STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

AGENCY CLERK
2015 APR -6 P 12:43

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA NO.: 2013009490
DOAH NO.: 14-1333
RENDITION NO.: AHCA- 15-0212 -S-OLC

L & S SENIOR CARE, INC. d/b/a
ARCADIA OAKS ASSISTED LIVING,

Respondent.
_______________________________________/

FINAL ORDER

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

1. The Agency has jurisdiction over the above-named Respondent pursuant to Chapter 408, Part II, Florida Statutes, and the applicable authorizing statutes and administrative code provisions.

2. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1) The Election of Rights form advised of the right to an administrative hearing.

3. The parties have since entered into the attached Settlement Agreement. (Ex. 2)

Based upon the foregoing, it is **ORDERED:**

1. The Settlement Agreement is adopted and incorporated by reference into this Final Order. The parties shall comply with the terms of the Settlement Agreement.

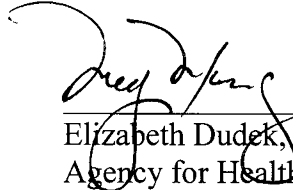
2. The Respondent shall pay the Agency $3,000. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

Office of Finance and Accounting
Revenue Management Unit
Agency for Health Care Administration
2727 Mahan Drive, MS 14
Tallahassee, Florida 32308

Filed April 8, 2015 10:21 AM Division of Administrative Hearings

3. Count II of the Administrative Complaint is hereby voluntarily dismissed.

ORDERED at Tallahassee, Florida, on this 6 day of April, 2015.



Elizabeth Dudek, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

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

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 6 day of April, 2015.

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Bldg. #3, Mail Stop #3
Tallahassee, Florida 32308-5403
Telephone: (850) 412-3630

Jan Mills Facilities Intake Unit (Electronic Mail)	Finance & Accounting Revenue Management Unit (Electronic Mail)
Andrea M. Lang, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Evelyn Donato, Administrator L & S Senior Care, Inc. d/b/a Arcadia Oaks Assisted Living 1013 East Gibson Street Arcadia, Florida 34266 (U.S. Mail)
Lynne A. Quimby-Pennock Administrative Law Judge Division of Administrative Hearings (Electronic Mail)	

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA,
AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case No. 2013009490

L&S SENIOR CARE, INC.
d/b/a ARCADIA OAKS ASSISTED LIVING,

Respondent.
_______________________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, State of Florida, Agency for Health Care Administration (hereinafter "the Agency"), by and through its undersigned counsel, and files this Administrative Complaint against the Respondent, L&S SENIOR CARE, INC. d/b/a/ ARCADIA OAKS ASSISTED LIVING (hereinafter "the Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes (2013), and states:

NATURE OF THE ACTION

This is an action to impose an administrative fine against an assisted living facility in the sum of SIX THOUSAND FIVE HUNDRED DOLLARS ($6,500.00) based upon three (3) Class II violations.

JURISDICTION AND VENUE

1. The Court has jurisdiction over the subject matter pursuant to Sections 120.569 and 120.57, Florida Statutes (2013).

2. The Agency has jurisdiction over the Respondent pursuant to Sections 20.42 and 120.60, and Chapters 408, Part II, and 429, Part I, Florida Statutes (2013).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code.

EXHIBIT 1

PARTIES

4. The Agency is the licensing and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state regulations, statutes and rules governing such facilities. Chapters 408, Part II, and 429, Part I, Florida Statutes (2013); Chapter 58A-5, Florida Administrative Code. The Agency may deny, revoke, or suspend any license issued to an assisted living facility, or impose an administrative fine in the manner provided in Chapter 120, Florida Statutes (2013). Sections 408.815 and 429.14, Florida Statutes (2013).

5. The Respondent was issued a license by the Agency (License Number 9716) to operate a 65-bed assisted living facility located at 1013 East Gibson Street, Arcadia, Florida 34266, and was at all times material required to comply with the applicable state regulations, statutes and rules governing assisted living facilities.

COUNT I
The Respondent Failed To Ensure Adequate Supervision Of Residents In Violation Of Rule 58A-5.0182(1), Florida Administrative Code

6. The Agency re-alleges and incorporates by reference paragraphs one (1) through five (5).

7. Pursuant to Florida law, an assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.

(1) Facilities shall offer personal supervision, as appropriate for each resident, including the following:

(a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, Florida Administrative Code.

(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 individual.

(c) 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; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.

