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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

FAIRWAY PARK RETIREMENT
FACILITY, CORP.,

Respondent.
_______________________________/

AHCA No. 2017001604
License No. 8673
File No. 11953662
Provider Type : Assisted Living Facility

EMERGENCY SUSPENSION ORDER AND 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, Fairway Park Retirement Facility, Corp. (hereinafter "the Respondent"), was issued a license by the Agency to operate a six (6) bed assisted living facility (hereinafter "Facility") located at 16324 Southwest 99th Court, Miami, Florida 33157, 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).

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 six (6) 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 (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; and . . . (j) [a]ccess to adequate and appropriate health care consistent with established and recognized standards within the community." § 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, every assisted living facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Chapters 408, Part II, 429, Part I, F.S. and Rule Chapter 59A-35, F.A.C., and this rule chapter. Fla. Admin. Code R. 58A-5.019(1).

11. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. Fla. Admin. Code R. 58A-5.019(3)(a)3.

12. 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).

FACTS JUSTIFYING EMERGENCY ACTION

13. On or about February 10, 2017, the Agency completed a survey of the Respondent's Facility.

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

a. A resident of the Facility suffered from seizures, anemia, dementia, gastroesophageal reflux disease, and hypertension. The resident was incontinent of bowel and bladder, and had a Stage II decubitus ulcer. The resident, who was bed bound and suffered from contraction of the hands, was receiving Hospice care, and required total assistance with all activities of daily living and medication administration.

b. Among the resident's prescribed medications was Dilantin, and anti-seizure medication.

c. On or about December 5, 2016, the resident was placed on continuous care under Hospice as the resident had experienced a seizure. When the resident's Dilantin levels were found to be at therapeutic levels on December 7, 2016, the Hospice continuous care was discontinued.

d. The Respondent's administrator denies knowledge of the December 5, 2016, seizure. The Respondent's administrator believed the Hospice care was related to the resident's decubitus ulcer, a condition the Respondent's administrator indicated did not exist.

e. At some point after December 7, 2016, the Respondent determined it would crush the resident's prescribed medications, including Dilantin, in with the resident's meals.

f. The resident often refused to eat regular meals and thus the resident's prescribed medications were not ingested.

g. There is no indication that the health care providers, including the Hospice service providers, or family members, were notified of either the change of means of medication administration or the resident's refusal to eat which necessarily resulted in the resident not receiving prescribed medications.

h. On December 31, 2016, the resident suffered, in the presence of a family member, another seizure-like event.

i. The family member immediately notified the Respondent's administrator, who was not at the Facility, and the administrator did not appear at the Facility or otherwise respond to this report of an emergent condition.

j. On January 1, 2017, the resident experienced a third seizure-like event in the presence of a family member. The family member immediately contacted the administrator, who was in the Facility. The administrator asserts she filmed the event to share with the resident's health care providers. The Respondent's administrator asserts she showed this video of the resident's seizure-like event to a Hospice nurse she later contacted, but this nurse denies ever being shown a video of the event. The Respondent's administrator did not provide a copy of this purported video to Agency personnel despite the Agency's request.

k. The Respondent's administrator did not contact emergency services while witnessing the resident's seizure-like event. The Respondent's administrator did not contact the resident's physician regarding the resident's December 31, 2016, or January 1, 2017, seizure-like events.

l. When the Respondent's administrator ultimately reported to a Hospice nurse the resident's January 1, 2017, seizure-like event, the Hospice nurse immediately had the resident transferred to a hospital emergency department where the resident was diagnosed at intake with, *inter alia*, suspected cardio-vascular event, seizure, and acute pyelonephritis, a sudden and severe kidney infection, and malnutrition.

m. The resident was admitted to in patient hospitalization and died on January 6, 2017.

n. The Respondent's records related to the resident do not document any of the significant changes above described. No entries were made in the resident's record related to the resident's care, services, or conditions since the resident's admission, despite clear significant changes in the resident's condition and care needs.

o. Among the care provided by Hospice to the resident referenced above was daily personal care. A certified nursing assistant of Hospice reports that she visited the resident on many of the days of December. The resident's diaper had often not been changed since the assistant's visit the prior day. Similarly, a family member of the resident reports having changed the resident's diaper one evening and, on the family member's return the following day, the diaper had not been changed.

