STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

195 MATTIE M. KELLY BOULEVARD OPERATIONS, LLC d/b/a DESTIN HEALTHCARE AND REHABILITATION CENTER,

Respondent.
_____/

AHCA No. 2022005525
License No. 16210961
File No. 14609
Provider Type: Nursing Home

IMMEDIATE MORATORIUM ON ADMISSIONS AND EMEGENCY SUSPENSION ORDER

THE PARTIES

1. The Agency for Health Care Administration ("the Agency"), is the licensing and regulatory authority that oversees nursing homes in Florida and enforces the state statutes and administrative rules governing nursing homes. Chs. 400, Part II, 408, Part II, Fla. Stat. (2021), Ch. 59A-4, Fla. Admin. Code. As part of its authority, the Agency may issue emergency orders on a nursing home when the circumstances dictate this type of action. §§ 120.60, 408.814, 400.121, Fla. Stat. (2021).

2. The Respondent, 195 Mattie M. Kelly Boulevard Operations, LLC, d/b/a Destin Healthcare and Rehabilitation Center ("the Respondent"), was issued a license by the Agency, License Number 16210961, to operate a one hundred nineteen (119) bed nursing home located at 195 Mattie M. Kelly Boulevard, Destin, Florida 32541-2811 ("the Facility"). 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. (2021). "The licensee is legally responsible for all aspects of the provider operation." Id. "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in Section 408.802," Florida Statutes (2021). § 408.803(12), Fla. Stat. (2021). Nursing homes are regulated by the Agency under Chapter 400, Part II, Florida Statutes (2021), and listed in Section 408.802, Florida Statutes (2021). § 408.802(10), Fla. Stat. (2021). The management company of record for this nursing home is Josera, LLC, d/b/a Independence Living Centers.

3. The Respondent holds itself out to the public as a nursing home that complies with the state laws governing nursing homes. These laws exist to protect the health, safety and welfare of nursing homes residents. As individuals receiving services from a nursing home, the nursing home residents are entitled to receive the benefits and protections under Chapters 120, 408, Part II, and 400, Part II, Florida Statutes (2021), and Chapter 59A-4, Florida Administrative Code.

4. As of the date of this Emergency Order, the census at the Facility is one hundred seven (107) residents/clients.

THE AGENCY'S EMERGENCY ORDER AUTHORITY

5. Under Florida law, the Agency may impose an emergency suspension order or immediate moratorium on admissions as defined in section 120.60, Florida Statutes (2021), 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. (2021).

6. Under Florida law, if the Agency finds that an 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. (2021).

LEGAL DUTIES OF A NURSING HOME

Minimum Nursing Staff / Self-Imposed Moratorium for Staff Shortages

7. Under Florida law,

(3)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing home facilities. These requirements must include, for each facility:

a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.

b. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.

c. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.

2. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties.

3. Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public.

4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be counted twice.

(b) Paid feeding assistants and nonnursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.

(c) Licensed practical nurses licensed under chapter 464 who are providing nursing services in nursing home facilities under this part may supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel providing services in such facilities in accordance with rules

adopted by the Board of Nursing.

§ 400.23(3)(a)1, Fla. Stat. (2021) (emphasis added).[1]

8. Under Florida law:

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(n) Comply with state minimum-staffing requirements:

1. A facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for 6 consecutive days. For the purposes of this subparagraph, any person who was a resident of the facility and was absent from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission. Failure by the facility to impose such an admissions moratorium is subject to a $1,000 fine.

2. A facility that does not have a conditional license may be cited for failure to comply with the standards in s. 400.23(3)(a)1.b. and c. only if it has failed to meet those standards on 2 consecutive days or if it has failed to meet at least 97 percent of those standards on any one day.

3. A facility that has a conditional license must be in compliance with the standards in s. 400.23(3)(a) at all times.

§ 400.141(1)(n), Fla. Stat. (2021) (emphasis added).

9. Under Florida law: In accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Fla. Admin. Code R. 59A-4.108(4).

Resident Rights

10. Under Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall

[1] The requirement for minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day was recently reduced to 2.0 hours of direct care per resident per day. House Bill 1239, 2022 Legislative Session. The violation in this case occurred prior to the change in the law. The provider is in violation of both the prior and current version of the law.

treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: . . . (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the Agency. (n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis. § 400.022(1)(l), (n), Fla. Stat. (2021).

