



agency for persons with disabilities
State of Florida

Charlie Crist,
Governor

..

Jane E. Johnson,
Agency Director

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June 1, 2007

Facsimile Transmittal and Overnight Courier

Honorable Cindy S. Lederman
Juvenile Justice Center
3300 NW 27 Avenue
Miami, FL 33142

Re: Rainbow Ranch Group Homes

Dear Judge Lederman:

This morning the Agency for Persons with Disabilities entered the enclosed Emergency Suspension Order suspending the licenses of three Rainbow Ranch Group Homes. Residents of two of those homes are children in dependency proceedings before your honor.

This Order is the result of the investigation that I advised you of at the hearing on May 25, 2007. The Agency has secured appropriate placements for each of the residents and will move all that are not subject to the dependency proceedings before you today.

We have advised Mr. Mishael and Department of Community Affairs representatives.

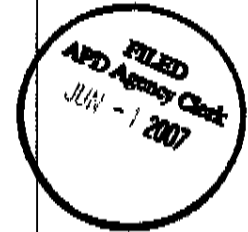
Sincerely,


John Newton
General Counsel

// enclosure

cc: Alan Mishael
Lisa Bobotas
Veronica Robinson

STATE OF FLORIDA
AGENCY FOR PERSONS WITH DISABILITIES



IN RE:

RAINBOW RANCH GH #1, INC.,
GH
RAINBOW RANCH GH #2, INC., and
RAINBOW RANCH GH #3, INC.,

Certificate No. 11-840 -
Certificate No. 11-740- GH
Certificate No. 11-804- GH

EMERGENCY LICENSE SUSPENSION ORDER

Jane E. Johnson, Director, Agency for Persons with Disabilities ("Agency"), pursuant to the legislative authority granted by sections 120.60(6) and 393.0673(4), Florida Statutes, (2006) orders an emergency suspension of all residential facility licenses issued to Rainbow Ranch GH # 1, Inc., Rainbow Ranch GH #2, Inc., and Rainbow Ranch GH #3, Inc. This Order states the grounds for this action.

THE AGENCY'S RESPONSIBILITY AND AUTHORITY

1. The Agency for Persons with Disabilities is the state agency charged with administering services to persons with disabilities pursuant to Chapter 393, Florida Statutes.
2. Section 393.0673(4), Florida Statutes (2006), empowers the Agency to issue an order immediately suspending or revoking a license when it determines that any condition in the facility presents a danger to the health, safety, or welfare of the residents in the facility.

RAINBOW RANCH GROUP HOMES

3. Rainbow Ranch GH, Inc. #1, Inc., Rainbow Ranch GH, Inc. #2, Inc. and Rainbow Ranch GH, Inc. #3, Inc. ("Rainbow Ranch") are under common ownership and control. Each is a residential group home licensed by the Agency for Persons with Disabilities.

4. The locations of the homes are:

Group Home # 1, 310 Northwest Drive, Miami, Florida

Group Home #2, 1890 NE 37 Avenue, Homestead, Florida

Group Home #3, 17335 Southwest 248 Street, Homestead, Florida.

5. In addition to providing residential services through its group home licenses, Rainbow Ranch also has contracted with the Agency to provide the children with various Medicaid Waiver developmental disability services including in home support services, residential habilitation services, respite care, behavioral assessment, and non residential support services.

THE RESIDENTS OF RAINBOW RANCH GROUP HOMES

6. The eight residents of these licensed facilities are developmentally disabled and suffer from serious medical problems as well. Seven of the eight are children. Four children are dependent children in the custody of the Department of Children and Families.

7. Just some of the diagnoses for the residents are: Mental Retardation, Prader-Willi Syndrome, Precocious Puberty, Asthma, Hyper-Tension, Seizure Disorders, Autism, Mental Retardation, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder – with psychotic features, Diabetes, Extreme Aggression, and Mild Mental Retardation.

8. These fragile residents are especially susceptible to health and safety risks generated by environmental conditions, poor management practices, inadequate supervision or neglect.

9. Conditions in the homes, especially inadequate supervision, resistance to providing information, and irresponsible medication practices by the common management present a danger to the health, safety, and welfare of the residents in the facilities.

THE DEATH OF D.M. AND FOLLOWING INVESTIGATION

10. On Wednesday, May 23, 2007, a twelve year old autistic resident of one of the Rainbow Ranch homes ("D.M.") died unexpectedly during a trip with other residents in the care of Rainbow Ranch employees. D.M.'s Support Plan states he "is very healthy in physical terms."

