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STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

AHCA No. 2022009824
License No. 13252
File No. 11969444
Provider Type: Assisted Living Facility

ROYAL INTEGRA PARKSQUARE
LESSEE, LLC, d/b/a PLAZA AT
PARKSQUARE,

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. (2022), 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. (2022).

2. The Respondent, Royal Integra Parksquare Lessee, LLC d/b/a Royal at Parksquare (hereinafter "Respondent"), was issued a license (license number 13252) by the Agency to operate a one hundred fifty (150) bed assisted living facility (hereinafter "Facility")

located at 2940 Northeast 207th Street, Aventura, Florida 33180, 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. (2022). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2022). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2022). § 408.803(12), Fla. Stat, (2022). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2022), and listed in Section 408.802, Florida Statutes (2022). § 408.802(11), Fla. Stat. (2022). Assisted living facility patients are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2022).

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 (2022), 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 seven (107) 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 (2022), 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. (2022). 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. (2022).

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) [a]ssistance with obtaining access to adequate and appropriate health care..." § 429.28(1), Fla. Stat. (2022): Assisted living facilities must provide a safe living environment pursuant to Section 429.28(1)(a), Florida Statutes.

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).

FACTS JUSTIFYING EMERGENCY ACTION

9. On June 23, 2022, the Agency commenced a survey of the Respondent Facility.

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

a. Between approximately March 20, 2022, and June 29, 2022, several separate incidents of potential resident abuse or neglect occurred in the Facility. None of these actions resulted in investigative or corrective action by the Respondent.

b. Resident number two (2):

i. On or about April 11, 2022, the Resident, who suffered from dementia, resisted a staff member's effort to shower the Resident. The staff member, staff member "C," after failing to successfully reason with the resident, grabbed the resident and dragged the resident to the shower resulting in the resident's knees being scraped by the flooring and requiring bandaging.

ii. Neither the Respondent's internal Facility incident reports nor the resident's written records contained any documentation of the event. There is no evidence the event was reported to Florida's Department of Children and Families as potential abuse, *see generally*, Section 415.1034, Fla. Stat. (2022), and the event was not reported to the Agency as an adverse incident, *see generally*, Section 429.23, Fla. Stat. (2022).

iii. The Respondent's Director of Nursing, who was identified by a staff member who witnessed the incident as the individual who bandaged the Resident's scraped knees, denied the incident ever occurred.

iv. On June 29, 2022, Agency personnel observed the Resident tied into a wheelchair with a belt. The Resident was crying.

v. The Respondent's staff member "K" candidly admitted that she had belted the Resident in the chair as a result of the resident wandering and suffering incontinence.

vi. The Resident's records contain no physician orders ordering the use of restraints, and Respondent could produce no policy and procedure or training regime for staff on the use of restraints. *See generally*, Section 429.41(1)(j), Fla. Stat. (2022); Rule 59A-36.007(8), Florida Administrative Code.

c. Resident number one (1):

i. The Resident suffered unexplained bruising to the shoulder on or about May 5, 2022, as documented solely by a cellular phone photograph taken and maintained by a staff member of the Respondent.

ii. Neither the Respondent's internal Facility incident reports nor the Resident's written records contained any documentation of the event. There is no evidence the event was reported to Florida's Department of Children and Families as potential abuse, *see generally*, Section 415.1034, Fla. Stat. (2022), and the event was not reported to the Agency as an adverse incident, *see generally*, Section 429.23, Fla. Stat. (2022).

iii. The Resident suffered two (2) falls on or about March 20, 2022, and May 4, 2022. The falls are described as falls resulting from the wheelchair falling backwards and the Resident hitting his or her head. The sole documented medical attention was the Director of Nursing placing an ice pack to the head. There is no indication that the Resident's physician or responsible party were notified of the falls. See, Rule 59A-36.007(1)(d), Florida Administrative Code.

iv. There is no evidence the event was reported to Florida's Department of Children

and Families as potential abuse or neglect, *see generally*, Section 415.1034, Fla. Stat. (2022), and the event was not reported to the Agency as an adverse incident, *see generally*, Section 429.23, Fla. Stat. (2022).

