**STATE OF FLORIDA**
**AGENCY FOR HEALTH CARE ADMINISTRATION**

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

CADIZ ALF, LLC,

Respondent.
_____/

AHCA No. 2023001698
License No. 13607
File No. 11969845
Provider Type : Assisted Living Facility

# IMMEDIATE MORATORIUM ON ADMISSIONS

THIS CAUSE came on for consideration before the Secretary of the Agency for Health Care Administration, or his 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, Cadiz ALF, LLC (hereinafter "Respondent"), was issued a license (license number 13607) by the Agency to operate a six (6) bed assisted living facility (hereinafter "Facility") located at 6425 Southwest 107th Avenue, Miami, Florida 33173, 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). The Respondent holds itself out to the public as an assisted living facility that fully complies with state laws governing such providers.

4. 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 five (5) 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. 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).

**FACTS JUSTIFYING EMERGENCY ACTION**

9. On January 24, 2023, the Agency commenced a survey of the Respondent's Facility.

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

a. Respondent experienced several separate incidents of alleged resident abuse or neglect in Respondent's Facility. None of these actions resulted in either an internal investigation or the consideration of, or implementation of, interventions to reduce the likelihood of recurrence by Respondent.

b. Resident number two (2):

i. Between September 12, 2022, and December 14, 2022, resident number (2) was hospitalized under Florida's Baker Act, Section 394.451 (2022) *et seq.*, as a result of the resident's violent and anxious behaviors.

ii. The resident shared a room with a second resident, resident number one (1).

iii. Two (2) of Respondent's caregivers (hereinafter "Staff") candidly admit that resident number (2) was violent, that they were often threatened by the resident, and that they often had to verbally de-escalate the resident from threats to throw a chair or other furnishing and slamming of doors.

iv. The Staff indicated resident number two (2) had an expressed dislike for resident number one (1).

v. Staff explained that their response to the resident number two's (2's) behaviors

were to remove a nightstand and lamp from the residents' room, to remove stirrups from the wheelchair and immobilize the wheelchair, to attempt to keep the resident away from resident number one (1) at meals, and to remove all knives from the kitchen.

vi. The Staff indicated that on two (2) separate occasions, the relative representative of resident number one (1) reported to Staff that resident number one (1) had confided that resident number two (2) would strike or beat resident number one (1) during the night.

vii. Staff member "B" specifically recalls resident number one (1) informed her that resident number two (2) was mistreating resident number one (1) on at least one (1) occasion.

viii. Staff reported these allegations to Respondent's administrator.

ix. The resident's relative requested that resident number one (1) be moved to another room and was told that there were no other beds available, and that resident number two (2) had been moved to that room as a result of other resident complaints.

x. Staff member "C" indicated that resident number one (1) had reported to the staff member that resident number two (2) had assaulted resident number one (1), though any such activity was not directly observed by the caregiver.

xi. Approximately two (2) months ago, resident number two (2) pushed resident number three (3) to the ground resulting in a bump on the head.

xii. Staff heard the event and responded to protect resident number three (3).

xiii. Respondent's administrator, who documented the multiple times resident

number two (2) was hospitalized for the resident's behaviors, denies knowledge of the specific events, including the complaints of resident number one (1), and the complaints of the resident's relatives of resident number one (1) being assaulted by resident number two (2).

xiv. Respondent's records regarding the resident do not memorialize any of these observations of resident number two's (2's) behaviors or any staff or residents who may have been subject to or witnessed these behaviors.

c. Resident number one (1):

i. The resident was re-admitted to Respondent's Facility on January 14, 2023, with a new prescription of Lactulose 20g/30 ml solution to be taken 30 ml two (2) times daily and to schedule a follow-up with the resident's physician in one (1) week.

ii. On January 24, 2023, the resident's January 2023 medication observation record did not reflect that the medication prescribed on January 14, 2023, had been provided to the resident. On January 26, 2023, the bottle of the medication was full.

iii. On January 26, 2023, a second January 2023 medication observation record (which had not been present on January 24, 2023) was provided by Respondent which reflected the resident had in fact been provided this prescribed medication.

iv. Respondent' administrator could not explain the second provided medication observation record, did not know the initials of the person who purportedly provided the medication to the resident, and could not explain how the

medication was annotated as provided while the medication on hand remained unadministered.