11. His death remains unexplained.

12. The Agency began investigation of the circumstances of D.M.'s death. The Department of Children and Families also began an investigation. And the Agency began review of all of the Rainbow Ranch group homes, and performed research of all reports or indications of possible abuse that may have occurred at the homes.

13. The information gathered substantiates systemic, continuing management deficits sufficient to threaten the health and safety of the developmentally disabled clients residing there, including lack of client supervision, undocumented medication, and impermissible client restraints.

14. D.M. was a twelve-year-old Agency developmental disabilities client with autism and other developmental disorders. His mother could no longer control him because of his aggression towards himself and others. The Agency admitted him to the waiver program in January 2003 and provided group home placement and immediate behavioral services in that home.

15. On May 23, 2007 Rainbow Ranch employees took D.M. and other residents of two homes to a flea market for haircuts. D. M. became unresponsive and lost consciousness after being restrained by one or more Rainbow Ranch employees in a van while parked at the flea market. After unsuccessful attempts to revive him with cardiopulmonary resuscitation, paramedics took him to a hospital where he was pronounced dead.

16. The Department of Children and Families ("Department") initiated an immediate investigation of possible abuse, neglect, or abandonment, advising Rainbow Ranch owners/operators that the staff members involved should not come to work or be around children, pending investigation results.

17. The Department's report states that four Rainbow Ranch staff took eight young developmental disability clients to the flea market for haircuts. Reportedly, D.M. was screaming and hitting the other children and continued having behavioral difficulties while the staff stopped by a bank to get money for the

haircuts. When they arrived at the flea market, the driver dropped off two staff persons and three children in front of the market, parked the van with the engine running, and ran inside with another child to get something to drink, leaving one staff person alone with the remaining children in the van. The driver states that when he came back, D.M. began yelling, screaming, and kicking, so he asked the other staff person if she needed any help. Reportedly, she declined it. The driver heard D.M. talking to the staff person and presumed everything was okay. The driver says that they suddenly noticed that D.M. was silent and non-responsive. They took him out of the van and attempted to revive him and called 911. Reportedly, D.M. still had a pulse but then died. The driver stated that, to his knowledge, no one hit D.M. or used excessive force.

18. The staff person left in the van with D.M. reported that she laid D.M. down on the seat and restrained his legs to keep him from kicking out the window. She added that D.M. told her he was okay. But when she saw that D. M.'s mouth was open, the staff person turned him over on his back and noticed that he was not breathing. The employee added that she only restrained D.M.'s legs when he was aggressive. She denied using excessive force. She added that she was aware D.M. was taking seizure medication, but he showed no signs of seizure.

19. D. M.'s Behavioral Analysis Services Plan advises in a section titled "What to do if [D.M.] Engages In Physical Aggression/Verbal Aggression/Property Destruction": "Do not use a restraint as this may be a desired outcome."

20. D. M.'s diagnoses do not include cardiac disorders.

21. One of the children present reported that D.M. had a problem so he had to be restrained. The child explained that the staff person in the van restrained D.M. by putting his hands behind his back. He said that D.M. did not cry for help but the child could not remember what D.M. said when the staff person asked if he was okay. He then informed the investigator that he himself had been restrained 19 times by Rainbow Ranch staff. To restrain him, he said, the staff would pull his arm upward while he lay across the bed.

22. The Department's Report includes a history of six [undated] investigations of reported abuse involving D.M. at Rainbow Ranch, including the summaries following. All include some element of inadequate supervision or medication issues. Report No. 2007-323182, opened upon a report that D.M. was hit by another child at Rainbow Ranch and closed with some indicators of bruises and welts and inadequate supervision; Report No. 007-303829, closed with some indicators of lack of supervision, no indicators of environmental hazards or medical neglect; Report No. 2006-407198 (child on child physical abuse), closed with some indicators of bruises and welts but no indicators of physical injury and noting juvenile offender was transferred; Report No. 2006-400376, also involving D.M. and another child, closed with no indicators of physical injury or bizarre punishment; Report No. 2006-377639, closed with no indicators of beatings, physical injury, inappropriate/excessive restraints, or failure to protect; and Report No. 2005-388221, involving unexplained injuries to D.M. but closed with no indicators of bruises, welts, or physical injuries.