v. The Resident's family member photographed the Resident with a black eye in February 2022. The family member had not been notified of any incident that would have led to this injury.

vi. Neither the Respondent's internal Facility incident reports nor the Resident's written records contained any documentation of the event. There is no evidence the event was reported to Florida's Department of Children and Families as potential abuse, *see generally*, Section 415.1034, Fla. Stat. (2022), and the event was not reported to the Agency as an adverse incident, *see generally*, Section 429.23, Fla. Stat. (2022).

d. Resident number one hundred seventeen (117):

i. The Resident passed away in the Facility on May 3, 2022.

ii. The Resident's record contained four (4) copies of the Resident's "Do Not Resuscitate Order," a document indicating that the Resident did not desire the application of resuscitative care in the event the Resident was found unresponsive.

iii. The Respondent's Administrator performed cardiopulmonary resuscitation on the Resident after the Resident was found unresponsive, stating that she had been so instructed by emergency services and that she knew the Resident did not have a "Do Not Resuscitate Order" of record.

iv. The Respondent's personnel records do not reflect that the Respondent's Administrator had undergone training or certification in the performance of cardiopulmonary resuscitation. In addition, there was no documentation reflecting the Administrator had completed mandatory core continuing education. *See,* Rule 59A-

36.011(10)(c), Florida Administrative Code.

e. On June 23, 2022, four (4) staff members were observed in the Facility to meet the resident needs of over one hundred ten (110) residents. In the Memory Care Unit, with eighteen (18) residents, a single staff member was assigned to meet resident needs.

f. Registers reflecting the response by staff to resident calls for assistance by the residents utilizing the residents' individual call pendant reflect that, for the period June 1 through 24, 2022, two hundred fifty-eight (258) of these resident calls for assistance were left unanswered by the Respondent's staff for a period in excess of thirty (30) minutes each.

g. The Respondent's personnel records for staff member "O," the sole staff member serving the eighteen (18) residents in the Memory Care Unit, did not document that the staff member had received any of the required training for caregivers in an assisted living facility, including, but not limited to, First Aid and cardiopulmonary resuscitation, emergency procedures, "Do Not Resuscitate Orders," and Alzheimer's and Related Disorders training. *See*, Rule 59A-36.011, Florida Administrative Code.

h. The Respondent's personnel records for staff members "C" and "K" do not reflect any investigative or disciplinary action related to the events above described. There is no record that the staff members received any additional training in resident abuse or neglect, or that any other action addressing the staff members' behaviors towards the Respondent's resident had been recognized or addressed.

i. As of the date of this Order, the Respondent's staff members "C," "K," and "O", continue in the Respondent's employ and are actively scheduled to provide direct care services to residents in the near future.

j. Though again undocumented, staff and residents indicate that at some point

within the past two (2) months the Facility's fire alarm system activated. Neither residents nor staff on duty knew what action to take in such an event.

k. The local fire authority with jurisdiction requires that fire drills be conducted in the Facility every two (2) months. The Respondent could produce no records documenting these drills are conducted, and aware and alert residents and the Respondent's staff members indicate that fire drills are not regularly conducted within the Facility.

l. The Respondent's Administrator confirms the event, but denies the existence of a fire. The Administrator indicates some residents on the second floor were evacuated and the building re-populated upon receiving clearance from the responding fire department. A previous staff member of the Respondent indicates that a microwave oven in the Memory Care Unit was removed after the fire alarm and it was the source of the fire alarm's activation. She adds that the Memory Care Unit was not evacuated as staff on duty did not know how to respond to a fire alarm.

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. (2022), Ch. 408, Part II, Fla. Stat. (2022); 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. (2022); Fla. Admin. Code R. 58A-5.023(3)(a). Residents of assisted living facilities must receive the care and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 58A-5.0182(1). 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.