Administration and Management of Nursing Home Facilities

11. Under Florida law, every licensed facility shall comply with all applicable standards and rules of the agency and shall: (a) Be under the administrative direction and charge of a licensed administrator. § 400.141(1)(a), Fla. Stat. (2021). No nursing home shall operate except under the supervision of a licensed nursing home administrator, and no person shall be a nursing home administrator unless he or she is the holder of a current license as provided in chapter 468. § 400.20, Fla. Stat. (2021). The licensee of each nursing home must have full legal authority and responsibility for the operation of the facility. The licensee of each facility must designate one person, who is licensed by the Florida Department of Health, Board of Nursing Home Administrators under Chapter 468, Part II, F.S., as the Administrator who oversees the day-to-day administration and operation of the facility. Fla. Admin. R. 59A-4.103(4)(a)-(b).

FACTS JUSTIFYING AN IMMEDIATE MORATORIUM ON ADMISSIONS AND EMERGENCY SUSPENSION OF LICENSE

12. On April 10, 2022, the Agency commenced a survey of the Facility.

13. A review of the Facility records revealed an average daily census of 112-114.

14. Based upon this census, the Facility identified residents requiring assistance with activities of daily living ("ADL") from assistance of 1-2 staff members to total dependence, make up a large percentage of its resident population. ADLs include dressing (77%), bathing (97%), transfer (81%), eating (91%), and toileting (83%). The Facility has 17 residents who require a 2-person assist with transfers and 4 residents who are dependent on staff for eating.

15. The survey team conducted 19 staff interviews, all of which revealed concerns with inadequate staffing. The survey team conducted interviews with 12 interviewable residents, all of which voiced concerns with inadequate staffing. Two non-interviewable residents had visible ADL needs. One Quality Assurance Committee group interview revealed "dire" staffing concerns. A total of 9 weeks of Facility staffing records were reviewed. The Facility failed to meet minimum state staffing guidelines for 58 out of 63 days reviewed. By law, the Facility was required to self-impose a moratorium on resident admissions. § 400.141(1)(n), Fla. Stat. (2021).

16. The survey team found that all of the residents were at immediate risk due to the continual short staffing of nurses and certified nurse assistants ("CNA"). Multiple staff interviews revealed that the Facility staff are working extra shifts frequently and have very heavy patient assignments during work. The staff expressed feelings of being very tired and frustrated because they could not provide the care that the residents require. Multiple resident interviews revealed complaints about excessive waits after incontinent episodes as well as the lack of showers due to the inadequate staff level. In fact, some residents were concerned for the staff and one resident actually became tearful when describing how hard the staff are working. Many residents stated that they are reluctant to call for assistance because the staff are working so hard. One resident stated he would like to go outside and smoke, or just sit in the courtyard, but cannot on a regular basis due to the inadequate staffing level. Another resident has to go to bed at 4:00

p.m. depending on the staffing levels. As a result the grossly inadequate staff levels, all of the residents are at immediate increased risk for poor outcomes.

17. Most disturbing, after the Facility's administration repeatedly informed corporate management of the inadequate staff levels over an extended period of time and the law requiring the self-imposition of a moratorium on resident admissions, corporate management overrode the legislative moratorium mandate and compelled the Facility to accept new resident admissions. The admissions/discharge reports revealed that the Facility admitted 17 new residents during January 2022, 19 new residents during February 2022; 19 new residents in March 2022, and 2 new residents during April 2022. There is nothing in the Facility records indicating that these new residents were informed of the Facility's inadequate staffing levels. The corporate decision to continue resident admissions when the Facility was experiencing a severe staffing shortage exacerbated an inadequate staffing problem into a resident crisis.

