STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AGENCY CLERK
2021 JUL 20 A 11: 22

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

LINDSAY'S ALTERNATIVE CARE, INC.,

Respondent.
_____/

Case No. 21-171PH

AHCA Nos. 2021000903
2019005762
License No. 9506
File No. 11965079
Provider Type: Assisted Living Facility
RENDITION NO.: AHCA- 21 - 7016 -S-OLC

FINAL ORDER

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

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

2. The agency action seeking license revocation is withdrawn. The Respondent shall comply with the requirement terms of the Settlement Agreement.

3. The Respondent shall pay the Agency $10,888.75. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 60 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

ORDERED at Tallahassee, Florida, on this 19th day of July, 2021.

Kimberly R. Smoak, Deputy Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

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

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 20th day of July, 2021.

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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Nicola L.C. Brown, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Joan Clark Lindsay, Administrator Lindsay's Alternative Care, Inc. 5873 NW 46th Drive Coral Springs, FL 33067 (U.S. Mail)
Teresita A. Vivó, Esquire Informal Hearing Officer Agency for Health Care Administration (Electronic Mail)	Joan Clark Lindsay, Administrator Lindsay's Alternative Care, Inc. Post Office Box 670416 Coral Springs, FL 33067-0007 (U.S. Mail)

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case Nos.: 2021000903
2019005762
Facility Type: Assisted Living
License No.: 9506
File No.: 11965079

LINDSAY'S ALTERNATIVE CARE, INC.,

Respondent.

_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), by and through its undersigned counsel, and files this Administrative Complaint against the Respondent, Lindsay's Alternative Care, Inc. ("Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2020), and alleges:

NATURE OF THE ACTION

This is an action against an assisted living facility to impose an administrative fine in the amount of ten thousand five hundred dollars ($10,500.00) plus survey fees of three hundred eighty-eight dollars seventy-five cents ($388.75) for a total assessment of ten thousand eight hundred eighty-eight dollars seventy-five cents ($10,888.75), and revoke Respondent's license to operate an assisted living facility based upon one (1) Class I deficient practice and one (1) unclassified deficient practice.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 20.42, 120.60, and Chapters 408, Part II, and 429,

EXHIBIT 1

Part I, Florida Statutes (2020).

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

PARTIES

3. The Agency is the regulatory authority responsible for licensure of assisted living facilities and enforcement of all applicable federal regulations, state statutes and rules governing assisted living facilities pursuant to the Chapters 408, Part II, and 429, Part I, Florida Statutes, and Chapter 59A-36, Florida Administrative Code, respectively.

4. Respondent operated a six (6) bed facility located at 5783 NW 48th Drive, Coral Springs, FL 33067, and was licensed as an assisted living facility, license number 9506.

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

COUNT I

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

7. That Florida law provides:

> (7) The facility shall notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making appointments for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.
>
> Section 429.26(7), Florida Statutes (2020).

8. That Florida law provides:

> (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 59A-36.012, F.A.C.
(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

Rule 59A-36.007(1), Florida Administrative Code.

9. That between December 9, 2020 through December 16, 2020, the Agency conducted a complaint survey at Respondent's facility.

10. That based on observation, record review, and interview, Respondent failed to provide care and services appropriate to the needs of 1 out of 4 sampled residents (Resident #1).

11. That Respondent's undated fall prevention policy and procedure titled, "Safe Steppers-Fall Interventions" outlined measures to be instituted for patient at potential risk for falls to include:

- Call light placed within reach
- Bed brake on
- Bed in low position
- Q2 hourly round checks

12. That a review of Respondent's undated policy and procedure regarding communication of patient change in status noted that it was the policy of the facility to inform residents, family, health care providers, case managers, social workers or guardians (next of kin) in the event of the following:

- Accident/incident occurring
- Residents needed to be transferred to a hospital

- An emergency or change in residents physical or mental status.

The following procedure will be implemented:

- The staff in charge of the operation of the facility at any given time will perform the following in the order listed.
- Dial 911 for transfer to the nearest hospital in case of an emergency. A completed transfer must be sent with the resident.
- Contact the Resident's Physician

13. That a review of Respondent's undated policy and procedure related to responding to the unresponsive resident indicated the following:

> Purpose: To provide the best opportunity to prevent death by following accepted standards for CPR in accordance with the American Red Cross and American Heart Association. In the absence of a signed activated Do Not Resuscitate Form, and/or Hospice, the staff is to perform the following steps: Procedure: 1) If a resident is found unresponsive the staff member will attempt to physically stimulate the resident by calling their name and gently shaking them by the shoulders. If unresponsive, look, listen, and feel for respiration and pulse, the staff member is to call for help and dial 911. 2) Return to the resident and begin to follow CPR protocol. 3) CPR is to continue until the EMT/Paramedics take over.

