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. 2018005807
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. (2017), 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. (2017).

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. (2017). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2017). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2017). § 408.803(11), Fla. Stat, (2017). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2017), and listed in Section 408.802, Florida Statutes (2017). § 408.802(13), Fla. Stat. (2017). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2017). 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 (2017), and Chapter 58A-5, Florida Administrative Code.

5. As of the date of this Immediate Moratorium on Admissions, the census at the Facility is one hundred nine (109) 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 (2017), 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. (2017). 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. (2017).

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… (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community." § 429.28(1), Fla. Stat. (2017).

8. Under Florida law, 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).

9. 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).

SURVEY OF THE RESPONDENT

10. On or about April 19, 2018, the Agency completed a survey of the Facility.

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

a. In the early morning of April 4, 2018, a resident of the Facility passed away while the Respondent's staff members observed. The resident did not have an order to withhold cardiopulmonary resuscitation in the event of an emergency.[1]

b. The resident, at some time before 10:12 p.m. on April 3, 2018, indicated to staff that the resident was not ready for sleep, and asked to sit near the nurses' station.[2]

[1] At a nursing station, the Respondent maintained a listing of individuals who had completed advanced directives indicating the withholding of cardiopulmonary resuscitation in the event of an emergent condition. This resident was not listed and no advanced directive indicating a desire to have cardiopulmonary resuscitation from the resident was obtained or maintained in its records related to the resident.

[2] No licensed nurses were in the Respondent Facility during the events described.

c. A video tape recorded by the Respondent commencing at 10:12 p.m. on April 3, 2018, reflects the following:

i. 10:12 p.m. – Three (3) staff members transfer the resident to a reclining chair.

ii. 11:15 to 11:36 P.M. – The resident is noted with a blood pressure wrist cuff on at 11:19. The resident sat in the recliner continuously with an arm occasionally twitching. At one point, a staff member wipes the resident's head with a damp paper towel and repositions the resident's arm.

iii. 11:36 p.m. – A staff member obviously observes the resident, but does not touch the resident.

iv. 11:42 p.m. – The same staff member makes a phone call.

v. 11:43 p.m. – The resident makes a pained facial expression. Staff in the vicinity take no apparent action.

vi. 11:47 p.m. – The same staff member that made the phone call repositions the resident's arm onto the recliner.

vii. 11:48 p.m. – A staff member appears to look at the resident and appears to express distress or worry, but takes no action to address, touch, or check on the resident's well-being.

viii. 11:50 p.m. – The resident's arm goes limp. A staff member standing near the resident makes the sign of the cross and signals with a swipe of the arms to a co-worker. The co-worker approaches the resident and walks away wiping tears from her eyes. No further action related to the resident is taken by any staff member.

ix. 11:59 p.m. – The supervisor on duty looks at the resident, does not talk to or

touch the resident, and appears to dial a number on a cellular phone.

x. 12:01 a.m. – A local law enforcement officer arrives on scene, checks the resident for a pulse, and asks for gloves.

xi. 12:03 a.m. – The officer gets help from a male staff member of the Facility, a staff member assigned to another area of the Facility, and moves the resident to the floor.

xii. 12:04 p.m. – The law enforcement officer commences chest compressions on the resident. Four (4) staff members observe the law enforcement officer's efforts, but offer no assistance.

xiii. 12:07 a.m. – Emergency medical personnel arrive on scene, connect and effectuate an automated external defibrillation device, but receive no response from the resident.

xiv. 12:09 a.m. – Emergency medical personnel cover the resident with a sheet.

d. At no time during the above-described period did the Respondent's staff members check the resident to determine the presence of breaths or pulse. No staff member was observed monitoring any results produced by the blood pressure cuff.

e. At no time during the above-described period did the Respondent's staff members initiate cardiopulmonary resuscitation or utilize the automated external defibrillation device maintained within the Facility.

f. The law enforcement officer reports the resident lacked a pulse when he arrived.

