STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

REBULL SENIOR LIVNIG, INC.,

Respondent.

/

AHCA No. 2019013261
License No. 7838
File No. 11911930
Provider Type: Assisted Living Facility

EMERGENCY SUSPENSION ORDER

THIS CAUSE came on for consideration before the Secretary of the Agency for Health Care Administration, or her 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. (2019), Ch. 59A-36, 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. (2019).

2. The Respondent, Rebull Senior Living Inc. (hereinafter "the Respondent"), was issued a license by the Agency to operate a six (6) bed assisted living facility (hereinafter "the Facility") located at 10790 Southwest 43rd Terrace, Miami, Florida 33165, and was at all material times required to comply with the statutes and rules governing such facilities.

3. As the holder of such a license, the Respondent is a licensee. "Licensee" means "an individual, corporation, partnership, firm, association, or governmental entity, or other entity that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2019). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2019). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2019). § 408.803(11), Fla. Stat, (2019). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2019), and listed in Section 408.802, Florida Statutes (2019). § 408.802(13), Fla. Stat. (2019). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2019).

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 (2019), and Chapter 59A-36, Florida Administrative Code.

5. As of the date of this Emergency Suspension Order, the census at the Facility is five (5) residents/clients.

THE AGENCY'S EMERGENCY ORDER AUTHORITY

6. The Agency may impose an immediate moratorium or emergency suspension as defined in section 120.60, Florida Statutes (2019), 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. (2019). 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. (2019).

LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

Resident Rights

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) 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. 429.55 which are consistent with established and recognized standards within the community..." § 429.28(1), Fla. Stat. (2019).

Medication Labeling and Orders

8. Florida law provides:

> (7) MEDICATION LABELING AND ORDERS.
> (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:
> 1. The resident's name; and,
> 2. The identification of each medicinal drug in the container.
> (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage

container to another.
(c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.

Fla. Admin. Code R. 59A-36.008(7).

FACTS JUSTIFYING EMERGENCY ACTION

9. On August 21, 2019, the Agency completed a survey of the Respondent Facility.

10. Based upon this survey, the Agency makes the following findings:

a. Soon after entry to the Facility on August 20, 2019, at 8:28 a.m., Agency personnel observed a Facility staff member stuffing a white paper bag filled with four (4) medication blister packs into the Facility's clothes dryer. After several requests, the staff member produced the bag for Agency inspection. The contents included blank medication observation records, two (2) packages of Metformin with ten (10) pills missing from the PM package and four (4) pills missing from the AM package, and two (2) packages of Immodium with ten (10) pills missing from the PM package and three (3) pills missing from the AM package.

b. The staff member explained that the Facility Administrator had instructed the staff member to discontinue providing the Metformin to resident number three (3), but the staff member had not had a chance to dispose of the medication.

Resident number three (3)

c. Resident #3 is eighty-one (81) years old and suffers from Angina Pectoris, Systolic Congestive Heart Failure, Dermatophytosis, Hypertension, Arteriosclerotic Heart Disease, Syncope, Dementia, history of Atrial Fibrillation, Microcytic Anemia, Diabetes Mellitus – insulin dependent, and Acute Encephalopathy.

d. The resident's physician indicated that on August 1, 2019, she prescribed a home health agency to administer insulin to the resident along with a prescription for insulin. The physician further indicated that she had not prescribed the oral blood sugar medication Metformin for the resident as it was contraindicated for the resident because the medication would increase the resident's risk of kidney failure.

e. The Facility could produce no insulin as prescribed or any evidence that a home health agency had been contracted to provide insulin administration for the resident.

f. The resident's medication observation records reflect that the Facility had been providing Metformin to the resident.

g. The Facility could not produce a prescription for the use of Metformin to treat the resident. *See,* Rule 59A-36.015(3)(c), Florida Administrative Code.

h. The resident had been prescribed Imodium and no order to discontinue the medication was contained in the Facility records for the resident.

i. The Facility's Administrator indicated that the Facility had discontinued providing Imodium to the resident as the resident was constipated.

j. There was no documentation that the resident's physician had been contacted regarding any of the above described medication discrepancies.

k. The pharmacy serving the resident produced records reflecting that a prescription for the insulin Levemir was processed on August 7, 2019, and Metformin on August 8, 2019.

l. The Facility could not produce the insulin provided by pharmacy.

m. The resident was hospitalized on August 10, 2019 with hospital records reflecting the resident's chief complaint of "passed out" and syncope.