14. That a review of Respondent's undated policy and procedure regarding incident reporting indicated the following:

> Purpose: To assure proper documentation of all incidents for reporting purposes, including investigation, analysis, and quality improvement or preventative action; to be administered by the Risk Manager.
> Policy: An incident shall be completed for an happening which is not consistent with the routine operation of the facility or routine care of a particular resident/patient, this includes employees and visitors. Incidents are defined as accidents or untoward events that may eventuate in undesirable outcome.
> Procedure: It will be the responsibility of the employee, nursing or medical staff member mostly closely involved in the incident, having special information regarding the incident to complete a written incident report.
> Note: No one should fail to complete an incident report form simply because it is thought that someone else involved has done so or was more closely involved.
> It is the responsibility of the employee's immediate supervisor to see that it is accurately completed, and to complete the incident investigation Report.
> The written incident report and incident investigation report form must be completed and received in the Risk Management Office within 24 hours.

15. That a review of Respondent's undated job descriptions/work assignments indicated that each direct care staff member must ensure the resident's welfare and be aware of the resident's whereabouts and condition and perform regular room/bed checks.

16. That on December 9, 2020, at approximately 12:40 PM, during an interview with Respondent's Assistant Administrator #1, a Registered Nurse, Petitioner's Representative requested to review the facility's incident report related to an incident with Resident #1 that occurred on December 1, 2020. The report was completed and provided to Petitioner's Representative on December 10, 2020.

17. That a review of the incident/accident report dated December 1, 2020, revealed the following:

- Resident #1 was found on the floor on December 1, 2020, at 7:50 AM, and was moaning, not responsive to verbal/tactile stimulation, sustained a laceration on his/her head, had 8 respirations, and an oxygen saturation of 60%.
- Resident #1 was transported to the hospital on December 1, 2020, at 1:20 PM by Emergency Medical Services (EMS).
- The facility was to re-educate its staff in fall-preventions, resident monitoring, and emergency procedures to prevent reoccurrence of a similar event.

18. That on December 9, 2020, at approximately 9:36 AM, during an interview with Staff B, she stated that the following:

- She arrived at the facility on December 1, 2020 at 7:00 AM to start her shift.
- She saw Staff A who worked the 7:00 PM - 7:00 AM shift on the previous day, in the laundry area of the facility.
- The laundry area is located at the front of the house on the opposite side of the house of Resident #1's bedroom, immediately to the left when you enter the home, pass the door leading into the garage.
- The Resident's bedroom was on the opposite side of the laundry room.

- She heard someone falling (a loud bump) in Resident #1's bedroom and she immediately yelled to Staff A that Resident #1 had fallen in his/her room.
- Upon opening the resident's bedroom door and entering the bedroom, Resident #1 was lying face down on the floor, on the left side of the hospital bed, between the bed and the wall.
- She and Staff A rolled Resident #1 over, and the resident was conscience but non-verbal with a bruise on right side of his/her forehead.
- Neither she nor Staff A conducted an assessment (including checking of pulse and/or respirations) of Resident #1 after rolling him/her over to determine the extent of the resident's injuries and condition.
- She retrieved the Hoyer lift (lift) from the garage and they placed Resident #1 in the lift to take the resident to the bathroom, so they could shower the resident.
- After showering Resident #1, she and staff B took Resident #1 to his/her bed to dry and dress the resident.
- They then took Resident #1 to the living room area to sit down in the reclining chair at around 8:00 AM.

19. That on December 9, 2020, at approximately 11:26 AM, during an interview with Respondent's Assistant Administrator #2, he stated the following:

- Resident #1 was relatively sufficient up until about 4 months ago.
- In the latter days staff have had to provide more assistance to the resident.
- Just sitting in the recliner, Resident #1 would slouch, and staff had to reposition the resident. The same would occur when the resident was in his/her bed, and that continued for the last couple of months.
- Resident #1 would constantly roll in the hospital bed.
- Half-bed rails were place on the right side of the resident's bed.
- He moved Resident #1's hospital bed against the wall near the east window of the room on November 30, 2020 from its previous location (free standing about 6 feet from the wall/window).

