STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

LIVEWELL OPERATIONS II, INC. d/b/a LIVEWELL AT COURTYARD PLAZA,

Respondent.
_____/

AHCA No. 2019015124
License No. 7169
File No. 11911412
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 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, Livewell Operations II Inc. d/b/a Livewell at Courtyard Plaza (hereinafter "Respondent"), was issued a license (license number 7169) by the Agency to operate a one hundred twenty (120) bed assisted living facility (hereinafter "Facility") located at 15520

Northwest 2nd Avenue, North Miami Beach, Florida 33160, 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, 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(11), Fla. Stat. (2019). Assisted living facility residents 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 Immediate Moratorium on Admissions, the census at the Facility is one hundred eleven (111) 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

Supervision

7. 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.

Fla. Admin. Code R. 59A-36.007(1).

Resident Rights

8. Florida law provides:

> 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; and . . . (j) [a]ccess to adequate and appropriate health care consistent with established and recognized standards within the community." § 429.28(1), Fla. Stat. (2019).

Assisted living facilities must provide a safe living environment pursuant to Section 429.28(1)(a), Florida Statutes.

Fla. Admin. Code R. 59A-36.014(3)(a).

FACTS JUSTIFYING EMERGENCY ACTION

9. On September 25, 2019, the Agency completed a survey of the Facility.

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

a. Resident number one (1):

i. The resident was transported by non-emergency medical transport to a hospital emergency department on September 15, 2019, and subsequently transferred to a trauma unit.

ii. Hospital records reflect the resident suffered from a subdural hematoma and presented with facial swelling and bruising to the left side of the face, swelling and bruising on the right side of the face, a swollen eyelid, and bleeding from the mouth. Broken bones in the face were identified. Hospital records opine the bruising had occurred at least twenty-four (24) hours prior to hospitalization, and perhaps up to seventy-two (72) hours prior to the evaluation.

iii. Facility staff indicate the resident had been identified as "not feeling well" and acting unusually for at least thirty (30) hours prior to the decision to transport the resident to the emergency department.

iv. On September 14, 2019, a certified nursing assistant reported to the Facility's director of nursing on two (2) occasions that the resident was breathing fast and was found in the shower in the early hours of the morning. The director of nursing directed that the resident be monitored and declined to direct the resident's transfer for further medical evaluation.

v. There is no documentation of this exchange, and no indication that the change in condition of the resident was reported to the resident's health care provider or representative.

vi. The resident was ultimately transferred to the hospital after a staff member reported to Facility's director of nursing, on September 15, 2019, that the resident appeared weak, dizzy, and disoriented. The director of nursing made this decision based upon information from direct care staff that the resident was dizzy and lethargic. The director of nursing indicated that no mention of facial swelling or discoloration was made by direct care staff.

vii. A co-resident reports that the co-resident witnessed resident number one (1) suffer a fall on September 13, 2019, and September 14, 2019. Both times, the co-resident reports that Facility staff assisted the resident after the fall.

viii. A Facility caregiver acknowledges that prior to the resident's hospitalization, the caregiver had, with a co-worker, noted the resident's face to be swollen and bruised. This individual indicates the co-worker was to report the swelling to management.

ix. The Facility's records contain no documentation of the resident suffering falls on September 13 or 14, 2019, nor any evidence that the resident's health care provider or representative was notified of these events.

x. The Facility's records contain no documentation that the Facility had investigated the cause of the resident's falls or considered or implemented any interventions to minimize the risk of recurrence.

xi. The resident is sixty-five (65) years of age and suffers from multiple diagnoses including chronic hyponatremia, dementia, hypertension, coronary artery disease, seizure disorder, and paranoid type schizophrenia.

xii. The Facility's documentation regarding the above described is a post-hospitalization internal incident report which reflects the resident seemed disoriented, dizzy, and walking with head down. The internal report specifically documented, "... the resident had no bruising, resident only seemed disoriented, dizzy, and had a change in behavior."

xiii. As of the date of the survey, the Facility had not completed or submitted to the Agency adverse incident reports as required by law. *See,* § 429.23, Florida Statutes (2019).

b. Residents numbered two (2) and three (3):

i. Resident number two (2) is seventy-two (72) years of age and has diagnoses including early onset dementia and Type II diabetes mellitus.

