STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No. 2015003658

BRISTOL COURT MANAGEMENT LLC d/b/a BRISTOL COURT ASSISTED LIVING,

Respondent.
_____/

FINAL ORDER

Having reviewed the Administrative Complaint, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The Election of Rights form advised of the right to an administrative hearing. The Respondent received the Administrative Complaint and Election of Rights form (Ex. 2), but did not timely file the Election of Rights form or other hearing request with the Agency Clerk. The Respondent thus waived the right to a hearing to contest the allegations and sanction sought in the Administrative Complaint. Cann v. Department of Children and Family Services, 813 So.2d 237 (Fla. 2d DCA 2002).

Based upon the foregoing, it is **ORDERED:**

2. The findings of fact and conclusions of law set forth in the Administrative Complaint are adopted and incorporated by reference into this Final Order.

3. The Respondent shall pay the Agency $1,500.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

Central Intake Unit
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 61
Tallahassee, Florida 32308

ORDERED at Tallahassee, Florida, on this 1 day of September, 2015.

Elizabeth Dudek, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 1st day of September, 2015.

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Thomas J. Walsh II, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Prem Shah Registered Agent and Administrator Bristol Court Management LLC 3479 54th Avenue North St. Petersburg, Florida 33714 (U.S. Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA No. 2015003658

BRISTOL COURT MANAGEMENT LLC d/b/a
BRISTOL COURT ASSISTED LIVING,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), by and through its undersigned counsel, and files this Administrative Complaint against the Respondent, Bristol Court Management LLC d/b/a Bristol Court Assisted Living ("Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2014), and alleges:

NATURE OF THE ACTION

This is an action against an assisted living facility to impose an administrative fine in the amount of one thousand five hundred dollars ($1,500.00) based upon three (3) uncorrected Class III deficiencies.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 20.42, 120.60, and Chapters 408, Part II, and 429, Part I, Florida Statutes (2014).

2. Venue lies pursuant to Florida Administrative Code R. 28-106.207.

EXHIBIT

"1"

PARTIES

3. The Agency is the regulatory authority responsible for licensure of assisted living facilities and enforcement of all applicable federal regulations, state statutes and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code, respectively.

4. Respondent is licensed as a one hundred fifteen (115) bed assisted living facility ("the Facility"), license number 11970, located at 3479 54th Avenue North, St. Petersburg, Florida 33714.

5. Respondent was at all times material hereto a licensed facility under the licensing authority of the Agency, and was required to comply with all applicable rules and statutes.

COUNT I

6. The Agency re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. That Florida law provides:

> An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.
> (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:
> (a) Monitor 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 individual.
> (c) 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; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
> (e) A written record, updated as needed, of any significant changes as defined in

subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.
Rule 58A-5.0182(1), Florida Administrative Code.

8. That on January 30, 2015, the Agency completed a complaint survey of Respondent's facility.

9. That based upon the review of records and interview, Respondent failed to ensure that it provided care and services, including personal supervision, appropriate to the needs of residents including, inter alia, the failure to supervise residents in Respondent's outside courtyard area including smoking residents, the same being contrary to the mandates of law.

10. That Petitioner's representative reviewed Respondent's footage from a closed circuit security camera encompassing the facility's courtyard area which reflected the following commencing at 7:20 A.M. on January 8, 2015:

a. Resident number four (4) was walking toward the resident's garden area in the courtyard when resident number four (4) saw resident number seventeen (17) walking toward resident number four (4).

b. There was an exchange of words as resident number seventeen (17) got closer.

c. The residents stopped and there were a few words exchanged and then resident number four (4) swung at resident number seventeen (17) and missed.

d. Resident number seventeen (17) reacted by hitting back and then threw resident number four (4) on the ground and kept beating on the resident.

e. When resident number seventeen (17) finally stopped and got off resident number four (4), the fight lasted about forty-five (45) seconds.

f. Another resident was seen coming back into the facility who must have called the staff because three (3) staff members, all from the first floor, showed up and kept the two residents separated.

g. Resident number seventeen (17) came back towards resident number four (4) who had gotten up off the ground.

h. There was no staff present on the video until the third resident came and got the staff members.

