STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Petitioner,

v.

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Respondent.
_____/

DOAH No. 15-0212

AHCA No. 2014011974

RENDITION NO.: AHCA-15 -0616 -S-OLC

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH No. 14-5640

AHCA No. 2014010307

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH No. 15-0038

AHCA No. 2014003526

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH No. 15-0214

AHCA No. 2014003521

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Petitioner,

v.

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Respondent.
_____/

DOAH No. 15-0302
Former DOAH No. 14-1861

AHCA No. 2014002452

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH No. 15-0303
Former DOAH No. 14-1922

AHCA No. 2014001438

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH No. 15-0438

AHCA No. 2014001642

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH No. 15-1084

AHCA No. 2015000694

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

AHCA No. 2015000277
(Immediate Moratorium on Admissions)

FINAL ORDER

Having reviewed the attached Notices of Intent to Deny, Administrative Complaints, and Immediate Moratorium on Admissions, all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the attached Notices of Intent to Deny, Administrative Complaints and Election of Rights forms, and Immediate Moratorium on Admissions to the Provider. (Composite Ex. 1) The parties have since entered into the attached Settlement Agreement, which is adopted and incorporated by reference into this Final Order. (Ex. 2)

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

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

3. The Provider shall pay the Agency $47,750.00. If full payment has already been made, the cancelled check is your receipt 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 payable to the "Agency for Health Care Administration" and containing the AHCA case numbers should be sent to:

Central Intake Unit
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 61
Tallahassee, Florida 32308

4. The Notices of Intent to Deny licensure issued to the Provider are withdrawn.

5. The Immediate Moratorium on Admissions issued to the Provider is lifted.

ORDERED at Tallahassee, Florida, on this 8 day of October, 2015.

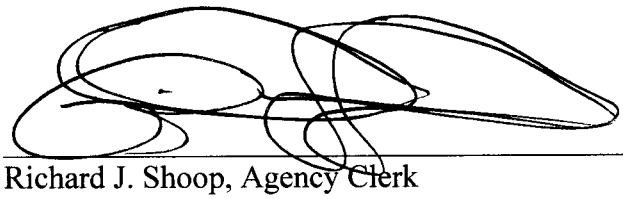
Elizabeth Dudek, Secretary
Agency for Health Care Administration

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 9th day of October, 2015.



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

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Craig Behrenfeld, Esquire Barnett, Bolt, Kirkwood, Long & Koche, P.A. 601 Bayshore Boulevard, Suite 700 Tampa, FL 33606 (Electronic Mail) ceb@barnettbolt.com
Catherine Anne Avery, Unit Manager Licensure Unit Agency for Health Care Administration (Electronic Mail)	Craig H. Smith, Esquire Hogan & Lovells US LLP 215 South Monroe Street, Suite 602 Tallahassee, FL 32311 (Electronic Mail) craig.smith@hoganlovells.com
Arlene Mayo Davis, Field Office Manager Local Field Office Agency for Health Care Administration (Electronic Mail)	Derek M. Daniels, Esquire McCumber, Daniels, Buntz, Hartig & Puig, P.A. 204 South Hoover Boulevard, Suite 130 Tampa, FL 33609 (Electronic Mail) ddaniels@mccumberdaniels.com
Thomas M. Hoeler, Chief Facilities Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Lourdes Naranjo, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)
The Honorable Cathy M. Sellers Division of Administrative Hearings (Electronic Filing)	

2014011974

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Certified Article Number
9414 7266 9904 2021 2801 52
SENDERS RECORD

December 15, 2014

CERTIFIED

Bonnie Williamson
GV Lauderhill, LLC
13770 58th Street North, Suite 312
Clearwater, FL 33760

File Number: 11910377
License Number: 5113
Provider Type: assisted living facility

RECEIVED
FACILITY INTAKE UNIT
DEC 18 2014
Agency for Health Care Administration

RE: Complaint Number 2014011974 14555 Sims Road, Delray Beach

Notice Of Intent To Deny Renewal Application

Dear Ms. Williamson:

It is the decision of this Agency that the renewal application filed by GV Lauderhill, LLC, with regard to Grand Villa of Delray East be DENIED. A standard license will not be issued. The specific basis for this determination is due to the applicant's failure to meet minimum licensure requirements pursuant to Sections 408.806(7), 408.815(1)(b),(c), and (d) and 429.14(1)(a), (e), (h), and (k). Since being issued a provisional license on 12/31/2012, the facility has had numerous complaint surveys that have resulted in continuous deficient practice and unsatisfactory outcomes, including resident deaths.

On September 16 – 17, 2013, a Change of Ownership with the Extended Congregate Care Survey was conducted in conjunction with follow-up surveys to complaint #'s 2012013036, 2012011719, 2013002704, 2013002988, and 2013006283. Additionally, inspections for the following seven complaints were conducted; #2013006287, #2013006293, #2013007212, #2013007489, #2013007590, #2013008825, and #2013002415. The facility was not in compliance and the inspection resulted in seven Class III deficiencies relative to Admissions, Staffing Standards, Training, Food Service, Physical Plant and Staffing Requirements.

On November 26 – 27, 2013, a revisit survey was conducted and the facility had two uncorrected class III deficiencies regarding Training. The facility failed to ensure training certificates were completed with the appropriate components for in-service trainings.

On December 17, 2013, Complaint Survey #2013012888 was conducted at the facility. The facility was not in compliance and had deficiencies. The facility was cited with one Class II deficiency regarding Resident Care and Supervision. The facility failed to provide appropriate supervision to meet the needs of the resident and to prevent an elopement which resulted in a death.

On January 13 – 14, 2014, Complaint Survey #2014000283 was conducted at the facility. The facility was cited with one Class II deficiency specifically regarding Resident Care-Rights and Facility Procedures. The facility failed to honor resident rights, provide a safe living environment and provide appropriate supervision to meet the needs of the residents. Residents were reported missing during this complaint survey visit.

On March 11 – 14, 2014, Complaint Survey #2014002332 was conducted at the facility. The facility was cited with two Class I deficiencies and one Class II deficiency regarding Resident Care and Supervision and Administrator responsibilities. Two Class III deficiencies were cited for failure to provide a safe

living environment and an environment free of foul odors and medication storage and disposal. The facility failed to provide adequate supervision to meet the needs of a resident which resulted in a death.

On September 15 – 19, 2014, Complaint Survey #'s 2014006798, 2014007413, 2014007531, 2014007823, 2014008637, and 2014008836 were conducted. The facility was not in compliance and was cited with one Class II deficiency regarding Resident Care and Supervision and three Class III deficiencies regarding Resident Care & Facility Procedures, Medication Administration, Medication Labeling & Orders, and Staffing Standards.

The facility failed to: provide adequate staff, care and services to meet the needs of the residents; provide residents freedom to participate in, interact, and benefit from community events; follow appropriate professional infection control standards and; properly administer prescription medications and label them correctly.

The facility has not promoted the safety and physical well-being of residents. The facility has demonstrated and continues to demonstrate deficient practice in the areas of Resident Care & Supervision, Resident Care-Rights & Facility Procedures, Staffing Standards-Administrators, and Physical Plant-Safe Living Environment. The facility has not complied with Florida Statutes, Sections 408.806(7), 408.815(1)(b),(c), and (d) and 429.14(1)(a), (e), (h), and (k).

Between September 16, 2013 and September 19, 2014, Grand Villa of Delray East was cited with two Class I deficiencies, four Class II deficiencies and ten Class III deficiencies.

EXPLANATION OF RIGHTS

Pursuant to Section 120.569, F.S., you have the right to request an administrative hearing. In order to obtain a formal proceeding before the Division of Administrative Hearings under Section 120.57(1), F.S., your request for an administrative hearing must conform to the requirements in Section 28-106.201, Florida Administrative Code (F.A.C), and must state the material facts you dispute.

SEE ATTACHED ELECTION AND EXPLANATION OF RIGHTS FORMS.

If you have any questions or need further assistance, please call Erika Potter-Morgan at 850-412-3433 or e-mail at Erika.Potter-Morgan@ahca.myflorida.com.

Sincerely,

Catherine Avery, Manager
Assisted Living Unit
Agency for Health Care Administration

cc: Legal Intake Unit, MS# 3

Grand Villa Of Delray East
December 15, 2014

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: Grand Villa Of Delray East

Case Number: 2014011974

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed Notice of Intent to Deem Incomplete and Withdraw from Further Review of the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Deem Incomplete and Withdraw from Further Review or some other notice of intended action by AHCA.**

An Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Deem Incomplete and Withdraw from Further Review or any other proposed action by AHCA.

If an Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please reply using this Election of Rights form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

Please return your ELECTION OF RIGHTS to:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS:

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Deem Incomplete and Withdraw from Further Review, or other notice of intended action by AHCA and I waive my right to object and have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the proposed penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Deem Incomplete and Withdraw from Further Review, or other proposed action by AHCA, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Deem Incomplete and Withdraw from Further Review or other proposed action by AHCA, and I 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 Subsection 120.57(1), Florida Statutes. It must be **received** by the Agency Clerk at the address above **within 21 days** of receipt of this proposed administrative action. The request for formal hearing must conform to the requirements of Rule 28-106.201, Florida Administrative Code, which requires that it contain:

1. The name and address of each agency affected and each agency's file or identification number, if known;
2. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any;
3. An explanation of how your substantial interests will be affected by the Agency's proposed action;
4. A statement of when and how you received notice of the Agency's proposed action;
5. A statement of all disputed issues of material fact. If there are none, you must state that there are none;
6. A concise statement of the ultimate facts alleged, including the specific facts you contend warrant reversal or modification of the Agency's proposed action;
7. A statement of the specific rules or statutes you claim require reversal or modification of the Agency's proposed action; and
8. A statement of the relief you are seeking, stating exactly what action you wish the Agency to take with respect to its proposed action.

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

License Type: Assisted Living Facility License Number: 5113

Licensee Name: Grand Villa Of Delray East

Contact Person: _____
Name Title

Address: _____
Street and number City Zip Code

Telephone Nbr.: _____ Fax Nbr.: _____

Email (optional): _____

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

Signed: _____ **Date:** _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No.: 2014010307
Return Receipt Requested:
7002 2410 0001 4240 1349

GV LAUDERHILL LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW State of Florida, Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this administrative complaint against GV Lauderhill LLC d/b/a Grand Villa of Delray East (hereinafter "Grand Villa of Delray East"), pursuant to Chapter 429, Part I, Chapter 408, Part II, and Section 120.60, Florida Statutes (2014), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $5,000.00 pursuant to Sections 429.14 and 429.19, Florida Statutes (2014), for the protection of public health, safety and welfare.

JURISDICTION AND VENUE

2. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes (2014), and Chapter 28-106, Florida Administrative Code (2014).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2014).

PARTIES

4. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities pursuant to Chapter 429, Part I, Chapter 408, Part II, Florida Statutes (2014), and Chapter 58A-5 Florida Administrative Code (2014).

5. Grand Villa of Delray East operates a 170-bed assisted living facility located at 1455 Sims Road, Delray Beach, Florida 33484. Grand Villa of Delray East is licensed as an assisted living facility under license number 5113. Grand Villa of Delray East was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I

GRAND VILLA OF DELRAY EAST FAILED TO ADEQUATELY PROVIDE CARE AND SERVICES APPROPRIATE TO MEET THE NEEDS OF THE RESIDENTS BY NOT PROPERLY ASSESSING MONITORING AND SUPERVISING AND DID NOT PROMOTE SAFETY AND PHYSICAL WELL-BEING OF AT-RISK RESIDENTS.

RULE 58A-5.0182(1), FLORIDA ADMINISTRATIVE CODE

(RESIDENT CARE/SUPERVISION STANDARDS)

CLASS II VIOLATION

6. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. Grand Villa of Delray East was cited deficient practice as the result of a complaint investigation survey that was conducted on September 19, 2014.

8. A complaint investigation survey was conducted on September 19, 2014. Based on observation, interview, and record review, it was determined that the facility failed to adequately provide care and services appropriate to meet the needs of the residents by not properly assessing, monitoring, or supervising and did not promote safety and physical well-being to 5 out of 6 at-risk residents (residents # 1, 2, 14, 15, and 16).

9. Review of resident # 1 ' s record indicated that she was admitted to the facility on 3/31/2014 with medical diagnoses of syncope, collapse, osteoarthritis, muscle weakness and visual and hearing impairment. Review of her Admission Health Assessment dated 4/1/2014 indicated that the resident was alert and oriented, and required Physical Therapy (PT) and Home Health Nurse visits for monitoring. Further review of this assessment indicated that she needed to have fall precautions, required supervision for ambulation with a walker, dressing, and self-care, and required assistance with bathing, toileting and transfers with 1 person.

10. Review of resident #1's Nursing Notes dated on 4/8/2014 indicated that the caregiver found the resident on the floor in her room at 4:30am, the resident was alert and oriented, complained of left hip pain and sustained several skin tears on her extremities. This nursing note indicated that the resident said that she "fell out of bed trying to roll over" and she was transferred via ambulance to the hospital for evaluation.

11. Review of resident #1's Nurses Notes dated on 5/29/2014 indicated that the resident was readmitted to the facility from the rehabilitation unit, after she received hip surgery from the fall she sustained on 4-8-14. This nursing note indicated that the resident was unable to ambulate, needed a wheel chair for mobility and required assistance with all of her activities of daily living (ADLs).

12. Review of resident #1's Nurses Notes dated on 6/2/2014 indicated that the resident had complaints of left shoulder pain and left hip pain after she slipped off her bed at 10:00am. This nursing note indicated that upon assessment, the resident had no apparent injury and an investigation was conducted by the nursing manager, which concluded that the resident had been monitored during the previous night shift and no fall was reported.

13. Further review of this nursing note indicated that at around 12:00pm the Home Health Nurse assessed the resident and notified the physician that the resident had left shoulder and left hip pain, and the resident was subsequently sent to the hospital for evaluation. This nursing note indicated that the resident returned to the facility at 7:00pm and no additional documentation was provided to show that any monitoring or safety precautions were implemented after her readmission from the hospital.

14. Review of resident #1's Nurses Note dated on 6/6/2014 indicated that the resident was found on the floor near her bed at 9:05am and she was assessed by the nurse to have no injury. Review of the Nurses Note dated on 7/18/2014 indicated that the resident was found on the floor in her bathroom at 11:00am and she complained of head, shoulder, and hip pain. This note indicated that the resident stated that "she lost her balance while getting up from the commode" and she was sent to the hospital for evaluation. Review of this note indicated that there was no additional documentation of the resident's readmission to the facility, no discharge instructions given for her care or follow-up physician appointments, or nursing assessments/monitoring after the resident sustained a head injury.

15. Review of resident #1's Nurses Note dated on 9/3/2014 indicated that the resident was readmitted from the rehabilitation unit and her Health Assessment dated on 8/28/2014 indicated that she required assistance with ambulation with a wheelchair, bathing and dressing.

This assessment also indicated that the resident required physical and occupational therapy for overall muscle weakness.

16. Review of resident #1's Nurses Notes dated on 9/4/2014 indicated that the resident was found on the floor in her room at 12:15am and she was alert and refused to go to the hospital for evaluation. This note indicated that there was no additional documentation of any resident monitoring or notification to the physician regarding her recent fall.

17. Further review of this Nurses Note indicated that the nurse received a phone call from resident #1's roommate at 11:05pm and informed her that the resident was on the bathroom floor and bleeding from her head. This note indicated that the 3pm-11pm shift nurse and the 11pm-7am shift nurse assessed the resident and transferred her to the hospital for evaluation.

18. Review of resident #1's nurses notes dated on 9/5/2014 indicated that the resident was readmitted to the facility with head injury, unsteady gait, and muscle weakness, and she was treated in the hospital for a scalp laceration, right upper arm hematoma, and left leg laceration. This note indicated that the resident was placed on Home Health nursing services for wound care and physical therapy due to weakness and imbalance.

19. Review of the resident's record indicated that there was no additional documentation to show any facility monitoring, accident-prevention interventions or safety precautions for the resident after her readmission from the hospital.

20. In an interview conducted on 9/17/2014 at approximately 8:35 AM, with the Registered Nurse (RN) Manager, she stated that the resident had a history of falls, was very unsteady when standing, and was using a wheelchair for mobility. In an observation at this time, another direct care staff member approached the RN nurse manager and told her that resident #1 had just fallen in her room. In an observation at this time inside resident #1's room with the RN

nurse manager, the resident was found lying supine on the floor and the resident complained of head, neck, shoulder and back pain.'

21. In an interview with resident #1 at this time, she stated that she "was attempting to get up to arrange her clothing, her feet got tangled together and she fell", and that she had been on the floor "all night" last night and no staff came into her room until about 8:00am.

22. In an interview, conducted on 9/17/2014 at 9 AM, with the 7am-3pm shift caregiver, she stated that she does not usually check up on resident #1 until after 8:00am because the resident preferred to "sleep in." She stated that on 9-17-14 at 8:15AM, she entered resident #1's room and found her lying on the floor. She stated that the resident required assistance for ambulation and transfers, used a wheelchair for support when transferring since she was very unsteady and had history of numerous falls.

23. In an interview conducted on 9/17/2014 at approximately 10:30AM with the LPN Wellness Manager, she stated that resident #1 had numerous falls due to overall weakness and she required assistance with mobility but could transfer herself independently. She stated that the resident had not been identified to require monitoring checks by the staff despite of the resident s fall history and assessed safety precaution.

24. In an observation on 9/17/2014 at 12:30PM, resident #1 was wheeled into the Dining Room by a staff member and she was positioned next to the table, and the staff member walked away. In an observation at this time, the resident stood up from her wheelchair, pulled the dining room chair from underneath the table and transferred herself into the dining room chair without any staff supervision or assistance. The resident presented to be swaying and unstable at this time.

25. Review of resident #1's Home Health Agency Plan of Care dated on 9/6/2014 indicated that the Risk Assessment tool determined the resident was a very high health and fall risk, was extremely hard of hearing, and having very poor eyesight. In an interview on 9/17/2014 at approximately 12:30 PM with the Home Health RN, she confirmed that the resident is alert, very assertive and determined to remain independent, but had a history of poor safety awareness which resulted in numerous falls. She stated that the expectation was that the facility staff would provide assistance with all ADL care and monitoring for fall risk as per the resident's health assessment.

26. In an interview conducted on 9/18/2014 at approximately 10:00AM, with the LPN Resident Care Supervisor, she stated the facility had no official policy or protocol for monitoring residents during the day or night, regardless of their assessed safety or fall-prevention status. She stated that she understood resident #1 to have been independent, used a wheelchair for mobility and was able to transfer herself, but that she had a history of repeated falls due to general weakness, visual impairment, and poor safety awareness.

27. She stated that she did not have any documentation to prove that the resident had been reevaluated after her numerous falls or any safety interventions implemented to prevent or reduce the resident's fall risk. She also stated that the facility had not engaged in any discussions with the resident's physician regarding the resident's potential change in condition.

28. In an interview conducted on 9/19/2014 at 3:30 PM with resident #1's Physician Assistant, she stated that the resident had suffered numerous falls while in the facility and that she examined the resident on 9/18/2014, found that the resident was cognitively good, but the resident had a decline in her judgment and safety awareness. She also stated that she

recommended that the resident must be transferred to a higher level of care to receive nursing/rehabilitation services and increased monitoring to prevent further injuries.

29. Review of Resident # 2's record indicated that he was admitted to the facility on 8/20/2014 with diagnoses including history of fall with hip fracture, surgical site infection, bowel obstruction with colostomy, hypertension, congestive heart failure, urinary incontinence, depressive disorder with psychosis and abnormality of gait. Review of the resident's health Assessment dated on 8-18-14 indicated that the resident was alert and oriented, required assistance with ambulation, bathing and dressing, and required supervision with toileting and transfers. The assessment also indicated that the resident was able to perform his own colostomy care, and he used a walker and/or a wheelchair for his mobility.

30. In an observation on 9/16/2014 at approximately 9:40 AM the resident was in his room sitting in a wheel chair wearing only a pull-up diaper/brief and presented to be short of breath. In an interview with the resident at this time, he stated that he was increasingly fatigued during the past few days and that he had fallen several times since he has been living there because his legs were very weak and had difficulty walking. He stated that he was independently mobile in his room with his wheelchair and transferred to the toilet by himself "hanging on to the cabinet for support." He also stated that he changed his own colostomy bag when he needed, but was experiencing greater difficulty performing this task.

31. Review of resident #2's Nurses Notes dated on 8/24/2014 indicated that the resident was found on the floor of the activity room at 10:00am and he was assessed to have no injury, except a skin tear to his right elbow. Review of the resident's Nurses Note dated on 9/8/2014 indicated that the facility nurse was contacted by telephone by the resident and informed her that he had fallen in his room.

32. Review of this note indicated that the resident was found in a sitting position on the floor with a laceration on the back of his head and he was sent to the hospital for evaluation. Review of this note indicated that the resident returned to the facility the same day with a diagnosis of closed head injury and scalp laceration and he received closure staples for this laceration. Further review of the resident's record indicated that there was no documentation of further resident monitoring of neurological status or implementation of any fall prevention/safety interventions.

33. Review of resident #2's Nurses Note dated on 9/9/2014 indicated that the resident was found on the floor in his room at 2:30am and he stated that he "slipped off sofa" and had no injury. Further review of the resident's record indicated that there was no documentation of physician notification or implementation of any fall prevention/safety interventions after the resident ' s 2nd consecutive fall in the last 24-hour period.

34. Review of resident #2's Nurses Note dated on 9/11/2014 indicated that the resident slipped and fell in his bathroom at 4:00am and that he suffered no injury. Further review of the resident ' s record indicated that there was no documentation of further resident monitoring or implementation of any fall prevention/safety interventions after this fall.

35. Review of resident's #2's Home Health Agency initial nursing evaluation dated on 8/22/2014 indicated that the resident had dyspnea with minimal exertion, and had functional limitations with ambulation, incontinence, hearing and endurance. This evaluation indicated that the resident demonstrated proper knowledge and good technique with his daily colostomy care, but had weakness and difficulty with ambulation and transfers due to poor balance, which required supervision at all times.