23. In addition to the abuse investigations involving D.M., the Agency found that the Department of Children and Families has conducted ten abuse investigations involving other children residing at Rainbow Ranch. Seven of the ten confirmed supervision deficiencies to some degree. The investigations are:

Report No. 2007-335885: the Department of Children and Families investigated a February 28, 2007 report the G.C. had spots of blood in his diaper. A physician at Baptist Hospital diagnosed diaper rash and prescribed ointment. On March 6 and 15, 2007, DCF received reports that the child had a bite mark on his left cheek, scratches on his arms, and decreased tone in his rectum, giving rise to the belief that his roommate sexually assaulted him in the Rainbow Ranch group home. Jackson Rape Treatment Center diagnosed anal penetration. The Department could not ascertain who might be responsible for the sexual abuse. G.C.'s inability to communicate limited his ability to report and protect himself. The Department closed the case with no indicators of lack of supervision and a low risk level because the child had been removed from the home.

Report No. 2007-323182: The Department investigated a February 7, 2007 report that a small child hit another child who weighs 200 lbs. The larger child retaliated by hitting the smaller child in the arm, which developed a bruise. Rainbow Ranch staff noticed the bruise the next morning and took the child to the hospital, where X-

rays revealed his arm was broken. The report concluded with some indicators of inadequate supervision and neglect.

Report No. 2007-319980: The Department investigated a report alleging that Rainbow Ranch staff restrained and pushed one of the resident children, who sustained scratches to his chest and neck. The investigator observed a red mark on the child's neck. The child could not provide a clear explanation but indicated that a Rainbow Ranch staff person named "Tabitha" was involved. Tabitha responded that the child was combative but she did not push or restrain him. The Department staffed the case with a child protective team and closed it as inconclusive of injury or abuse since the child could provide no detail and the staff person denied the incident.

Report No. 2007-303829: This case investigation is noted in the Department's summary investigation of D.M.'s death. On January 8, 2007 the Department received a report alleging abrasions on D.M.'s neck and arms, sores on his arms and legs, and bruises in the shape of fingers. D.M. was not able to tell the investigator how he received the injuries. A second report received the next day alleged that Rainbow Ranch neglected D. M., overmedicated him, and that he had to be hospitalized because he was overmedicated. The investigation states that D.M. said another child injured him; the staff reported his injuries to be self-inflicted. The investigator

stated that he would monitor the facility, contact owner David Glatt as to the complainant's concerns, and concluded the report with a finding of some indicators of inadequate supervision.

Report Nos. 2006-446770 and 2006-453285: These reports received September 7 and 18, 2006, alleged that a mentally handicapped child residing at Rainbow Ranch had scratches on his face, a black eye, that another child continually hurt him but the staff would do nothing about it. Rainbow Ranch responded that the child was supervised 11 hours a day but would pretend to be asleep, then get up and try to sexually molest other children, who hit him to protect themselves. The investigation noted several prior incident reports in reference to these altercations. The investigative report concluded without implications of abuse or findings of maltreatment.

Report No.2006-477762: On October 26, 2006, a complainant alleged suspicions that a child's caregiver dispensed medications to the child at non-prescribed times and with non-prescribed doses, causing side effects of sleepiness, excessive drooling, and tremors. The investigator reported low risk of harm, observing that the home was clean and the medications locked in a kitchen cabinet. The report concluded that there were some indicators of medical neglect based on a teacher' report that she observed the child sleeping in class, shaking, and trembling. The teacher added that a

psychiatrist visiting the school immediately stated that the child was over-medicated. Additionally, the child's therapist reported to the investigator that he noticed the child falling asleep and having tremors. It concluded with few implications of maltreatment "as there is really no way to know if this child was overmedicated or if an adjustment was needed."

Report No. 2006-407198: This report is listed in the investigation of D.M.'s death. Here, a complainant alleged on June 29, 2006 that other children had been hitting D.M., bruising his face and nose. The investigative report stated that the child who hit him, a "child/juvenile offender", had been removed to another home, and risk to D.M. was therefore low.

Report No. 2006-401833: On June 20, 2006, a complainant reported that Rainbow Ranch staff tied up the children and left them in a dark room. The complainant did not know how frequently this occurred or the length of time staff left the children in the room. The complainant added that D.R. had a dark bruise on his left shoulder and has also been seen with scratch marks on his face. The staff responded that D.R. scratches himself in his sleep. The investigator concluded that risk of harm was low because the child did not implicate any staff members and staff members have never observed any staff abusing the children. The investigator added

that the child said he was coached by his mother and concluded that there was no credible evidence to support the allegations.

