STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 21N-00051

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing via Microsoft Teams video conferencing in the above-referenced matter on October 22, 2021 at 10:04 a.m.

APPEARANCES

For Petitioner: [redacted] Authorized Representative ("AR")

For Respondent: Thomas Caufman, Esq.

STATEMENT OF ISSUE

Petitioner appeals Respondent's action to discharge her from [redacted] (the "Facility"). Respondent carries the burden of proof by clear and convincing evidence.

SUMMARY OF PROCEEDINGS

On September 2, 2021 at 9:44 a.m. the hearing was convened via Microsoft Teams video conferencing. The hearing was initially scheduled as a telephonic hearing, it was changed to a Microsoft Teams video conferencing at Petitioner's request.

Petitioner is the resident at the facility. Petitioner was not present during this proceeding. [redacted] Petitioner's son, appeared as Petitioner's witness. [redacted] ("Resp't Wit. 1"), Facility Administrator ("FA"); [redacted] M.D. ("Resp't Wit. 2"), Petitioner's personal physician and Medical Director ("MD"), appeared as Respondent's witnesses. Also present was Neal Boyle, in-house counsel for Respondent; Mia Mckown, co-counsel for Respondent; Diane Guldin, Court Reporter with Phipps Reporting, appeared with no objection. Sean Ellsworth and Arthur Hankin, attorneys for Resp't Wit. 2., also appeared.

Respondent objected to both Petitioner's family members interjecting and simultaneously representing Petitioner. The undersigned ruled that only one person may represent Petitioner during the hearing. Petitioner requested a short recess. Upon return to the record, Petitioner requested the hearing be continued to further prepare with only one family member as the representative. All parties agreed to reconvene on September 10, 2021 at 9:30 a.m.

On September 10, 2021 at 9:33 a.m., the hearing was reconvened. All previous parties were present except for Diane Guldin, court reporter. Tracy Brown, court reporter from Phipps recording, was present with no objection. Approximately ninety (90) minutes into the record, the undersigned noticed an additional unknown participant on the Microsoft Teams Videoconference. She identified herself as Erin Swafford, Senior Counsel for Respondent. She had joined the videoconference a few minutes after it started. Petitioner had no objection to her appearance, and she would not be providing testimony. The hearing was reconvened on the same day at 12:48 p.m., following a lunch break. During the break it was determined a two to three-minute

portion after the recess of the previous September 2, 2021 record had been cut off. The undersigned advised both parties and there was no objection to that portion of the record being excluded. It was also determined that Petitioner's witness had not been placed under oath at the September 2, 2021 hearing. He was administered the oath at the start of the proceeding on September 10, 2021. Dr. [redacted] ("Resp't Wit. 3"), expert witness; and [redacted] ("Resp't Wit. 4"), Registered Nurse and Assistant Director of Nursing, appeared as Respondent's witnesses. The hearing was continued as there was insufficient time for cross examination of Resp Wit.4.

On September 27, 2021 at 9:51 a.m., the hearing was reconvened. All previous participants appeared. The cross examination of Resp Wit. 4 was concluded. Also, the completion of direct and cross-examination of Resp. Wit. 1 took place. Respondent requested Judicial Notice of 42 Code of Federal Regulation 483. Respondent indicated he had several more witnesses. Parties agreed to provide witness list to each other by October 8, 2021 and reconvene on October 15, 2021 at 9:30 a.m.

On October 12, 2021, Petitioner contacted the Office of Appeal Hearings ("OAH") and requested October 15, 2021 hearing be postponed until October 18, 2021 due to Respondent not providing their witness list by October 8, 2021 as agreed. Continuance granted to October 18, 2021 at 10:00 a.m.

On October 18, 2021, the same parties appeared for Petitioner. For Respondent, Thomas Caufman, Mia McKown, [redacted] Erin Swafford, present. [redacted] ("Resp't Wit 5"), Lifestyle Manager; [redacted] ("Resp't Wit. 6"), Certified Nursing Assistant; [redacted] ("Resp't. Wit. 7"), Licensed Practical Nurse ("LPN"); and [redacted] ("Resp't. Wit. 8"), Director of Nursing, appeared as

Respondent's witnesses. Tracy Brown, Court Reporter for Phipps Reporting, also appeared. The hearing was continued to October 22, 2021 to allow Petitioner's witness to appear and closing statements.

