STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

THE CHILDREN'S PLACE AT HOMESAFE, INC. d/b/a HOMESAFE,

Respondent.
_____/

AHCA No: 2025002213
License No. 74
File No. 57000090
Provider Type : RTC

IMMEDIATE LIMITED MORATORIUM ON ADMISSIONS

THIS CAUSE came on for consideration before the Secretary of the State of Florida, Agency for Health Care Administration, or a duly appointed designee, who, after a careful review and consideration, finds and concludes as follows:

THE PARTIES

1. The State of Florida, Agency for Health Care Administration ("the Agency"), is the licensure and regulatory authority that oversees residential treatment centers for children and adolescents in Florida and enforces the applicable state statutes and rules governing such facilities. Chs. 394, Part IV, and 408, Part II, Fla. Stat. (2024); Ch. 65E-9, Fla. Admin. Code. As part of its oversight, the Agency has the authority to impose emergency orders, including an emergency suspension orders and immediate moratorium on admissions, when circumstances dictate such action. §§ 394.902, 408.814, 120.60, Fla. Stat. (2024); Fla. Admin. Code R. 65E-9.004(3).

2. The Respondent, The Children's Place at Home Safe, Inc. d/b/a Homesafe ("the Respondent"), was issued a license by the Agency (License Number 74) to operate a twelve (12) person residential treatment center for children and adolescents, located at 654 Lyons Road, West

Palm Beach, Florida 33411 ("the Facility"). § 394.875(2), Fla. Stat. (2024). The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services pursuant to Sections 394.491, 394.495 and 394.496, Florida Statutes, to children and adolescents who meet the target population criteria specified in section 394.493(1)(a), (b), or (c), Florida Statutes. § 394.875(1)(c), Fla. Stat. (2024).

3. The Florida Legislature has expressed its intent that certain principles guide the development and implementation of the publicly funded child and adolescent mental health treatment and support systems. These guiding principles include that: The system should be centered on the child, adolescent, and family, with the needs and strengths of the child or adolescent and his or her family dictating the types and mix of services provided. . . . Through an appropriate screening and assessment process, treatment and support systems should identify, as early as possible, children and adolescents who are in need of mental health services and should target known risk factors. . . . Children and adolescents should receive services within the least restrictive and most normal environment that is clinically appropriate for the service needs of the child or adolescent. . . . The delivery of comprehensive child and adolescent mental health services must enhance the likelihood of positive outcomes and contribute to the child's or adolescent's ability to function effectively at home, at school, and in the community. . . . Mental health services for children and adolescents must be provided in a sensitive manner that is responsive to cultural and gender differences and special needs. § 394.491(1), (6), (7), (11) and (15), Fla. Stat. (2024).

4. As the holder of a license to operate a residential treatment center for children and adolescents, the Respondent is a "licensee" as defined by Section 408.803(9), Florida Statues (2024), and is "legally responsible for all aspects of the provider operation." § 408.803(9), Fla.

Stat. (2024). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2024). § 408.803(12), Fla. Stat. (2024). The Agency regulates residential treatment centers for children and adolescents under Chapter 394, Part IV, Florida Statutes (2024), and listed in Section 408.802, Florida Statutes (2024). § 408.802(7), Fla. Stat. (2024). Individuals receiving services within a residential treatment center for children and adolescents are "clients." §§ 394.67(2), 408.803(6), Fla. Stat. (2024).

5. The census at the Facility as of the date of this Immediate Limited Moratorium on Admissions is seven (7).

THE AGENCY'S
MORATORIUM ON ADMISSIONS AUTHORITY

6. Under Florida law, the Agency may impose an immediate moratorium or emergency suspension as defined in subsection 120.60, Florida Statutes (2024), 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. (2024).

7. Under Florida law, 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. (2024).

8. Under Florida law, in accordance with Part II of Chapter 408, Florida Statutes, the Agency may impose a moratorium on elective admissions to a licensee or any program or portion of a licensed facility if the Agency determines that any condition in the facility presents a threat to the public health or safety. § 394.902, Fla. Stat. (2024).

9. Under Florida law, an immediate moratorium on admissions shall be placed on the facility when it has been determined that any condition in the facility presents an immediate or

direct threat to the health, safety, and well being of children in the facility. Fla. Admin. Code R. 65E-9.004(3)(a). The following situations are examples of threats constituting grounds for a moratorium: 1. Inappropriate or excessive use of restraint and seclusion; 2. The presence of children who need more care than can be provided by the facility; 3. Food supply inadequate to provide proper nutrition to children; 4. Lack of sufficient staff who are skilled and competent to provide for or to meet the immediate needs of the children; 5. Notification by the local fire marshal's office or county health department that conditions exist which impose an immediate threat to the children; or 6. Significant or repeated staff error resulting in failure to administer medications as prescribed. Fla. Admin. Code R. 65E-9.004(3)(a).