11. That Petitioner's representative reviewed Respondent's records related to resident number four (4) during the survey and noted as follows:

a. The resident's health assessment documented:

i. Diagnoses were dementia, bilateral knee replacement done in 2005 and 2008, left eye injury (accident in 1975), HTN, hearing aid (left & right) and osteoarthritis.

ii. The resident needed assistance with all activities of daily living and needed assistance with medication.

b. The resident was admitted to the facility on April 20, 2013, and discharged on September 10, 2014 to an adult child's home.

c. The medical record and hospital records of January 8, 2015 reflect:

i. The resident went to the hospital at 8:30 A.M.

ii. The resident was assaulted at the respondent facility and brought to the emergency room via ambulance.

iii. The resident indicated to hospital staff that the resident was defending the resident's garden.

iv. The resident was documented as having multiple lacerations on the face and hands. Two of the facial lacerations required sutures; the lower lip and left temple.

v. A facial CT was done with no acute fractures.

vi. The final diagnoses were: Assault, head injury, lip laceration, abrasions, shin tears and facial lacerations.

vii. The resident was discharged back to the Respondent facility on September 8, 2014 at 12:30 P.M.

12. That Petitioner's representative reviewed Respondent's records related to resident number seventeen (17) during the survey and noted as follows:

a. The resident's health assessment documented:

i. Diagnoses were CAD, memory loss, COPD, tobacco dependent, stroke and seizure disorder.

ii. The resident needs assistance with all activities of daily living and medications.

iii. The resident was alert and oriented times three (3) and a fall risk.

b. The resident lives on the second floor where the lower functioning residents reside.

c. The resident was admitted to the facility on May 20, 2014, and discharged from the facility on September 22, 2014.

13. That Respondent's staff members who came out to help after the resident fight was over on January 8, 2015 were staff members "C,", "F," and "G." Staff members "F" and "G" are no longer employed by Respondent.

14. That Petitioner's representative interviewed Respondent's staff member "C" on January 30, 2015, regarding the January 8, 2015 event, and the staff member indicated as follows:

a. The fight happened early in the morning around 7:20 am.

b. "That is the time we are all very busy getting the residents ready for breakfast. We don't have enough time to be outside watching the residents smoke. We are told to check on the residents every two hours but I try to get out there at least every hour. I just do a quick look before going back inside. Any of the residents can go outside to smoke even the ones from the second story. The residents on the first floor are pretty high functioning and the ones on the second floor are lower functioning. They are all out there together when they smoke or just want to go outside."

15. That Petitioner's representative observed the smoking patio courtyard on January 30, 2015 at 9:30 A.M. and noted that there was no staff present though there were residents outside in the gazebo smoking.

16. That Petitioner's representative observed the smoking patio courtyard on January 30, 2015 at 3:00 P.M. and noted that there was no staff present though there were residents observed walking to and from the gazebo in the courtyard area.

17. That Petitioner's representative interviewed resident number two (2) on January 30, 2015 at 4:40 P.M. who stated there are fights there all the time, inside and outside; it doesn't make any difference. No one watches residents, especially outside.

18. That Petitioner's representative observed on January 30, 2015 at 2:08 P.M. resident number nine (9) carrying around a container of wiping cloths used for resident peri care on the east side of the building, second floor, with no facility staff supervising the resident's activity.

The resident had apparently taken the wipes out of a supply area and the direct care staff had to talk him into giving them back to her.

19. That Respondent's facility has a census of ninety-eight (98) on January 30, 2015 consisting of residents suffering from Alzheimer's and dementia well as limited mental health residents.

20. That all residents are allowed to be outside in the courtyard smoking or just walking around and the residents are unsupervised while in the courtyard.

21. That by the time staff got outside to stop the fight between residents numbered four (4) and seventeen (17) on January 8, 2015, resident number four (4) already had multiple contusions.

22. That Petitioner's representative telephonically interviewed Respondent's administrator on February 2, 2015 at 2:00 P.M. who stated:

a. We have the staff check on the residents at least every two hours inside and outside.

b. We try to know what they are doing but that doesn't always happen.

c. We do have a camera outside and we try to monitor it during the day.

d. We are going to have to try and figure a way to better supervise the residents outside.

