STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

LARKIN COMMUNITY HOSPITAL II, LLC, d/b/a FLORIDIAN GARDENS ASSISTED LIVING FACILITY,

Respondent.
_____/

AHCA No. 2016013816
License No. 12489
File No. 11968608
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 his 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. (2016), Ch. 58A-5, Fla. Admin. Code. As part of its statutory oversight responsibilities, the Agency has the authority to impose emergency orders, including a limitation of license, a moratorium on admissions and an emergency suspension order, when circumstances dictate such action. §§ 120.60(6), 408.814, Fla. Stat. (2016).

2. The Respondent, Larkin Community Hospital II, LLC d/b/a Floridian Gardens Assisted Living Facility (hereinafter "the Respondent"), operates a one hundred eighty (180) bed assisted living facility (hereinafter "Facility") located at 17250 Southwest 137th Avenue, Miami,

Florida 33177, and was at all material times required to comply with the applicable 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. (2016). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2016). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2016). § 408.803(11), Fla. Stat, (2016). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2016), and listed in Section 408.802, Florida Statutes (2016). § 408.802(13), Fla. Stat. (2016). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2016). 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 (2016), and Chapter 58A-5, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the census at the Respondent's Facility is one hundred forty-six (146) residents/clients.

THE AGENCY'S MORATORIUM AUTHORITY

6. The Agency may impose an immediate moratorium or emergency suspension as

defined in section 120.60, Florida Statutes (2016), 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. (2016). 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. (2016).

LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

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…" § 429.28(1), Fla. Stat. (2016).

8. Under Florida law, all assisted living facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), Florida Statutes. Fla. Admin. Code R. 58A-5.023(3)(a).

9. 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; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) Maintaining a written record, updated as needed, of any significant changes, any illnesses which resulted in medical attention, changes in the method of medication administration, or other changes which resulted in the provision of additional services. Fla. Admin. Code R. 58A-5.0182(1).

10. Under Florida law:

(3) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

Number of Residents	Staff Hours/Week
0-5	168
6-15	212
16- 25	253
26-35	294
36-45	335
46-55	375
56- 65	416
66-75	457
76-85	498
86-95	539

For every 20 residents over 95 add 42 staff hours per week.

Fla. Admin. Code R. 58A-5.019(3)(a)(1).

11. Under Florida law, notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. Fla. Admin. Code R. 58A-5.019(3)(b).

12. Under Florida law, 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. Rule 58A-5.019(1), Florida Administrative Code.

SURVEY OF THE RESPONDENT

13. On or about December 1, 2016, the Agency completed a survey of the Respondent's Facility.

14. Based upon this investigation, the Agency makes the following findings:

a. A male resident of the facility has diagnoses including hypertension, DMII, and hypercholesterolemia.

b. Two (2) of the Respondent's staff members and three (3) alert and oriented residents all report observing this male resident inappropriately touching and kissing female residents within the Facility.

c. The sibling of one of the female residents, who has been subject to this resident's inappropriate touching, informed the Respondent's previous administrator of the male resident's behavior. This same sibling reported this on-going inappropriate behavior to the Respondent's current administrator in both October and November, 2016.

d. The Respondent's administrator initially denied knowledge of the allegations regarding this male resident's inappropriate touching. When presented with a Facility internal incident report dated November 2, 2016, documenting the complaints of the female resident's adult child, the Respondent's administrator recalled the event. The administrator indicated that she did not believe the complaint constituted an allegation of

resident abuse or neglect.

e. The Respondent's administrator and staff have taken no action in response to their observations of inappropriate touching by one resident to other residents or the complaints of this resident's inappropriate touching of female residents.

f. This inappropriate touching was not recognized by the Respondent's administrator as an allegation of or abuse. The event was not immediately reported to Florida's Department of Children and Families, Adult Protective Services (hereinafter "APS"), no post-event assessment of the victim resident was conducted, and the Facility records contain no documentation of the event, other than the complaint voiced by the female resident's relative, a complaint which was not acted upon.