LEGAL REQUIREMENTS FOR RESIDENTIAL TREATMENT CENTERS FOR CHILDREN AND ADOLESCENTS

10. The Respondent holds itself out to the public as a residential treatment center for children and adolescents that complies with the applicable state laws. The laws governing these types of facilities exist to protect the health, safety and welfare of the clients that reside within them. As the recipients of the care and services provided at a residential treatment center for children and adolescents, the clients are entitled to the benefits and protections under Chapters 394 and 408, Florida Statutes (2024), as well as Chapter 65E-9, Florida Administrative Code.

Operating Standards – Written Procedures

11. Florida law provides:

> (2) Written procedures. The provider shall establish and implement written procedures that ensure compliance with all provisions of this rule.

Fla. Admin. Code R. 65E-9.005(2)

Staff-Communication

12. Florida law provides:

> (2) Staff communication. The provider's personnel procedures shall ensure and require the inter-communication among staff of information regarding children necessary to the performance of each staff responsibility, including between working shifts, staff changes and consultations with professional staff. Where one staff member or one program group relies upon information provided through this required free interchange of information, these interactions shall be documented in writing and maintained in the respective children's case files.

Fla. Admin Code R. 65E-9.007(2)

Operating Standards – Facility Buildings/Furniture

13. Florida law provides:

> (5) Facility standards.
> (a) Buildings, grounds and equipment.
> 6. The interior and exterior of buildings and the furniture and furnishings shall be safe, comfortable, reasonably attractive, in good repair and shall function for the purpose for which such building and furniture has been designed.

Fla. Admin. Code R. 65E-9.005(5)(a)6.

THE AGENCY'S SURVEY AND FINDINGS OF FACT

14. After careful consideration, the Agency finds that the Respondent is presently in substantial non-compliance with the statutes and rules that govern residential treatment centers for children and adolescents in Florida and that this substantial non-compliance has resulted in current conditions at the Facility that present a threat to the health, safety or welfare of its clients and an immediate serious danger to the public health, safety or welfare. The Agency further finds that this threat and immediate serious danger is of such a degree and magnitude that it warrants an immediate limited moratorium on admissions to the Facility pursuant to the above-stated provisions of law.

15. On February 10, 2025, the Agency commenced a survey of the Respondent and its

Facility. During the survey, the Agency's surveyors reviewed records, observed conditions and conducted interviews. Based upon this survey, the Agency finds as follows:

16. February 10, 2025, the Facility census was nine (9) Residents. Three (3) residents were absent without official leave (AWOL). One (1) resident, however, returned to the Facility by law enforcement while the surveyor was onsite. Of the nine (9) residents currently onsite, five (5) residents had a history of suicidal ideations and/or self-harming/cutting tendencies.

17. On February 1, 2025, at approximately 11:11 pm, Resident #1, a fifteen (15) year-old adolescent, was found by the staff deceased in the Resident's bathroom after the Resident had hung oneself on the highest bathroom door hinge using a belt from the Resident's bath robe.

18. The Facility records for Resident #1 indicated the following:

a. Resident #1 was admitted to the Facility on January 16, 2025.

b. Diagnosis included Posttraumatic Stress Disorder.

c. Medications at admissions:

i. Lexapro 20 MG in AM for mood swings.

ii. Hydroxyzine 30 MG in AM for anxiety.

iii. Abilify 20 MG in AM for mood swings.

iv. Lithium 300 MG twice a day for mood swings.

v. Topiramate 50 MG twice a day for depression.

d. Resident#1's History included:

i. Sexual abuse dating back to age six (6).

ii. Suicidal ideation.

iii. Numerous Baker Acts for suicidal ideation, gestures and attempts. (Including overdosing on Tylenol and cutting).

iv. Ingesting screws and batteries with most recent being November 2024.

v. Command hallucination, depression, dissociation, trauma symptoms, self-harm, eating disorder behaviors, academic and behavioral problems in school.

19. On January 25, 2025, Resident #1 went on an outing with other Facility residents and staff, leaving at 5:30 pm and arriving back at Facility at 11:00 pm.

20. On January 26, 2025, Resident #1 went to the Youth Development Professional II (YDP) #11 and told the YDP that the Resident was depressed and thinking of harming oneself. The YDP #11 indicated the following happening during this interaction with Resident #1:

a. Resident #1 told the YDP #11 that the Resident had a screw and was going to swallow it, but then changed Resident's mind. Resident #1 gave the screw to the YDP #11.

b. YDP #11 checked the Resident's room and did not see any missing screws and questioned the Resident, who stated the Resident did not remember where the screw came from.

c. YDP #11 had a conversation with Resident #1 about writing negative thoughts and writing in positive ways. YDP #11 told Resident #1 to write about what the Resident likes about oneself.

d. After YDP #11 talked with Resident #1 for a while, the Resident felt better.

e. YDP #11 notified the Program Supervisor and Therapist of the interaction.