36. In an interview conducted on 9/18/2014 at approximately 10:30 AM, with the LPN Wellness Manager, she stated that resident #2 had experienced numerous falls in the facility as a result of his overall weakness. She stated that the resident required assistance with mobility and transfers, and he had not been identified to require frequent checks by the staff.

37. In an interview conducted on 9/19/2014 at 2:30 PM with the Home Health RN she stated that resident #2's overall condition had declined since his admission to the facility and that the resident was able to ambulate with the walker when admitted, but had become increasingly weak and fatigued with minimal exertion lately. She stated that the resident was having difficulty with transfers and was using his wheelchair for mobility, and that he was forgetful and could not recall the details of the recent falls.

38. She stated that the resident was able to perform his own colostomy care only when she would prepare the colostomy supplies for him, which facilitated the process for him. She stated that she was concerned with the current level of safety monitoring for the resident due to the repeated falls and she felt he needed to be transferred to a higher level of care.

39. In an observation on 9-17-14 at 10:45am, with the nurse, in the main hallway outside the dining room, resident #14 was walking independently with a rolling walker without any assistance. In an interview with the nurse at 10:50am, she stated that resident #14 usually walks without assistance and that since he does not call out for assistance, the facility does not extend assistance out to him and because he is able to walk independently with an unsteady gait. She stated that she was not aware of the resident's assessed functional status.

40. Review of resident #14's health assessment dated on 8-11-14 indicated that he was diagnosed with Parkinson' s disease (PD), constipation, and senile dementia. Further review

of his assessment indicated that he needed assistance with all of his activities of daily living (ADLs) including ambulation, transferring, grooming and toileting.

41. In an interview with resident #14's physical therapist on 9-17-14 at 11:45am, she stated that she was currently treating the resident for gait and general functional training and he had history Parkinson's disease (PD) and general mobility difficulties. She stated that even after the resident received his PD medications in the morning, he needed contact guard supervision with walking and needed assistance with walking when his PD medications wore off, like later during the day and at night.

42. She also stated that the resident needed assistance with transfers and ambulation to go to and from the bathroom for toileting, grooming, and bathing activities due to his decreased mobility and safety awareness. She stated that the resident told her that he constantly transferred and ambulated by himself to go to the bathroom and she advised him against doing that without assistance. She also stated that she has had previous weekly meetings with the facility nurses and communicated the resident's current care needs to them.

43. In an observation on 9-17-14 at 2:05pm, resident #15 was ambulating with a rolling walker independently and without assistance in the front lobby. In an interview with resident #15 on 9-17-14 at 2:15pm, she stated that she was used to walking by herself since it took so long for the staff to respond to her. She stated that she felt unstable at times while walking.

44. Review of resident #15 ' s health assessment dated on 6-25-14 indicated that she was diagnosed with hypertension, neuropathy to her lower extremities, macular degeneration, and previous fracture to her ribs. Further review of her assessment indicated that she needed assistance with ambulation, transferring and toileting.

45. In an interview with resident #16 on 9-18-14 at 9:45am, she stated that she walked to the bathroom on her own because when she use to call for help, it would take too long for the caregivers to arrive. She stated that it hurts to stand up due to her pressure sore, but she stood up, transferred by herself to her motorized wheelchair and propel herself whenever she needed to go to the bathroom.

46. In an interview with resident #16's home health nurse on 9-18-14 at 9:50am, she stated that she understood that the resident ambulated independently because the resident told her that the caregivers do not respond on time. She stated that the resident was not able to safely ambulate or transfer independently.

47. Review of resident #16's health assessment dated on 9-3-14 indicated that she was diagnosed with abnormal gait, severe osteoarthritis and leg edema. Further review of her assessment indicated that she needed assistance with ambulation and bathing.

48. Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.0182(1), Florida Administrative Code, herein classified as a Class II violation, which warrants an assessed fine of $5,000.00.

CLAIM FOR RELIEF

WHEREFORE, the Agency requests the Court to order the following relief:

1. Enter a judgment in favor of the Agency for Health Care Administration against Grand Villa of Delray East on Count I.

2. Assess an administrative fine against Grand Villa of Delray East based on Count I for the violation cited above.

3. Assess costs related to the investigation and prosecution of this matter, if the Court finds costs applicable.

4. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2014). Specific options for administrative action are set out in the attached Election of Rights. All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to the ***Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, MS #3, Tallahassee, Florida 32308.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN TWENTY-ONE (21) DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER

Lourdes A. Naranjo, Esq.
Fla. Bar No.: 997315
Assistant General Counsel
Agency for Health Care Administration
8333 N.W. 53rd Street
Suite 300
Miami, Florida 33166

Copies furnished to:

Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration
5150 Linton Blvd. – Suite 500
Delray Beach, Florida 33484
(U.S. Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to Eric Townsend, Administrator, Grand Villa of Delray East, 13770 58th Street North, Suite 312, Clearwater, Florida 33760 on this 22nd day of October, 2014.

Lourdes A. Naranjo, Esq.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GV Lauderhill LLC d/b/a Grand Villa of Delray East **AHCA No.: 2014010307**

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine** or **Administrative Complaint.**

Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308.
Phone: 850-412-3630 Fax: 850-921-0158. https://apps.ahca.myflorida.com/efile/

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fine or Fee, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

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

Signed:_____ **Date:**_____

Print Name:_____ Title:_____

Late fee/fine/AC

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

AHCA No.: 2014003526
Return Receipt Requested:
7009 0080 0000 0586 0452

ADMINISTRATIVE COMPLAINT

COMES NOW State of Florida, Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this administrative complaint against GV Lauderhill LLC d/b/a Grand Villa of Delray East (hereinafter "Grand Villa of Delray East"), pursuant to Chapter 429, Part I, Chapter 408, Part II, and Section 120.60, Florida Statutes (2013), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $3,000.00 pursuant to Sections 429.14 and 429.19, Florida Statutes (2013), for the protection of public health, safety and welfare and welfare, and a survey fee in the amount of $500.00

pursuant to Section 429.19(2)(c) and 429.19(7), Florida Statutes (2013).

JURISDICTION AND VENUE

2. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes (2013), and Chapter 28-106, Florida Administrative Code (2013).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2013).

PARTIES

4. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities pursuant to Chapter 429, Part I, Chapter 408, Part II, Florida Statutes (2013), and Chapter 58A-5 Florida Administrative Code (2013).

5. Grand Villa of Delray East operates a 170-bed assisted living facility located at 14555 Sims Road, Delray Beach, Florida 33484. Grand Villa of Delray East is licensed as an assisted living facility under license number 5113. Grand Villa of Delray East was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I

GRAND VILLA OF DELRAY EAST FAILED TO PROVIDE A SAFE ENVIRONMENT TO THE FACILITY'S MEMORY CARE UNIT (MCU) RESIDENTS AND TO EXTEND ADEQUATE AND APPROPRIATE HEALTH CARE TO THE RESIDENTS.

SECTION 429.28(1), FLORIDA STATUTES

(RESIDENT RIGHTS AND FACILITY PROCEDURES STANDARDS)

CLASS II VIOLATION

6. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. Grand Villa of Delray East was cited deficient practice as the result of a complaint investigation survey that was conducted on January 14, 2014.

8. A complaint investigation survey was conducted on January 14, 2014. Based on observation, record review, and interview, it was determined that the facility failed to provide a safe environment to the facility's memory care unit (MCU) residents due to having a malfunctioning door in the MCU and the facility failed to extend adequate and appropriate health care to 6 out of 11 sampled residents assessed to be elopement risks (Residents #1, #2, #3, #4, #5, and #6) by not referring them to their individual physicians and not monitoring them adequately. The findings are as follows.

9. Review of Resident #6's record indicated that the resident's elopement risk assessment dated on 12-20-13 and performed by the facility's registered nurse, indicated that the

resident was an elopement risk and needed increased staff monitoring because he was cognitively impaired with confusion.

10. In an interview with the direct care nurse on 1-13-14 at 1:35pm, she stated that on 1-4-14 Resident #6's wife took the resident out of the facility without signing him out, and this resident was discovered to be missing for more than 15 minutes. She stated at this time that caregiver A found out that the resident was missing as caregiver A performed her 2-hour resident checks and caregiver A informed her immediately of the missing resident.

11. She stated at this time that she proceeded to call the resident on his cell phone and his wife answered, and the resident's wife told her that everything was okay and she said she was testing the facility to ensure adequate missing-resident response.

12. In an interview with the direct care nurse on 1-13-14 at 1:45pm, she stated that she used to work in the MCU a few months ago and she did not know of the MCU security doors to be malfunctioning. She stated at this time that she knew that the MCU door alarms were not overly loud and they could not be heard from one end of the MCU to the other if activated.

13. In an interview with caregiver A on 1-14-14 at 9:45am, she stated that she saw Resident #6 on 1-4-14 at approximately 2:15pm in the main lobby. Then, at around 2:45pm on the same

day, she did not see him around, so she started looking for him in the main area of the facility. She stated at this time that she looked for him in his room, in the bathrooms, and in the activity room, but she did not find him. She stated at this time that she asked the receptionist if the resident had left and they confirmed that the resident was not signed out from the facility in the log book located in the main lobby. She stated at this time that she notified the direct care nurse and she attempted to call the resident on his personal cell phone but no one answered at first.

14. She stated at this time that the staff searched the whole facility but they did not find the resident and then his wife answered the resident's cell phone and she said the resident was fine, that they went out for a little while and they will return to the facility in short time. She stated at this time that the resident returned to the facility with his wife later on the same day without incident.

15. Review of the incident report dated on 1-4-14 indicated that Resident #6 went missing from the main facility at 2:51pm and that the resident's wife contacted the facility at 4:00pm on the same day to notify the facility that the resident was okay. Further review of the incident report indicated that the resident's wife was told after the incident, to sign the

resident out every time they go out of the facility and the resident remains on the established 2-hour monitoring check.

16. In an interview with the memory care unit (MCU) nurse on 1-13-14 at 3:00pm, she stated that Resident #12 is the only current resident in the MCU who has wandering and exit-seeking behaviors.

17. In an interview with the Administrator on 1-13-14 at 3:55pm, she stated that the 10 main facility residents identified by the registered nurse to be an elopement risk in December 2013 were:

A. Resident #1: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

B. Resident #2: assessed to be an elopement risk and to be placed in the MCU.

C. Resident #3: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

D. Resident #4: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

E. Resident #5: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

F. Resident #6: assessed to be an elopement risk with increased monitoring.

G. Resident #7: assessed to be an elopement risk with increased monitoring.

H. Resident #8: assessed to be an elopement risk with increased monitoring.

I. Resident #9: assessed to be an elopement risk with increased monitoring.

J. Resident #10: assessed to be an elopement risk with increased monitoring.

18. The Administrator stated on 1-13-14 at 4:00pm, that Resident #2 was identified to be an elopement risk on 12-19-13, like the other at-risk residents, and the resident's family was contacted to inform them that the resident could not remain in the main facility side and needed to be transferred to the exit-controlled MCU. She stated at this time that the only action the facility has made with the identified at-risk residents was only to contact their family members to inform them of the elopement risk results and has not made contact with their physicians; nor made efforts to modify the resident's exit-seeking behaviors or actually move the residents to the MCU.

19. She stated at this time that the facility's regional manager and her made the decision to not immediately issue any discharge notices or initiate steps to move any of the identified at-risk residents, which went against the recommendations of their risk assessments. She stated at this time that the facility's intent was to further observe these at-risk residents, for an undetermined period of time, by means of

maintaining an accurate 2-hour check log on all the at-risk main facility residents and re-assess the at-risk residents sometime in the future.

20. She stated at this time that upon review of the resident log records, the main facility at-risk residents have not been 100% monitored since the 2-hour check logs have missing monitoring data in them, and the facility has not re-assessed any of them or contacted any of their physicians regarding their elopement risk.

21. Review of the resident check logs dated from 1-2-14 to 1-13-14 indicated that the staff did not record the 2-hour checks accurately for every resident in the main facility assessed to be an elopement risk, including: Resident #6 was not monitored on 1-2-14 from 6am to 2pm, on 1-7-14 from 7am to 3pm and on 1-12-14 from 7am to 9pm, Resident #5 was not monitored on 1-3-14 at 2pm and on 1-12-14 from 3pm to 9pm, Resident #10 was not monitored on 1-3-14 at 2pm and on 1-12-14 from 3pm to 9pm, Resident #8 was not monitored on 1-3-14 at 6am and on 1-12-14 from 3pm to 9pm and Resident #9 was not monitored on 1-5-14 from 7am to 3pm, on 1-6-14, 1-7-14, and 1-8-14 from 7am to 1pm and on 1-12-14 from 3pm to 9pm.

22. In an interview with the direct care nurse on 1-13-14 at 4:35pm, she stated that there was no documentation that the

physicians of any of the residents with an increased elopement risk were contacted to discuss their status.

23. Review of the elopement risk residents' records did not indicate that their physicians were contacted by the facility to notify them of their increased elopement risk status, including the following:

24. Review of Resident #2's record indicated that she was admitted to the facility on 8-15-12 with diagnoses including Coronary Artery Disease and Orthostasis. Review of the resident's health assessment dated on 11-6-13 indicated that she was independent with all of her activities of daily living, that she needed skilled nursing services and was a fall risk.

25. Review of the resident's elopement risk assessment dated on 12-19-13 indicated that the resident was an elopement risk and needed to be transferred to the MCU. Review of the resident's progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment or any behavior modification strategies being implemented.

26. Review of Resident #4's record indicated that she was admitted to the facility on 1-31-11 with diagnoses including Alzheimer's disease, left eye blindness, Hypertension, and Coronary Artery Disease. Review of the resident's health assessment dated on 3-27-12 indicated that she was independent

with all of her activities of daily living, with exception to bathing which she needed supervision with, she needed to walk with a walker, had fall precautions, and was cognitively impaired.

27. Review of the resident's elopement risk assessment dated on 12-20-13 indicated that the resident was an elopement risk and needed to be transferred to the MCU or issue a discharge notice from the facility. Review of the resident's progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment or any behavior modification strategies being implemented.

28. Review of Resident #3's record indicated that she was admitted to the facility on 9-11-12 with diagnoses including Dementia and Spinal Stenosis. Review of the resident's health assessment dated on 9-26-13 indicated that she needed assistance with all of her activities of daily living, except with eating which she was independent, that she needed fall prevention, she had gait instability and had memory loss. Review of the resident's elopement risk assessment dated on 12-20-13 indicated that the resident needed to be transferred to the MCU or issue a discharge notice from the facility. Review of the resident's progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment or any behavior modification strategies being implemented.

29. Review of Resident #1's record indicated that she was admitted to the facility on 3-12-12 with diagnoses including Chronic Vertigo, Hypertension, Depression, and Hypothyroidism. Review of the resident's health assessment dated on 11-13-13 indicated that she needed assistance with all of her activities of daily living, except with ambulation and eating which she was independent, that she needed safety precaution, she was unsteady and forgetful. Review of the resident's elopement risk assessment dated on 12-19-13 indicated that the resident was an elopement risk. Review of the resident's progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment.

30. Review of Resident #5's record indicated that he was admitted to the facility on 1-10-11 with diagnoses including Dementia. Review of the resident's health assessment dated on 12-5-13 indicated that he needed assistance with all of his activities of daily living, except with eating which he was independent, that he needed fall prevention and he had gait instability. Review of the resident's elopement risk assessment dated on 12-20-13 indicated that the resident was wandering, needed to be transferred to the MCU or issue a discharge notice from the facility. Review of the resident's progress notes did not indicate any communication with his physician regarding the outcome of his elopement risk assessment.

31. In an observation on 1-14-14 at 8:30am, Resident #9 was walking independently from the main lobby to the front entrance courtyard of the facility. In an interview with the resident at this time, she stated that she has been living in the facility for approximately 10 weeks and that she likes it living there. She stated at this time that she is independent and knows how to get around the facility. The resident presented to be alert and minimally confused at this time. Review of the resident's elopement risk assessment dated on 12-19-13 indicated that the resident was at risk for elopement, she required increased monitoring, and did not need to be transferred to the MCU.

32. Review of Resident #12's record indicated that he was admitted to the facility on 11-26-13 with diagnoses including Dementia, Alzheimer's disease, and Hypertension. Review of his health assessment dated on 6-20-13 indicated that the resident needed assistance with ambulation (with "unaware of unsafe areas" noted) and supervision with transferring (with no comments noted) and needed assistance with self-administration of medication.

33. Review of his move-in assessment dated on 8-6-13 indicated that he was not oriented to his surroundings or daily routine, and it was noted that he is a wanderer. Review of the resident's elopement risk assessment dated on 12-18-13 indicated

that he was an elopement "high" risk with a total score of 32, with any score greater than 10 indicated as a risk. Review of the resident's progress notes did not indicate any communication with his physician regarding the outcome of his elopement assessment or any behavior modification strategies being implemented.

34. In an observation on 1-14-14 at 5:00am, the MCU doorway leading to the main facility was not locked or alarmed. In an observation on 1-14-14 at 10:25am, Resident #12 was walking independently in the MCU hallways with visual supervision by the direct care staff. The surveyor attempted to interview the resident at this time but it was not possible because he presented to be considerably confused.

35. In an observation on 1-14-14 at 5:00am, the MCU doorway leading to the main facility, it was not locked or alarmed.

36. In an interview with the supervising MCU nurse on 1-14-14 at 5:10am, she stated that the MCU security coded doorway leading to the main facility was supposed to be working properly, but it is not because it was unlocked since the beginning of her shift at 11:00pm last night. In an observation on 1-14-14 at 5:10am, the MCU doorway leading to the main facility was not locked or alarmed. In further observations at this time, it was also noted that the front door of the main

facility, which is approximately 100 yards from the MCU security coded door, was unlocked and could be opened by pressing of the door bars without any alarms sounding and reentry from the outside was not possible because the door was locked after it closed.

37. In an interview with the supervising MCU nurse on 1-14-14 at 5:15am, she stated that the main facility front door is unlocked and not alarmed, and anyone can leave but the door remains locked from the outside. She also stated at this time that the MCU to main facility doorway was malfunctioning by being unlocked today and that this also occurred approximately a month ago.

38. In an interview with the supervising MCU nurse on 1-14-14 at 5:55am, she stated that she attempted to reset the MCU security door a few times that night, but it did not reset, and that once she contacted the Administrator by telephone, she walked through another resetting method which made the MCU door lock and properly function again.

39. In an interview with the Administrator on 1-14-14 at 10:35am, she stated that the missing spots on the at-risk resident log were there because the direct care staff did not record that some residents left the facility with family members and/or they may have forgot to record their observations altogether. She stated at this time that besides the MCU-main

facility door malfunctioning today, it was not locking a couple of weeks ago and the door was reset with the code in order to function properly again.

40. Based on the foregoing facts, Grand Villa of Delray East violated Section 429.28(1), Florida Statutes, herein classified as a Class II violation, which warrants an assessed fine of $3,000.00.

SURVEY FEE

Pursuant to Section 429.19(7), Florida Statutes (2013), AHCA may assess a survey fee in the amount of $500.00 to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits.

CLAIM FOR RELIEF

WHEREFORE, the Agency requests the Court to order the following relief:

1. Enter a judgment in favor of the Agency for Health Care Administration against Grand Villa of Delray East on Count I.

2. Assess an administrative fine against Grand Villa of Delray East based on Count I for the violation cited above.

3. Assess a survey fee of $500.00 against Grand Villa of Delray East on Count I for the violation cited above.

4. Assess costs related to the investigation and prosecution of this matter, if the Court finds costs applicable.

5. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2013). Specific options for administrative action are set out in the attached Election of Rights. All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to the ***Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, MS #3, Tallahassee, Florida 32308.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN TWENTY-ONE (21) DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER

Lourdes A. Naranjo, Esq.
Fla. Bar No.: 997315
Assistant General Counsel
Agency for Health Care Administration
8333 N.W. 53rd Street
Suite 300
Miami, Florida 33166

Copies furnished to:

Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration
5150 Linton Blvd. - Suite 500
Delray Beach, Florida 33484
(U.S. Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to GV Lauderhill LLC, 13770 58th Street North, Suite 312, Clearwater, Florida 33760 on this 6th day of June, 2014.

Lourdes A. Naranjo, Esq.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GV Lauderhill LLC d/b/a Grand Villa of Delray East **AHCA No.: 2014003526**

ELECTION OF RIGHTS

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Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fine or Fee, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

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

Signed:_____ Date:_____

Print Name:_____ Title:_____

Late fee/fine/AC

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No.: 2014003521
Return Receipt Requested:
7009 0080 0000 0586 0445

GV LAUDERHILL LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW State of Florida, Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this administrative complaint against GV Lauderhill LLC d/b/a Grand Villa of Delray East (hereinafter "Grand Villa of Delray East"), pursuant to Chapter 429, Part I, Chapter 408, Part II, and Section 120.60, Florida Statutes (2013), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $22,000.00 pursuant to Sections 429.14 and 429.19, Florida Statutes (2013), for the protection of public health, safety and welfare, and a survey fee in the amount of $500.00 pursuant to Section 429.19(2)(c) and 429.19(7), Florida Statutes (2013).

JURISDICTION AND VENUE

2. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes (2013), and Chapter 28-106, Florida Administrative Code (2013).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2013).

PARTIES

4. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities pursuant to Chapter 429, Part I, Chapter 408, Part II, Florida Statutes (2013), and Chapter 58A-5 Florida Administrative Code (2013).

5. Grand Villa of Delray East operates a 170-bed assisted living facility located at 14555 Sims Road, Delray Beach, Florida 33484. Grand Villa of Delray East is licensed as an assisted living facility under license number 5113. Grand Villa of Delray East was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I (Tag 25)

GRAND VILLA OF DELRAY EAST FAILED TO PROVIDE CARE AND SERVICES APPROPRIATE TO MEET THE NEEDS OF RESIDENTS, FAILED TO PROVIDE PERSONAL SUPERVISION, AND FAILED TO PROVIDE AWARENESS OF THE GENERAL HEALTH AND SAFETY OF RESIDENTS.

