STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

GRACE MANOR AT LAKE MORTON, LLC,

Respondent.
_____/

AHCA No. 2020009686
License No. 5217
File No. 11910053
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. 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, Grace Manor at Lake Morton, LLC (hereinafter "Respondent"), was issued a license by the Agency to operate a fifty (50) bed assisted living facility (hereinafter "the Facility") located at 610 East Lime Street, Lakeland, Florida 33801, 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, governmental entity, or other 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 patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2019). The Respondent holds itself out to the public as an assisted living facility that fully complies with state laws governing such providers.

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 census at the Facility is seven (7) 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]ssistance with obtaining access to adequate and appropriate health care. § 429.28(1), Fla. Stat. (2019).

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.

Fla. Admin. Code R. 59A-36.007(1).

Staffing Standards

9. Florida law provides:

ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.

Fla. Admin. Code R. 59A-36.010(1).

FACTS JUSTIFYING EMERGENCY ACTION

10. On June 1, 2020, the Agency completed a survey of the Facility.

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

a. On May 22, 2020, the Facility residents were tested for the COVID-19 virus.

b. As a result of this testing, on May 26-27, twenty-eight (28) of the residents had received a positive test result and were hospitalized. By June 1, 2020, a total of thirty-three (33) residents had received a positive test result and were hospitalized.

c. Since May 30, 2020, and including June 1, 2020, a strike team from the Division of Veteran's Affairs has been in the Facility to assist in implementing appropriate care and services to minimize the risk of further contagion. The professionals in this strike team instructed the staff in the use of personal protective equipment for both staff and residents and principles of isolation care to minimize risk of the spread of contagion.

d. On June 1, 2020, a resident who had recently received a positive test for the

COVID-19 virus was seated in the common dining area of the Facility. The resident was awaiting the lunch meal and a drink was before the resident on a table. Co-located in the common area were three (3) other residents and three (3) staff members.

e. None of the residents were wearing any personal protective equipment. Staff members were wearing only masks and no other personal protective equipment. The common area was not of sufficient size to allow the residents and the staff members to exercise recommended social distancing.

f. Though staff members did wear masks, the staff members intermittently donned gloves when providing resident care or services. Observations of resident care did not include staff members doffing personal protective equipment between providing care to the several residents, the washing of hands between care and services, or the changing of masks between episodes of resident care.

g. The Respondent and its staff, including the Administrator, were aware that the one of the residents in the common area had recently received a positive test result for the COVID-19 infection. When questioned why the resident was not isolated from other residents or staff, the Administrator excused this failure asserting the resident's behavior of wandering prevented the Facility from effectively isolating the resident. When questioned why personal protective equipment was not being utilized in accordance with the guidance of the several health agencies; including the Emergency Orders of the Governor, the Emergency Orders of the state Emergency Management Agency, the guidance of the Agency, and the verbal directives of the strike team from the Division of Veteran's Affairs, the Administrator denied knowledge of the scope of these directives.

h. The Facility did not have identified areas for resident isolation in the event a

resident was suspected of having obtained the virus, or an identified isolation or quarantine area for individual residents who may have been in contact with persons suspected of having the virus. The Facility has no policy and procedure and could not demonstrate means or mechanisms to effectively implement isolation or quarantine procedures for the safety of the Facility's resident census.

i. The known COVID-19 positive resident was transported to a local hospital on June 1, 2020.

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. 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.

13. Residents of assisted living facilities must receive the care and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 59A-36.010(1). The Facility administrator is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. Fla. Admin. Code R. 59A-36.010(1).

14. As the facts reflect, the Respondent has failed to meet these minimum licensure standards and these failures are not isolated events, but operational and management system deficiencies affecting the health, safety, and well-being of Respondent's current or future resident population.

15. The COVID-19 virus is an easily transmitted respiratory infection that presents

severe risk to persons who are aged, infirm, or suffer from co-morbiditics including, but not limited to, immune system deficiency, respiratory disease, diabetes, and obesity. *See generally*, Publications of the Centers for Disease Control.

16. The Governor of the State of Florida issued, on March 1, 2020, Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to this authority, several Emergency Orders have been issued by the Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most vulnerable to the effects of infection. Among those Emergency Orders was DEM Order 20-006, dated March 15, 2020, delineating minimum screening standards for persons entering identified facilities, including assisted living facilities.