21. On February 1, 2025, at 12:00 pm, five (5) residents, including Resident #1, went to Miami for an outing with staff YDP #3 and YDP #6.

a. While riding home in the van from the Miami outing, Resident #1 began getting anxious. YDP #3 indicated that the Resident had a moment and stated, "it looked

like an Anxiety/Panic attack, and Resident #1 was crying."

b. YDP #6 was unable to console Resident #1. YDP #6 switched places with YDP #3. YDP #6 took over driving and YDP #3 went to the back of the van and spoke to Resident #1.

c. Resident #1 made the comment to YDP #3 while crying, that the Resident did not want the Resident's family to see the Resident get buried.

d. YDP #3 discussed positive affirmation to Resident #1 and the Resident calmed down.

e. YDP #3 asked Resident #1 if the Resident wanted the YDP to sit with the Resident and the Resident told YDP #3 that he could go back to his seat. YDP #3 indicated that Resident #1 was back to Resident's self and appeared happy and fine after they spoke for a few minutes.

f. The group went to a restaurant to pick up dinner and brought it back to the Facility at 7:39 pm per the Facility logbook.

g. YDP #3 was only scheduled to work till the group returned from the outing at 7:39 pm and left the Facility after the group returned to Facility.

h. YDP #3 did not tell anyone what Resident #1 had told him, but texted the Program Supervisor at approximately 7:39 pm, that they need to talk about Resident #1 and Resident #1 getting "anxious" on the trip. The Program Supervisor responded that they would talk on Tuesday, February 4, 2025, when YDP #3 returned to work. Both YDP #3 and the Program Supervisor did not follow the Facility's policy on staff communication and failed to put into place safeguards for Resident #1.

i. YDP #3 stated, "I had shot a text to Ms. Monique [Program Supervisor] saying

[Resident #1] had a moment. I don't think I told anyone about [Resident #1's] comment. [Resident #1] was back to normal after we talked."

j. YDP #3 failed to follow the Facility's self-harm policy and procedure for Resident #1 and failed to communicate the incident to oncoming staff when YDP #3's shift ended and left the facility. Fla. Admin. Code R. 65E-9.005(2) and 65E-9.007(2).

22. On February 1, 2025, the Facility staff last documented check of Resident #1 was at 9:30 pm, although the 9:30 pm check was not a visual check of Resident #1. Rather, the staff saw a light on in the Resident's bathroom, but did not actually see the Resident.

23. On February 1, 2025, at 11:11 pm, the Facility staff found Resident #1 hanging from the Resident's bathroom door hinge with the Resident's bed robe belt tied around the Resident's neck.

24. The Respondent's Client Supervision and Accountability R0714 policy revision date May 14, 2019, document that the staff will ensure the safety and welfare of clients in care and indicated:

1. Supervision of clients is the primary responsibility of direct care staff. 24 hour awake supervision will be provided in all facilities.
2. Minimum staff to client ratios are as follows:
a. STGC: 1:4 during awake hours and 1:6 during sleep hours.
3. Consistent with "normalcy" expectations, each program ' s behavior management system, and each client ' s individualized treatment plan, client may earn privileged unsupervised time either on or off campus. Any unsupervised time will be approved in advance and staff are to know the whereabouts of the client at all times.
4. Direct care staff members are responsible for documenting the following supervision information in the Program Logbook:
a. A 30 minute census of clients during awake hours
b. A 15 minute census for clients during sleep hours
c. The activity that clients have been participating in
d. Clients who leave or return to the facility
e. Staff within the group home
f. Visitors
5. At each shift change, the outgoing staff members will provide a briefing of events from their shift to include location of all residents assigned. The oncoming staff

member should make a visual observation of all youth present prior to assuming supervision responsibility and prior to the outgoing staff member completing their shift and exiting the facility.
Bed Checks
1. Bed checks are to be conducted any time clients are in their bedroom
2. Staff must conduct bed checks every 15 minutes throughout the time any client is in his/her bedroom

25. The Facility policy and procedures for Residents expressing "Self-Harm" documented:

POLICY: Facility staff are trained in how to respond to observation, allegation, and disclosures indicating potential client self-harm and/or suicide. This policy does not prescribe client treatment planning, intervention goals and strategies, or specific counseling techniques and theories.
PURPOSE: To promote the safety and well-being of clients through responsive self-harm management practices. To establish procedures to ensure that children who demonstrate, or have demonstrated, any self-harming behaviors are responded to in ways that aim to:
□ Safeguard their immediate safety to the extent possible in the circumstances
□ Prevent harm from occurring or reduce the risk of harm
1. Facility staff are provided with guidelines for clients, either demonstrating a history of suicidal ideation, tendencies, attempts, gestures, or threats at the time of intake or during placement.
2. When a client engages in self-injurious behaviors or a suicide attempt, reasonable measures should be taken to reduce or prevent continuation of the behavior:
a. The first person on the scene should implement emergency measures, including dialogue and contacting 911.
b. If staff witnesses a client in the act of self-harming, the scene and situation should be assessed to determine any intervention needed for client safety.
c. Close off the room or area to provide privacy.
d. Confiscate items or materials that were used in incident and secure in a safe place.
e. Assign staff to stay with the other clients, if necessary.
3. If a client verbalizes thoughts or a plan related to suicidal ideation or self-injurious behaviors:
a. If there is not an immediate threat of harm, staff should notify the therapist or Clinical Director for clinical assessment.
b. Staff should maintain 1:1 supervision until the therapist or Clinical Director can assess the client.
c. The therapist or Clinical Director will determine and prescribe the intervention, which may include de-escalation, contracting for safety, or initiating a Baker Act.
d. If a therapist or Clinical Director is not available, staff should implement emergency measures and contact local law enforcement for assistance.
4. Incident reporting and notification guidelines should be followed.
5. Staff should document the sequence of events and action taken in the Program Logbook

6. Therapist will document all pertinent information, the outcome of their assessment (if applicable), and resolution to the crisis in the client record.
7. The Program Supervisor and/or Program Administrator will conduct a residential group meeting to reassure clients and process feelings regarding the incident.
8. A staff meeting will be held to review the circumstances surrounding the suicide attempt/plan/ideation and conduct a clinical case review.