- He did not adjust the height of the bed to a low position. However, he placed a cushioned pillow against the right-side rails and the left side against the wall for staff to use while the resident was in bed as a safety precaution.

20. That on December 9, 2020, between 12:13 and 12:34 PM, during an interview with Assistant Administrator #1, she stated the following:

- Staff A called her on December 1, 2020, at approximately 7:50 AM and described that Resident #1 had a bruise.
- Staff A did not describe that the resident fell.
- She told Staff A that she would come to the facility and would assess the resident's bruising. Resident #1 began to exhibit behavioral issues and would not perform his/her normal activities of daily living (ADLs) about 2 months prior to the incident of December 1, 2020. Resident #1 also thrashed and kicked a lot while in the hospital bed daily.
- Due to these changes the resident required more monitoring and supervision.
- Staff used half bed rails on the right side of the hospital bed only for the resident's safety and Assistant Administrator #2 moved the bed the previous day (11/30/2020) against the wall near the east window (moved by AA#2).
- Prior to the incident on December 1, 2020, Resident #1 was able to perform his/her ADLs with assistance with no behavioral issues.
- She received another call from Staff A on December 1, 2020, sometime after 12:00 PM.
- Staff A told her that Resident #1 didn't look well.
- When she arrived at the facility on December 1, 2020, she found Resident #1 sitting in the reclining chair in the living room and noticed that the resident had slow breathing.
- She stated the resident's oxygen saturation was at 60% at that time and the device read the resident's heart rate to be 206, which she felt was an erroneous reading.
- She called 911 sometime after 12:00 PM.
- She administered Resident #1 supplemental oxygen from the oxygen concentrator that belonged to another resident at the facility, Resident #3.
- She noticed that Resident #1 had a hematoma (a swelling or mass of blood confined to an organ, tissue or space) above his/her right eye, which was black and blue, and a red scratch-like scar beneath the resident's eyebrow.

- After the paramedics left the facility to transport Resident #1 to the hospital and the police officers were conducting their investigation that afternoon, she learned that Resident #1 had fallen off his/her bed earlier that day.
- Staff B described to her how Resident #1 was found lying on the floor, flat on his/her face earlier on December 1, 2020, and how she did not consider how this event involving Resident #1 was one that she needed to look at right away and with urgency.
- She was last in the facility on November 30, 2020 at 10:00 PM for about 10 or 15 minutes conducting a check of the facility to observe residents and staff.
- Upon arrival, she saw Staff A standing outside at the front door of the facility on her cellphone and no other facility staff members were present at the facility.
- She went inside and checked on the residents, including Resident #1. Resident #1 was asleep in the hospital bed.
- She then left the facility and Staff A remained on duty to care for the residents that evening. She did not say anything to Staff A regarding her lack of presence in the facility observing the residents at the time of her arrival.
- She agreed that Staff A should have been in the facility observing and monitoring the residents at all times. She was not sure how long Staff A had been outside prior to her arrival. However, Staff A did come back into the building shortly before she departed.

21. That on December 10, 2020, at 11:30 AM, during an interview with Staff A, she stated the following:

- She worked in the facility for approximately 2.5 years and usually took care of Resident #1 during her shifts in the facility from 7:00 PM to 7:00 AM.
- She last checked on Resident #1 in his/her room around 10:00 PM the previous night (11/30/2020) and Resident #1 was sleeping. She closed the room door and allowed the resident to continue to sleep.
- On December 1, 2020, around 7:00 AM, she was alerted by Staff B that Resident #1 fell in his/her bedroom. She found the resident on the floor on the left side of the hospital bed.
- She called Assistant Administrator #1 at around 7:50 AM to inform her that Resident #1 had some bruising to his/her lower extremities.

