FILED
AHCA
AGENCY CLERK

2016 SEP 29 P 12: 18

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

SNR 23 GRACE MANOR LEASING, LLC,
d/b/a GRACE MANOR ASSISTED LIVING
AND MEMORY CARE,

Respondent.
_______________________________________/

DOAH No. 16-4913
AHCA No. 2016008332
License No. 11955
File No. 11967955
Provider Type: Assisted Living Facility
RENDITION NO.: AHCA- 16 - 0700 -S-OLC

FINAL ORDER

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

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (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)

2. The Respondent shall pay the Agency $70,500.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

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

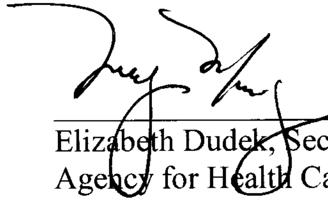
3. The Respondent shall comply with the conditions of licensure set forth in the Settlement Agreement.

4. The action for license revocation is withdrawn.

5. The Immediate Moratorium on Admissions (AHCA No. 2016007836) is lifted.

Filed January 31, 2019 3:31 PM Division of Administrative Hearings

ORDERED at Tallahassee, Florida, on this 28 day of September, 2016.



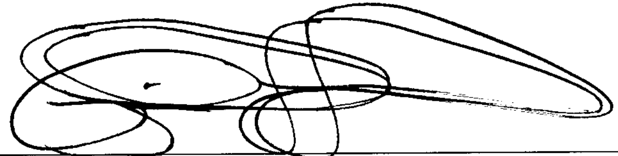
Elizabeth Dudek, Secretary
Agency for Health Care Administration

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 29th day of September, 2016.



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)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Carlton Enfinger, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Ivy Hernandez, Vice President Grace Manor Assisted Living and Memory Care 1321 Herbert Street Port Orange, Florida 32129 (U.S. Mail)

Thomas M Hoeler, Chief Facilities Counsel Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Cynthia A. Mikos, Esq. Allen Dell, P.A. 202 South Rome Avenue, Suite 100 Tampa, Florida 33606 (U.S. Mail)
Yolanda Y. Green Administrative Law Judge Division of Administrative Hearings (Electronic Mail)	

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

AHCA No. 2016008332
License No. 11955
File No. 11967955
License Type: Assisted Living Facility

SNR 23 GRACE MANOR LEASING, LLC,
d/b/a GRACE MANOR ASSISTED LIVING
AND MEMORY CARE,

Respondent.
_______________________________________/

ADMINISTRATIVE COMPLAINT

The Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), by and through the undersigned counsel, issues this Administrative Complaint against the Respondent, SNR 23 Grace Manor Leasing, LLC, d/b/a Grace Manor Assisted Living and Memory Care ("the Respondent"), pursuant to Sections 120.569 and 120.57, Florida Statutes, and alleges:

NATURE OF THE ACTION

This is an action to revoke the Respondent's license to operate this assisted living facility, impose an administrative fine of $70,000.00 based upon four Class I violations and impose a survey fee of $500.00.

PARTIES

1. The Agency is the licensing and regulatory authority that oversees assisted living facilities in Florida and enforces the applicable state statutes and rules governing such facilities. Ch. 408, Part II, Ch. 429, Part I, Fla. Stat. (2016), Ch. 58A-5, Fla. Admin. Code. The Agency may deny, revoke, and suspend any license issued to an assisted living facility and impose an

EXHIBIT "1"

administrative fine for a violation of the Health Care Licensing Procedures Act, the authorizing statutes or applicable rules. §§ 408.813, 408.815, 429.14, 429.19, Fla. Stat. (2016). In addition to licensure denial, revocation or suspension, or any administrative fine imposed, the Agency may assess a survey fee against an assisted living facility. § 429.19(7), Fla. Stat. (2016).

2. The Respondent was issued a license by the Agency to operate an assisted living facility ("the Facility") located at 1321 Herbert Street, Port Orange, Florida 32129, and was at all times material required to comply with the statutes and rules governing assisted living facilities.

COUNT I
Admissions – Continued Residency

3. Under Section 429.26(1), Florida Statutes (2016):

> (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

4. Under Section 429.26(9), Florida Statutes (2016):

> (9) A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.

5. Under Rule 58A-5.0181(4), Florida Administrative Code:

> (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.
>
> (a) The resident may be bedridden for up to 7 consecutive days.
>
> (b) A resident requiring care of a stage 2 pressure sore may be retained provided that:
>
> 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider;
>
> 2. The condition is documented in the resident's record; and
>
> 3. 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.
>
> (c) A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
>
> 1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice that coordinates and ensures the provision of any additional care and services that may be needed;
>
> 2. Continued residency is agreeable to the resident and the facility;
>
> 3. An interdisciplinary care plan, which specifies the services being provided by hospice and those being provided by the facility, is developed and implemented by a licensed hospice in consultation with the facility; and
>
> 4. Documentation of the requirements of this paragraph is maintained in the resident's file.
>
> (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
>
> (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only

> receive services from the assisted living facility's staff within the scope of the facility's license.
>
> (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.
>
> (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.

6. On 07/07/2016 and 07/08/2016, the Agency conducted a complaint survey at the Respondent's Facility.

7. Based upon observation, record review and interview, the Respondent failed to ensure that one (Resident #5) of four sampled residents was appropriate for continued residency at the Respondent's Facility.

8. The Facility's Administrator failed to assess the appropriateness of Resident #5's residency at the Facility after Resident #5 exhibited multiple instances of sexually inappropriate behavior with female residents in the Facility, which placed all forty-seven female residents in the Facility at risk.

9. A review of the Facility's admission and discharge log revealed that Resident #5 was admitted to the Facility on 05/11/2016.

10. A review of Resident #5's record revealed Resident #5's Health Assessment, Form 1823, dated 05/15/2016.

11. The date on the resident's Health Assessment appeared to be altered.

12. The Health Assessment physician signature page was signed by a medical doctor.

13. The rest of the Health Assessment was filled out in the same handwriting, as observed on the last page of the Health Assessment, where the Administrator signed and listed services being provided to Resident #5.

14. The Health Assessment listed Resident #5 as has having dementia with behavioral disturbances, but the Resident's cognitive status was listed as "calm."