(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), Florida Administrative Code, any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

Rule 58A-5.0182(1), Florida Administrative Code.

8. On or about July 18, 2013, the Agency conducted a Biennial Survey of the Respondent's facility.

9. Based on observation, interview and record review, the facility failed to provide supervision and assistance to prevent an unplanned weight loss for one (1) of three (3) residents sampled for weight loss, specifically Resident number twenty two (22).

10. An observation of Resident number twenty two (22) during the noon meal in the main dining room revealed the resident sitting at a table with three (3) male residents. Resident number twenty two (22) was complaining that he/she did not like the meal being served. Resident number twelve (12) asked Resident number twenty two (22) if he/she was going to eat the meal, if not, Resident number twelve (12) would eat it. Resident number twenty two (22) gave the meal to Resident number twelve (12). No staff intervened or asked Resident number twenty two (22) if he/she wanted a substitute meal.

11. After twenty five (25) minutes the surveyor approached Staff D and relayed the information that Resident number twenty two (22) did not like the meal and had given the food to Resident number twelve (12). Staff D stated, "Yes, Resident number twenty two (22) doesn't

like the food here. Resident number twenty two (22) gives it to Resident number twelve (12) all the time." After surveyor intervention, Resident number twenty two (22) then received a ham and cheese sandwich on wheat bread. Resident number twenty two (22) ate half of the sandwich and gave the other half to Resident number twelve (12). Resident number twenty two (22) then left the dining room.

12. During an interview with Resident number twenty two (22) on July 18, 2013 at approximately 2:00 p.m. Resident number twenty two (22) stated that he/she just doesn't like the food at the facility.

13. A review of Resident number twenty two's (22) medical record revealed no documentation the physician was notified of weight loss and no efforts made to identify the food preferences of Resident number twenty two (22). Resident number twenty two (22) was admitted to the facility on April 9, 2013 with diagnoses including Dementia, Osteoporosis, Pancreatitis, Hypertension and GERD. Resident number twenty two's (22) initial weight on April 9, 2012 was 145 pounds. Resident number twenty two's (22) weight on May 16, 2013 was 140 pounds. This was a five (5) pound weight loss from the resident's initial weight. Resident number twenty two's (22) weight on July 18, 2013 was 136 pounds. A review of Resident number twenty two's (22) weights between April 9, 2013 and July 18, 2013 revealed a nine (9) pound weight loss.

14. An interview with Staff A on July 18, 2013 at approximately 2:05 p.m. revealed Staff A was aware Resident number twenty two (22) did not like the food and was giving it to Resident number twelve (12). Staff A stated attempts were made to move Resident number twenty two (22) to another table, but Resident number twenty two (22) refused. Staff A agreed she did not notify the physician of Resident number twenty two's (22) weight loss and had not tried other approaches to ensure Resident number twenty two (22) did not have an unplanned weight loss.

15. The Respondent's deficient practice constituted a Class II violation in that it

related to the operation and maintenance of a provider or to the care of clients which the Agency determined directly threatened the physical or emotional health, safety, or security of the clients, other than a Class I violation. Section 429.19(2)(b), Florida Statutes (2013).

16. The Agency shall impose an administrative fine for a cited Class II violation in an amount not less than one thousand dollars ($1,000.00) and not exceeding five thousand dollars ($5,000.00) for each violation as set forth in Section 429.19(2)(b), Florida Statutes (2013). A fine shall be levied notwithstanding the correction of the violation.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of ONE THOUSAND FIVE HUNDRED DOLLARS ($1,500.00) pursuant to Section 429.19(2)(b), Florida Statutes (2013).

COUNT II

The Respondent Failed To Provide A Safe, Decent Living Environment, Free From Abuse And Neglect In Violation Of Rule 58A-5.0182(6)(a)-(d), Florida Administrative Code And Section 429.28(1)(a) and (b), Florida Statutes (2011)

17. The Agency re-alleges and incorporates by reference paragraphs one (1) through five (5).

18. Pursuant to Florida law, (a) a copy of the Resident Bill of Rights as described in Section 429.28, Florida Statutes, or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, Florida Administrative Code.

(b) In accordance with Section 429.28, Florida Statutes, the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.

(c) The address and telephone number for lodging complaints against a facility or

facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with Disabilities, 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.

(d) The statewide toll-free telephone number of the Florida Abuse Hotline "1(800)96-ABUSE or 1(800)962-2873" shall be posted in full view in a common area accessible to all residents.

