STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION 2019 JAN 29 P 2:15

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

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

Respondent.
_____/

AHCA Case Nos. 2018018126
2018017822
2019000966
License No. 12603
File No. 11968715
Provider Type: Assisted Living Facility
RENDITION NO.: AHCA-19 -0041 -S-OLC

FINAL ORDER

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

1. The Agency issued the attached Immediate Moratorium on Admissions (Ex. 1), and Administrative Complaint and Election of Rights form (Ex. 2), to the Respondent. The parties have since entered into the attached Settlement Agreement, which is adopted and incorporated by reference into this Final Order. (Ex. 3).

2. The Respondent shall pay the Agency $26,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

3. The Respondent shall comply with the conditions set forth in the settlement agreement.

4. The action seeking license revocation is withdrawn.

5. The Immediate Moratorium on Admissions is lifted effective the date of this Final Order.

ORDERED at Tallahassee, Florida, on this 29 day of January, 2019.

Mary C. Mayhew, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

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

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 29th day of January, 2019.

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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Keisha Woods, Unit Manager Licensure Unit Agency for Health Care Administration (Electronic Mail)
Central Intake Unit Agency for Health Care Administration (Electronic Mail)	Patricia Caufman, Field Office Manager Local Field Office Agency for Health Care Administration (Electronic Mail)

Katrina Derico-Harris Medicaid Accounts Receivable Agency for Health Care Administration (Electronic Mail)	Kimberly Smoak, Chief of Operations Bureau of Health Quality Assurance Agency for Health Care Administration (Electronic Mail)
Shawn McCauley Medicaid Contract Management Agency for Health Care Administration (Electronic Mail)	Nicola L. C. Brown Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)
Thomas M. Hoeler, Chief Facilities Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Amy W. Schrader, Esquire Baker, Donelson, Bearman, Caldwell & Berkowitz, PC 101 N. Monroe St., Suite 925 Tallahassee, Florida 32301 aschrader@bakerdonelson.com Counsel for Respondent (Electronic Mail)

FILED
AHCA
AGENCY CLERK
2018 DEC -5 P 2:31

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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Tallahassee, FL 32308
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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

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

Respondent.
_____/

Case Nos.: 2018018126
License No.: 12603
File No.: 11968715
Facility Type: Assisted Living

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), by and through its undersigned counsel, and files this Administrative Complaint against the Respondent, Senior Living IV Sun City, LLC d/b/a Inspired Living at Sun City Center ("Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2018), and alleges:

NATURE OF THE ACTION

This is an action against an assisted living facility to impose an administrative fine in the amount of forty-five thousand dollars ($45,000.00) plus survey fees of five hundred dollars ($500.00) for a total sum of forty-five thousand five hundred dollars ($45,500.00), and revoke Respondent's license to operate an assisted living facility based upon two (2) Class I deficient practices and one (1) Class II deficient practice.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 20.42, 120.60, and Chapters 408, Part II, and 429, Part I, Florida Statutes (2018).

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

EXHIBIT 2

PARTIES

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

4. Respondent operates a seventy-eight (78) bed assisted living facility located at 1320 33rd Street Southeast, Ruskin, Florida 33573, and is licensed as an assisted living facility, license number 12603.

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

COUNT I

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

7. That Florida law provides:

> (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.
>
> Section 429.26(7), Florida Statutes (2018).

8. That Florida law provides;

> 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.

Rule 58A-5.0182(1), Florida Administrative Code.

9. That on or about December 3, 2018, the Agency conducted a complaint survey at Respondent's facility.

10. That based on observation, record review, and interview, Respondent failed to provide care and services appropriate to the needs of its residents accepted for admission to the facility. Specifically, Respondent failed to provide the level of oversight, supervision, care and services required to address the inappropriate behavior of three residents, (Residents #1, #2, and #3), who required a higher level of personal supervision due to ongoing physical and sexual aggression toward other facility residents and facility staff. Additionally, Respondent failed to document and provide ongoing assessment of its residents, as required under the facility's own policy, and failed to notify the responsible parties for victims following incidents involving resident-on-resident sexual abuse for one sampled resident (Resident #4).

11. That on or about December 3, 2018, between 9:00 AM and 4:00 PM, Petitioner's representative observed Resident #1 running his/her wheelchair into other residents' wheelchairs, as well as running into residents who were walking in the hallways.

Additionally, Petitioner's representative observed Resident #1 grabbing or attempting to grab other residents as they wheeled or walked by Resident #1.

12. That a review of Resident #1's record revealed documentation of a resident Health Assessment (AHCA Form 1823) dated October 19, 2018, indicating a diagnosis of dementia.

13. That further review of Resident #1's record revealed ten (10) incidents of aggressive behavior toward other unnamed facility residents between October 5, 2018 and November 12, 2018, which included the following:

- Punched a resident and ran over another resident's foot on October 5, 2018,
- Agitated, yelling banging doors, "touching other residents" on October 11, 2018,
- Grabbing other residents' wheelchairs and attempting to strike female resident on October 12, 2018,
- Hospitalized on October 15, 2018 and October 21, 2018,
- Meds changed October 22, 2018,
- Agitated, yelling and banging on doors on October 25, 2018, October 26, 2018, and October 31, 2018,
- Med changes November 1, 2018,
- Approaching and grabbing residents and staff on November 3, 2018,
- Attempted to punch another resident on November 8, 2018,
- Kicking a resident on November 12, 2018, and
- Ran [his/her] wheelchair into another resident and hit a resident in the face on November 12, 2018.