17. The Agency has issued Guidance and Clarification on Division of Emergency Management Emergency Order 20-006 to its licensed providers and on March 18, 2020 issued an alert notifying licensed providers that all staff or other individuals admitted to a nursing home must don face masks and that caregivers must wear gloves when providing resident care.

18. The ease of contagion and the effects of infection presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate prophylactic procedures to both assure appropriate treatment of a potentially infected resident and protect the remainder of a Facility's population from the risk of spread of the infection.

19. Similarly, the prevalence of the COVID-19 virus in the general community mandates that providers be proactive and unwavering in implementing procedures to screen all persons entering the facility for signs or symptoms of infection. For those not exhibiting such signs or symptoms, including residents, providers must assure exclusion or, where appropriate,

compliance with safe preventative practices designed to minimize the risk of the virus being spread by or infecting other residents, staff, or third parties allowed entrance under current limitations.

20. 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.

21. In this instance, the Respondent has demonstrated an inability or unwillingness to implement proactive action to protect residents, staff, and third parties from the challenges presented by COVID-19. These failures are demonstrated by the Respondent's failure to consistently undertake and implement basic of protective measures, including the use of personal protective equipment for staff and residents, the use of isolation, and the implementation of social distancing practices. These failures constitute a demonstrated general disregard of the recommended actions to minimize the risk of infection.

22. Here, a known COVID-19 patient is readily allowed to co-mingle with both staff and other non-positive COVID-19 residents. The resident is not isolated or removed from the non-infected residents. The resident is not wearing any personal protective equipment. Other residents are permitted by the Respondent to intermingle with a known COVID-19 resident without the Respondent taking any demonstrable action to don the non-infected residents in personal protective equipment or to ensure social distancing is maintained. The Facility staff wear only masks, donning gloves for isolated activities, and not demonstrating any effort to doff personal protective equipment between the provision of services to the several residents or to take such safety precautions as hand washing between providing these services.

23. Despite a significant portion of the Facility residents having been determined COVID-19 positive in the recent past, the Respondent has not implemented aggressive and vigorous actions to protect staff and residents from further contagion. This inaction cannot be excused by ignorance. State and local health authorities have gone to great lengths to educate providers of residential care of the precautions necessary to minimize the risk of the spread of the contagion. In addition, the Respondent has received hands on advice from the Department of Veteran's Affairs strike team for several days, yet the Respondent has not demonstrated the willingness to or ability to implement such protective services. The Respondent has simply failed to heed the warnings of public health advisories and did not implement these protections. Individually and collectively, these facts reflect the Respondent's failure to appreciate and protect residents from COVID-19 and its ravages.

24. The totality of these facts illustrates that the Facility Administrator has failed in the legal responsibility to properly oversee the operation and maintenance of the Facility, including the management of all staff and the provision of appropriate care to all residents. 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. The Respondent may not ignore a known danger to the detriment of those persons to whom the Respondent has undertaken the responsibility for their safety and well-being.

25. The scope of services which assisted living facility personnel provide is wide and varied. Competency in these services cover care and services which may be provided on a daily basis or required only in emergent conditions. The Respondent, by failing to provide staff with competencies in isolation and contagion prevention practices has not provided qualified staff to meet resident needs. The capability of staff to competently provide these services must be

assured at all times. This responsibility falls ultimately on the Facility administrator. This responsibility is one for which that Respondent has demonstrated failure.

26. 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 defiance of public health advisories, 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.

27. 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. 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).

28. 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

29. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 429, Part I, Florida Statutes, and Chapter 59A-36, Florida Administrative Code.

30. Each resident of an assisted living facility has the statutory right to live in a safe and decent living environment and to receive care and services, including supervision, appropriate to meet their needs. § 429.28(1)(a), Fla. Stat. (2019).

31. 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.

32. 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.

33. 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 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.

34. 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:

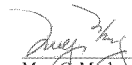
35. An Immediate Moratorium on Admissions is imposed on this assisted living facility and the Facility shall not admit any new residents or readmit any former residents, unless it receives express written authorization from the Agency's local Field Office Manager.

36. 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.

37. 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 2nd day of June 2020.



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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