15. Resident #5 was assessed as not being a danger to himself or others.

16. Resident #5 was assessed as being able to have his needs met in an assisted living facility.

17. Resident #5's health assessment listed Resident #5 as being "independent with all activities of daily living."

18. On 07/07/2016 at 6:55 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

19. During the interview, the Facility's Administrator reported that she had filled out the Health Assessment, form 1828, because she did not receive a health assessment from the Resident's previous placement.

20. The Administrator acknowledged that the date on the health assessment was altered, but the Administrator could not identify who altered the date on the health assessment.

21. The Administrator could not provide a date on which Resident #5 was assessed by a health care provider.

22. Review of Resident #5's resident chart revealed an Advanced Registered Nurse Practitioner ("ARNP") note dated 06/02/2016.

23. The ARNP note stated, "Patient (Resident #5) was found in room with a naked woman (Resident #7), in bed."

24. The ARNP note further described Resident #5 as having a "sexual addiction."

25. Resident #5's file did not contain any other notes that reflected the date of the incident.

26. On 07/07/2016 at 5:21 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

27. During the interview, the Administrator stated that Resident #5 was admitted from another assisted living facility.

28. The Administrator further stated that Resident #5's previous facility reported that Resident #5 was "touchy feely" with staff members, but not with other residents in the facility.

29. On 07/07/2016, the Agency's surveyor conducted an interview with Employee D.

30. During the interview, Employee D reported that she was concerned about Resident #5 before he was admitted to the Facility due to his history.

31. Employee D further reported that the Facility's Administrator was aware of Resident #5's past inappropriate sexual behaviors.

32. On 07/08/2016 at 12:20 p.m., the Agency's surveyor conducted a telephonic interview with the administrator of Resident #5's previous assisted living facility.

33. During the interview, the administrator of Resident #5's previous assisted living facility stated that Resident #5 had been a resident at his facility.

34. The administrator further reported that Resident #5 had consensual sex with another resident at Resident #5's previous facility and had exposed himself to another resident at the facility.

35. The administrator reported that the facility's staff had to increase Resident #5's supervision.

36. Review of Resident #5's resident chart revealed no record of the Respondent having obtained a new 1823 health assessment for Resident #5 after he exhibited a significant change of reported sexualized behavior.

37. Review of Resident #5's records revealed no documentation that the Respondent obtained a psychiatric evaluation as requested by Resident #5's physician.

38. Review of Resident #5's record revealed no indication that Resident #5 was reviewed or re-evaluated for continued residency at the Facility upon exhibition of sexual behavior.

39. On 07/09/2016 at 3:52 p.m., the Agency's surveyor conducted an interview with Resident #5's sister.

40. During the interview, Resident #5's sister reported that Resident #5 had sexual behaviors.

41. Resident #5's sister reported that Resident #5 would go up and down the street and ask people for sexual intercourse.

42. Resident #5's sister further reported that Resident #5 was diagnosed with bipolar mania.

43. Resident #5 needed to be placed into an environment with an intense degree of supervision, which was not available in the Respondent's Facility.

44. Resident #5 was not appropriate or was no longer appropriate for admission into the Respondent's Facility.

45. The Respondent should not have admitted Resident #5 into its Facility and should not have allowed Resident #5 to continue to reside in the Facility in the absence of a high degree of supervision.

46. The Respondent's actions or inactions constituted a Class I violation.

47. Under Florida law, class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the Agency

determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. § 408.813(2)(a), Fla. Stat. (2016).

48. The Agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation. § 408.813(2)(a), Fla. Stat. (2016). The Agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. § 429.19(2)(a), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $10,000.00 against the Respondent.

COUNT II
Resident Care – Supervision

49. Under Section 429.26(7), Florida Statutes (2016):

> (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

50. Under Rule 58A-5.0182(1), Florida Administrative Code (2016):

> (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 that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

51. The Agency realleges and incorporates, by reference, paragraph six (6) as though fully set forth herein.

52. Based upon observation, record review and interview, the Respondent failed to provide appropriate supervision for one (Resident #5) of five sampled residents.

53. By failing to provide appropriate supervision to Resident #5 after he exhibited inappropriate sexual behaviors, the Facility placed all female residents at the Facility at risk of sexual abuse, including Resident #6, Resident #7, and Resident #9.

54. Resident #6, Resident #7, and Resident #9 all had reported that Resident #5 made sexual advances and sexual contact with them.

55. On 07/07/2016 at 4:45 p.m., the Agency's surveyor conducted an interview with a private duty aide for Resident #8.

56. During the interview, the private duty aide for Resident #8 reported that Resident #5 would wander in residents' rooms and had a history of being sexually inappropriate.

57. The private duty aide for Resident #8 further reported that there were current accusations of having sexual relations with two current residents.

58. On 07/07/2016 at 5:04 p.m., the Agency's surveyor conducted an interview with

the Assistant Health and Wellness Director ("AHWD").

59. During the interview, the AHWD reported that other residents in the Facility had complained about Resident #5.

60. The AHWD stated that she reported those concerns to the Administrator.

61. When asked by the Agency's surveyor what issue the residents were complaining about, the AHWD stated, "Inappropriate comments."

62. The AHWD reported that Resident #5 had been given a forty-five (45) days' notice to leave the Facility due to the "inappropriate comments."

63. On 07/08/2016 at 12:41 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

64. During the interview, the Administrator confirmed that she had knowledge of Resident #7 being found naked with Resident #5.

65. The Administrator reported that she became aware of Resident #7 being found naked in Resident #5's room the day after the event.

66. The Administrator could not recall the actual date of the occurrence.

67. The Administrator admitted that there was no documentation to show that the event occurred.

68. The Administrator stated that she did not report the incident.

69. The Administrator confirmed that she did not have any investigation reports or other investigation documentation for Resident #5 or Resident #7.

70. On 07/08/2016 at 5:30 p.m., the Agency's surveyor conducted an interview Resident #9.

71. During the interview, Resident #9 reported that Resident #5 lived by her room in

the Facility when Resident #5 moved into the Facility in May 2016.

72. Resident #9 reported that, on one occasion, Resident #5 entered her room and began touching her arm.

73. Resident #9 reported that Resident #5 then started toucher her right breast, put his hand down her shirt, and started looking down her robe.

74. Resident #9 further reported that Resident #5 grabbed his crotch and asked if Resident #9 "wanted it."

75. Resident #9 reported that she rejected Resident #5's sexual advances and ordered Resident #5 to exit her room.

76. Resident #9 reported that she informed Employee E.

77. Resident #9 further reported that, upon informing Employee E of the situation, Employee stated, "[it] shouldn't happen and I'll let someone know."