Rule 58A-5.0182(6)(a)-(d), Florida Administrative Code.

Pursuant to 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) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

Section 429.28(1)(a) and (b), Florida Statutes (2011).

19. On or about July 18, 2013, the Agency conducted a Biennial Survey of the Respondent's facility.

20. Based on observation, record review and interview, the facility failed to ensure each residents right to a safe environment free of hazards; failed to obtain a written order from the Physician for two (2) residents, specifically Resident number three (3) and resident number five (5),. observed with half side rails; and failed to maintain good infection control practices during dining and with residents on isolation precautions.

21. On July 17, 2013 at approximately 10:00 a.m., the water temperature in the women's bathroom sink on the 100 hallway was tested at 136 degrees. A test of the men's

bathroom sink on the 100 hallway was 136 degrees. The water temperatures were checked in the resident rooms closest to the hot water source on the 100 wing, and other random resident rooms.

22. Resident number one (1); Room 102's water temperature was 132 degrees from the bathroom sink; Resident number two (2); Room 108's water temperature was 132 degrees from the bathroom sink; Resident number twelve (12); Room 116's water temperature was 132 degrees from the bathroom sink; Resident number fourteen (14) and Resident number fifteen (15) in Room 112, water temperature was 132 degrees from the bathroom sink; Resident number twenty nine (29); Room 212's water temperature was 124 degrees from the bathroom sink; Resident number thirty (30); Room 101's water temperature was 137 degrees from the bathroom sink. All residents in the affected rooms have some level of cognitive impairment with a potential for injury.

23. On July 17, 2013 at 3:30 p.m. a call was made to the Florida Department of Health about hot water temperatures and the surveyor spoke with Environmental Specialist III.

24. The Environmental Specialist III came to the facility July 18, 2013 at 8:30 a.m. A retest of the water on the 100 wing revealed the water temperature in the men and women's bathroom to be 140 degrees. A retest of the water temp in Room 101's bathroom sink was 140 degrees. Room 108's bathroom sink water was 133 degrees; Room 212, the furthest room from the water heater was 124 degrees.

25. A Contractor from the facilities plumbing company arrived at the facility at approximately 10:00 a.m. on July 18, 2013 and tested the water and agreed the water temperature was above regulatory standards. The plumbing contractor stated, "At these temperatures it would only take seconds for someone to be scalded badly. This is why showers have closure valves in case someone fell, but the sink (bathrooms and kitchens) don't have them."

26. A check of the water heater revealed a defective part for circulating the water needed to be replaced and would have to be shipped overnight to arrive on July 19th. The

plumbing contractor would return on July 19th and replace the part. The Environmental Specialist III stated he would return on July 19th to ensure the repairs were completed and the water temperatures were 120 degrees or below.

27. An interview with the Administrator on July 17, 2013 at 12:50 p.m. revealed she was unaware of the increased temperature of the water in the public bathrooms and the resident rooms on the 100 hallway.

28. An interview on July 18, 2013 at 10:25 a.m. with Staff H revealed Staff H knew the water temperature was too hot, and she would keep regulating the temp until she felt it was safe for residents when providing care.

29. During an interview with Staff A on July 18, 2013 at 10:30 a.m., Staff A stated, "I didn't know it was too hot, no staff or residents complained" (about the water temps).

30. During an interview with the family member of Resident number fourteen (14) and Resident number fifteen (15) on July 18, 2013 at 10:30 a.m., the family member stated she often comes to the facility to have lunch with her grandparents and noticed the water was extremely hot when washing the dishes. The family member stated she was concerned the water temperatures might burn one of her grandparents because of their confusion levels.

31. An interview on July 18, 2013 at 1:25 p.m. with Staff I revealed she had informed Staff A three (3) or four (4) days ago that the water seemed to be to be too hot. Staff I stated she was testing the water temperature on herself and making adjustments before washing or bathing any residents to prevent injury.

32. In an interview with Resident number one (1) on July 18, 2013 at 1:30 p.m., the resident stated, "When I take a shower the water is extremely hot, but I never told anyone." "It gets scalding and I have to keep turning it down."

33. During an interview with Resident number twelve (12) on July 18, 2013 at 1:45 p.m., Resident number twelve (12) stated, "Yes, the water is a little too warm and you have to be

careful, I never thought to tell management, didn't think it was my duty."

