IMMEDIATE MORATORIUM ON ADMISSIONS

THIS CAUSE came on for consideration before the Secretary of the Agency for Health Care Administration, or her duly appointed designee, who after careful review of the matter at hand and being otherwise fully advised, finds and concludes as follows:

THE PARTIES

1. The Agency for Health Care Administration (hereinafter “the Agency”), is the licensure and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state statutes and rules governing assisted living facilities. Chs. 408, Part II, and 429, Part I, Fla. Stat. (2019), Ch. 59A-36, Fla. Admin. Code. As part of its statutory oversight responsibilities, the Agency has the authority to impose emergency orders, including a limitation of license, a moratorium on admissions and an emergency suspension order, when circumstances dictate such action. §§ 120.60(6), 408.814, Fla. Stat. (2019).

2. The Respondent, Pavilion Gardens, LLC d/b/a Pavilion Gardens (hereinafter “Respondent”), was issued a license (license number 7469) by the Agency to operate a forty (40) bed assisted living facility (hereinafter “Facility”) located at 71 West 30th Street, Hialeah, Florida
33012, and was at all material times required to comply with the statutes and rules governing such facilities.


4. The Respondent holds itself out to the public as an assisted living facility that complies with the laws governing assisted living facilities. These laws exist to protect the health, safety and welfare of the residents of assisted living facilities. As individuals receiving services from an assisted living facility, these residents are entitled to receive the benefits and protections under Chapters 120, 408, Part II, and 429, Part I, Florida Statutes (2019), and Chapter 59A-36, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the current census at the Facility is thirty-five (35) residents/clients.

THE AGENCY’S EMERGENCY ORDER AUTHORITY

6. The Agency may impose an immediate moratorium or emergency suspension as
defined in section 120.60, Florida Statutes (2019), on any provider if the Agency determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client. § 408.814(1), Fla. Stat. (2019). If the Agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license, the Agency may take such action by any procedure that is fair under the circumstances. § 120.60(6), Fla. Stat. (2019).

LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

Resident Rights

7. Under Florida law, “No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) [l]ive in a safe and decent living environment, free from abuse and neglect; (b) [b]e treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy; and . . . (j) Assistance with obtaining access to adequate and appropriate health care…” § 429.28(1), Fla. Stat. (2019): Assisted living facilities must provide a safe living environment pursuant to Section 429.28(1)(a), Florida Statutes. Fla. Admin. Code R. 59A-36.014(3)(a).

Supervision

8. Florida law provides:

An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.
(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:
(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.
(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and
emotional well-being of the resident.
(c) Maintaining a general awareness of the resident’s whereabouts. The resident may travel independently in the community.
(d) Contacting the resident’s health care provider and other appropriate party such as the resident’s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident’s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.


**Staffing Standards**

9. Florida law provides:

(3) STAFFING STANDARDS
(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

<table>
<thead>
<tr>
<th>Number of Residents</th>
<th>Staff Hours/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>168</td>
</tr>
<tr>
<td>6-15</td>
<td>212</td>
</tr>
<tr>
<td>16-25</td>
<td>253</td>
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<tr>
<td>26-35</td>
<td>294</td>
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<tr>
<td>36-45</td>
<td>335</td>
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<tr>
<td>46-55</td>
<td>375</td>
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<td>56-65</td>
<td>416</td>
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<td>66-75</td>
<td>457</td>
</tr>
<tr>
<td>76-85</td>
<td>498</td>
</tr>
<tr>
<td>86-95</td>
<td>539</td>
</tr>
</tbody>
</table>

For every 20 residents over 95 add 42 staff hours per week.

... 5. A staff member who has completed courses in First Aid and Cardiopulmonary Resuscitation (CPR) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
(a) Documentation of attendance at First Aid or CPR courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and CPR.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager’s time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility’s staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.

(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents’ scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 59A-36.007, F.A.C.

(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or representatives.

(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a) if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 59A-5.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents’ contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41(1)(a), F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met.

1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if the plan increases the staff to needed levels to meet resident needs.
2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.