23. That the above reflects Respondent's failure to ensure that it provided care and services, including personal supervision, appropriate to the needs of residents including, inter alia, the failure to supervise the outside courtyard area and residents who smoke.

24. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

25. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2013), and Respondent was cited with a Class III deficient practice.

26. That Respondent was given a mandatory date of March 10, 2015.

27. That on March 13, 2015, the Agency completed a follow-up to the January complaint survey of Respondent's facility.

28. That based upon the review of records and interview, Respondent failed to ensure that it provided care and services, including personal supervision, appropriate to the needs of residents including, inter alia, the failure to supervise residents in Respondent's outside courtyard area including smoking residents, the same being contrary to the mandates of law.

29. That Petitioner's representative interviewed Respondent's administrator on March 13, 2015 at 10:25 A.M. who indicated as follows:

a. He confirmed there was no specific correction mentioned in plan of correction related to proper daily resident supervision, as related to the assault of an unsupervised resident out on the patio at the facility in January.

b. In regards to residents being supervised on the 2nd and 1st floors, "Residents are separate to the best of my ability."

c. The facility has one person who is responsible to take residents down in groups, three or four times (trips), to take them to smoke. The aide is with them while they smoke.

d. This process three (3) weeks prior; the first week of February and the residents on the second floor seem to be okay with it.

e. The first floor is happier about the change.

f. The second floor are the Dementia residents with some dementia on the 1st floor.

g. "Residents can leave when they want to unless we feel like it is not in their best interest not to leave; we won't allow them."

h. This is deemed by the Administrator, family and doctor.

i. It is his expectation that the residents are checked on every fifteen (15) to thirty (30) minutes by direct care staff.

30. That Petitioner's representative observed the smoking patio several times during the survey and interacted with residents, noting the following:

a. March 13, 2015 at 3:15 P.M.

i. Multiple residents were outside on the smoking patio at this time.

ii. Resident number two (2), a resident on the smoking patio, indicated that the resident had been at the facility for one (1) year, comes outside to smoke twice a day, and facility staff are never present when residents are out smoking.

iii. Resident number three (3), a resident on the smoking patio, indicated that the resident had been at the facility for two (2) years, the resident comes out to smoke several times a day, and the resident is never accompanied by staff when outside smoking. The resident further indicated the resident cannot leave the facility at all; "They won't let me leave, and I don't know why I can't leave."

iv. Resident number four (4), a resident on the smoking patio, indicated that the resident had been at the facility for two (2) years now, can leave the facility when the resident wants to, and comes out to smoke at different times of the day whenever the resident wants to, but "Staff

is not always out here with us."

b. March 13, 2015 at 11:10 A.M. - Eight (8) residents were observed at this time with no facility staff member present or in sight.

c. March 13, 2015 at 12:56 P.M. – Twelve (12) residents were observed at this time with no facility staff member present or in sight.

d. March 13, 2015 at 2:08 P.M. – Ten (10) residents were observed at this time with no facility staff member present or in sight.

31. That Petitioner's representative interviewed Respondent's staff member "C" during the survey who indicated as follows:

a. She has been working at the facility for a while now.

b. A lot of the residents are upset on the second floor because they can no longer come down to smoke as often.

c. She does always supervise the residents while on the smoking patio.

d. She thinks a staff member is supposed to be out on the patio with residents when they are smoking, however that doesn't happen all the time.

32. That the above reflects Respondent's failure to ensure that it provided care and services, including personal supervision, appropriate to the needs of residents including, inter alia, the failure to supervise the outside courtyard area and residents who smoke.

33. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

34. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2013), and Respondent was cited with a Class III deficient practice.

35. That the same constitutes an uncorrected Class III deficiency as defined by law.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(c), Florida Statutes (2014).

COUNT II

36. The Agency re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

37. That Florida law provides

> Assistance with self-administration of medication includes:
> (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.
> (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
> (c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.
> (d) Applying topical medications.
> (e) Returning the medication container to proper storage.
> (f) Keeping a record of when a resident receives assistance with self-administration under this section.
> § 429.256(3), Florida Statutes (2014).