ii. Resident number three (3) is sixty-two (62) years of age and has diagnoses including aggressive behavior and seizure disorder. The resident was not identified on the resident's health assessment as presenting a danger to self

or others.

iii. On September 19, 2019, both residents were transported to the hospital after the residents had a physical altercation. Hospital records reflect that resident number two (2) presented with a black eye.

iv. The Facility's records document that both residents were returned to the Facility on the following day with no change in orders.

v. Internal incident reports reflect the residents were sent to the hospital after having engaged in an altercation at the facility's courtyard smoking area. Law enforcement was called.

vi. The internal incident reports also document that resident number two (2) struck resident number three (3) for blowing smoke in the face of resident number two (2). The reports further document that resident number two (2) complained of pain to the back and face after the altercation.

vii. There is no documented indication that this event was reported to the residents' health care providers, the residents' representatives, or adult protective services.

viii. The Facility's records contain no documentation that the Facility had investigated the altercation or considered or implemented any interventions to minimize the risk of recurrence.

ix. The Facility director of nursing indicated that in response to the incident, she verbally instructed resident number three (3) not to take such actions on the resident's own, and that under no circumstance is punching another resident permitted.

x. As of the date of the survey, the Facility had not completed or submitted to the Agency adverse incident reports as required by law. *See,* § 429.23, Florida Statutes (2019).

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, *inter alia*, a safe and decent living environment, free from abuse and neglect, and access to adequate and appropriate health care consistent with established and recognized standards within the community. An assisted living facility must protect these resident rights. § 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 a failure to ensure its residents receive care and services, including supervision, appropriate to meet resident needs, and a failure to ensure resident rights are honored. These failures include the Respondent's failure to maintain

written records, 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, and the failure to ensure resident rights to be free from abuse or neglect are honored.

15. The Respondent has failed to meet its minimum obligations.

16. An assisted living facility is required to provide care and services appropriate to resident needs. This regulatory obligation encompasses several obligations. *See*, Rule 59A-36.007(1), Florida Administrative Code. Inclusive of these requirements is the provision of appropriate resident supervision, the provision of health care, the maintenance of a written record of significant changes, and notification to health care providers and resident representative of significant changes a resident may experience.

17. The facts clearly reflect that the Respondent's current systems have failed to encompass and implement these minimum requirements.

18. A resident suffered multiple falls in a single day, witnessed by a co-resident and responded to by Facility staff. The Respondent's personnel knew or should have known of each of these falls. Nonetheless, the Respondent failed to take any action in response to these falls.

19. These significant events were not documented in the resident's records. There is no indication medical attention or assessment was obtained in response to the falls. No investigation of the circumstances surrounding the fall events were undertaken in an effort to identify interventions to prevent future falls. The resident's health care provider and responsible party were not notified of the incidents, depriving the health care provider and responsible party of the opportunity to evaluate the resident's well-being and, if desired, mandate further health care services.

20. Similarly, a caregiver readily acknowledges that the caregiver and a colleague noted unexplained bruising on a resident's face. The observation was purportedly reported to Facility management. No record exists of the event. No documentation of the significant change – unexplained bruising – exists. No documentation of the resident's health care provider and responsible party being notified exists. This report by caregivers, if completed, was either ignored or discounted without any documentation to reflect the processes utilized by the Respondent in reaching its decision to take no action.

21. Last, a caregiver reports a significant change in resident behavior and management directs no action until the following day when non-emergency transport services were contacted. The resident's condition, including bruising, upon arrival of transport services and upon entry in the hospital emergency room, reflect bruising or edema existing for at least twenty-four (24) hours, a fact consistent with caregiver statements. Despite this, the Respondent inexplicably delayed in obtaining medical services for the resident.

22. To exacerbate the lack of care and services, the Respondent failed to undertake any post-event action to evaluate the performance of its operations and staff to timely address the well-being of the resident and other similarly situated residents. The Respondent took no action to investigate the circumstances surrounding a resident's multiple falls. No investigation of the circumstances surrounding the fall events were undertaken in an effort to identify interventions to prevent future falls. Similarly, the Respondent took no action to investigate the causation of a resident's bruising and edema, a fact which the Respondent's staff readily admit observing and reporting. The Respondent's sole documented response to the bruising was documenting the absence of bruising on an internal report following the resident's hospitalization.