g. No consideration was demonstrated by the Respondent of the health and well-being of the male resident engaging in inappropriate behaviors or of the female residents who may be subject to such behaviors.[1] No progress notes of the complained of events or any assessment of the male or female residents involved are documented in the Respondent's records.

h. The Respondent's personnel are mandatory reporters of abuse and neglect under Florida law. *See*, § 415.1034, Fla. Stat. (2016).

i. The Respondent has no written policy and procedure on recognizing, reporting, or investigating abuse, neglect or exploitation. The Respondent has no system by which it receives and responds to allegations of resident abuse, neglect, or exploitation.

j. Chapter 415, Florida Statutes, defines abuse, neglect, and exploitation as follows:

(1) "Abuse" means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a

[1] During the latter part of the survey, the Respondent's administrator directed the male resident was to be monitored, however no means by which that monitoring was to be implemented by staff was described.

vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.

...

(16) "Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

§ 415.102(1, and 16), Fla. Stat. (2016).

k. Facility records reflect that all staff had been timely trained on resident rights in an assisted living facility and recognizing and reporting resident abuse, neglect, and exploitation. *See*, Rule 58A-5.0191(2)(c), Florida Administrative Code.

l. No member of Respondent's staff, including its administrator, reported the activities of the male resident, or the failure to provide protective or support services to the female residents subject to the male resident's advances, to the Florida Department of Children and Families, Adult Protective Services. *See generally*, Chapter 435, Florida Stateutes (2016).

m. Eight (8) residents, or over five percent (5%) of the Respondent's resident census, have suffered falls in the recent past. These falls are summarized as follows:

i. An eighty-eight (88) year old resident, who requires assistance in transferring, toileting, and self-care, has suffered a fall at least three (3) times. For each, the resident's spouse had to summon assistance from Facility staff.

ii. A ninety-seven (97) year old resident who utilizes a walker suffered a fall on October 5, 2016 at approximately 5:00 PM, and required transfer to a hospital

emergency room. This resident also suffered a fall on June 27, 2016, at 9:50 AM while attempting to get out of bed. The June fall was witnessed by, and reported by, the resident's roommate. As a result of the June 2016 fall, the resident suffered a laceration and contusion with soft tissue injury requiring four (4) staples.

iii. An eighty-four (84) year old resident was found in the bathroom at 3:50 AM on October 13, 2016, with wounds to the arms, leg, and "hit in the face," and required transfer to a hospital emergency room.

iv. A sixty-eight (68) year old resident was found on the floor on October 18, 2016, at 2:50 AM. The resident reports that a roommate came to the resident's aide as staff is not around and never seen at night. Records reflect the resident had suffered several falls within the past month. The Respondent's internal incident report regarding the October 18, 2016, fall reflects that staff located the resident after the fall.

v. A sixty-eight (68) year old resident fell from a wheel chair while attempting to turn the wheel chair on October 18, 2016, at 11:00 PM.

vi. An eighty-eight (88) year old resident had a health assessment, (also known as a "Form 1823"), a health care provider completed document describing the diagnoses and care requirements for residents of assisted living facilities, which required "Fall Precautions." On November 2, 2016, at 2:10 AM, the resident was found on the floor and required transfer to a hospital emergency room. Records reflect the resident was treated for multiple superficial skin avulsions of the left upper arm and forearm, and multiple contusions with a soft-tissue hematoma to the forehead and left periorbital area. The Respondent could not demonstrate that any fall precautions had been implemented to address the resident's needs either before or after the resident's November 2, 2016, fall.

Facility records also document this resident suffered a fall on June 8, 2016 when staff found the resident on the floor. This fall required transfer to a hospital emergency room for a hematoma to the right eye. The resident also suffered a fall on May 3, 2016. This May incident is documented by the Respondent in two (2) separate internal incident reports, one documenting the resident required transfer to a hospital emergency room and one documenting the resident was uninjured and required no medical attention.

vii. A sixty-eight (68) year old resident, also with a noted need for "Fall Precautions," fell on October 19, 2016, at 2:00 PM and required care from a hospital emergency department. This resident had also suffered a fall on July 7, 2016, when found on the bathroom floor at 8:35 PM by a family member of the resident's roommate. This fall also resulted in transfer to a hospital emergency department. The Respondent could not demonstrate any fall precautions which had been implemented to address the resident's needs either before or after the resident's falls.