FACTS JUSTIFYING EMERGENCY ACTION

10. On January 18, 2020, the Agency completed a survey of the Respondent Facility.
11. Based upon this survey, the Agency makes the following findings:

    Resident Number One (1)

    a. The resident was admitted to the Facility on November 13, 2019.

    b. Though the resident was admitted without a health assessment, see, Rule 59A-36.006(2), Florida Administrative Code, the resident was admitted by the FACT Team, an intensive case management unit for persons suffering from mental illness.

    c. The resident’s prescribed medications included psychotropic medications such as Haldol, and diagnoses included schizophrenia.

    d. During the afternoon of November 16, 2019, the resident eloped from the Facility. The resident’s sibling was contacted initially. After the sibling was unsuccessful in locating the resident, law enforcement was contacted. Law enforcement located the resident and returned the resident to the Facility the following day.

    e. There is no indication that the Respondent undertook any action after this elopement incident to evaluate or address the resident’s supervision needs. Though the Facility policy and procedure requires that residents at risk of wandering or elopement be assessed “... at the time of admission and as needed,” no assessment for this resident was completed. In addition, there is no indication that the resident’s health care providers, including the case management FACT Team, were notified of the elopement.
f. The Respondent could not demonstrate that it weighed or implemented any interventions, such as active monitoring of the resident’s whereabouts, to address the resident’s known elopement behaviors. The Respondent’s failure to contact the resident’s health care providers deprived the health care providers, including the FACT Team, from exercising their expertise and resources in addressing the resident’s needs.

g. The Facility records reflect the resident did not receive prescribed medications on November 21 and 22, 2019. The Respondent notes it contacted the pharmacy regarding medications, but it appears insurance concerns were delaying further supply. Again, there is no indication that the resident’s health care providers, including the case management FACT Team, were notified of the failure of the resident to receive prescribed medications, including psychotropics, a concern which may have been subject to resolution by the FACT Team.

h. On November 23, 2019, at 2:00 a.m., the resident was observed scaling an exterior fence by another resident. The observing resident promptly reported to the Facility staff member that resident number one (1) had been seen climbing a fence and leaving the Facility grounds.

i. The staff member who was informed of this event, the sole staff member on duty for a resident census of thirty-eight (38) residents, conducted a search of the premises without success in locating the resident.

j. The staff member then contacted the Respondent’s administrator who directed the staff member to wait until 7:00 a.m. and then call the resident’s family, case management, and law enforcement.
k. At approximately 6:30 a.m., law enforcement contacted the Facility. The resident had been located deceased having fallen from a four (4) story building.

Resident Number Two (2)

1. The resident eloped from the Facility on November 4, 2019.

m. The Respondent did not contact the resident’s family, health care providers, responsible parties, or law enforcement. There is no indication that any search for the resident was conducted. No required reporting, such as adverse incident reporting, see generally, Rule 59A-36.016, Florida Administrative Code, was completed.

n. The resident has not returned to the Facility to date and the resident’s whereabouts are not known by the Respondent.

o. The administrator concluded, “They want to leave, so they leave.”

12. The minimum staff hours mandated by Florida law for an assisted living facility with a census of thirty-eight (38) residents is three hundred thirty-five (335) hours per week. Staffing schedules reflect the Respondent has been staffing the Facility with two hundred eight (208) hours weekly, a mere two thirds of the minimum staff required by law.

13. Of the staff that the Respondent does maintain, at least two (2), including the administrator, did not have evidence of elopement procedures maintained in their personnel records. See generally, Rule 59A-36.011(3) and (12), Florida Administrative Code. In addition, the Respondent has failed to ensure that one (1) staff member who has demonstrated training in cardiopulmonary resuscitation and First Aid is in the facility at all times. The Respondent failed to comply with this minimum requirement, see, Rule 59A-36.010(3), Florida Administrative Code, even after having been directed by Agency personnel to comply with this requirement.
during the Agency’s multi-day inspection.

NECESSITY FOR EMERGENCY ACTION

14. The Agency is charged with the responsibility of enforcing the laws enacted to protect the health, safety and welfare of residents and clients in Florida’s assisted living facilities. Ch. 429, Part I, Fla. Stat. (2019), Ch. 408, Part II, Fla. Stat. (2019); Ch. 59A-36, Fla. Admin. Code. In those instances, where the health, safety or welfare of an assisted living facility resident is at risk, the Agency will take prompt and appropriate action.

15. The residents of assisted living facilities enjoy a statutorily enacted Bill of Rights which mandates that assisted living facilities provide, inter alia, a safe and decent living environment, free from abuse and neglect, and access to adequate and appropriate health care consistent with established and recognized standards within the community. An assisted living facility must protect these resident rights. § 429.28, Fla. Stat. (2019); Fla. Admin. Code R. 59A-36.007(6). Residents of assisted living facilities must receive the care and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 59A-36.007(1).

16. Residents who reside in assisted living facilities oftentimes suffer from disease or disability. They typically consist of the frail, elderly or vulnerable. By law, the Respondent has been licensed and entrusted to provide care and services to this class of people, and as such, must comply with the statutes and rules that have been enacted for the special needs of these residents.