- Assistant Administrator #1 did not instruct her to do anything specifically and informed her she would be at the facility later in the day.
- She and Staff B picked the resident up from the floor and assisted the resident with a shower. She then assisted the resident to sit on the reclining chair in the living room and gave the resident some ginger tea, which the resident did not finish.
- On December 1, 2020, at approximately 11:45 AM, she noticed that Resident #1 was pale and unresponsive, and she picked up the resident's arm and it was limp.
- She did not check the resident's pulse, respirations or conduct any further assessment to determine if the resident was breathing.
- On December 1, 2020, at approximately 11:50 AM, she notified Assistant Administrator #1 of Resident#1's condition and Assistant Administrator #1 told her that she was on her way to the facility.
- Sometime from 11:50 AM to 12:45 PM, she administered a nebulizer treatment (a machine that provides a fine mist to assist with breathing) to the resident, and this did not improve the resident's unresponsive status. The nebulizer machine belonged to a former deceased resident.
- There was no physician order for a nebulizer treatment for Resident #1.
- Assistant Administrator #1 arrived onsite on December 1, 2020, at approximately 12:45 PM, and administered oxygen to the resident but this did not improve the resident's status.
- Assistant Administrator #1 called 911, and Emergency Medical Services (EMS) showed up shortly thereafter and performed CPR on the resident. EMS then took the resident to the hospital.
- She did not monitor Resident #1 during her shift on November 30, 2020, between 11:00 PM until December 1, 2020 at 7:00 AM. She fell asleep during these hours.
- She was not aware that she needed to monitor any of the facility residents overnight.
- She felt she should have called 911 for Resident #1 on December 1, 2020 at 7:00 AM, when she identified that the resident sustained injuries after having fallen from his/her bed.
- She was trained to initiate First-Aid and CPR without having to receive specific orders from the Administrator or Assistant Administrator.

22. That on December 10, 2020, at approximately 2:06 PM, during an interview with Staff B, she

stated the following:

- On December 1, 2020, at approximately 7:00 AM, when Resident #1 was discovered on the floor, neither she nor Staff A immediately contacted 911.
- Assistant Administrator #1 called 911 on December 1, 2020, sometime after 12:00 PM for emergency medical personnel to evaluate and treat Resident #1.
- She did not know when Resident #1 was last checked on because she did not work the previous night shift on November 30, 2020.

23. That Staff B demonstrated to Petitioner's Representative what transpired on December 1, 2020, between 7:00 AM to approximately 12:00 PM. Staff B placed Resident #1's hospital bed as it was found when she first responded to the resident on December 1, 2020, and how the resident was found lying face down on the floor between the left side of the bed and the wall. She also raised the 2 half bed rails on the right side of the bed and as they were on the night of the incident. Staff B stated the bed was not lowered and the facility did not have any call-lights or pendants.

24. It was determined that the 2 half-bed rails were applied to provide a full rail on the right side of the resident's hospital bed.

25. That on December 10, 2020, at approximately 2:23 PM, during an interview with Assistant Administrator #2, he stated the following:

- For every resident experiencing an emergency, it was the facility's procedure for staff to assess the resident, call 911 and perform CPR for any resident who did not have a Do Not Resuscitate order, and contact him.
- Staffs A and B who were present at the facility on December 1, 2020, did not adequately intervene when Resident #1 was found on the floor and sustained injuries due to this accident which required for either of these staff members to have immediately called 911.

26. That on December 10, 2020, at approximately 2:39 PM, during an interview with Respondent's Administrator, a Licensed Practical Nurse (LPN), she stated the following:

- Resident #1's health status had recently declined, and the resident required a greater amount supervision and assistance with his/her activities of daily living.
- Resident #1 thrashed around a lot while in bed and became more confused a few months earlier.
- She relied on Assistant Administrators #1 and #2 to operate the facility regularly since she was not able to go onsite that frequently.
- Staff A informed her of the incident involving Resident #1 on December 1, 2020, at approximately 11:50 AM. Staff A described the resident as not looking well and having fallen earlier. Staff A described that Resident #1 was not responding to verbal commands.
- She told Staff A to call 911 and that Assistant Administrator #1 was on her way to the facility.
- Staff members were required to call 911 during every resident emergency and this was the first thing to do. Staff were also trained to call 911 whenever there was a change in status of any resident.
- Staff members did not need to be instructed to call 911 and perform First Aid.