g. Though accounts vary among staff, the Respondent's on-duty supervisor indicated that during the above-described period, she attempted to call the resident's spouse and was unsuccessful. The spouse had expressed some concern over the resident being transferred

to other health care facilities. After being unsuccessful in reaching the resident's spouse, the supervisor called the Respondent's administrator, who instructed the supervisor to contact the resident's adult child. The supervisor did so and the adult child indicated that he or she would call back. Thereafter, the supervisor called for emergency services.

h. During this event, there were a total of seven (7) staff members in the entire Facility to serve the resident census. Four (4) of these staff were described as certified nursing assistants. None of these staff members could, upon questioning, describe how to determine if cardiopulmonary resuscitation was necessary (i.e. the lack of pulse or breathing), or describe the process of administering cardiopulmonary resuscitation. The personnel records for these staff members did not contain any documentation that any of them had received training or certification in cardiopulmonary resuscitation.

i. The Respondent's on-duty supervisor was aware of the procedures to determine the need for cardiopulmonary resuscitation. Personnel records and interview reflect that the staff member was appropriately trained in cardiopulmonary resuscitation. Despite these qualifications, the supervisor did not check the resident for pulse or breathing, did not direct others to do so, and did not initiate cardiopulmonary resuscitation. Instead, the supervisor made several phone calls.

j. Six (6) of the Respondent's other staff described as certified nursing assistants were also interviewed and their personnel files reviewed. Only one (1) of those individuals could appropriately describe how to determine if cardiopulmonary resuscitation was necessary or describe the process of administering cardiopulmonary resuscitation. The personnel records for these staff members did not contain any documentation indicating that they had received training or certification in cardiopulmonary resuscitation other than one (1) staff

member whose cardiopulmonary resuscitation certification had expired in April 2017.

k. The Respondent's administrator incorrectly indicated that all of Facility staff were trained in cardiopulmonary resuscitation and that staff on-site during the above-described event had checked the resident's pulse during the event.

l. Ninety-five (95) of the Respondent's current census have not executed an order to withhold cardiopulmonary resuscitation in the event of an emergency.

m. Since the above-described event, the Respondent has taken no action to determine the qualifications and skills of its personnel to ensure that, in the event of a resident losing breath or pulse, that cardiopulmonary resuscitation would promptly be initiated. The Respondent neither investigated the incident nor completed the adverse incident reporting processes required by law. *See,* § 429.23, Fla. Stat. (2017).

n. The Respondent has not undertaken or instituted any action designed to ensure that appropriate emergency health care could, or would, be provided to residents in like or similar situations as that described above.

o. 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 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), (16), Fla. Stat. (2017).

12. Since December 2017, four (4) residents were identified who had suffered falls within the Facility. These falls, and Respondent's responses, are described below:

a. Resident number one (1):

i. The resident was noted with a black eye during the survey.

ii. A hospital record reflected that the resident had been admitted to the hospital on April 11, 2018, with a right supraorbital, front scalp swelling, and a hematoma.

iii. The resident was discharged to Facility with hospice care.

iv. The Respondent's records contain no progress notes for the resident for two (2) months prior to the fall and hospitalization.

v. The sole source of information on the circumstances surrounding the resident's fall was a staff member who indicated the resident suffered a fall while at the nurses' station.

vi. Absent from the record was any indication that Respondent assessed or reviewed interventions to protect the resident from future falls following the resident's return to Respondent after the hospitalization.

b. Resident number two (2):

i. The resident's health assessment indicated the resident needed fall precautions. No description of these precautions was documented and no evidence reflects that any precautions were implemented.

ii. The resident suffered a fall on December 25, 2017, and was sent to the hospital

for emergency services.

iii. The resident described the fall as occurring when the resident reached for a napkin.

iv. The resident suffered a laceration to the right forehead and a hematoma. The resident was returned to the Facility with directions from the hospital to follow up with the resident's primary care physician within two (2) weeks.