17. In this instance, the Respondent has demonstrated an inability or unwillingness to ensure that the Respondent meets its regulatory responsibilities to provide care and services, including supervision, appropriate to meet resident needs. The regulatory scheme requires, that as part of these responsibilities, an assisted living facility provide care and service, including supervision, appropriate to resident needs. In addition, an assisted living facility must maintain a
general awareness of the whereabouts of those individuals in their care.

18. The Respondent has not been able to demonstrate its compliance with this regulatory provision. The Respondent knew that a resident with mental illness diagnoses actively sought to elope from the Facility. After one (1) successful elopement, the Respondent chose to take no action to assure the continuing safety and well-being of the resident. No elopement assessment was undertaken though clearly indicated by the Respondent’s own policy and procedure. No notification to third parties charged with the health and well-being of the resident, including health care providers and the intensive case management agency that placed the resident in the Respondent’s care, was provided. The Respondent did nothing to address a known risk to the resident.

19. Inexplicably, the Respondent failed to provide assistance and access to critical medications to this resident. Whether or not this lack of medication contributed to the resident’s future behavior and ultimate death need not be determined. Care and services appropriate to resident needs must necessarily encompass an obligation of an assisted living facility to take such action as within its power to secure and provide prescribed medications and, in the failure to obtain medications, to notify a resident’s health care providers and responsible parties, including case management services, of the resident’s lack of prescribed medications.

20. The Respondent knew, or should have known, the demonstrated elopement behavior of resident number one (1) indicated the need to evaluate and address the behavior. The Respondent, in the face of this challenge, opted to take no action to fulfill its mandate to provide care and services appropriate to resident needs, including supervision and the maintenance of a general awareness of the resident’s whereabouts.

21. This is not an isolated event. Resident number two (2) eloped from the Facility
on November 4, 2019. The Respondent took no action to respond to this event, ignoring its responsibilities imposed by law to take action to protect the resident’s well-being.

22. The events surrounding these two (2) residents reflect the Respondent’s inability or unwillingness to provide the care and services to residents appropriate to the residents’ needs.

23. The Respondent’s staffing decisions further indicate the Respondent’s apparent disregard of the regulatory minimum standards enacted to regulate assisted living facilities. The Respondent has maintained a staffing schedule that falls far below regulatory hourly minimums. In addition, the staff scheduled and serving resident needs lack the minimum qualifications to provide services in emergent conditions.

24. Standing alone, the Respondent’s staffing practices present conditions placing residents at risk of harm. Of particular concern is the Respondent’s apparent disregard of this risk by its failure to assure that at least one (1) staff member competent in cardiopulmonary resuscitation and First Aid be on-site at all times, despite Agency personnel affirmatively directing the Respondent to comply with this minimum standard.

25. This behavior demonstrates the Respondent’s apparent disregard for the regulatory scheme designed and implemented to assure quality of care and minimize risk to residents.

26. The failures above discussed are not isolated events, but constitute a systemic failure of the Respondent to assure that resident health and well-being is protected to the minimum standards of law.

27. The Respondent’s acts and omissions reflect the Respondent’s failure to protect residents from abuse or neglect. The Respondent’s laissez faire reaction to resident elopement, whether as a result of inadequate training, institutional neglect, or inadequate staffing, cannot protect resident well-being.
28. These facts demonstrate the Respondent’s inability or unwillingness to assure that each resident receives the care and services, including supervision, appropriate to resident needs. This failure necessarily impacts the health, safety, and well-being of residents. Where known behaviors placing residents at risk are ignored; where qualified staff are not provided; where inadequate number of staff are the institutional norm, residents’ health and well-being is placed at risk. Residents are placed at needless risk to health and safety, risks that placement in the assisted living facility were, at least in part, meant to be minimized.

29. The Repondent has demonstrated no understanding of its requirement to monitor and respond to the static health and behavioral conditions of residents entrusted in its care. Not only must a provider assure that care and services appropriate to meet resident needs be provided at a resident’s admission, this duty continues, and its contours expand, as a resident suffers from progressive or temporary changes in health and behavior. An assisted living facility must be diligent to recognize and respond to these issues to maintain the facility’s responsibility to provide care and services. The failure to assure these elements are operational and place each resident at immediate risk.