38. That Florida law provides:

> (3) ASSISTANCE WITH SELF-ADMINISTRATION.
> (a) Any unlicensed person providing assistance with self administration of medication must be 18 years of age or older, trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.
> (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed.
> (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also

return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
Rule 58A-5.0185(a through d), Florida Administrative Code.

39. That on January 30, 2015, the Agency completed a complaint survey of Respondent's facility.

40. That based upon observation and interview, Respondent failed to ensure that the assistance with self-administration of medications met the minimum requirements of law.

41. That Petitioner's representative observed Respondent's staff member "E" assisting with self-administration of medication during the survey on the first floor east wing and noted as follows:

a. A medication technician, staff member "E," was observed with two (2) medication cups in her hand, one inside the other, and in her other hand, a glass of water.

b. She gave one cup to a resident, placing it in the resident's hand while the resident was seated in the hallway.

c. This left one medicine cup in the staff member's hand.

d. The staff member encouraged the resident to take the pills, handing the resident the glass of water she had in her other hand. "Here's your water, drink up," she said.

e. The resident then took the pill cup and then drank the water she had handed him.

f. Staff member "E" then walked over to the medication cart inside the nurse's station and placed the remaining medication cup in the top drawer of the cart.

g. Staff member "E" was asked why she didn't give the other cup to the resident and she stated that it wasn't for that resident and the resident it was intended for was not close by anyway.

42. That Petitioner's representative reviewed Respondent's personnel records during the survey and noted that staff member "E" had successfully completed the required the four (4) hour medication training course and was up to date on her training.

43. That the above reflects Respondent's failure to ensure that assistance with self-administration of medications was performed within minimum requirements of law including, but not limited to, not telling the resident what the medications were for, letting the resident see the medication card, and putting another resident's medication in a cup and placing it in the top drawer of the medication cart to wait for the resident to come and get it.

44. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

45. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2013), and Respondent was cited with a Class III deficient practice.

46. That Respondent was given a mandatory date of March 10, 2015.

47. That on March 13, 2015, the Agency completed a follow-up to the January complaint survey of Respondent's facility.

48. That based upon observation and interview, Respondent failed to ensure that the assistance with self-administration of medications met the minimum requirements of law.

49. That Petitioner's representative observed Respondent's staff member "H" assisting with self-administration of medication on March 13, 2013, at 1:45 P.M. on the One West Nurses

Station and noted as follows:

a. Staff member "H" was wearing a glove on her right hand over an ace bandage.

b. She did not change the glove, wash her hands or use hand sanitizer prior to unlocking the medication cart and preparing medication for the observation of the medication pass.

c. Staff member "H" had the single unit dosing cards in the left hand, pushing the pill on one side of the bubble card with her thumb and picking it out with her fingers on the back side of the card with her gloved right hand and placed it in a small medication cup directly in front of her on the nurse's desk.

d. She did this with four pills.

e. She placed it in the resident's hand, encouraging the resident to "Take your medicine."

f. Staff member "H" picked up a pen with her gloved hand, signed out the narcotic in the narcotic book and with the pen still in her hand, and continued to pour the medication for the next resident.

g. While speaking to another resident, she rubbed her forehead with the gloved hand.

h. After the second resident, staff member "H" used the sanitizer on just her finger tips, with that same glove on and stated "Oops."

50. That Petitioner's representative interviewed Respondent's administrator on March 13, 2015, at 4:50 p.m., and, when he was informed of the above events, he stated he would look into that.

51. That Respondent's director of nurses was unavailable for interview.

52. That Petitioner's representative reviewed Respondent's Infection Control Policy and

Procedure, undated, and noted it provided "POLICY - wash hands or use hand sanitizing gel before assisting the 1st resident and after assisting every resident."

53. That Petitioner's representative reviewed Respondent's personnel records during the survey and noted that a certificate of completion for the Medication Technician Class dated September 17, 2014 for staff member "H."

54. That the above reflects Respondent's failure to ensure that the assistance with self-administration of medications met the minimum requirements of law including but not limited to the failure to follow Respondent's policies and procedures, the failure to identify medications, and the failure to assure medications individually prepared.

55. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

56. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2013), and Respondent was cited with a Class III deficient practice.

57. That the same constitutes an uncorrected Class III deficiency as defined by law.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(c), Florida Statutes (2014).

COUNT III

58. The Agency re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

59. That Florida law provides:

> (1) 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) Live in a safe and decent living environment, free from abuse and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
Section 429.28(1)(a), Florida Statutes (2014).

60. That Florida law provides that all facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. Rule 58A-5.0182(c), Florida Administrative Code.

61. That on January 30, 2015, the Agency completed a complaint survey of Respondent's facility.

62. That based upon the review of records and interview, Respondent failed to ensure that it provided a safe and decent living environment, free of hazards and with existing architectural, mechanical, electrical and structuring systems and appurtenances maintained in good working order, including but not limited to a known infestation of bed bugs, the same being contrary to the mandates of law.

63. That based upon the review of records and interview, Respondent failed to ensure that it provided a safe and decent living environment, free of hazards and with existing architectural, mechanical, electrical and structuring systems and appurtenances maintained in good working order, including but not limited to a known infestation of bed bugs, the same being contrary to the mandates of law.

64. That since the Respondent facility has failed to provide the residents with a clean and decent living environment; this has directly threatened the physical and emotional health of the residents living at the facility.

65. That Petitioner's representative telephonically interviewed on February 2, 2015 at 10:00 AM an environmental supervisor of the local Department of Health who indicated as follows:

a. He confirmed the Respondent facility has had an ongoing problem with bedbugs.

b. The Department has recommended that the facility contract with a professional pest company.

c. Bedbugs are in the facility walls and they move from room to room.

d. Spraying is not an effective treatment at this time.

66. That Petitioner's representative reviewed documentation from the local Department of Health during the survey and noted as follows:

a. An electronic mail dated February 4, 2015, from the Environmental Supervisor II from the local Department of Health stated when she looked back at the complaint log and at past inspections, she confirmed that the complaints for bedbugs have been ongoing since September 2013.

b. The most recent inspection dated February 4, 2015, confirmed the facility still had an infestation of bed bugs and there were recommendations and suggestions for treatments.

c. The last Health Department inspection report for the facility, dated January 13, 2015, was "Unsatisfactory," and further documenting:

i. Violation number twenty-seven (27), "Infestation/Presence" was noted.

ii. The Health Department documented observation of live infestation and recommended the facility use a professional service to treat the entire second floor.

iii. The report directed the facility to correct the following: "[t]reat, clean, and sanitize all floors, walls, clothing, furniture, and bedding in the rooms. Observed live bed bugs in rooms indicated. Professional services are recommended. Clean and sanitize rooms. Especially along walls. Observed, dead bugs in rooms indicated."

67. That Petitioner's representative reviewed Respondent[s pest control service invoices and noted the last invoice from Orkin Pest Company, dated January 29, 2015, reflects treatment of only the three (3) rooms listed on the health departments report; rooms two hundred four (204), two hundred twenty-one (221), and two hundred seven (207).

68. That Petitioner's representative interviewed on January 30, 2015 at 2:00 PM Respondent's assistant administrator who indicated as follows:

a. He had treated the rest of the rooms.

b. The reason he does the treatment for most of the rooms is because he does a better job.

c. He treats the residents' rooms and furniture and has even had to throw away some residents' clothes.

d. He buys products from the store and sprays the rooms.

e. He uses a powder that is sold over the counter to kill bedbugs and treats wall plugs and light fixtures in the residents' rooms.

f. He knows the products available are not as powerful as what the professionals use, but they have been able to help reduce the bedbug problem.

69. That Petitioner's representative interviewed and interacted with on January 30, 2015 at 11:30 AM resident number eleven (11), an alert and oriented individual, and noted as follows:

a. There were sheets with small black bugs and spots of dried blood observed on the resident's bed (photo taken).

b. The resident thought the rash was a result of an allergic reaction from medication the resident had been taking.

c. During the interview, the resident would not allow the nurse surveyor to look at or photograph the rash on the resident's back.