14. That Resident #1's record contained no additional documentation for the remainder of November and December, although during staff interviews, facility staff (including the Executive Director and the Health and Wellness Director) stated Resident #1 still displayed aggressive behavior toward other residents.

15. That on or about November 3, 2018, at approximately 10:16 AM, during an interview with the Health and Wellness Director regarding residents' behaviors, she reported

that Resident #1 had aggressive behavior and his/her last hospitalization was due to those behavior.

16. That on or about November 3, 2018, at approximately 4:36 PM, during an interview with the Executive Director, she confirmed that Resident #1 was still displaying aggressive behavior.

17. That on or about December 3, 2018, at approximately 1:50 PM, Petitioner's representative observed Resident #1 in the "aquarium room," sitting in his/her wheelchair behind Resident #4, who was also in his/her wheelchair.

18. That Resident #1 grabbed Resident #4 by the right shoulder and neck, yanking Resident #4 backwards, shaking Resident #4, and hitting Resident #4 on the back.

19. That Resident #4 was screaming, "Let go of me," "Get off of me" "Ouch, you are hurting me."

20. That there was no staff present in the area to supervise the situation or available to intervene.

21. That Petitioner's representative and another colleague were present and pulled Resident #4's wheelchair forward, and called for staff assistance.

22. That Staff "F" arrived and intervened, while commenting, "Where are the floor staff, this always happens."

23. That following the incident, Staff "F" stated, "This happens frequently and the floor staff are never around."

24. That a review of Resident #2's record on December 3, 2018, revealed a history of touching other residents inappropriately, exposing himself/herself, and wandering around the facility naked.

25. That Resident 2's record further noted six (6) incidents of sexual abuse on Resident

#4 between October 2, 2018 and December 3, 2018, and included the following:

- Walking around naked or partially dressed October 2, 2018,
- Attempting to hit a resident on October 3, 2018,
- Touching and rubbing female resident's breast on October 10, 2018, and after being redirected, went back and did it again.
- Walking naked in hallway on October 11, 2018, October 12, 2018, October 16, 2018, and October 17, 2018
- Rubbing female's breast on October 25, 2018,
- Physically aggressive to another resident on October 31, 2018,
- Walking naked on November 1, 2018,
- Exposed [himself/herself] to female resident on November 3, 2018,
- Walking naked on November 6, 2018,
- Staff was busy with other resident, resident makes way to female resident and fondled her breasts under her shirt, staff redirected, later had another altercation with male resident saying "hey watch out now," the other resident got too close, punches were thrown on November 10, 2018, and
- Had physical altercation with male resident on November 10, 2018 and November 22, 2018.

26. That on or about December 3, 2018, at approximately 11:15 AM, Petitioner's representative observed Resident #2 in the dining room standing behind Resident #4, who was sitting in his/her wheelchair at a table.

27. That Resident #2 had his/her hand extended between Resident #4's back and the wheelchair close to Resident #4's waist/buttocks area.

28. That on or about December 3, 2018, at approximately 1:55 PM, Petitioner's representative observed Resident #2 reaching out and trying to grab Resident #4 as the resident passed by.

29. That a review of Resident #4's record revealed a resident Health Assessment (AHCA Form 1823) dated October 11, 2017, indicating a diagnosis of Alzheimer's.

30. That Resident #4's record revealed one (1) documented incident of sexual abuse by

Resident #2 on August 8, 2018.

31. That there were no other incidents documented in Resident #4's record of sexual abuse by Resident #2.

32. That Resident #4's record included one documentation of notification to the resident's responsible party following the incident noted above.

33. That on or about December 3, 2018, at approximately 11:15 AM, during an interview with Staff "E," she stated there had been incidents with Resident #2 touching other residents inappropriately, and added that she had only witnessed Resident #2 touching Resident #4 and no other female residents.

34. That on or about December 3, 2018, at approximately 12:03 PM, during an interview with Resident #9's family member, he/she stated "I have seen inappropriate touching right out in the open. Resident #2 was touching Resident #4 and I reported it. It happened a couple weeks ago. I reported it to the Health and Wellness Director."

35. That on or about December 3, 2018, at approximately 11:40 AM, during an interview with Staff "D," she stated that Resident #2 has sexually harassed Resident #4.

36. That according to Staff "D," Resident #2 approached Resident #4 when staff were not around.

37. That Staff "D" further stated she did not know whether Resident #4's daughter was notified of the incidents, but had informed management many times and nothing was done.

38. That on or about December 3, 2018, at approximately 3:00 PM, during an interview with the Health and Wellness Director, she stated that Resident #2 was sexually inappropriate with Resident #4.

39. That the Health and Wellness Director confirmed the multiple incidents of sexual

abuse toward Resident #4 that were documented in Resident #2's chart to be accurate.

40. That the Health and Wellness Director confirmed Resident #2 and Resident #4's rooms were in the same hallway, adjacent to each other, and both residents shared the same common and dining areas.

41. That Respondent did not provide documentation of any interventions it provided to protect Resident #4 from Resident #2 frequently seeking out Resident #4 and sexually harassing and abusing that resident.

42. That on or about December 3, 2018, at approximately 9:37 AM, during an interview with Staff "A, she stated Resident #3 was sexually inappropriate with staff and other residents, including making facial expressions, touching staff, touching female residents, and grabbing and playing with Resident #3's own genitals in the common areas in front of female residents.