34. An observation on July 17, 2013 at 10:00 a.m. revealed Room 114 had yellow paper around the door knob. An interview with Staff H on July 17, 2013 at approximately 10:00 a.m. revealed the yellow paper would identify Resident number four (4) was on isolation precautions. At approximately 1:30 a.m., the physical therapist was ambulating Resident number one (1) in the hallway. Staff F was pushing Resident number four (4) in the hallway towards the front of the facility. Resident number one (1) sat down on a bench in the hallway and the physical therapist walked over to Resident number four (4) and put her hand on the residents shoulder. When Staff F did not intervene, the surveyor informed the physical therapist about Resident number four's (4) isolation precautions. The physical therapist went immediately to wash her hands and Resident number four (4) was returned to the isolation room.

35. During the noon meal on July 18, 2013, Resident number four (4), Resident number twenty one (21), Resident number twenty three (23), Resident number twenty four (24), Resident number twenty five (25), and Resident number twenty six (26), were observed sitting in a small dining area off of the 100 hallway, four (4) female residents were sitting at one table and two (2) male residents were sitting at another table. The meal included meat loaf, mashed potatoes, a cooked green leafy vegetable, and a roll. Staff H was in the dining room serving meals to all residents. Staff H was observed moving between residents, touching residents, their eating utensils, and allowing residents to touch her and kiss her gloved hands. Staff H was not observed sanitizing her hands or changing her gloves between resident interactions. Resident number twenty three (23) is blind and unable to know the position of the meal items without cueing. Resident number twenty three (23) had a piece of meatloaf approximately six (6) inches in length. Resident number twenty three (23) was not assisted in cutting the meatloaf to make it easier to eat. Staff H sat between two (2) female residents touching both residents' meals without sanitizing her hands. One (1) resident dropped a piece of meatloaf on the floor and Staff H

picked up the meatloaf and put it in the trash. At that time she did change gloves but did not wash or sanitize her hands. Staff H began to feed Resident number twenty three (23), helping put the spoon to the resident's mouth. Resident number twenty three (23) was then able to eat. Resident number twenty six (26) asked for something to drink, the aide picked up the glass by touching the drinking surface and handed it to the resident without first sanitizing her hands. Staff H continued to assist both residents with their meal, wiping their mouths with napkins, and picking up food items from each resident.

36. By 12:20 p.m., Staff H was observed moving between tables to assist Resident number twenty four (24) by removing the completed lunch plate from the table. Staff H was then observed moving back to the ladies table, again without sanitizing her hands, touching the rim of Resident number twenty three's (23) glass with her un-sanitized gloved hands.

37. At 12:30 p.m., Staff H, while still wearing the same dirty gloves, placed a piece of meatloaf in Resident number twenty three's (23) hand for the resident to eat. Throughout the meal, Staff H moved from one table to another and one resident to another without sanitizing her hands or changing her gloves. At 12:35 p.m., Rice Krispy treats arrived for dessert. Staff H began passing out the Rice Krispy treats while removing the dirty dishes from the table. During the meal, Staff H conversed with the residents, encouraging them to eat their meal while addressing the residents as "Honey, Hon and Sweetie."

38. An observation of Resident number three (3) during the tour revealed the resident in his/her room in a wheelchair. Resident number three's (3) bed was in the left side of the room with two (2) half-rails in the upright position extending to the middle of the bed. The rails were secured to the frame. A record review revealed the resident had an order for side-rails on admission in March, 2012, but the order expired after six (6) months and was not renewed the physician.

39. An interview with Resident number three (3) on July 18, 2013 at approximately

1:30 p.m. revealed the resident was not aware of the reason for the side rails and stated they were more of a hindrance than an aid when in bed or transferring to and from the bed. "When I turn from side to side in the bed, I often bang my hand on the rail and I get a bruise. That really hurts! I would rather not have the rails."

40. Resident number five (5) was observed in a room, sitting in a wheelchair. An observation of the Resident's room revealed two (2) half rails were on the resident's bed. A review of the resident's chart revealed no order for side rails. Staff A acknowledged Resident number five (5) did not have an order for side rails. She stated when Resident number five (5) was admitted, the bed was uncomfortable and the bed was replaced with a bed with side rails already attached and were never removed. An observation of Resident number five (5) on July 18, 2013 at approximately 2:30 p.m. revealed the resident in bed with the side rails down.

41. The Respondent's deficient practice constituted a Class II violation in that it related to the operation and maintenance of a provider or to the care of clients which the Agency determined directly threatened the physical or emotional health, safety, or security of the clients, other than a Class I violation. Section 429.19(2)(b), Florida Statutes (2013).