p. The family of this resident had frequently observed, during the month of December 2016, the resident's medication being crushed and mixed in the resident's meals. The family member readily identified an individual who

performed these services for the resident.

q. This individual identified is not a staff member of the Respondent.

r. The Respondent has residing within its Facility two (2) individuals who are not residents. Family members of the resident above described, and a second alert and oriented, though non-ambulatory resident, indicate that these two (2) non- staff persons regularly perform assistance with resident medications, and assistance with resident activities of daily living, including incontinence care and bathing. The Respondent's administrator readily admits that one (1) of these two (2) individuals works nights assisting with resident care and medication assistance, and that the other individual "helps out." At least one (1) of these individuals do not pay the Respondent for the room and board of the individual.

s. The Respondent has no personnel records for these individuals. There is no documentation or other indicia that these individuals have any qualifications to perform resident care and services, including, but not limited to, training or instruction on assistance with medications, assistance with activities of daily living, recognizing resident abuse, neglect, or exploitation, or the other required areas of training and education required by law for staff of assisted living facilities. Fla. Admin. Code R. 58A-5.0191. Similarly, there is no documentation or other indicia that these individuals had undergone the criminal history background screenings required for staff of assisted living facilities. § 408.809, Fla. Stat. (2016); Ch. 435, Fla. Stat. (2016).

t. On February 6, 2017, Agency personnel arrived at the Respondent Facility.

Five (5) residents were on-site. There were no staff of the Respondent in the Facility. The two (2) non-staff members were on site, with one indicating to Agency personnel that the Respondent's administrator had gone to the grocery store. Over one (1) hour later, the Respondent's administrator appeared and asserted she had left the Facility to take a staff member for medical attention. The residents had been left without trained supervision, including an individual trained in cardiopulmonary resuscitation and First Aid. Fla. Admin. Code R. 58A-5.019(3)(a)5.

u. The Respondent's staffing schedules, which must be maintained by law, reflect staff shifts by persons who the Respondent's administrator indicate are no longer employed by the Respondent. *See*, Fla. Admin. Code R. 58A-5.019(3)(c). The Respondent's only verified employees are the Respondent's administrator and one other individual. The Respondent's staffing schedules do not reflect twenty-four (24) hour staff coverage for residents by these two (2) individuals.

v. Medication observation records are not maintained for all residents. The initials on the medication records which are maintained reflect all medications were assisted by either the Respondent's administrator or other staff member. The staffing schedules and these records are inconsistent.

w. Weight record for the residents are not maintained by the Respondent. *See*, Fla. Admin. Code R. 58A-5.024(3)(f). A family member of the resident discussed at length above estimates the resident lost approximately eighty (80) pounds prior to the resident's death.

x. The Respondent knew or should have known that it had insufficient qualified staff to meet resident needs. The Respondent knew or should have known that significant events involving residents were not being reported to health care providers and family. The Respondent knew or should have known that its medication observation records were not being maintained as required by law. The Respondent knew or should have known that its operations were not meeting minimum requirements of law.

y. By 10:00 a.m. on February 10, 2017, residents had yet to receive medications scheduled for 8:00 a.m. ingestion. Resident medications were observed throughout the Facility; unsecured and unsupervised. The medications included opiates. Syringes were located in a kitchen drawer.

z. Among these unsecured medications were medications for the alert and oriented non-ambulatory resident identified above. Of note was that the medications, dispensed in day-identified "bubble" packaging, had not been used for February 7, 8, or 9, 2017. The resident's medication observation record, however, was annotated to reflect that the medications had been provided. When questioned, the Respondent's staff member on site, one of the two qualified staff members of the Respondent, acknowledged that she had annotated the medications as provided, but had not in fact provided the prescribed medication to the resident.

NECESSITY FOR EMERGENCY ACTION

15. 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.

16. 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. An assisted living facility must protect these resident rights, including the provision of a safe and decent living environment. § 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.

17. In this instance, the Respondent has failed to ensure that these minimum requirements of law are being met. These failures permeate the entirety of the Facility and its operations.