18. The Agency's findings as a result of the resident interviews mirrored each other in large part. They resident interviews revealed as follows:

a. Resident #2 stated that he can shower himself, but needed help getting his brace on his right arm. The Resident showed the surveyor his arm revealing a contracted wrist. The Resident stated it is getting worse, that he cannot put the brace on himself, and that the Facility does not have enough CNAs to help. He states the staffing has gotten worse. The surveyor observed the Resident's arm splint in the resident's wheelchair beside the bed. The resident is unable to reach it. He stated something has to be done about the staff. At times, he stated he has waited over an hour for staff assistance. He stated there are times there is only one CNA on the floor.

b. Resident #3 stated that the last couple of months things have gotten bad at the Facility. She stated the staff are working hard, but they do not have enough staff to take care of the residents. She did not remember when she had a bath last, and stated she laid in urine for 16 hours one day. She could not remember when it was, she thinks it was about one month ago. Resident #3 was observed in a hospital gown. She stated the food is terrible, but she has to eat it, or go hungry. Later, Resident #3 was observed awake, sitting up in bed, and wearing a night gown. The Resident stated that she has lived at the Facility for 3 years. When asked about any concerns, Resident #3 stated that the Facility is short-handed. The staff was doing its best, but that it is not enough.

c. Resident #4 stated the Facility is short-staffed and that the residents are not receiving the care they need. She stated that she has had a severe injury and needs help getting out of bed. She stated she could change herself, but the facility won't let her do that. She stated she was supposed to have a bath last Saturday, but the staff does not give baths because they do not have enough CNAs. Resident #4 stated she has waited for 2 hours for the call light to be answered and stated she has laid in feces for 4 hours in the recent past, though unable to provide an exact date. She stated she does not have any skin breakdown yet. She is supposed to receive a specific type of care regularly because of her severe injury, but has not received the care. She stated she has had to stay in bed all day because the Facility does not have enough CNAs to assist her getting out of bed. The resident requires a mechanical lift. Resident #4 was observed in a hospital gown.

d. Resident #5 was observed and noted to be confused. The resident was observed lying in bed, in a hospital gown. Notably, a dark brown substance was observed under all of the residents' fingernails.

e. Resident #6 was observed with greasy hair.

f. An interview with Resident #7 revealed that the Resident has not had a shower in a while.

g. Resident #8 was interviewed in the Resident's room. The Resident stated that he is supposed to wear a splint, but there is not enough staff to help him put it on. He stated he is scheduled for a bath on Sundays and Thursdays, but has not had a bath for at least a week. He stated he wants to get up out of bed, but he has to be lifted with a mechanical lift and the Facility does not have enough staff to assist him out of bed. He stated he wants to get up and go sit outside in the courtyard. He ordered a big television so that he can at least watch television since he has to lay in bed all the time.

h. Resident #9 was interviewed and stated that she did not remember when she last received a shower. The resident was observed in a hospital gown.

i. Resident #10 was interviewed and stated that things are very bad at the Facility. In fact, she asked a family member to find a better facility for her. The Resident stated that on this past Saturday, there was one 1 CNA for 60 residents. She stated on Saturday, her family member came to visit and found feces on the floor. She stated that her family member helped clean her, but could not lift her to get her out of bed. There was no staff to help. She stated she has to go to bed at 4:00 p.m. because if the staff does not put her down before they leave, she will not be able to go to bed until after 10:00 p.m. She stated she had to stay up until 10:00 p.m. last Sunday night. She stated she was in bed from Friday evening at 4:00 until Sunday morning. She stated she was in one position because she could not move herself. She stated she had a bowel movement sometime after she went to bed on Friday at 4:00 p.m. and that her family member had to clean her up when she visited on Saturday. She stated her family member called law enforcement because the family member was so disgusted with the Resident's care at the Facility.

j. Resident #11 was interviewed and stated she has not had a bath in a long time. She stated that she has been receiving a bath only one time per month. She stated she requires two staff to bathe her, so she wondered if that was why she is not receiving her baths.

19. Similarly, the Agency's findings as a result of the staff interviews mirrored each other in large part. The staff interviews revealed as follows:

a. An interview with Staff A, Licensed Practical Nurse ("LPN"), revealed that Staff A has worked at the Facility almost 5 years. She stated that for the past few months, the Facility has been short staffed. The staff is supposed to work 8-hour shifts, but some of the staff work double shifts. Some nurses are doing 12-hour shifts to cover the resident care needs. Staff A stated that she tries to pick up at least 1 or 2 double shifts per week, but is very tired. Some other staff work more double shifts, but she does only one or two. The Facility is advertising positions, trying to hire, but is not getting staff. She added that the Facility has had some home health agency help, and everyone is working hard and getting tired. Some staff simply quit. The Facility does not have a Director of Nursing or an Assistant Director of Nursing. When asked whether resident care needs were being met, Staff A stated that the staff is doing the best it can, everyone is really working extra hard. Staff A admitted that the CNAs are so busy, that bathes and showers are behind.