70. That Petitioner's representative interviewed on January 30, 2015 at 11:30 AM resident number ten (10), an alert and oriented individual, who indicated as follows:

a. The resident had been treated for bedbugs and head lice.

b. The facility had even thrown away some of the resident's roommate's clothes.

c. The resident stated the bugs keep coming back.

71. That Petitioner's representative interviewed and interacted with on January 30, 2015 at 3:00 PAM resident number eight (8), an alert and oriented individual, and noted as follows:

a. The resident had bites all over the resident's torso and left elbow.

b. The resident allowed a nurse with the survey team to take a photograph.

c. There were red raised areas that appeared to be similar to insect bites, with scratch marks where the resident had been scratching.

d. The resident stated the staff knew about the rash, but were not doing anything about it.

72. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted that the resident went to a local hospital for multiple bedbug bites to the back and the hospital gave the resident hydroxyzine to control the itching because an infection can develop if the bite is scratched and the skin is broken.

73. That Petitioner's representative interviewed on January 30, 2015 at 5:45 PM resident number one (1), an alert and oriented individual, who indicated that the bedbugs are still in the facility; "I don't think they will ever go away."

74. That Petitioner's representative reviewed Respondent's records related to resident number two (2) during the survey and noted:

a. The resident was sent to the hospital on July 31, 2014, after complaining of a rash.

b. The resident told the emergency room doctor the resident had been seen by a dermatologist after living at the facility a couple of days.

c. The dermatologist told the resident the rash was from bedbugs.

d. The hospital documentation identified the cause was possible bed bugs.

75. That Petitioner's representative interviewed on January 30, 2015 at 12:40 PM resident number two (2), an alert and oriented individual, who indicated as follows:

a. The resident had concerns related to bed bugs from a few months back in July, 2014.

b. The resident went to the hospital and was treated for bedbug bites.

c. The resident received treatment, again, on November 26, 2014, at a local hospital for bed bug bites.

d. The resident had recently seen bed bugs in multiple resident rooms.

76. That Petitioner's representative interviewed on January 30, 2015 at 12:40 PM Respondent's staff member "A" who indicated as follows:

a. She had been employed at the facility for a couple months and worked from 7:00 A.M. to 3:00 P.M. Monday through Friday showering the residents.

b. The residents have complained of bed bugs and head lice.

c. She had been applying medication to the residents, but, it seems the problem kept coming back.

d. She confirmed some of the residents had rashes and head lice.

e. Lots of residents have expressed to her that they have bed bugs in their bed and room area and they are being bitten at night.

f. "I have seen them myself crawling around resident room."

g. In November 2014, resident number two (2) had a really bad rash on the back and shoulder areas which she believed were from bed bugs, and she related this information to management.

h. Until the bedbugs are completely gone, she will continue to use a body oil that prevents the bedbugs from biting her.

i. "I haven't been bitten yet."

j. Resident number eleven (11) is a resident she had recently treated for head lice and the resident also had a rash on the torso.

77. That the above reflects Respondent's failure to ensure a safe and decent living environment, free of hazards and with existing architectural, mechanical, electrical and structuring systems and appurtenances maintained in good working order including but not limited to the failure to ensure the effective eradication of a known infestation of bed bugs over an extended period of time despite demonstrated failure of current eradication techniques, the failure to follow treatment advise of the health authority with jurisdiction, and the failure to engage professional extermination services to perform services necessary to address the infestation.

78. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of a provider or to the care of clients which directly threatens the physical or emotional health, safety, or security of the clients, other than class I violations.

79. That the same constitutes a Class II offense as defined by law, Section 408.813(2)(b), Florida Statutes (2014).

80. That Respondent admitted the allegations of paragraphs eighty-two (82) through one hundred (100) in Agency case number 2015001821.

81. That Respondent was given a mandatory date of March 10, 2015.

82. That on March 13, 2015, the Agency completed a follow-up to the January complaint survey of Respondent's facility.

83. That based upon the review of records and interview, Respondent failed to ensure that it provided a safe and decent living environment, and residents treated with respect and dignity, including but not limited to a known infestation of head lice and the treatment modalities utilized for residents.

84. That Petitioner's representative noted during a tour of the Respondent facility on March 13, 2015, that seated in various places within the facility were five (5) female residents with hair approximately one inch long.

