STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

YMP GRAND COURT LAKES OPCO, LLC d/b/a GRAND COURT LAKES,

Respondent.
_____/

AHCA No. 2021009285
License No. 8390
File No. 11953671
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. (2021), 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. (2021).

2. The Respondent, YMP Grand Court Lakes OPCO, LLC d/b/a Grand Court Lakes (hereinafter "Respondent"), was issued a license by the Agency to operate a one hundred ninety-one (191) bed assisted living facility (hereinafter "the Facility") located at 280 Sierra Drive, North Miami, Florida 33179, 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. (2021). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2021). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2021). § 408.803(12), Fla. Stat, (2021). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2021), and listed in Section 408.802, Florida Statutes (2021). § 408.802(11), Fla. Stat. (2021). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2021). 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 (2021), and Chapter 59A-36, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the census at the Facility is one hundred twenty-seven (127) 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 (2021), 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. (2021). 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. (2021).

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. (2021): 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 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. 59A-36.007(1).

FACTS JUSTIFYING EMERGENCY ACTION

9. On July 2, 2021, the Agency completed a survey of the Respondent Facility.

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

a. Between March 20, 2021, and May 17, 2021, six (6) residents suffered falls. Many resulted in injury and required medical attention, and one (1) resident overdosed twice in December 2020 and was found unresponsive at the facility.

b. Resident number twenty-three (23):

i. The resident suffered falls three (3) days in a row while the resident was attempting to transfer.

ii. The resident's health assessment, Form 1823, dated November 21, 2020, documented the resident required fall precautions and needed assistance with ambulation, bathing, dressing, self-care, toileting, and transferring.

iii. A facility incident report dated March 20, 2021, documented that staff observed the resident on the floor. The resident reported the resident was attempting to transfer from bed to wheelchair when the resident fell.

iv. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

v. There is no indication that Respondent had instituted any fall precautions as identified on the resident's health assessment.

vi. Another facility incident report dated March 21, 2021, noted the resident suffered a fall at 10:50 p.m. in the resident's room. Respondent's certified nursing assistant reported that the resident was discovered on the floor during rounds. When asked what happened, the resident informed the certified nursing assistant that the resident was attempting to get up and lost balance. The resident was evaluated by paramedics but remained at the facility.

vii. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

viii. A third facility incident report noted that the resident was found sitting next to the resident's bed while staff was conducting rounds. A progress note dated March 22, 2021, indicated that the resident was sent to the hospital due to the resident being in pain from the fall.

ix. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

c. Resident number twenty-two (22):

i. Resident number twenty-two (22) fell twice in two (2) months and suffered a hematoma to the head.

ii. The resident's health assessment, Form 1823, dated February 23, 2021, showed a history of falls and the potential for further falls. The resident required fall precautions and needed supervision with bathing, dressing, eating, self-care, toileting, and transferring.

iii. A facility incident report dated March 26, 2021, documented that staff observed the resident fall while playing activities. The resident did not

complain of pain at the time, but staff noted the resident sustained a skin tear.

iv. There is no indication that Respondent had instituted any fall precautions as identified on the resident's health assessment.

v. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

vi. A second facility incident report dated April 8, 2021, documented that around 7:30 a.m., the resident was found during rounds with a large hematoma on the back of the resident's head. When asked how the resident sustained the injury, the resident reported to staff that the resident was playing in the corner of the resident's room and fell. The resident was transferred to the hospital and remained hospitalized for one (1) week for post mechanical fall and head trauma.

vii. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

viii. There was no documented re-assessment for fall risk in the resident's record.

ix. Respondent's director of nursing confirmed that the Respondent did not reassess residents but instead used what was indicated on the resident's health assessment.

d. Resident number seventeen (17):

i. The resident fell four (4) times between April 2021 and May 2021 and sustained a right humerus fracture.