v. Absent from the record was any indication that the Respondent assessed or reviewed interventions to protect the resident from future falls following the resident's return to the Facility after the hospitalization, or that the follow up appointment with the primary care physician was coordinated or conducted.

c. Resident number three (3):

i. The resident's health assessment indicated the resident needed fall precautions. No description of these precautions was documented and no evidence reflects that any precautions were implemented.

ii. The resident suffered a fall on February 10, 2018, and was sent to the hospital for emergency services.

iii. The resident described the fall as occurring when the resident tried to sit down.

iv. The resident's records reflect an entry describing the resident had suffered a fall, had been evaluated by a nurse with an emphasis on neurological status, and was sent by Respondent to the hospital emergency department. The resident's responsible party was notified.

v. The resident was returned to the Facility the same day with instructions to provide follow up care with the resident's primary physician within one (1) to

two (2) days because the problem was ongoing and worsening.

vi. The following day the resident was hospitalized after suffering a second fall, the resident describing the fall occurring when the person assisting with the resident's ambulation fell and the resident attempted to break the fall of the individual assisting.

vii. The Respondent's records document a nurse evaluated the resident after a certified nursing assistant reported finding the resident on the floor. The resident was sent by the Respondent to the hospital emergency department. The resident's responsible party was notified.

viii. Hospital records identify posterior disc bulges in the L5-S1 and T12-L1 levels.

ix. The resident was discharged back to the Facility on February 14, 2018, with diagnoses of hypertensive disorder and low back pain.

x. The hospital recommended that the resident be provided a rolling walker with a seat and continuing care on an outpatient basis including blood work within three (3) days, consultation with a neurologist, and follow up with the resident's primary care physician within one (1) week.

xi. Absent from the record was any indication that the Respondent provided the recommended walker to the resident or that the recommended follow up care was coordinated or conducted.

xii. The resident again was admitted to the hospital on February 21, 2018, with complaints of abnormal laboratory results and lower back pain.

xiii. The resident was readmitted to the Facility on February 22, 2018, with a diagnosis of Hypokalemia and directions for a urinalysis within one (1) week

and follow up with the resident's primary care physician within three (3) to four (4) days.

xiv. Absent from the record was any indication of this hospitalization or that the recommended follow up care was coordinated or conducted.

xv. The resident again was admitted to the hospital on February 24, 2018, with complaints of nausea, vomiting "X4," and dark urine with a foul odor.

xvi. The Respondent's notes document that the resident was unable to hold down food, vomited four (4) times, was lethargic and had a foul odor to and dark urine. The Respondent thus had the resident sent to the hospital for evaluation.

xvii. The resident passed away on March 10, 2018, in the hospital with cause of death listed as cardiovascular arrest, septic shock, and multi-organ failure.

d. Resident number four (4):

i. The resident's health assessment indicated the resident needed fall precautions. No description of these precautions was documented.

ii. The resident suffered a fall on March 19, 2018, and was sent to the hospital for emergency services.

iii. The Respondent's incident report concludes the resident fell over another resident's legs while attempting to rise unassisted from a couch in the common area.

iv. The resident was hospitalized with a broken traumatic fracture through the right distal femur.

v. The resident was discharged to a rehabilitation center on March 25, 2018, and re-hospitalized on March 27, 2018, where a shoulder fracture from the fall was

diagnosed.

e. Resident number five (5):

i. The resident's health assessment indicated the resident needed fall precautions. No description of these precautions was documented and no evidence reflects that any precautions were implemented.

ii. The resident suffered a fall on March 7, 2018, said fall reported by the resident's spouse who did not reside in the Facility.

iii. The resident was sent to the hospital for emergency services.

iv. Hospital records reflect a diagnosis of fracture to the right orbital floor, severe, with extensive intra-orbital emphysema, contusion of the right eye, right wrist sprain, and a distal radius fracture with apparent intra-articular extension from accidental fall from bed.

v. Hospital discharge records document a recommendation for a consult with a facial surgeon within one (1) or two (2) days.

vi. Absent from the record was any indication that the recommended follow-up care was coordinated or conducted.

vii. Absent from the record was any indication that the Respondent assessed or reviewed interventions to protect the resident from future falls following the resident's return to the Respondent after the hospitalization.