43. That a review of Resident #3's record on December 3, 2018, revealed documentation of resident Health Assessment (AHCA Form 1823) dated January 22, 2018, indicating Resident #3 had a diagnosis of frontal lobe dementia.

44. That Resident #3's record further revealed a psychological evaluation dated November 13, 2018, due to Resident #3 having an increased sex drive and sexually inappropriate behavior toward female residents.

45. That between October 21, 2018 and December 1, 2018, there were five (5) documented incidents of aggressive or inappropriate sexual behavior by Resident #3 with unidentified female residents or facility staff, including the following:

- Inappropriate touching and exposure of penis to female residents on October 21, 2018,
- Aggressive toward staff, and exit seeking behavior on November 8, 2018 and

November 10, 2018,

- Meds changed on November 15, 2018,
- Acted out sexually and exposed himself to staff on November 29, 2018, and
- Made a sexual gesture to a female resident on December 1, 2018.

46. That Respondent had no documentation to reflect it notified the responsible parties of the female residents who were subjected to Resident #3's inappropriate behavior.

47. That on or about December 3, 2108, at approximately 4:39 PM, during an interview with the Executive Director, she confirmed the sexual abuse that occurred between Resident #2 and Resident #4.

48. That the Executive Director stated if the incidents were not documented in Resident #4's chart or notes, then the resident's responsible party was not notified following the incidents of sexual abuse.

49. That the Executive Director acknowledged Resident #1 still displayed aggressive behavior, and that Resident #3 displayed inappropriate sexual behavior to, and in front of, female residents.

50. That the Executive Director stated the intervention taken to address those residents' inappropriate behaviors was medication changes.

51. That the aforementioned facts reflect Respondent's failure to provide the appropriate level of oversight, supervision, care, and services required to address the inappropriate behavior of Residents #1, #2, and #3, who required a higher level of personal supervision due to ongoing physical and sexual aggression toward other facility residents and facility staff. Additionally, Respondent failed to document and provide ongoing assessment of its residents, as required under the facility's own policy, and failed to notify the responsible parties for victims following incidents

involving resident-on-resident sexual abuse of Resident #4.

52. The deficient practice described in this count constituted, in part, the basis for an Emergency Order of Immediate Moratorium on Admissions, which the Agency imposed upon the Respondent on or about December 5, 2018, pursuant to Sections 408.814 and 120.60(6), Florida Statutes (2018).

53. The Agency determined that this deficient practice was related to the care of residents which presented an imminent danger to those residents or a substantial probability that death or serious physical or emotional harm would result therefrom, and cited Respondent for a Class I deficiency.

54. That the same constitutes a Class I offense as defined in Section 408.813(2)(a), Florida Statutes (2018).

55. The Agency shall impose an administrative fine for a cited Class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. A fine shall be levied notwithstanding the correction of the violation. Section 429.19(2)(a), Florida Statutes (2018).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of ten thousand dollars ($10,000.00).

COUNT II

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

57. That Florida law provides:

> (6) RESIDENT RIGHTS AND FACILITY PROCEDURES.
>
> (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area,

and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.

(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.

(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888) 831-0404; Disability Rights Florida, 1(800) 342-0823; the Agency Consumer Hotline 1(888) 419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800) 96-ABUSE or 1(800) 962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and must be a minimum of 14-point font.

(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:

1. Resident responsibilities;
2. Alcohol and tobacco;
3. Medication storage;
4. Resident elopement;
5. Reporting resident abuse, neglect, and exploitation;
6. Administrative and housekeeping schedules and requirements;
7. Infection control, sanitation, and universal precautions; and
8. The requirements for coordinating the delivery of services to residents by third party providers.

(e) Residents may not be required to perform any work in the facility without compensation, unless the facility rules or the facility contract includes a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.

(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

(g) In addition to the requirements of Section 429.41(1)(k), F.S., the use of physical restraints by a facility must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical restraint.

Rule 58A-5.0182(6), Florida Administrative Code.

58. That Florida law provides:

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s.429.27.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making appointments for health care services, the provision of or arrangement of transportation to health care appointments, and the performance of health

care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida.

Section 429.28(1) and (2), Florida Statutes (2018).

59. That Florida law provides:

(1) 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. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

Section 429.26(1), Florida Statutes (2018).

60. That on or about December 3, 2018, the Agency conducted a complaint survey at Respondent's facility.

61. That based on observation, record review, and interview, Respondent failed to honor resident rights to live in a safe and decent living environment, free from abuse and neglect. Specifically, Respondent failed to adhere to its own abuse policy to ensure all residents who resided in the facility were free from resident-on-resident sexual and physical abuse from three residents, (Residents #1, #2 and #3), who displayed aggressive behavior. Additionally, Respondent failed to ensure resident rooms were clean and free of hazards for one resident, (Resident #2), who was identified as a fall risk.

62. That on or about December 3, 2018, at approximately 11:15 AM, Petitioner's representative observed Resident #2 in the dining room standing behind Resident #4 who was sitting in a wheelchair at a dining room table.

63. That Resident #2 had a hand extended down Resident #4's back and the wheelchair

near the Resident #4's waist/buttocks area.

64. That Staff "E" who witnessed the incident stated that there were previous incidents with Resident #2 touching other facility residents inappropriately.