78. Review of Resident #9's resident chart revealed no documentation in the resident's record regarding any incidents involving other residents, including Resident #5.

79. On 07/08/2016 at 5:56 p.m., the Agency's surveyor conducted an interview with Employee E.

80. During the interview, Employee E reported that Resident #9 had informed Employee E of the incident in which Resident #5 entered Resident #9's room, touched Resident #9's breast, and looked down Resident #9's shirt.

81. Employee reported that she informed the AHWD of Resident #9's allegation of sexual abuse.

82. On 07/08/2016 at 5:45 p.m., the Agency's surveyor conducted an interview with Resident #9's daughter-in-law.

83. During the interview, Resident #9's daughter-in-law reported that she had purchased a whistle for Resident #9 to blow for Resident #9's own safety.

84. Resident #9's daughter-in-law was informed by the Facility that Resident #5 had been moved.

85. On the basis of being informed by the Facility that Resident #5 had been moved, Resident #9's daughter-in-law reported that she had no more concerns for Resident #9's safety.

86. On 07/08/2016 at 6:00 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator and AHWD.

87. During the interview, the Administrator and AHWD denied having knowledge of Resident #5's inappropriate behavior with Resident #9.

88. The Administrator and AHWD further reported that Resident #5 was moved into a different room in the Facility on 06/04/2015.

89. The Administrator and AHWD reported that Resident #5 was moved into a different room because of financial reasons and not because of behavioral incidents at the Facility.

90. On 07/07/2016 at 7:00 p.m., the Agency's surveyor conducted an interview with Employee D.

91. During the interview, Employee D reported that she had witnessed two separate events in which Resident #5 was making inappropriate physical contact with Resident #6.

92. Employee D reported that she had immediately informed the AHWD.

93. Employee D reported that the AHWD told Employee D that she would "take care of [Resident #5's inappropriate sexual behavior]."

94. Employee D further reported that the Facility's Administrator had a meeting with

the Facility's staff the week of 06/28/2016 in which the Administrator instructed staff members to lock residents' doors to prevent Resident #5 from being allowed to enter other residents' rooms.

95. On 07/08/2016 at 12:41 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

96. During the interview, the Administrator reported that she was made aware of the event between Resident #5 and Resident #6 on 06/21/2016.

97. The Administrator further reported that she did not report this event because there was no real evidence that there was sexual contact.

98. The Administrator reported that she had a meeting with the Facility's staff members and told them to lock residents' room doors to prohibit Resident #5 from walking into other residents' rooms.

99. On 07/08/2016 at 10:43 a.m., the Agency's surveyor conducted an interview with Resident #6's physician.

100. During the interview, Resident #6's physician confirmed that he was never notified of any events, which were sexual in nature, involving his patient, Resident #6.

101. On 07/07/2016 at 6:45 p.m., the Agency's surveyor conducted an interview with Resident #5.

102. During the interview, Resident #5 reported that the Facility's staff keeps him locked in his room because they think he's a "sexual predator."

103. Resident #5 reported that the Facility was full of women and that they all loved him and wanted to be with him.

104. The Agency's surveyor asked Resident #5 if he has even touched another female

resident at the Facility.

105. In response to the surveyor's question, he reported, "Sure, I kiss them and I touch them."

106. Resident #5 reported that he kissed and touched Resident #6 and Resident #7.

107. Resident #5 reported that the Facility has only four male residents and that he had "needs."

108. On 07/08/2016, the Agency's surveyor conducted an interview with Resident #5's physician.

109. During the interview, Resident #5's physician stated that he informed the AHWD that Resident #5 needed a psychiatric evaluation and close monitoring.

110. The Respondent failed to appropriately supervise Resident #5 while Resident #5 was residing in the Facility with female residents.

111. The Respondent's actions or inactions constituted a Class I violation.

112. Under Florida law, "class I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation. § 408.813(2)(a), Fla. Stat. (2016).

113. Under Florida law, "class I" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and

not exceeding $10,000 for each violation. § 429.19(2)(a), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $10,000.00 against the Respondent.

COUNT III
Resident Care – Rights & Facility Procedures

114. Under Rule 58A-5.0182(6), Florida Administrative Code:

> (6) RESIDENT RIGHTS AND FACILITY PROCEDURES.
> (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
> (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
> (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888) 831-0404; Disability Rights Florida, 1(800) 342-0823; the Agency Consumer Hotline 1(888) 419-3456, and the statewide toll-free telephone number of the Florida Abuse Hotline, 1(800) 96-ABUSE or 1(800) 962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and must be a minimum of 14-point font.
> (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
> 1. Resident responsibilities;
> 2. Alcohol and tobacco;
> 3. Medication storage;
> 4. Resident elopement;
> 5. Reporting resident abuse, neglect, and exploitation;
> 6. Administrative and housekeeping schedules and requirements;
> 7. Infection control, sanitation, and universal precautions;

and

8. The requirements for coordinating the delivery of services to residents by third party providers.

(e) Residents may not be required to perform any work in the facility without compensation, unless the facility rules or the facility contract includes a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.

(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

(g) In addition to the requirements of Section 429.41(1)(k), F.S., the use of physical restraints by a facility must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical restraint.

115. Under Section 429.28(1), Florida Statutes (2016):

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

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

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

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

116. Under Section 429.28(2), Florida Statutes (2016):

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility

> and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida.

117. The Agency realleges and incorporates, by reference, paragraph six (6) as though fully set forth herein.

118. Based upon record review, observation and interview, the Respondent failed to ensure that four (Resident #6, Resident #7, Resident #8, and Resident #9) of five sampled residents lived in an environment free from abuse and neglect.

119. The Administrator failed to address or investigate allegations of abuse and allowed one resident (Resident #5) to remain in the facility after allegations that he had sexually assaulted three female residents (Resident #6, Resident #7, and Resident #9).

120. The Administrator failed to investigate allegations by Resident #8 of possible sexual misconduct by another resident. The lack of investigation and follow through on allegations of abuse put all fifty-three residents in facility at risk of abuse.

121. In addition, the facility failed to make available the telephone numbers for lodging complaints against the Facility or against the Facility's staff members.

122. On 07/07/2016 at 4:20 p.m., the Agency's surveyor conducted an initial tour of

the Facility.

123. During the initial tour, the Agency's surveyor did not observe telephone numbers for lodging complaints against the Facility or the Facility's staff members.