viii. An eighty-three (83) year old resident, whose Form 1823 indicated the resident required twenty-four (24) hour nursing or psychiatric care, was found on November 4, 2016 at 1:40 AM with redness to the right side of the head and eye. These injuries required transfer to a hospital emergency room.

n. An eighty-five (85) year old resident is receiving Hospice services from a third party provider. As part of those services, an Interdisciplinary Care Plan,[2] entered into between the Hospice provider and the assisted living facility to address ongoing care needs to be performed by the separate providers, documented that the Respondent was to reposition the resident every three (3) hours. A Facility internal incident report dated October 21, 2016, documented that the resident had not gotten out of bed in three (3)

[2] *See*, Rule 58A-0181(4)(c), Florida Administrative Code.

days and had acquired red spots to the lower body. The licensed practical nurse completing this report, dated November 20, 2016, indicated that the Facility was understaffed with only three (3) certified nursing assistants on duty.

o. The Respondent did not file an adverse incident report, as required under Section 429.23, Florida Statutes (2016), in response of any of the incidents recited above.

p. The Respondent's staffing schedule, documenting the staffing patterns for the Facility, *see*, Rule 58A-5.019(3)(c), Florida Administrative Code, reflects the Respondent staffed the Facility with five hundred thirty-nine (539) hours of direct care staff for each week in the month of November, 2016. Based upon the resident census provided by the Respondent during these periods (one hundred forty-five (145) to one hundred fifty-two (152) residents), six hundred twenty-three (623) staffing hours are the minimum staff hours required by law. The Respondent's direct care staff hours were under minimum requirements by at least two (2) full time equivalent positions.

q. For three (3) of the four (4) weeks of November, the Respondent staffed the 9:00 PM to 7:00 AM shift on its South Wing, with a resident census of approximately eighty (80), with two (2) caregivers. The same number of staff, two (2), were available on this shift on the Facility's West Wing, housing approximately seventy (70) residents, with approximately seventeen (17) of those residents under Hospice care.

r. The Respondent has no written policy and procedure related to resident falls. The Respondent's internal incident reports related to resident falls routinely recite that the subject resident and staff were re-educated regarding safety and avoiding injury. The Respondent produced no documentation of the contents of such educational programs or the times, means, and educators who would provide such education.

s. Most of the above described incidents were memorialized in a Facility internal incident report. These reports do not reflect any investigation of the cause of the event, any assessment of the subject resident related to the need for further services, or any weighing or consideration of interventions to prevent recurrence other than the recitation of resident re-education on safety.

t. The Respondent's administrator could not identify any methodology by which the Respondent's internal incident reports were reviewed to identify whether any interventions, such as staff training or the implementation of new policy or procedure related to specific concerns, such as resident falls, could or should be considered.

15. On October 4, 2016, the Respondent was cited by the Agency for violations of minimum standards related to the provision of care and services appropriate to resident need, *see*, Rule 58A-5.0182(1), Florida Administrative Code, and the provision of adequate staffing, *see*, Rule 58A-5.019(3). Contemporaneous with this October survey, the Respondent was provided a directed plan of correction by the Agency, delineating interventions that the Respondent should take to address the Agency's immediate concerns as identified in the cited deficiencies. Among those interventions was the development and implementation of policies and procedures designed to ensure that adequate supervision to meet resident care and service needs would be met. In addition, the Respondent was directed to revise its staffing pattern to ensure that sufficient staffing to meet resident care and service needs would be met. The Respondent was directed to implement these corrective actions by November 7, 2016.

16. As of November 30, 2016, the Respondent has failed to adequately address these Agency identified issues.

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS

17. 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. (2016), Ch. 408, Part II, Fla. Stat. (2016); Ch. 58A-5, Fla. Admin. Code. In those instances, where the health, safety or welfare of an assisted living facility resident is at risk, the Agency will take prompt and appropriate action.