65. That Staff "E" stated that she had only seen Resident #2 touch Resident #4.

66. That on or about December 3, 2018, at approximately 1:55 PM, Petitioner's representative observed Resident #2 reaching out and trying to grab Resident #4 as the resident passed by.

67. That a review of Resident #2's record conducted on December 3, 2018, revealed multiple incidents of touching other residents inappropriately, exposing self, and wandering naked in the facility. The following events were documented in Resident #2's chart:

- October 2, 2018 - This AM was coming out of apartment naked after a care staff had already been in to get [the resident] dressed,
- October 2, 2018 - Resident walked into dining room with only [underwear] and t-shirt,
- October 3, 2018 - Approximately 1:10pm had to be directed away from another resident as [he/she] struck out with [his/her] hands and hit another resident that was passing by in a wheelchair,
- October 10, 2018 - Touching and rubbing another female resident's breast. Quickly stopped and redirected. Writer was helping another resident and [the resident] walked back over and grabbed the same resident's breast again,
- October 11, 2018 - Walking naked in hallway,
- October 12, 2018 - Walking naked in hallway,
- October 16, 2018 - Seen by family member of another resident walking out of room naked with [underwear] around ankles,
- October 17, 2018 - Came out of apartment naked,
- October 18, 2018 - Resident continues to be very aggressive by screaming and yelling,

- October 23, 2018 - Walking without clothes and [without using a walker],
- October 24, 2018 - Wandering hallway naked,
- October 25, 2018 - Rubbed on a female's breast,
- October 31, 2018 - Resident very aggressive and violent to another resident by kicking and punching [the resident],
- November 1, 2018 - Walking around naked,
- November 3, 2018 - Pants down, and front private area showing standing in front of female resident, care staff redirected, female resident unable to convey what happened,
- November 6, 2018 - 12:00 PM wandering hallway naked,
- November 10, 2018 - Staff was busy with other resident, resident makes way to female resident and fondled her breasts under her shirt, staff redirected, later had another altercation with male resident saying "hey watch out now," the other resident got too close, punches were thrown, families and doctor aware,
- November 13, 2018, November 18, 2018 - Came out of apartment naked, and
- November 22, 2018 - Altercation with another resident, hitting each other.

68. That on or about December 3, 2018, at approximately 3:00 PM, during an interview with the facility's Health and Wellness Director, she stated that Resident #2 was not sexually inappropriate with staff, but was sexually inappropriate with Resident #4.

69. That during a tour of Respondent's facility, Petitioner's representative observed there were two separate dining areas and two separate common areas separated by a long hallway where administrative offices were located.

70. That Resident #2 and Resident #4's rooms were on the same hallway across the hall from each other, and both residents shared the same dining area and common seating area.

71. That on or about December 3, 2018, at approximately 12:03 PM, during an interview with Resident #9's family member, he/she stated "I have seen inappropriate touching

right out in the open. Resident #2 was touching Resident #4 and I reported it. It happened a couple weeks ago. I reported it to the Health and Wellness Director."

72. That review of Resident #4's record revealed a health assessment dated October 11, 2017, indicating a diagnosis of Alzheimer's.

73. That review of a care note regarding Resident #4 dated August 9, 2018, read: "resident sitting in hallway and was approached by male resident who attempted to touch [him/her] between legs, staff immediately separated them, Advanced Registered Nurse Practitioner (ARNP) and family notified."

74. That Petitioner's representative requested from the Health and Wellness Director additional documentation regarding other incidents between Resident #2 and Resident #4, and notification of Resident #4's family, but no additional documentation was provided.

75. That on or about December 3, 2018 at approximately 4:39 PM, during an interview with the Executive Director, she acknowledged and confirmed the multiple incidents of sexual abuse between Resident #2 and Resident #4 that were documented in Resident #2's record.

76. That when requested, the Executive Director could not provide documentation for Resident #4, who was the victim of abuse from Resident #2, including further details of the incidents, whether an investigation was conducted, or if Resident #4's responsible party was notified.

77 That the Executive Director also did not provide documentation of any type of assessment of Resident #4 following the documented incidents of abuse by Resident #2.

78. That on or about December 3, 2018, at approximately 9:37 AM, during an interview

with Staff "A," she stated that Resident #3 was sexually inappropriate with staff and with other residents.

79. That according to Staff "A," Resident #3 made facial expressions with his tongue, and touched other care staff including Staff "A."

80. That Staff "A" further stated Resident #3 touched a female resident on the shoulder, and "play[ed] with" himself in the common area.

81. That a review of Resident #3's record on December 3, 2018, revealed the following events:

- October 21, 2018 - 12:57 PM Sexually inappropriate behavior, sat next to a female resident and with hands rubbed up her leg and asked her "what do you want to do,"
- October 21, 2018 - 1:01 PM late entry for October 20, 2018 at 11:00 AM Pulled penis out of shorts in the common area and was trying to get the attention of a female resident, redirected,
- November 8, 2018 - Confrontational with staff,
- November 15, 2018 - Medication changes for behavior,
- November 29, 2018 - late entry for November 26, 2018 Resident asked staff to sit next to [him,] as [he] needed a female to help [him]. While [Resident #3] was doing this [he] was grabbing [his] penis with [his] hand and rubbing them up and down, and
- December 1, 2018 - Made a sexually inappropriate gesture to another female resident. Explained to the resident it was inappropriate.

82. That on or about December 3, 2018, between 9:00 AM and 4:00 PM, Petitioner's representative observed Resident #1 running his/her wheelchair into other residents' wheelchairs, as well as running into residents who were walking in the hallways.

