STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SANTA BARBARA BH, INC., d/b/a VILLA SERENA VIII,

Respondent.
_____/

AHCA No. 2019010390
License No. 5059
File No. 11911402
Provider Type: Assisted Living Facility

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. 58A-5, 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, Santa Barbara BH, Inc. d/b/a Villa Serena VIII (hereinafter "Respondent"), was issued a license (license number 5059) by the Agency to operate a twelve (12) bed assisted living facility (hereinafter "Facility") located at 3321 Southwest 24th Terrace,

#23, Miami, Florida 33145, and was at all material times required to comply with the statutes and rules governing such facilities.

3. As the holder of such a license, the Respondent is a licensee. "Licensee" means "an individual, corporation, partnership, firm, association, or governmental entity, that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2019). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2019). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2019). § 408.803(11), Fla. Stat, (2019). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2019), and listed in Section 408.802, Florida Statutes (2019). § 408.802(11), Fla. Stat. (2019). Assisted living facility residents are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2019).

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 58A-5, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the census at the Facility is eleven (11) 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) [a]ccess to adequate and appropriate health care consistent with established and recognized standards within the community." § 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. 58A-5.023(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 58A-5.020, 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.

Fla. Admin. Code R. 58A-5.0182(1).

Staffing Standards

9. Florida law provides:

(3) STAFFING STANDARDS.
(a) Minimum staffing:
...
(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 58A-5.0182, F.A.C.

Fla. Admin. Code R. 58A-5.019(3)(a)4 and (b).

FACTS JUSTIFYING EMERGENCY ACTION

10. On July 3, 2019, the Agency completed a survey of the Respondent Facility.

11. Based upon this survey, the Agency makes the following findings:

a. The Respondent's policy and procedure on elopement includes, *inter alia*, a provision that all residents be screened for risk of elopement and that law enforcement be contacted in the event of an elopement.

b. The Respondent's resident records do not contain an elopement risk assessment for any of its residents.

c. Resident number one (1):

i. The resident was admitted to the Facility on June 7, 2019.

ii. The Respondent did not conduct an elopement assessment on the resident.

iii. The day following the resident's admission, the resident started to tell Facility staff that the resident did not want to stay at the Facility and would leave.

iv. There is no indication that the Respondent reacted to these verbal indications of an intent to elope from the Facility.

v. On June 10, 2019, at approximately 5:00 p.m., the resident eloped from the Facility.

vi. There is no indication that law enforcement or the resident's responsible party was contacted relating to the resident's unplanned absence and unknown whereabouts.

vii. The Respondent was informed by a local hospital that the resident was admitted to the hospital after having been delivered by ambulance on June 12, 2019. The resident had fallen and suffered from dizziness, a contusion to the head, areas of skin discoloration, was unresponsive, dehydrated, and suffering hallucinations.

viii. After having been discharged from the hospital, the resident returned to the Facility on July 1, 2019. The Respondent, despite the previous elopement, took no action to assess the resident for elopement risk or to implement any interventions to lessen the likelihood of the resident's future elopement.

ix. On July 2, 2019, the resident again eloped from the Facility.

x. There is no indication that the Respondent called law enforcement or the resident's responsible party after this elopement.

xi. In addition, the Respondent had not obtained the resident's prescribed medications upon the resident's return from hospitalization.

d. From 10:00 p.m. to 6:00 a.m. of every day, the Respondent does not staff the Facility with qualified personnel to meet resident anticipated and unanticipated needs.

e. The Respondent's management requires that staff "clock out" at 10:00 p.m. each evening. Though the staff remain on site, housing being part of the staff compensation, the staff members are aware of or responsive to residents only in the event a resident cries out or otherwise alerts an often sleeping staff member of the resident's needs. In such a case, the staff member would respond, clocking in immediately before responding to the resident's cries, and clocking out immediately after addressing the issue.

f. At least one (1) of the resident's suffers from incontinence of bowel and bladder. The resident has consistently been waking with feces in the bed. Respondent's administrator, aware of the nightly events of incontinence, indicates that should the resident call out to alert staff, staff would address the resident's care needs.

g. Minimum staffing hours for an assisted living facility housing eleven (11) residents is two hundred twelve (212) hours weekly. *See,* Rule 58A-5.019(3)(a), Florida Administrative Code. The Respondent is providing staffing for only one hundred seventy-two (172) hours per week.

h. At least three (3) of the current residents have been identified by their health care providers as requiring fall precautions due to the residents' physical impairments.

i. The Respondent has not developed or implemented any interventions directed to minimize the risk that these residents suffer falls.

j. One (1) of the residents recently suffered a fall. This resident's record is devoid of any indication that the resident was re-assessed by the health care provider or that any interventions were devised or implemented to minimize the risk of the resident suffering another fall. A second resident suffered falls in both March and May of this year. Despite having been cited by the Agency in May 2019 for this failure of supervision, the Respondent has still failed to take any action to devise or implement interventions to address the known propensity to suffer falls exhibited by this resident.