124. On 07/08/2016 at 5:30 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

125. During the interview, the Facility's Administrator confirmed that the Long Term Care Ombudsman, Agency Consumer Hotline, and the Florida Abuse Hotline telephone numbers were not posted anywhere in the Facility.

Resident #7

126. On 07/08/2016 at 11:34 a.m., the Agency's surveyor conducted a follow-up interview with the AHWD.

127. During the follow-up interview, the AHWD stated that Employee E had come to her and reported that she had walked by Resident #5's room and overheard Resident #5 state, "I have a resident in my room."

128. Resident #7 was found by Employee E laying in Resident #5's bed with her clothes removed from the waist down.

129. The AHWD reported that they did not investigate this event and they did not notify Resident #7's family or physician.

130. The Agency's surveyor conducted a review of Resident #7's resident records.

131. Review of Resident #7's resident records revealed that she was admitted to the Facility on 02/21/2013.

132. Review of Resident #7's resident records further revealed that her health assessment, form 1823, listed her diagnosis as suffering from dementia and anxiety.

133. Review of Resident #7's health assessment form assessed her as requiring assistance with dressing, bathing, walking, toileting, and transferring.

134. On 07/08/2016 at 5:15 p.m., the Agency's surveyor conducted an interview with Resident #7.

135. During the interview, Resident #7 reported that a male resident entered her room.

136. When asked by the Agency's surveyor if Resident #7 gave Resident #5 permission to enter her room, Resident #7 stated that Resident #5 would just enter the room.

137. When asked by the Agency's surveyor if Resident #5 had ever touched her, Resident #7 stated, "Yes."

138. In responding to the Agency's surveyor's questions regarding any inappropriate touching by Resident #5, Resident #7 moved her hands over her breasts so as to cover them.

139. Resident #7 further stated that Resident #5 would force his tongue in her mouth.

140. Resident #7 reported that Resident #5 kept asking her to have sexual intercourse with him.

141. Resident #7 reported that Resident #5 would take Resident #7's clothes off and ask Resident #7 to touch him sexually.

142. Resident #7 then reported that Resident #5 "just took [Resident #7]."

143. Resident #7 stated that Resident #5 laid on top of her with no clothing on and staff members interrupted Resident #5 by knocking on the door.

144. Resident #7 reported that the experience was "terrible."

145. Review of Resident #7's resident record revealed no information regarding the incident that occurred between Resident #5 and Resident #7.

146. The Respondent failed to have Resident #7 assessed or evaluated for injury or

psychological harm.

147. The Respondent failed to notify Resident #7's physician and family of the incident that occurred between Resident #5 and Resident #7.

Resident #9

148. On 07/08/2016 at 5:30 p.m., the Agency's surveyor conducted an interview with Resident #9.

149. During the interview, Resident #9 reported that, when Resident #5 moved into the Facility in May 2016, Resident #5 resided in a room that was nearby Resident #9's room.

150. Resident #9 reported that, on one occasion, Resident #5 had entered her room and began touching her arm.

151. Resident #9 reported that Resident #5 then started touching her right breast, put his hand down Resident #9's shirt, and started looking down her robe.

152. Resident #9 stated that Resident #5 grabbed his crotch and asked if Resident #9 "wanted it."

153. In response to Resident #5's inappropriate sexual advances, Resident #9 denied Resident #5 sexual advances and requested Resident #5 to leave her room.

154. Upon being asked to leave Resident #9's room, Resident #5 stated, "Think about it, and let me know."

155. Resident #9 reported that she informed Employee E of what had occurred in her room.

156. In response to Resident #9's complaint of being inappropriately touched, Employee E stated that what had occurred "shouldn't happen and [Employee E will] let someone know."

157. The Agency's surveyor conducted a review of Resident #9's resident records.

158. Review of Resident #9's resident records revealed that Resident #9 was assessed as requiring supervision for all activities of daily living.

159. Review of Resident #9's resident records revealed her diagnosis as suffering from anxiety.

160. Review of Resident #9's resident records revealed no documentation regarding any event involving other residents, including Resident #5.

161. On 07/08/2016 at 5:45 p.m., the Agency's surveyor conducted an interview with Resident #9's daughter-in-law.

162. During the interview, Resident #9's daughter-in-law reported that Resident #5 had been residing at the Facility for about three weeks before Resident #5 started entering Resident #9's room.

163. Resident #9's daughter-in-law reported that Resident #9 had informed her that Resident #5 had touched her breast.

164. Review of Resident #9's resident record revealed no information regarding the incident that occurred between Resident #5 and Resident #9.

165. The Respondent failed to have Resident #9 assessed or evaluated for injury or psychological harm.

166. The Respondent failed to notify Resident #9's physician of the incident that occurred between Resident #5 and Resident #9.

Resident #6

167. The Agency's surveyor conducted a second review of Resident #5's chart revealed a note, which was written by the AHWD, dated 06/20/2016.

168. The note by the AHWD stated that she heard a female resident in the Facility yelling, "Get out!" on the 300 hall of the Facility.

169. The note also stated that Resident #5 was found in Resident #6's room.

170. The note stated that Resident #5's sister was contacted and told that she needed to pick up Resident #5 because "[Resident #5's] behavior was alarming"

171. The Agency's surveyor reviewed documentation that Resident #6's family was notified.

172. The Agency's surveyor did not find any documentation that either resident was undressed.

173. On 07/07/2016 at 7:00 p.m., the Agency's surveyor conducted an interview with Employee D.

174. During the interview, Employee D reported that she had witnessed two separate events in which Resident #5 was making inappropriate physical contact with Resident #6.

175. On 07/07/2016 at 7:57 p.m., the Agency's surveyor conducted an interview with Employee E.

176. During the interview, Employee E reported that she found Resident #5 in Resident #6's room on 06/20/2016.

177. Employee E further stated that, when she asked Resident #5 what he was doing, Resident #5 responded, "I am a man and I have needs."

178. The Agency's surveyor conducted a review of Resident #6's chart.

179. Review of Resident #6's chart revealed that Resident #6 was admitted to the Facility on 05/11/2015.

180. Resident #6's health assessment, form 1823, which was dated 03/02/2016,

assessed Resident #6 as requiring assistance with ambulation, dressing, grooming, and transferring.