83. That on or about December 3, 2018, at approximately 1:50 PM, Petitioner's representative observed Resident #1 grab Resident #4 by the right shoulder and neck, yanking Resident #4 backwards, shaking Resident #4, and hitting Resident #4 on the

back.

84. That Resident #4 was screaming, "Let go of me." "Get off of me." "Ouch, you are hurting me."

85. That there was no staff present in the area to supervise or intervene.

86. That Petitioner's representative and another colleague were present and pulled Resident #4's wheelchair forward, and called for staff assistance.

87. That a review of Resident #1's record included the following documentation:

- October 5, 2018 - 1:45 PM punched another resident in the face. The other resident grabbed Resident #1's arms to avoid being hit. Residents were separated, 3:35 PM Ran over another residents toes with [his/her] wheelchair in the west wing. The other resident slapped [Resident #1] on [his/her] arm. Resident #1 slapped the other resident in the face,
- October 11, 2018 - The past week has been agitated, yelling, screaming, banging on doors grabbing and shaking doorknobs, wandering the hallways touching other residents, and showing aggression. Trying to redirect, not working. ARNP and [spouse] notified,
- October 12, 2018 - 1:38 PM Noted to be extremely agitated, ambulating in rolling walker, grabbing other residents' wheelchairs and yanking them. Attempted to strike a female resident, staff intervened and got hit. Tried to redirect, [spouse] notified,
- October 15, 2018 - 1:35 PM Extremely agitated and combative, hitting with hands, grabbing objects projecting them at staff and residents. Altered mental status, sent to hospital,
- October 22, 2018 - 3:44 PM Agitated, kicking and banging on other resident doors, was eventually redirected,
- October 25, 2018 - Extremely anxious, wandering the community, yelling out, knocking on doors,
- October 27, 2018 - Banging on resident doors,
- October 31, 2018 - 2:02 PM wandering the community restlessly, worked up yelling out random words, refusing care,

- November 3, 2018 - Order for as needed medication for increased agitation. Wandering the community yelling and difficult to redirect. Approaching other residents and staff grabbing/pulling on them,
- November 4, 2018 - 5:41 AM Combative and confused,
- November 6, 2018 - 6:41 AM Awake with aggressive behavior and restless, as needed medication administered,
- November 7, 2018 - 2:00 AM Awake, restless, and combative, redirected multiple times,
- November 8, 2018 - Attempted to punch another resident in the head with fist,
- November 10, 2018 - 10:23 PM Found by staff in another resident's bed only wearing a brief, resisted staff,
- November 12, 2018 - 2:41 PM Banging and shaking resident doors, kicking the back of another resident's feet while sitting, resisted care, and
- November 12, 2018 - 4:19 PM Resident agitated, banging on other resident doors, wandering up and down the hallways in wheelchair bumping into other residents. Backed wheelchair into another resident, ran over the other resident's toes twice and hit the resident in the face. Separated by staff and redirected.

88. That on or about December 3, 2018, Petitioner's representative reviewed Respondent's Abuse/Neglect policy dated 2014, and modified on March 30, 2016.

89. That the Abuse/Neglect policy required that any witnessed abuse was to be reported to the Executive Director and the Regional Director of Operations, an incident report would be filled out, the Executive Director would do an investigation, and enlist Adult Protective Services, the state licensing agency, and/or the local Ombudsman's office.

90. That Respondent's policy also required notification to the resident's responsible party by the Executive Director, and local law enforcement would be called.

91. That on or about December 3, 2018 at approximately 4:39 PM, during an interview

with the Executive Director, she acknowledged that the facility did not follow its Abuse/Neglect policy in reporting incidents of abuse, investigating those incidents, and notifying affected residents' responsible parties.

92. That the Executive Director did not produce any documentation or evidence of notification to the agencies outlined in Respondent's Abuse/Neglect policy.

93. That the Executive Director did not produce documentation indicating that any of the residents physically or sexually assaulted by Residents #1, #2, and #3, received any assessment or follow-up after the documented incidents.

94. That during a tour of the facility on December 03, 2018 at approximately 9:16 AM, Petitioner's representative observed a substance that appeared to be feces in the shower and on the shower mat in Room #113.

95. That during a follow up observation of Room #113 at approximately 2:10 PM, Petitioner's representative noted that feces was still in the shower and on the shower mat.

96. That at approximately 1:40 PM, Petitioner's representative observed in Room #140, two white cords, one of which was stretched across the room from the cable connection to the television, and a walker sitting in the middle of the room. The room was occupied by Resident #2.

97. That a review of Resident #2's record revealed the resident was a fall risk, had a history of falls, had an unsteady gait, and noncompliance with using a walker to ambulate.

98. That on or about December 3, 2018, at approximately 4:39 PM, during an interview with the Executive Director, she acknowledged that there was feces in the shower area in Room #113, and the unsafe cable in Room #140.

99. That the aforementioned facts reflect Respondent's failure to adhere to its own abuse policy to ensure all residents who resided in the facility were free from resident-on-resident sexual and physical abuse from three residents who displayed aggressive behavior. Additionally, Respondent failed to ensure resident rooms were clean, and free of hazards for a resident who was identified as a fall risk.

100. The deficient practice described in this count constituted, in part, the basis for an Emergency Order of Immediate Moratorium on Admissions, which the Agency imposed upon the Respondent on or about December 5, 2018, pursuant to Sections 408.814 and 120.60(6), Florida Statutes (2018).