42. The Agency shall impose an administrative fine for a cited Class II violation in an amount not less than one thousand dollars ($1,000.00) and not exceeding five thousand dollars ($5,000.00) for each violation as set forth in Section 429.19(2)(b), Florida Statutes (2013). A fine shall be levied notwithstanding the correction of the violation.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of THREE THOUSAND FIVE HUNDRED DOLLARS ($3,500.00) pursuant to Section 429.19(2)(b), Florida Statutes (2013).

COUNT III

Respondent Failed To Ensure A Safe And Comfortable Living Environment Free From Hazards In Violation of Rule 58A-5.023(3), Florida Administrative Code

43. The Agency re-alleges and incorporates by reference paragraphs one (1) through five (5).

44. Pursuant to Florida law, (a) all facilities must:

1. Provide a safe living environment pursuant to Section 429.28(1)(a), Florida Statutes (2012), and

2. Must be maintained free of hazards; and

3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order.

(b) Pursuant to Section 429.27, Florida Statutes (2012), residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:

1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident;

2. A closet or wardrobe space for hanging clothes;

3. A dresser, chest or other furniture designed for storage of personal effects;

4. A table, bedside lamp or floor lamp, and waste basket; and

5. A comfortable chair, if requested.

(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.

(d) Residents who use portable bedside commodes must be provided with privacy during use.

(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be threadbare.

Rule 58A-5.023(3), Florida Administrative Code.

45. On or about July 18, 2013, the Agency conducted a Biennial Survey of the Respondent's facility.

46. Based on observation, interview and record review, the facility failed to maintain a safe environment, free from hazards, maintaining furnishings in good condition.

47. On July 17, 2013 at approximately 10:00 a.m., the water temperature in the women's bathroom sink on the 100 hallway was tested at 136 degrees. A test of the men's bathroom sink on the 100 hallway was 136 degrees. The water temperatures were checked in the resident rooms closest to the hot water source on the 100 wing, and other random resident rooms.

48. Resident number one (1); Room 102's water temperature was 132 degrees from the bathroom sink; Resident number two (2); Room 108's water temperature was 132 degrees from the bathroom sink; Resident number twelve (12); Room 116's water temperature was 132 degrees from the bathroom sink; Resident number fourteen (14) and Resident number fifteen (15) in Room 112, water temperature was 132 degrees from the bathroom sink; Resident number twenty nine (29); Room 212's water temperature was 124 degrees from the bathroom sink; Resident number thirty (30); Room 101's water temperature was 137 degrees from the bathroom sink. All residents in the affected rooms have some level of cognitive impairment with a potential for injury.

49. On July 17, 2013 at 3:30 p.m. a call was made to the Florida Department of Health about hot water temperatures and the surveyor spoke with Environmental Specialist III.

50. The Environmental Specialist III came to the facility July 18, 2013 at 8:30 a.m. A retest of the water on the 100 wing revealed the water temperature in the men and women's

bathroom to be 140 degrees. A retest of the water temp in Room 101's bathroom sink was 140 degrees. Room 108's bathroom sink water was 133 degrees; Room 212, the furthest room from the water heater was 124 degrees.

51. A Contractor from the facilities plumbing company arrived at the facility at approximately 10:00 a.m. on July 18, 2013 and tested the water and agreed the water temperature was above regulatory standards. The plumbing contractor stated, "At these temperatures it would only take seconds for someone to be scalded badly. This is why showers have closure valves in case someone fell, but the sink (bathrooms and kitchens) don't have them."

52. A check of the water heater revealed a defective part for circulating the water needed to be replaced and would have to be shipped overnight to arrive on July 19th. The plumbing contractor would return on July 19th and replace the part. The Environmental Specialist III stated he would return on July 19th to ensure the repairs were completed and the water temps were 120 degrees or below.

53. An interview with the Administrator on July 17, 2013 at 12:50 p.m. revealed the Administrator was unaware of the increased temperature of the water in the public bathrooms and the resident rooms on the 100 hallway.

54. An interview on July 18, 2013 at 10:25 a.m. with Staff H revealed Staff H knew the water temperature was too hot, and she would keep regulating the temp until she felt it was safe for residents when providing care.

55. During an interview with Staff A on July 18, 2013 at 10:30 a.m., Staff A stated, "I didn't know it was too hot, no staff or residents complained" (about the water temperatures).