181. Review of Resident #6's health assessment, form 1823, diagnosed Resident #6 as suffering from Alzheimer's disease.

182. Review of Resident #6's resident chart did not document any events involving Resident #5.

183. On 07/08/2016 at 9:45 a.m., the Agency's surveyor attempted to interview Resident #6, but, at the time of the interview, Resident #6 was not alert or oriented and was unable to be interviewed by the Agency's surveyor.

184. On 07/08/2016 at 10:25 a.m., the Agency's surveyor conducted an interview with the AHWD.

185. During the interview, the AHWD reported that Employee E came to her on 06/20/2016 and reported that Employee E had heard yelling from Resident #6's room and Resident #5 was found in Resident #6's room.

186. When Employee E entered Resident #6's room, Resident #5 was observed taking his pants off.

187. When the AHWD spoke with Resident #5 about the incident, Resident #5 did not directly answer her questions.

188. The AHWD reported that she did not inform the resident's family or physician about the incident.

189. When asked why the note, written by the AHWD and dated 06/20/2016, did not mention Resident #5 being naked or removing his pants in the presence of Resident #6, the AHWD stated that she did not include that information in the note due to confidentiality.

190. The AHWD confirmed that no other documentation occurred involving the incident between Resident #5 and Resident #6.

191. The AHWD reported that the Facility's staff were informed to lock residents' doors so that Resident #5 could not enter other residents' rooms.

192. The AHWD confirmed that some of the Facility's residents could unlock their doors, while others were not capable of doing so.

193. On 07/08/2016 at 8:00 a.m., the Agency's surveyor conducted an interview with Resident #6's son.

194. During the interview, Resident #6's son reported that he went to visit Resident #6 three or four days after 06/20/2016.

195. Resident #6's son reported that, when he was at the Facility, the AHWD told him that Resident #5 was found in his mom's room exposing himself to her.

196. Resident #6's son was informed that no physical contact was made between the residents.

197. Resident #6's son stated that the AHWD reported that Resident #5 had been removed from the Facility was not going to return.

198. Resident #6's son stated that he was pleased with the Respondent's response to remove Resident #5 from the Facility.

199. However, Resident #6's son was unaware that, at the time of the interview with the Agency's surveyor, Resident #5 had been residing in the Facility since the beginning of July 2016.

200. Review of Resident #6's resident record revealed no information regarding the incident that occurred between Resident #5 and Resident #6.

201. The Respondent failed to have Resident #6 assessed or evaluated for injury or psychological harm.

202. The Respondent failed to notify Resident #6's physician and family of the incident that occurred between Resident #5 and Resident #6.

Resident #8

203. On 07/08/2016 at 3:47 p.m., the Agency's surveyor conducted an interview with Resident #8's wife.

204. During the interview, Resident #8's wife reported that a female resident, Resident #10, would come into Resident #8's room uninvited.

205. Resident #8's wife reported that Resident #10 would come into Resident #8's room and watch Resident #8 urinate and Resident #10 would rub "on him."

206. Resident #8's wife reported that her husband is confused and cannot give consent.

207. Resident #8's wife reported that she informed the AHWD about Resident #10 entering her husband's room "about a dozen times."

208. Resident #8's wife reported that, on 07/08/2016, Resident #10 was found in Resident #8's bathroom, sitting on the toilet with nothing below her waist.

209. Resident #8's wife stated that, when she reported the inappropriate touching and situation to the Administrator, the Administrator told her, "I don't have a problem, you do."

210. On 07/08/2016 at 5:26 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

211. During the interview, the Administrator reported that Resident #8's wife accused Resident #10 of "being a predator."

212. The Administrator reported that there is no documentation of any investigation or

documentation of the reported occurrences in the resident or Facility files.

213. The Administrator reported that she did not investigate the allegations because Resident #10 has dementia and often wanders into other residents' rooms.

214. The Administrator reported that only Resident #8's wife witnessed the alleged events, and not staff, so no investigation was completed.

215. The Agency's surveyor conducted a review of the Facility's grievance log.

216. Review of the grievance log revealed no documentation regarding grievances related to Resident #5 or Resident #10.

Facility's Abuse Policies and Procedures

217. On 07/08/2016 at 10:58 a.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

218. During the interview, the Administrator reported that all of the Facility's staff members receive training in abuse online.

219. The Administrator further reported was unaware of the Facility's policy on abuse and was unaware if the Facility provided training on chain-of-command reporting.

220. The Administrator stated that she would look to see what policies the Facility had with respect to resident abuse.

221. The Agency's surveyor conducted a review of the Facility's "Abuse, Fraud, and Wrongdoing" policy, which was undated.

222. The policy stated, "The Administrator will investigate any reports of abuse, fraud, or other wrongdoing…if a report of abuse fraud, or other wrongdoing is received: A) The Administrator is notified immediately. B) Any urgent medical or safety issues are addressed immediately. C) The Administrator or other designated representative initiates an

investigation...All appropriate parties are notified of the outcome of the investigation."

223. The Agency's surveyor conducted a review of the online training curriculum that all Facility staff members receive on resident abuse and neglect.

224. Review of the online training curriculum revealed that Facility staff members were trained on how to report resident abuse in the Facility.

225. The online training curriculum stated, "If you suspect abuse or neglect of a resident, don't hesitate to report it. Don't assume that someone else will take care of it or that the person being abused is capable of getting help. If he or she really needs it, follow the reporting procedures outlined in your organization's policies."

226. On 07/08/2016 at 9:45 a.m., the Agency's surveyor conducted an interview with Employee B.

227. During the interview, Employee B confirmed that Employee B received online training in abuse, neglect, and exploitation.

228. Employee B confirmed that for any allegations or observed abuse or neglect, Employee B would immediately tell the Administrator and the AHWD.

229. Employee B reported that Employee B did not receive training on the Facility's chain of command.

230. On 07/08/2016 at 12:37 p.m., the Agency's surveyor conducted an interview with Employee H.

231. During the interview, Employee H confirmed that Employee H received online training in abuse, neglect, and exploitation.

232. Employee H confirmed that for any allegations or observed abuse or neglect, Employee H would immediately tell the Administrator and the AHWD.

233. Employee H reported that Employee H did not receive training on the Facility's chain of command.

234. On 07/08/2016 at 1:15 p.m., the Agency's surveyor conducted an interview with Employee K.

235. During the interview, Employee K confirmed that Employee K received online training in abuse, neglect, and exploitation.

236. Employee K confirmed that for any allegations or observed abuse or neglect, Employee K would immediately tell the Administrator and the AHWD.