b. An interview with Staff D, CNA, revealed that she is tired. She stated that the Facility works short every shift and she cannot provide the type of care she wants to provide to the residents. Staff D stated she just tries to do her best. She stated tonight will be a good night because the Facility has four staff members, which is very unusual. She is concerned about speaking up.

c. An interview with Staff D, CNA, revealed that she works evenings and tries to help out by picking up extra shifts. The Facility just called and asked if she could come in today. She picks up where she can, works a double shift now and again, and stays late to help the next shift. The Facility has been short-staffed for few months now and that the Facility needs more staff who want to work. The Facility has a great team that helps each other, but it is tiring. When asked whether any services are not being met, she stated that the Facility is behind on showers and bathes. It is trying to get caught up, but the C wing has a lot of mechanical lift patients. It is trying to get 2-3 done each shift, but it is not easy when it is short-staffed. She makes sure she rounds as often as she can and tries to keep everyone clean, dry and comfortable. She helps with hydration and meals, and also makes sure that the residents are safe.

d. An interview with Staff F, a registered nurse ("RN"), revealed that she was a night shift nurse. She stated the staffing is pitiful. She works the A wing frequently. She stated she has worked the A wing on the night shift as the only staff member and that she had covered the residents on Serenity wing as well. The census of both units is 54. She

could not remember the date, but thinks it was a couple of weeks ago. She stated she cannot check and change residents every two hours, but she made sure every resident was changed at least 2 times in her shift. She stated the staff at this Facility work their tails off, do not complain and have an amazing attitude. She stated when she was working by herself, the residents were trying to take care of her. She stated they kept asking her if she needed anything, offered her snacks and kept telling her to sit down and rest.

e. An interview was conducted with Staff K, CNA, who has been employed at the Facility for almost a year. When asked how the residents' care needs are being met, she stated that the staff is trying to get showers done and catch up on that. Management does not help much, the nurses help. The Facility is short-staffed and overworked. She wishes that management could just hire more staff because "we need them." When asked whether any services were not being met, she stated that the showers were behind. She rounds often on her patients, makes sure they get what they need, tries to keep them clean, dry and comfortable. She stated that the CNAs shower the residents, but some are not documenting their care with showers and bathes because they just do not have the time.

f. Interviews with Staff L, LPN, and Staff P, RN, echoed the same concerns and sentiments. Staff P stated the unit is well staffed for the first time in a long time. She stated it is not often that they have that much staff. She stated the weekends are usually very short staffed, and since they have more staff on this shift, they will try to make up some of the showers that have been missed.

g. On April 12, 2022, at 2:55 p.m., an interview was conducted with the Activities Director. She had just been promoted from the Assistant Activities Director two weeks prior. She stated that the Facility has been short staffed for a while and that she helps out wherever she can. The Facility needs more help in the laundry and with showers. The Facility used to have a grievance committee, but not any longer. The Facility has been understaffed for weeks.

h. On April 13, 2022, at 4:15 p.m., a telephone interview was conducted with the Medical Director with the QAPI team. The Medical Director stated that he spoke with the Regional Vice President back on February 23, 2022, at 2:23 p.m., to discuss the staffing concerns. The Medical Director stated that the nursing levels are at a dire level and there is not enough staff to take care of the residents. The Medical Director stated the staffing levels are not acceptable and the company has not responded to concerns. He stated no harm from a medical perspective has happened with the residents because he rounds with the nurses every Friday, that the staff is on top of everything, and that they do not hesitate to call him. He also stated the Regional Vice President stated that the Facility must have 112 residents in order to meet financial needs. The Medical Director stated the staff have done a commendable job, but with less and less nursing, it is becoming more and more difficult every day. He stated he is not sure how long the Facility could keep this going, and that corporate needs to understand the Facility could not keep going on forever. He stated basic needs are being met minimally, but not as

well as they should be.

