**STATE OF FLORIDA**
**AGENCY FOR HEALTH CARE ADMINISTRATION**

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

D & F ASSOCIATES, LLC, d/b/a ALAFIA VILLAGE,

Respondent.
_____/

AHCA No. 2020011657
License No. 9059
File No. 11964530
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. (2020), 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. (2020).

2. The Respondent, D & F Associates, LLC d/b/a Alafia Village (hereinafter "the Respondent"), was issued a license by the Agency to operate a seventy-nine (79) bed assisted living facility (hereinafter "the Facility") located at 3918 South Kings Avenue, Brandon, Florida

33511, 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. (2020). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2020). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2020). § 408.803(11), Fla. Stat, (2020). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2020), and listed in Section 408.802, Florida Statutes (2020). § 408.802(11), Fla. Stat. (2020). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2020). 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 (2020), and Chapter 59A-36, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the census at the Facility is forty-six (46) 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 (2020), 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. (2020). 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. (2020).

## 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. (2020): 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.

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 July 6, 2020, the Agency completed a survey of the Respondent Facility.

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

a. On July 4, 2020, three (3) of the Respondent's residents were confirmed positive for the COVID-19 virus. As of July 6, 2020, the three (3) residents had not been moved from their rooms to any form of isolation and had not been seen by their healthcare providers or hospitalized for evaluation.

b. When asked on July 6, 2020, for the Respondent's infection control policies and

procedures to assure care for residents in light of COVID-19, the Respondent indicated the Facility had no such policies or procedures. The Respondent utilizes only surgical masks, cloth masks, and gloves as personal protective equipment.

c. At 12:30 p.m., on July 6, 2020, a staff member was observed entering the room of resident number one (1), a COVID-19 positive resident. The staff member wore only a cloth mask and gloves. The staff member assisted the resident in cleaning after the noon meal, exited the room, and entered the staff break room. The staff member did not remove her protective gear or engage in handwashing.

d. In the staff break room, the staff member encountered resident number five (5), a COVID-19 negative resident, who was seated at a table having a beverage. The staff member greeted resident number five (5) and touched the resident with her gloved hands fresh from providing care to resident number one (1). The staff member then removed and disposed of the gloves, washed her hands, and donned a fresh pair of gloves.

e. This same staff member then proceeded to the room of resident number three (3), a COVID-19 positive resident entering the room at 12:40 p.m. The staff member repositioned the resident, touched and arranged the resident's food tray, offered assistance in eating, and again repositioned the resident. The staff member then removed her gloves and shut the door to the resident's room.

f. The staff member acknowledged to Agency personnel that she was aware the resident had tested positive for the COVID-19 virus. She further indicated that her responsibilities include the care for all residents of the Facility and that she has never worn a gown, face shield, or N95 mask while caring for residents.

g. At 12:45 p.m., resident number two (2), a COVID-19 positive resident, exited the

resident's room and proceeded down the hallway. The resident wore no protective equipment. The resident was re-directed with some difficulty to the resident's room by a staff member who donned gloves to physically re-direct the resident. The staff member told the resident the resident must remain in the resident's assigned room.

h. When asked of the Facility's plans in caring for residents in light of the COVID-19 positive residents, the Facility administrator indicated that there would be no change of rooms for or the assignment of dedicated staff to the positive residents. The administrator believed the use of Lysol, surgical and cloth masks, and gloves would be sufficient for staff to prevent the spread of the virus, and that the removal of one of the resident's wheelchair, resident number three (3), would prevent that resident from spreading the virus.

i. Two (2) of the Respondent's staff members, resident assistants, were interviewed in the afternoon of July 6, 2020. Both indicated that they care for the three (3) COVID-19 residents and other residents of the Facility. They had not received any training in caring for the COVID-19 residents or isolation practice or procedure. The mandate to wear masks and gloves were the only guidance provided by the Respondent.

j. The Respondent's resident care coordinator confirmed on July 6, 2020 that she had received no training related to COVID-19 and had provided no training to the staff. She was aware from an ambulance transport provider that training in COVID-19 and prevention of spread was required, but had not pursued obtaining the training.

k. The Respondent did not have identified areas for resident isolation in the event that 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 COVID-19 virus. The Respondent has no policy and procedure and could not demonstrate means or mechanisms to effectively implement isolation or quarantine procedures for the safety of the Respondent's resident census.

l. On July 6, 2020 at 3:57 p.m., a table and chairs were noted blocking a hallway from the memory care unit to the common area. This ad hoc blockade was to prevent resident number two (2), a COVID-19 positive resident, from exiting the resident's room and accessing the common area. The blocked hallway also contained the rooms of at least two (2) other non-COVID-19 positive residents.

**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. (2020), Ch. 408, Part II, Fla. Stat. (2020); 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 the 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-morbidities 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 the authority therein, 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 residential facilities 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 unique challenges presented by the Coronavirus. These failures are demonstrated by the Respondent's failure to undertake and implement plans for minimizing the spread of the virus. Even the most basic of protective measures have not been implemented including, but not limited to, the use of personal protective equipment for staff and residents at all times, the use of isolation or quarantine for identified COVID-19 positive residents or COVID-19 exposed residents, and the implementation of social distancing practices. These failures constitute a demonstrated general disregard of the recommended actions to minimize the risk of Coronavirus infection or spread.

22. Here no demonstrable comprehensive action has been taken since the diagnosis of three (3) residents with COVID-19. While masks and gloves are nominally utilized for the residents' care, staff have not been trained on the proper use of the equipment to minimize spread of the virus. Staff admit a lack of training. The Respondent's 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. The Respondent's demonstrated efforts at isolation or quarantine of COVID-19 positive residents fall far below community standards, exhibit a lack of understanding of the virus' contagion, and fail to respect the rights and dignity of residents. Effective infection control does not include the building of furniture barricades or depriving residents of their assistive devices, such as wheelchairs, to rob the residents of mobility.

24. The Respondent has not implemented aggressive and vigorous actions to protect 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 coronavirus. The Respondent has not implemented sufficient effective protections despite the warnings of public health advisories.

25. Individually and collectively, these facts reflect the Respondent's failure to appreciate and protect residents from the coronavirus and its ravages. The totality of these facts illustrates the administrator of the Facility has failed in the administrator's legal responsibility to oversee the operation and maintenance of the Facility including the management of all staff and the provision of appropriate care to all 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. 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.

27. 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 the Respondent has demonstrated failure.

28. 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. 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.

29. 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. (2020), 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. (2020). "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. (2020).

30. 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

31. 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.

32. 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. (2020), and to receive care and services, including supervision, appropriate to meet their needs.

33. 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.

34. 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.

35. 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.

36. 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.

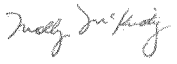
**IT IS THEREFORE ORDERED THAT:**

37. 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.

38. 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.

39. 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 (2020), at the time that such action is taken.

**ORDERED** in Tallahassee, Florida, this 8th day of July 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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