26. A review of the Facility logbook for January 25, 2025, January 26, 2025, January 31, 2025, and February 1, 2025, revealed that the bedroom checks were not completed every 15 minutes per the Supervision and Accountability policy.

27. A review of the Facility logbook for January 25, 2025, documents at 9:00 pm three (3) residents were in their rooms. (Resident #3, #5 and #8) At 10:30 pm, it documents four (4) residents are offsite on an outing. (Resident #1, #3, #4 and #9) At 11:00 pm, the logbook documents change of shift with the name of the residents census. The residents on the outing return at 11:00 pm.

28. On January 26, 2025, at 12:00 am the Facility logbook documents seven (7) youths are secure and safe in assigned rooms. Bedroom checks are not completed until midnight January 26, 2025, this is a three (3) hour lapse in room checks from 9:00 pm -12:00 am.

29. A review of the Facility logbook for January 31, 2025, documents at 10:00 pm all others in rooms. Seven (7) residents (except one (1) Baker Act and three (3) eloped from Facility). The 11:00 pm shift change documents seven (7) residents onsite, one (1) Baker Acted and three (3) elopements). On January 31, 2025, at 11:05 pm, all clients appear to be sleeping in their rooms (Except Baker Act and 3 on elopement). This is a one (1) hour lapse for fifteen (15) minute room checks for January 31, 2025.

30. The census on February 1, 2025, for the Facility was eleven (11) residents; seven (7) residents were onsite; three (3) residents were AWOL and one (1) was resident was hospitalized on a Baker Act.

31. The Facility staff schedule for February 1, 2025, for the 11:00 pm-7:00 am shift was YDP #10 and YDP #11.

32. The Facility logbook for February 1, 2025, through February 2, 2025, indicated the following:

a. At 12:00 pm, five (5) Residents, including Resident #1, went to Miami for an outing at a museum with staff YDP #3 and YDP #6.

b. 7:14 pm – Two (2) Residents (#3 and #8) left the Facility without permission heading north on Lyons.

c. 7:30 pm –Five (5) residents are AWOL from Facility and one (1) resident was Baker Acted.

d. 7:39 pm - Five (5) residents and two (2) staff arrived at the Facility from their outing in Miami.

e. 8:00 pm – The Residents were completing chores and taking showers.

f. 8:30 pm – "Shelter calm nothing to report." Per YDP #9.

g. 9:00 pm – Residents #1, #5, #2, and #10 in assigned rooms. Resident #4 in the living room at a table.

h. 9:10 pm – Resident #3 and #8 back onsite and refusing to come in.

i. 9:30 pm - Residents #1, #5, #2, and #10 in assigned rooms. Resident #4 in the living room at a table. (Staff YDP #9 "initials"). (This was the last time that YDP #6 told YDP #9 that YDP #6 saw Resident #1 in Resident's room)

j. 9:40 pm – Resident's #3 and #8 tried to come into the Facility without being searched. Resident #3 kicking door and was told if Resident #3 continues police to be called. Resident #8 agreed to a search and came in, but then refused to let them

complete the search and went back outside.

k. 10:01 pm – Resident #3 consented to search, but refused to go to bed.

l. 10:07 pm – Resident #8 consented to search.

m. 10:17 pm – PBSO called, Deputy onsite (residents refusing to be searched)

n. 10:27 pm - PBSO Deputy onsite

o. 10:35 pm - Escorts Resident #3 and #8 back inside both refusing to go to assigned rooms.

p. 10:37 pm - PBSO offsite

q. The Logbook documents "End of shift" census shows seven (7) residents, listing each resident, onsite with three 3 AWOL, listing the resident names and one (1) Baker Acted, listing the name. Three (3) Staff's names were listed who were on that shift, 3:00 pm - 11:00 pm, YDP #9, YDP #5 and YDP #6.

r. Start of next shift 11:00 pm - 7:00 am, February 1, 2025. Staff: YDP #8 and YDP #10. Residents: seven (7) with three (3) AWOL and one (1) Baker Act.

s. 11:00 - pm room check conducted by writer YDP #8

t. 11:00 pm – Resident #1 not responding to writer YDP #8 when room check conducted. YDP #8 called YDP #9 for help.

u. 11:03 pm - 911 called advising couldn't enter Resident #1's bathroom

v. 11:06 pm - YDP #8 called Program Supervisor letting her know that we couldn't enter Resident #1's bathroom.