ii. The resident's health assessment, Form 1823, dated June 19, 2019,

included a history of muscle weakness. The assessment indicated the resident required no precautions and was independent with ambulation, bathing, dressing, eating self-care, toileting and transferring.

iii. A facility incident report dated April 15, 2021, noted the resident was found sitting on the bathroom floor during rounds. The resident stated the resident lost balance while using the restroom and hit the resident's face. Staff noted redness on the resident's forehead where the resident complained of pain. The resident was transferred to the hospital.

iv. The resident's hospital record dated April 24, 2021, showed that the resident complained of pain in the right shoulder and the right knee. The record further indicated that the resident "demonstrated comminuted surgical neck fracture of the right proximal humerus with impaction and posterior angulation."

v. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

vi. A facility incident report dated April 27, 2021, showed "... upon rounds resident stated while [resident] was dressed to get ready for an appointment [the resident] slipped and fell. A small tear was noted on the right knee, [the resident] is complaining of pain on the arm." The resident was transferred to the hospital.

vii. The resident's hospital record dated April 30, 2021, showed "patient with a past medical history of recent humerus fracture (right arm in sling), chronic back pain..."

viii. There is no indication that Respondent either considered or

implemented any interventions to prevent further falls by the resident.

ix. A facility incident report dated May 11, 2021, indicated that the resident reported to have hit the resident's head against a nightstand while bending down. The resident did not complain of pain at the time, but staff noted a cut on the right side of the resident's forehead. The resident was offered to be sent to the hospital for further evaluation but refused.

x. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

xi. Another facility incident report dated May 12, 2021, revealed that at 5:15 a.m., staff observed the resident on the floor. The resident stated the resident was going to the bathroom and fell. Staff noted a small cut over the resident's right eye. The resident refused to go to the hospital.

xii. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

xiii. The facility records related to the resident contained no documented reassessment for fall risk. There was also no documentation of an updated health assessment following the resident's multiple falls.

e. Resident number twenty (20):

i. On April 22, 2021, the resident fell and suffered a hematoma to the head.

ii. The resident's health assessment, Form 1823, dated August 17, 2020, included a history of muscle weakness and impaired mobility. The resident required no precautions and needed assistance with ambulation, bathing, dressing, self-care, toileting, and transferring.

iii. The resident's hospital record, dated April 22, 2021, noted, "patient states [] was getting off the toilet, reaching for [] wheelchair, when [] fell, falling onto [] side, hitting the back of [] head, patient endorses pain in the head, posteriorly, vertex. The patient also endorses right- hand pain as well as pain in [] neck, back, low back, sides, and left shoulder."

iv. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

v. Respondent had not assessed the resident for risk of falls. Respondent's director of nursing confirmed that the facility did not reassess residents but instead used what was indicated on the resident's health assessment.

f. Resident number two (2):

i. The resident's health assessment, Form 1823, dated January 22, 2020, indicated medical diagnoses including dementia with behavioral disturbance.

ii. The resident, who resided on the memory care unit, sustained a hip fracture on May 10, 2021, after wandering into another resident's room and was pushed by that resident. Staff confirmed that the resident was always confused and walked into other residents' room believing it to be the resident's room.

iii. A progress note indicated "resident found upon rounds on the hallway floor in memory care in a sitting position. The resident asked why [] is sitting on the floor. The resident stated another resident pushed

[the resident]. Upon assessment, the resident was not able to get up. 911 called resident transported to [hospital]."

iv. When asked about the incident with the resident, Respondent's director of nursing stated that the other resident who pushed the resident was educated on the need to get assistance from staff instead of confronting residents.

v. The resident's record lacked any documentation of an investigation into the incident surrounding the resident's fall and resulting fractured hip. Beside speaking to the other resident, Respondent neither considered nor implemented any interventions to prevent further falls by the resident.

vi. There is no indication that Respondent either considered or implemented any interventions to prevent residents from wandering into other residents' rooms.

