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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SENIOR LIVNG IV SUN CITY, LLC d/b/a INSPIRED LIVING AT SUN CITY CENTER,

Respondent.
_____/

AHCA No. 2018017822
License No. 12603
File No. 11968715
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. (2018), 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. (2018).

2. The Respondent, Senior Living IV Sun City, LLC d/b/a Inspired Living at Sun City Center (hereinafter "the Respondent"), operates a seventy-eight (78) bed assisted living facility (hereinafter "the Facility") located at 1320 33rd Street Southeast, Ruskin, Florida 33573,

license number 12603, 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, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency." § 408.803(9), Fla. Stat. (2018). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2018). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2018). § 408.803(11), Fla. Stat, (2018). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2018), and listed in Section 408.802, Florida Statutes (2018). § 408.802(13), Fla. Stat. (2018). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2018).

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 (2018), 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 forty-nine (49) 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 (2018), 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. (2018). 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. (2018).

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. (2018).

8. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager

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

9. Under Florida law, the owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. … § 429.26(1), Fla. Stat. (2018).

SURVEY OF THE RESPONDENT

10. On or about December 5, 2018, the Agency completed a survey of the Respondent's Facility.

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

a. The Respondent's policy on abuse and neglect, dated 2014, and modified on March 30, 2016, provides, *inter alia*, as follows:

i. "Abuse: any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a Resident.

ii. "Neglect: failure to provide a resident with the goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm illness [sic].

iii. "Reporting:

1. "9. Any employee witnessing, suspecting, or having knowledge of abuse is required to report it immediately to the Executive Director and Regional Director of Operations.

2. "14. The Executive Director will investigate the allegation and will enlist the services of APS, the state licensing agency, and/or the local Ombudsman for assistance.

3. "15. The Executive Director will notify the Resident's Responsible Person of a report of alleged abuse or neglect involving a resident.

4. "16. The Executive Director will immediately notify the RDO and/or the appropriate regional personnel of the situation.

5. "17. Local law enforcement authorities will be contacted when physical abuse involving physical injury, sexual abuse, a crime, or when death other than by disease processes occurs to a resident because of alleged actions by a staff member, visitor, or other resident.

iv. "Action - ... 23. In the event the perpetrator is a fellow Resident, the Resident's condition will be immediately evaluated to determine the most suitable action and placement for the Resident considering the safety of the resident as well as the safety of other Residents and employees of the Community."

b. On December 3, 2018, at approximately 11:15 a.m., Agency personnel observed resident number one (1), a male, place a hand down the back of a wheelchair occupied by a female resident, resident number four (4), reaching the female resident's lower waist or buttocks. Staff intervened and re-directed resident number one (1).

c. On December 3, 2018, at approximately 1:50 p.m., Agency personnel observed resident number two (2), a male, grab a female resident by the neck and right shoulder and shake and strike the female resident. As no facility staff were in the immediate area, Agency personnel intervened and separated the residents from one another.

d. Facility records related to resident number one (1) document the following incidents since October 2018:

i. October 2, 2018 – Walking around naked or partially dressed.

ii. October 3, 2018 – Attempted to hit a resident.

iii. October 10, 2018 – Touching and rubbing a female resident's breast and, after being re-directed, returned and repeated the same behavior.

iv. October 11, 2018 – Walking naked in the hallway.

v. October 12, 2018 – Walking naked in the hallway.

vi. October 16, 2018 – Walking naked in the hallway.

vii. October 17, 2018 – Walking naked in the hallway.

viii. October 25, 2018 – Rubbing a female resident's breast.

ix. October 31, 2018 – Physically aggressive to another resident.

x. November 1, 2018 – Walking naked in the hallway.

xi. November 3, 2018 - Exposed genitals to a female resident.

xii. November 6, 2018 – Walking naked in the hallway.

xiii. November 10, 2018 – Fondled a female resident.

xiv. November 10, 2018 – A physical altercation with a male resident.

xv. November 22, 2018 – A physical altercation with a male resident.

xvi. Numerous falls were also noted.

xvii. The female resident identified in the above events was resident number four (4), the same resident who Agency personnel observed being inappropriately touched by resident number one (1) as above described.

e. Facility records related to resident number four (4) document only one contact with the resident's responsible party or family member regarding the resident being the subject of the behaviors of resident number one (1). With the exception of that annotation, none of the other incidents of inappropriate behavior by resident number one (1) directed toward resident number four (4) were documented in the records of resident number four (4).

f. Resident number one (1) occupied a room immediately adjacent to the room of resident number four (4), and the resident's disease process prevented Agency personnel from effectively communicating with the resident.

g. The family member of resident number four (4) was not aware of the other incidents of inappropriate behavior by resident number one (1) directed toward resident number four (4).

h. Facility records related to resident number two (2) document the following incidents since October 2018:

i. October 5, 2018 – Punched and ran over the foot of another resident with a wheel chair.

ii. October 11, 2018 – Agitated, yelling, banging doors, "touching other resident."

iii. October 12, 2018 – Grabbing other residents' wheel chairs and attempt to strike a female resident.

iv. October 15, 2018 – Hospitalized.

v. October 21, 2018 – Hospitalized.

vi. October 22, 2018 – Medications changed.

vii. October 25, 2018 – Agitated, yelling, and banging on doors.

viii. October 27, 2018 – Banging on doors.

ix. October 31, 2018 – Agitated, yelling, and banging on doors.

x. November 1, 2018 – Medications changed.

xi. November 8, 2018 – Attempted to strike another resident.