85. That Petitioner's representative interviewed Respondent's staff member "H" regarding resident number thirteen (13) and the staff member indicated:

a. The resident had lice and shaving the head was treatment for that.

b. "They did it to others too, to get rid of the lice. But that's O.K., right? I mean [the resident] doesn't know..."

86. That Petitioner's representative interviewed Respondent's administrator regarding

residents with shaved heads and the administrator indicated:

a. When asked why the heads were shaved, he stated that that was what they had to do.

b. They couldn't get rid of the lice.

c. When asked whose decision it was to shave heads for lice treatment, he stated the assistant administrator.

d. When asked how many heads were shaved, he replied, "Two, I think."

87. That Petitioner's representative telephonically interviewed Respondent's assistant administrator during the survey who indicated as follows:

a. That's the only way we could get rid of the lice.

b. Some of these people were treated multiple times, and we just couldn't get rid of it.

c. He was the one who decided to shave the heads, and he performed the act.

d. He was not a barber but he's shaved others heads in the past and felt comfortable doing it.

e. There were around seven (7) residents heads that were shaved, four (4) women and three (3) men.

88. That according to the Centers for Disease Control (CDC) guidelines for treating lice, shaving one's head is not listed as a treatment. The CDC recommends several over the counter and prescription medications for use. Shampooing the head once and again in a week, using the fine comb, to comb out the nits (head lice eggs) will suffice.

89. That Petitioner's representative interviewed the power of attorney for resident number thirteen (13) on March 13, 2015 at 2:30 P.M. who indicated as follows:

a. She gave permission to have the resident's hair cut, but if she had known they were going to shave the resident's head, she would have declined that.

b. "I can't think of a medical condition where you would have to have your head shaved."

c. When asked who she spoke to on the telephone, she stated that it was either the assistant administrator or administrator, she was not sure, who called her and told her that the resident had been treated a couple of times and they couldn't get rid of them.

90. That Petitioner's representative reviewed Respondent's records related to resident number thirteen (13) during the survey and noted as follows:

a. In the resident's medical history and diagnosis, the first diagnosis listed is dementia; the resident's Physical or Sensory Limitation listed as confused; and Cognitive or Behavioral status was confused.

b. Section Two, Self-care, lists the resident needs assistance for handling personal affairs, handling financial affairs and making phone calls.

c. A progress note dated February 4, 2015 at 11:35 a.m. reads "I spoke to resident [adult child] regarding head lice. The resident has been treated but [] is now asking for a haircut to relive [] discomfort. The [adult child] stated this is ok," signed by Respondent's assistant administrator.

d. The notes do not reveal any treatment documentation for head lice.

91. That Petitioner's representative observed and interacted with resident number eighteen (18) and noted the resident's hair cut close to the scalp, approximately one inch long, and the resident was not capable of participating in an interview.

92. That Petitioner's representative interviewed Respondent's director of nurses regarding head lice in the facility and the director indicated as follows:

a. When asked how many residents were being treated for head lice, she stated two (2).

b. She provided a dermatology consult form for resident number nineteen (19), which reads diagnosis pediculosis capitus (head lice) and a Dermatitis. Treatment: Eliminate cream from neck to toes X 1 dose. Repeat in one week. Benzyl Alcohol 5% lotion apply to scalp & hair. Apply 12-24 oz every 7 days X 2 doses. Stromectol a mg by mouth one dose repeat in 10 days. Singed by the practitioner on February 25, 2015.

c. Also was a facsimile cover sheet dated March 3, 2015, for resident number eighteen (18) to the pharmacy for Nix- apply to washed hair, leave on 10 minutes. Rinse and comb out nits and lice. May repeat in 7 days if lice still present.

d. When asked if any staff had been infected, she stated no.

e. She stated that resident number eighteen (18) went to the dermatologist's office, and the resident's hair was full of knots and we couldn't get a brush through it.

93. The assistant administrator asked the resident if they could shave the resident's head, because the resident has no power of attorney or guardian; the resident's mental status is the resident does have dementia and makes own decisions.