RULE 58A-5.0182(1), FLORIDA ADMINISTRATIVE CODE

(RESIDENT CARE/SUPERVISION STANDARDS)

CLASS I VIOLATION

6. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. Grand Villa of Delray East was cited with deficient practice as the result of a complaint investigation survey that was conducted on March 14, 2014.

8. A complaint investigation survey was conducted on March 14, 2014. Based on record review, observation, and interview, it was determined that the assisted living facility failed to provide care and services appropriate to meet the needs of 2 out of 9 sampled residents (Resident #1 & Resident #5). The assisted living facility failed to provide personal supervision, including two-hour checks, failed to follow their own policy and procedures, and failed to provide awareness of the general health and safety of Resident #1 who was found expired. The findings include the following.

9. Record review of the incident report submitted to the Agency by the facility revealed that Resident #1 had passed on 03-06-14. Further review found the facility only indicated Resident #1 was found "unresponsive on floor". Record review revealed the Agency's status of the report was "closed" as a result of the lack of details.

10. Record review of the police report dated 03-06-14 revealed the deputy responded to the call at 7:56 AM and arrived at 8:05 AM for a death investigation. He indicated Resident #1 was unresponsive and was pronounced dead on the scene. He also indicated that a routine check every two hours was in Resident #1's charts.

11. Record review of the fire rescue report dated 03-06-14 revealed the call was received at 7:44:03 AM and was on location at 7:50:14 AM. Record review revealed a chief complaint of "unresponsive, pulseless, and apneic." Record review indicated the skin temperature was cold and pale. Record review revealed "female prone on the ground next to her bed. Pt was unresponsive, pulseless and apneic. Pt. was noted to have rigor mortis and fixed and dilated pupils."

12. Record review of a statement written by Staff F on 03-08-14 revealed she wrote she was in the laundry room when the Staff G said who was in the hospital. When she went to go

do her rounds and check on Resident #1, she did not see her in her bed. She immediately remembered that it was Resident #1 who went to the hospital so she put on the paper that Resident #1 went to the hospital not knowing it was a different room # who really was in the hospital. She wrote, "the whole thing was a miscommunication".

13. Record review of a statement written by Staff G revealed it was dated 03-06-14 (the date of the incident). Record revealed she wrote that Resident #1 came to the wellness center for her evening medications at 4:30 PM. At around 9:00 PM the memory care nurse called her to ask her to go to Resident #1's room to check on her air conditioner because Resident #1 was feeling hot. She gave Resident #1 her 9:00 PM medications and adjusted the air conditioner. She took the medication without difficulty and left with Resident #1 in her reclining chair. She wrote at the end of her shift, she gave the report to the night nurse and the two aides that Resident #10 in room 282 was in the hospital.

14. Record review of a statement written by Staff E (not dated) revealed Resident #1 was not acting out of the ordinary on the 3:00 PM - 11:30 PM shift where she provided care to Resident #1. She gave her a shower at 6:30 PM - 7:30 PM and checked in on her last at around 9:30 PM. During the 9:30 PM check, she found Resident #1 asleep in her recliner with her television on. She said at around 10:00 PM, Resident #1 called for someone to turn on her air conditioner and that was the last time she saw her.

15. Record review of the communication log revealed Resident #1 fell in the club room on 03-04-14. Further review revealed Resident #10 was admitted to the hospital due to shortness of breath on 03-05-14. Record review found Resident #1 was not listed on the communication log as being sent out to the hospital on 03-05-14. Record review found Resident #1 was unresponsive in the communication log on 03-06-14.

16. Record review of the Resident check log revealed twelve current Residents were being checked on every two hours. Record review found Resident #1 was on the list. Record review revealed Resident #1 was listed as last checked on 03-05-14 at 9:07 PM. Record review revealed "HOS" for Resident #1 for 11:00 PM, 1:00 AM, 3:00 AM, and 5:00 AM. Record review found Resident #1 was "found" on 03-06-14 at 7:03 AM.

17. Record review of Resident #1's file revealed she was admitted to the facility on 12-21-12. Record review found a Resident condition log which revealed on 03-06-14 at 7:00 AM" Resident found in apartment by aide on the floor unresponsive. Resident was lying on her neck with her feet up in the air in between the bed and the chair. Supervisor notified and nurse on duty called to assist. Record review of Resident #1's condition log revealed Resident #1 had her most recent falls documented on 03-04-14, 02-27-14, 02-01-14, 01-23-14, and 11-11-13.

18. Record review of Resident #1's Medication Observation Record (MOR) confirmed that Resident #1 received her 9:00 PM medications on 03-05-14; Atorvastatin 20 mg (milligram) tablet and Travatan z 0.004xopth 2.5 (eye drops).

19. Record review of Resident #1's health assessment, dated 01-28-14, revealed Resident #1 uses a walker, needs assistance with all activities of daily living (ADL's), and is a fall risk. Record review revealed Resident #1 needed daily observation of whereabouts.

20. Record review of an elopement assessment of Resident #1 dated 12-20-13 revealed "Resident requires a lot of redirection and is cognitively impaired. Resident requires increased staff monitoring due to decreased mobility. Resident can remain in AL but family should be informed about upcoming need or exit controlled unit".

21. Record review of photographic evidence obtained of Resident #1's body found the entire right side of her face was black and blue from her chin to her ear, including her ear. Record review found one of her arms was also black and black.

22. Record review revealed the facility failed to follow proper policy and procedure. Record review revealed that approximately 40 minutes had passed from the time Staff A found Resident #1 at approximately 7:03 AM until the time the facility contacted emergency medical services (called 911). Record review of the facility's walkie-talkie log revealed Staff A signed out a walkie-talkie on 03-06-14.

23. Observations on 03-10-14 at approximately 1:35 PM found the bedroom of Resident #1 located on the left side of room #278. Observations found a bed on the left wall in the middle of the room. Observations found a quarter bed rail as well as a hand rail on the left side of the bed (closest to the window). Observations found a reclining chair against the left wall between the window and the bed. Observations found the space between the bed and the reclining chair was approximately one and a half feet. Observations found room #278 was approximately 78 steps away from the wellness center.

24. Observations on 03-10-14 at approximately 2:50 PM found the daughter of Resident #1 and the Administrator speaking in the hallway of the second floor. Observations found the daughter was visibly upset and said to the Administrator "to stop lying to her".

25. Observations found the daughter stated that she called the doctor's office and they told her they were not present at the facility after the death of her mother and that her mother died from breaking her neck and falling. She stated the police officer told that to the doctor's office. The daughter stated she was even told by the staff that her mother broke her neck, fell,

and died. Observations found the daughter was upset that the details of her mother's death were held from her.

26. In an interview with the Administrator on 03-10-14 at approximately 10:04 AM, she stated that Resident #1 passed away last Wednesday (03-05-14). She stated she is still conducting an investigation. She stated an [source] came last Friday. She stated she was asking about Resident #1. She stated she is doing her investigation right now but she knows at around 7:00 AM in the morning Staff A went into Resident #1's apartment and found her on the floor and got a supervisor.

27. She stated Staff A determined that Resident #1 was unresponsive and got a supervisor who contacted another supervisor. She stated between her and memory care nurse, they evaluated that Resident #1 had passed. She stated she called 911 and when the paramedics came they determined that Resident #1 passed and they contacted the Sheriff's Office.

28. She stated the police officer investigated and contacted Resident #1's primary care physician. She stated a police officer always comes on the scene until the funeral home comes. She stated she still does not have concrete evidence. She stated she cannot make an opinion of whether she fell but she died as a result of her getting out of bed. She stated she called Resident #1's daughter, but she was not in on Friday because she was moving. She stated Resident #1 had a half rail and she will speculate that she tried using it to get out of bed. She stated she thought Resident #1 may have "gotten caught and did a summersault". She stated this was Thursday , 03-06-14, when the police officer was there.

29. In an interview with Staff A on 03-10-14 at approximately 10:25 AM, she stated she works the morning shifts (6:00 AM to 2:30 PM). She stated she found Resident #1 on the floor at 7:03 AM on 03-06-14. She stated she did not see Resident #1 in the bed, but found her

on the floor. She stated she went to get the nurse right away. She stated Resident #1 slept in a private bedroom.

30. She stated Resident #1 was "ambulatory and had a good stance". She stated she had a side rail and it was raised. She stated when she found her she was really scared and got the nurse. She stated she only called her name and Resident #1 did not respond so she ran and got the nurse. She stated she ran and got Staff B. She stated she found her in the wellness center on the second floor. She stated she went back in there with Staff B. She stated she thinks she only took one minute to get her. She stated she does not remember much because she was scared. She stated she was not in the room when the paramedics came. She stated she thinks Staff B called 911.

31. In an interview with the Administrator on 03-10-14 at approximately 10:41 AM, she stated she did not get a statement from Staff B. She stated Resident #1 was on a two hour check. She stated Staff F told her she thought Resident #1 was in the hospital.

32. In an interview with Staff B on 03-10-14 at approximately 10:46 AM, she confirmed that Resident #1 resided in room #278. She stated Resident #1 has a roommate but they were in separate bedrooms. She stated it is a two bedroom apartment. She stated she got in a 6:00 AM that morning.

33. She stated she was in the wellness center passing medications when Staff A came in. She stated Staff A implied that Resident #1 was not breathing. She stated they saw Resident #1 on the side of the bed. She stated Resident #1 was cold when she touched her. She stated it looked like it had been a few hours since she passed. She stated Resident #1 was stiff. She stated she took a blood pressure cuff but did not use it because she touched her and that was it.

34. She stated she got the memory care nurse who worked over night. She stated it was a little after 7:00 AM when Staff A got her. She stated it takes her not even a minute to get to Resident #1's room from the wellness center. She stated Resident #1 was on the floor and her "body was kind of in a ball". She stated she could not see her face because "her bottom half was on top". She stated it was like she flipped out of the bed. She stated she had a bed rail in a raised position. She stated she did not get caught in the bed rail. She stated she couldn't see her neck because her body was folded in half. She stated she then ran down to the memory care unit and grabbed the nurse from the night shift. She stated she also grabbed Staff D. She stated Staff A stayed with Resident #1 while she got the nurse. She stated around 7:30 AM, Staff D entered Resident #1's room. She stated there is not a supervision issue during the day, but she cannot speak for what happens at night.

35. In an interview with the Administrator on 03-10-14 at approximately 10:57 AM, she stated she has not gotten a statement from Staff D. She stated, "if you came an hour later she would have had more done". She stated she was not in on Friday to do an investigation. She stated the facility had twelve Residents on two hour checks and Resident #1 was one of them. She stated now there are eleven Residents.

36. She stated Resident #1 was obviously taken care of on the 3-11 PM shift. She stated Staff F maintains that she was told by Staff G the wrong information. She stated Staff F was double thinking herself. She stated Staff F told her Resident #1's bed was made so she thought Resident #1 was in the hospital because that is what Staff G told her. She stated she thought that maybe Resident #1 went into Resident #7 room. She stated Resident #1 was found on the other side of the bed and Staff F could not see her on the floor when she opened the door.

37. She stated Staff F maintains that she went in there at 11:00 PM and the bed was made and Resident #1 was not in there. She stated the only time Staff F went into Resident #1's room was at 11:00 PM. She stated she does not know why Staff F was in there just once. She stated "it still is not gelling". She stated Resident #10 was the Resident that went to the hospital that night. She stated Resident #10 was in room #282; which is two doors away from Resident #1.

38. She stated there is a communication log for Residents that go to the hospital. She stated Staff F told her she checked on Resident #1 once and her bed was made so she believed she was the Resident in the hospital. She stated sometimes Resident #1 goes into other Resident rooms at night because she did not like being alone.

39. In an interview with the Administrator on 03-10-14 at approximately 11:16 AM, she stated she did not know why Staff G would be talking about someone in the hospital. She stated Staff G is just "a medtech and only gives out medications".

40. In an interview with Staff C on 03-10-14 at approximately 11:22 AM, she stated she keeps the communication log if Residents go to the hospital, have a medication change, or if there are any complaints. She stated she also documents falls in the communication log. She stated she is not the only one that writes in it. She stated the person who is dealing with the Resident writes in it. She stated the 03-04-14 fall of Resident #1 appeared to be written by a medtech.

41. She stated Resident #1 was trying to sit down and missed the chair. She stated Resident #1 has had about three falls. She stated she heard that they found Resident #1 in her room. She stated she knows it was a fall, but does not know anything else. She stated there are two people that work at the facility at night on the second floor. She stated if the Resident falls

and cannot reach the call light it would be really hard to know if the Resident fell. She stated if they do not have an alert bracelet it would have to be if they are going on rounds or passing by.

42. She stated Resident #1 was supposed to be watched every two hours. She stated there was an incident that night and someone thought she was in the hospital. She stated there is not a supervision issue it was a miscommunication issue.

43. In an interview with Staff D on 03-10-14 at approximately 11:29 AM, he stated he was in the memory care unit and one of the medtech's came up to him and said one of the Residents had fallen. He stated he found Resident #1 on the other side of the bed. He stated he was unable to see her when he opened the door.

44. He stated there was no Staff in there when he walked in. He stated he believes that the bed was not completely made and looked like someone had been in it. He stated it was half and half. He stated it was roughly 7:10 AM when Staff B got him. He stated he had to walk around the bed in order to see Resident #1 on the floor. He stated she was in a tumble position and not lying flat. He stated he did not touch her at all. He stated he is not aware of anyone assessing her to see if she was breathing. He stated when he saw her, he advised the Staff not to touch her but to call 911. He stated there looked like there was a little blood pooled on her forehead. He stated he did not call 911 and does not know who called 911. He again stated when he got into the room no Staff were present.

45. In an interview with the Administrator on 03-10-14 at approximately 12:01 PM, she stated Resident #1's primary care physician was notified that day. She stated Resident #1's primary care physician is the physician that comes to the facility.

46. In an interview with the Administrator on 03-10-14 at approximately 12:10 PM, she stated that the facility had been previously put under a plan of correction (POC). She stated

the facility has not completed the plan of correction and they have not implemented any changes in the two hour check system. She stated they are currently tightening the system so they have a better awareness of people's comings and goings. She stated no Resident was taken off the two hour check list.

47. In an interview with both the son and daughter of Resident #1 on 03-10-14 at approximately 1:43 PM, the son stated that the daughter was Resident #1's power of attorney (POA). The daughter stated her mother was getting old, but when the facility called to say her mother had passed, the Administrator told her she had some bad news and she does not remember her words, but she said her mother passed that morning or during that night.

48. She stated she the police officer took the phone from the Administrator and he said to them that she died from an age related death and her heart probably gave away. The daughter stated her mother would get up in the middle of the night to use the bathroom. She stated she was notified by the [source] that she fell and the facility did not notify her about that.

49. She stated they did not know if she passed in bed or she fell on the floor. She stated the call from the [source] shocked her. She stated the [source] inquired if Resident #1 broke her neck. She stated after she spoke to the [source], she was very upset and called the Administrator; it was then that she told her Resident #1 fell on the floor.

50. She stated she told her she did not know if she broke her neck but she was found on the floor. She stated the Administrator told her they found Resident #1 on one of the shifts. She stated Resident #1 had a bed rail, but the bed rail was not on the right side. She stated it was supposed to be on the other side. She stated it was put on by the store and Resident #1 cried that she needed it changed to the other side so she could have access to the bathroom and her walker.

She stated Resident #1 claimed it was not on the side that she wanted. She stated it had been on for about a week.

51. She stated she does not like that she was not told the truth. She stated she was told that they walked around every couple of hours to look at the patients, but does not know if that happened. She stated Resident #1 could have used a little more supervision, but whether she got it or not, she does not know. She stated they were left in the dark about what happened.

52. She stated the sheriff even told them that she died in bed. She stated she is not sure if the doctor signed a death certificate. She stated the doctor was not around when she passed. She stated Resident #1 could communicate her needs. She stated they had a phone in Resident #1's room that they just bought her. The son stated that the night before she was found she called him to tell him that she needed the air turned on because she was uncomfortable. He stated he told her to call downstairs and the facility will adjust it for her. She stated that once in a while Resident #1 had someone that showered her that was not nice. She stated she showered three times a week. She stated if you asked questions someone would not talk to her.

53. She stated she does not have any of the names of the Staff though. She stated the facility used to always call when Resident #1 fell. She stated Resident #1 had a fall history and it started getting worse. She stated she fell a week before in the dining room because she could not get a hold of chair. She stated she was going to ask the doctor if she needed to go to a wheelchair. She stated Resident #1 used a walker but had no problem walking.

54. In an interview with Staff A on 03-10-14 at approximately 2:40 PM, she stated she could not see Resident #1 on the floor from the door. She stated she found Resident #1 in between the bed and the recliner.

55. In an interview with the daughter of Resident #1 on 03-10-14 at approximately 3:22 PM, She stated she knew her mother's routine very well. She stated she would be in the recliner until about 10:00 PM watching television. She stated she even knew she would watch [name of the show] and then would go to bed.

56. In an interview with Staff E on 03-10-14 at approximately 3:25 PM, she stated she works the 3 PM to 11:30 PM shift. She stated she bathed Resident #1 from 6:30 PM to about 7:30 PM the night she passed. She stated she bathed her for about an hour. She stated Resident #1 was acting normal. She stated Resident #1 was very talkative.

57. She stated she did the two hour checks and she saw Resident #1 at around 9:15 PM. She stated she was checking in on her because she was a two hour check Resident. She stated at the time she observed her sitting in the recliner. She stated she had a tendency to unmake the bed. She stated when she first went in at 3:00 PM, Resident #1's bed was made. She stated for the two hour checks, if the Resident is not in the room she is supposed to go look for them. She stated Resident #1 was on the special list to watch. She stated Resident #1 was in the club room most of the time. She stated she would not go to the club room after she was in her pajamas. She stated she put Resident #1 in her pajamas after the shower. She stated she did not believe Resident #1 went to another Resident room at night.

58. She stated Resident #1 would be in three places; the club room, the dining room or her room. She stated she never knew she went into any Resident room besides her own. She stated she would find her in the recliner or her bed. She stated sometimes if you put her in the bed she would try to get up even though she was afraid to fall. She stated Resident #1 would tell her that. She stated when she went into Resident #1's room at around 9:15 PM, she had unmade her bed and she did not want her to touch it. She stated she would fold the covers over and if she

tried and pull it back, Resident #1 would get mad at her. She stated she was dozing off a little bit when she saw her.

59. She stated she peaked in and that's it. She stated she did not do a thorough observation but she could tell she was breathing. She stated she went in at around 10:00 PM and she was sitting on her bed. She stated she was facing the door not the window. She stated her thermostat was outside of the bedroom. She stated she does not remember if the television was on but the light was on and the door was slightly open.

60. She stated Resident #1 wanted the air on because she said it was too hot. She stated she would not tell anyone that Resident #1 went to the hospital because she was sitting there. She stated Staff G is a good medtech but she does not know if she goes into Resident rooms. She stated Staff G does not do two hour checks. She stated she does the two hour checks.

61. In a phone conversation with the physician of Resident #1 on 03-11-14 at approximately 9:05 AM, he stated he had not signed the death certificate of Resident #1 but he plans on it. He stated he does not know the cause of her death. He stated he did hear rumors of how she died. He stated he heard she had a fractured neck. He stated his office notified him of this yesterday. He stated he was notified on Sunday (03-09-14) that Resident #1 passed. He stated he was not told at that point anything about her neck.

62. In a phone interview with the son of Resident #1 on 03-11-14 at approximately 9:13 AM, he stated that yesterday was the first time he found out that his mother fell when she passed. He stated they did not know, but all the Staff knew, that they thought his mother went to the hospital, and they did not check on her. He stated the facility neglected to do two hour checks on her. He stated that usually the facility would call the daughter of Resident #1 if she went to the hospital or if she fell. He stated that everyone knew about it except for her family. He stated

the doctor was not there nor did he make a report which was contrary to what they were told. He stated everyone in the facility knew there was a mistake made except for her family.

63. In a phone conversation with the physician of Resident #1 on 03-11-14 at approximately 9:21 AM, he stated Resident #1 had mild diabetes and a mild stool issue but she had no major pressing medical issues. He stated she was recently diagnosed with diabetes and put on medications for it. He stated he started seeing her in December of 2013. He stated the last time he saw her was on 12-30-13. He stated the last time his office saw her was on 02-24-14 when she was put on the diabetic medication. He stated when he gets cases like this where he cannot determine the cause of death he will just put her diagnoses. He stated he cannot view her body nor can he verify if she had broken her neck or not.

64. In a phone interview with Staff F on 03-11-14 at approximately 9:54 AM, she confirmed she works the night shifts at the facility. She stated her and another person on the floor are responsible for doing the two hour checks. She stated they take turns doing the two hours checks. She stated the night that Resident #1 passed away it was her turn to do the rounds.

65. She stated she went into Resident #1's room and she did not see her in there and automatically thought she went into hospital because a nurse told her a Resident went to the hospital. She stated she got confused. She stated she started with her room but she did not see her in there. She stated she went her in there because she was on her list. She stated she thought it was her in the hospital. She stated the Staff G told her that Resident #1 was in the hospital in the laundry room. She stated she forgot which room number went to the hospital. She stated Staff G did not give her a name, she just gave her a room number.

66. She stated when she found out it wasn't Resident #1, she found out it was the Resident in room #282 in the hospital. She stated Resident #1 was in room 278. She stated her

bed was undone like someone went to bed. She stated it was halfway folded. She stated after she did not see Resident #1, she thought she was the one in the hospital. She stated she put her down on the list that she was in the hospital and she did not go in there the rest of the night. She stated the medtech's are supposed to let them know after the shift which Residents went to the hospital. She stated it is a verbal notification.

67. She stated she does not know how the facility documents Residents in the hospital. She stated they told her verbally in the laundry room, but they are supposed to tell her when she was in the nursing station. She stated she was supposed to have a meeting, but they did not have a meeting that night because they were doing laundry and the medtech just came up to them and told them. She stated the 3 PM to 11 PM Staff were supposed have a meeting when they get there at 11:00 PM but Staff G was still working so she did not tell us until a half hour later.