13. In this instance, the Respondent has demonstrated a failure to ensure that it can provide a safe and decent living environment, free from abuse and neglect, and to provide care and services appropriate to resident needs. The facts reflect numerous incidents of possible resident abuse and neglect ranging from intentional staff action to injuries of unknown origin to residents. The Respondent has demonstrated its inability to or unwillingness to respond to these incidents. No investigation of the incidents is undertaken. The incidents are not reported to Florida's Department of Children and Families as potential abuse or neglect, and the events are not reported to the Agency as an adverse incident. No personnel action is taken against staff known to have participated in some of the events. No additional training or other personnel education is conducted to assure resident rights are honored. Staff known to be involved in some of the incidents remain scheduled to provide resident care and services.

14. While it is unknown which if any of the resident falls described above may be prevented, Florida law requires assisted living facilities to provide care and services appropriate to resident needs, including supervision, to those entrusted to the assisted living facility's care. The Respondent has demonstrated either the inability or unwillingness to weigh or implement action directed to the prevention of falls or minimizing the risk of falls among its residents known to the Respondent to be at risk.

15. The Respondent has not demonstrated that it employs adequate qualified staff to meet resident needs. Over two hundred fifty (250) calls for assistance by residents went unanswered, and resident needs unaddressed, for over thirty (30) minutes in a period of twenty-four (24) days. One (1) staff member, the sole staff member to provide care for eighteen (18) residents who required care in a secured memory care unit, did not have even the minimum mandatory training required by law for persons caring for Florida's vulnerable population in assisted living facilities. Staff are unaware of mechanisms to respond to the sounding of the fire alarm system as the Respondent has failed to conduct mandatory drills to educate staff, and residents, on the means to evacuate and protect the health and safety of residents, staff, and third parties, in the event of a fire. An apparently untrained staff member performed cardiopulmonary resuscitation on a resident without training in the procedure, and in direct contravention of the resident's expressed desires to forgo such care.

16. The failures above discussed are not isolated events, but constitute a systemic failure of the Respondent to assure that resident rights to be free from abuse or neglect and protected and to ensure that 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 of the Facility and present risks that future abuse or neglect may occur. The Respondent is aware of these conditions. The Respondent may not ignore a known danger to the detriment of those persons to whom the Respondent has undertaken the responsibility for their health, safety, or welfare.

17. 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, or welfare of residents. Where known behaviors placing residents at risk are ignored, where known fall risk service needs are not

provided, residents' health, safety, or welfare is placed at risk. 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.

18. The Respondent has demonstrated an inability to recognize, investigate, and address potential incidences of resident abuse or neglect. Florida law requires that mandatory reporters, such as assisted living facility staff, report potential incidents of abuse or neglect to Florida's Department of Children and Families. § 415.1034, Fla. Stat. (2022). Florida law requires that adverse incidents be investigated, reported, and acted upon. § 429.23, Fla. Stat. (2022). An assisted living facility must be diligent to recognize and respond appropriately and promptly to these issues when presented to maintain the Respondent's responsibility to provide care and services. The failure to assure these elements are operational, as demonstrated by the failures described herein, place each resident at immediate risk.

19. 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.

20. 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. (2022), and are not receiving the care and services to which they are entitled, 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. (2022). "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. (2022).

21. 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

22. 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.

23. 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. (2022), and to receive care and services, including supervision, appropriate to meet their needs, Fla. Admin. Code R. 59A-36.007(1).

24. 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 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.

25. 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.

26. 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 the regulatory minimum standards required to operate an assisted living facility are met. 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.

27. 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:

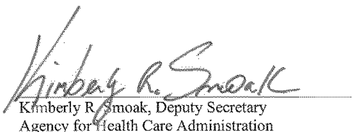
28. An Immediate Moratorium on Admissions is imposed on this assisted living facility and the Facility shall not admit any new residents or readmit any former residents, unless it receives express written authorization from the Agency's local Field Office Manager.

29. 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.

30. 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 (2022), at the time that such action is taken.

ORDERED in Tallahassee, Florida, this 6th day of July 2022.



Kimberly R. Smoak, 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.