On October 21, 2021, the OAH received Petitioner's Motion to Disqualify Opposing Counsel based upon Mr. Caufman's relationship to an AHCA official. After business hours on the same date, the OAH received Respondent's Response to Petitioner's Motion to Disqualify Opposing Counsel.

On October 22, 2021, the same parties appeared for Petitioner. Appearing for Respondent: Thomas Caufman, Mia McKown, [redacted] Neal Boyle present. Tracy Brown, Court Reporter for Phipps Reporting, also appeared. The undersigned addressed and denied Petitioner's Motion to Disqualify Opposing Counsel. The record was left open through December 3, 2021 for both parties to provide proposed Final Orders. Petitioner also requested a copy of the record from OAH.

Between October 22, 2021 and November 3, 2021, the undersigned discovered portions of the recorded hearing record were irretrievable.

On November 3, 2021, the undersigned issued an Order for Parties to Respond Due to Loss of Recording of Hearing. Both parties agreed that the undersigned's notes, recollection, and the transcription from Phipps reporting would be used by the undersigned in the decision-making of the Final Order.

Petitioner submitted evidence, which was marked and entered as Petitioner's Exhibits one ("1") through fifteen ("15"). Petitioner's Exhibits two (2), eight (8) and fourteen (14) are recordings. Respondent submitted evidence, which was marked and entered as Respondent's Exhibits one ("1") through eleven ("11").

The proposed orders were timely received from both parties. The record closed on December 3, 2021.

Petitioner's Position

Petitioner does not wish to leave the facility. Petitioner took the position that she wished to transfer out of the skilled nursing facility ("SNF") area of the Facility and back to the independent living ('IL") area of the Facility with personalized care. Petitioner never requested to be removed from the Facility and that it would be in the best interest of the Petitioner's welfare to stay at the Facility. Petitioner believes there is no medical basis for her to be removed and that the Facility is choosing not to meet Petitioner's non-medical needs, even though they can do so. Petitioner believes the Facility has an issue with AR and a discharge of Petitioner is not the appropriate venue for the Facility to address those problems.

Respondent's Position

Respondent took the position that AR's numerous requests for services on behalf of Petitioner cannot be met by the Facility. Petitioner, through AR, has demanded immediate service for a large volume of detailed, non-emergency, daily needs, thereby making it impossible for the Facility to meet her needs. Respondent believes that AR's filing of multiple grievances regarding Petitioner's unmet needs further support their position. Respondent believes AR specifically stated the Facility cannot meet Petitioner's needs and requested to be transferred to an alternate setting.

FINDINGS OF FACT[1]

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The Facility is a Continuing Care Retirement Community that allows residents access to multiple levels of care on a single campus. (Hr'g R. September 2, 2022.)

2. Petitioner is ninety-three (93) years old and currently resides in the Facility. She is legally blind, immobile, incontinent, and unable to initiate communication or requests. Petitioner has been a resident of the Facility for fifteen (15) years. Petitioner entered the SNF setting in 2014. (*Id.*)

3. The Facility's medical records includes documentation of Petitioner's medical conditions and the care provided by the Facility to Petitioner. The medical records also include complaints and concerns voiced by AR on behalf of Petitioner. (Pet'r Ex. 8; Pet'r Ex. 13-15; Resp't Ex. 4-6.)

4. The Facility's medical records from the month of January 2021 documents at least eight (8) separate dates with communications from AR regarding her dissatisfaction with Petitioner's pillow arrangement and neck position. The medical records show no indication of Petitioner in distress when these communications were made. (Resp't Ex. 4 at 277-318.)

5. Respondent provided a compilation of numerous grievances filed by AR from January 2021 through June 2021. All were unfounded. (Resp't Ex. 7; Resp't Wit. 1 Test. September 27, 2021.)

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[1] Citations within the Findings of Fact and Conclusions of Law in this order follow Florida Rule of Appellate Procedure 9.800 and *The Bluebook: A Uniform System of Citation* as the standard for citation.

6. On June 29, 2021, Petitioner sent an email to Respondent with subject: "[redacted] should be return to independent living" which stated in part:

> "It is clear from the ongoing and repeated neglect of my mother by your nursing staff, as demonstrated this morning by the nurse failing to be concerned that my mother received her medications and supplements timely… and the limited resources of your activity staff, my mother would clearly be better off back an independent living apartment with private care. My mother's actual nursing needs…can be easily handled by myself, hospice and/or private duty aides. I am insisting arrangements be made to that effect…"

(Pet. Ex. 7 at 1.)