237. Employee K reported that Employee K did not receive training on the Facility's chain of command.

238. On 07/08/2016 at 3:45 p.m., the Agency's surveyor conducted an interview with Employee J.

239. During the interview, Employee J confirmed that Employee J received online training in abuse, neglect, and exploitation.

240. Employee J confirmed that for any allegations or observed abuse or neglect, Employee J would immediately tell the Administrator and the AHWD.

241. Employee J reported that Employee J did not receive training on the Facility's chain of command.

242. On 07/08/2016 at 4:30 p.m., the Agency's surveyor conducted an interview with Employee I.

243. During the interview, Employee I confirmed that Employee I received online training in abuse, neglect, and exploitation.

244. Employee I confirmed that for any allegations or observed abuse or neglect,

Employee I would immediately tell the Administrator and the AHWD.

245. Employee I reported that Employee I did not receive training on the Facility's chain of command.

246. The Respondent's actions or inactions constituted class I violations.

247. Under Florida law, "class I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation. § 408.813(2)(a), Fla. Stat. (2016).

248. Under Florida law, "class I" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. § 429.19(2)(a), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $40,000.00 against the Respondent.

COUNT IV
Staffing Standards – Administrators

249. Under Section 429.176, Florida Statutes (2016):

> If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52.

250. Under Rule 58A-5.019(1), Florida Administrative Code:

(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Chapters 408, Part II, 429, Part I, F.S. and Rule Chapter 59A-35, F.A.C., and this rule chapter.

(a) An administrator must:

1. Be at least 21 years of age;

2. If employed on or after October 30, 1995, have, at a minimum, a high school diploma or G.E.D.;

3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and

4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before December 1, 2014, are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to July 1, 1997, are not required to take the competency test unless specified elsewhere in this rule.

5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.

(b) In the event of extenuating circumstances, such as the death of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:

1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and

2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.

(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each

> licensed for 16 or fewer beds and all within a 15 mile radius of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities.
>
> (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to July 1, 1997, are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not simultaneously serve as an administrator of any other facility.
>
> (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, May 2013, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002.

251. The Agency realleges and incorporates, by reference, paragraph six (6) as though fully set forth herein.

252. Based on observation, record review, and interview, the Administrator failed to ensure appropriate care to all residents by failing to investigate and report allegations of sexual abuse for four (Resident #6, Resident #7, Resident #8, and Resident #9) of five sampled residents.

253. By failing to follow the Facility's abuse policy and neglecting to investigate and report allegations of abuse, all fifty-three residents at the facility were put at risk.

254. Resident #8's wife stated that, when she reported the inappropriate touching and situation to the Administrator, the Administrator told her, "I don't have a problem, you do."

255. On 07/08/2016 at 5:26 p.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

256. During the interview, the Administrator reported that Resident #8's wife accused

Resident #10 of "being a predator."

257. The Administrator reported that there is no documentation of any investigation or documentation of the reported occurrences in the resident or Facility files.

258. The Administrator reported that she did not investigate the allegations because Resident #10 has dementia and often wanders into other residents' rooms.

259. The Administrator reported that only Resident #8's wife witnessed the alleged events, and not staff, so no investigation was completed.

260. The Agency's surveyor conducted a review of the Facility's grievance log.

261. Review of the grievance log revealed no documentation regarding grievances related to Resident #5 or Resident #10.

262. On 07/08/2016 at 10:58 a.m., the Agency's surveyor conducted an interview with the Facility's Administrator.

263. During the interview, the Administrator reported that all of the Facility's staff members receive training in abuse online.

264. The Administrator further reported was unaware of the Facility's policy on abuse and was unaware if the Facility provided training on chain-of-command reporting.

265. The Administrator stated that she would look to see what policies the Facility had with respect to resident abuse.

266. The Agency's surveyor conducted a review of the Facility's "Abuse, Fraud, and Wrongdoing" policy, which was undated.

267. The policy stated, "The Administrator will investigate any reports of abuse, fraud, or other wrongdoing...if a report of abuse fraud, or other wrongdoing is received: A) The Administrator is notified immediately. B) Any urgent medical or safety issues are addressed

immediately. C) The Administrator or other designated representative initiates an investigation...All appropriate parties are notified of the outcome of the investigation."

268. The Respondent's actions or inactions constituted a class I violation.

269. Under Florida law, "class I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation. § 408.813(2)(a), Fla. Stat. (2016).

270. Under Florida law, "class I" violations are defined in s. 408.813. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. § 429.19(2)(a), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose an administrative fine of $10,000.00 against the Respondent.

COUNT V
Survey Fee

271. The Agency realleges and incorporates, by reference, paragraphs one (1) through (2), Count I, Count II, Count III, and Count IV as though fully set forth herein.

272. On 07/07/2016 through 07/08/2016, the Agency conducted a complaint survey at the Respondent's Facility, which resulted in violations that are the subject of the complaint.

273. Under Florida law, in addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed

fee or $500, 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 conducted under s. 429.28(3)(c) to verify the correction of the violations. § 429.17(7), Fla. Stat. (2016).

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to impose a survey fee of $500.00 against the Respondent.

COUNT VI
License Revocation

274. The Agency realleges and incorporates by reference Counts I through IV.

275. Under Section 408.815(b)-(c), Florida Statutes (2016):

> (1) In addition to the grounds provided in authorizing statutes, grounds that may be used by the agency for denying and revoking a license or change of ownership application include any of the following actions by a controlling interest:
> ...
> (b) An intentional or negligent act materially affecting the health or safety of a client of the provider.
> (c) A violation of this part, authorizing statutes, or applicable rules.

276. Under Section 429.14(1)(e)1., Florida Statutes (2016):

> (1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee, any person subject to level 2 background screening under s. 408.809, or any facility staff:
> ...
> (e) A citation for any of the following violations as specified in s. 429.19:
> 1. One or more cited class I violations.

277. The Respondent's actions or inactions constituted an intentional or negligent act materially affecting the health or safety of a client of the provider, a violation of Chapter 429,

Part I, or its applicable rules, and one or more class I violations.

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, seeks to revoke Respondent's license to operate an assisted living facility.