g. Resident number eighteen (18:)

i. The resident sustained a lumbar fracture on May 16, 2021. The facility's incident report stated staff observed the resident attempting to sit down and lost balance. The resident was offered to be taken to the hospital but refused.

ii. The following day, May 17, 2021, the resident complained of back pain and was transferred to the hospital. The resident was diagnosed with a fractured lumbar.

iii. The resident's health assessment, Form 1823, dated August 10, 2020, included medical diagnoses and a history of advanced dementia, diabetes type 2, hypertension, muscle weakness, degenerative joint

disease, and unsteady gait. The resident required fall precautions and supervision with bathing and dressing.

iv. A review of resident number eighteen's record reflected the resident was under guardianship. The resident's guardian explained that "residents under the guardianship program are unable to make medical decisions." However, there was no documentation that the resident's guardian was contacted and notified of the fall that occurred the previous day.

v. There is no indication that Respondent either considered or implemented any interventions to prevent further falls by the resident.

vi. There is no indication that Respondent had instituted any fall precautions as identified on the resident's health assessment.

h. When asked if the Facility had any fall prevention policies in place, Respondent's administrator stated "No." The administrator explained that her consultant had not informed her of the need to have such a policy in place.

i. Facility records included a document that instructed staff what to do if a resident fell, and that was to leave the resident in place and call emergency services.

j. Resident number seventeen (17) overdosed twice at the facility within four (4) days in December 2020 and was found unresponsive.

i. A progress note for the resident dated December 9, 2020, revealed that on December 8, 2020, the resident was found in bed unresponsive, cardiopulmonary resuscitation was initiated, 911 was notified, and the resident was transported to the hospital.

ii. The resident's hospital record, dated December 8, 2020, noted the patient had a prior history of heroin abuse and presented to the Emergency department for overdose.

iii. It was later determined that resident number seventeen (17) and another resident left the facility on December 8, 2020, to seek heroin. After returning to the facility, resident number seventeen (17) went to another resident's bathroom and took the drug. The other resident called for assistance after resident number seventeen (17) passed out on the bed.

iv. A progress noted dated December 11, 2020, showed that the resident was lethargic and had an altered mental status. The resident was treated with Narcan at the facility but remained lethargic and unable to respond. The resident received continuous oxygen saturation and became more alert and oriented after a second oxygen treatment. Non-emergency was contacted for further evaluation.

k. The facility's policy and procedure regarding illegal and recreational drugs and alcohol provided that "no illegal or recreational drugs are allowed in the premises."

l. Respondent demonstrated no affirmative action regarding the illegal substance use at the facility.

m. There was no documentation that staff or residents were reeducated about the facility's policy and procedures regarding drug use, nor was there any training for staff to assist residents affected by substance abuse.

n. There was no documentation of an investigation of the two incidents of drug overdose.

o. Although resident number seventeen (17) was restricted from leaving the facility independently and sent to a drug rehabilitation center after the second overdose, there were no additional preventive measures implemented to prevent a subsequent drug overdose after the December 8, 2020, event.

p. There were no incident reports regarding resident number seventeen's drug overdoses. The Administrator stated that Adverse Incident Reports (AIRs) were not filed if the incident could be prevented.

q. The above recited findings resulted from survey activity by Agency personnel ending on June 7, 2021.

r. On June 7, 2021, prior to exiting the facility, Respondent's administrator was informed of the Agency's concerns related to Respondent's failure to create, implement, or provide fall prevention precautions, and Respondent's failure to weigh or implement resident specific interventions after a resident suffers from a fall or experiences a drug overdose.

s. The Agency returned to Respondent's facility on July 2, 2021, and makes the following findings related to the July 2, 2021, survey.

t. Resident number (20):

i. This resident suffered falls and injury as identified above.

ii. The resident suffered a fall on June 28, 2021 but did not notify Respondent's staff until June 29, 2021.

iii. The resident was hospitalized and remains hospitalization as of July 2, 2021.

u. Respondent's administrator, when asked on July 2, 2021, of what steps Respondent had undertaken to address resident fall precautions or monitoring residents

for illicit substance abuse, candidly admitted that Respondent had undertaken no action to assess or address either of these issues.