Report No. 2006-400376: A complainant reported to the Department on June 17, 2006, that an autistic and mentally retarded child, M.D., was "acting out and the facilities owner tied his feet and hands together and put him in a closet." The child, who is non-verbal, demonstrated to the investigator how he was tied up by crossing his legs. His mother removed him from Rainbow Ranch with the assistance of Miami-Dade Police, and told the investigator she did not want him returning to the Rainbow facility. The investigative report concluded that the risk level associated with the case was high because the child does not speak clearly, but he is safe as he is no longer residing at Rainbow Ranch. The investigator found no credible evidence of maltreatment, bizarre punishment or abuse, adding that David Glatt and other staff members denied allegations of physical injuries and bizarre punishment. The report concluded that no intervention was necessary.

23. Report No. 2006377639: On May 8, 2006, the Department received a complaint that D.M. was sleeping in a closet because there was insufficient room for him, and that he had bruises from being strapped down to a bed. The complainant also alleged that the group home employees were not trained to address the children's problems and used the bed to punish the children. The complainant alleged that the owner knew of the punishment but did nothing about

it. The investigator did not see any marks on the child indicative of abuse, but the child did have a sore on his arm that appeared to be self-inflicted. The investigative report concluded that the charges were malicious, the bruises self-inflicted, and the risk of harm to the children low. The report stated that there were no indicators of abuse.

24. There is other documentation of Rainbow Ranch's mismanagement, inadequate staffing, and inadequate supervision supporting finding of immediate danger to the developmentally disabled children residing at any of the Rainbow Ranch group homes.

25. In an April 2, 2007 memorandum to the Agency's Central Office, Agency employee Hilary Jackson reported that she had received complaints about Rainbow Ranch Homes #1 and #2 (#3 received a temporary license on May 10, 2007) from three waiver support coordinators. (Waiver support coordinators assist agency clients in obtaining their Medicaid services.)

26. One coordinator, Ms. Gloria Sue Diaz, sent Ms. Jackson an e-mail on March 6, 2007 to formally advise her of her continued concerns with Rainbow Ranch, including the following: (A) A lack of a direct care worker for her client despite repeated statements from David Glatt that the client needs one-to-one supervision and a high number of direct care hours; (B) A lack of certified behavioral assistant services in place, despite approval of the services, a behavior assistant plan, documented billing for the services—with staff stating that there has never been a certified behavioral assistant there, and without

knowledge as to the service itself; (C) Reports of a lack of cooperation from owner David Glatt and staff to outside providers, complaints from service providers that Mr. Glatt will not allow any information to be shared unless he is doing the talking, that the school psychologist reports that Mr. Glatt "is crazy and tries to get anyone fired who doesn't do what he wants," and that Mr. Glatt manipulates through intimidation; (D) Requests by Rainbow Ranch management that she change her client's doctor to the doctor Rainbow Ranch uses, lack of adherence to medication dosages and schedules. She added that she believed "a thorough investigation needs to occur to establish whether these issues are valid and the client's well-being at risk.

27. Ms. Jackson's memorandum adds that February 13, 2007, she received another complaint regarding Rainbow Ranch from a mother regarding her son "G.C." The mother reported that G.C. appeared to be overmedicated when she took him home for Thanksgiving. She was concerned about a bite mark on the side of G.C.'s face but nobody gave her any explanation of it, that when she has attempted to visit G.C., no one would open the door to the group home, although there were vehicles in the driveway. She added that she does not receive return phone calls from owner David Glatt.

28. On March 1, 2007, Ms. Jackson adds that she and Kirk Ryan, another Agency employee, spoke with Marc Kepner, a Clinical Psychologist Intern, who had contacted the Agency with concerns about two young Rainbow Ranch residents who attend the school where he works. Mr. Kepner reported that one of them appeared lethargic but seemed to be improving. He was also very

concerned about the sexually inappropriate behaviors the two children display towards each other and staff. He emphasized that they should not live in the same group home.

29. Also on March 1, Ms. Jackson and Kirk Ryan spoke with a former Rainbow Ranch manager, Anne Seide, who worked in two of the Rainbow Ranch homes. Ms. Seide raised many concerns, including incidents in the log book not reported to the Agency as required, consumers administered too much medication, doctors not signing appropriate medically related forms for consumers, and staff being physically attacked by clients due to sexual aggression, and inadequate staffing. She told Ms. Jackson that Rainbow Ranch provided only two staff persons for four clients, and that on the evening shift, two staff persons were available for seven children.