v. The resident was hospitalized on January 21, 2023, with fecal impaction.

vi. Upon hospitalization, the resident was noted by hospital personnel to have numerous unexplained purple bruises on the resident's abdomen, thighs, calves, arms, and shoulders.

vii. The resident passed away while hospitalized on January 24, 2023.

viii. Staff member "C" indicated that resident number one (1) had reported to the staff member that resident number two (2) had assaulted the resident.

ix. Family members of the resident had reported on two occasions in January 2023 to staff member "B" that resident number two (2) had assaulted resident number one (1).

x. Respondent's records regarding the resident do not memorialize any of these allegations of assault.

d. Resident number three (3):

i. Approximately two (2) months ago, the resident was forcibly pushed by resident number two (2) to the ground resulting in a bump on the head of resident number three (3).

ii. Staff heard the event and responded to protect resident number three (3).

iii. The resident did not receive medical care or evaluation after the event.

iv. Respondent did not notify the resident's health care provider or responsible party of the event.

v. Respondent did not document the event in the records of the resident.

vi. Respondent did not take any action or implement any interventions to protect the resident from further physical assault by resident number two (2).

e. None of the incidents of assaultive or violent behaviors of resident number two (2) have been documented by Respondent.

f. There is no indication that the health care provider of residents numbered one (1), two (2), or three (3) were notified of the assaultive and violent behaviors of which the residents either imposed or suffered the results.

g. Respondent's administrator denied knowledge of the behaviors of resident number two (2), though the documentation of several involuntary commitments of the resident for mental health evaluations were memorialized by the administrator.

h. While Respondent's administrator acknowledges that he removed a lamp from the room of resident number two (2), the administrator denies this action was related to the resident's behaviors but provided no other explanation.

i. Respondent terminated staff members "B" and "C" during the Agency's survey activity.

j. Of the remaining three (3) residents of the Facility, two (2) suffer from disease processes that prevent them from meaningful interactions with staff or regulators and could not provide any information regarding the behaviors of resident number two (2) while the third provided no relevant information.

**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). Residents of assisted living facilities must receive the care and services, including supervision, appropriate to their needs. Fla. Admin. Code R. 59A-36.007.

13. Residents who reside in assisted living facilities oftentimes suffer from disease or disability. They typically consist of the frail, elderly or vulnerable. By law, the Respondent has been licensed and entrusted to provide care and services to this class of people, and as such, must comply with the statutes and rules that have been enacted for the special needs of these residents.

14. In this instance, 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.

15. The facts reflect numerous incidents of possible resident abuse and neglect ranging from actual physical assault to residents by another resident to threatened physical threat by that same resident to staff.

16. Respondent has demonstrated its inability to or unwillingness to respond to these incidents. No investigation of the incidents was 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 adverse incidents.

17. While it is unknown which, if any, of the hostile behaviors of resident number two (2) 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.

18. Respondent has demonstrated either the inability or unwillingness to weigh or implement action directed to the protection of and safety of its residents and staff from a known threat.

19. In addition, Respondent has not demonstrated that it timely instituted orders for medication. Here, resident medication was in Respondent's possession, but the named resident was not assisted with the self-administration of the medication as required. Particularly troubling is the presentation by Respondent of a medical record indicating the medication was in fact provided, while the medication remained on site unused. Respondent's administrator denied knowledge of these discrepancies and could not provide any explanation for the document.

20. The failures above discussed are not isolated events but constitute a systemic failure of Respondent to assure that residents' rights to be free from abuse or neglect are 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. Respondent is aware of these conditions. Respondent may not ignore a known danger to the detriment of those persons to whom Respondent has undertaken the responsibility for their health, safety, or welfare.

21. These facts demonstrate 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, 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.

22. 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 facility'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.

23. These deficient practices have occurred over time and affect each of Respondent's resident census. 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.

24. 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, 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).

25. 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

26. 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.

27. 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).

28. 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.

29. 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.

30. The Respondent's deficient practices exist presently and will continue if the Agency does not act promptly. The Respondent's Administrator has not assured that 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.

31. 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:**

32. 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.

33. 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.

34. 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 30th day of January 2023.

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.**