xii. November 12, 2018 – Kicked a resident, ran his wheel chair into another resident, and struck another resident in the face.

xiii. November 13, 2018 – Hospitalized after suffering a fall.

i. Facility records related to resident number three (3) document the following incidents since October 2018:

i. October 21, 2018 – Inappropriate touching of another resident and exposing genitals to a female resident.

ii. November 8, 2018 – Aggressive towards staff and exit seeking.

iii. November 15, 2018 – Medications changed.

iv. November 29, 2018 – Acting out sexually and exposed genitals to staff.

v. December 1, 2018 – Made a sexual gesture to a female resident.

j. With the exception of the single notification to the family member of resident number four (4) referenced above, records do not reflect that the responsible party or family members of the several residents who were subjected to inappropriate behaviors or assault as described above were notified of the incidents involving their loved ones.

k. There is no indication that the residents who were subject to the aggressive, assaultive, or sexually inappropriate sexual behaviors described herein were assessed by the Respondent for injury or harm after the subject events.

l. The Respondent's management, though acknowledging actual familiarity with the above-described events, could produce no investigation of any of the events as required by the Respondent's Abuse and Neglect policies and Procedures.

m. The Respondent's management could demonstrate no interventions designed and implemented to protect the residents from the above documented ongoing behaviors or to protect other residents from such behaviors.

n. Only a single call to the Department of Children and Families, Adult Protective Services, regarding the above described events, was of record.

o. There is no indication that the Respondent's management weighed or considered whether residents number one (1), two (2), or three (3), continued to meet residency criteria in light of the residents' on-going behaviors.

p. The Respondent's management instituted an increased level of personal supervision of residents number one (1) and two (2) prior to Agency personnel leaving the facility on December 4, 2018. This supervision was not a constant one-to-one supervision.

q. All of the Respondent's residents reside in a secure memory care unit to address the cognitive deficiencies of the residents.

r. Chapter 415, Florida Statutes, defines "neglect" as follows:

> (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(16), Fla. Stat. (2018).

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS

12. 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. (2018), Ch. 408, Part II, Fla. Stat. (2018); 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.

13. 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. (2018); 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.

14. In this instance, the Respondent has grossly failed to ensure that these minimum requirements of law are being met. At least three (3) residents are known to engage in behaviors of a sexual or violent nature, many directed toward other residents. Other than the provision of

prescribed medications, the Respondent, despite actual knowledge of the behaviors, could not demonstrate any action or consideration it undertook to address the residents' behaviors to protect the residents and all other residents from the potential for harm. The Respondent could demonstrate no action or intervention it undertook to prevent or minimize the likelihood such events would occur, but could demonstrate only actions it took to intervene while the inappropriate activity was occurring and the provision of medications. The failure to adequately intervene with the ongoing behaviors does not ensure the safe and decent environment, free from abuse and neglect, required by law for residents of an assisted living facility.

15. Significantly, the Respondent has demonstrated that its policies and procedures regarding abuse and neglect have not been implemented. Several provisions of its policy, including notification of third parties, the investigation of each event, and the evaluation of a resident perpetrator for suitable intervention or placement, were not followed in the multiple events documented in resident records. Any protections which such policy and procedure could have provided to facility residents, staff, and visitors, were not activated, and the behaviors continued, placing all residents at risk. Where abuse and neglect systems fail, the safety and well-being of facility residents are at immediate risk.

16. Similarly, there is no indication that the Respondent considered or determined whether any of the three (3) residents with known and recurrent violent or inappropriate behaviors continued to meet residency criteria for an assisted living facility. See, § 429.26(1), Fla. Stat. (2018). There is no indication whether the Respondent weighed or considered whether it possessed or could arrange for the care and services necessary to protect these residents from their own behaviors and protect other residents from these same behaviors.

17. The failure to address these incidents is a failure to provide care and services

appropriate to resident needs. Absent from the Respondent's records were any indication that the subjects of the violent or inappropriate behaviors of these three (3) residents had been evaluated or assessed for injury or harm. With one exception, there is no indication that the family members or responsible parties of the residents subjected to behaviors or assaults were notified of the events. The residents of this Facility suffer from cognitive limitations which inhibit or prohibit the residents from reporting injury, abuse, neglect, or discomfort. The Respondent could not demonstrate any actions it undertook to assure these victims were healthy and safe after being subjected to assault or inappropriate behaviors. Further, the Respondent deprived the residents' family members or responsible parties of the knowledge of the events which may impact these person's decisions regarding the future care and safety of their loved ones. Despite the actual knowledge that a resident focused inappropriate sexual behavior upon a particular resident, the Respondent took no action to separate or further protect the female resident, leaving this resident assigned to a room directly adjacent to that of her tormentor.

18. These failures individually and cumulatively demonstrate the Respondent's lack of understanding of its obligation as a licensee.

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

20. 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. (2018). 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. (2018). "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. (2018).

CONCLUSIONS OF LAW

21. 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.

22. 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. (2018).

23. 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.

24. 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 resident protection have not been implemented.

25. 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. Respondent's inaction to cease such conduct illustrates the Respondent's 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 current residents or future residents receive the appropriate care, services, and environment dictated by Florida law.

26. 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:

27. An Immediate Moratorium on Admissions is placed on the 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.

28. This Immediate Moratorium on Admisions shall be posted and visible to the public at the Respondent's assisted living facility. § 408.41(4), Fla. Sta. (2018).

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

30. 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 (2018), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 5 day of December, 2018.

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
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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