7. On June 29, 2021, the FA responded to the email advising AR would be updated with any information. (*Id*. at 1-2.)

8. On July 2, 2021, AR sent another email to the FA with additional reasons Petitioner should be returned to independent living. The email contained bullet points describing three separate concerns about Petitioner's care provided by the Facility in the previous two days. In addition, AR described staff as "rushing" Petitioner when administering medications. AR also expressed her concerns about of long stretches of more than one (1) hour in which no one from the Facility checks on Petitioner. In the email, AR suggests possible explanations as follows:

> - The revolving door of aides and nurses, such that few choose to be attentive, expecting someone else to be?
> - A failed system of training, monitoring and supervision?
> - Short-staffing, so staff feel rushed, "too busy, " and are less conscientious?
> - There are a few aides and nurses who do things well repeatedly, so maybe it relates to the aptitudes of the assigned staff?
>
> If my mother was to live in independent living with private aides, the staffing would be more consistent and well trained and supervised. They would not treat my mother like just another generic resident-and if they did, they would be "gone." In addition, my mother would be able to sleep

> when she was sleepy, eat and drink when she was hungry or thirsty, and have food that was more to her liking.

(*Id*. at 2-3.)

9. On July 2, 2021, the FA responded to AR email acknowledging receipt and someone would follow up with AR soon. (*Id*. at 3.)

10. Between July 2, 2021 and July 5, 2021, AR sent the FA more emails identifying her perceived shortfalls in the Facility's care of Petitioner. (*Id*. at 3-6.)

11. On July 6, 2021, AR sent an email message to the Facility in response to a telephone voice mail from the Facility requesting AR attend a meeting regarding a potential move of her mother. AR advised the Facility in part:

> Before any meeting with Skilled Nursing staff: 1. [redacted] must agree that there is the possibility for my mother two move back to IL. 2. A contract will need to be drawn up with agreeable terms—and the "T"'s crossed and the "I"s dotted."
> I was perplexed as to why you thought anything with Care Center staff was appropriate before the above. In any case, I hope it is clear now.

(*Id*. at 6.)

12. On July 7, 2021, the FA sent email to AR asking her to set up a meeting to "discuss your request for a transfer." (*Id*. at 6-7.)

13. On July 7, 2021, AR reiterated her email from July 6, 2021 and added in part that "my mother…will have to agree…It is heartening to know this change is being considered." (*Id*. at 7-8.)

14. On July 7, 2021, the FA invited AR to "a careplan (sic) meeting this Friday to discuss the possibility of a move." (*Id*. at 8-9.)

15. On July 7, 2021, AR replied to the FA in an email in relevant part:

> As I have made clear, there is no potential for my mother to move voluntarily until two things have been accomplished: 1. [redacted] must agree that

> there is the possibility for my mother two move back to Independent Living. 2. A contract will need to be drawn up with agreeable terms—and the "T"'s crossed and the "I"s dotted." There is no point in any meeting until those two things have been accomplished—unless it is to say that you will not let her move back into IL under any circumstance, in which case there is no need for a meeting.
>
> The only purpose of a move will be if it can improve my mother's care …
> The last Care Plan meeting was on June 9th…The next one would be in September in the absence of something significant changing… At this point there is nothing of significance happening.

(*Id*. at 9-10.)

16. On July 15, 2021, AR sent an email to the FA expressing her concerns for Petitioner's care at the Facility. AR wrote, "Thus, I am once again requesting that my mother had the option—if suitable of arrangements can be made through our respective attorney's—to return to an apartment in independent living." (*Id*. at 10.)

17. Between July 16 and July 30, 2021, an Observation Report indicated there was no Discharge Planning in place for Petitioner. (Resp't Ex. 6 at 103.)

18. On July 16, 2021, the Facility issued a "Nursing Home Transfer and Discharge Notice" (the "Notice") to Petitioner. The Notice indicates the following, "This form is required for those transfers or discharges initiated by the nursing home facility, and not by the resident or by the resident physician or legal guardian or representative." (Pet'r Ex. 6.)