w. 11:11 pm - Called PBSO to let them know we've entered the bathroom. Resident #1 appeared unresponsive.

x. 11:15 pm - PBSO arrived, the deputy made the call to announce time of death.

y. 11:46 pm – Program Supervisor arrived onsite.

z. 12:00 Midnight - Residents on hallway where Resident #1 was moved to conference room. (Same four (4) residents on outing). On the other side of the building/hallway Residents #3 and #8 were in rooms and staff YDP #10 sat in hallway supervising residents.

aa. 12:34 am – Coroner's office arrived onsite (Crime scene).

bb. 12:34 am - Clinical Director arrived onsite.

cc. 12:43 am - Medical Examiner onsite

dd. 12:48 am - Removal transport onsite

ee. 1:00 am - 2 clients in rooms other 4 remain in the conference room.

ff. 1:22 am, 1:26 am and 1:31 am - Detective talking to staff.

gg. Deputy gave YDP #8 a case number.

hh. 1:45 am – two (2) residents in assigned rooms sleeping and four (4) residents in conference room. Three (3) AWOL and one (1) Baker Act.

ii. 2:00 am - all residents back in assigned rooms

jj. 2:12 am - PBSO offsite

kk. 2:30 am - Site is calm all is well

ll. 2:45 am - All residents remain onsite

mm. 3:00 am - Status remains the same

33. The Facility's Program Supervisor indicated:

a. YDP #3 had left the Facility as soon as the YDP returned from the February 1, 2025, outing to Miami. YDP #3 was technically off the clock and was supposed to be leaving at 3:00 pm.

b. The Program Supervisor asked YDP #3 if Resident #1 was suicidal, wanted to die and the YDP said "no, he would have brought [Resident #1] back (from the outing)."

c. YDP #3 texted another staff member that was working the morning shift about Resident #1 getting anxious on the trip. This was the farthest trip Resident #1 had gone on.

d. The Facility's Program Director failed to follow the Facility's self-harm policy and procedure for Resident #1 and failed to communicate the incident to oncoming staff when his shift ended and left the Facility. Fla. Admin. Code R. 65E-9.005(2) and 65E-9.007(2).

34. YDP #9 indicated the following:

a. YDP #9 stated that on February 1, 2025, at 11:00 pm shift was just arriving and YDP #8 went to do room checks. YDP #8 yelled down the hall and said she needed YDP #9's assistance.

b. YDP #8 knocked on Resident #1's bathroom door and did not get a response. The door was locked, and the light was on. The residents can lock it from the inside. We have a special key that we use to pop the lock, but we could not get it to open.

c. YDP #9 called 911 initially, YDP thought at 11:03 pm, to tell them we could not gain access to the bathroom. YDP #9 ran down to get another key. YDP #9 called the Program Supervisor.

d. Once in Resident #1's bathroom, YDP #9 was on the telephone with the Program Supervisor and YDP #8 went into the bathroom and saw Resident #1. YDP #8 stated that the Resident #1 was dead.

e. YDP #9 called 911 back since no one had arrived yet to let 911 know we gained access to bathroom and that Resident #1 appeared to be dead. No CPR was initiated.

f. When YDP #9 called 911 again, the police were already walking down the hall. The police went into the bathroom and then told us Resident #1 was definitely dead.

g. The last time YDP #9 saw Resident #1 on February 1, 2025, was around 8:30 pm. Resident #1 had asked to use the phone; we do not allow them to make calls past 8:00 pm. YDP #9 did not know who Resident #1 wanted to call.

h. YDP #9 indicated that when residents are in their rooms, there are 15-minute checks. When residents are outside, there are 30-minute checks. YDP #9 thought the 15-minute checks began after 11:00 pm.

i. YDP #9 failed to follow the Facility's policy and procedures for direct care staff responsibility to perform thirty (30) minute and fifteen-minute checks on Residents. Fla. Admin. Code R. 65E-9.005(2).

35. YDP #8 indicated the following:

a. YDP #8 was a floater on February 1, 2025.

b. YDP #8 stated that she had been working in the Facility for two and half years.

c. YDP #8 indicated that the incident occurred on February 1, 2025, and that she came in for the 11:00 pm-7:00 am shift. YDP #8 arrived a little earlier and was talking to the residents who walked off, they were being defiant. I told them we are not having this tonight.

d. YDP #8 got a call and stepped outside for a brief minute and then came in and clocked in at 10:58 pm on February 1, 2025, and began to do her room checks.

e. YDP #8 checked everyone's room; the doors are closed, but not locked. The residents can lock the door, but we will unlock it.

f. When YDP #8 reached Resident #1's room, YSP #8 noticed the Resident was not in bed.

g. YDP #8 saw the bathroom light on and called Resident #1's name. Resident #1 did not answer. TDP #8 believed Resident #1 did not hear YDP #8. YDP #8 knocked on the door several times and then realized Resident #1 was not responding.

h. YDP #8 yelled down the hallway by sticking her head out the door. I asked YDP #9 to come to Resident #1's room and YDP #9 came down. We both knocked on the bathroom door and called Resident #1's name.