68. She stated it was around a little before 11:30 PM; maybe 11:20 PM. She stated she saw Resident #1's recliner and she was not in it. She stated the hallway light was on but the television and bedroom light were off. She stated she found out in the morning that Resident #1 was not the one in the hospital.

69. She stated when she was about to leave they called her to come and they told her to go into Resident #1's room. She stated she goes home at 7:30 AM so it was around 7:25 AM. She stated Resident #1 was in the corner on the floor, and "it was weird", she did not expect it. She stated she was on the left side of the bed in the corner. She stated it looked like she was balled up. She stated it looked like she tried getting out of bed and got her foot stuck in the railing. She stated she did not see her foot but she was told that. She stated she just took a quick glance and it was a total shock. She stated the "maintenance guy went in there and touched her

and said yes she is dead she is cold". She stated she heard a rumor that Resident #1 had broken her neck. She stated she could not see Resident #1 from the door but had to walk over to the other side of the bed.

70. In a phone conversation with Staff G on 03-11-14 at approximately 10:35 AM, she confirmed she is a medtech and works the 3 PM to 11:30 PM shift on the second floor of the facility. She stated she usually gives a report, but the girls are sometimes in the laundry room. She stated she puts it on paper in the 24 hour book and she tells them as well. She stated all the girls know there is a 24 hours book.

71. She stated she gave Resident #1 her medications and she was the one that put the air on for her. She stated she adjusted the thermostat and put it at 60 something degrees around 9:00 PM. She stated she gave medications to her at the same time. She stated when the nurse called her she said she would turn on the air when she went into to give Resident #1 her medications. She stated Resident #1 was sitting at the edge of the bed when she came in and she got up and sat in her recliner. She stated she gave her medications and eye drops every night. She stated about 9:00 PM was the last time she saw her.

72. She stated when she left her she was still sitting in the recliner. She stated Resident #1 told her she was showered that evening. She stated Resident #1 does not go to another Resident room. She stated when she was there, there was another Resident, Resident #8, in Resident #1's room. She stated she was in there when she got there and when she left. She stated Resident #8 always told her what Resident #1 would need. She stated that when she told Staff F about the Resident in the hospital, she gave her the name and the room of the Resident. She stated Staff F took her pen and wrote 282 on her own hand.

73. In a phone interview with the responding police officer on 03-11-14 at approximately 11:26 AM, he stated he arrived to the facility around 8:00 AM. He stated it looked like Resident #1 attempted to get out of bed. He stated he was told she was checked on every two hours and she was last checked on a little after 7:00 AM. He stated the facility looked at her chart and told him Resident #1 was last checked at around 5:00 AM. He stated Resident #1 was found lying on the side of her bed.

74. He stated she did have signs of rigor mortis. He stated she could have been there for three or four hours. He stated Resident #1 was up against the wall leaning to her left side. He stated he was told she had scoliosis of the spine. He stated he spoke to Resident #1's doctor and he told him he would sign the death certificate. He stated he spoke to Resident #1's family and told them Resident #1 attempted to get out of bed and her heart gave out.

75. He stated according the facility, he was given an exact time she was checked on. He stated he was specifically told Resident #1 was checked on at 4:52 AM and was scheduled to be checked every two hours. He stated he did not see the paperwork though. He stated know that he knows this information, Resident #1's time of death is skewed. He stated the rigor mortis threw him off but it now makes sense. He stated the rails were not straight up. He stated it appeared as if she attempted to use the bed rail to get up and fell over it.

76. In a phone conversation with the son of Resident #1 on 03-11-14 at approximately 11:41 AM, he stated he viewed his mother's body and her right side of her face was puffy, bruised, and black and blue. He stated her legs were clean but he left arm was also bruised. He stated she did not have scoliosis or curvature of the spine. He stated she would lean her head forward when she walked but she could pick it up if you asked her to do so.

77. In an interview with the Administrator on 03-11-14 at approximately 2:20 PM, she stated she had not been able to conduct an investigation as of yet. She stated there is not much to do with it though. She stated it was a miscommunication between the 3-11 shift and the 11-7 shift. She stated Staff F could have mistakenly checked the wrong room if her bed was not made.

78. In an interview with the Administrator on 03-11-14 at approximately 3:08 PM, she stated the communication log is a log that Staff uses to see if a Resident is in the hospital. She stated it would have been helpful if Staff F checked that log. She stated if Staff F did not know about the communication log it would disappoint her.

79. In a phone interview with the Administrator on 03-12-14 at approximately 1:45 PM, she stated she does not know who called 911 and does not know why it took approximately 40 minutes to do so. In a phone interview with Staff A on 03-12-14 at approximately 3:51 PM, she stated she did not touch Resident #1 when she found her nor did she do CPR (Cardiopulmonary Resuscitation). She stated she did not know if Resident #1 had a Do Not Resuscitate Order (DNRO) because the nurse is supposed to know that.

80. In a phone interview with Staff H on 03-13-14 at approximately 4:37 PM, she stated she has been working at the facility since September 16, 2013. She stated she works the 11 PM to 7 AM shift. She stated she is the only nurse at the facility at night time. She stated she works usually on the memory care side and she will go to the assisted living side if they need anything. She stated they come get her if they need anything and she will check on it and she would be the one to call 911.

81. She stated when they found Resident #1; she was changing shifts and called 911 when she was notified. She stated she is not sure of what time she called 911. She stated she was

notified after 7 AM in the morning about Resident #1. She stated she went to her room and saw she was on the side of the bed lying on the floor with her head down and her lower body on top and one of her legs were hanging in between the side rails. She stated she called 911 and the call dropped and 911 called back and the Resident care supervisor spoke to them and told them that Resident #1 needed a paramedic and they came after that.

82. She stated she was there when the paramedics came. She stated the Administrator was there. She stated the Administrator told her to go home. She stated the paramedics came very fast within 5 minutes of calling. She stated that Staff B notified her and Staff D at the same time.

83. In an interview with Staff B on 03-14-14 at approximately 2:17 PM, she stated in an emergency, she would see if the Resident is conscious, see if they are breathing, and check the book to see if there is a DNR. If they are, she will not resuscitate them. She stated if a Resident fell out of bed she would check for injuries and see if they were in pain. She stated if they had any issues she would call 911. She stated it would be her responsibility to call 911. She stated she did not call 911 because she did not know what to do because it was the first time she encountered something like that so she went to get another nurse and they took it from there.

84. In an interview with the Resident care supervisor on 03-14-14 at approximately 2:40 PM, she stated 2:40 PM, she has been working at the facility since February 18, 2014. She stated she came in the morning the day Resident #1 passed away. She stated she would estimate that she came in around 7:35 AM. She stated at that point in time Staff did not call 911 as of yet. She stated she is not really sure why they did not. She stated she went upstairs and went into her room and called the Administrator. She stated while she was calling the Administrator, Staff H

she was calling 911. She stated she does not know the process from the time Staff A found Resident #1 but she has to notify a supervisor which would be the nurse and she would call 911.

85. She stated she believes that Staff A notified Staff H. She stated Staff H works in the memory care unit. She stated she is the night nurse and works in the memory care unit.

86. In an interview with Staff I on 03-14-14 at approximately 2:58 PM, she stated she has been working at the facility since November. She stated if a CNA would go to her and say there is something wrong, she would have to stop doing what she was doing go check. She stated CAN 's are supposed to stay and walkie-talkie her. She stated she would assess the Resident and ask them if they are in any pain. She stated she would call 911 immediately. She stated if they were not responsive she would call 911 immediately. She stated the CNA ' s are instructed to stay with the Resident and to call a medtech or nurse.

87. In an interview with Staff J on 03-14-14 at approximately 3:03 PM, she stated the CNA is supposed to page her on the walkie-talkie and she would go and assist the Resident. She stated they are not supposed to leave the Resident. She stated a nurse is supposed to call 911 but if the nurse is already in the room they would go and call 911. She stated if she found a Resident not responsive she would call 911 immediately. She stated she usually gives a verbal report in the wellness center and they have a 24 hour book they write in for Residents that go to the hospital.

88. In an interview with Staff K on 03-14-14 at approximately 3:15 PM, she stated she has been working at the facility for 9 years. She stated she is supposed to call the nurse right away if she finds a Resident in distress. She stated she would put on the emergency light in the room. She stated they have to stay with a Resident until the nurse and she would call 911. She

stated she believes that Staff A notified Staff H. She stated Staff H works in the memory care unit. She stated she is the night nurse and works in the memory care unit.

89. In an interview with Staff I on 03-14-14 at approximately 2:58 PM, she stated she has been working at the facility since November. She stated if a CNA would go to her and say there is something wrong, she would have to stop doing what she was doing go check. She stated CAN 's are supposed to stay and walkie-talkie her. She stated she would assess the Resident and ask them if they are in any pain. She stated she would call 911 immediately. She stated if they were not responsive she would call 911 immediately. She stated the CNA ' s are instructed to stay with the Resident and to call a medtech or nurse.

90. In an interview with Staff J on 03-14-14 at approximately 3:03 PM, she stated the CNA is supposed to page her on the walkie-talkie and she would go and assist the Resident. She stated they are not supposed to leave the Resident. She stated a nurse is supposed to call 911 but if the nurse is already in the room they would go and call 911. She stated if she found a Resident not responsive she would call 911 immediately. She stated she usually gives a verbal report in the wellness center and they have a 24 hour book they write in for Residents that go to the hospital.

91. In an interview with Staff K on 03-14-14 at approximately 3:15 PM, she stated she has been working at the facility for 9 years. She stated she is supposed to call the nurse right away if she finds a Resident in distress. She stated she would put on the emergency light in the room. She stated they have to stay with a Resident until the nurse gets there. She stated the nurse would call 911 if the Resident needed emergency services. She stated if a Resident went to the hospital she is supposed to check the 24 hour book.

92. In an interview with Staff L on 03-14-14 at approximately 3:21 PM, she stated she has been working at the facility for 7 months. She stated if an emergency happened she would call the nurse. She stated she would use the walkie-talkie. She stated she is going to stay with the Resident and that is why they have the walkie-talkie. She stated when the nurse comes they would call 911 if they needed to. She stated she thinks if the Resident is not responsive they would call 911 immediately. She stated they are supposed to have a shift change meeting at the end of each shift in the wellness center. She stated there is a book that documents Residents that are in the hospital.

93. Observations on 03-10-14 at approximately 3:49 PM, while walking the halls with the Administrator, found Resident #5 standing behind her wheelchair in the middle of a hallway on the second floor. Observations found Resident #5 was asking for assistance. Observations found no Staff around the halls to provide assistance. Observations found the Administrator had to assist Resident #5 into her wheelchair and took her into the wellness center.

94. In an interview with the Administrator on 03-21-14 at approximately 2:40 PM, she acknowledged the findings.

95. Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.0182(1), Florida Administrative Code, herein classified as a Class I violation, which warrants an assessed fine of $10,000.00.

COUNT II (Tag 77)

GRAND VILLA OF DELRAY EAST FAILED TO BE RESPONSIBLE FOR THE OPERATION OF THE FACILITY AND THE ADEQUATE CARE OF ALL RESIDENTS.

RULE 58A-5.019(1), FLORIDA ADMINISTRATIVE CODE

(STAFFING STANDARDS)

CLASS I VIOLATION

96. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

97. A complaint investigation survey was conducted on March 14, 2014. Based on record review, observation, and interview, it was determined that the Administrator failed to be responsible for the operation of the facility and the provision of adequate care to all residents. The findings include the following.

98. Record review of the facility's recent compliance history revealed the facility was cited at A0030 (Resident Care - Rights & Facility Procedures) as a class II from a complaint inspection completed on 1-13-14 and 1-14-14. Record review found the facility was cited at A0025 (Resident Care - Supervision) as a class II from a complaint inspection completed on 12-12-13 to 12-16-13. Record review of a revisit conducted at the facility on 11-26-13 and 11-27-13 found A0091 (Training - Documentation and Monitoring) and E203 (ECC - Staffing Requirements), both cited at a class III, were uncorrected.

99. Record review of the incident report submitted to the Agency by the facility revealed that Resident #1 had passed on 03-06-14. Further review found the facility only indicated Resident #1 was found "unresponsive on floor". Record review revealed the Agency's status of the report was "closed" as a result of the lack of details.

100. Record review of the police report dated 03-06-14 revealed the deputy responded to the call at 7:56 AM and arrived at 8:05 AM for a death investigation. He indicated resident #1 was unresponsive and was pronounced dead on the scene. He also indicated that a routine check every two hours was in Resident #1's charts.

101. Record review of the fire rescue report dated 03-06-14 revealed that the call was received at 7:44:03 AM and was on location at 7:50:14 AM. Record review revealed a chief complaint of "unresponsive, pulseless, and apneic." Record review indicated the skin temperature was cold and pale. Record review revealed "female prone on the ground next to her bed. Pt was unresponsive, pulseless, and apneic. Pt. was noted to have rigor mortis and fixed and dilated pupils".

102. Record review of the resident check log revealed twelve current residents were being checked on every two hours. Record review found Resident #1 was on the list. Record review revealed Resident #1 was listed as last checked on 03-05-14 at 9:07 PM. Record review revealed "HOS" for Resident #1 for 11:00 PM, 1:00 AM, 3:00 AM, and 5:00 AM. Record review found Resident #1 was "found" on 03-06-14 at 7:03 AM.

103. Record review revealed the facility failed to follow proper policy and procedure. Record review revealed that approximately 40 minutes had passed from the time Staff A found Resident #1 at approximately 7:03 AM, until the time the facility contacted emergency medical services (called 911).

104. Record review of email correspondence sent by the Administrator on 03-12-14 she wrote, "in reviewing the statements I have from employees it appears there is some back and forth with getting and securing a supervisor to assess the situation because of the change of shift".

105. Record review of e-mail correspondence sent by the administrator on 03-12-14 she wrote, "the past year has had turnover of key personnel managers resulting in monthly trainings with no follow up paperwork, sign in sheets or certificates. It has been extremely challenging finding the right managers with commitment to ensure compliance with policies and procedures".

106. Observations on 03-10-14 at approximately 2:50 PM found the daughter of Resident #1 and the Administrator speaking in the hallway of the second floor. Observations found the daughter was visibly upset and said to the Administrator "to stop lying to her". Observations found the daughter stated that she called the doctor's office and they told her they were not present at the facility after the death of her mother and that her mother died from breaking her neck and falling.

107. She stated the police officer told that to the doctor's office. The daughter stated she was even told by the staff that her mother broke her neck, fell, and died. Observations found the daughter was upset that the details of her mother's death were held from her.

108 In an interview with the Administrator on 03-10-14 at approximately 10:04 AM, she stated that Resident #1 passed away last Wednesday (03-05-14). She stated she is still conducting an investigation. She stated she is doing her investigation right now but she knows at around 7:00 AM in the morning, Staff A, went into Resident #1's apartment and found her on the floor and got a supervisor. She stated staff A determined that Resident #1 was unresponsive and got a supervisor who contacted another supervisor.

109. She stated between her and memory care nurse, they evaluated that Resident #1 had passed. She stated she called 911 and when the paramedics came they determined that Resident #1 passed and they contacted the Sheriff's Office. She stated the police officer

investigated and contacted Resident #1's primary care physician. She stated a police officer always comes on the scene until the funeral home comes. She stated she still does not have concrete evidence. She stated she cannot make an opinion of whether she fell but she died as a result of her getting out of bed.

110. She stated she called Resident #1's daughter but she was not in on Friday because she was moving. She stated Resident #1 had a half rail and she will speculate that she tried using it to get out of bed. She stated she thought Resident #1 may have "gotten caught and did a summersault". She stated this was Thursday, 03-06-14, when the police officer was there.

111. In an interview with the Administrator on 03-10-14 at approximately 10:41 AM, she stated she did not get a statement from Staff B. She stated Resident #1 was on a two hour check. She stated Staff F told her she thought Resident #1 was in the hospital.

112. In an interview with the Administrator on 03-10-14 at approximately 10:57 AM, she stated she has not gotten a statement from Staff D. She stated, "if you came an hour later she would have had more done". She stated she was not in on Friday to do an investigation. She stated she was moving and could not come into the facility.

113. She stated the facility had twelve residents on two hour checks and Resident #1 was one of them. She stated now there are eleven residents. She stated Resident #1 was obviously taken care of on the 3-11 PM shift. She stated Staff F maintains that she was told by Staff G the wrong information. She stated Staff F was double thinking herself. She stated Staff F, told her Resident #1's bed was made so she thought Resident #1 was in the hospital because that is what Staff G told her. She stated Resident #1 was found on the other side of the bed and Staff F could not see her on the floor when she opened the door.

114. She stated Staff F maintains that she went in there at 11:00 PM and the bed was made and Resident #1 was not in there. She stated the only time Staff F went into Resident #1's room was at 11:00 PM. She stated she does not know why Staff F was in there just once. She stated "it still is not gelling". She stated Resident #10 was the resident that went to the hospital that night. She stated Resident #10 was in room #282; which is two doors away from Resident #1. She stated there is a communication log for residents that go to the hospital. She stated Staff F told her she checked on Resident #1 once and her bed was made so she believed she was the resident in the hospital. She stated sometimes Resident #1 goes into other resident rooms at night because she did not like being alone.

115. In an interview with the Administrator on 03-10-14 at approximately 11:16 AM, she stated she did not know why Staff G would be talking about someone in the hospital. She stated Staff G is just "a medtech and only gives out medications".

116. In an interview with the Administrator on 03-10-14 at approximately 12:01 PM, she stated resident #1's primary care physician was notified that day. She stated Resident #1's primary care physician is the physician that comes to the facility.

117. In an interview with the administrator on 03-10-14 at approximately 12:10 PM, she stated that the facility had been previously put under a plan of correction (POC). She stated the facility has not completed the plan of correction and they have not implemented any changes in the two hour check system. She stated they are currently tightening the system so they have a better awareness of people's comings and goings. She stated no resident was taken off the two hour check list.

118. In an interview with both the son and daughter of Resident #1 on 03-10-14 at approximately 1:43 PM, the son stated that the daughter was Resident #1's power of attorney

(POA). The daughter stated her mother was getting old but when the facility called to say her mother had passed; the Administrator told her she had some bad news and she does not remember her words, but she said her mother passed that morning or during that night. She stated the police officer took the phone from the Administrator; he said to them that she died from an age related death and her heart probably gave away.

119. She stated she was notified by the [source] that she fell and the facility did not notify her about that. She stated they did not know if she passed in bed or she fell on the floor. She stated the call from the [source] shocked her. She stated the [source] inquired if Resident #1 broke her neck. She stated after she spoke to the [source] she was very upset and called the administrator and it was then that she told her Resident #1 fell on the floor.

120. She stated she told her she did not know if she broke her neck, but she was found on the floor. She stated the administrator told her they found Resident #1 on one of the shifts. She stated Resident #1 had a bed rail but the bed rail was not on the right side. She stated it was supposed to be on the other side. She stated it was put on by the store and Resident #1 cried that she needed it changed to the other side, so she could have access to the bathroom and her walker. She stated Resident #1 claimed it was not on the side that she wanted it had been on for about a week.

121. She stated she does not like that she was not told the truth. She stated she was told that they walked around every couple of hours to look at the patients, but does not know if that happened. She stated Resident #1 could have used a little more supervision, but whether she got it or not she does not know. She stated they were left in the dark about what happened. She stated the sheriff even told them that she died in bed.

122. In a phone conversation with the physician of Resident #1 on 03-11-14 at approximately 9:05 AM, he stated he had not signed the death certificate of Resident #1 at the time of the call but he plans on it. He stated he does not know the cause of her death and that there were rumors of how she died. He stated he heard she had a fractured neck, his office notified him of this yesterday. He stated he was notified on Sunday (03-09-14) that Resident #1 passed and was not told at that point anything about her neck.

123. In a phone interview with the son of Resident #1 on 03-11-14 at approximately 9:13 AM, the following was revealed. He stated that yesterday was the first time he found out that his mother fell when she passed. He stated they did not know, but all the staff knew, that they thought his mother went to the hospital and they did not check on her. The son stated the facility neglected to do two hour checks on her. He stated that usually the facility would call the daughter of Resident #1, if she went to the hospital or if she fell. He stated that everyone knew about it except for her family. He stated the doctor was not there nor did he make a report which was contrary to what they were told. He stated everyone in the facility knew there was a mistake made except for her family.

124. In a phone interview with the responding police officer on 03-11-14 at approximately 11:26 AM, the following was revealed. He arrived to the facility around 8:00 AM. Resident #1 looked as if she attempted to get out of bed. He stated he was told she was checked on every two hours and she was last checked on a little after 7:00 AM. The facility looked at her chart and told him Resident #1 was last checked at around 5:00 AM. He stated Resident #1 was found lying on the side of her bed; she did have signs of rigor mortis and that she could have been there for three or four hours.

125. He stated Resident #1 was up against the wall leaning to her left side. He stated he was told she had scoliosis of the spine. He stated according the facility, he was given an exact time she was checked on; he was specifically told Resident #1 was checked on at 4:52 AM and was scheduled to be checked every two hours. He stated he did not see the paperwork though. He stated now that he knows this information Resident #1's time of death is skewed. He stated the rigor mortis threw him off but it now makes sense.

126. In an interview with the administrator on 03-11-14 at approximately 2:20 PM, she stated she had not been able to conduct an investigation as of yet. She stated there is not much to do with it though. She stated it was a miscommunication between the 3-11 shift and the 11-7 shift. She stated Staff F could have mistakenly checked the wrong room if her bed was not made. She stated she gave the [source] my contact information so she did not have to provide them same documentation twice.

127. In an interview with the Administrator on 03-11-14 at approximately 3:08 PM, she stated the communication log is a log that staff use to see if a resident is in the hospital. She stated it would have been helpful if Staff F checked that log. She stated if Staff F did not know about the communication log it would disappoint her.

128. In a phone interview with the Administrator on 03-12-14 at approximately 1:45 PM, she stated she does not know who called 911 and does not know why it took approximately 40 minutes to do so.

