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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

CRESTWOOD NURSING CENTER, INC. d/b/a
CRESTWOOD NURSING CENTER,

Respondent.
_______________________________________/

AHCA No. 2019013677
License No. 1454096
File No. 35402
Provider Type: Nursing Home

IMMEDIATE MORATORIUM ON ADMISSIONS

THIS CAUSE came before the Secretary of the Agency for Health Care Administration, or her duly appointed designee, who after careful review of the record 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 nursing homes in Florida and enforces the applicable state statutes and rules governing nursing homes. Chs. 408, Part II, and 400, Part II, Fla. Stat. (2019), Ch. 59A-4, 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, Crestwood Nursing Center, Inc. d/b/a Crestwood Nursing Center (hereinafter "the Respondent"), was issued a license by the Agency to operate a nursing home (hereinafter "the Facility") located at 501 South Palm Avenue, Palatka, Florida 32177. The

licensed capacity of the Facility is sixty-five (65) residents.

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. (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). Nursing homes are regulated by the Agency under Chapter 400, Part II, Florida Statutes (2019), and listed in Section 408.802, Florida Statutes (2019). § 408.802(11), Fla. Stat. (2019). Nursing home residents are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2019). The Respondent holds itself out to the public as a nursing home that fully complies with state laws governing such providers.

4. The current census of the Respondent as of this date is forty-seven (47) residents.

THE AGENCY'S MORATORIUM ON ADMISSIONS AUTHORITY

5. Under Florida law, the Agency may impose an emergency suspension order or immediate moratorium on admissions 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).

6. Under Florida law, if the Agency finds that an 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 A NURSING HOME

7. Under Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. § 400.022(1)(l), Fla. Stat. (2019).

8. Under Florida law: "The Administrator of each nursing home must designate one registered nurse as a Director of Nursing (DON) who shall be responsible and accountable for the supervision and administration of the total nursing services program. When a Director of Nursing is delegated institutional responsibilities, a full time qualified registered nurse (RN), as defined in Chapter 464, F.S., must be designated to serve as Assistant Director of Nursing. In a facility with a census of 121 or more residents, an RN must be designated as an Assistant Director of Nursing." Fla. Admin. Code R. 59A-4.108(1).

9. Under Florida law, "All staff personnel who provide care, and at the resident's option, private duty nurses or personnel who are not employees of the facility, must be knowledgeable of, and have access to, the resident's plan of care." Fla. Admin. Code R. 59A-4.109(4).

10. Under Florida law: "The internal risk management and quality assurance program is the responsibility of the facility administrator." § 400.147(2), Fla. Stat. (2019).

FACTS JUSTIFYING AN IMMEDIATE MORATORIUM ON ADMISSIONS

11. On August 29, 2019, the Agency completed a survey of the Facility.

12. Based upon the survey, the Agency makes the following findings:

a. Resident number two (2):

i. The resident was receiving third party Hospice services.

ii. Physician's orders included orders as follows:

1. Morphine 0.5 ml/20 mg per ml every four (4) hours;

2. Morphine 0.5 ml/20 mg per ml every four (4) hours as needed;

3. Ativan 1 mg every four (4) hours;

4. Ativan 1 mg every four (4) hours as needed;

5. May hold medications if the patient is sedated. May continue as needed.

iii. Medication administration records for the resident document the resident was administered the prescribed morphine and Ativan on at least six occasions during August 18, 2019, at 8:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 5:30 p.m., and 8:00 p.m., and on August 19, 2019 at 12:00 a.m.

iv. A nursing note of August 18, 2019, at 10:07 a.m. documents, "Resident is non-responsive, family notified and in facility. Resident on 4 liters of oxygen via nasal cannula due to apnea."

v. A nursing note of August 18, 2019 at 12:23 p.m. documents, "Hospice discontinued all medications except morphine and Ativan. Resident's eyes no longer reactive to light, respirations are approximately 8 per minute. 02 (oxygen) via nasal cannula, pulse 70."

vi. A nursing note of August 18, 2019 at 2:24 p.m. documents, "Resident being

medicated every 2 hours as instructed by hospice nurse. Respiration 7 per minute. Currently unarousable again."

vii. A nursing note of August 19, 2019 at 9:04 a.m. documents, "Resident only responsive to painful stimuli. Upon assessment by the hospice nurse sent patient to the emergency room."

viii. The hospice nurse made the decision to transfer the resident to the emergency department on August 19, 2019 due to the resident's condition. The hospice nurse is adamant that she did not advise the Facility's nursing staff to administer the medications every two (2) hours as documented in the nursing notes.

ix. The resident was determined by emergency room staff to have experienced an overdose and Narcan was administered.