i. YDP #8 told YDP #9 to call 911. That was about 11:03 PM. At that time, YDP #8 said to Resident #1, "I am opening the door." YDP #8 was thinking maybe Resident #1 had an earpiece on listening to music and could not hear me.

j. YDP #8 tried to use the key, and it would not open. Both YDP #8 and YDP #9 kept trying to use the Key to open the door. The YDPs called the Program Supervisor to let her know what was happening with Resident #1. The Program Supervisor advised to jiggle the door and push in hard. We pushed it and it opened. YDP #8 opened the door and did not see Resident #1 in the bathroom or shower.

k. After that YDP #8 saw, with her peripheral view, something behind the door, thinking Resident #1 was standing behind the door. YDP #8 pulled the door open and then realized Resident #1 hung oneself. YDP #8 did not touch Resident #1; the YDP was in shock. YDP #8 told YDP #9 to call 911 and tell them Resident #1 was unresponsive.

l. YDP #8 is CPR certified, but did not perform CPR on Resident #1. She stated that Resident #1 was white and had no skin color (Resident #1 was Hispanic with a non-white skin color.) YDP #8 indicated that if she saw another color, she would have performed CPR.

m. YDP # stated that law enforcement came at 11:15 pm and pronounced Resident #1 dead. Resident #1 was not even blue, was totally white.

36. YDP #6 indicated:

a. YDP #6 was hired on in October 2024.

b. On February 1, 2024, YDP #6 indicated that she went on the outing with YDP #3 and five (5) residents, including Resident #1.

c. Resident #1 seemed to be upset on the way back from the out outing to the Facility, but Resident #1 would not talk to YDP #6. That is when YDP #6 switched places with YDP #3. YDP #6 and YDP #3 did talk to staff that Resident #1 had a moment, but Resident #1 seemed in a better mood and spirits when the outing group went to a restaurant.

d. YDP #6 indicated that she never heard that Resident #6 say anything about Resident #1 not wanting the Resident's parents to see Resident get buried.

e. YDP #3 did tell YDP #6 something, but not that because there was a client sitting behind me. YDP #6 thought Resident #1 said something that she did not want to see her mother get married again.

f. The outing group was going to sit down at a restaurant, but did not because of how Resident #1 was feeling, YDP #3 and YDP #6 decided to pick up food. YDP #6 let them know Resident #1 had a moment, but did not remember what YDP #6 said

exactly.

g. YDP #6 indicated no one is assigned to room checks or anything. The thirty (30) minute checks when on milieu and fifteen (15) minutes in rooms, is what YDP #6 guessed as the policy.

h. YDP #6 was doing room checks and YDP #9 was documenting the checks in logbook during her shift on February 1, 2025.

i. YDP #6 indicated she saw Resident #1 at 9:00 pm sitting on the Resident's bed with her back to me. It looked like Resident #1 was organizing something.

j. YDP #6 indicated her next observation of Resident #1's room was at 9:30 pm. YDP #6 did not see Resident #1, but saw the light on in the bathroom. YDP #6 did not call out to the Resident.

k. On February 1, 2025, YDP #6 stated that she did the room observations, but another staff member wrote the observations in the book.

l. YDP #6 indicated that sometimes she will go into the room, and other times she looks through the window of the door.

m. YDP #6 indicated that staff just communicate with each other. There is always two (2) people onsite with the residents and always census.

n. YDP #6 failed to follow the Facility's policy and procedures for communicating and documenting a resident with suicidal ideations and safety checks including room checks every fifteen (15) minutes on residents in their bedroom and every thirty (30) minutes when residents are in the Facility, but not in their bedroom. Fla. Admin. Code R. 65E-9.007(2) and 65E-9.005(2).

37. On February 11, 2025, at approximately 11:47 am, YDP #11 indicated:

a. YDP #11 had been at the facility for 20 years in March.

b. YDP #11 had an interaction with Resident #1 on January 26, 2025, and indicated the following:

i. Resident #1 was depressed and thinking of harming herself.

ii. YDP #11 had a conversation with Resident #1 about writing negative thoughts and writing in positive ways. YDP #11 told Resident #1 to write about what the Resident likes about oneself; Resident #1 liked to color and music.

iii. Resident #1 gave YDP #11 a screw which the Resident said that was from the Resident's door. YDP #11 asked if the Resident was going to swallow it, and the Resident said the Resident did not know.

iv. YDP #11 went into Resident #1's bedroom and checked the room's doors for missing screws. No screws were missing. Resident #1 said that she didn't know where the Resident got the screw from.

v. YDP #11 told the Resident that YDP #11 was going to inform Program Supervisor and the therapist about their conversation. Resident #1 was fine after that.

vi. YDP #11 called the supervisor, but I didn't document it in the book. I informed the Program Supervisor on that Sunday and relayed it to the next shift in the shift report.

c. With Resident #1, it was about people liking the Resident. Resident #1 was at the Facility for only a couple of weeks. We were getting to know Resident #1. The Resident loved the staff, just not the other residents.

d. When asked if the person who does the observations writes in the logbooks, YDP

#11 responded "it can go both ways."