129. In a phone interview with the Administrator on 03-12-14 at approximately 3:00 PM, she asked if she would be able to use the Agency's investigation for her 15-day report. After informed that she might not receive it within the timeframe. She inquired if she would be able to use the information obtained during the exit conference. She stated she will not be at the facility

tomorrow if the surveyor should show up. She stated she has to close on her house and won't be able to be at the facility.

130. In a phone interview with the Administrator on 03-12-14 at approximately 3:59 PM, she stated she would not be available until Monday for she is will be closing on a house.

131. In an interview with the business office manager on 03-14-14 at approximately 3:28 PM, she stated the last time DNRO training was offered by the facility was in August of 2013. She stated it was 08-06-13. She stated any staff hired after that day would not have DNRO training through the facility. She stated she sent an e-mail to me on 03-12-14 with all of the DNRO trainings she found of staff that worked on 03-06-14. She stated that only two staff that worked on 03-06-14 (the day in which resident #1 had been found expired) had DNRO training.

132. Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.019(1), Florida Administrative Code, herein classified as a Class I violation, which warrants an assessed fine of $10,000.00.

COUNT III (Tag 90)

GRAND VILLA OF DELRAY EAST FAILED TO PROVIDE DOCUMENTATION THAT DO NOT RESUSCITATE ORDER TRAINING (DNRO) WAS OFFERED TO STAFF.

RULE 58A-5.0191(11), FLORIDA ADMINISTRATIVE CODE

(DO NOT RESUSCITATE ORDERS TRAINING STANDARDS)

CLASS II VIOLATION

133. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

134. A complaint investigation survey was conducted on March 14, 2014. Based on interview and record review, it was determined that the assisted living facility failed to provide proper documentation that Do Not Resuscitate Orders Training (DNRO) was completed and/or offered for a minimum of 4 out of 5 (Staff B, Staff D, Staff E, and Staff F) sampled Staff member reviewed. The findings include the following.

135. In a phone interview with the Administrator on 03-13-14 at approximately 3:59 PM, she stated that both DNRO trainings requested could not be found. She stated she cannot provide me with something that she does not have.

136. In an interview with Staff B on 03-14-14 at approximately 2:17 PM, she stated she is not sure if the facility has a policy on DNRO's.

137. In an interview with the Resident Care Supervisor on 03-14-14 at approximately 2:40 PM, she stated she should know which residents have a DNRO, but she is still in training and does not know the process.

138. In an interview with Staff I on 03-14-14 at approximately 2:58 PM, she stated the facility has not offered her DNRO training. She stated she has been working at the facility since November of 2013.

139. In an interview with Staff L on 03-14-14 at approximately 3:21 PM, she stated the facility has not offered her DNRO training. She stated she has been working at the facility for seven months. She stated she does not know where the residents DNRO's are kept (Staff L provides direct care to residents).

140. In an interview with the business office manager on 03-14-14 at approximately 3:28 PM, she stated the last time DNRO training was offered by the facility was in August of 2013. She stated it was 08-06-13. She stated any staff hired after that day would not have DNRO

training through the facility. She stated she sent an email to me on 03-12-14 with all of the DNRO trainings she found of staff that worked on 03-06-14. She stated that only two staff that worked on 03-06-14 (the day in which Resident #1 had been found expired) had DNRO training.

141. Record review of e-mail correspondence sent by the facility on 03-12-14 revealed 31 staff members worked on 03-06-14. Record review revealed the facility only sent two certificates of two separate staff members in which received DNRO training.

142. Record review of e-mail correspondence sent by the facility on 03-14-14 revealed the Administrator stated that she "could not confirm. Had class offered but cannot secure proof" to an e-mail in which she was asked if Staff A and Staff F had DNRO training.

143. Record review of an e-mail sent by the facility on 03-18-14 revealed there are 29 current Staff members which are working at the facility that were hired after August of 2013. Record review revealed Staff B, Staff D, Staff E, and Staff F were included in the 29 staff members mentioned above.

144. Record review of staff B revealed she was hired on 08-26-13. Record review revealed Staff B did not have any documentation to show she had the required DNRO training.

145. Record review of Staff D revealed he was hired on 01-08-14. Record review revealed Staff D did not have any documentation to show he had the required DNRO training.

146. Record review of Staff E revealed she was hired on 01-07-14. Record review revealed Staff B did not have any documentation to show she had the required DNRO training.

147. Record review of Staff F revealed she was hired on 11-26-13. Record review revealed Staff F did not have any documentation to show she had the required DNRO training.

148. Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.0191(11), Florida Administrative Code, herein classified as a Class II violation, which warrants an assessed fine of $2,000.00.

SURVEY FEE

Pursuant to Section 429.19(7), Florida Statutes (2013), AHCA may assess a survey fee in the amount of $500.00 to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits.

CLAIM FOR RELIEF

WHEREFORE, the Agency requests the Court to order the following relief:

1. Enter a judgment in favor of the Agency for Health Care Administration against Grand Villa of Delray East on Counts I, II, and III.

2. Assess an administrative fine against Grand Villa of Delray East based on Counts I, II, and III for the violations cited above.

3. Assess a survey fee of $500.00 against Grand Villa of Delray East on Counts I, II, and III for the violations cited above.

4. Assess costs related to the investigation and prosecution of this matter, if the Court finds costs applicable.

5. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2013). Specific options for administrative action are set out in the attached Election of Rights. All requests for hearing shall be made to the Agency for

Health Care Administration, and delivered to the ***Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, MS #3, Tallahassee, Florida 32308.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN TWENTY-ONE (21) DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER

Lourdes A. Naranjo, Esq.
Fla. Bar No.: 997315
Assistant General Counsel
Agency for Health Care Administration
8333 N.W. 53rd Street
Suite 300
Miami, Florida 33166
305-718-5906

Copies furnished to:

Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration
5150 Linton Blvd. – Suite 500
Delray Beach, Florida 33484
(U.S. Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to GV Lauderhill LLC, 13770 58th Street North, Suite 312, Clearwater, Florida 33760 on this 22nd day of May, 2014.

Lourdes A. Naranjo, Esq.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GV Lauderhill LLC d/b/a Grand Villa of Delray East

AHCA No.: 2014003521

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine** or **Administrative Complaint.**

Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fine or Fee, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

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

Signed:_____ **Date:**_____

Print Name:_____ Title:_____

Late fee/fine/AC

2014002452

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RECEIVED
FACILITY INTAKE UNIT
MAR 14 2014
Agency for Health Care Administration

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 13, 2014

Certified Article Number
7196 9008 9111 2625 1362
SENDERS RECORD

Bonnie Williamson
RE: GRAND VILLA OF DELRAY EAST
GV Lauderhill, LLC
13770 58th Street North, Suite 312
Clearwater, Florida 33760

RE: Case Number: 2014002452

NOTICE OF INTENT TO DENY

Dear Administrator,

It is the decision of this Agency that the Grand Villa Of Delray East Change of Ownership Provisional License upgrade to a Standard Assisted Living License be DENIED. The Specific Basis for this determination is due to the applicant's failure to meet minimum licensure requirements pursuant to Sections 408.815 (1)(b)(c)(f) and 429.14 (1)(a)(k). Since being issued a provisional license on 12/31/2012, the facility has had three complaint surveys that have resulted in unsatisfactory outcomes.

On December 17, 2013, Complaint Survey #2013012888 was conducted at the facility and the facility was cited with a class II deficiency regarding Resident Care & Supervision. The facility failed to provide appropriate supervision to meet the needs of the resident and to prevent an elopement which resulted in a death. On 01/27/2014, the revisit for Complaint Survey #2013012888 was conducted and the facility corrected the deficiency.

On January 14, 2014, Complaint Survey #2014000283 was conducted at the facility and the facility was cited with a class II deficiency regarding Resident/Patient/Client Rights and Quality of Care/Treatment. The facility failed to honor resident rights and provide a safe living environment. The facility failed to provide appropriate supervision to meet the needs of its residents again. Incidents of residents missing were reported during the survey visit. On 02/21/2014, the revisit for Complaint Survey #2014000283 was conducted and the facility corrected the deficiency.

On March 7, 2014, Complaint Survey #2014002332 was conducted at the facility and the facility was cited with a class II deficiency regarding Resident Care & Supervision again. The facility failed to provide adequate supervision to meet the needs of a resident which resulted in a death. The revisit for Complaint Survey #2014002332 is pending. The facility has demonstrated and continues to demonstrate deficient practice in the areas of Resident Care & Supervision and have not complied with Florida Statutes, Sections 408.815 (1)(b)(c)(f) and 429.14 (1)(a)(k).

EXPLANATION OF RIGHTS

Pursuant to Section 120.569, Florida Statutes, (F.S.) you have the right to request an administrative hearing. In order to obtain a formal proceeding before the Division of Administrative Hearings under Section 120.57(1), F.S., your request for an administrative hearing must conform to the requirements in Section 28-106.201, Florida Administrative Code (F.A.C), and must state the material facts you dispute.

SEE ATTACHED ELECTION OF RIGHTS FORM

Sincerely,

Susan Kamplain

for Shaddrick A. Haston, Manager
Assisted Living Unit
Bureau of Long Term Care Services

SH/pottere

Copy to: Delray Beach Field Office - 09
LTCOC District 09
Jan Mills, General Counsel Office

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GRAND VILLA OF DELRAY EAST

CASE NUMBER: 20140024S2

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed Notice of Intent to Deny of the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Fine, Administrative Complaint**, or some other notice of intended action by AHCA.

An Election of Rights must be returned by mail or by fax within twenty-one (21) days of the day you receive the attached Notice of Intent to Impose a Fine, Administrative Complaint or any other proposed action by AHCA.

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(Please reply using this Election of Rights form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

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Agency for Health Care Administration
Attention: Agency Clerk
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Tallahassee, Florida 32308
Phone: (850) 412-3630 Fax: (850) 921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS:

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AHCA, and I request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Division of Administrative Hearings.

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2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: Assisted Living Facility License number: 5113

Licensee Name: GRAND VILLA OF DELRAY EAST

Contact person: _____
Name Title

Address: _____
Street and number City Zip Code

Telephone No. _____ Fax No. _____

Email (optional) _____

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

Signed: _____ **Date:** _____

Print Name: _____ Title: _____

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

AHCA No.: 2014001438
Return Receipt Requested: 7009 0080 0000 0586 0346

ADMINISTRATIVE COMPLAINT

COMES NOW State of Florida, Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this administrative complaint against GV Lauderhill LLC d/b/a Grand Villa of Delray East (hereinafter "Grand Villa of Delray East"), pursuant to Chapter 429, Part I, Chapter 408, Part II, and Section 120.60, Florida Statutes (2013), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $5,000.00 pursuant to Sections 429.14 and 429.19, Florida Statutes (2013), for the protection of public health, safety and

welfare, and a survey fee in the amount of $500.00 pursuant to Section 429.19(2)(c) and 429.19(7), Florida Statutes (2013).

JURISDICTION AND VENUE

2. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes (2013), and Chapter 28-106, Florida Administrative Code (2013).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2013).

PARTIES

4. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities pursuant to Chapter 429, Part I, Chapter 408, Part II, Florida Statutes (2013), and Chapter 58A-5 Florida Administrative Code (2013).

5. Grand Villa of Delray East operates a 170-bed assisted living facility located at 14555 Sims Road, Delray Beach, Florida 33484. Grand Villa of Delray East is licensed as an assisted living facility under license number 5113. Grand Villa of Delray East was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I

GRAND VILLA OF DELRAY EAST FAILED TO PROVIDE SUPERVISION TO RESIDENTS WHO WERE DIAGNOSED WITH DEMENTIA.

RULE 58A-5.0182(1), FLORIDA ADMINISTRATIVE CODE

(RESIDENT CARE AND SUPERVISION STANDARDS)

CLASS II VIOLATION

6. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. Grand Villa of Delray East was cited with deficient practice as the result of a complaint investigation survey that was conducted from December 12, 2013 to December 16, 2013.

8. A complaint investigation survey was conducted from December 12, 1013 to December 16, 2013. Based on observation, record review and interview, it was determined that the facility failed to provide supervision to 3 out of 5 sampled residents (Resident #s 1, #2, and #3) who were diagnosed with Dementia. The findings include the following.

9. In an interview with the Director of Nursing (DON) on 12-12-13 at 9:50am, she stated that Resident #1 was determined to have been missing from the facility on 12-9-13 at approximately 9:00pm. She stated that due to the resident's condition, he was placed in the facility's memory care unit (MCU). She stated at this time that on 12-9-13 at around 11:00pm, the law enforcement staff found Resident #1 unconscious

with his body floating inside the western-most lake of the facility property.

10. In an interview with the Administrator on 12-12-13 at 10:25am, she stated that on 12-9-13 at around 8:00pm, Caregiver #1 assisted Resident #1 to bed in his room (#166); Caregiver #1 then went to assist Resident #4 to bed in her room (#170), which is located next to #166. She stated at this time that on 12-9-13 at around 9:00pm, the supervising MCU nurse realized that Resident #1 was not in his room. The supervising MCU nurse mobilized an immediate search within the MCU of the facility, which upon not locating the resident there it turned into a facility-wide search.

11. She stated at this time that upon the supervising MCU nurse not being able to locate Resident #1 in the facility on 12-9-13 at around 9:30pm, the supervising MCU nurse notified her and then they contacted the local authorities to help find the resident. She stated at this time that on 12-9-13 at around 11:00pm, the law enforcement staff found the lifeless body of Resident #1 in the western-most lake of the facility property.

12. Review of Resident #1's record indicated that he was admitted to the facility on 10-30-13 with diagnoses including Dementia. Review of the resident's health assessment dated on 10-29-13 indicated that the resident needed supervision with ambulation (with "redirection" noted) and transferring (without

any comments noted) and he also needed assistance with self-administration of medication.

13. Review of the resident's facility-developed memory support care-level assessment dated on 10-17-13 indicated that he did not need assistance with ambulation or transfers. Further review of the care-level assessment form revealed it had not been signed and dated by the required parties (the responsible party, the community representative and the Executive Director); the designated signature area for each party was left blank.

14. In an interview with the MCU staff nurse on 12-12-13 at 12:05pm, she stated that Resident #1 would regularly walk around the MCU independently and without an assistive device, and he would rarely use his wheelchair to get around.

15. In an interview with the supervising MCU nurse on 12-12-13 at 3:30pm, he stated that he continually saw Resident #1 walking independently without supervision or an assistive device all around the MCU and that on 12-9-13 at 7:30pm, the resident was walking around the MCU. He stated at this time that Resident #1 was well aware that if he holds any of the 4 MCU door bars for over 10 seconds, it will unlock and open. He stated at this time that the exit door next to the MCU nursing station would sometimes not buzz/alarm when forced open and would stay deactivated for some time and that resident #1 would regularly

open this and other coded entry doors in the MCU, without entering any codes or alarms going off.

16. He stated at this time that this would happen every day and that there was no care plan developed in order to mitigate this behavior for Resident #1. He stated at this time that Caregiver #1 reported to him on 12-9-13 at around 8:00pm, that she assisted Resident #1 into his bed. He further stated at around 8:15pm, Caregiver #1 requested his assistance to place Resident #2 in his bed who was in the same room as Resident #1. He stated at this time that although he did not look at Resident #1's side of the dimly lighted room at that time; Caregiver #1 confirmed to him that Resident #1 was in his bed when they assisted Resident #2 into his bed at that time.

17. He stated at this time that on 12-9-13 at around 9:00pm, he performed rounds in the MCU and realized that Resident #1 was not in his bed and he notified the 3 caregivers in the MCU to begin a search for Resident #1 within the MCU. He stated at this time that him and his MCU staff looked all around in the MCU for Resident #1 and could not find him, and that he did not hear any door alarms go off during the evening of 12-9-13. He stated at this time that on 12-9-13 at around 10:00pm, they called 911 to aid in the search of the resident to which law enforcement staff responded to the facility and found the resident's body on 12-9-13 around 11:00pm.

18. In an interview with the supervising MCU nurse on 12-13-13 at 4:15pm, he stated that he verbally notified his former MCU supervisor several times about the malfunctioning doors that would not alarm or reset in the MCU during the past month and that he relied on her to report this malfunction to administration for proper repair. He stated that up to 12-9-13, he had no reason to believe that the MCU security doors were repaired.

19. In an interview with Caregiver #1 on 12-12-13 at 4:00pm, she stated that Resident #1 used to always walk around the MCU independently, without any assistive device and that on 12-9-13 shortly before 8:00pm, he was indeed walking around the unit and she assisted him to his bed. She stated at this time that shortly after 8:00pm, she helped Resident #1's roommate, Resident #2 into his bed and she remembers that Resident #1 was in his own bed at that time. She stated at this time that a short time thereafter, she was emptying the residents 'garbage around the MCU activity area and she saw Resident #1 and #2 walking together in the memory care unit (MCU) hallway and then saw them go into their room together, and that this was not uncommon because both of these residents were avid walkers and would walk around the whole MCU. She stated at this time that around 8:45pm, she went on break outside of the MCU and into the main facility employee break room. She stated at this time that

shortly thereafter, the supervising MCU nurse called her to notify her that resident #1 was not in his room and to assist him with a search of resident #1 in the MCU. She stated at this time that resident #1 was not found until after the law enforcement staff arrived to the facility and found resident #1's body in the lake.

20. In an interview with the Administrator on 12-12-13 at 12:20pm, she stated that based on the facility's investigation on the events surrounding Resident #1's elopement on 12-9-13, she could determine with moderate level of certainty that the resident left the locked MCU around 8:00pm, most likely following an employee out of the coded south door, which leads to the general facility hallway.

21. In an observation on 12-12-13 from 3:00pm to 3:15pm in the MCU, Resident #2 was walking independently with a rolling walker, in and out of the MCU dining room into the hallway and back into the dining room and he then went inside the MCU kitchen. It was observed at this time that no persons or staff members were present in aforementioned areas to supervise or assist Resident #2.

22. In an attempt to interview Resident #2 on 12-12-13 at 3:10pm, it was not possible because the resident presented to be alert and considerably confused. In an observation on 12-12-13 at 3:15pm, the Activity Director was notified that Resident #2

was inside the MCU kitchen and she immediately went to his side to assist him outside the kitchen and into the MCU activity area where other residents and staff members were present.

23. In an interview with the Activity Director on 12-12-13 at 3:15, she stated that Resident #2 is one of a few residents in the MCU which likes to walk all over the place, wanders and although he does not actively seek exit from the MCU, he would occasionally attempt to walk outside the MCU if a door was opened. She stated at this time that Resident #3 is another current resident who walks around independently. She stated Resident #1 used to also walk independently throughout the MCU and he would exhibit wandering and exit-seeking behaviors and Resident #1 would set off door alarms on a daily basis.

24. Review of Resident #2's record indicated that he was admitted to the facility on 11-26-13 with diagnoses including Dementia, Hypertension and Coronary Artery Disease. Review of his health assessment dated on 11-26-13 indicated that the resident needed assistance with ambulation (with "assistive device" noted) and transferring (with "for safety" noted) and needed medication administration. Review of the resident's facility-developed memory support care-level assessment dated on 11-6-13 indicated that he did not need assistance with ambulation or transfers.

25. Further review of the care-level assessment form revealed it had not be signed and dated by all 3 required parties (the responsible party, the community representative, and the Executive Director); the designated signature area for the responsible party and the Executive Director was left blank.

26. Review of the facility elopement drills dated on 4-3-13, 7-18-13, and 10-24-13 indicated that the supervising MCU nurse participated in this training on 7-18-13 and caregivers #1, #2, and #3 did not participate in any of these elopement drills or trainings.

27. In an interview with the Administrator on 12-13-13 at 9:45am, she stated that she was aware that all the 4 ingress/egress doors in the MCU do unlock/open after holding their bars for an extended period to comply with fire codes and that they make a loud buzzing/alarming noise when opened. She stated at this time that she was not aware that any of these doors were not functioning correctly.

28. In an interview with Caregiver #2 on 12-13-13 at 10:30am, she stated that she knew Resident #1 well, she was working in the MCU on 12-9-13 and she last saw the resident in his room on 12-9-13 at approximately 8:00pm. She stated at this time that she did not hear any of the door alarms go off on the evening of 12-9-13, but she was aware that the ingress/egress door located next to the MCU nursing station had been

malfunctioning for about one month because it would sometimes not buzz or alarm when opened. She stated that she has mentioned this to her supervisor, the former MCU supervisor, but nothing had been done about it because the door was not fixed.

29. In an interview with the Administrator on 12-13-13 at 12:50pm, she stated that the facility has not yet examined the individual resident behaviors in the MCU to reduce the risk of elopements. She also stated at this time that the security door contractor was called on 12-10-13 to review the door security systems in the MCU so they can adjust the timing parameters in the doors, because the doors used to stay unlocked/open for a few more seconds after coded ingress/egress.

30. In an interview with the DON and the Administrator on 12-13-13 at 1:30pm, they both stated that they have not been informed or were aware of any of the MCU security doors to have been malfunctioning during the past 3 months.

31. In an interview with the Administrator on 12-16-13 at 10:05am, she stated that the facility's nurse performs a move-in/care-level assessment on every resident in the facility and every direct care staff member uses this assessment as the basis of the individual care extended to each resident. In an interview with the DON on 12-16-13 at 12:00pm, she confirmed that the MCU and general facility residents receive an initial

care-level assessment that is used as a care plan by the direct care staff.

32. In an observation on 12-16-13 at 11:00am, Resident #3 was walking independently without an assistive device in the MCU main hallway; he then went towards the MCU lobby's front door and attempted to open the door by pressing on the bar for approximately 5 seconds and the door sounded a barely-audible alarm to which the MCU staff nurse responded to and redirected the resident to the activity area.

33. Review of Resident #3's record indicated that he was admitted to the facility on 11-26-13 with diagnoses including Dementia, Alzheimer's disease and Hypertension. Review of his health assessment dated on 6-20-13 indicated that the resident needed assistance with ambulation (with "unaware of unsafe areas" noted) and supervision with transferring (with no comments noted) and needed assistance with self-administration of medication.