19. The Notice indicates Petitioner will be transferred or discharged to her daughter's private home. The Notice indicates the reason that for the discharge is, "Your needs cannot be met in this facility." That discharge was signed by the FA and the MD. *(Id.* at 1-2.*)*

20. The medical records indicate that AR has lodged numerous complaints. (Pet'r Ex. 5.)

21. On July 6, 2021, the MD entered Resident Progress notes at 3:13 p.m., as follows:

> Met with Director of Nursing and Administrator to care concerns of [Petitioner]. The daughter is unhappy with the care she is receiving in skilled care. We are unable to meet the resident's needs. Facility to proceed with alternate placement as requested by resident's daughter.

(Pet'r Ex. 5.)

22. There was a "great deal" of correspondence through texting and emails between AR and the facility in 2021. The MD used this correspondence to support the conclusion that the Facility was unable to meet the resident's non-medical needs. (Resp't Wit. 2 Test. September 2, 2021.)

23. The Facility was unable to meet the need of AR's concerns is that Petitioner could not understand staff whose native language was not English and had an accent. The date of this concern is unknown. (Resp't Wit. 2 Test. September 10, 2021.)

24. No medical record entries were made indicating the specific needs the Facility could not meet or any attempts the facility made to meet the unmet needs. The unmet non-medical needs were not addressed in the medical chart. Discharge was not necessary for Petitioner's welfare. Petitioner is stable at the Facility and stable for discharge. The Notice was signed because Petitioner's non-medical needs could not be met at the Facility. (*Id.*)

25. The Facility did not discuss a possible discharge of Petitioner in the medical record prior to AR's email to the Facility dated June 29, 2021. Prior to June 29, 2021,

the medical records did not indicate the Facility could not meet Petitioner's needs. (Pet'r Ex. 8; Pet'r Ex. 13-15; Resp't Ex. 4-6).

26. The Facility believes Petitioner's needs outweigh what they can provide, and Petitioner's demands are above reasonable request. The Facility has limited resources, and AR pulls staff away from other residents and other staff duties in the Facility to meet her demands. These demands have an impact on morale in the Facility. Staff feels AR will call AHCA to threaten their license any time something happens. The Facility believes Petitioner cannot return to IL because she is unable to self-evacuate. (Resp't Wit 1 testimony September 27, 2021.)

27. In May, June and July 2021, staff typically initiated communication with AR four (4) times daily regarding Petitioner and activities of the day. AR informed staff that the Facility does not meet Petitioner's needs because they do not have audio-enabled programming for the visually impaired. AR requested staff be available to change Petitioner's entertainment needs at specific times throughout the day until 10:00 p.m. Staff believed this was unreasonable. (Resp't Wit 5 Test. October 18, 2021.)

28. AR has placed signage in Petitioner's room indicating how high the bed should be at rest, and after meals. AR has specific positioning requests for Petitioner. There have been days when AR has telephoned staff between fifteen (15) and twenty (20) times to express Petitioner's needs. AR has called more than one telephone line into the Facility simultaneously. (Resp't Wit 7 Test. October 18, 2021; Resp't Wit 8 Test. October 18, 2021.)

29. On one occasion, while LPN was tending to three other patients with priority needs, AR requested to speak with her. LPN advised other staff to let AR know she

would call her back shortly. AR called the concierge, the nurse's desk, and Petitioner's room simultaneously within ten (10) minutes. (*Id*.)

30. Petitioner's constant needs and reprimands diminish staff's ability to care for other residents. (Resp't Wit 7 Test. October 18, 2021.)

31. Staff believes that AR says that, "She is her mother's voice…anything that she says is like her mother turning on her call light and asking for it." Staff has voiced concerns of AR's behavior escalating when she is upset. AR has belittled staff members with accents by intentionally saying they don't speak English and informed staff members they are incompetent. AR demands and behaviors have taken a toll on staff morale. Staff feels Petitioner's needs cannot be met because AR demands "would require someone to be in the room 24/7." (Resp't Wit 8 Test. October 18, 2021)

32. The attempt to discharge Petitioner is solely because of a contentious relationship between AR and the Facility management and owners. The requests are solely for the comfort and well-being of Petitioner. The signage in Petitioner's room was meant to assist staff and visitors of Petitioner's likes and needs. The phone system at the Facility is an abomination and no one can get through on the phone lines. (Hr'g R. October 18, 2021.)

CONTROLLING LAW

33. Section 400.0255(15), Florida Statutes, provides the Department of Children and Families, Office of Appeal Hearings, jurisdiction over the subject matter of this proceeding and the parties. This section further prescribes this order as the final administrative decision of the Department of Children and Families.