101. The Agency determined that this deficient practice was related to the care of residents which presented an imminent danger to those residents or a substantial probability that death or serious physical or emotional harm would result therefrom, and cited Respondent for a Class I deficiency.

102. That the same constitutes a Class I offense as defined in Section 408.813(2)(a), Florida Statutes (2018).

103. The Agency shall impose an administrative fine for a cited Class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. A fine shall be levied notwithstanding the correction of the violation. Section 429.19(2)(a), Florida Statutes (2018).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of ten thousand dollars ($10,000.00) per violation, for a total sum of thirty thousand dollars ($30,000.00).

COUNT III

104. The Agency re-alleges and incorporates paragraphs (1) through (5), and Counts I and II, as if fully set forth herein.

105. That Florida law provides:

> 1) ADMINISTRATORS. 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 Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter.
> (a) An administrator must: 1. Be at least 21 years of age; 2. If employed on or after October 30, 1995, have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before December 1, 2014, are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to July 1, 1997, are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.
> (b) In the event of extenuating circumstances, such as the death of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4 of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.
> (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile radius of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.

(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to July 1, 1997, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not simultaneously serve as an administrator of any other facility.
(e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, May 2013, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002.

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

106. That on or about December 3, 2018, the Agency conducted a complaint survey at Respondent's facility.

107. That based on observation, record review, and interviews, Respondent failed to ensure that its Administrator supervised the operation and maintenance of the facility and provided the required level of management of care and supervision to all residents of the facility.

108. That a review of Respondent's Abuse and Neglect Policy Dated 2014, and modified on March 30, 2016, read, in part, as follows:

Reporting:

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 (RDO).

10. The Executive Director will ensure that appropriate procedures are followed, forms are submitted, and specified timelines are followed per state regulations.

11. An incident report will be filled out as needed.

14. The Executive Director will investigate the allegation and enlist the services of Adult Protective Services (APS), the state licensing agency and/or the local Ombudsman for assistance.

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

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.

Action:

23. In the event the perpetrator is a fellow Resident, the Resident's condition will immediately be 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.

109. That a review of Resident #2's record revealed multiple documented incidents of inappropriate sexual behavior to include sexual abuse on Resident #4.

110. That Resident #4's record contained no documentation to indicate that the facility notified Resident #4's responsible party, APS, the local Ombudsman or the local police following the documented sexual behaviors and abuse by Resident #2 toward Resident #4.

111. That a review of Resident #1's record revealed multiple incidents of resident-on-resident physical abuse on unidentified residents.

112. That there was no documentation of notification to responsible parties of the victims, APS, local Ombudsman or the local police.

113. That a review of Resident #3's record revealed multiple incidents of resident-on-resident sexual abuse to other residents, including the resident exposing his/her genitals, making sexual gestures to other residents, and touching other residents

inappropriately.

114. That there was no documentation of notification to the responsible parties of the victims, APS, the local ombudsman or local law enforcement in Resident #3's record.

115. That on or about December 3, 2018, during an interview with the Executive Director, she confirmed that the facility's Abuse and Neglect policy and procedure dated March 30, 2016, was the policy and procedure currently in effect.

116. That the Executive Director stated if there were no documentation in the resident charts of notification to their responsible parties following incidents of sexual or physical abuse, then the responsible parties were not notified.

117 That the Executive Director did not produce documentation regarding investigation of the incidents of inappropriate physical and/or sexual conduct of Residents #1, #2, and #3, nor any documentation of the assessment of the victims of the abuse documented in Resident #1's, Resident #2's, and Resident #3's records.

118. That the Executive Director confirmed that the only documented action taken by the facility with regards to Resident #1's inappropriate conduct, was to redirect the resident during each incident.

119. That the aforementioned facts reflect Respondent's failure to ensure that its Administrator supervised the operation and maintenance of the facility and provided the required level of management of care and supervision to all residents of the facility.

120. The deficient practice described in this count constituted, in part, the basis for an Emergency Order of Immediate Moratorium on Admissions, which the Agency imposed upon the Respondent on or about December 5, 2018, pursuant to Sections 408.814 and 120.60(6), Florida Statutes (2018).

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

122. That the same constitutes a Class II offense as defined in 408.813(2)(b), Florida Statutes (2018).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of five thousand dollars ($5,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(b), Florida Statutes (2018).

COUNT IV

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

124. That pursuant to Section 429.19(7), Florida Statutes (2018), in addition to any administrative fines imposed, the Agency may assess a survey fee, equal to the lesser of one half of a facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits to verify the correction of the violations.

125. That Respondent is therefore subject to a survey fee of five hundred dollars ($500.00), pursuant to Section 429.19(7), Florida Statutes (2018).

WHEREFORE, the Agency intends to impose a survey fee of five hundred dollars ($500.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(7), Florida Statutes (2018).

COUNT V

126. The Agency re-alleges and incorporates paragraphs (1) through (5) and Counts I through III, as if fully set forth herein.

127. That Florida law provides:

> (1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, any person subject to level 2 background screening under s. 408.809, or any facility staff:
> (a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
> ...
> (e) A citation for any of the following violations as specified in s. 429.19:
> (1) One or more cited class I violations.
>
> Section 429.14(1)(a) and (e)((1), Florida Statutes (2018).