CLAIM FOR RELIEF

WHEREFORE, the Petitioner, State of Florida, Agency for Health Care Administration, respectfully seeks a final order that:

1. Makes factual and legal findings in favor of the Agency.
2. Imposes the relief set forth above.

Respectfully Submitted,

D. Carlton Enfinger, Senior Attorney
Florida Bar No. 739450
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone (850) 412-3658
Facsimile (850) 922-9634
E-Mail Carlton.Enfinger@ahca.myflorida.com

- and -

Devan Desai, Assistant General Counsel
Florida Bar No. 121399
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone (850) 412-3699
Facsimile (850) 922-9634
Email: Devan.Desai@ahca.myflorida.com

NOTICE

Pursuant to Section 120.569, F.S., any party has the right to request an administrative hearing by filing a request with the Agency Clerk. In order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), F.S., however, a party must file a request for an administrative hearing that complies with the requirements of Rule 28-106.2015, Florida Administrative Code. Specific options for administrative action are set out in the attached Election of Rights form.

The Election of Rights form or request for hearing must be filed with the Agency Clerk for the Agency for Health Care Administration within 21 days of the day the Administrative Complaint was received. If the Election of Rights form or request for hearing is not timely received by the Agency Clerk by 5:00 p.m. Eastern Time on the 21st day, the right to a hearing will be waived. A copy of the Election of Rights form or request for hearing must also be sent to the attorney who issued the Administrative Complaint at his or her address. The Election of Rights form shall be addressed to: Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 3, Tallahassee, FL 32308; Telephone (850) 412-3630, Facsimile (850) 921-0158.

Any party who appears in any agency proceeding has the right, at his or her own expense, to be accompanied, represented, and advised by counsel or other qualified representative. Mediation under Section 120.573, F.S., is available if the Agency agrees, and if available, the pursuit of mediation will not adversely affect the right to administrative proceedings in the event mediation does not result in a settlement.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the Administrative Complaint and Election of Rights form were served to the below named persons/entities by the method designated on this 25th day of July, 2016.

D. Carlton Enfinger, Senior Attorney
Florida Bar No. 739450
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone (850) 412-3658
Facsimile (850) 922-9634
E-Mail Carlton.Enfinger@ahca.myflorida.com

- and -

Devan Desai, Assistant General Counsel
Florida Bar No. 121399
Office of the General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone (850) 412-3699
Facsimile (850) 922-9634
Email: Devan.Desai@ahca.myflorida.com

Cynthia A. Mikos, Esq. Allen Dell, P.A. 202 South Rome Avenue, Suite 100 Tampa, Florida 33606 Via Electronic Mail at: cmikos@allendell.com	Administrator Grace Manor Assisted Living and Memory Care 1321 Herbert St. Port Orange, FL 32129 Via Certified Mail: 9171999991703363504290

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Re: SNR 23 Grace Manor Leasing, LLC, d/b/a Grace Manor Assisted Living and Memory Care **ACHA No. 2016008332**

ELECTION OF RIGHTS

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

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

Please return your Election of Rights form to this address:

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

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

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

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

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

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

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

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

Licensee Name: ______________________________

Contact Person: ______________________ Title: ______________

Address: ______________________________
Number and Street City Zip Code

Telephone No. ______________________ Fax No. ______________________

E-Mail (optional) ______________________________

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

Signed: ______________________________ Date: ______________

Printed Name: ______________________________ Title: ______________

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

DOAH No. 16-4913

v.

AHCA No. 2016008332
License No. 11955
File No. 11967955
Provider Type: Assisted Living Facility

SNR 23 GRACE MANOR LEASING, LLC,
d/b/a GRACE MANOR ASSISTED LIVING
AND MEMORY CARE,

Respondent.
_______________________________________/

SETTLEMENT AGREEMENT

The Petitioner, State of Florida, Agency for Health Care Administration ("the Agency"), and the Respondent, SNR 23 Grace Manor Leasing, LLC, d/b/a Grace Manor Assisted Living and Memory Care, ("the Respondent"), pursuant to Section 120.57(4), Florida Statutes, enter into this Settlement Agreement ("Agreement") and agree as follows:

WHEREAS, the Respondent is an assisted living facility licensed pursuant to Chapter 408, Part II, and Chapter 429, Part I, Florida Statutes, and Chapter 58A-5, Florida Administrative Code, and

WHEREAS, the Agency is the licensing and regulatory authority over the Respondent; and

WHEREAS, the Agency issued the Respondent an Administrative Complaint seeking the revocation of the Respondent's license to operate this assisted living facility, administrative fines in the amount of seventy thousand dollars ($70,000.00), and a survey fee in the amount of five hundred dollars ($500.00); and

EXHIBIT "2"

WHEREAS, the Respondent requested a formal hearing by filing an election of rights form; 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

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

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

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

3. Upon full execution of this Agreement, the Respondent agrees to waive any and all proceedings to which it may be entitled including, but not limited to, an informal proceeding under Subsection 120.57(2), Florida Statutes, a formal proceeding under Subsection 120.57(1), Florida Statutes, appeals under Section 120.68, Florida Statutes; and declaratory and all writs of relief in any court or quasi-court of competent jurisdiction; and agrees to waive compliance with the form of the Final Order (findings of fact and conclusions of law) to which it may be entitled, provided, however, that this agreement shall not be deemed a waiver by either party of its right to judicial enforcement of this Agreement.

4. Upon full execution of this Agreement, the parties agree as follows:

a. The Respondent shall pay the Agency $70,500.00 within 30 days of the entry of the Final Order as full and final payment required under this Agreement.

b. The Respondent's previous Executive Director (Administrator) who was present during the survey of July 9, 2016, shall not be permitted to serve in any capacity with the Facility.

c. The Respondent shall retain and maintain a third party auditor or consultant to monitor compliance with the conditions set forth below as well as general Facility compliance for a period of twelve (12) months from the Final Order.

d. The Respondent shall maintain risk management oversight over the Facility. The risk management oversight shall include a Designated Risk Manager who shall oversee an ongoing Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of outcomes of resident care and quality of life and present documentation and evidence of ongoing program implementation to survey staff or upon request by the Agency. The Designated Risk Manager must have risk manager training or experience. The Designated Risk Manager shall be a full-time employee (or contractor) of the Facility. The Designated Risk Manager shall track all adverse incidents in addition to other duties designated through the QAPI program. The QAPI program must be ongoing, comprehensive and must address the full range of care and services provided by the Facility. At a minimum, the QAPI program must: (i) Address all systems of care and management practices, and (ii) Reflect the complexities, unique care and services that the facility provides, and include any concerns related to outcomes associated with areas identified in the facility assessment that are not adequately addressed as documented in the assessment; and (iii) remain in place for a period of at least twelve (12) months.