Resident number two (2)

n. The resident is eighty-one (81) years old and was, at the time of the Agency survey, hospitalized due to shortness of breath and had diagnoses including Osteoporosis, Hypertension, Diabetes Mellitus – insulin dependent, and Right Tibia pain or swelling.

o. The resident's physician indicated that on August 8, 2019, she prescribed a home health agency to administer insulin to the resident and had increased the resident's insulin coverage effective August 1, 2019 due to a high level of hyper glycohemoglobin. The physician further indicated she had not been notified of the resident's hospitalization and that she had not prescribed the oral blood sugar medication Metformin for the resident as it was contraindicated because the medication would increase the resident's risk of kidney failure.

p. The resident's medication observation record reflected the resident had been prescribed the insulin Levemir 100 units/ml, however the record did not reflect the resident had been provided the medication since August 1, 2019. The medication observation record also reflected the resident had been provided the oral medication Metformin 500 mg twice daily since August 1, 2019.

q. The Facility records related to the resident contained a folder with home health agency documentation reflecting the home health agency discontinued providing insulin to the resident on May 7, 2019. Absent from the resident's records was any order for home health agency administration of insulin for the resident from May 8, 2019 to the date of review, and no documentation that the Facility had contacted the resident's physician regarding the resident's August 19, 2019 hospitalization. *See,* Rule 59A-36.007(1), Florida Administrative Code.

r. The pharmacy serving the resident indicated that the prescribed insulin for the resident was delivered and signed for by the Facility on August 8, 2019. Produced pharmacy records reflected that a prescription for the insulin Levemir 100 unit/ ML Vial was processed on August 8, 2019 and Metformin on July 24, 2019.

s. The Respondent's controlling interest denies ever receiving insulin from the pharmacy for the resident and confirmed that the resident had not received insulin since May 7, 2019.

t. The resident's preliminary diagnoses from the hospital was an acute and chronic respiratory failure with hypoxia, abnormal levels of other serum enzymes, acute pulmonary edema with possible developing right lower lobe infiltrate, and acute kidney failure.

Resident number one (1)

u. The resident, now deceased, was seventy-seven (77) years old and suffered from, *inter alia*, Type II Diabetes Mellitus.

v. The resident was admitted to the Facility on May 20, 2019 and received insulin administration from a home health agency from May 26, through June 2, 2019.

w. The resident was hospitalized on May 22, June 1, and June 3, 2019.

x. The May 22, 2019 hospitalization resulted in a discharge with diagnoses including Cellulitis, UTI, and a fall and required fall precautions and antibiotic medications.

y. The Facility records related to the resident do not contain any indication that the Facility staff members instituted any fall precautions or arranged for any follow up care after this incident.

z. The June 1, 2019 hospitalization was as a result of hypoglycemia with the resident's blood sugar level recorded by emergency response personnel at thirty-three (33).

aa. The June 3, 2019 hospitalization was as a result of a second fall of unknown reason with head injury and a laceration. The resident's blood sugar level was recorded by emergency response personnel at thirty-one (31). Hospital records

conclude the resident's altered mental status upon admission was likely due to hypoglycemia.

bb. The Facility could not produce any record related to services provided by the home health agency, or prescriptions for insulin. The Facility records related to the resident did not document any communication with the resident's physician related to these three (3) hospitalizations. *See,* Rule 59A-36.015(3)(c), Florida Administrative Code.

cc. The Facility records for the resident did not contain any indication that the Facility had considered or implemented any actions or interventions after any of the resident's multiple hospitalizations to reduce the risk of injury related to falls or to address blood sugar deficiencies identified by emergency and hospital caregivers.

NECESSITY FOR EMERGENCY ACTION

11. 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. (2019), Ch. 408, Part II, Fla. Stat. (2019); Ch. 59A-36, 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.

12. 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. Assisted living facilities must also assist residents in obtaining adequate and appropriate health care. An assisted living facility must protect these resident rights, including the provision of a safe and decent living environment. § 429.28, Fla. Stat. (2019); Fla. Admin. Code R. 59A-36.014(3)(a). Residents of assisted living facilities must receive the care

and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 59A-36.007(1).

13. Residents who 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 demonstrated an inability or unwillingness to ensure that it provides an environment that is free of abuse or neglect, that residents receive prescribed health care, and that care and services appropriate to resident needs are provided.

15. The failures of the Respondent to meet minimum requirements presents an immediate threat to residents.

16. Here, the Respondent has demonstrated a systemic failure in the management of resident prescribed medication needs. Physician orders are not obtained or maintained, the lack of which impedes if not prohibits the Respondent from ensuring compliance with a physician's medication treatment scheme. Resident medications are delivered by the pharmacy and received by the Respondent's personnel, but the receipt thereof is denied, and the medications are absent from resident medication storage.

