead
 24 of 10 spot coolers, or they should have had 70 fans
 25 instead of 40 fans, some specific action that you can

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1 point to, other than residents died, they had high
 2 temperatures when they arrived at Memorial and,
 3 therefore, they didn't keep them safe, they died, is
 4 there anything else?
 5 I am just trying to understand the full set of
 6 facts that you are basing this revocation on.
 7 **MR. ECENIA:** I will object to the form of the
 8 question.
 9 **A We were not in the facility. We don't run**
 10 **nursing homes at the Agency for Healthcare**
 11 **Administration. We don't know exactly what measures**
 12 **could have or should have been taken with this. That's**
 13 **up to the facility to decide, and in a manner to meet**
 14 **the individual needs of all the residents under their**
 15 **care.**
 16 **What we do know are the indications that I**
 17 **already shared with you about the deaths and the**
 18 **temperatures and the concern of the temperature in the**
 19 **facility and the lack of sufficient fans for the**
 20 **residents that were there.**
 21 Q And let me just ask you this. If the facility
 22 was to demonstrate that the facility has -- as the
 23 Agency has, subsequent to Hurricane Irma, suggested, has
 24 a backup generator capable of providing air conditioning
 25 power for 96 hours after a hurricane event and has a --

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1 whatever, has the perfect-world standby bus, has all
 2 kinds of fail-safe measures, is it the Agency's view
 3 that the entire staff of this hospital -- this nursing
 4 home and the everybody associated with it is just so
 5 incompetent that they can't be trusted with care of
 6 residents?
 7 **MR. ECENIA:** I will object to the form of the
 8 question.
 9 **THE WITNESS:** Well, the facility didn't have
 10 safe temperatures for the residents that were
 11 there. So I can't compare this to a situation
 12 where there's ideal measures in place.
 13 In any situation when you are dealing with
 14 frail individuals who have unique medical needs,
 15 you can't just have a system and expect it to
 16 self-run and everyone be safe.
 17 We expect currently for facilities to have
 18 policies and procedures to prohibit abuse and
 19 neglect, to have systems in place that identify
 20 issues before they escalate. Just because those
 21 systems are there doesn't necessarily mean that
 22 they are executed properly.
 23 So we are always looking at what actually
 24 happened in facilities on a case-by-case basis to
 25 see if the facility acted appropriately to protect

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1 the patients in their care.
 2 **BY MR. SMITH:**
 3 Q So there is no other specific act that you can
 4 point to? I just want to make sure I've got everything
 5 and there is no specific action or omission by the
 6 facility other than that their power went out, these
 7 residents died and had high body temperatures, so they
 8 must have not properly cared for them and provided a
 9 safe environment?
 10 **A We made our decision to proceed with the**
 11 **actions based upon limited information, because of the**
 12 **criminal investigation and a lack of access to records**
 13 **and information. As more information becomes available,**
 14 **we'll certainly review that. So far, the information**
 15 **that has come to light has not contraindicated the**
 16 **actions that we have taken.**
 17 Q But you don't have any other facts because you
 18 were limited in what you could gather due to the
 19 criminal investigation?
 20 **A Yes.**
 21 Q Have you been asked to form any or have you
 22 formed any professional or expert opinions that you plan
 23 to share in this proceeding?
 24 **A I am not sure what that might be that we**
 25 **haven't already discussed.**

1 Q Since this is my chance to find out, so if you
2 have any others, I just want to know. Do you have any
3 other professional opinions that you don't feel like we
4 explored today?

5 A **I can't think of anything.**

6 Q Do we agree that Hurricane Irma was an
7 unprecedented event in our lifetimes in terms of the
8 scope of damage that it caused?

9 **MR. ECENIA:** I object to the form of the
10 question.

11 **THE WITNESS:** I think in terms of the
12 disruption to the state, yes, it was unprecedented.

13 In terms of power outages, it was
14 unprecedented.

15 In terms of facility damage, we may have
16 incurred more facility damage in other storms that
17 we have experienced as a state.

18 Every storm is unique. There were definitely
19 challenges with this storm as it related to how
20 much of the state was affected and how much we saw
21 facilities with challenges in executing their
22 comprehensive emergency management plans, certainly
23 from a perspective of having to be creative, we saw
24 that across hundreds of facilities, between nursing
25 homes and assisted living facilities.

1 **I have heard the concept of local emergency operation
2 centers having access to resources that they can deploy,
3 but I don't know exactly how that -- whether it's a
4 state issue or a local issue or how that happens.**

5 Q Would you consider that to be among the
6 lessons learned, that there could be better
7 communication of where those types of resources might be
8 available for facilities that were having problems with
9 power restoration?

10 A **I think I would have to defer to the emergency
11 management professionals on whether or not that would be
12 helpful. I do think that what we saw with this storm in
13 terms of gas shortages, difficulty with transportation
14 due to mass evacuations, that the concept of relying on
15 external resources is not ideal. And that is part of
16 the reason that we put together emergency rules to
17 require the facilities actually have those resources on
18 site.**

19 Q As far as the emergency rule, is the Agency
20 also proceeding with the normal rule-making process for
21 developing rules to have backup generator power at
22 nursing homes and ALFs?