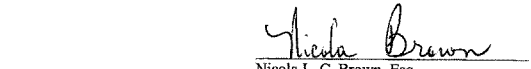
128. That Florida law provides:

> (1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:
> (b) An intentional or negligent act materially affecting the health or safety of a client of the provider.
> (c) A violation of this part, authorizing statutes, or applicable rules.
>
> Section 408.815(1)(b) and (c), Florida Statutes (2018).

WHEREFORE, the Agency intends to revoke the license of Respondent to operate an assisted living facility in the State of Florida.

Respectfully submitted this 17th day of December, 2018.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE AADMINISTRATION



Nicola L. C. Brown, Esq.
Fla. Bar. No. 0492507
Agency for Health Care Administration
525 Mirror Lake Drive N., 330H
St. Petersburg, FL 33701
727.552.1946 (office)
Nicola.Brown@ahca.myflorida.com

NOTICE

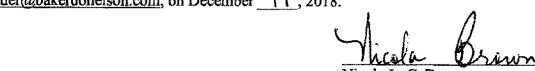
The Respondent is notified that it/he/she has the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If the Respondent wants to hire an attorney, it/he/she has the right to be represented by an attorney in this matter. Specific options for administrative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

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

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

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served via electronic mail to Amy W. Schrader, Esq., Attorney for Respondent, at aschrader@bakerdonelson.com, on December 17, 2018.



Nicola L. C. Brown

Copy furnished to:
Pat Caufman
Field Office Manager
Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: SENIOR LIVING IV SUN CITY, LLC **AHCA No.: 2018018126**
d/b/a INSPIRED LIVING AT SUN CITY CENTER

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. The Election of Rights form may be returned by mail or by facsimile transmission, but must be filed with the Agency Clerk within 21 days by 5:00 p.m., Eastern Time, of the day that you received the Administrative Complaint. If your Election of Rights form with your selected option (or request for hearing) is not timely received by the Agency Clerk, the right to an administrative hearing to contest the proposed agency action will be waived and an adverse Final Order will be issued. In addition, please send a copy of this form to the attorney of record who issued the Administrative Complaint.

(Please use this form unless you, your attorney or your qualified representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.) The address for the Agency Clerk is:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _____ I waive the right to a hearing to contest the allegations of fact and conclusions of law contained in the Administrative Complaint. I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the fine, sanction or other agency action.

OPTION TWO (2) _____ I admit the allegations of fact contained in the Administrative Complaint, but I wish to be heard at an informal hearing (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine, sanction or other agency action should be reduced.

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

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before

the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

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

Licensee Name: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (Optional) _____

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

Signed: _____ Date: _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case Nos. 2018018126
2018017822
2019000966

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

Respondent

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Senior Living IV Sun City, LLC d/b/a Inspired Living at Sun City Center (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondent is an assisted living facility licensed pursuant to Chapters 429, Part I, and 408, Part II, Florida Statutes, Section 20.42, Florida Statutes and Chapter 58A-5, Florida Administrative Code; and

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondent, pursuant to Chapters 429, Part I, and 408, Part II, Florida Statutes; and

WHEREAS, the Agency issued an Immediate Moratorium on Admissions directed to Respondent on or about December 5, 2018: and

WHEREAS, the Agency served Respondent with an Administrative Complaint on or about December 17, 2018, notifying Respondent of the Agency's intent to revoke Respondent's

licensure to operate an assisted living facility in the State of Florida and impose administrative fines in the sum of forty-five thousand dollars ($45,000.00), and a survey fee of five hundred dollars ($500.00) for a total sum of forty-five thousand five hundred dollars ($45,500.00); and

WHEREAS, the Agency cited Respondent with an unclassified deficient practice on or about December 17, 2018, event ID number PSXN11, violation "Z816," for which an administrative fine of five hundred dollars ($500.00) may be assessed; and

WHEREAS, the parties have negotiated and agreed that the best interest of all the parties will be served by a settlement of this proceeding; and

NOW THEREFORE, in consideration of the mutual promises and recitals herein, the parties intending to be legally bound, agree as follows:

1. All recitals herein are true and correct and are expressly incorporated herein.

2. Both parties agree that the "whereas" clauses incorporated herein are binding findings of the parties.

3. Upon full execution of this Agreement, Respondent agrees to waive any and all appeals and proceedings to which it may be entitled including, but not limited to, informal proceedings under Subsection 120.57(2), Florida Statutes, formal proceedings under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that no agreement herein shall be deemed a waiver by either party of its right to judicial enforcement of this Agreement. Respondent specifically waives the necessity of the drafting of or service of an administrative complaint for the relief stipulated to in this Agreement as the same relates to the December 17, 2018 survey resulting in the citation of

the "7.816" violation and the assessment of a fine of five hundred dollars ($500.00) as a result thereof as referenced above.