27. That on December 11, 2020, at approximately 12:55 PM, during an interview with Assistant Administrator #1, she stated the following:

- Resident #1 did not have a physician order for supplemental oxygen.
- She used Resident #3's oxygen concentrator machine on Resident #1 because she found Resident #1 short of breath and with a faint pulse when she arrived on December 1, 2020, at approximately 12:00 PM.
- She administered about 2 liters of oxygen to Resident #1 with Resident #3's oxygen mask.
- The police arrived on December 1, 2020, at approximately 12:15 PM, and EMS arrived shortly thereafter.
- EMS performed CPR on the resident immediately after they arrived at the facility. She did not know how long EMS personnel remained in the facility before they transported the resident to the hospital.
- The resident had a hematoma on her forehead, had shallow respirations and almost no pulse when she assessed the resident on December 1, 2020.
- She worked in the facility as the assistant administrator for about 22 years.

- She was at the facility on November 30, 2020, at about 10:00 PM and that AA #2 was at the facility on November 30, 2020, at 3:00 PM to move Resident #1's bed from being about 2 feet from the wall to placing the bed immediately next to the wall. This was done because the resident began having "thrashing" movements on or about November 17, 2020, and the resident's physician ordered medications for the resident and half bed rails.
- It was expected that the direct care staff members must monitor the residents throughout the night, at least once per hour, and the staff must not sleep during the overnight shift. Staffs A and B should have called 911 on December 1, 2020, when it was determined that Resident #1 fell and injured herself.

28. That on December 15, 2020, at approximately 2:25 PM, during an interview with Police Detective #1, she stated Staff A explained to her that she last saw Resident #1 on November 30, 2020, at 10:00 PM and found the resident on the floor on December 1, 2020, after 7:00 AM. The detective stated she was informed that the resident's bed presented to have slid or rolled on its wheels, despite Staff A's account that the bed wheels were in the locked position.

29. That Detective #1 stated the resident was found to have extensive physical injuries on December 1, 2020, including a considerable gash on her head and some other injuries to her head and knees. She stated Staff A informed her that she waited for Assistant Administrator #1 to arrive to the facility for over 4 hours before 911 was called and the resident was found by EMS with 8 breaths per minute.

30. That Detective #1stated the facility staff should have contacted 911 immediately after the resident was found after her fall to activate the first aid and emergency response.

31. That review of the ambulance response record dated December 1, 2020, indicated the following:

- Emergency Medical Services (EMS) response was initiated from a facility telephone call on December 1, 2020, at 12:31PM.
- EMS was dispatched at 12:32 PM and arrived at the facility at 12:35 PM.

- EMS personnel reached Resident #1 at 12:38 PM, departed the facility at 12:54 PM, and arrived at the hospital at 12:59 PM.
- Staff A communicated to EMS personnel that Resident #1 went unresponsive and her breathing started to decrease.
- Staff A also communicated to emergency personnel that the resident fell approximately 3 hours prior.
- EMS personnel found the resident sitting in the chair, unresponsive, without a pulse, and apneic (temporary cessation of breathing).
- The resident had a hematoma above her right eye, contusion to right shoulder and a contusion and abrasion to the right knee.
- EMS personnel provided cardiopulmonary resuscitation (CPR) to Resident #1 at 12:38 PM, the resident had a 0/0 blood pressure, 0 pulse and 0 respiration at 12:39 PM, applied supplemental oxygen at 12:43 PM, the resident had a pulse of 23 beats per minute at 12:44 PM, applied 1mg of epinephrine intraosseously (injection directly into the bone) at 12:48 PM, 12:51 PM, 12:54 PM and 12:58 PM, the resident had 0 pulse and 0 respiration at 12:48 PM and 26 beats per minute pulse at 1:01 PM.

32. That Petitioner's representative reviewed several photographic evidences which depicted the scene of the event taken by law enforcement. (photographic evidence available)

33. That a review of Resident #1's hospital records indicated the following:

- The resident arrived at the hospital's emergency room by EMS on December 1, 2020, at 1:05 PM, with a diagnosis of cardiac arrest.
- The resident had a certification of death on December 1, 2020, at 1:12 PM, with no cause of death listed, and the resident's body was released to the medical examiner's office.
- The resident fell earlier that morning and hit her head. The resident presented to be in asystole with no blood pressure and no spontaneous breath sounds, was unresponsive, had ecchymosis to the face, the right temporal, and periorbital regions, had no pulse and was in cardiac arrest.