23 A **Yes.**

24 Q Would a system deficit that was perhaps
25 brought to light by Hurricane Irma be the fact that

1 **BY MR. SMITH:**

2 Q And putting aside Hollywood Hills
3 specifically, do you believe there were any lessons from
4 Hurricane Irma that exposed what I call "deficits" in
5 the emergency preparedness and response infrastructure
6 in the state?

7 A **Whenever you go through an event the scope and
8 size of Hurricane Irma, there's always lessons to be
9 learned. I think one of the biggest takeaways that we
10 had as an agency was the need for facilities to be
11 self-sufficient without power for extended periods of
12 time and not rely on power restoration as the way to
13 create a stable temperature environment in facilities.**

14 **To that end, we have initiated an emergency
15 rule to require nursing homes and assisted living
16 facilities to have emergency power sources that keep
17 temperatures at a comfortable level for up to four days
18 to create stability during a four-day period that will
19 enable the limited resources available in response to
20 storms to be shared in a way that is -- creates a safe
21 environment for folks in the state.**

22 Q Are you aware if the emergency operation
23 center, division of emergency management, has an
24 inventory of available generators at state agencies?

25 A **I am not specifically aware of how that works.**

1 nursing homes were not considered to be priorities for
2 power restoration by the utility companies?

3 A **I can't speak for the power restoration
4 priorities. I think that in some cases, even with
5 restoration priority, when you have massive power
6 outages in such a large part of an area, it's difficult
7 to make priorities based upon geographic locations. So
8 I would defer to the power professionals in terms of the
9 challenges of that.**

10 **But again, I think that the concept of doing
11 what we can to make sure healthcare facilities are
12 self-sufficient will assist.**

13 Q Are you aware of Representative Book's bill to
14 require that nursing homes be given priority in power
15 restoration?

16 A **I am aware that that's the content of several
17 bills that have been filed.**

18 Q So at least some people observed that to be a
19 deficit that should be filled?

20 **MR. ECENIA:** I will object to the form of the
21 question.

22 **BY MR. SMITH:**

23 Q Apparently, they filed bills to address an
24 issue.

25 A **I am not familiar with what -- how that would**

1 be carried out by utility companies. I think that would
2 be a question for them in terms of what does it mean if
3 a facility is a priority.

4 When you look at 3,000 assisted living
5 facilities around the state, many of which are embedded
6 in neighborhoods, I am not sure that making assisted
7 living facilities a priority doesn't mean that everyone
8 is a priority. So those are big challenges that need to
9 be evaluated.

10 But I think, again, the emergency, the power
11 professionals are best equipped to indicate whether or
12 not those are solutions that will help.

13 Q Did you have any feedback as to the
14 effectiveness of the Florida Health STAT system,
15 database system, as a result of Hurricane Irma, did you
16 get any feedback from providers as to whether they felt
17 like it was working, not working?

18 A I don't know that there was a lot of feedback
19 from providers other than I think some providers felt
20 that they were contacted multiple times, that that could
21 have been a little more efficient.

22 So there are always opportunities to improve
23 the systems that we use, and one of the things that
24 we've looked at with Florida Health STAT is a way to
25 expand the ability for a greater variety of people to

1 use this system and, as I mentioned before, whenever you
2 go through a situation like this, you are looking at
3 lessons learned and ways to improve whatever systems
4 that you use.

5 Q Any other opinions, have I got everything?
6 MR. ECENIA: There is certainly going to be
7 another -- other depositions that are to be taken
8 in this case, and I think depending on what is said
9 and who says it, she certainly may have additional
10 opinions, but I am not aware of any other at this
11 time.

12 MR. SMITH: Then I have no other questions.
13 Thank you.

14 MR. ECENIA: She'll read.
15 (Proceedings concluded at 12:45 p.m.)
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CERTIFICATE OF OATH

1
2
3 STATE OF FLORIDA)
4 COUNTY OF LEON)
5
6
7

8 I, the undersigned authority, certify that
9 the above-named witness personally appeared before me
10 and was duly sworn.

11
12 WITNESS my hand and official seal this
13 4th day of December, 2017.
14
15
16
17

18 SANDRA L. NARGIZ, RMR, CRR, RPR
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22 EXPIRES: APRIL 18TH, 2018
23
24
25

CERTIFICATE OF REPORTER

1
2
3 STATE OF FLORIDA)
4 COUNTY OF LEON)
5

6 I, SANDRA L. NARGIZ, Registered Professional
7 Reporter, certify that the foregoing proceedings were
8 taken before me at the time and place therein
9 designated; that my shorthand notes were thereafter
10 translated under my supervision; and the foregoing pages
11 numbered 1 through 96 are a true and correct record of
12 the aforesaid proceedings.

13 I further certify that I am not a relative,
14 employee, attorney or counsel of any of the parties, nor
15 am I a relative or employee of any of the parties'
16 attorney or counsel connected with the action, nor am I
17 financially interested in the action.

18 DATED this 4th day of December, 2017.
19
20
21

22 SANDRA L. NARGIZ, RMR, CRR
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