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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA No. 2021001807
License No. 5839
File No. 11910916
Provider Type: Assisted Living Facility

ALDERSGATE RETIREMENT, INC. d/b/a
EPWORTH VILLAGE RETIREMENT
COMMUNITY,

Respondent.
_______________________________________/

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. (2020), 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. (2020).

2. The Respondent, Aldersgate Retirement, Inc. d/b/a Epworth Village Retirement Community (hereinafter "Respondent"), was issued a license (license number 5839) by the Agency to operate a two hundred (200) bed assisted living facility (hereinafter "Facility")

located at 5300 West 16th Avenue, Hialeah, Florida 33012, 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, that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2020). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2020). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2020). § 408.803(11), Fla. Stat, (2020). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2020), and listed in Section 408.802, Florida Statutes (2020). § 408.802(11), Fla. Stat. (2020). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2020). The Respondent holds itself out to the public as an assisted living facility that fully complies with state laws governing such providers.

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 (2020), 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 sixty-one (161) 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 (2020), 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. (2020). 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. (2020).

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; and . . . (j) Assistance with obtaining access to adequate and appropriate health care..." § 429.28(1), Fla. Stat. (2020): 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).

Supervision

8. 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).

Staffing Standards

9. Florida law provides:

> Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.

Fla. Admin. Code R. 59A-36.010(2)(b).

> Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.

Fla. Admin. Code R. 59A-36.010(3)(c).

FACTS JUSTIFYING EMERGENCY ACTION

10. On February 1, 2021, the Agency completed a survey of the Facility.

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

a. In the months of December 2020 and January 2021, twenty-seven (27) residents,[1] suffered a total of forty-six (46) falls with varying severity in injury. Many of the residents had suffered at least two (2) falls within this two (2) month period.

b. The Respondent's fall prevention policy and procedure requires that Respondent "... completes a fall risk tool for residents upon admission within 24 hours." Based thereon, the Respondent would develop an initial fall risk care plan with interventions based upon the resident's risk factors. The policy further mandates that the Respondent review the fall risk tool after a resident experienced a fall and update the tool should risk factors be identified that changed.

c. None of the Respondent's records related to the subject residents contained a completed fall risk tool upon admission assessing risk for falls or addressing potential interventions.

d. None of the Respondent's records related to the subject residents contained any indication that the Respondent investigated the fall, determined whether the fall was preventable, or retrained staff as to any interventions.

e. Resident number six (6), who suffered three (3) falls during this period, suffered two (2) of the falls within a three (3) day period. The resident was hospitalized a day after the second fall and was diagnosed with a brain bleed.

f. Despite these falls, and prior documented falls, the Respondent could not produce any documentation reflecting any effort to assess the resident's risk for falls or any effort to weigh or implement interventions to minimize the risk the resident would suffer

[1] Residents numbered one (1), three (3), four (4), five (5), six (6), seven (7), eight (8), nine (9), ten (10), eleven (11) twelve (12), thirteen (13), fourteen (14), fifteen (15), sixteen (16), seventeen (17), eighteen (18), nineteen (19), twenty (20), twenty-one (21), twenty-two (22), twenty-three (23), twenty-four (24), twenty-five (25), twenty-six (26), twenty-seven (27), and twenty-eight (28).

further falls.

g. Resident number nine (9) suffered three (3) falls within a two (2) week period commencing December 20, 2020. The first two (2) falls resulted in the resident suffering skin tears. After the last fall of January 3, 2021, the resident continued to complain of pain. On January 5, 2021 the resident's health care provider was finally informed of the fall and x-rays were ordered. These x-rays, completed on January 6, 2021, reflected the resident had suffered rib fractures. The resident was hospitalized the following day.

h. Despite these falls, and prior documented falls, the Respondent could not produce any documentation reflecting any effort to assess the resident's risk for falls or any effort to weigh or implement interventions to minimize the risk the resident would suffer further falls.

i. Resident number five (5) suffered a fall on December 6, 2020. The resident was found hours after the fall and hospitalized with bruising, a bluish tint to the fingers and foaming at the mouth. The resident suffered a fractured hip and required surgery. The transport to the hospital is estimated to have occurred at least five (5) hours after the resident had experienced the fall.

j. Though the September 24, 2018 Health Assessment, form 1823, for resident number five (5) clearly indicated that fall precautions were required for the resident, the Respondent's records related to the resident reflected no assessment, care plan, or interventions to minimize the risk of falls for the resident.

k. Resident number three (3) suffered falls on December 12, 2020 and January 15, 2021. The resident was hospitalized after the December 2020 fall as a result of a deep laceration to the forehead requiring stiches.

l. Though the January 17, 2020 Health Assessment, form 1823, for resident number three (3) clearly indicated that fall precautions were required for the resident, the Respondent's records for reflected no assessment, care plan, or interventions to minimize the risk of falls for the resident, even after the resident suffered falling events.

m. Resident number four (4) suffered falls on December 12, 20, and 21, 2020. The falls resulted in the resident suffering a skin tear, a bruise to the forehead, and a laceration to the scalp.

n. The Respondent's records related to resident number four (4) reflected no assessment, care plan, or interventions to minimize the risk of falls for the resident, even after the resident suffered falling events.

o. The Respondent's director of nursing indicated that after a resident suffers a fall, the resident is assessed by a licensed practical nurse and rounds by staff to observe the resident every forty-five (45) minutes is implemented. The Respondent's administrator indicated residents are observed by staff on an hourly basis.