e. The last time YDP #11 saw Resident #1 was on Thursday, January 30, 2025. Resident #11 made YDP #11 flowers, Resident #1 was vibrant and seemed fine.

f. YDP #11 trains the staff to document. If there are any concerns, we notify the Program Supervisor and the therapist. If there are any concerns of harm, we call the police.

g. When asked how often checks are being done on the Residents, YDP #11 responded that it is every 30 minutes, and between 11-7 it is 15 minutes and in between the 30 minutes if something happens document what's going on.

h. YDP #11 indicated that the staff write in the logbook in red if it is important information such as a resident being disrespectful, not going to school, AWOL, not taking medication.

i. After Resident #1 reported the suicidal ideation to YDP #11 and YDP #11 communicated the ideation to the Program Supervisor.

j. The staff failed to place Resident #1 on special monitoring, which violated the Facility's policy for reporting self-harm and/or suicide and failed to communicate and or document the ideation with other staff members and to Resident #1's treatment providers. Fla. Admin. Code R. 65E-9.005(2) and Fla. Admin Code R. 65E-9.007(2)

38. A review of the Facility's building revealed that the door to each resident room has a glass insert to look into room and has a lock. The bathroom door has a lock that locks from the inside. There is a metal hook on door that is screwed into door. The hinges on the inside of the bathroom door are large, stick out and are accessible to hang from. There is a shower, with a

shower head that is metal with a tension rod (non-weight bearing) for the shower curtain and a toilet and sink. The hinges on the inside of the door are where Resident #1 hung from with the bathrobe belt. It was unknown if the Resident used the chair in bathroom.

39. On February 10, 2025, when asked about the unsafe ligatures (bathroom door hinges) and the robe belt used by Resident #1 to hang oneself, the Administrator responded that the Facility is considering bringing in a consultant to be a "fresh set of eyes" about the locks on the doors and the room set- up. Fla. Admin. Code R. 65E-9.005(5)(a)6.

40. During a follow-up visit on February 17, 2025, the Administrator acknowledged that the Facility had not addressed the ligature risks in the Facility. The Facility was in the process of making changes, but did not provide examples. The Administrator indicated that the Facility had been looking at ligature risks, but there was no way to do anything about the hinges. The Administrator stated that the Facility could have the locks replaced. The Facility had received a quote from a locksmith to change out the door handles that will not have a lock, stating that it is a passage handle and can get approved right away.

41. On February 18, 2025, the Administrator emailed the surveyor indicating that the Facility received the quote yesterday afternoon, on February 17, 2025, and approved the work to be done this morning to our Facilities Manager. The vendor will need to order the replacement door handles, and they will be installed as soon as possible.

42. On February 19, 2025, during a follow up visit, the Program Supervisor stated that she is aware of ligature risks, but not all of them, and indicated that someone is coming next Wednesday (February 26, 2025) from the insurance company for compliance to see what the Facility can do different.

43. Per the Facility's internal investigation notes, on February 2, 2025, at 1:50 am, law

enforcement met with the Program Supervisor and Clinical Director to notify that Resident #1 had in fact hung oneself in the bathroom using one of the metal hinges on the back of the bathroom door and Resident #1's robe belt.

44. Per the Facility's internal investigation notes, the Facility concluded that its policy was not followed for the supervision of clients while in their bedrooms, since Resident #1 was not physically seen at the 9:30 pm checks per YDP #6 (who did the checks) and Resident #1 was not found until after 11:00 pm.

THE NECESSITY FOR THE IMMEDIATE LIMITED MORATORIUM ON ADMISSIONS

45. The Agency is charged with the responsibility of enforcing the laws designed to protect the health, safety and welfare of clients in Florida's residential treatment centers for children and adolescents. Ch. 394, Part IV, Fla. Stat. (2024), Ch. 408, Part II, Fla. Stat. (2024); Ch. 65E-9, Fla. Admin. Code. Where the health, safety and welfare of such a resident is at risk, the Agency will take prompt and appropriate action. Ensuring the protection of these children and adolescents from abuse and neglect is an essential purpose of the Agency.

46. The Facility has exhibited current conditions which reflect deficient practices with respect to ensuring its own policies and procedures for communication and documentation by staff of resident interaction including but not limited to, response, reporting, and preventing of Resident #1's ideation of self-harm on multiple occasions; direct care staff member's responsibility for supervision and resident checks; and unsafe furnishings, including but not limited to door locks and large door hinges with ligature risks in which Resident #1 used to hang oneself. Fla. Admin. Code R. 65E-9.005(2), 65E-9.007(2), 65E-9.005(5)(a)6, and 65E-9.006(3). These deficiencies pose an immediate threat to the health and safety of Facility's residents. Children and adolescents must be safeguarded from these types of failures of communication, inaction, and understanding

of supervised care by the Facility staff. The staff failed to follow policies and procedures to safeguard the residents from risk of self-harm, including but not limited to, the understanding of timely resident checks and documentation of those checks. The staff failed to properly identify an adolescent resident, who had a history of suicidal ideations and suicide attempts and had made suicidal ideations in the last four days, was at high risk for self-harm and ultimately killed oneself while under the Facility's care. These deficiencies pose an immediate threat to the health and safety of the Facility's residents that are suicide risks. Children and adolescents must not be subjected to such threats and dangers in a licensed location that is required to maintain a safe and decent therapeutic environment. Fla. Admin Code R. 65E-9.005(2) and 65E-9.007(2). By law, Facility grounds are required to be maintained in a safe manner and kept free of hazardous conditions. Fla. Admin Code R. 65E-9.005(5)(a)2.