56. During an interview with the family member of Resident number fourteen (14) and Resident number fifteen (15) on July 18, 2013 at 10:30 a.m., the family member stated she often comes to the facility to have lunch with her grandparents and noticed the water was extremely hot when washing the dishes. The family member stated she was concerned the water

temperatures might burn one of her grandparents because of their confusion levels.

57. An interview on July 18, 2013 at 1:25 p.m. with Staff I revealed she had informed Staff A three (3) or four (4) days ago that the water seemed to be to be too hot. Staff I stated she was testing the water temperature on herself and making adjustments before washing or bathing any residents to prevent injury.

58. In an interview with Resident number one (1) on July 18, 2013 at 1:30 p.m., the resident stated, "When I take a shower the water is extremely hot, but I never told anyone." "It gets scalding and I have to keep turning it down."

59. During an interview with Resident number twelve (12) on July 18, 2013 at 1:45 p.m., Resident number twelve (12) stated, "Yes, the water is a little too warm and you have to be careful, I never thought to tell management, didn't think it was my duty."

60. On July 17, 2013 at approximately 9:30 a.m. during a tour of the facility several resident rooms were identified to have carpet stains in the 100 hallway. Resident Rooms 101, 102, 111, 116, 119 and 312 had dirty carpets and black scuff marks on the doors and walls. Room 101 had peeling and chipped paint on the wall behind the front door. The mechanical room also on the 100 unit was filled with wheelchairs, walkers, an electric scooter, a mattress, a small refrigerator and other miscellaneous items. The maintenance room on the 300 hallway was filled with carpet remnants, plywood, and shelving that was piled to the ceiling.

61. A call was made to the Desoto County Fire Inspector who arrived on July 17, 2013 and verified the combustible items stored in the mechanical room was a hazard and must be removed.

62. The Respondent's deficient practice constituted a Class II violation in that it related to the operation and maintenance of a provider or to the care of clients which the Agency determined directly threatened the physical or emotional health, safety, or security of the clients, other than a Class I violation. Section 429.19(2)(b), Florida Statutes (2013).

63. The Agency shall impose an administrative fine for a cited Class II violation in an amount not less than one thousand dollars ($1,000.00) and not exceeding five thousand dollars ($5,000.00) for each violation as set forth in Section 429.19(2)(b), Florida Statutes (2013). A fine shall be levied notwithstanding the correction of the violation.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, intends to impose an administrative fine against the Respondent in the amount of ONE THOUSAND FIVE HUNDRED DOLLARS ($1,500.00) pursuant to Section 429.19(2)(b), Florida Statutes (2013).

CLAIM FOR RELIEF

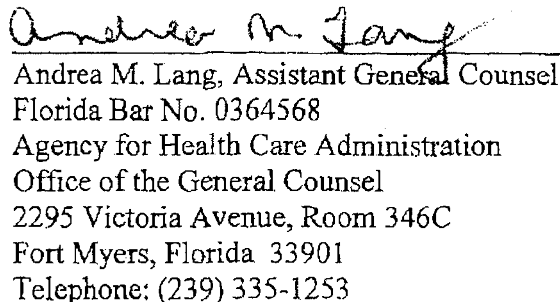
WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, respectfully requests the Court to grant the following relief:

1. Enter findings of fact and conclusions of law in favor of the Agency.

2. Impose an administrative fine against the Respondent in the amount of SIX THOUSAND FIVE HUNDRED DOLLARS ($6,500.00).

3. Order any other relief that the Court deems just and appropriate.

Respectfully submitted on this 5th day of November, 2013.



Andrea M. Lang, Assistant General Counsel
Florida Bar No. 0364568
Agency for Health Care Administration
Office of the General Counsel
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901
Telephone: (239) 335-1253

Copy furnished to:

Evelyn Donato, Administrator L&S Senior Care, Inc. d/b/a/ Arcadia Oaks Assisted Living 1013 East Gibson Street Arcadia, Florida 34266 (U.S. Certified Mail)	Andrea M. Lang, Assistant General Counsel Office of the General Counsel Agency for Health Care Administration 2295 Victoria Avenue, Room 346C Fort Myers, Florida 33901 (Interoffice Mail)
M.C. Edwards, Registered Agent L&S Senior Care, Inc. d/b/a/ Arcadia Oaks Assisted Living 1001 North U.S. Highway One, Suite 400 Jupiter, Florida 33477 (U.S. Certified Mail)	Harold Williams Field Office Manager Agency for Health Care Administration 2295 Victoria Avenue, Room 340A Fort Myers, Florida 33901 (Electronic Mail)