34. Review of the resident's move-in assessment dated on 8-6-13 indicated that he was not oriented to his surroundings or daily routine, and it was noted that he is a wanderer.

35. In an interview with former MCU supervisor on 12-16-13 at 12:25pm, she stated that she did not experience any malfunction with the MCU security doors, nor was she notified of any malfunction of the MCU doors by the staff. She stated at

this time that she understood every MCU resident to be an elopement risk and the facility did not perform any specific resident elopement assessments.

36. The facility failure to provide supervision appropriate to 3 residents that suffered from Dementia directly affected the safety and well-being of the residents (Resident #1, #2, and #3). The facility also failed to adequately assess each resident upon admission to ensure appropriate supervision.

37. Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.0182(1), Florida Administrative Code, herein classified as a Class II violation, which warrants an assessed fine of $5,000.00.

SURVEY FEE

Pursuant to Section 429.19(7), Florida Statutes (2013), AHCA may assess a survey fee in the amount of $500.00 to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits.

CLAIM FOR RELIEF

WHEREFORE, the Agency requests the Court to order the following relief:

1. Enter a judgment in favor of the Agency for Health Care Administration against Grand Villa of Delray East on Count I.

2. Assess an administrative fine against Grand Villa of Delray East based on Count I for the violation cited above.

3. Assess a survey fee of $500.00 against Grand Villa of Delray East on Counts I and II for the violations cited above.

4. Assess costs related to the investigation and prosecution of this matter, if the Court finds costs applicable.

5. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2013). Specific options for administrative action are set out in the attached Election of Rights. All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to the ***Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, MS #3, Tallahassee, Florida 32308.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN TWENTY-ONE (21) DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER

Lourdes A. Naranjo, Esq.
Fla. Bar No.: 997315
Assistant General Counsel
Agency for Health Care Administration
8333 N.W. 53rd Street
Suite 300
Miami, Florida 33166

Copies furnished to:

Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration
5150 Linton Blvd. - Suite 500
Delray Beach, Florida 33484
(U.S. Mail)

CERTIFICATE OF SERVICE

I **HEREBY CERTIFY** that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to Judi Christiano, Administrator, Grand Villa of Delray East, 14555 Sims Road, Delray Beach, Florida 33484 on this 24th day of March, 2014.

Lourdes A. Naranjo, Esq.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GV Lauderhill, LLC d/b/a Grand Villa of Delray East **AHCA No.: 2014001438**

ELECTION OF RIGHTS

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Phone: 850-412-3630 Fax: 850-921-0158.

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OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fine or Fee, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

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

Signed: **Date:**_____

Print Name:_____ Title:_____

Late fee/fine/AC

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No.: 2014001642
Return Receipt Requested: 7009 0080 0000 0586 0469

GV LAUDERHILL, LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW State of Florida, Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this administrative complaint against GV Lauderhill, LLC d/b/a Grand Villa of Delray East (hereinafter "Grand Villa of Delray East"), pursuant to Chapter 429, Part I, Chapter 408, Part II, and Section 120.60, Florida Statutes (2013), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $1,250.00 pursuant to Sections 429.14 and 429.19, Florida Statutes (2013), for the protection of public health, safety and welfare.

JURISDICTION AND VENUE

2. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes (2013), and Chapter 28-106, Florida Administrative Code (2013).

3. Venue lies pursuant to Rule 28-106.207, Florida Administrative Code (2013).

PARTIES

4. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities pursuant to Chapter 429, Part I, Chapter 408, Part II, Florida Statutes (2013), and Chapter 58A-5 Florida Administrative Code (2013).

5. Grand Villa of Delray East operates a 170-bed assisted living facility located at 1455 Sims Road, Delray Beach, Florida 33484. Grand Villa of Delray East is licensed as an assisted living facility under license number 5113. Grand Villa of Delray East was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I

GRAND VILLA OF DELRAY EAST FAILED TO ENSURE THAT CERTIFICATES WERE COMPLETED WITH ALL REQUIRED COMPONENTS FOR IN-SERVICE TRAINING FOR STAFF.

RULE 58A-5.0191(12), FLORIDA ADMINISTRATIVE CODE

(DOCUMENTATION & MONITORING STANDARDS)

CLASS III VIOLATION

6. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

7. Grand Villa of Delray East was cited deficient practice as the result of Change of Ownership (CHOW) with ECC (extended congregate care) surveys that were conducted on September 17, 2013 and November 27, 2013.

8. A Change of Ownership (CHOW) with ECC (extended congregate care) survey was conducted on September 17, 2013. Based on record review and an interview, it was determined that the facility failed to ensure certificates were completed with all required components for in-service training for one of 3 sampled staff (Staff C). The findings include the following.

9. On 9/16/13 at 10:40 AM, the personnel file for Staff C was reviewed and a list of in-service trainings with one person's signature at the top of the first page was presented by the Administrator and resident care supervisor in response to a request for the staff member's training. Staff C was hired on 5/11/12 and the list was dated 3/27/13.

10. Upon further review, it was revealed the business office manager had signed the training list (she is not CORE trained). Therefore, the following in-services did not have certificates with all of the required components, specifically a qualified trainer's credentials:

a) DNRO (do not resuscitate order) policy and procedure.

b) elopement policy and procedure.

c) emergency preparedness and evacuation training and incident reporting.

d) resident rights and reporting abuse, neglect and exploitation.

e) infection control.

11. These findings were acknowledged by the Administrator again during interview at 3 PM on 9/17/13.

12. A revisit Change of Ownership (CHOW) with ECC (extended congregate care) survey was conducted on November 27, 2013. Based on record review and interview, it was determined that the facility failed to ensure certificates were completed with all required components for in-service training, for 3 of 3 sampled employee files reviewed (Employees A, B & C). The findings include the following.

13. During interview with the ED (Executive Director), conducted on 11/27/2013 beginning at 8:30 AM, she acknowledged

that this facility did not issue training certificates for employees. She stated they only document attendance of employee trainings on a sign-in sheet for attendance of staff in-services. The requirement that all employees are to be issued training certificates with the required components was reviewed at this time (specifically related to credentials of trainer and number of hours of each training).

14. The ED stated it was not the policy and procedure of this company to issue individual training certificates for employees and that she would review this area of concern with corporate. This facility's current training manual with DVDs and a grid noting the various trainings that are required was reviewed with the ED. This manual contained blank individual training certificates to be utilized upon completion of each required employee training. The Administrator acknowledged that this facility does not currently utilize these certificates.

15. The following employees did not have certificates of training that contained all of the required components for the following staff in-service trainings that are to be conducted within 30 days of hire.

16. Employee A - (Resident Care Assistant with a date of hire noted as 03/01/2010):

a) DNRO (Do Not Resuscitate Order) policy & procedure.

b) Elopement policy & procedure.

c) Emergency Preparedness and Evacuation training and Incident Reporting.

d) Resident Rights and Reporting Abuse, Neglect and Exploitation.

e) Infection Control.

17. Employee B - (Resident Care Assistant with a date of hire noted as 06/08/2011):

a. DNRO (Do Not Resuscitate Order) policy & procedure.

b) Elopement policy & procedure.

c) Emergency Preparedness and Evacuation training and Incident Reporting.

d) Resident Rights and Reporting Abuse, Neglect and Exploitation.

e) Infection Control.

18. Employee C - (Resident Care Assistant with a date of hire noted as 05/10/2012):

a) DNRO (Do Not Resuscitate Order) policy & procedure.

b) Elopement policy & procedure.

c) Emergency Preparedness and Evacuation training and Incident Reporting.

d) Resident Rights and Reporting Abuse, Neglect and Exploitation.

e) Infection Control.

19. This is an uncorrected deficiency from the survey of September 17, 2014.

20 Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.0191(12), Florida Administrative Code, herein classified as an uncorrected Class III violation, which warrants an assessed fine of $500.00.

COUNT II

GRAND VILLA OF DELRAY EAST FAILED TO (1) ENSURE A NURSE WAS EITHER STAFFED OR CONTRACTED TO PROVIDE ECC (EXTENDED CONGREGATE CARE) AS NEEDED FOR RESIDENTS; (2) FAILED TO IDENTIFY AN ECC SUPERVISOR RESPONSIBLE FOR THE PROVISION OF ECC SERVICES IF NEEDED; (3) FAILED TO ENSURE AND DOCUMENT THAT DIRECT CARE STAFF AND THE ECC SUPERVISOR RECEIVED TRAINING AS REQUIRED.

RULE 58A-5.030(4), FLORIDA ADMINISTRATIVE CODE

(STAFFING REQUIREMENT STANDARDS)

CLASS III VIOLATION

21. AHCA re-alleges and incorporates paragraphs (1) through (5) as if fully set forth herein.

22. A Change of Ownership (CHOW) with ECC (extended congregate care) survey was conducted on September 17, 2013. Based on an interview and record review, it was determined that the facility failed to: 1) ensure a nurse was either staffed or

contracted to provide ECC (extended congregate care) as needed for residents; 2) failed to identify an ECC supervisor responsible for the provision of ECC services if needed; 3) failed to ensure and document that direct care staff and the ECC supervisor received training as required. The findings include the following.

23. On 9/16/13 at 1 PM, the Administrator was interviewed and stated she did not know if the corporate office was going to continue renewing the ECC license the facility currently has, so there was no ECC supervisor or nurse identified and no residents requiring ECC services.

24. Review of employee records indicated no ECC training was being conducted for direct care staff. However, during review of residents with the memory support supervisor (nurse) and the resident care supervisor (nurse), it was revealed there were 3 residents who were not able to ambulate which would require them to be put on ECC services. Under ECC guidelines, residents who are able to transfer with assistance can remain at the facility if they have a service plan and nursing assessments. Therefore the 3 residents identified should have been placed under the facility's current ECC license.

25. The administrator again acknowledged on 9/17/13 at 3 PM that the facility was not sure whether they were going to

continue holding and utilizing an ECC specialty license which would allow these residents to remain at the facility.

26. A Change of Ownership (CHOW) with ECC (extended congregate care) survey was conducted on November 27, 2013. Based on record review and interview, it was determined the facility did not maintain documentation of ECC (Extended Congregate Care) training for 3 of 3 employee records reviewed (Employees A, B & C). The findings include the following.

27. During interview with the ED (Executive Director), conducted on 11/27/2013 beginning at 8:30 AM, she acknowledged that this facility did not issue training certificates for employees related to ECC training. She stated they only document attendance of employee trainings. The requirement that all employees are to be issued training certificates with the required components was reviewed at this time.

28. The ED stated it was not the policy and procedure of this company to issue individual training certificates for employees and that she would review this area of concern with corporate. This facility's training manual with DVDs and a grid noting the various trainings that are required was reviewed. This manual contained blank individual training certificates to be utilized upon completion of each required employee training. The Administrator acknowledged that this facility does not utilize these certificates. The Administrator also acknowledged

that there was no documentation (including sign-in sheets) that reflected the following employees had received ECC training:

a) Employee A - Resident Care Assistant (date of hire noted as 03/01/2010).

b) Employee B - Resident Care Assistant (date of hire noted as 06/08/2011).

c) Employee C - Resident Care Assistant (date of hire noted as 05/01/2012).

29. This is an uncorrected deficiency from the survey of September 17, 2013.

30. Based on the foregoing facts, Grand Villa of Delray East violated Rule 58A-5.030(4), Florida Administrative Code, herein classified as an uncorrected Class III violation, which warrants an assessed fine of $750.00.

CLAIM FOR RELIEF

WHEREFORE, the Agency requests the Court to order the following relief:

1. Enter a judgment in favor of the Agency for Health Care Administration against Grand Villa of Delray East on Counts I and II.

2. Assess an administrative fine against Grand Villa of Delray East based on Counts I and II for the violations cited above.

3. Assess costs related to the investigation and prosecution of this matter, if the Court finds costs applicable.

4. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2013). Specific options for administrative action are set out in the attached Election of Rights. All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to the ***Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, MS #3, Tallahassee, Florida 32308.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN TWENTY-ONE (21) DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER

Lourdes A. Naranjo, Esq.
Fla. Bar No.: 997315
Assistant General Counsel
Agency for Health Care Administration
8333 N.W. 53rd Street
Suite 300
Miami, Florida 33166
305-718-5911

Copies furnished to:

Arlene Mayo-Davis
Field Office Manager
Agency for Health Care Administration
5150 Linton Blvd. - Suite 500
Delray Beach, Florida 33484
(U.S. Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to Judi Christiano, Administrator, Grand Villa of Delray East, 14555 Sims Road, Delray Beach, Florida 33484 on this 16th day of April, 2014.

Lourdes A. Naranjo, Esq.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GV Lauderhill, LLC **AHCA No.: 2014001642**
d/b/a Grand Villa of Delray East

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine** or **Administrative Complaint.**

Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fine or Fee, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, the Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

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

Signed:_____Date:_____

Print Name:_____ Title:_____

Late fee/fine/AC

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.

_____/

AHCA No.: 2015000694
Return Receipt Requested:
7002 2410 0001 4240 1936

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration ("AHCA"), by and through the undersigned counsel, and files this Administrative Complaint against GV Lauderhill, LLC d/b/a Grand Villa of Delray East (hereinafter "Grand Villa of Delray East"), pursuant to Chapter 429, Part I, and Section 120.60, Florida Statutes, (2014), and alleges:

NATURE OF THE ACTION

1. This is an action to impose an administrative fine of $10,000.00 pursuant to Sections 429.14, and 429.19, 408.809(1)(e), and 429.174, Florida Statutes (2014), for the protection of the public health, safety and welfare.

2. As a result of unannounced complaint surveys conducted from 01/05/2015 through 01/09/2015, the Agency entered an Immediate Moratorium on Admissions on 01/09/2015, because the Agency found that the current conditions at the assisted living facility presented a direct and immediate threat to the health, safety or welfare of the residents and warranted the imposition of an immediate moratorium on admissions.

JURISDICTION AND VENUE

3. This Court has jurisdiction pursuant to Sections 120.569 and 120.57, Florida Statutes, and 28-106, Florida Administrative Code.

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

PARTIES

5. AHCA is the regulatory authority responsible for licensure and enforcement of all applicable statutes and rules governing assisted living facilities, pursuant to Chapter 429, Part I, Florida Statutes (2014), and Chapter 58A-5, Florida Administrative Code.

6. Grand Villa of Delray East operates a 170-bed assisted living facility located at 14555 Sims Road, Delray Beach, Florida 33484. Grand Villa of Delray East is licensed as an assisted living facility license number ALF 5113. Grand Villa of Delray East was at all times material hereto a licensed facility under the licensing authority of AHCA and was required to comply with all applicable rules and statutes.

COUNT I (Tag 0010)

GRAND VILLA OF DELRAY EAST FAILED TO MONITOR THE CONTINUED APPROPRIATENESS OF PLACEMENT FOR ONE RESIDENT
Rule 58A-5.0181(4), Florida Administrative Code
(ADMISSIONS-CONTINUED RESIDENCY)

CLASS II VIOLATION

7. AHCA re-alleges and incorporates paragraphs (1) through (6) as if fully set forth herein.

8. During an unannounced licensure complaint surveys, conducted from 01/05/2015 through 01/09/2015, and based on record review, observation and interview, it was determined that the facility failed to monitor the continued appropriateness of placement, for 1 out of 8 residents that resides in the facility (resident #22) .

9. As a result of these surveys, an Immediate Moratorium on Admissions was placed on Grand Villa of Delray East, LLC [AHCA No. 2015000277] on 01/09/2015.

10. In an interview with resident #22 on 01/05/2015 at 2:25pm, she stated that she had lived in the facility since May 2014 and she had substantial physical limitations due to a fused right knee and generalized weakness. She stated that her physical limitations made her move very slowly and she was used to perform her activities of daily living (ADLs) on her own, since it was difficult to engage the facility staff to supervise or observe her while performing her ADLs. She stated that she gave up attempting to call on the staff to assist her because it became too burdensome on them. She stated that she walked/ambulated, transferred, went to the toilet and dressed independently, without staff oversight and that about 3 weeks ago, she fell while attempting to transfer and ambulate to reach for her glasses on the counter inside her room. She stated that she injured her face when she fell and had to go to the hospital. She stated that at another previous time, she cut her left leg on a drawer in her bedroom while she tried to dress herself. In an observation on 01/05/2015 at 2:30pm, the resident attempted to transfer from sitting in a stationary chair to standing and to reach for her rolling walker, but she was not able to safely stand up due to her fused right knee, which made her substantially unstable and she had to immediately sit back down in the stationary chair. The resident presented to be alert and oriented without any signs of confusion at this time.

11. Review of resident #22's record indicated that she was admitted to the facility on 5/09/2014 with diagnoses including deep vein thrombosis, hypertension, arthritis and depression. Review of the resident's health assessment dated on 5/09/2014 indicated that she required physical and occupational therapy services and needed monitoring for safety precautions. Review of the resident's health assessment dated on 8/11/2014 indicated that she required physical and

occupational therapy (PT and OT) and skilled nursing services and needed "monitoring for safety" precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, grooming, toileting and transferring. Review of the resident's Medicaid assistive care services medical necessity evaluation dated on 8/11/2014 indicated that the resident needed individual assistance with her ADLs, including ambulation, transferring, grooming, toileting and dressing.

12. Review of resident #22's facility condition log dated on 8/29/2014 indicated that she fell in her room at 7:10 pm she was bleeding from her arm and leg, and was transported to the hospital for further evaluation. The resident's condition log dated on 10/22/2014 indicated that the resident suffered a skin tear on her hand at 6:30pm while she attempted to stop the elevator door from closing, while ambulating without direct supervision and her injury was treated in the facility. The resident's condition log dated on 10/27/2014 indicated that the resident was found on the floor next to her bed by a staff member and suffered no apparent injury. This note indicated that the resident attempted to undress without direct supervision and slipped on the floor. The resident's condition log dated on 12/14/2014 indicated that she was found on the floor in her room at 9:45 pm she was lying on her back bleeding from her face, and was transported to the hospital for further evaluation. This note indicated that the resident attempted to reach for her glasses before she slipped and fell on the floor. Review of the resident's assignment log dated on 01/02/2015 indicated that the resident needed a level of care that did not include direct staff supervision or observation with her ADLs including ambulation, dressing, grooming and transferring. Further review of the resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's safety risk or increased resident monitoring.

13. In an interview with the resident care supervisor (RCS) on 01/06/2015 at 1:45 pm, she stated that she understood that resident #22 was mostly independent with her ADLs, including ambulation, dressing and transferring, without any need for direct staff supervision. She stated on 01/06/2015 at 4:30 pm that the facility did not implement any demonstrable interventions to reduce or prevent future accidents or falls for the resident after her hospitalizations on 8/29/2014 and 12/14/2014. She stated that the resident was evaluated and treated by PT through the home health agency (HHA) and that she was not aware if the resident received OT services as requested by the physicians on her health assessments dated on 5/09/2014 and 8/11/2014. She stated that besides the HHA staff reassessment log dated from 12/30/2014 to 01/05/2015, the facility did not have further documentation of the specific PT services extended to the resident and she did not describe further resident care extended by the facility.

14. In an interview with the caregiver on 01/06/2015 at 3:50 pm, she stated that she responded to resident #22's fall on 12/14/2014 immediately after she was called on by another caregiver at about 9:30 pm. She stated that the resident was found on the floor in her room and the resident was lying on her back with her nose and head bleeding, and the rolling walker was toppled over resting on or by the resident's head. She stated that the resident described that she was trying to reach for something and was not being supervised by anyone before she fell. She stated that she understood the resident to be independent with her ADLs, not needing direct supervision, including toileting, transferring and ambulation. She did not explain how she engaged the resident to call for facility staff assistance or how she would anticipate the resident's needs.

15. In an interview with resident #22's physician on 01/08/2015, at 2:15 pm, he stated that the resident initially needed assistance with her ADLs in May and June 2014 due to her fused right knee and her previous bilateral hip replacements. He stated that the resident had an extensive

medical history, including surgeries like a total knee replacement and bilateral hip replacements, osteomyelitis and severe arthritis, which further complicated her pathological functional status. He stated that he relied on the PT services to further assess the resident's functional status and he initially ordered for the patient to receive PT services on 6/30/2014, but did not readily have any PT or OT services information to ascertain the resident's complete functional status. He stated that this resident's case was of a "very debilitated woman who was significantly infirmed" and he was not aware of the specific safety precautions the facility established for the resident because he did not have anything documented representing that the facility provided him with such information.

16. In an interview with resident #22's physical therapist assistant and home health agency (HHA) administrator on 01/07/2015 at 4:00pm, they stated that their HHA was responsible to deliver PT services for resident #22 and the resident was initially evaluated on 8/07/2014 from orders of the physician for abnormal gait , generalized muscle weakness and functional decline. They stated that the resident initially ambulated less than 25 feet with minimal assistance using a rolling walker (RW), needed set-up assistance with grooming, assistance with dressing to maintain her safety, minimal assistance with bathing and contact guard assistance for transfers. They stated that the resident participated in 10 PT sessions and that on 9/03/2014 she requested to stop PT services because she believed she no longer needed it. They stated that the PT evaluations and treatments were continually communicated to the facility nurses at the facility and the facility was given the PT services written reports, as attached. They stated that the resident had been instructed by PT services to use call bell system and to properly use her RW. They stated that on 9/03/2014, the resident's PT evaluation indicated that she ambulated 80 feet with contact guard assistance and that the physical therapist did not recommend the resident to use a cane for ambulation. They stated that the physician ordered PT services once again on 12/29/2014 due to the resident's 2

recent falls the latter part of December 2014. They stated that on the PT evaluation on 12/30/2014, the resident was capable of ambulating 25 feet, 2 times with standby assistance using the RW and needed contact guard assistance for transfers, toileting and showers. They stated that the resident had no functional range of motion on her right knee due to a fusion and believed that she was currently in a slow progression to standby assistance/supervision with ambulation and transfer to maintain her safety. They stated that they are not aware of the facility's specific efforts to supervise the resident with her ADLs or personal care and that the facility had not discussed in totality with the HHA staff the resident's recent injuries or falls. In an interview with the HHA administrator on 01/09/2015 at 9:45 am, she stated that the HHA staff conducted resident case conferences with the facility staff, including the RCS, approximately 3 to 4 times per month and shared daily reports as needed. She stated that the written reports are handed to the facility nursing staff and the facility administrator requested the HHA to help develop a facility generalized resident safety program about a month ago, but this was not followed up on by the facility. She stated that the HHA had not received any physician order from the facility to provide OT services to the resident.