34. That a review of Resident #1's health assessment form (AHCA Form 1823) dated May 19, 2017, revealed diagnoses of Hyperthyroidism, Hypertension, Hyperlipidemia, Depression and Legally Blind. The resident had Cognitive Impairment, an Unsteady Gait, and required assistance with Ambulation, Bathing, Dressing, Grooming, Toileting and Transfers.

35. That review of the Resident #1's "monthly assessment notes" indicated that on November 3, 2020, the resident started to show increased anxiety and agitation, and was very restless. The notes further indicated that the resident underwent a change in level of function and her walking capability was decreased.

36. That on December 10, 2020 at approximately 2:45 PM, during an interview with Assistant Administrator #2, he stated that overnight staff was required to check on the residents every 2-4 hours and that the staff was not allowed to sleep during the overnight shifts. He stated there was presently no method to log the direct care staff members monitoring the residents every 2-4 hours during the night and that the facility did not have specific policies and procedures regarding resident bed rail use or resident monitoring.

37. That on December 11, 2020, at approximately 1:00 PM, during an interview with Assistant Administrator #1, she stated that after the event involving Resident #1 on December 1, 2020, she wanted to implement a system that required the staff to monitor all the residents every hour during the overnight shifts, but presently did not have anything in place to ensure this was being done by the staff. She stated, the facility did not have any method to presently document any resident monitoring or supervision by the staff.

38. That on December 14, 2020, at approximately 3:45 PM, during an interview with the Administrator, she stated that she was aware that the First Aid/CPR certifications for Assistant Administrator #1, Staff A, and Staff B expired on December 1, 2020. She also acknowledged

that none of the responding Staff members involved in Resident #1's incident were current with First Aid and CPR training. She reported, the facility did not immediately implement the re-education of staff in fall-prevention, resident monitoring, and emergency procedures to prevent a reoccurrence of a similar event involving Resident #1 on 12/01/2020.

39. That a review of Staff B's employee record indicated that the staff member was hired on June 28, 2020 and received First aid/CPR training on December 3, 2020 which expires on December 3, 2022. The record indicated that the staff B's previous First aid/CPR training was done in May 2018 and expired in May 2020. However, there was no documentation to reflect that Staff B was certified to provide First aid/CPR services on December 1, 2020.

40. That a review of Staff A's employee record indicated that the staff member was hired on October 1, 2016 and received First aid/CPR training on December 3, 2020 which expires on December 3, 2022. The record indicated that Staff A's previous First aid/CPR training was done in May 2018 and it expired in May 2020. However, there was no documentation to reflect that Staff A was certified to provide First aid/CPR services on December 1, 2020.

41. That a review of Assistant Administrator 1's employee record indicated that the staff member was hired on March 10, 1999, received First aid/CPR training in May 2018, and it expired in May 2020. Assistant Administrator #1's record indicated that she had a State of Florida Registered Nurse (RN) license but there was no other documentation of an updated CPR training.

42. That the facts above reflect Respondent's failure to provide care and services appropriate to the needs of residents, including inter alia, failing to obtain immediate emergency care for a resident who fell out of the bed and sustained injuries and subsequently died.

43. The Agency determined that this deficient practice was a condition or occurrence related to the

operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.

44. That the same constitutes a Class I offense as defined in Florida Statute 429.19(2)(a) (2020).

WHEREFORE, the Agency intends to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(2)(a), Florida Statutes (2020).

COUNT II

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

46. That Florida law provides:

> Care Provider Background Screening Clearinghouse.-
> (b) Until such time as the fingerprints are enrolled in the national retained print arrest notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency.
> (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.
> (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic fingerprint submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; sex; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.

Section 435.12(2), Florida Statutes (2018).

47. That on January 28, 2019, the Agency conducted an abbreviated re-licensure survey at Respondent's facility.

48. That based on record review and interview, Respondent failed to maintain the employment status of all employees within the Agency's Clearinghouse Background Screening database for 3 out of 11 staff members (Staffs C, D, and E).

49. That a review of Respondent's employee roster on the Agency's Clearinghouse Background Screening database revealed that three former staff members, Staffs C, D, and E, did not have end dates listed.

50. That the Administrator was present during the survey and confirmed the findings, and no further documentation or information was provided.