94. That Petitioner's representative interviewed Respondent's consulting nurse who indicated that she herself had brought the lice home with her, and the director of nurses had given her a treatment of shampoo to bring home with her, which she used to treat herself at her home. She had to treat herself twice to get rid of the head lice.

95. That the above reflects Respondent's failure to ensure that it provided a safe and decent living environment, and residents treated with respect and dignity, including but not limited to a known infestation of head lice and the treatment modalities utilized for residents.

96. The Agency determined that this deficient practice was a condition or occurrence related to the operation and maintenance of the provider or to the care of clients which indirectly or potentially threaten the physical or emotional health, safety, or security of clients.

97. That the same constitutes a Class III offense as defined in Florida Statute 429.19(2)(c) (2013), and Respondent was cited with a Class III deficient practice.

98. That the same constitutes an uncorrected deficiency as defined by law.

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five hundred dollars ($500.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(c), Florida Statutes (2014).

Respectfully submitted this 5 day of May, 2015.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION

The Sebring Building
525 Mirror Lake Dr. N., Suite 330
St. Petersburg, Florida 33701
Telephone: (727) 552-1945
walsht@ahca.myflorida.com

By: _____
Thomas J. Walsh II, Esq.
Fla. Bar No. 566365

NOTICE

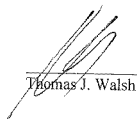
The Respondent is notified that it/he/she has the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If the Respondent wants to hire an attorney, it/he/she has the right to be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights form.

The Respondent is further notified if the Election of Rights form is not received by the Agency for Health Care Administration within twenty-one (21) days of the receipt of this Administrative Complaint, a final order will be entered.

The Election of Rights form shall be made to the Agency for Health Care Administration and delivered to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Mail Stop 3, Tallahassee, FL 32308; Telephone (850) 412-3630.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7011 0470 0000 4509 4101 on May 15, 2015 to Prem Shah, Registered Agent of and Administrator for Bristol Court Management LLC d/b/a Bristol Court Assisted Living, 3479 54th Avenue North, St. Petersburg, Florida 33714.



Thomas J. Walsh II

Copy furnished to:

Patricia R. Caufman, FOM

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: Bristol Court Management LLC
d/b/a Bristol Court Assisted Living

AHCA No: 2015003658

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed agency action by the Agency for Health Care Administration (AHCA). The title may be Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint. Your Election of Rights may be returned by mail or by facsimile transmission, **but must be filed within 21 days** of the day that you receive the attached proposed agency action. **If your Election of Rights with your selected option is not received by AHCA within 21 days of the day that you received this proposed agency action, you will have waived your right to contest the proposed agency action and a Final Order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your **Election of Rights** to this address:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308.
Telephone: 850-412-3630 Facsimile: 850-921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _____ I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint and I waive my right to object and to have a hearing. I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) _____ I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I wish to be heard at an informal proceeding (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

License Type: _____ (ALF? Nursing Home? Medical Equipment? Other Type?)

Licensee Name: _____ License Number: _____

Contact Person: _____ Title: _____

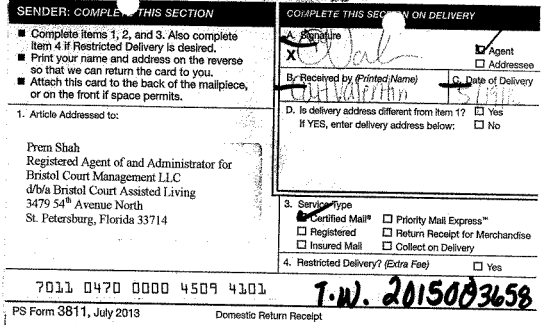
Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____ E-Mail (optional) _____

I hereby certify that I am duly authorized to submit this Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____ Date: _____

Print Name: _____ Title: _____



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Prem Shah
Registered Agent of and Administrator for
Bristol Court Management LLC
d/b/a Bristol Court Assisted Living
3479 54th Avenue North
St. Petersburg, Florida 33714

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☒ Agent
☐ Addressee

B. Received by (Printed Name)
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

7011 0470 0000 4509 4101

T.W. 20150803658

PS Form 3811, July 2013 Domestic Return Receipt

EXHIBIT

"2"