13. On December 2, 2016, the Agency issued an Immediate Moratorium on Admissions against the Respondent. This emergency order identified 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). The factual

basis of this emergency action included the Respondent's failure to appropriately provide monitoring and staffing necessary to minimize the risk of residents suffering falls.

14. The emergency order was lifted on August 24, 2017, after the Respondent had demonstrated corrective action.

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS

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. (2017), Ch. 408, Part II, Fla. Stat. (2017); 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 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. (2017); 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 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 ensure that residents are free from abuse and neglect, and that medical attention is appropriately provided, has not been devised and implemented.

18. This extent of the systemic failures of the Respondent's operations are illustrated not only in the events of the late night of April 3rd, but in the Respondent's failure to or inability to recognize and address the myriad of care issues presented.

19. The Respondent failed to take action to assure it has sufficient qualified staff to recognize a resident's need for emergency care and services. The Respondent failed to undertake action to assure its staff were trained in and competent to provide cardiopulmonary resuscitation in emergent situations. The Respondent failed to train its staff members to assure awareness to contact competent and qualified staff to provide emergency services.

20. These failures, individually and cumulatively, demonstrate the Respondent's lack of understanding of its obligation to ensure that its residents are protected from abuse, neglect, or exploitation, be the abuse an act or omission.

21. No concept of the provision of access to adequate and appropriate health care consistent with established and recognized standards within the community would encompass a situation where the staff of a licensed assisted living facility idly stand by while a resident experiences medical crisis before their eyes. No concept of the provision of access to adequate and appropriate health care consistent with established and recognized standards within the community would encompass the failure to provide emergency services, such as cardiopulmonary resuscitation, to a resident who clearly took the resident's the last breath in the presence of the very personnel charged with the resident's care.

22. The Respondent has again demonstrated an inability or unwillingness to ensure that it's staff provides care and services care and services, including supervision, appropriate to meet resident needs. The lack of these services include the lack of demonstrable institution of fall precautions.

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 again 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.

24. Exacerbating these deficient practices, the Respondent has consistently failed to ensure that follow up appointments and services are arranged and provided. The lack of follow up care may complicate existing conditions of residents or prohibit the timely discoverer of related conditions.

25. 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 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.

26. 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.

27. 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. (2017). 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. (2017). "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. (2017).

CONCLUSIONS OF LAW

28. 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.

29. 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. (2017).

30. 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 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.

31. 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.

32. 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.

33. 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:

34. 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 unless authorized by the Agency in writing.

35. This Immediate Moratorium on Admisions shall be posted and visible to the public at the assisted living facility. § 408.41(4), Fla. Sta. (2017).

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

37. The Agency shall promptly proceed with the filing of an administrative action against the Respondent based upon the facts set out within this order. The Agency shall provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2017), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 20th day of April, 2018.

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
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 the date of October 4, 2016 until revoked by the Secretary.

Justin M. Senior, Secretary

2/24/17
Date

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RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

MEMORANDUM

To: Justin Senior, Secretary

From: Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance

Date: April 16, 2018

Subject: Delegation of Authority

I will be out of the office on business travel from April 17 – 20. Ryan Fitch will serve as the acting Deputy Secretary of the Division of Health Quality Assurance during this time.

Should you have any questions or issues that arise, please contact Ryan at 43797 or Traci Gerrell at 44334.

Thank you.

cc: Ryan Fitch
Laura MacLafferty
Nikole Helvey
Kim Smoak
Scott Waltz
Kelly Bennett
Lucy Frederick
Annette Howard-Lewis
Cindy Krell
Katelyn White