x. Absent from the records was any indication of or explanation for the Respondent's deviation from the physician's orders related to the administration of morphine and Ativan both in respect to the prescribed periodic administration of the medications, and the prescribed discontinuation of the medications in the event the patient became sedated. There was no documentation that the resident's physician was contacted related to the ongoing administration of morphine and Ativan.

xi. Despite the clear prescriptive parameters of the resident's morphine and Ativan, the Respondent administered the medications to the resident as often as every two (2) hours while the prescribed parameter was four (4) hours and failed to discontinue the medications when the resident grew sedated and in fact through a period where the resident presented as non-responsive.

b. Resident number one (1):

i. On August 17, 2019, the resident reported to the Respondent's Social Service Director that a staff member had slapped the resident while the resident was receiving incontinence care. Two (2) staff members were named.

ii. The Respondent's Director of Nursing was also the Respondent's Abuse Coordinator and Risk Manager.

iii. The Respondent's Social Services Director took written statements from the staff members alleged to have mistreated the resident and sent the staff members home. The Social Services Director also notified law enforcement, and Florida's Department of Children and Families, Adult Protective Services.

iv. The Social Services Director allowed the subject staff members to return to their employment on August 19, 2019.

v. The Respondent's policy and procedure requires that upon a report of abuse or neglect, the Administrator shall be notified of the allegation and a written investigation, along with corrective action, must be completed and the resident notified of the outcome.

vi. The Respondent could not produce any evidence that a written investigation was completed, that corrective actions or interventions were considered or implemented, or that the resident was notified of the outcome.

vii. The Respondent failed to follow its policy in the internal investigation of this event.

viii. Additionally, this resident was prescribed Lactulose to address ammonia levels in the blood. Elevated ammonia levels can affect an individual's behaviors

and mood.

ix. The medication administration record further reflects that the resident's prescribed Lactulose was administered only two (2) times total during the week of August 6 through 14, 2019. This record also reflects that the medication was discontinued on August 14, 2019, though the Respondent could produce no physician's order reflecting this prescriptive change.

c. Resident number ten (10):

i. The resident was "Full Code," meaning that in the event the resident became unresponsive, the resident desired that cardiopulmonary resuscitation be initiated.

ii. A nursing note dated August 11, 2019 at 10:45 p.m. documents, "While receiving report from off going nurse, nursing assistant called for assistance to patient's room. Upon entering the room, the patient was assessed with no response to verbal stimuli, pulse palpated without results, code blue called. Crash cart was called to the room. At 10:50 p.m. compressions were started. 911 was called. Six rounds of compressions and breathes were performed. EMS arrived, assessed the patient, and transported the patient to the hospital."

iii. Absent from the records was any indication of or explanation for the Respondent's failure to initiate cardiopulmonary resuscitation to the resident upon the discovery of the resident's non-responsiveness at 10:45 p.m., or any indication as to why emergency services were not contacted, and cardiopulmonary resuscitation not initiated until five (5) minutes thereafter.

iv. The resident expired at the hospital.

d. The Respondent could not produce an automated external defibrillator (AED).

The Respondent's policy and procedure requires the use of the AED in emergent conditions.

e. Of sixteen (16) personnel records reviewed of the nursing and certified nursing assistant staff, eight (8) lack valid certification of training in cardiopulmonary resuscitation.

f. Eight (8) of the nurses were interviewed during the survey, and none could identify the location of the Facility's crash cart for use in emergent conditions.

g. The Respondent's Assistant Director of Nursing candidly acknowledges that she was aware that resident number two (2) continued to be administered morphine and Ativan despite the resident having grown unresponsive, respirating at seven (7) to eight (8) respirations per minute and being unresponsive to light.

h. The Director of Nursing acknowledges that he was informed of the events surrounding resident number two (2) by the Assistant Director of Nursing, but no further action was taken.

i. The Administrator denied prior knowledge of the events described above related to residents numbered two (2) and ten (10).

j. The Respondent could produce no evidence of responding to the events described above related to residents numbered one (1), two (2) and ten (10). No adverse incidents were recorded for the events related to residents numbered two (2) and ten (10). No investigations of the events were undertaken. No corrective action, such as staff training, staff competency testing, or audits of medication compliance were either considered or undertaken.

13. In this instance, after careful and due consideration, the Agency determines that

the practices and conditions at the Facility, as set forth more specifically above, present (1) a threat to the health, safety or welfare of residents of the Facility, (2) a threat to the health, safety or welfare of a client, (3) an immediate serious danger to the public health, safety or welfare, and (4) an immediate or direct threat to the health, safety, or welfare of the residents that constitutes sufficient factual and legal grounds justifying the imposition of an Immediate Moratorium on Admissions to this nursing home.