17. Physician orders for home health services to facilitate the administration of prescribed medications are not implemented, leaving only unlicensed staff to provide medication assistance services for residents clearly requiring medication administration. Unexplained are the presence of, and assistance with self-administration of, medications intended for treatment of diabetes which had not been ordered by the residents' physicians.

18. These errors and omissions were or should have been obvious to the Respondent. Medication observation records reflecting a prescription of insulin which is not being

administered would alert any provider to take action to assure compliance with the prescriptive milieu. The cessation of insulin administration services by a third-party home health provider without a concordant physician's order to discontinue insulin or its administration would alert any provider to further action to assure the resident's diabetic treatment needs were being met. A resident suffering hospitalization with identified critically low blood sugar readings would and should alarm any provider to assure that the resident's diabetic treatment needs are being met upon the resident's return from hospitalization.

19. Here, the Respondent has demonstrated that these alarming events do not prompt the Respondent to undertake the action required by law. The residents' physicians are not contacted when their patients undergo a significant change, such as hospitalization. Abrupt and unexplained cessation of home health services for insulin administration is not addressed with the resident, the health care provider, or the family. Medications for which the Respondent has no physician's order are not only provided to the resident, but withheld from the resident at the determination of non-licensed Facility staff. No action to safeguard a resident after multiple falls is instituted, even after multiple incidents.

20. These failures illustrate conditions under which residents and their ongoing health and well-being is simply not being provided by the Respondent. The Respondent's systemic and repeated failures related to medication, access to health care, and compliance with physician orders endanger the health and safety of the Respondent's residents.

21. Clearly, this presents an immediate risk to residents.

22. Residents have a right to receive services in a safe and decent living environment free from neglect and abuse. § 429.28, Fla. Stat. (2019). The acts and omissions of the Respondent has violated that right.

23. These deficient practices permeate Facility operations.

24. Individually and collectively, these facts reflect that the residents of this Facility are not currently residing in a safe and decent living environment free from abuse and neglect, § 429.28(1)(a) and (b), Fla. Stat. (2019). The residents are not receiving the assistance with obtaining access to adequate and appropriate health care, § 429.28(1)(j), Fla. Stat. (2019). Resident medication management is far below minimum standards of law. *See generally*, Rule 59A-36.008, Florida Administrative Code. 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. (2019). "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. (2019).

25. The Respondent's deficient practices exist presently; have existed in the past, and more likely than not will 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.

CONCLUSIONS OF LAW

26. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 429, Part I, Florida Statutes, and Chapter 59A-36, Florida Administrative Code.

27. Each resident of an assisted living facility has the statutory right to live in a safe and decent living environment free from abuse and neglect, and access to adequate and

appropriate health care. § 429.28(1), Fla. Stat. (2019), and to medication management services in compliance with physician specifications, Fla. Admin. Code R. 59A-36.008.

28. 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 emergency suspension of the Respondent's licensure to operate an assisted living 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 emergency suspension of the Respondent's licensure to operate an assisted living facility in the State of Florida.

29. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an emergency suspension of the Respondent's licensure 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 for resident health, safety and welfare because of the complete lack of qualified staff, and (3) being placed in an assisted living facility where the regulatory mechanisms enacted for residents protection have been repeatedly overlooked.

30. The Respondent's deficient practices exist presently, have existed for an extended period of time in the past without corrective action, and will 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. Such deficient practices and conditions justify the imposition of an emergency suspension of licensure. Less restrictive actions, such as the assessment of administrative fines or the implementation of a moratorium on admissions, will not ensure that the current residents or future residents receive the appropriate care, services, and environment dictated by Florida law.

31. 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 facts and circumstances. This remedy is narrowly tailored to address the specific harm in this instance.

IT IS THEREFORE ORDERED THAT:

32. The Respondent's license to operate this assisted living facility is **SUSPENDED** effective August 23, 2019, at 5:00 p.m.

33. Upon receipt of this order, the Respondent shall post this Emergency Order on its premises in a place that is conspicuous and visible to the public.

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

35. The Agency shall promptly file an administrative action against the Respondent based upon the facts set out in this Emergency Suspension Order and provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2019), at the time that such action is taken.

ORDERED in Tallahassee, Florida, this 22nd day of August, 2019.

Mary C. Mayhew, 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.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

DELEGATION OF AUTHORITY
To Execute
Emergency Orders

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

This delegation of authority shall be valid from the date of February 1, 2019 until revoked by the Secretary.

Mary C. Mayhew, Secretary

2/6/19
Date

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