30. Ms. Seide informed the Agency that one of her first experiences was finding one of the clients always asleep and barely walking. On her third night there, she refused to work with a client in that condition and insisted that he be taken to the hospital. The hospital diagnosed the client with meningitis and he remained hospitalized. Ms. Seide also noticed that the group home residents were provided meals delivered by a restaurant during the week but on weekends "there was hardly any food to eat." She stated that the clients were eating whatever the staff could gather from the food bank, a church organization David Glatt contracted with in order to pick up food donated by Publix and other companies. Ms. Seide also informed the Agency that the Rainbow Ranch staff

"hardly made it past their probation period because of lack of training and poor management." When she started working the day shift, Ms. Seide witnessed the staff stress, with the clients "always agitated and out of control."

31. On Ms. Seide's referral, Rainbow Ranch employed her brother for the night shift at one of the homes. Her brother was the only staff person scheduled at night. Her brother related to her that about three weeks before, when he reported to work he heard a child crying, and found the child in pain due to swelling of his arm. He contacted Ms. Seide, but she was alone and could not reach any administrators. The child went to sleep, but awakened with a swollen, discolored arm. Rainbow Ranch staff took him to the hospital, where he was diagnosed with a broken arm. Ms. Seide added that had there been another staff person with her brother, he could have taken the child to the hospital that night.

32. Ms. Seide described an incident in which she had to "go to their rescue at Flagler" one weekend recently because a Rainbow Ranch staff worker had no food to give the clients but had managed to find some hot dogs, which she gave the clients without bread. One of the clients wanted more hotdogs because he was still hungry; there were no more hotdogs and the client punched the staff person in the eye. When Ms. Seide arrived, a witness, not employed by Rainbow Ranch, confirmed this incident. Ms. Seide was then given a credit card so she could order food from a Chinese restaurant.

33. Following her meeting with Ms. Seide, Ms. Jackson began requesting the case notes from other waiver support coordinators. Ms. Jackson observed that many of the support coordinators and parents or guardians shared concerns

regarding their children being overmedicated and unavailability of the employee/director Mr. David Glatt.

34. Ms. Jackson also obtained prescription records from a pharmacy for the eight Agency clients residing at Rainbow Ranch homes. Documents obtained from Rainbow Ranch on May 29, 2007 indicate that the prescriptions had run out without being timely refilled. Proper medication procedures would have ensured seeking refills in time to avoid running out. The drugs are: Depakote – an anticonvulsant for seizures and for acute treatment of manic episodes in bipolar disorder; Seroquel – an antipsychotic, psychotropic; Amphetamine Salt – a combination drug, central nervous system stimulant used in ADHD and narcolepsy; also known as Adderall; Adderall – a combination drug, central nervous system stimulant used in ADHD and narcolepsy; Zyprexa – an anti psychotic; mostly used for schizophrenia and bipolar disorder; and Hydroxyzine Pam – also known as Vistaril, used for anxiety treatment.

35. In response to the initial complaints, Agency Area Office 11 initiated inspections of two Rainbow Ranch group homes on February 28, 2007. At that time, Agency inspectors documented problems with medication records, failure to comply with incident-reporting requirements, failure to provide physician follow-up to a medical incident resulting in an emergency room visit, lack of consent forms, insufficient staffing, and various administrative and record keeping violations. The Area Office issued both Rainbow Ranch homes Notices of Non-Compliance.

36. In a memorandum dated March 9, 2007, Area Administrator Evelyn Alvarez stated that the review of Rainbow Ranch homes disclosed evidence of inadequate supervision of Agency clients, unauthorized use of "posey mitts" (a restrictive device), and medical neglect through delayed attention and treatment. Ms. Alvarez recommended additional review, given the adverse reports regarding Rainbow Ranch management practices from so many sources.

37. Ms. Alvarez added that the provider's use of threats and intimidation towards agency staff, agency administration, and support coordinators also appears to warrant agency action. She stated that she had received complaints from support coordinators that David Glatt treats them with disrespect, uses profanity and intimidation tactics, calls clients "F***** animals," refers to parents/families/guardians as "animals" or "crack w____s," fabricates information, and is unresponsive to telephone calls and request for information from families or the support coordinators.

38. Agency records document Rainbow Ranch's inadequate management practices. A Corrective Action Plan dated January 27, 2007 required that Rainbow Ranch obtain background screening, provide appropriate staff training, submit the required Emergency Plan, report staff vacancies as required, post information regarding the Florida Advocacy Council, and provide proof of Worker's Compensation insurance. Rainbow Ranch's response was basically to deny the deficiencies and question the Agency's authority on many issues.