18. The residents of assisted living facilities enjoy a statutorily enacted Bill of Rights which mandates that assisted living facilities provide a safe and decent living environment, free from abuse and neglect and to treat residents with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. An assisted living facility must protect these resident rights. § 429.28, Fla. Stat. (2016); Fla. Admin. Code R. 58A-5.023(3)(a). The residents that 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.

19. In this instance, the Respondent has failed to ensure that these minimum requirements of law are being met. The residents are currently living in an environment where a systemic process to protect residents from abuse and neglect has not been devised and implemented. The residents are currently living in an environment where a systemic process to ensure the provision of care and services appropriate to resident needs has not been devised and implemented.

20. This extent of the Respondent's inability to understand, recognize, report, and

prevent abuse, neglect, and exploitation is vividly illustrated by the apparent conclusion by the Respondent's administrator that a male resident may engage in inappropriate touching of female residents. The Respondent has demonstrated a failure to consider any disease process or other causation for the male resident's behaviors, or the physical or emotional impact on female residents subject to such behaviors. The Respondent has failed to demonstrate an understanding of its obligation to ensure all residents of an assisted living facility must be protected from abuse, neglect, or exploitation, be the abuse be from affirmative actions of a fellow resident, or the facility's neglect to protect other residents from such advances.

21. No concept of a safe and decent living environment for residents of an assisted living facility encompasses that a resident would be subject to unwanted physical advances from fellow residents. No concept of care and services for residents of an assisted living facility includes the failure to address known inappropriate behaviors. No concept of care and services for residents of an assisted living facility includes the intentional or negligent infliction of emotional distress, embarrassment, and disrespect of female residents as demonstrated by this event.

22. The Respondent has also demonstrated an inability or unwillingness to provide care and services appropriate to meet resident needs.

23. The Respondent has actual knowledge of multiple falls experienced by residents, many requiring a higher level of care at hospitals as a result of the falls. The Respondent has actual knowledge that certain residents require "Fall Precautions" to ensure their health safety and well-being. Despite this knowledge, the Respondent has demonstrated no means or mechanism by which it provides any interventions to prevent falls, any analysis of the causation of resident falls, or any meaningful consideration or implementation of interventions which are

designed to minimize the risk of recurrence of resident falls. The Respondent has failed to recognize, and respond to, known negative incidents suffered by over five (5%) of its resident census.

24. Exacerbating these deficient practices, the Respondent has consistently failed to provide sufficient staffing. Florida law mandates a minimum number of hours for resident care givers on a weekly basis based upon the resident census. The Respondent has failed by at least two (2) full time equivalent positions to meet that standard for the month of November 2016. Minimum staffing hours of law do not, however, prescribe the staffing levels on any given shift.

25. Even a cursory reading of the above recited facts related to resident falls reflect that many occur during the night shift. The Respondent has implemented a staffing schedule that provides for an approximate one (1) staff to forty (40) resident ratio (1:40), despite its actual knowledge of residents experiencing injury causing falls during these hours.

26. The Respondent's staffing insufficiencies are such that the Respondent's licensed practical nurse notes in a Facility incident report this understaffing as a contributing factor for the Respondent's failure to ensure a Hospice patient received necessary care and services.

27. Residents are not provided a safe and decent living environment where these basic protections from abuse or neglect are not provided. Both the Respondent's administrator and at least two (2) direct care staff were aware of the inappropriate touching or behaviors exhibited by a male resident. All three (3) took no action. As such, the Respondent has demonstrated that these protections are not being provided within the Facility.

28. The administrator of an assisted living facility 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. *See*, Rule 58A-5.019(1), Florida Administrative Code. The Respondent's

administrator has clearly failed ensure its staff has provided care and services appropriate to resident needs.

29. The Respondent knew of multiple falls by residents. Despite this, the Respondent took no action or inadequate action to assess, evaluate, and respond to these falls in a manner designed to prevent recurrence or further injury. The Respondent knew or should have known that the health care provider for at least two (2) residents had prescribed the residents be subject to fall precautions. The Respondent took no action to devise or implement such precautions, either before or after these residents had experienced the very falls which such precautions were meant to prevent. The Respondent knew or should have known that one (1) resident required twenty-four (24) hour nursing or psychiatric care, services the Respondent could not provide.