51. The Respondent's actions or inactions constituted a violation of Sections 435.12, Florida Statutes (2018).

52. Under Florida law, in addition to the requirements of part II of Chapter 408, the Agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in Chapter 120 against a licensee for a violation of any provision of Part I or Chapter 429, Part II of Chapter 408, or applicable rules, or for any of the following actions by a licensee, for the actions of any person subject to level 2 background screening under Section 408.809, Florida Statutes, or for the actions of any facility employee: ... Failure to comply with the background screening standards of Chapter 429, Part I, Section 408.809(1), or Chapter 435, Florida Statutes. § 429.14(1)(f), Fla. Stat. (2018).

53. Under Florida law, regardless of the class of violation cited, instead of the fine amounts listed in paragraphs (a)-(d), the agency shall impose an administrative fine of $500 if a facility is

found not to be in compliance with the background screening requirements as provided in s. 408.809. § 429.19(2)(e), Fla. Stat. (2018).

54. Under Florida law, the Agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include: Violating any provision of this part, authorizing statutes, or applicable rules. § 408.813(3)(b), Fla. Stat. (2018).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of five hundred dollars ($500.00) against the Respondent.

COUNT III

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

56. That pursuant to Section 429.19(7), Florida Statutes (2020), in addition to any administrative fines imposed, the Agency may assess a survey fee, equal to the lesser of one half of a facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under Section 429.28(3)(c), Florida Statues (2020), to verify the correction of the violations.

57. That as a result of the complaint investigation, Respondent was cited with findings of violations which were the subject of the complaint.

58. That Respondent is therefore subject to a survey fee of three hundred eighty-eight dollars seventy-five cents ($388.75) pursuant to Section 429.19(7), Florida Statutes (2020).

WHEREFORE, the Agency intends to impose a survey fee of three hundred eighty-eight dollars seventy-five cents ($388.75) against Respondent, an assisted living facility in the State of Florida, pursuant to § 429.19(7), Florida Statutes (2020).

COUNT IV

59. The Agency re-alleges and incorporates Paragraphs one (1) through five (5) and Count I through III, as if fully set forth herein.

60. That Florida law provides:

> In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, any person subject to level 2 background screening under s. 408.809, or any facility staff:
> (a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
> (e) A citation for any of the following violations as specified in s. 429.19:
> 1. One or more cited class I violations.
>
> Section 429.14(1)(a) and (e)(1), Florida Statutes (2020).

61. That Florida law provides:

> In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:
> (b) An intentional or negligent act materially affecting the health or safety of a client of the provider.
> (c) A violation of this part, authorizing statutes, or applicable rules.
>
> Section 408.815(1)(b) and (c), Florida Statutes (2020).

62. That Respondent was cited for a Class I deficient practice.

63. That Respondent's acts or omissions constituted an intentional or negligent act which seriously affected the health, safety, or welfare of its residents.

64. That Respondent's acts or omissions violated statutes and rules that regulate assisted living

facilities.

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

Respectfully submitted this 18th day of March 2021.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION

By: Nicola Brown

Nicola L. C. Brown
Assistant General Counsel
Fla. Bar. No. 492507
Agency for Health Care Administration
525 Mirror Lake Drive N., 330H
St. Petersburg, FL 33701
727.552.1946 (office)
Nicola.Brown@ahca.myflorida.com

NOTICE

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

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

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

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7020 2450 0001 7045 6124 on March 18th, 2021, to Joan Clarke Lindsay, Administrator, Lindsay's Alternative Care, Inc., 5783 NW 48th Drive, Coral Springs, FL 33067, and by U.S. Regular Mail to Eudoniphyr Esmie, Registered Agent, Lindsay's Alternative Care, Inc., 6775 NW 108 Avenue, Parkland, FL 33076.

Nicola Brown

Nicola L. C. Brown

Copy furnished to:

Arlene Mayo-Davis, RN
Field Office Manager
Agency for Health Care Administration

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: LINDSAY'S ALTERNATIVE CARE, INC. **Case Nos.: 2021000903**
2019005762

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed agency action by the Agency for Health Care Administration (AHCA). The title may be Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint. Your Election of Rights may be returned by mail or by facsimile transmission **but must be filed with the Agency Clerk within 21 days by 5:00 p.m., Eastern Time,** of the day that you receive the attached proposed agency action. **If your Election of Rights with your selected option is not received by AHCA within 21 days of the day that you received this proposed agency action, you will have waived your right to contest the proposed agency action and a Final Order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your **Election of Rights** to this address:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

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

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

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

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

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

Licensee Name: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (Optional) _____

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

Signed: _____ Date: _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

Case No.:21-171PH
AHCA Nos.: 2021000903
2019005762
License No.: 9506

vs.