NECESSITY FOR EMERGENCY ACTION

11. 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. (2021), Ch. 408, Part II, Fla. Stat. (2021); 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.

12. 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. (2021); 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).

13. 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.

14. In this instance, Respondent has demonstrated a failure to ensure that it can provide a safe and decent living environment, free from abuse and neglect, and to provide care and services appropriate to resident needs.

15. Respondent has not been able to demonstrate its compliance with these regulatory provisions.

16. Respondent knew or should have known that residents required precautions related to falls for several residents. The residents' health care providers had specifically identified in the resident health assessment, Form 1823, that the residents required fall precaution. Despite this, Respondent has not demonstrated any action to devise and implement a falls prevention protocol or program to address known resident care needs.

17. Respondent knew or should have known, that specific residents of the facility suffered multiple falls over a brief period of time. Despite this, Respondent has not demonstrated any action, active or passive, to devise and implement interventions to minimize the risk that these residents suffer further episodes of falls.

18. Respondent knew or should have known, that a resident obtained and utilized illicit substances resulting in the resident's overdose and resulting emergency treatment. Despite this, Respondent has not demonstrated any action, active or passive, to devise and implement interventions to minimize the risk that residents possess illicit substances within the facility's confines, to educate residents or staff on facility policies regarding the possession of illicit substances, or to weigh and implement resident specific interventions to address the known and exhibited behavior of a resident who suffered an illicit substance overdose.

19. In each of the above resident identified scenarios, Respondent undertook no interventions. In each of the above resident identified scenarios, the resident quickly thereafter suffered the same of similar event, most resulting in further resident negative impact.

20. Not only did Respondent have actual knowledge of the falls and illicit drug abuse within the facility prior to the Agency's initial survey activity ending June 7, 2021, Respondent was specifically told of the deficient practice identified by the Agency related to resident care, services, and supervision on June 7, 2021.

21. Respondent, armed with this the knowledge of this identified failure to provide

care and services appropriate to meet resident needs, consciously chose to undertake no corrective action. Two (2) weeks later, a resident whose fall history was specifically identified by the Agency, suffered yet another fall resulting in the resident's hospitalization, a status that remains up to and including today.

22. While it is unknown which if any falls may be prevented, Florida law requires assisted living facilities to provide care and services appropriate to resident needs, including supervision, to those entrusted to the assisted living facility's care.

23. Respondent has demonstrated either the inability or unwillingness to weigh or implement action directed to the prevention of falls or minimizing the risk of illicit substance abuse among its residents known to Respondent to be at risk.

24. The failures above discussed are not isolated events but constitute a systemic failure of Respondent to assure that resident care and services are being provided to its resident census in accordance with the minimum standards of law. These failures present an immediate risk to residents of the Facility and present risks that abuse or neglect may occur. Respondent is aware of these conditions. Respondent may not ignore a known danger to the detriment of those persons to whom Respondent has undertaken the responsibility for their safety and well-being.

25. These facts demonstrate 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 known fall risk service needs are not provided, 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.

26. Repondent has demonstrated no understanding of its requirement to provide care and services appropriayte to resident needs where risk of falls or illicit substance abuse are presented. 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.

27. These deficient practices have occurred over time and affect each of Respondent's resident census. Respondent has demonstrated, through its lack of attention to these regulatory minimum standards 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.

28. These multiple failures resulted 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. (2021), 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. (2021). "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. (2021).

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. (2021), and to receive care and services, including supervision, appropriate to meet their needs, Fla. Admin. Code R. 59A-36.007(1).

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 minimum 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 (2021), at the time that such action is taken.

ORDERED in Tallahassee, Florida, this 2nd day of July 2021.

Kimberly R. Smoak, Deputy 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.