NOTICE

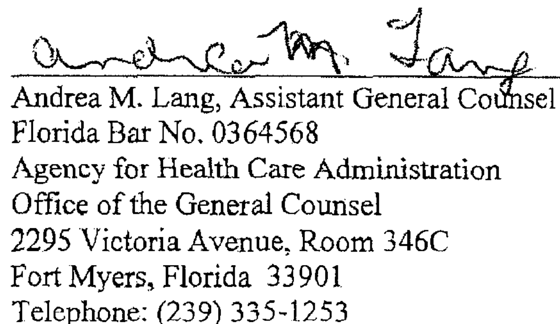
RESPONDENT IS NOTIFIED THAT IT/HE/SHE HAS A RIGHT TO REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO SECTIONS 120.569 AND 120.57, FLORIDA STATUTES. THE RESPONDENT IS FURTHER NOTIFIED THAT IT/HE/SHE HAS THE RIGHT TO RETAIN AND BE REPRESENTED BY AN ATTORNEY IN THIS MATTER. SPECIFIC OPTIONS FOR ADMINISTRATIVE ACTION ARE SET OUT IN THE ATTACHED ELECTION OF RIGHTS.

ALL REQUESTS FOR HEARING SHALL BE MADE AND DELIVERED TO THE ATTENTION OF: *THE AGENCY CLERK, AGENCY FOR HEALTH CARE ADMINISTRATION, 2727 MAHAN DRIVE, BLDG #3, MS #3, TALLAHASSEE, FLORIDA 32308; TELEPHONE (850) 412-3630.*

THE RESPONDENT IS FURTHER NOTIFIED THAT IF A REQUEST FOR HEARING IS NOT RECEIVED BY THE AGENCY FOR HEALTH CARE ADMINISTRATION WITHIN TWENTY-ONE (21) DAYS OF THE RECEIPT OF THIS ADMINISTRATIVE COMPLAINT, A FINAL ORDER WILL BE ENTERED BY THE AGENCY.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form has been served to: Evelyn Donato, Administrator, L&S Senior Care, Inc. d/b/a Arcadia Oaks Assisted Living, 1013 East Gibson Street, Arcadia, Florida 34266, by U.S. Certified Mail, Return Receipt No. 7011 1570 0002 1695 9440 and to M. C. Edwards, Registered Agent, L&S Senior Care, Inc. d/b/a Arcadia Oaks Assisted Living, 1001 North U.S. Highway One, Suite 400, Jupiter, Florida 33477 by U. S. Certified Mail, Return Receipt No. 7011 1570 0002 1695 9457 on this 5th day of November, 2013.



Andrea M. Lang, Assistant General Counsel
Florida Bar No. 0364568
Agency for Health Care Administration
Office of the General Counsel
2295 Victoria Avenue, Room 346C
Fort Myers, Florida 33901
Telephone: (239) 335-1253

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: Arcadia Oaks Assisted Living **ACHA No. 2013009490**

ELECTION OF RIGHTS

This Election of Rights form is attached to an Administrative Complaint. It may be returned by mail or facsimile transmission, but must be received by the Agency Clerk within 21 days, by 5:00 pm, Eastern Time, of the day you received the Administrative Complaint. If your Election of Rights form or request for hearing is not received by the Agency Clerk within 21 days of the day you received the Administrative Complaint, you will have waived your right to contest the proposed agency action and a Final Order will be issued imposing the sanction alleged in the Administrative Complaint.

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

Please return your Election of Rights form to this address:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _______ I admit to the allegations of fact and conclusions of law alleged in the Administrative Complaint and waive my right to object and to have a hearing. I understand that by giving up the right to object and have a hearing, a Final Order will be issued that adopts the allegations of fact and conclusions of law alleged in the Administrative Complaint and imposes the sanction alleged in the Administrative Complaint.