39. Within twenty four hours of D.M.'s death the Agency for Persons with Disabilities and the Department of Children and Families established around the

clock monitoring in each Rainbow Ranch Group home as an interim measure to protect the residents while the evaluation and investigation resulting in this Order were concluded and to assure the safety of the residents, pending relocation if necessary, to other group homes. This monitoring is not an adequate long term protection. It is no substitute for the supervision provided by a fully staffed and responsible home. It is also no substitute for a home that can be depended upon to comply with medication requirements.

40. The Agency and the Department have identified suitable placements for each resident of the Rainbow Ranch group homes and have made the necessary arrangements to ensure appropriate transition to the placement homes.

41. Immediate suspension of Rainbow Ranch's group home licenses fulfills the requirements of sections 393.0673(4) and 120.60(6), Florida Statutes (2006).

42. The facts sufficiently demonstrate a threat of imminent and irreparable harm to the minor residents of Rainbow Ranch Group Homes, Inc.

43. Emergency suspension of Rainbow Ranch's licenses is the least restrictive means of addressing that threat.

44. Suspension of all Rainbow Ranch group home licenses is the least restrictive means of alleviating danger to the health, safety, and welfare of the clients

45. Suspension is fair under the circumstances because the Agency is expediting investigation and will initiate formal disciplinary proceedings in compliance with section 120.60(6)(c), Florida Statutes, and Rule 28-107.005(3), Florida Administrative Code. Also Rainbow Ranch was given notice of concerns

about the deficiencies in its supervision, medication practices, and record keeping. Its response of April 24, 2007 has been considered.

46. The Agency's suspension procedure provides the same procedural protection granted by other statutes, the Florida and United States Constitution.

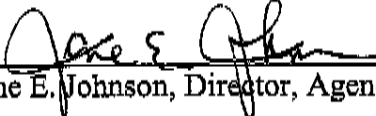
47. Establishing the effective date and time of this order as 6:00 p.m. June 1, 2007 will ensure the effective and appropriate relocation of the residents of the Rainbow Ranch group homes.

Based on the foregoing, the Director of the Agency for Persons with Disabilities concludes that continued licensure and operation of Rainbow Ranch Group Homes, Inc. constitutes an immediate and serious danger to the children residing there and that immediate suspension of its licenses to operate a group home is necessary and fair under the circumstances.

WHEREFORE, in accordance with Sections 120.60(6) and 393.0673(5), Florida Statutes, (2006) it is ORDERED THAT:

1. An emergency suspension, effective 6:00 p.m., June 1, 2007, is imposed immediately on all of Rainbow Ranch Group Home licenses, Certificate No. 11- 840 – GH, Certificate No. 11-740- GH, Certificate No. 11-804- GH.; and
2. Prompt formal disciplinary proceedings against Rainbow Ranch Group Homes, Inc., will be instituted and acted upon, in compliance with the provisions of section 120.60(6), Florida Statutes (2006); and
3. This order shall be filed in accordance with section 120.54(4), 120.569, and 120.57(1), Florida Statutes.

DONE AND ORDERED this 1ST day of June, 2007.


Jane E. Johnson, Director, Agency for Persons with Disabilities

NOTICE OF APPELLATE RIGHTS

Pursuant to sections 120.60(6) (c) and 120.68, Florida Statutes, the agency's findings of immediate danger, necessity, and procedural fairness are judicially reviewable.

Review of this order is governed by the Florida Rules of Appellate Procedure. Appellate proceedings may be commenced by filing one copy of a Petition for Review in accordance with Rule 9.100, Florida Rules of Appellate Procedure, with Michael McGuckin, Agency Clerk of the Agency for Persons with Disabilities, and a second copy of the Petition, accompanied by the filing fee, with the appropriate District Court of Appeal within 30 days of the date this Order is filed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a correct copy of this Emergency License Suspension Order has been furnished by United States Mail to Gloria G. Auston, 17335 SW 248 Street, Miami, Florida 33031, by United States Mail and facsimile transmission to Therese F. Glatt, 310 Northwest Drive, Miami, Florida, 33126, and by facsimile transmission and U.S. Mail to Alan I. Mishael, P.A., and Lisa Bobotas, counsel for Rainbow Ranch Group Homes, at Mellon Financial Center, 1111 Brickell Avenue, Suite 2920, Miami, Florida 33131 this 1st day of June, 2007.


Michael McGuckin, Agency Clerk