30. These deficient practices have occurred over time and affect each of the Respondent’s resident census. The Respondent has demonstrated, through its lack of attention to these regulatory minimum standards and direct defiance to Agency direction, an inability to recognize its ongoing deficient practices and the failure to implement corrective action to address this non-compliance. The net result is the failure to provide those services for which the residents have contracted, and the law requires. These multiple failures necessarily result in the deprivation of resident rights to a safe and decent living environment, free from abuse and neglect, and access to appropriate health care.
31. Individually and collectively, these facts reflect that the residents of this Facility are not currently residing in a safe and decent living environment free from abuse and neglect, § 429.28(1)(a) and (b), Fla. Stat. (2019), and are not receiving the care and services, including supervision, appropriate to resident needs, Fla. Admin. Code R. 59A-36.007(1). No resident of an assisted living facility should be placed in such an environment. The Legislature created the Assisted Living Facilities Act. §§ 429.01, et seq., Fla. Stat. (2019). “The purpose of this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decision making ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state, . . . to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of several state agencies. § 429.01(2), Fla. Stat. (2019).

32. The Respondent’s deficient practices exist presently; have existed in the past, and more likely than not will continue to exist if the Agency does not act promptly. If the Agency does not act, it is likely that the Respondent’s conduct will continue.

**CONCLUSIONS OF LAW**


34. Each resident of an assisted living facility has the statutory right to live in a safe and decent living environment, § 429.28(1)(a), Fla. Stat. (2019), and to receive care and services, including supervision, appropriate to meet their needs, Fla. Admin. Code R. 59A-36.007(1).
35. Based upon the above stated provisions of law and findings of fact, the Agency concludes that: (1) an immediate serious danger to the public health, safety, or welfare presently exists at the Respondent’s Facility which justifies an immediate moratorium on admissions, and (2) the present conditions related to the Respondent and its Facility present a threat to the health, safety, or welfare of a resident, which requires an immediate moratorium on admissions.

36. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an Immediate Moratorium on Admissions is necessary in order to protect the residents from (1) the unsafe conditions and deficient practices that currently exist, (2) being placed at risk of living in an environment ill-equipped to provide for resident health, safety and welfare because of supervision and care deficiencies, and (3) being placed in an assisted living facility where the regulatory mechanisms enacted for residents’ protection have been repeatedly overlooked.

37. The Respondent’s deficient practices exist presently and will more likely than not continue to exist if the Agency does not act promptly. If the Agency does not act, it is likely that the Respondent’s conduct will continue. The Respondent’s Administrator has not assured that regulatory minimums required to operate an assisted living facility are met. The Facility’s operations illustrate either a lack of knowledge or an inability to or unwillingness to meet these minimum requirements. Such deficient practices and conditions justify the imposition of an Immediate Moratorium on Admissions. Less restrictive actions, such as the assessment of administrative fines, will not ensure that the current residents or future residents receive the appropriate care, services, and environment dictated by Florida law.

38. The emergency action taken by the Agency in this particular instance is fair under the circumstances and the least restrictive action that the Agency could take given the facts and
circumstances. This remedy is narrowly tailored to address the specific harm in this instance. The Agency stands ready to take greater action, including an Emergency Suspension Order, if the Respondent does not promptly come into compliance with the regulations governing assisted living facilities.

**IT IS THEREFORE ORDERED THAT:**

39. An Immediate Moratorium on Admissions is imposed on this assisted living facility and the Facility shall not admit any new residents or readmit any former residents, unless it receives express written authorization from the Agency’s local Field Office Manager.

40. Upon receipt of this order, the Respondent shall post this Order on its premises in a place that is conspicuous and visible to the public.

41. The Agency shall promptly file an administrative action against the Respondent based upon the facts set out in this Immediate Moratorium on Admissions and provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2019), at the time that such action is taken.

**ORDERED** in Tallahassee, Florida, this 21st day of January 2020.

\[Signature\]

Mary C. Mayhew, Secretary
Agency for Health Care Administration

**NOTICE OF RIGHT TO JUDICIAL REVIEW**

This emergency order is a non-final order subject to facial review for legal sufficiency. See Broyles v. State, 776 So.2d 340 (Fla. 1st DCA 2001). Such review is commenced by filing a petition for review in accordance with Florida Rules of Appellate Procedure 9.100(b) and (c). See Fla. R. App. P. 9.190(b)(2). In order to be timely, the petition for review must be filed within thirty (30) days of the rendition of this non-final emergency order.
DELEGATION OF AUTHORITY
To Execute
Emergency Orders

I specifically delegate the authority to execute Emergency Orders to Molly McKinstry, Deputy Secretary, Health Quality Assurance or her delegate.

This delegation of authority shall be valid from the date of February 1, 2019 until revoked by the Secretary.

Mary C. Mayhew, Secretary

Date