34. Title 42 Code of Federal Regulations Section 483.15 sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

> (c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
> **(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**
> (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
> (D) The health of individuals in the facility would otherwise be endangered;
> (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (F) The facility ceases to operate.
> (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.
> (2) ***Documentation.*** **When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.**
> (i) **Documentation in the resident's medical record must include:**
> **(A) The basis for the transfer per paragraph (c)(1)(i) of this section.**
> **(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).**

(**ii) The documentation required by paragraph (c)(2)(i) of this section must be made by -**
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident
(B) Resident representative information including contact information.
(C) Advance Directive information.
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals,
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
(3) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must -
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(**ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section**;
…

[Emphasis added].

CONCLUSIONS OF LAW

35. The findings show the Facility seeks to involuntarily discharge Petitioner to AR's home, claiming that based on AR's requests, the Facility cannot meet her needs. This is one of the six reasons provided in federal regulations for which a nursing facility may involuntarily discharge a resident.

36. The findings show that AR is Petitioner's daughter, Power of Attorney, and Health Care Surrogate. The findings show AR has lodged numerous grievances against the Facility. In addition, the findings show AR has made numerous demands

that the staff at the Facility take immediate action regarding her requests. The findings show AR has filed AHCA complaints against the Facility which were unfounded. The findings show on June 29, 2021, AR sent an email to Respondent with requesting Petitioner be returned to IL. In this email AR made allegations of neglect by the Facility and that Petitioner would be better off back an IL apartment with private care. AR indicated her mother's actual nursing needs can be easily handled by herself, hospice, and/or private duty aides. The undersigned concludes AR believes the Facility cannot meet the needs of Petitioner.

37. The controlling law requires that prior to discharging a resident, the Facility must meet certain requirements. Those requirements include documenting the resident's medical record on the basis for the transfer and the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). The findings show the Facility listed no specific resident needs that cannot be met in the medical record. The findings show the medical records do include AR's dissatisfaction with the Facility's abilities to meet Petitioner's needs, but the same medical records indicate the Facility consistently meets Petitioner's needs as required by law. The findings show that prior to AR's email on June 29, 2021, there were no medical records indicating a transfer or discharge was being initiated by the Facility. The findings show that the transfer request was initiated by AR on Petitioner's behalf in the June 29, 2021 email. The findings show that the Discharge Notice indicates, "This form is required for those transfers or discharges initiated by the nursing home facility, and not by the resident or by the resident physician or legal guardian or representative." The undersigned finds the Facility can meet Petitioner's

needs, both medical and non-medical, and had no intention of discharging her prior to the June 29, 2021 email requesting a transfer to IL. The undersigned finds the Discharge Notice does not apply in this scenario because the transfer or discharge was not initiated by the Facility but was initiated by Petitioner.

38. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The Facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the resident for a safe and orderly transfer or discharge from the Facility. The undersigned cannot and has not considered either of these issues. The undersigned has considered only whether the discharge is for a lawful reason.

39. Any discharge by the Facility must comply with all applicable federal regulations, Florida Statutes, and AHCA requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the AHCA's health care facility complaint line at (888) 419-3456.

40. The controlling authorities require a higher standard of proof in nursing home discharge hearings; there must be substantial and credible evidence at the level of clear and convincing.

41. After careful review of the evidence and testimony, the undersigned concludes that Respondent has not met its burden of proof in showing it cannot meet Petitioner's needs. While the undersigned understands Respondent's position that AR's demands and complaints are excessive and unreasonable; the medical records show the Facility has excelled in its care of Petitioner under this duress. The undersigned also concludes this transfer request was initiated by Petitioner, not the Facility, therefore the Notice

would not be an appropriate response to Petitioner's request to transfer to IL as Petitioner's needs are being met by the Facility.

DECISION

Based on the foregoing Findings of Fact, Controlling Law and Conclusions of Law, this appeal is GRANTED. The Facility is ORDERED to immediately readmit Petitioner to the Facility. If a bed is not currently open to readmit Petitioner, the Facility must readmit Petitioner as soon as a bed becomes available.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Suite I, Room 129, 2415 North Monroe Street, Tallahassee, FL 32303-4190. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 18 day of January, 2022,

in Tallahassee, Florida.

Judith R. Schneider

Judith Schneider
Hearing Officer
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