18. These failures are clearly illustrated with the deficient care and services provided to a Hospice resident in the Respondent's care. The Respondent changed the mode of medication administration without the health care provider's knowledge or consent. This change of mode of administration directly resulted in the resident not receiving prescribed medications when the resident declined meals. These medications included the resident's Dilantin prescribed to address the resident's seizures. This critical information was neither recognized as significant nor reported to the health care provider or family. The Respondent's administrator was informed of a resident experiencing seizure-like activity on December 31, 2016, and did not respond to the

event in any manner. The Respondent's administrator witnessed the resident experiencing seizure-like activity on January 1, 2017. Rather than obtaining emergency medical attention, rather than contact the resident's health care provider, the administrator filmed the resident's suffering and awaited until the following day to mention the event to a health care provider.

19. There can be no dispute that this resident was deprived of the care and services appropriate to the resident's needs. The resident experienced emergent situations to which the Respondent was non-responsive. The resident's prescribed medications, including medication to address seizures, were not provided. The resident lost weight and this weight loss was not noted or addressed. The resident's hygienic care was not provided.

20. As a result, the resident's right to be free from abuse or neglect in an assisted living facility has been violated. The resident was deprived of the care and services, including medical attention, for which the resident had contracted and Respondent had an affirmative legal duty to provide.

21. Caregivers on site are not qualified to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs. The Respondent is utilizing individuals who have no demonstrable capabilities or qualifications to provide the care, services, and protections residents of assisted living facilities must receive. Residents, dependent on the services of competent individuals to meet resident needs, have been abandoned by the Respondent to the care of untrained and unqualified individuals.

22. Medication management for all residents is in dissaray. Assistance of self-administration medications are provided by untrained unqualified staff, medication records are incorrectly annotated or falsified, *see*, Florida Administrative Code Rule 58A-5.01919(5), and medications are not kept in a secure and ordered manner. Fla. Admin. Code R. 58A-5.0185(6).

23. Medication records are a critical part in a health care provider's determinations of the efficacy of the medication and in determining alterations in the medication milieu. Where medication records are incorrect or false, the health and well-being of residents is placed at risk.

24. The Respondent's administrator, charged with the overall management of the Facility staff and ensuring appropriate resident care and services, *See*, Rule 58A-5.019(1), has demonstrated an inability or unwillingness to fulfill the administrator's regulatory mandates. The administrator knowingly allowed unqualified and untrained staff to provide resident care and services. The administrator knowingly left residents without appropriate supervision. The administrator knowingly did not respond to reports of a resident experiencing seizure-like activity on December 31, 2016. On January 1, 2017, the administrator observed this same resident, with a diagnosis of seizures, exhibiting seizure-like behavior and, in response thereto filmed the event rather than seek appropriate medical attention. The administrator knew or should have known medication records were not accurate and that medications were not securely maintained within the confines of the Facility.

25. Individually and collectively, these examples demonstrate that the Respondent's administrator is not managing the Facility in a manner that ensures the minimum care and service standards mandated by law.

26. 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. (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

27. 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.

28. 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. (2016).

29. 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 the Respondent's 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.

30. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an Emergency Suspension of the Respondent's Licensure and an Immediate Moratorium on Admissions to the Respondent's Facility are 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.

31. 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. In addition to this deficient practice, the Respondent's inaction in failing to evaluate and address these events illustrates the Respondent's inability or unwillingness to appreciate the potential dangers of its deficient practices, be they personnel or procedure related. Such deficient practices and conditions justify the imposition of an Emergency Suspension of Licensure and 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.

32. 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:

33. The Respondent's license to operate this assisted living facility is **SUSPENDED** effective February 13, 2017 at 5:00 p.m.

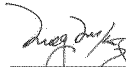
34. An **IMMEDIATE MORATORIUM ON ADMISSIONS** is imposed upon entry of this order.

35. 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.

36. As of the effective date and time of the suspension, the Respondent shall not operate this assisted living facility.

37. The Agency shall promptly file an administrative action against the Respondent based upon the facts set out in this emergency order and provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2016), at the time that such action is taken.

ORDERED in Tallahassee, Florida, this 10 day of February, 2017.



Justin M. Senior, 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
Emergency Suspension Orders

I specifically delegate the authority to execute Emergency Suspension Orders 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

12/1/16
Date

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