4. Upon full execution of this Agreement:

   a. Respondent agrees to pay twenty-five thousand five hundred dollars ($25,500.00) in administrative fines and a survey fee of five hundred dollars ($500.00) for a total assessment of twenty-six thousand dollars ($26,000.00) to the Agency within thirty (30) days of the entry of the Final Order; and

   b. The Agency agrees to lift the Immediate Moratorium on Admissions.

   c. Respondent agrees to obtain and maintain the services of an independent assisted living facility and limited nursing services consultant for a period of two (2) years from the date of a Final Order adopting this Agreement or until earlier relieved of this provision by the Agency. Respondent shall cause its consultant(s) to complete quarterly, commencing on or before February 28, 2019, a written report evaluating the facility's standard licensure operations, including but not limited to facility practices, procedures, and training related to resident abuse, neglect, and exploitation. In addition, Respondent shall cause its consultant(s) to complete quarterly, commencing on or before February 28, 2019, a written report evaluating the facility's limited nursing services operations. Said quarterly reports, and all notes, audits, or other work product of the consultants referenced in this sub-paragraph shall be maintained by Respondent and shall be available to the Agency for Agency review upon request.

   d. Respondent's consultant(s) shall conduct an in-person training on resident rights, and recognizing and reporting resident abuse, neglect, or exploitation, one time every six (6) months, commencing no later than June 30, 2019, for a period of two

(2) years. The training referenced herein shall be provided to all staff of Respondent, without regard to the character of the individuals' assigned work tasks, including management and administrative personnel. The training materials, documented attendance records, and curricula shall be maintained by Respondent and available for Agency review upon request.

e. Florida law permits Agency action to deny or revoke licensure based upon the violation of the provisions of Chapter 408, Part II, 429, Part I, and Chapter 58A-5, Florida Administrative Code. *See,* § 408.815(1), Florida Statutes (2018). Should Respondent be cited for a Class I, a Class II deficient practice, or three (3) or more uncorrected Class III or IV deficient practices on any survey or surveys for a period of two (2) years from the date of the Final Order, the Agency may utilize said deficient practice(s), if proven, to revoke Respondent's licensure in addition to and as a supplement to any provision of law authorizing an action for revocation of licensure; and

f. The Agency shall dismiss Count V of the Administrative Complaint in Agency case number 2018018126, seeking revocation of Respondent's licensure to operate an assisted living facility in the State of Florida; and

g. Should Respondent fail to implement any or all of the provisions of this paragraph four (4), Respondent shall be subject to liquidated damages in a sum not to exceed one hundred dollars ($100.00) per day and may be utilized in the Agency's discretion as contractual grounds for licensure action including, but not limited to, licensure revocation.

5. Venue for any action brought to enforce the terms of this Agreement or the Final Order entered pursuant hereto shall lie in Circuit Court in Leon County, Florida.

6. By executing this Agreement, a) Respondent denies the allegations raised in the Administrative Complaint and surveys referenced herein, and b) The Agency asserts the validity of the allegations raised in the Administrative Complaint and surveys referenced herein. No agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, which constitutes an "uncorrected" deficiency from surveys identified in the administrative complaint.

7. The Agency may use the deficiencies from the surveys identified in the administrative complaint in any decision regarding licensure of Respondent, including, but not limited to, licensure for limited mental health, limited nursing services, extended congregate care, or a demonstrated pattern of deficient practice. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Respondent acknowledges and agrees that this Agreement shall not preclude or estop any other federal, state, or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the administrative complaint and notice of intent to deny as modified herein. This agreement does not prohibit the Agency from taking action regarding Respondent's Medicaid provider status, conditions, requirements or contract. The parties stipulate that the deficient practices alleged in the Administrative Complaint shall not be the sole basis for future licensure action.

8. Upon full execution of this Agreement, the Agency shall enter a Final Order adopting and incorporating the terms of this Agreement and closing the above-styled case.

9. Each party shall bear its own costs and attorney's fees.

10. This Agreement shall become effective on the date upon which it is fully executed by all the parties.

11. Respondent for itself and for its related or resulting organizations, its successors or transferees, attorneys, heirs, and executors or administrators, does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter and the Agency's actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement, by or on behalf of Respondent or related or resulting facilities/organizations. Nothing in this paragraph limits the parties from enforcement of this Agreement as provided in paragraph five (5) of this Agreement.

12. This Agreement is binding upon all parties herein and those identified in paragraph eleven (11) of this Agreement.

13. In the event that Respondent was a Medicaid provider at the subject time of the occurrences alleged in the complaint herein, this settlement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any sanctions pursuant to Rule 59G-9.070, Florida Administrative Code.

14. Respondent agrees that if any funds to be paid under this agreement to the Agency are not paid within thirty (30) days of entry of the Final Order in this matter, the Agency may deduct the amounts assessed against Respondent in the Final Order, or any portion thereof, owed by Respondent to the Agency from any present or future funds owed to Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to Respondent by the Agency for said amounts until paid.

15. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. Respondent has the capacity to execute this Agreement.

16. This Agreement contains and incorporates the entire understandings and agreements of the parties.

17. This Agreement supersedes any prior oral or written agreements between the parties.

18. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

19. All parties agree that a facsimile signature suffices for an original signature.

20. The following representatives hereby acknowledge that they are duly authorized to enter into this Agreement.

Molly McKinstry, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Building #1
Tallahassee, Florida 32308

DATED: 1/29/19

Amy W. Schrader, Esq.
Counsel for Respondent
101 North Monroe Street
Suite 925
Tallahassee, Florida 32301
Florida Bar No. 621358

DATED: 1/23/19

Stefan Grow, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
Florida Bar No. 93585

DATED: 1/29/19

Name: Lindsay Hacker
Title: Chief Financial Officer
Senior Living IV Sun City Center, LLC
d/b/a Inspired Living at Sun City Center
1320 33rd Street SE
Sun City, Florida 33570

DATED: 1/23/2019

Nicole L. C. Brown, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive North, Suite 330G
St. Petersburg, Florida 33701
Florida Bar No. 492507

DATED: 1/23/19