p. The Respondent could produce no documentation reflecting the institution of any policy to complete or the conduct of nursing assessments or observational rounds by staff after a resident suffered a fall. The Respondent could demonstrate no system by which resident falls are consistently documented, reported, or addressed by the Facility. The Respondent's staff interviewed could not accurately identify residents who had suffered falls or the number of falls within the Facility in the recent past.

q. In February and July 2020, separate residents were successful in eloping from the Facility. The residents' Health Assessment, form 1823, for both of these residents, residents numbered one (1) and two (2), identified the residents as at risk for elopement.

r. The Respondent's policies and procedures regarding resident elopement require that the Respondent maintain hourly monitoring, documented in a log, of those residents identified as at risk for elopement.

s. The Respondent could produce no log reflecting the hourly monitoring of residents identified as at risk of elopement covering the period both before and after these resident elopements.

t. The Respondent maintains a binder at the front gate with photographs and identifying information on forty-two (42) residents identified at risk for elopement. Security personnel stationed at this gate are instructed not to allow these individuals egress through the gate and to contact Facility personnel in such situations. The Respondent's administrator indicated, however, that only thirteen (13) resident are at risk of elopement.

u. The Respondent's sole demonstrated intervention to the elopements was the repair of a front gate. Both residents were able to evade the Facility's security personnel-based protection identified above.

v. The Respondent's staffing patterns do reflect that the Respondent maintains the minimum staff-to-resident ratios mandated by law.

NECESSITY FOR EMERGENCY ACTION

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. (2020), Ch. 408, Part II, Fla. Stat. (2020); 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.

13. 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. (2020); 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).

14. 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.

15. In this instance, the Respondent has demonstrated a failure to ensure that staff can provide a safe and decent living environment, free from abuse and neglect, and to provide care and services appropriate to resident needs.

16. The Respondent has not been able to demonstrate its compliance with these regulatory provisions. The Respondent knew that its residents were suffering falls. The Respondent knew of its own policy and procedure requiring initial assessments for residents at risk of falls and the implementation of interventions and the re-assessment of residents and the implementation of interventions after a resident suffers a fall.

17. Despite this, the Respondent has demonstrated a vacuum of compliance with its policy and procedures with its failure to complete either initial or post fall assessments of its resident population suffering from both the risk of and actual falling behavior.

18. These failures present an ongoing risk that residents at risk of or suffering falls

within the Facility will not receive care and services, including supervision, to protect them. Resident rights to a safe and decent living environment are not honored where known risk to resident health and safety are not addressed and interventions implemented.

19. The scope of these failures is not isolated but extend throughout the Facility and its operations. The Respondent has no discernable process to identify residents at risk of falls, to report and respond to resident falls, or to devise and implement interventions to minimize risk of resident falls. Word of mouth with un-memorialized policy and undocumented services do not create safety systems which can be effectively implemented, monitored, and enforced.

20. The Respondent's responses to resident falls is inconsistent and not effective in meeting resident care needs. The Respondent does not consistently ensure that residents who suffered from falls receive the proper care and services to protect them from possible recurrence. The Respondent does not consistently ensure that residents who suffered from falls receive medical assessments to assure that any indicated treatment or intervention is provided.

21. Similarly, the Respondent has demonstrated a failure to ensure its systems protect against risk of resident elopement. The Respondent's system of security guard monitoring to prevent resident elopement has been demonstrated to be ineffective. The Respondent's system to regularly monitor residents at risk of elopement while the residents are within the Facility has not been implemented. These failures demonstrate that residents at risk of elopement within Respondent's Facility are not receiving the type of or quantum of care and services necessary to provide protection of the residents from their individualized exit-seeking behaviors

22. Whether these conditions are caused in part by inadequate staffing is not the issue. Minimum staffing hours do not in themselves assure necessary care and services are provided. The Respondent has failed to assure that sufficient qualified staff are available to meet resident

care and service needs, be they routine or emergency. The Respondent is required to meet adequate staffing needs to provide required services and care. *See,* Fla. Admin. Code R. 59A-36.010(3)(c).

23. The failures above discussed are not isolated events but constitute a systemic failure of the Respondent to assure that resident care and services are being provided to its resident census in accordance with the minimum standards of law. These failures present an immediate risk to residents and present risks that they are not residing in a safe and decent living environment free from abuse or neglect. The Respondent is aware of these conditions. It may not ignore an apparent danger to the detriment of those persons to whom the Respondent has undertaken the responsibility for their safety and well-being.

24. These facts demonstrate the Respondent's inability or unwillingness to assure that each resident receives the care and services, including supervision, appropriate to resident needs. This failure necessarily impacts the health, safety, and well-being of residents. Where known behaviors placing residents at risk are not addressed, residents' health and well-being is placed at risk, risks that placement in the assisted living facility were, at least in part, meant to be minimized.

25. These deficient practices have occurred over time and affect each of 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 practices 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.

26. These multiple failures result in the deprivation of resident rights to a safe and decent living environment, free from abuse and neglect, and access to appropriate health care.

27. Individually and collectively, these facts reflect that the residents are not currently residing in a safe and decent living environment free from abuse and neglect, § 429.28(1)(a) and (b), Fla. Stat. (2020), 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. (2020). "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. (2020).

28. 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

29. 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.

30. 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. (2020), and to receive care and services, including supervision, appropriate to meet their needs, Fla. Admin. Code R. 59A-36.007(1).

31. 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.

32. 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.

33. 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 operate an assisted living facility are met. The Respondent'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.

34. 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:

35. 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.

36. 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.

37. 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 (2020), at the time that such action is taken.

ORDERED in Tallahassee, Florida, this 2nd day of February 2021.

Molly McKinstry, Deputy 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.