17. Review of resident #22's hospital emergency department (ED) record dated on 8/29/2014 indicated that she arrived to the hospital by emergency transportation due to injuries from a fall while ambulating in the facility. This record indicated that the hospital instituted fall prevention measures for the resident and she sustained skin tears to her right forearm and knee. Further review of this record indicated that her symptoms were moderate and she was prescribed pain medications and wound care, and was discharged from the hospital ED back to the facility. Review of the hospital ED record dated on 12/14/2014 indicated that she arrived to the hospital by emergency transportation due to injuries from a fall while standing over her RW in the facility.

This record indicated that the hospital instituted fall prevention measures for the resident and she sustained face, neck and scalp abrasions, closed head injury and cervical sprain. Further review of this record indicated that the resident had swelling and tenderness to her neck area, she was prescribed wound care and diagnostic imaging to rule out fractures, and was discharged from the hospital ED back to the facility.

18. In an interview with the regional operations manager on 01/05/2015 at 2:05 pm she stated that the facility performed investigations on the fall events of resident #22, but it is not at liberty to share those investigations with the Agency, and that she was not aware of any reassessment resident #22 needed for the facility to reconsider her continued residency.

19. Based on the foregoing, Grand Villa of Delray East violated Rule 58A-5.0181(4), Florida Administrative Code, a Class II deficiency that carries, in this case, an assessed fine of $5,000.00.

COUNT II (Tag 0025)

GRAND VILLA OF DELRAY EAST FAILED TO ADEQUATELY PROVIDE CARE AND SERVICES TO MEET THE NEEDS OF RESIDENTS BY NOT PROVIDING THEIR ASSESSED ACTIVITIES OF DAILY LIVING (ADLS) SUPERVISION
Rule 58A-5.0182(1), Florida Administrative Code
(RESIDENT CARE-SUPERVISION)

CLASS II DEFICIENCY

20. AHCA re-alleges and incorporates paragraphs (1) through (6) as if fully set forth herein.

21. During an unannounced licensure complaint surveys, conducted from 01/05/2015 through 01/09/2015, and based on record review, observation and interview, it was determined that the facility failed to adequately provide care and services to meet the needs of 6 out of 8 at-risk

residents (resident #s 20, 21, 22, 23, 24 and 25) by not providing their assessed activities of daily living (ADLs) supervision and specialized safety precaution requirements.

22. In an interview with resident #22 on 01/05/2015 at 2:25pm, she stated that she had lived in the facility since May 2014 and she had substantial physical limitations due to a fused right knee and generalized weakness. She stated that her physical limitations made her move very slowly and she was used to performing her ADLs on her own, since it was difficult to engage the facility staff to supervise or observe her while performing her ADLs. She stated that she gave up attempting to call on the staff to assist her because it became too burdensome on them. She stated that she walked/ambulated, transferred, went to the toilet and dressed independently, without staff oversight and that about 3 weeks ago, she fell while attempting to transfer and ambulate to reach for her glasses on the counter inside her room. She stated that she injured her face when she fell and had to go to the hospital. She stated that at another previous time, she cut her left leg on a drawer in her bedroom while she tried to dress herself. In an observation on 01/05/2015 at 2:30pm, the resident attempted to transfer from sitting in a stationary chair to standing and to reach for her rolling walker, but she was not able to safely stand up due to her fused right knee, which made her substantially unstable and she had to immediately sit back down in the stationary chair. The resident presented to be alert and oriented without any signs of confusion at this time.

23. Review of resident #22's record indicated that she was admitted to the facility on 5/09/2014 with diagnoses including deep vein thrombosis, hypertension, arthritis and depression. Review of the resident's health assessment dated on 5/09/2014 indicated that she required physical and occupational therapy services and needed monitoring for safety precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, grooming, toileting and transferring. Review of the resident's health assessment dated on 8/11/2014 indicated

that she required physical and occupational therapy (PT and OT) and skilled nursing services and needed "monitoring for safety" precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, grooming, toileting and transferring. Review of the resident's Medicaid assistive care services medical necessity evaluation dated on 8/11/2014 indicated that the resident needed individual assistance with her ADLs, including ambulation, transferring, grooming, toileting and dressing.

24. Review of resident #22's facility condition log dated on 8/29/2014 indicated that she fell in her room at 7:10pm she was bleeding from her arm and leg, and was transported to the hospital for further evaluation. The resident's condition log dated on 10/22/2014 indicated that the resident suffered a skin tear on her hand at 6:30pm while she attempted to stop the elevator door from closing, while ambulating without direct supervision and her injury was treated in the facility. The resident's condition log dated on 10/27/2014 indicated that the resident was found on the floor next to her bed by a staff member and suffered no apparent injury. This note indicated that the resident attempted to undress without direct supervision and slipped on the floor. The resident's condition log dated on 12/14/2014 indicated that she was found on the floor in her room at 9:45pm she was lying on her back bleeding from her face, and was transported to the hospital for further evaluation. This note indicated that the resident attempted to reach for her glasses before she slipped and fell on the floor. Review of the resident's assignment log dated on 01/02/2015 indicated that the resident needed a level of care that did not include direct staff supervision or observation with her ADLs including ambulation, dressing, grooming and transferring. Further review of the resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's safety risk or increased resident monitoring.

25. In an interview with the resident care supervisor (RCS) on 01/6/2015 at 1:45pm, she stated that she understood that resident #22 was mostly independent with her ADLs, including ambulation, dressing and transferring, without any need for direct staff supervision. She stated on 01/06/2015 at 4:30pm that the facility did not implement any demonstrable interventions to reduce or prevent future accidents or falls for the resident after her hospitalizations on 8/29/2014 and 12/14/2014. She stated that the resident was evaluated and treated by PT through the home health agency (HHA) and that she was not aware if the resident received OT services as requested by the physicians on her health assessments dated on 5/09/2014 and 8/11/2014. She stated that besides the HHA staff reassessment log dated from 12/30/2014 to 01/05/2015, the facility did not have further documentation of the specific PT services extended to the resident and she did not describe further resident care extended by the facility.

26. In an interview with the caregiver on 01/06/2015 at 3:50pm, she stated that she responded to resident #22's fall on 12/14/2014 immediately after she was called on by another caregiver at about 9:30pm. She stated that the resident was found on the floor in her room and the resident was lying on her back with her nose and head bleeding, and the rolling walker was toppled over resting on or by the resident's head. She stated that the resident described that she was trying to reach for something and was not being supervised by anyone before she fell. She stated that she understood the resident to be independent with her ADLs, not needing direct supervision, including toileting, transferring and ambulation. She did not explain how she engaged the resident to call for facility staff assistance or how she would anticipate the resident's needs.

27. In an interview with resident #22's physician on 01/08/2015 at 2:15pm he stated that the resident initially needed assistance with her ADLs in May and June 2014 due to her fused right knee and her previous bilateral hip replacements. He stated that the resident had an extensive

medical history, including surgeries like a total knee replacement and bilateral hip replacements, osteomyelitis and severe arthritis, which further complicated her pathological functional status. He stated that he relied on the PT services to further assess the resident's functional status and he initially ordered for the patient to receive PT services on 6-30-14, but did not readily have any PT or OT services information to ascertain the resident's complete functional status. He stated that this resident's case was of a "very debilitated woman who was significantly infirmed" and he was not aware of the specific safety precautions the facility established for the resident because he did not have anything documented representing that the facility provided him with such information.

28. In an interview with resident #22's physical therapist assistant and home health agency (HHA) administrator on 01/07/2015 at 4:00pm, they stated that their HHA was responsible to deliver PT services for resident #22 and the resident was initially evaluated on 8/07/2014 from orders of the physician for abnormal gait , generalized muscle weakness and functional decline. They stated that the resident initially ambulated less than 25 feet with minimal assistance using a rolling walker (RW), needed set-up assistance with grooming, assistance with dressing to maintain her safety, minimal assistance with bathing and contact guard assistance for transfers. They stated that the resident participated in 10 PT sessions and that on 9/03/2014 she requested to stop PT services because she believed she no longer needed it. They stated that the PT evaluations and treatments were continually communicated to the facility nurses at the facility and the facility was given the PT services written reports, as attached. They stated that the resident had been instructed by PT services to use call bell system and to properly use her rolling walker They stated that on 9/03/2014, the resident's PT evaluation indicated that she ambulated 80 feet with contact guard assistance and that the physical therapist did not recommend the resident to use a cane for ambulation. They stated that the physician ordered PT services once again on 12/29/2014 due to

the resident's 2 recent falls the latter part of December 2014. They stated that on the PT evaluation on 12/30/2014, the resident was capable of ambulating 25 feet, 2 times with standby assistance using the rolling walker and needed contact guard assistance for transfers, toileting and showers. They stated that the resident had no functional range of motion on her right knee due to a fusion and believed that she was currently in a slow progression to standby assistance/supervision with ambulation and transfer to maintain her safety. They stated that they are not aware of the facility's specific efforts to supervise the resident with her ADLs or personal care and that the facility had not discussed in totality with the HHA staff the resident's recent injuries or falls. In an interview with the HHA administrator on 01/09/2015 at 9:45am, she stated that the HHA staff conducted resident case conferences with the facility staff, including the RCS, approximately 3 to 4 times per month and shared daily reports as needed. She stated that the written reports are handed to the facility nursing staff and the facility administrator requested the HHA to help develop a facility generalized resident safety program about a month ago, but this was not followed up on by the facility. She stated that the HHA had not received any physician order from the facility to provide OT services to the resident.

29. Review of resident #22's hospital emergency department (ED) record dated on 8/29/2014 indicated that she arrived to the hospital by emergency transportation due to injuries from a fall while ambulating in the facility. This record indicated that the hospital instituted fall prevention measures for the resident and she sustained skin tears to her right forearm and knee. Further review of this record indicated that her symptoms were moderate, she was prescribed pain medications and wound care, and was discharged from the hospital ED back to the facility. Review of the hospital ED record dated on 12/14/2014 indicated that she arrived to the hospital by emergency transportation due to injuries from a fall while standing over her rolling walker in the

facility. This record indicated that the hospital instituted fall prevention measures for the resident and she sustained face, neck and scalp abrasions, closed head injury and cervical sprain. Further review of this record indicated that the resident had swelling and tenderness to her neck area, she was prescribed wound care and diagnostic imaging to rule out fractures, and was discharged from the hospital ED back to the facility.

30. In an interview with resident #23 on 01/05/2015 at 11:30am, she stated that she had been living in the facility since April 2014 and that the staff members are socially very nice and pleasant. She stated that she needed assistance with dressing, but was not offered help with this besides having a facility staff member come every morning to lay out some clothing on her bed for her to put on herself. She stated that since the facility staff is not engaged in assisting her with her ADLs, including ambulation and transferring it is difficult for her to continually have to tell the direct care staff what she needs every day. She stated that about a month ago, she fell in her room while attempting to stand up from her stationary chair. She stated that she got tripped up on her chair leg and fell on her shoulder, which was her previously operated shoulder and it became painful after the fall.

31. Review of resident #23's record indicated that she was admitted to the facility on 4/30/2014 with diagnoses including diabetes, peripheral neuropathy, hypertension and lower extremities paresthesias. Review of her health assessment dated on 12/16/2014 indicated that she must be on special fall precautions and must use her walker while ambulating. This health assessment indicated that she needed assistance with ambulation, dressing, bathing and transferring, with comment on her needing assistance of one person for bathing and dressing. Review of the resident condition log dated on 11/30/2014 indicated that the resident fell by tripping over a chair in her room at 12:00 pm and no injury was noted. Further review of the

resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's fall risk.

32. In an interview with staff nurse on 01/05/2015 at 1:55 pm she stated that she responded to resident #23 when she fell on 11/30/2014 and she understood that the resident was independent with her ADLs, including ambulation and transferring, without needing any staff assistance. She stated that upon her review of the resident's health assessment on 01/05/2015, she understood that the resident needed staff assistance with ambulation, dressing, bathing and transferring, but was confused on the physician comments that the resident needed assistance ambulating but may "walk independently with assistance from walker" and needed assistance transferring "from walker to transfer". She stated that the facility did not seek to get a clarification on these physician comments and she still understood that any required ADL assistance meant that the resident must receive personal assistance from a staff member. She stated that she was not aware of any fall precaution interventions applied to the resident due to her fall on 11/30/2014.

33. In an interview with the regional operations manager on 01/05/2015 at 2:05pm, she stated that she interpreted resident #23's health assessment dated on 12/16/2014, as attached, that the resident was independent with ambulation and transferring, and only needed the assistance from the walker, as a durable medical device, to perform those tasks. She stated that it was clear language, implying that the staff needed no clarification to identify the services needed.

34. In an observation on 01/5/2015 at 10:50am, resident #21 was walking independently without any staff supervision in the main lobby. Review of the resident's record indicated that he was admitted on 3/09/2013 with diagnoses including Paget's disease of the bone, hypertension and inguinal hernia. Review of the resident's health assessment dated on 8/10/2014

indicated that he had physical limitations of weakness and gait dysfunction, and needed special fall precautions. Further review of the health assessment's ADL evaluation indicated that the resident needed supervision with ambulation, dressing, grooming, toileting and transferring without explanation on how the resident would receive this supervision.

35. In an observation on 01/05/2015 at 10:55am, resident #24 was walking independently without any staff supervision in the main lobby. Review of the resident's record indicated that he was admitted on 10/20/2014 with diagnoses including diabetes, mild dementia and hypertension. Review of the resident's health assessment dated on 10/13/2014 indicated that he needed supervision with all of his ADLs, including ambulation and transferring.

36. In an observation on 01/05/2015 at 12:05pm, resident #25 was walking independently without any staff supervision in the main hallway near the dining room. Review of the resident's record indicated that she was admitted on 6/23/2011 with diagnoses including previous lumbar compression fracture and hypertension. Review of the resident's health assessment dated on 11/19/2014 indicated that she needed special fall precautions and needed supervision with ambulation.

37. In an observation on 01/05/2015 at 12:30pm, resident #20 was walking independently without any staff assistance in the main dining room. Review of the resident's record indicated that she was admitted on 6/08/2011 with diagnoses including cellulitis, hypertension, anemia, dermatitis, and lower extremity edema. Review of this resident's undated health assessment indicated that she had physical limitations that required her to use a walker for mobility and needed fall precautions, and needed assistance with ambulation, bathing, dressing, grooming, toileting and transferring. Further review of the health assessment's ADL evaluation

indicated that the resident used a walker for mobility without explanation on how the resident would receive assistance with ambulation, as concurrently assessed. Further review of the resident's record did not indicate that the facility addressed her undated health assessment.

38. Based on the foregoing Grand Villa of Delray East violated Rule 58A-5.0182(1), Florida Administrative Code, a Class II deficiency that carries, in this case, an assessed fine of $5,000.00.

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

A. Make factual and legal findings in favor of the Agency on Counts I and II.

B. Assess an administrative fine of $10,000.00 against Grand Villa of Delray East on Counts I and II pursuant to Sections 429.19(2)(b), Florida Statutes (2014).

C. Grant such other relief as this Court deems is just and proper.

Respondent is notified that it has a right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes (2014). Specific options for administrative action are set out in the attached Election of Rights Form. All requests for hearing shall be made to the Agency for Health Care Administration, and delivered to the ***Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #3, Tallahassee, Florida 32308, attention Agency Clerk, telephone (850) 412-3630.***

RESPONDENT IS FURTHER NOTIFIED THAT THE FAILURE TO RECEIVE A REQUEST FOR A HEARING WITHIN 21 DAYS OF RECEIPT OF THIS COMPLAINT WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

IF YOU WANT TO HIRE AN ATTORNEY, YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY IN THIS MATTER.

Lourdes A. Naranjo, Esquire
Fla. Bar 997315
Assistant General Counsel
Agency for Health Care Administration
8333 NW 53rd Street, Room 300
Miami, Florida 33166
(305) 718-5906

Copies furnished to:

Field Office Manager
Agency for Health Care Administration
(Inter-office mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Certified Mail, Return Receipt Requested to Eric Townsend, Administrator, Grand Villa of Delray East, 14555 Sims Road, Delray Beach, Florida 33484, on Jan. 26, 2015.

Lourdes A. Naranjo, Esquire

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: GV Lauderhill, LLC d/b/a **AHCA 2015000694**
Grand Villa of Delray Beach

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed action by the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine** or **Administrative Complaint.**

Your Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Administrative Complaint.

If your Election of Rights with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action by AHCA, you will have given up your right to contest the Agency's proposed action and **a final order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes (2008) and Rule 28, Florida Administrative Code.)

PLEASE RETURN YOUR ELECTION OF RIGHTS TO THIS ADDRESS:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ____ **I admit to the allegations of facts and law contained in the Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) ____ **I admit to the allegations of facts contained in the Administrative Complaint, but I 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 administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) ____ **I dispute the allegations of fact contained in the Administrative Complaint, and I request a formal hearing** (pursuant to Subsection 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 administrative 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. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any.
2. The file number of the proposed action.
3. A statement of when you received notice of the Agency's proposed action.
4. A statement of all disputed issues of material fact. If there are none, you must state that there are none.

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

License type: _____(ALF? nursing home? medical equipment? Other type?)

Licensee Name: _____License number:_____

Contact person: _____
Name Title

Address:_____
Street and number City Zip Code

Telephone No. _____Fax No. _____Email(optional)_____

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

Signed:_____ Date:_____

Print Name:_____ Title:_____

Late fee/fine/AC

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

GV LAUDERHILL, LLC, d/b/a GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

AHCA No. 2015000277
License No. 5113
File No. 11910377
Provider Type: Assisted Living Facility

IMMEDIATE MORATORIUM ON ADMISSIONS

THIS CAUSE came on for consideration before the Secretary of the Agency for Health Care Administration, or her duly appointed designee who, after a careful review of the matter at hand and being duly advised in the premises, finds and concludes as follows:

THE PARTIES

1. The Agency for Health Care Administration (hereinafter "the Agency"), is the governing authority responsible for the licensure and regulation of assisted living facilities in Florida and the enforcement of the applicable state statutes and rules governing assisted living facilities. Chs. 429, Part I, Fla. Stat., 408, Part II, Fla. Stat. (2014), Ch. 58A-5, Fla. Admin. Code. As part of its governing authority, the Agency may issue emergency orders when the circumstances dictate this type of action. §§ 120.60, 408.814, 429.14, Fla. Stat. (2014). The Agency has jurisdiction over the Respondent, GV Lauderhill, LLC d/b/a Grand Villa of Delray East (hereinafter "the Respondent"), an assisted living facility.

2. The Respondent was issued a standard license with extended congregate care specialty licensure by the Agency to operate a one hundred seventy (170) bed assisted living

facility located at 14555 Sims Road, Delray Beach, Florida, 33484 (hereinafter "the Facility"). § 429.11, Fla. Stat. (2014). 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. (2014). "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 (2014). § 408.803(11), Fla. Stat. (2014). Assisted living facilities are regulated by the Agency under Chapter 429, Part I, Florida Statutes (2014), and listed in Section 408.802, Florida Statutes (2014). § 408.802(13), Fla. Stat. (2014). Assisted living facility residents are thus clients. "Client" means "any person receiving services from a provider." § 408.803(6), Fla. Stat. (2014).

3. The Respondent holds itself out to the public as an assisted living facility that complies with the state laws governing assisted living facilities. These laws exist to protect the health, safety and welfare of the residents of assisted living facilities. As individuals receiving services from an assisted living facility, the residents are entitled to receive the benefits and protections under Chapters 120, 408, Part II, and 429, Part I, Florida Statutes (2014), and Chapter 58A-5, Florida Administrative Code.

4. As of the date of this Order, the census at the Respondent's Facility is one hundred sixty-six (166) residents/clients.

THE AGENCY'S EMERGENCY LICENSURE ACTION AUTHORITY

5. 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.

(2014).

6. The Agency may impose an immediate moratorium or emergency suspension of license order as defined in subsection 120.60, Florida Statutes, 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. (2014).

7. The Agency may deny, revoke, or suspend any license issued under Chapter 429, Part I, Florida Statutes, in the manner provided in Chapter 120, Florida Statutes, for any actions enumerated in Section 429.14, Florida Statues. § 429.14, Fla. Stat. (2014).

LEGAL DUTIES OF AN ASSISTED LIVING FACILITY

Resident Rights

8. No resident of an assisted living 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 ... (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. § 429.28(1)(a), (j), Fla. Stat. (2014).

9. Rule 58A-5.023(3)(a), Florida Administrative Code, provides as follows:

> All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 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

Resident Care Standards

10. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision, as appropriate for each resident, including the following: (a) Monitoring of

the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) Maintaining a written record, updated as needed, of any significant changes, any illnesses which resulted in medical attention, changes in the method of medication administration, or other changes which resulted in the provision of additional services. Fla. Admin. Code R. 58A-5.0182(1).