i. During the meeting, the performance improvement plan ("PIP") was discussed for missing residents' weights from October/November 2021 to February 2022. The Quality Assurance Performance Improvement ("QAPI") team identified resident weights were not being completed and discussed at the January 28, 2022, QAPI meeting. Staffing concerns were identified as a reason for weights not being completed. The previous Director of Nursing ("DON") was responsible for implementing the PIP in February of 2022, but never did. When the Regional Nurse came in March, she found the PIP had not been initiated, so it was started on March 2022. 100% of the weights have been completed.

j. On April 11, 2022, at 1:24 p.m., an interview was conducted with the Administrator. The Administrator stated that he knows that the staffing is an issue. He stated that he is trying to hire staff, but is not getting applicants. Signs are posted in the front of the building offering a $1,500 as a sign on bonus. The Facility has raised the CNA pay. He stated he can offer up to 18.00 per hour and is offering to pay for tolls for staff who have to cross the Mid- Bay Bridge. He stated he has also offered gas money to staff. He stated he is not getting applicants. The Facility Administrator confirmed that he has had many conversations with the corporate office regarding continued admission of residents.

k. On April 13, 2022, at 5:08 p.m., an interview was conducted with the Regional Vice President. The vice president stated he has had regular conversations with the Administrator regarding the staffing issues. He stated they are working on hiring new staff, and are working on incentives. He stated they are offering a $10,000 sign on for nurses and new pay scale, trying to compete with the local market. He stated they are using more home health agency staff. He admitted that the Facility did not stop admissions until the first of April, and stated when he has been in the building it looked like things seem to be managed well, and the residents were receiving care. He was informed of the concerns we have identified and the VP responded with, "We have significant work to do."

20. In this instance, after careful and due consideration, the Agency determines that the practices and conditions at the Facility, as set forth more specifically above, present (1) a threat to the health, safety or welfare of residents of the Facility, (2) a threat to the health, safety or welfare of a client, (3) an immediate serious danger to the public health, safety or welfare, and (4) an immediate or direct threat to the health, safety, or welfare of the residents that constitutes sufficient factual and legal grounds justifying the imposition of an Immediate Moratorium on

Admissions to this nursing home.

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS AND EMERGENCY SUSPENSION OF LICENSE

21. 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 nursing homes. Ch. 400, Part II, Fla. Stat. (2021), Ch. 408, Part II, Fla. Stat. (2021); Ch. 59A-4, Fla. Admin. Code. In those instances where the health, safety or welfare of a nursing home resident is at risk, the Agency will take prompt and appropriate action.

22. The Florida Legislature mandated that nursing homes self-impose a moratorium on resident admissions when staffing levels fall below minimum levels for two consecutive days. "A facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for 6 consecutive days." § 400.141(1)(n)1, Fla. Stat. (2021). The purpose of the statute is clear. When nursing home staffing falls below minimum levels, it is virtually a certainty that patient harm and indignity will follow. In the instant case, residents have had to lie in their own feces and urine for extended periods of time. At least one family member called law enforcement when the family member found a resident in such a condition. The lack of personal hygiene care and attention over a lengthy period of time has the potential for adverse results such as skin breakdown, inflammatory skin conditions, secondary infections, and other preventable outcomes. At least one resident spent an excessive amount of time without being repositioned in bed. Ultimately, if continued, this lack of care will eventually lead to pressure injuries. One resident was observed with a dark brown substance under all of the resident's fingernails. All of the interviewed residents have complained about the lack of showers. They have had to endure the indignity of the personal body odor. The Facility staff readily admits that it simply cannot

meet the resident needs due to the lack of staffing.

23. The Administrator and the Medical Director of the Facility repeatedly voiced their concerns to corporate management about the lack of Facility staffing. In response, corporate management weighed their concerns and consciously decided to place financial issues above that of resident care. The inappropriate response of corporate management was not only contrary to the standard of care for nursing home residents, it was directly contrary to Florida law. The self-imposition of a moratorium on resident admissions when staffing levels fall minimum levels for two consecutive days is **mandated** by Florida law. It is not discretionary on the part of the corporate management. It is not within the province of corporate management to disregard the Legislature's express direction. In fact, it is a circumstance in which the Legislature authorizes the imposition of an administrative fine regardless of correction by the nursing home. At the very least, the response of the Facility should have been to hire temporary staffing services to alleviate the immediate staffing shortcomings. Inexplicably, that was not done in this case. The disregard of this legal requirement is blatant.