LINDSAY'S ALTERNATIVE CARE, INC.,

Respondent.
_____/

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Lindsay's Alternative Care, Inc. (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondent is an assisted living facility licensed pursuant to Chapters 429, Part I, and 408, Part II, Florida Statutes, Section 20.42, Florida Statutes and Chapter 59A-36, Florida Administrative Code; and

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

WHEREAS, the Agency served Respondent with an Administrative Complaint on March 23, 2021, notifying Respondent of the Agency's intent to revoke Respondent's licensure

EXHIBIT 2

to operate an assisted living facility in the State of Florida and impose administrative fines in the amount of ten thousand five hundred dollars ($10,500.00) plus a survey fee of three hundred eighty-eight dollars seventy-five cents ($388.75) for a total assessment of ten thousand eight hundred eighty-eight dollars seventy-five cents ($10,888.75); and

WHEREAS, Respondent requested an informal administrative hearing challenging the allegations in the Administrative Complaint pursuant to § 120.57(2), Florida Statutes, in this action; and

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

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

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

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

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

4. Upon full execution of this Agreement:

a. Respondent agrees to pay administrative fines in the amount of ten thousand five hundred dollars ($10,500.00) plus a survey fee of three hundred eighty-eight dollars seventy-five cents ($388.75) for a total assessment of ten thousand eight hundred eighty-eight dollars seventy-five cents ($10,888.75) within sixty (60) days of the entry of the Final Order;

b. Respondent agrees to obtain and maintain the services of an ALF Core-Certified third-party consultant for a period of two (2) years. Respondent's consultant shall conduct an in-person training once every quarter on facility practices, procedures, and training related to resident supervision, quality assurance related to medical response, and core training, as well as review Respondent's practices and procedures related to resident supervision and medical response. Respondent shall cause its consultant to complete annually, commencing on or before August 1, 2021, and the following year, a written report evaluating the facility's practices, procedures, and training related to resident supervision and medical response. In addition, said annual report, and all notes, audits, or other work product of the consultant referenced in this sub-paragraph shall be maintained by Respondent and shall be available to the Agency for Agency review upon request; and

c. Count IV of the Administrative Complaint seeking revocation of Respondent's licensure to operate an assisted living facility in the State of Florida is dismissed.

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

6. By executing this Agreement, a) Respondent denies the allegations raised in the Administrative Complaint referenced herein and b) The Agency asserts the validity of the allegations raised in the Administrative Complaint referenced herein. No agreement made herein

shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, which constitutes an "uncorrected" deficiency from surveys identified in the administrative complaint.

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

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

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

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

11. Respondent for itself and for its related or resulting organizations, its successors or transferees, attorneys, heirs, and executors or administrators, does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter and the

Agency's actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement, by or on behalf of Respondent or related or resulting facilities/organizations. Nothing in this paragraph limits the parties from enforcement of this Agreement as provided in paragraph four (4) of this Agreement.

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

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

14. Respondent agrees that if any funds to be paid under this agreement to the Agency are not paid within sixty (60) days of entry of the Final Order in this matter, the Agency may deduct the amounts assessed against Respondent in the Final Order, or any portion thereof, owed by Respondent to the Agency from any present or future funds owed to Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to Respondent by the Agency for said amounts until paid.

15. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. Respondent has the capacity to execute this Agreement. The Respondent understands that it has the right to consult with its own independent counsel and has knowingly and freely entered into this Agreement. The Respondent understands that Agency counsel represents only the Agency, and that Agency counsel has not provided any legal advice to, or influenced, the Respondent in its decision to enter into this Agreement.

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

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

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

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

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

Kimberly R. Smoak, Deputy Secretary
Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Building #1
Tallahassee, Florida 32308

DATED: 7/19/2021

Joan Clark Lindsay, Administrator
Lindsay's Alternative Care, Inc.
5873 NW 48th Drive
Coral Spring, Florida 33067

DATED: 6/24/21

James D. Varnado, General Counsel
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308

DATED: 7/13/21

Nicola L. C. Brown, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
525 Mirror Lake Drive North, Suite 330G
St. Petersburg, Florida 33701

DATED: 6/28/2021