e. The Respondent shall ensure that the QAPI program includes written policies and procedures to include feedback, data collections systems and monitoring including adverse event monitoring that reflect, at a minimum: (i) Facility maintenance of effective systems to obtain and use feedback and input from facility staff, residents and family members including how such information will be used to identify problems that are high risk or high volume and opportunities for improvement, (ii) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

f. The Respondent shall ensure pre-service staff training for all new employees of the Facility, including contracted staff, that is consistent with their respective roles. At a minimum, the pre-service training shall include training in the areas of: communication, resident rights and facility responsibilities, abuse neglect and exploitation (ANE), QAPI, compliance, ethics and behavioral health.

g. The Respondent shall maintain written policies and procedures that address: (i) the prohibition against and prevention of and identification of ANE of residents and misappropriation of resident property and include at a minimum a process for screening potential employees for a history of abuse, neglect or mistreating residents including compliance with background screening requirements required in 408.809, FS., (ii) the provision to residents, families and staff information on how and to whom they may report concerns, incidents, and grievances without fear of retribution and identify, correct and intervene in situations in which abuse, including resident to resident abuse, neglect and/or misappropriation of resident property is likely to occur; and (iii) the process necessary to thoroughly investigate any such allegations.

h. The Respondent shall train all new employees, within 30 days of hiring, through orientation and on-going sessions, on issues related to: (i) Resident abuse prohibition practices, and (ii) Identifying events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute resident abuse. The training of new managerial employees shall also include the investigations of abuse.

i. The Respondent shall voluntarily dismiss its Petition for Review pending in the District Court of Appeal.

j. Should the Respondent not be in substantial compliance with the conditions contained in this Agreement, such non-compliance constitutes grounds for the denial of any license application that the Respondent may file with the Agency for this assisted living facility.

k. The action to revoke the Respondent's license shall be withdrawn.

l. The immediate moratorium on admissions shall be lifted without any further action by the Agency upon the entry of the Final Order adopting this Agreement, which Final Order will be filed within five (5) business days of the full execution of the Agreement.

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

6. By executing this Agreement, the Respondent neither admits nor denies the facts and legal conclusions raised in the Administrative Complaint. Nothing in this Agreement shall be deemed to preclude the Agency from using this assessment of fines in weighing future administrative actions regarding the Respondent including, but not limited to, decisions regarding the licensure of Respondent, including, but not limited to, licensure for limited mental health, limited nursing services, or extended congregate care. The Agency is not precluded from using the subject events for any purpose within the jurisdiction of the Agency. Further, Respondent acknowledges and agrees that this Agreement shall not preclude or estop any other federal, state or local agency or office from pursuing any cause of action or taking any action, even if based on or arising from, in whole or in part, the facts raised in the Administrative Complaint.

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 parties.

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

11. This Agreement is binding upon all parties and those persons and entities that are identified in the above paragraph.

12. In the event that the Respondent was a Medicaid provider at the time of the occurrences alleged in the Administrative Complaint, this Agreement does not prevent the Agency from seeking Medicaid overpayments related to the subject issues or from imposing any further sanctions pursuant to Rule 59G-9.070, Florida Administrative Code. This Agreement does not settle any pending or potential federal issues against the Respondent. This Agreement does not prohibit the Agency from taking any action regarding the Respondent's Medicaid provider status, conditions, requirements or contract, if applicable.

13. The Respondent agrees that if any funds to be paid under this Agreement to the

Agency are not timely paid as set forth in this Agreement, the Agency may deduct the amounts assessed against the Respondent in the Final Order, or any portion thereof, owed by the Respondent to the Agency from any present or future funds owed to the Respondent by the Agency, and that the Agency shall hold a lien against present and future funds owed to the Respondent by the Agency for said amounts until paid.

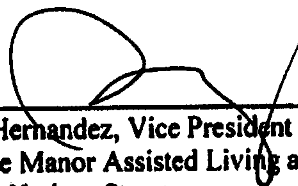
14. The undersigned have read and understand this Agreement and have the authority to bind their respective principals to it. The Respondent has the legal capacity to execute this Agreement. The Respondent understands that it has the right to consult with its own independent counsel and has knowingly and freely entered into this Agreement. The Respondent understands that Agency counsel represents only the Agency and that Agency counsel has not provided any legal advice to, or influenced, the Respondent in its 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.

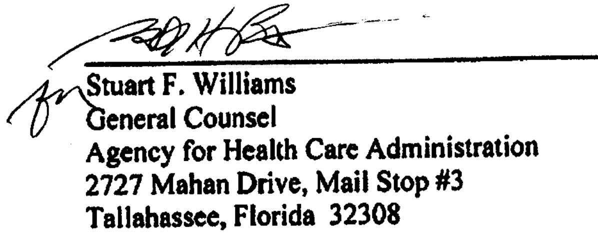
The following representatives acknowledge that they are duly authorized to enter into this Agreement.

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



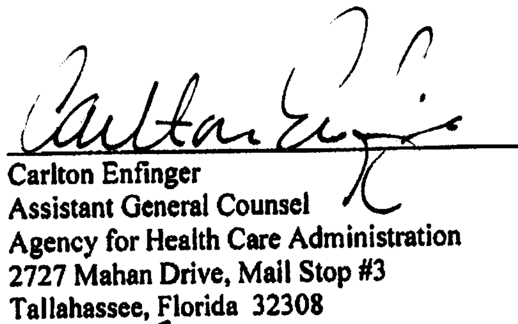
Ivy Hernandez, Vice President
Grace Manor Assisted Living and Memory Care
1321 Herbert Street
Port Orange, Florida 32129

DATED: 9/28/16



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

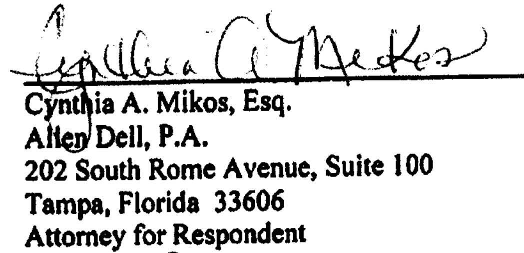
DATED: 9/28/16



Carlton Enfinger
Assistant General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308

DATED: 9-26-16

DATED: 9/23/16



Cynthia A. Mikos, Esq.
Allen Dell, P.A.
202 South Rome Avenue, Suite 100
Tampa, Florida 33606
Attorney for Respondent

DATED: 9/26/16