24. In the case at hand, the Facility fell below the minimum staffing levels for nursing homes for at least two months. This violation is extraordinary. Under such circumstances, the propensity of Facility staff to make errors rises exponentially. Unless the condition is abated, the risk of serious physical harm to the residents is imminent.

25. The health, safety and welfare of residents is always the primary concern of the Agency. This applies to their physical health as well as their mental wellbeing. Resident rights include the right to receive adequate and appropriate health care and protective and support services as well as the right to be treated courteously, fairly, and with the fullest measure of dignity. Notwithstanding the best efforts of a truly dedicated staff, the facts set forth above show

that the Facility did not fully honor those rights. While it understandable that nursing home residents will soil themselves, it is not acceptable to let them go for days and perhaps weeks on end without bathing. One resident was even observed with a dark brown substance under all of the resident's fingernails. All of the interviewed residents have complained about the lack of showers. They have had to endure the indignity of the personal body odor. The Facility staff, especially those who have worked at this Facility for some time, seemed apologetic for not being able to provide better care and attention to the residents. Staff should not have to feel this way when they have gone over and above the call of service when they have worked double shifts, extended shifts, and after their shift has ended.

26. The corporate management of the Respondent has prevented the administration of this Facility from performing its obligations. The Administrator repeatedly informed corporate management of the issues with staffing. Further, the Medical Director expressed his concerns to corporate management about the lack of staffing. These concerns and warnings occurred over a long period of time. This is not a case of inadvertent mistake or oversight. The decision to not self-impose a moratorium was a knowing decision. Far too many residents were admitted to the Facility at a time when the self-imposed moratorium should have been in place. The lack of care that those residents received was unwarranted. Had the moratorium on admissions been in place as required by Florida law, the existing residents in the Facility would have received better care and services from the limited staff in place. Hence, the point of the moratorium on admissions.

27. The Respondent's deficient practice exist presently; have existed in the past, and more likely than not will continue to exist if the Agency does not act promptly. The issue at hand is the corporate management of the Facility and its approach toward resident care, staff and the local Facility administration. The misplaced weight on financial concerns over immediate

resident care and the legal requirements of Florida law must be addressed.

28. An Immediate Moratorium on Admissions to this nursing home is necessary to protect the residents from (1) the unsafe conditions and deficient practices that currently exist in the facility, (2) being placed at risk of living in an environment ill-equipped to provide for resident health, safety and welfare, and (3) being placed in a nursing home where the statutory and regulatory mechanisms enacted for their protection have been breached.

CONCLUSIONS OF LAW

29. The Agency has jurisdiction over the Respondent pursuant to Chapters 408, Part II, 400, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

30. 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 to Respondent Facility, 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 to the Facility.

31. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an Emergency Order 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 a safe living environment, and (3) being placed in a nursing home where the regulatory mechanisms enacted for resident protection have been disregarded.

32. The Respondent's deficient practices exist presently and will more likely than not continue to exist if the Agency does not act promptly. Less restrictive actions, such as the

imposition of administrative fines, will not ensure that residents receive the appropriate care and services dictated by Florida law. 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 set of facts and circumstances of this particular matter. This remedy is narrowly tailored to address the specific harm in this instance.

IT IS THEREFORE ORDERED THAT:

33. An Immediate Moratorium on Admissions is placed on the Facility based upon the above-referenced provisions of law. The Respondent shall not admit any new individuals or readmit any discharged residents.

34. During the Immediate Moratorium on Admisions, the Agency will regularly monitor the Facility.

35. The Respondent's license to operate this nursing home is **SUSPENDED effective April 25, 2022, at 5:00 p.m.** The Respondent shall immediately take the appropriate steps to safely discharge the nursing home residents, notify any guardians and family members that are responsible for the residents and record the residents' new locations.

36. As of the effective date and time of the emergency suspension, the Respondent shall no longer operate this nursing home.

37. This Emergency Order shall be posted and visible to the public at the location of the Facility. § 408.814(4), Fla. Sta. (2021).

38. The Agency shall promptly proceed with the filing of an administrative action against the Respondent based upon the facts set out within this Emergency Order and any other facts that may be discovered during the Agency's continuing investigation. The Agency shall provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes

(2021), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 16th day of April, 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.