47. The Facility's deficient practices are located within the entire building and directly impact the health, safety, and welfare of its clients. The facts reflect a situation where a resident, with a history of suicidal ideation, gestures and attempts, clearly expressed thoughts of self-harm within a four-day span lending up to the client's suicide and the failure of the Respondent's staff to follow its own policy on how to respond, communicate and assess a resident who verbalizes thoughts or a plan related to suicidal ideation or self-injurious behaviors. These facts depict a situation where the Respondent's systems to effectively manage and treat its residents have failed in its implementation of its policies and procedures. These failures are in violation of the minimum requirements of law. Fla. Admin Code R. 65E-9.005(2) and 65E-9.007(2).

48. Of note, the Facility staff demonstrated a lack of knowledge of the Facility's policy for supervision and documenting supervision of residents in the Facility's logbook. In the days leading up to and including the night of the resident's suicide, the Respondent's staff failed to

supervise and document the appropriate time checks of every fifteen (15) minutes for residents who were in their individual bedrooms. The staff did not document actual visual checks of the resident that committed suicide for the two hours lending up the discovery of the resident's body in the resident's bathroom.

49. Despite the severity of the events of February 1, 2025, the Facility failed to retrain its staff on policies and procedures on how to respond to observation, allegation, and disclosures by a resident indicating potential self-harm and/or suicide nor has the staff been retrain on the responsibility for documenting room checks and communicating events from their shift to include the location of all residents assigned to oncoming staff. Further, the Facility failed to address the ligature risks throughout the building. Fla. Admin. Code R. 65E-9.005(5)(a)6.

50. These deficient practices are not isolated events, but systemic in nature, and in violation of the minimum requirements of law. Fla. Admin Code R. 65E-9.007(2), 65E-9.005(2) and 65E-9.005(5)(a)6.

51. Children and adolescents may not be placed in an environment where the staff entrusted with their care do not have competencies to provide care and services in a safe manner. This lack of staff competencies is not limited to the ability to recognize a resident exhibiting self-harm behaviors or ideations, but also encompass the failure to regularly check on residents, and communicate with one another about the behaviors of their residents.

52. The deficient conditions and practices identified have existed in the recent past, exist presently and will continue to exist if the Agency does not act promptly. These deficient conditions and practices directly affect the health and well-being of children of the Facility.

53. This immediate limited moratorium on admissions is necessary to prevent new admissions from being subjected to the unsafe conditions and deficient practices that currently

exist in the Facility.

54. The Agency expressly finds that circumstances exist in this instance that warrants this emergency action. The entry of this Order is necessary to protect prospective residents of the Facility from threat to their health, safety or welfare, and to assure that the Facility takes prompt action to correct the deficient practices that exist at its Facility to protect the current residents of the Facility.

55. This immediate limited moratorium on admissions is a narrowly tailored and is fair under the circumstances. The Agency limits this moratorium on the Facility's admissions to only clients who have a history of self-harm, suicidal ideations or suicide attempts. Less drastic relief, such as the assessment of administrative fines, will not address the situation in this case.

CONCLUSIONS OF LAW

56. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, and 394, Part IV, Florida Statutes (2024), and Chapter 65E-9, Florida Administrative Code.

57. Based upon the above-stated findings of fact, the Secretary concludes that the present conditions existing in the Facility present a direct and immediate threat to the health, safety or welfare of the public and the children residing in the Facility and warrants an immediate limited moratorium on admissions to new clients who do not have a history of self-harm, suicidal ideations or suicide attempts.

IT IS THEREFORE ORDERED:

58. An Immediate Limited Moratorium on Admissions allowing only the admission of new clients who do not have a history of self-harm, suicidal ideations or suicide attempts is placed on the Facility.

59. During the limited moratorium, no new children or previously discharged children

who have a history of self-harm, suicidal ideations or suicide attempts, shall be admitted to the Facility. Children for whom the provider is holding a bed may return to the Facility only after the child's parent or guardian has been informed that the Facility is under a moratorium on admissions and with the prior approval of the local Agency field office. During the limited moratorium, the Agency may regularly monitor the conditions at the Facility.

60. This emergency order shall be posted and visible to the public at the Facility until the moratorium is lifted.

61. The Agency shall promptly proceed with an administrative action against the Respondent based upon the facts set out in this emergency order and shall provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2024), at the time such action is taken.

ORDERED in Tallahassee, Florida, on this the 24th day of February, 2025.

Kimberly K. 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)-(c). See Fla.R.App.P. 9.190(b)(2). To be timely, the petition for review must be filed within 30 days of rendition of this emergency order.