30. The Respondent's substandard practices with respect to the completion of major and adverse incident reports fail to meet the minimum standards of law. These requirements are not mere record keeping mandates, but are required tools which demand a provider review reportable incidents for causation, provide treatment if required, and institute preventative measures for recurrence where available. Such mandates have not been demonstrated by the Respondent despite the identity of numerous events of residents suffering falls meriting the Respondent's exercise of these responsibilities.

31. The failure to meet requirements regarding incident reporting supplements the conclusion that care and services appropriate to resident needs are not being provided. The lack of resident supervision is highlighted by the failure to comply with incident reporting mandates.

32. The Respondent knew of inadequacies in its staffing. The Respondent had been cited by the Agency for inadequate staffing on October 4, 2016. The Agency issued a directed plan of correction which directed the Respondent to implement, by November 7, 2016, systems

to ensure the Facility is adequately staffed.

33. Rather than respond, the Respondent scheduled direct care staff hours below the minimum hours required by law.

34. The Respondent has not demonstrated any action by its administrator, or any other staff member, to address and correct these deficiencies cited on October 4, 2016, or to implement the interventions identified on the Agency's Directed Plan of Correction.

35. The Respondent's deficient conduct is widespread and permeates the Facility thus placing in jeopardy the health, safety and welfare of all of the current residents and potential future residents. The Respondent has known or should have known about the existence of these deficient practices.

36. 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 and with due recognition of personal dignity, individuality, and the need for privacy. § 429.28(1), Fla. Stat. (2016). No resident of an assisted living facility should be placed or maintained in such an environment. The Legislature created the Assisted Living Facilities Act. §§ 429.01, *et seq.*, Fla. Stat. (2016). "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. (2016).

CONCLUSIONS OF LAW

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

38. Each resident of an assisted living facility has the statutory right to live in a safe and decent living environment with the recognition of personal dignity, individuality, and the need for privacy. § 429.28(1)(a), Fla. Stat. (2016).

39. 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 to Respondent Facility, 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 to the Facility.

40. 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 systems designed and implemented to protect residents from abuse and neglect, and (3) being placed in an assisted living facility unit where the regulatory mechanisms enacted for residents protection have not been implemented.

41. 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 was aware of its deficient practice related to sufficient staffing and the provision of care and services appropriate to meet resident

needs. Respondent failed to implement those interventions demanded by the Agency in October 4, 2016, or to undertake any other action to ensure that minimum standards of law are met. The Respondent's inaction illustrates its inability to appreciate the potential dangers of its deficient practices. 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.

42. 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 set of facts and circumstances of this particular matter. This remedy is narrowly tailored to address the specific harm in this instance.

IT IS THEREFORE ORDERED THAT:

43. An Immediate Moratorium on Admissions is placed on Respondent's assisted living facility based upon the above-referenced provisions of law. The Respondent shall not admit or re-admit for services any individual until such time as this Immediate Moratorium on Admissions is lifted by the Agency in writing.

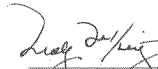
44. This Immediate Moratorium on Admisions shall be posted and visible to the public at the Respondent's assisted living facility until the moratorium is lifted. § 408.41(4), Fla. Sta. (2016).

45. During the Immediate Moratorium on Admisions, the Agency may regularly monitor the Respondent's Facility.

46. The Agency shall promptly proceed with the filing of an administrative action against the Respondent based upon the facts set out within this Order and any other facts that

may be discovered during the Agency's continuing investigation. The Agency shall provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2016), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 2 day of December, 2016.



Justin M. Senior, Interim 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.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

DELEGATION OF AUTHORITY
To Execute
Immediate Orders of Moratorium

I specifically delegate the authority to execute Immediate Orders of Moratorium to Molly McKinstry, Deputy Secretary, Health Quality Assurance, or her delegate.

This delegation of authority shall be valid from date of October 4, 2016, until revoked by the Secretary.

Justin M. Senior, Interim Secretary — **Date** 12/1/16

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