NECESSITY FOR EMERGENCY ACTION

12. 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. 58A-5, 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.

13. 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. 58A-5.023(3)(a). Residents of assisted living facilities must receive the care and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 58A-5.0182(1).

14. 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.

15. In this instance, the Respondent has demonstrated a failure to ensure that its residents are free from abuse or neglect, including the failure to provide care and services, including supervision, appropriate to meet resident needs. This is illustrated in the several factual findings described above.

16. The Respondent has entirely failed to meet its minimum obligations related to elopement.

17. An assisted living facility is required to devise and implement policy and procedures related to resident elopement. *See*, Rule 58A-5.0182(8), Florida Administrative Code. Inclusive of minimum requirements are the identification of residents either assessed to be at risk for elopement or with a history of elopement behavior. Here, the Respondent has residents both identified by the residents' health care provider as at risk for elopement and a resident with known elopement behavior. The stated purpose of this regulatory provision is "... so staff can be alerted to [resident] needs for support and supervision..." Rule 58A-5.0182(8)(a), Florida Administrative Code. The Respondent, intentionally or negligently, has failed to assess a resident known to be at risk for elopement as demonstrated by the resident's behaviors and statements. This resident has eloped two (2) times since June 2019.

18. During these elopements, the Respondent could not demonstrate that it implemented its elopement policy and procedure, including contacting law enforcement and resident responsible party, a communication mandated by law. *See*, Rule 58A-5.0182(8)(b)(c), Florida Administrative Code.

19. The net effect of these acts and omissions is the Respondent's failure to provide a safe and decent living environment, free form abuse or neglect, and the failure to provide supervision appropriate to resident needs. These are core services to be provided to residents of assisted living facilities, to assure the health, safety, and well-being of residents.

20. In addition, the Respondent has intentionally created a staffing pattern in direct conflict to the staffing requirements mandated by law. A staff member must be available to meet scheduled and unscheduled service needs of residents. The Respondent, however, has implemented a system that provides staffing at night only where a resident demands care. Residents are not the harbingers of their own care and supervision services. A provider is charged by law to supervise its residents on a twenty-four hour per day basis, meeting known and emergency care needs. ***See,*** § 429.02(5), Fla. Stat. (2019). The Respondent has, however, ignored this mandate. Even with the knowledge of a resident suffering incontinence during the night, the Respondent has pronounced that personal care would be provided only if the resident has the wherewithal to roust a caregiver.

21. This practice clearly places all residents at immediate risk. The vulnerable adults requiring assisted living care need that care and supervision due to a panoply of ailments, including frailty or diminished capacity. The onus for resident care and supervision lies solely with the assisted living facility, not merely upon the beck and call of a resident suffering an expected or unexpected care need.

22. Last, the Respondent has demonstrated an unwillingness or inability to provide supervision for residents likely to suffer falls. Despite having been cited by the Agency for this very deficient practice, the Respondent has demonstrated no action to undertake its regulatory responsibility to meet the supervision needs required to meet the needs of residents at risk of falls.

23. The failures discussed herein necessarily impact the health, safety, and well-being of residents. Where known fall risk or elopement behavior is not appropriately addressed resident health and well-being is placed at risk. Where staff are not available to meet anticipated and unanticipated care and service needs, 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.

24. These deficient practices have occurred over time and effect each of Respondent's resident census. The Respondent has demonstrated, through its lack of attention to these regulatory minimum standards, an inability to recognize its ongoing deficient practice 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.

25. 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.

26. 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. 58A-5.0182(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).

27. **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

28. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code.

29. 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. 58A-5.0182(1).

30. 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.

31. 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.

32. 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 address resident falls are met despite having been cited with the same deficient practice in recent months. 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.

33. 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.

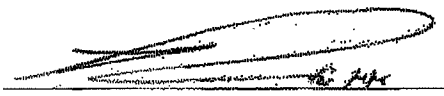
IT IS THEREFORE ORDERED THAT:

34. 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.

35. 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.

36. 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 5th day of July, 2019.



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.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

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

2/6/19
Date

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