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

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

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be

received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

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

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

Licensee Name: ______________________________

Contact Person: ______________________ Title: ______________

Address: ______________________________
Number and Street | City | Zip Code

Telephone No. ______________ Fax No. ______________

E-Mail (optional) ______________________________

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

Signed: ______________________ Date: ______________

Printed Name: ______________________ Title: ______________

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA,
AGENCY FOR HEALTH
CARE ADMINISTRATION,

Petitioner,

vs. Case No(s): 2013009490

L & S SENIOR CARE, INC. d/b/a
ARCADIA OAKS ASSISTED LIVING,

Respondent.
_______________________________/

SETTLEMENT AGREEMENT

Petitioner, State of Florida, Agency for Health Care Administration (hereinafter the "Agency"), through its undersigned representatives, and Respondent, L & S Senior Care, Inc. d/b/a Arcadia Oaks Assisted Living (hereinafter "Respondent"), pursuant to Section 120.57(4), Florida Statutes, each individually, a "party," collectively as "parties," hereby enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, Respondent is an Assisted Living Facility licensed pursuant to Chapters 408, Part II, and 429, Part I, Florida Statutes, Section 20.42, Florida Statutes and Chapter 58A-5, Florida Administrative Code; and

WHEREAS, the Agency has jurisdiction by virtue of being the regulatory and licensing authority over Respondent, pursuant to Chapter 429, Florida Statutes; and

WHEREAS, the Agency served Respondent with an administrative complaint on or about November 10, 2013, notifying the Respondent of its intent to impose administrative fines in the amount of $6,500; and

EXHIBIT 2

WHEREAS, Respondent requested a formal administrative proceeding by filing a Petition for Formal Administrative Hearing; and

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

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

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

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

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

4. Upon full execution of this Agreement, Respondent agrees to pay $3,000 in administrative fines to the Agency within thirty (30) days of the entry of the Final Order for Counts I and III of the Administrative Complaint. Count II of the Administrative Complaint is voluntarily dismissed by the Agency for Health Care Administration.

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

6. By executing this Agreement, Respondent neither admits nor denies, and the Agency asserts the validity of the allegations raised in the administrative complaint referenced herein. No agreement made herein shall preclude the Agency from imposing a penalty against Respondent for any deficiency/violation of statute or rule identified in a future survey of Respondent, which constitutes a "repeat" or "uncorrected" deficiency from surveys identified in the administrative complaint. The parties agree that in such a "repeat" or "uncorrected" case, the deficiencies from the surveys identified in the administrative complaint shall be deemed found without further proof.

7. No agreement made herein shall preclude the Agency from using the deficiencies from the surveys identified in the administrative complaint in any decision regarding licensure of Respondent, including, but not limited to, licensure for limited mental health, limited nursing services, extended congregate care, or a demonstrated pattern of deficient performance. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Respondent acknowledges and agrees that this Agreement shall not preclude or estop any other federal, state, or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the administrative complaint.

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

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

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

11. Respondent for itself and for its related or resulting organizations, its successors or transferees, attorneys, heirs, and executors or administrators, does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter and the Agency's actions, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement, by or on behalf of Respondent or related facilities.

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

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

14. Respondent agrees that if any funds to be paid under this agreement to the Agency are not paid within thirty-one (31) days of entry of the Final Order in this matter, the Agency may deduct the amounts assessed against Respondent in the Final Order, or any portion thereof, owed by Respondent to the Agency from any present or future funds owed to Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to Respondent by the Agency for said amounts until paid.

15. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it.

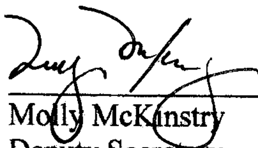
16. This Agreement contains and incorporates the entire understandings and agreements of the parties.

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

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

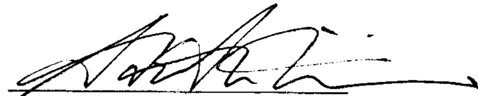
19. All parties agree that a facsimile signature suffices for an original signature.

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



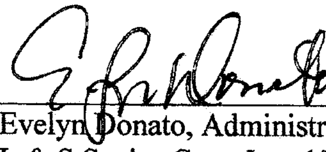
Molly McKinstry
Deputy Secretary
Agency for Health Care Administration
2727 Mahan Drive, Bldg #1
Tallahassee, Florida 32308

DATED: 4/6/15



Stuart F. Williams, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 3/22/15



Evelyn Donato, Administrator
L & S Senior Care, Inc. d/b/a
Arcadia Oaks Assisted Living
1013 East Gibson Street
Arcadia, Florida 34266

DATED: 3/5/15

Theodore Mack, Esq.,
Powell and Mack
3700 Bellwood Drive
Tallahassee, Florida 32303
Attorney for Respondent

DATED: 3/9/15

Andrea M. Lang, Senior Attorney
Agency for Health Care Administration
2295 Victoria Avenue
Fort Myers, Florida 33901

DATED: 3/16/15