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS

14. 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 nursing homes. Ch. 400, Part II, Fla. Stat. (2019), Ch. 408, Part II, Fla. Stat. (2019); Ch. 59A-4, Fla. Admin. Code. In those instances where the health, safety or welfare of a nursing home resident is at risk, the Agency will take prompt and appropriate action.

15. A nursing home must provide adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. § 400.022(1)(l), Fla. Stat. (2019). Residents of nursing homes suffer from disease or disability, are frail, elderly, or vulnerable. By law, the Respondent has been licensed and entrusted to provide care and services to this special class of people, and as such, must comply with the regulations, statutes and rules that have been enacted for the special needs of these residents.

16. Based upon the foregoing, (1) an immediate serious danger to the public health, safety, or welfare presently exists at the Facility, which justifies an immediate moratorium on

admissions, and (2) the present conditions related to the Facility present a threat to the health, safety, or welfare of a resident, which requires an immediate moratorium on admissions.

17. The Respondent's deficient conduct related to medication administration is in direct contrast to the community standards related to medication administration. Inexplicable deviations from the prescribed administration and discontinuation of medications constitute conditions that place all residents receiving medications at risk.

18. The Respondent's deficient conduct related to the administration of cardiopulmonary resuscitation in a timely manner similarly places each resident opting for the receipt of such services at risk that such services will not be effectively provided in an emergent condition.

19. The Respondent's deficient conduct and failure to take action to prevent recurrence places all residents at immediate threat to their health, safety and welfare. The Respondent has demonstrated an inability or unwillingness to evaluate its own performance and ensure its operations and staffing are equipped, both in competence and systems, to ensure that adequate and appropriate health care are provided to each of its residents. Both the failure to comply with prescribed medication administration protocols, and the inexplicable delay of the administration of potentially life-saving emergency care, demonstrate operations that are not administered in a manner to assure that the health care needs of residents are met in a timely and competent manner.

20. The above-recited facts reflect that that Respondent's risk management systems are ineffective to assure systemic operations designed to assure resident health, safety, and well-being. Each nursing home must implement a risk management system, including systems to report and investigate adverse incidents. *See generally*, § 400.147, Fla. Stat. (2019). The facts

reflect that the Respondent's risk management system failed to identify or recognize events that demand investigation and the development of interventions to improve facility performance.

21. Last, the Respondent has demonstrated that its systems designed to prevent abuse, neglect, or exploitation are not operational. The Respondent's abuse system failed in its entirety when a resident reported being abused by staff members. Rather than implement and follow its policy and procedure, the Respondent's staff member merely interviewed the alleged perpetrators and allowed the staff member's return to employment in the Facility.

22. The above-stated conditions present an immediate serious danger to public health, safety, or welfare and constitute a direct threat to the health, safety or welfare of residents and/or potential residents of the Facility. No resident of a nursing home should be placed in a hazardous environment.

23. The Respondent's deficient practice exist presently; have existed in the past, and more likely than not will continue to exist if the Agency does not act promptly.

24. An Immediate Moratorium on Admissions to this nursing home is necessary to protect the residents from (1) the unsafe conditions and deficient practices that currently exist in the facility, (2) being placed at risk of living in an environment ill-equipped to provide for resident health, safety and welfare, and (3) being placed in a nursing home where the statutory and regulatory mechanisms enacted for their protection have been breached.

CONCLUSIONS OF LAW

25. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

26. 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.

27. 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 a safe and sanitary living environment, and (3) being placed in a nursing home where the regulatory mechanisms enacted for residents protection have been overlooked.

28. The Respondent's deficient practices exist presently and will more likely than not continue to exist if the Agency does not act promptly. The Respondent has failed to identify, investigate, or address deficient practices that were or should have been known to the Respondent and its administration. 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 residents receive the appropriate care and services dictated by Florida law. 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:

29. An Immediate Moratorium on Admissions is placed on the Facility based upon the above-referenced provisions of law. The Respondent shall not admit any new individuals or

readmit any discharged residents unless permitted by the Field Office Manger in writing.

30. This Immediate Moratorium on Admisions shall be posted and visible to the public at the Respondent's nursing home. § 408.814(4), Fla. Sta. (2019).

31. During the Immediate Moratorium on Admisions, the Agency may regularly monitor the Facility.

32. The Agency shall promptly proceed with the filing of an administrative action against the Respondent based upon the facts set out within this emergency 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 (2019), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 30th 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

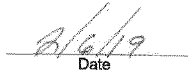
MARY C. MAYHEW
SECRETARY

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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