11. Florida law provides:

> (1) ADMISSION CRITERIA.
> (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license:
> 1. Be at least 18 years of age.
> 2. Be free from signs and symptoms of any communicable disease that is likely to be transmitted to other residents or staff; however, an individual who has human immunodeficiency virus (HIV) infection may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule.
> 3. Be able to perform the activities of daily living, with supervision or assistance if necessary.
> 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted.
> 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or by administration of medication.
> a. If the resident needs assistance with self-administration, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact.
> b. The facility may accept a resident who requires the administration of

medication, if the facility has a nurse to provide this service, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident.
6. Not have any special dietary needs that cannot be met by the facility.
7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapter 490 or 491, F.S.
8. Not require 24-hour licensed professional mental health treatment.
9. Not be bedridden.
10. Not have any stage 3 or 4 pressure sores. A resident requiring care of a stage 2 pressure sore may be admitted provided that:
a. Such resident either:
(I) Resides in a standard licensed facility and contracts directly with a licensed home health agency or a nurse to provide care, or
(II) Resides in a limited nursing services licensed facility and services are provided pursuant to a plan of care issued by a health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
b. The condition is documented in the resident's record and admission and discharge log; and
c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility.
11. Not require any of the following nursing services:
a. Oral, nasopharyngeal, or tracheotomy suctioning;
b. Assistance with tube feeding;
c. Monitoring of blood gases;
d. Intermittent positive pressure breathing therapy; or
e. Treatment of surgical incisions or wounds, unless the surgical incision or wound and the condition that caused it, has been stabilized and a plan of care developed.
12. Not require 24-hour nursing supervision.
13. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C.
14. Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator must base the decision on:
a. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule;
b. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and
c. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in Section 429.41, F.S. and Rule Chapter 69A-40, F.A.C.

* * *

> (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. ...

Fla. Admin. Code R. 58A-5.0181(1)(a) and (4).

THE AGENCY'S SURVEY FINDINGS

12. On January 5, 2015, the Agency commenced a survey of Respondent and its Facility.

13. Based upon this survey, the Agency finds, as found and set forth more specifically below, that the Respondent is in substantial non-compliance with the statutes and rules governing assisted living facilities.

14. A resident of the Facility, who is currently seventy-seven (77) years old, was admitted to the Facility in May 2014.

15. The resident's admitting Health Assessment[1] specifically identified the resident needed supervision with observation with all activities of daily living[2] except eating. In addition, the Health Assessment required "Safety Precaution" without further definition. The Health Assessment further directed that the resident receive physical therapy and occupational therapy.[3] The fifth page of this Health Assessment was completed by the Respondent's administrator noting that the resident needs observation daily by staff with activities of daily living. Absent from the records was any indication that the Respondent had sought guidance from the health

[1] *See*, § 429.26(4), Fla. Stat. (2014); Rule 58A-5.0181(2), Florida Administrative Code.
[2] *See*, § 42902(1), Fla. Stat. (2014).
[3] There is no indication that the directed occupational therapy was coordinated by the Respondent or otherwise provided.

care provider on the scope or character of the safety precautions directed in the Health Assessment.

16. This particular resident suffered the following:

a. August 29, 2014 – Resident found on the floor bleeding from the arm and leg. The resident was transported to a hospital emergency department.

b. September 10, 2014 - The resident was found on the floor and suffered a skin tear which required first aid treatment.

c. October 22, 2014 – The resident's hand was injured by an elevator door while ambulating in the hallway without supervision

d. October 27, 2014 – The resident was found on the floor, having fallen while dressing. No injuries were noted.

e. December 14, 2014 – The resident was found lying on the back on the floor. The resident's walker was found on top of the resident's face, and the resident was bleeding from the face and head. The resident was transported to a hospital emergency department.

17. The resident had received physical therapy from a third-party home health agency from August 7, 2014, through September 3, 2014. The initial evaluation noted that the resident required "contact guard assistance with transfers," a term explaining that manual assistance in direct contact with the resident was required. The tenth visit of September 3, 2014, noted the resident's functional capacities and further noted that the resident could ambulate eighty (80) feet with contact guard.

18. The home health agency staff completed a form summarizing each visit and noting the resident/patient's capabilities, progress, and needs. A copy of this form is left with the

Respondent Facility after each visit. In addition, home health agency staff personally met with the Respondent's staff on a weekly basis reporting on the status of residents treated by the home health agency.

19. Though requested, the Respondent failed to produce these home health agency treatment summaries and evaluations during the survey.

20. The home health agency was again ordered by the resident's physician to evaluate the resident for physical therapy on December 29, 2014, noting the resident had suffered two (2) falls within the previous week.[4] This evaluation, conducted on December 30, 2014, noted that the resident required contact guard for toileting, showering, and transfer, and stand-by assist for ambulation.

21. Despite these numerous events, the Respondent had not conducted investigations of the incidents, evaluated the resident for necessary interventions to provide care and services appropriate to the resident's demonstrated needs, completed required incident reports,[5] or evaluated the resident to determine the resident's continued appropriateness as an assisted living facility resident.

22. The Respondent could not demonstrate any mechanism by which it provided the care and services the resident required as documented in the resident's Health Assessment or periodic reports from the home health agency.

23. A second resident, who was eighty-eight (88) years of age, had a Health Assessment dated December 16, 2014, which specifically required as a special precaution "Fall Precautions." The Health Assessment further denoted that the resident required assistance with all activities of daily living except eating, must ambulate with a walker, and use a walker for

[4] The Facility records did not reflect that the resident has suffered two falls within two weeks prior to this order for physical therapy.
[5] *See*, § 429.23(2), Fla. Stat. (2014).

transfer. Absent from the records was any indication that the Respondent had sought guidance from the health care provider on the scope or character of the Fall Precautions directed in the Health Assessment.

24. Approximately two (2) months ago, the resident suffered a fall when the resident tripped over a chair during transfer. The fall exacerbated the resident's recovery from recent shoulder surgery.

25. The Respondent had not evaluated the resident for necessary interventions to provide care and services appropriate to the resident's demonstrated needs, or evaluated the resident to determine the resident's continued appropriateness as an assisted living facility resident.

26. The Respondent could not demonstrate any mechanism by which it provided the care and services the resident required as documented in the resident's Health Assessment.

27. A third resident, ninety-six (96) years of age, had a Health Assessment dated November 19, 2014, directing as special precautions "Precautions against falls." The assessment further required supervision with ambulation. Absent from the records was any indication that the Respondent had sought guidance from the health care provider on the scope or character of the fall precautions directed in the Health Assessment.

28. The Respondent could not demonstrate any fall precautions that it had instituted to meet the resident's specified care and service needs, or any mechanism to assure the resident received supervision while ambulating.

29. Another resident's Health Assessment noted a physical limitation requiring a walker for mobility. In addition, "Fall Precautions" were directed, and assistance was required for all activities of daily living except eating. Absent from the records was any indication that

the Respondent had sought guidance from the health care provider on the scope or character of the Fall Precautions directed in the Health Assessment.

30. Agency personnel observed this resident ambulating with a walker independently without any apparent staff assistance on both December 22, 2014, and January 6, 2015.

31. The Respondent could not demonstrate any fall precautions that it had instituted to meet the resident's specified care and service needs, on any mechanism to assure the resident received assistance while ambulating.

32. Last, a resident's Health Assessment noted that the resident had weakness and gait dysfunction. "Fall Precautions" were directed, and supervision was required for ambulation, dressing, and transfer. Absent from the records was any indication that the Respondent had sought guidance from the health care provider on the scope or character of either the Fall Precautions or supervision directed in the Health Assessment.

33. Agency personnel observed this resident ambulating with a walker independently without any apparent staff supervision on both December 22, 2014, and January 5, 2015.

34. The Respondent could not demonstrate any fall precautions it had instituted to meet the resident's specified care and service needs, on any mechanism to assure the resident received supervision while ambulating.

35. The Respondent was cited for deficient practice regarding the failure to provide care and services appropriate to the needs of residents accepted for admission to the facility[6] on March 14, 2014. In this cited deficient practice, the Respondent failed to implement its procedures related to every two hour checks of a resident and failed to implement its policy and procedure related to the contact of emergency services. The resident, who had a history of suffering from falls, was ultimately found on the floor of the resident's room and had passed.

[6] *See*, Rule 58A-5.0182(1), Florida Administrative Code.

36. Prior to the March 14, 2014, survey, the Respondent had received a directed plan of correction by the Agency as a result of a previous survey of the Facility on or about January 13-14, 2014. Accordingly, it appears that the Respondent had not successfully implemented correction action by the time of the March 14, 2014, survey.

37. On June 16, 2014, the Agency determined that the Respondent had corrected this deficient practice.

38. The Respondent was again cited for deficient practice regarding the failure to provide care and services appropriate to the needs of residents accepted for admission to the facility[7] on September 19, 2014. Though identifying deficient practice related to a total of five (5) identified residents, two (2) factual findings illustrate the scope of the identified non-compliance. For the resident who had been admitted to the Facility on March 31, 2014, the admitting Health Assessment specifically required fall precautions. By September 17, 2014, the resident had suffered four (4) separate documented falls, three (3) of which required a transfer to a hospital emergency department for evaluation and or treatment. Despite this series of events, the Respondent could not identify any methodology or interventions implemented to provide fall precautions for the resident. Similarly, for a second resident who had been admitted to the Respondent facility on August 20, 2104, the admitting Health Assessment specifically required assistance with ambulation, bathing, and dressing, and further required supervision with toileting and transfers. By September 17, 2014, the resident had suffered four (4) separate documented falls. Despite this series of events, the Respondent could not identify any methodology or interventions implemented to provide additional supervision or assistance to address the resident's frequent falls.

39. These findings constitute sufficient factual and legal grounds justifying the

[7] *See*, Id.

imposition of an Immediate Moratorium on Admissions on the Respondent.

THE NECESSITY FOR THE IMMEDIATE MORATORIUM ON ADMISSIONS

40. The Agency is charged with the responsibility of enforcing the laws enacted to protect the health, safety and welfare of residents and clients in Florida's assisted living facilities. Ch. 429, Part I, Fla. Stat. (2014), Ch. 408, Part II, Fla. Stat. (2014); Ch. 58A-5, Fla. Admin. Code. In those instances where the health, safety or welfare of an assisted living facility resident is at risk, the Agency will take prompt and appropriate action.

41. Oftentimes, residents of assisted living facilities suffer from physical and/or emotional limitations which necessitate the attentiveness to or assistance of others to ensure their safety and ongoing well-being. Florida's regulatory scheme recognizes this by requiring that residents receive care and services *as appropriate to the residents' individual needs.* (Emphasis added).

42. The Respondent has demonstrated a failure to provide the care and services required by its residents to minimize the risk of falls. The facts reflect numerous occasions where the Respondent was aware of the supervision or assistance needs of residents with ambulation and transfer, yet failed to demonstrate any methodology to assure that these care and service needs are being provided to the residents. The Respondent failed to undertake actions necessary to meet the identified needs associated with those individuals susceptible to suffering a fall and, potentially, injury resulting from falls.

43. The Respondent has actual knowledge of the residents under its care who are at increased risk of falls. The residents' Health Assessments particularly require precautionary care and service needs. In several instances, this knowledge was supplemented with numerous documented falls suffered by these residents with no mention of the residents being supervised or

assisted when the falls occurred. In one instance, this knowledge is reiterated by a third party provider which specifically documents the resident's need for heightened hands-on supervision and assistance for certain activities. This knowledge has not resulted, however, in increased or directed care and services which would minimize fall risk. Interventions typically undertaken include, but are not limited to, directed safety awareness work with residents, increased levels of staff supervision, increased frequency of monitoring, bed alarms, and the use of call pendants.

44. One of the residents discussed from the most recent survey illustrates how this deficient practice places residents at immediate risk. An elderly resident suffered four (4) separate documented incidents of falling, three (3) resulting in documented injury to the resident; two (2) of those necessitating care from a hospital emergency department. Three (3) of these incidents occurred during a period in which the resident was also undergoing periodic physical therapy, the physical therapy provider specifically documenting and communicating to the Respondent the need of the resident to have heightened, often hands-on, care and services, to ensure safety during activities of daily living. Despite this overwhelming knowledge of the risks presented to this resident, the Respondent took no concentrated actions to ensure the safety of the resident.

45. The Respondent is aware of, and has documented notification from health care providers, that other residents suffer from increased risk for falls. The Respondent cannot, however, identify any action it has taken to assure that care and services appropriate to meet the particular needs of these residents.

46. Residents of assisted living facilities enjoy a right to a safe and decent living environment, free from abuse and neglect, and access to adequate and appropriate health care consistent with established and recognized standards within the community. § 429.28(1), Fla.

Stat. (2014). Licensees who undertake to provide care and services to residents of assisted living facilities must be diligent to ensure that the Facility has both the capability to meet its residents' needs and to ensure services particular to a resident, such as interventions to protect from falls, are in fact provided.

47. The Respondent has demonstrated its failure to meet these requirements. The Respondent had previously been cited for the failures to its resident supervision capacity. Any corrective action that the Respondent may or may not have undertaken has proven unsuccessful. The Respondent has not demonstrated that is has undertaken action to ensure that adequate care and services appropriate to the needs of a resident at risk of falls reside in a safe living environment.

48. No resident of an assisted living facility must suffer from known risks to safety which are not addressed by the provider which has been entrusted to the resident's care.

49. It may be that the Respondent cannot meet the care and service needs appropriate to one or several of its residents. In such cases, the Respondent has an affirmative obligation to discharge these residents to an appropriate provider. Fla. Admin. Code R. 58A-5.0181(4). Here, the Respondent has failed to demonstrate that it has ensured its residents continue to meet the minimum requirements for residence in its assisted living facility when care and services appropriate to resident needs are not being provided.

50. The Respondent's deficient practices are not isolated incidents. These particular types of deficient practices have existed in the recent past, exist presently, and more likely than not will continue to exist if the Agency does not act promptly. In particular, the Respondent has been cited for deficient practice based on its failure to provide care and services appropriate to meet the needs of residents on three (3) separate occasions within the past ten (10) months. If

the Agency were to stand idly by, it is very likely that the Respondent's conduct will continue. The failure to implement mechanisms to ensure that resident care and service needs are met, and to ensure that appropriate action is taken in response to known resident dangers, such as increased risk of falls, place potential residents in unnecessary peril.

51. No successful efforts to resolve the conditions addressed have been demonstrated by the Respondent.

52. An Immediate Moratorium on Admissions is necessary to protect potential 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 an assisted living facility where the statutory and regulatory mechanisms enacted for their protection have been repeatedly breached.

CONCLUSIONS OF LAW

53. The Agency has jurisdiction over the Respondent, an assisted living facility in the State of Florida, pursuant to Chapter 408, Part II, Florida Statutes (2014), Chapter 429, Part I, Florida Statutes (2014), and Chapter 58A-5, Florida Administrative Code.

54. Based upon the above stated provisions of law and findings of fact, the Secretary concludes that the current conditions existing in the Respondent's Facility present a direct and immediate threat to the health, safety or welfare of current or potential residents and warrants an immediate moratorium on admissions.

55. The Agency expressly finds that exigent circumstances exist in this instance that warrant emergency action. This Immediate Moratorium on Admissions is the least restrictive means that the Agency can take against the Respondent to ensure the protection of the health, safety and welfare of the residents. The Agency has other remedies at its disposal, such an

emergency suspension order or emergency injunctive relief, which it may impose upon facilities that are in violation of the rules to such a degree that they present a direct and immediate threat to the health, safety or welfare of the residents. These remedies are more drastic than a moratorium or admissions. In choosing this less severe action, the Agency has taken into consideration all of the facts and circumstances of this matter as well as overall risk to resident wellbeing.

56. In addition, alternative remedies will not ensure immediate corrective action by the Respondent. The imposition of fines will not remedy the immediate risks presented by these conditions, including but not limited to the failure to ensure a safe and decent living environment with care and services provided appropriate to resident needs.

57. The Agency notes that it retains the right to impose a greater remedy, and will do so without hesitation, should the Respondent fail to act accordingly or the circumstances change.

IT IS THEREFORE ORDERED THAT:

58. The Respondent is placed under an **IMMEDIATE MORATORIUM ON ALL ADMISSIONS.**

59. The Respondent shall promptly post this Emergency Order on its premises in a place that is conspicuous and visible to the public.

60. The Respondent shall not admit any residents or readmit any prior residents at this Facility.

61. The Agency may monitor the conditions at the Respondent's Facility as needed after the issuance of this Emergency Order.

62. This Emergency Order shall continue in effect without limitation or interruption until further order of the Agency and shall run concurrently with any administrative actions. *See*,

§ 408.814(2), Fla. Stat. (2014).

63. The Agency will promptly file an administrative action against the Respondent based upon the facts set out in this Emergency Order and provide notice to the Respondent of the right to an administrative hearing when such action is taken.

ORDERED in Tallahassee, Florida, on this 9th day of January, 2015.

Elizabeth Dudek, 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.

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

DELEGATION OF AUTHORITY
To Execute
Immediate Orders of Moratorium

I specifically delegate the authority to execute Immediate Orders of Moratorium to Molly McKinstry, Deputy Secretary, Health Quality Assurance, or her delegate.

This delegation of authority shall be valid from date of October 1, 2010, until revoked by the Secretary.

Elizabeth Dudek

Elizabeth Dudek, Secretary

April 4, 2011

Date

2727 Mahan Drive, MS#1
Tallahassee, Florida 32308

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Petitioner,

v.

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Respondent.
_____/

DOAH 15-0212

AHCA 2014011974

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH 14- 5640

AHCA 2014010307

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH 15-0038

AHCA 2014003526

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

DOAH 15-0214

Petitioner,

AHCA 2014003521

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

DOAH 15-0302
Former DOAH 14-1861

Petitioner,

v.

AHCA 2014002452

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Respondent.
_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

DOAH 15-0303
DOAH: 14-1922

Petitioner,

v.

AHCA 2014001438

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH 15- 0438

AHCA 2014001642

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

DOAH 15- 1084

AHCA 2015000694

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

GV LAUDERHILL, LLC d/b/a
GRAND VILLA OF DELRAY EAST,

Respondent.
_____/

AHCA 2015000277
(Immediate Moratorium on Admissions)

SETTLEMENT AGREEMENT

The State of Florida, Agency for Health Care Administration ("the Agency"), and GV Lauderhill, LLC. d/b/a Grand Villa of Delray East ("the Provider"), pursuant to Section

EXHIBIT 2

120.57(4), Florida Statutes, enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, the Agency is the licensing and regulatory authority over the Provider pursuant to Chapter 408, Part II, Florida Statutes, and the authorizing statutes governing the license that the Provider holds; and

WHEREAS, Provider is an assisted living facility licensed pursuant to Chapter 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code; and

WHEREAS, the Agency served the Provider with Notice of Intent to Deny license applications and Administrative Complaint in the above-styled matters notifying the Provider of the Agency's intent deny licensure and impose sanctions on the Provider; and

WHEREAS, the Provider requested a formal administrative proceeding in each of the above styled matters; and

WHEREAS the Provider has since consented to a change of ownership and entered into an agreement with a prospective purchaser for the sale of assisted living facility; and

WHEREAS, the parties have agreed that a fair, efficient, and cost effective resolution of this dispute would avoid the expenditure of substantial sums to litigate the dispute; and

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

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

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

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

3. Upon full execution of the Agreement, the Provider agrees to waive any and all proceedings and appeals 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 (DOAH) of competent jurisdiction; and further 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 this Agreement shall not constitute a waiver by either party of its right to the judicial enforcement of this Agreement.

4. Upon full execution of this Agreement and the Agreement with the Change of Ownership applicant in the Notice of Intent case of 2015006738, the parties agree as follows:

a. The Provider shall pay the Agency $47,750.00 within 30 days of the date of the Final Order.

b. The Agency shall withdraw the Notices of Intent to Deny Licensure issued to the Provider, withdraw the actions for license revocation, issue a provisional license to the change of ownership applicant for the assisted living facility in accordance with the terms of the Settlement Agreement between the Agency and the change of ownership applicant, and lift the immediate moratorium on admissions.

5. Venue for any action brought to interpret, challenge or enforce the terms of this Agreement or its adopting Final Order shall lie solely within the State Circuit Court in Leon County, Florida.

6. By executing this Agreement, the Provider continues to deny the allegations set forth in the Administrative Complaints, but recognizes that the Agency continues to assert the validity of the allegations raised in the Administrative Complaints.

7. 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.

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

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

10. The Provider, for itself and its related or resulting organizations, successors or transferees, attorneys, heirs, and executors or administrators, discharges the Agency, its agents, representatives, and attorneys, of 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 the Provider or its related or resulting organizations.

11. This Agreement is binding upon all parties herein and those identified in the aforementioned paragraph of this Agreement.

12. In the event that the Provider was a Medicaid provider at the subject time of the occurrences alleged in the Administrative Complaints, this Agreement 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.

13. The Provider agrees that if any funds to be paid under this Agreement to the Agency are not timely paid per the terms of the Final Order, the Agency may deduct the amounts assessed against the Provider in the Final Order, or any portion thereof, owed by the Provider to the Agency from any present or future funds owed to the Provider by the Agency, and that the Agency shall hold a lien against present and future funds owed to the Provider by the Agency for

said amounts until paid.

14. The undersigned have read and understand this Agreement and have authority to bind their respective principals to this Agreement. The Provider understands that it has the right and opportunity to retain and seek the advice of own independent counsel. The Provider further understands that Agency counsel represents only the Agency and that Agency counsel has not provided any advice to the Respondent, or otherwise influenced it, regarding the decision to enter into this Agreement.

15. This Agreement contains the entire understandings and agreements of the parties. This Agreement supersedes any prior oral or written agreements between the parties. This Agreement may not be amended except in writing. Any attempted assignment of this Agreement shall be void.

16. All parties agree that a facsimile signature suffices for an original signature and that this Agreement may be executed in counterpart.

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

Molly McKinstry, Deputy Secretary
Division of Health Quality Assurance
Agency for Health Care Administration
2727 Mahan Drive, Bldg. 3
Tallahassee, Florida 32308

DATED: 10/8/15

Name: DENNIS FORTE
Title: President
GV Lauderhill, LLC
d/b/a Grand Villa of Delray East
1445 Sims Road
Delray Beach, FL 33484

DATED: 9/28/15

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

DATED: 9/29/15

Derek M. Daniels, Esquire
McCumber, Daniels, Buntz, Hartig
and Puig, P.A.
204 South Hoover Boulevard, Suite 130
Tampa, FL 33609

DATED: 9/28/15

Lourdes A. Naranjo, Senior Attorney
Office of the General Counsel
Agency for Health Care Administration
8333 NW 53rd Street, Suite 300
Doral, FL 33166

DATED: 9/29/2015