23. When presented with a violent exchange between residents, the Respondent again

demonstrated its failure to provide care and services, including supervision, to meet resident needs and ensure a safe and decent living environment, free from abuse and neglect, to residents.

24. It is clear that two (2) residents engaged in a violent exchange, the exchange of such severity to compel the Respondent to have the residents transported for emergency medical evaluation and to contact law enforcement.

25. Despite this initial recognition of the seriousness of the event, the Respondent then failed to take any demonstrable significant action to ensure that such an event does not recur, whether between the residents involved or involving the individual residents and third parties, including other residents, staff, or visitors.

26. The Respondent could not demonstrate that the involved residents' health care providers or responsible parties were notified, depriving those individuals of the opportunity to make health care or continued resident decisions to ensure resident safety.

27. The Respondent could not demonstrate any action to monitor, evaluate, or address aggressive behavior of the residents. No behavioral health interventions were considered or pursued. No routine monitoring of behaviors to protect the residents and third parties from aggressive episodes of the residents involved in the altercation were weighed or implemented. The Respondent's sole identified intervention was to inform one resident, a resident diagnosed with aggressive behaviors, that striking other residents is not allowed

28. The net effect of these acts and omissions is the Respondent's failure to provide a safe and decent living environment, free from abuse or neglect, and the failure to provide supervision appropriate to resident needs. These are core services to be provided to residents of assisted living facilities, to assure the health, safety, and well-being of residents.

29. The failures discussed herein necessarily impact the health, safety, and well-being

of residents. Where known falls, resident bruising and change in behavior, and resident violent behavior is not appropriately addressed, resident health and well-being is placed at risk. Where staff observations are reported, but no response is implemented to meet anticipated and unanticipated care and service needs, residents are placed at needless risk to health and safety, risks that placement in the assisted living facility were, at least in part, meant to be minimized.

30. These deficient practices have occurred over time and effect each of the Respondent's resident census. The Respondent has demonstrated, through its lack of attention to these regulatory minimum standards, an inability to recognize its ongoing deficient practice and the failure to implement corrective action to address this non-compliance. The net result is the failure to provide those services for which the residents have contracted, and the law requires.

31. These multiple failures necessarily result in the deprivation of care and services appropriate to resident needs, including supervision, and resident rights to a safe and decent living environment, free from abuse and neglect.

32. 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), and are not receiving the care and services, including supervision, appropriate to resident needs, Fla. Admin. Code R. 59A-36.007(1). No resident of an assisted living facility should be placed 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).

33. 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

34. 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.

35. Each resident of an assisted living facility has the statutory right to live in a safe and decent living environment, § 429.28(1)(a), Fla. Stat. (2019), and to receive care and services, including supervision, appropriate to meet their needs, Fla. Admin. Code R. 59A-36.007(1).

36. 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, 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.

37. 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 for resident health, safety and welfare because of supervision and care deficiencies, and (3) being placed in an assisted living

facility where the regulatory mechanisms enacted for residents' protection have been repeatedly overlooked.

38. 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's Administrator has not assured that regulatory minimums required to address resident falls are met despite having been cited with the same deficient practice in recent months. The Facility's operations illustrate either a lack of knowledge or an inability to or unwillingness to meet these minimum requirements. Such deficient practices and conditions justify the imposition of an Immediate Moratorium on Admissions. Less restrictive actions, such as the assessment of administrative fines, will not ensure that the current residents or future residents receive the appropriate care, services, and environment dictated by Florida law.

39. 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. The Agency stands ready to take greater action, including an Emergency Suspension Order, if the Respondent does not promptly come into compliance with the regulations governing assisted living facilities.

IT IS THEREFORE ORDERED THAT:

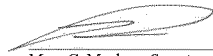
40. An Immediate Moratorium on Admissions is imposed on this assisted living facility and the Facility shall not admit any new residents or readmit any former residents, unless it receives express written authorization from the Agency's local Field Office Manager.

41. Upon receipt of this order, the Respondent shall post this Order on its premises in

a place that is conspicuous and visible to the public.

42. The Agency shall promptly file an administrative action against the Respondent based upon the facts set out in this Immediate Moratorium on Admissions 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 26th day of September, 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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