STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

REGENCY CARE OF BLOUNTSTOWN, LLC d/b/a BLOUNTSTOWN HEALTH AND REHABILITATION CENTER,

Respondent.
_____/

8533
AHCA No. 202000[redacted]
License No. 1652096
File No. 35960874
Provider Type: Nursing Home

IMMEDIATE MORATORIUM ON ADMISSIONS

THIS CAUSE came before the Secretary of the Agency for Health Care Administration, or her duly appointed designee, who after careful review of the record and being otherwise fully advised, finds and concludes as follows:

THE PARTIES

1. The Agency for Health Care Administration ("the Agency"), is the licensure and regulatory authority that oversees nursing homes in Florida and enforces the applicable state statutes and rules governing nursing homes. Chs. 408, Part II, and 400, Part II, Fla. Stat. (2019), Ch. 59A-4, Fla. Admin. Code. As part of its statutory oversight responsibilities, the Agency has the authority to impose emergency orders, including a limitation of license, a moratorium on admissions and an emergency suspension order, when circumstances dictate such action. §§ 120.60(6), 408.814, Fla. Stat. (2019).

2. The Respondent, Regency Care of Blountstown, LLC, d/b/a Blountstown Health and Rehabilitation Center ("the Respondent"), was issued a license by the Agency to operate a

nursing home (hereinafter "the Facility") located at 16690 Southwest Chipola Road, Blountstown, Florida 32424. The licensed capacity of the Facility is ninety-six (96) residents.

3. As the holder of such a license, the Respondent is a licensee. "Licensee" means "an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the Agency." § 408.803(9), Fla. Stat. (2019). "The licensee is legally responsible for all aspects of the provider operation." § 408.803(9), Fla. Stat. (2019). "Provider" means "any activity, service, agency, or facility regulated by the Agency and listed in s. 408.802" Florida Statutes (2019). § 408.803(11), Fla. Stat, (2019). Nursing homes are regulated by the Agency under Chapter 400, Part II, Florida Statutes (2019), and listed in Section 408.802, Florida Statutes (2019). § 408.802(10), Fla. Stat. (2019). Nursing home residents are thus clients. "Client" means "any person receiving services from a provider listed in s. 408.802." § 408.803(6), Fla. Stat. (2019). The Respondent holds itself out to the public as a nursing home that complies with state laws governing such providers.

4. The current census of the Respondent as of this date is eighty-one (81) residents.

THE AGENCY'S MORATORIUM ON ADMISSIONS AUTHORITY

5. Under Florida law, the Agency may impose an emergency suspension order or immediate moratorium on admissions as defined in section 120.60, Florida Statutes (2019), 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. (2019).

6. Under Florida law, if the Agency finds that an immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license, the Agency may take such action by any procedure that is fair under the circumstances. § 120.60(6), Fla. Stat. (2019).

LEGAL DUTIES OF A NURSING HOME

Resident Rights

7. Under Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the Agency. § 400.022(1)(l), Fla. Stat. (2019).

8. Under Florida law, all policies and procedures must be reviewed at least annually and revised as needed with input from the facility Administrator, Medical Director, and Director of Nursing. Each facility shall maintain policies and procedures in the following areas inlcuding but not limited to: infection control, nursing services, resident's rights and safety awareness. Each nursing home licensee must develop, implement, and maintain a written staff education plan which ensures a coordinated program for staff education for all facility employees. The staff education plan must be reviewed at least annually by the risk management and quality assurance committee and revised as needed. The staff education plan must include both pre-service and in-service programs. The staff education plan must ensure that education is conducted annually for all facility employees, at a minimum, in the following areas, including but not limited to: prevention and control of infection, accident prevention and safety awareness program, and resident's rights. Fla. Admin. Code R. 59A-4.106(2)-(5).

Physical Environment

9. Under Florida law, every licensed facility shall comply with all applicable standards and rules of the agency and shall ... (h) Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. § 400.022(1)(l), Fla. Stat. (2019).

10. Under Florida law, the licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible. Fla. Admin. Code R. 59A-4.122(1).

FACTS JUSTIFYING AN IMMEDIATE MORATORIUM ON ADMISSIONS

11. On May 8, 2020, the Agency completed a complaint survey of Respondent and its operations.

12. Based upon these visits, the Agency makes the following findings:

a. The Facility maintains an isolation area on the 400 Wing for known COVID-19 and suspected COVID-19 patients. Signage warns that resident rooms are isolation areas and require air borne precautions.

b. The rooms on the 400 wing did not contain disposal areas for personal protective equipment (hereinafter "PPE") in the individual rooms. Disposal areas were located in the hallway. There were hooks for gowns, resulting in the re-use of protective gowns by staff when caring for the several residents of the wing.

c. On May 7, 2020, all the doors of the resident rooms on this isolation wing were open. A certified nursing assistant was observed leaving the room of a confirmed COVID-19 patient in full PPE. Rather than doff the protective equipment, the nursing assistant began to enter the room of a resident suspected of contracting the virus. Prior to entry, the assistant was interrupted by Agency personnel inquiring about her failure to doff the PPE between the positive

and suspected COVID resident's rooms. The nursing assistant indicated that she had not been trained or instructed to change PPE when going between rooms.

d. On May 7, 2020, three (3) resident rooms located in the 400 Isolation wing contained residents who had recently received positive results for the COVID-19 virus. Each of these residents shared a room with a resident who, though suspected of having contracted the virus, had tested negative for infection.

e. Despite the fact that one (1) of the residents in each of these rooms had received recent positive COVID-19 results, the Respondent failed to remove and isolate the non-positive residents from the known positive residents, even if the Respondent may have suspected the non-positive residents may still be COVID positive and require further testing.

f. On May 6, 2020, two (2) resident rooms containing a known COVID-19 resident were located in the 500 and 600 Wings of the Facility. There was no signage indicating isolation or contact precautions, there was no PPE available for use, and the room doors were left open.

g. On May 7, 2020, at least eight (8) rooms, located throughout the Facility, housed suspected COVID-19 residents. These resident rooms were not designated by signage or otherwise as COVID-19 suspected cases and there was no PPE equipment available for use.

h. On May 7, 2020, at the urging of state emergency management staff and Veteran's Administration personnel, these residents were relocated to appropriate isolation areas within the Facility.

i. Staff screening materials were reviewed from April 30 through May 7, 2020. Records reflect that nineteen (19) staff members, from disparate departments of the Facility including direct care, nursing, dietary, and housekeeping, presented for their shifts reporting coughs, fever, shortness of breath, headache, loss of taste or muscle ache, often a combination of

several symptoms, and were nonetheless directed to report for service within the Facility. One of these individuals, a licensed practical nurse, was sent home on May 4, 2020, by representatives of Florida's Department of Health after the staff member had served residents for approximately four (4) hours.

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

NECESSITY FOR AN IMMEDIATE MORATORIUM ON ADMISSIONS

14. The Agency is charged with the responsibility of enforcing the laws enacted to protect the health, safety and welfare of residents and clients in Florida's nursing homes. Ch. 400, Part II, Fla. Stat. (2019), Ch. 408, Part II, Fla. Stat. (2019); Ch. 59A-4, Fla. Admin. Code. In those instances where the health, safety or welfare of a nursing home resident is at risk, the Agency will take prompt and appropriate action.

15. The COVID-19 virus is an easily transmitted respiratory infection that presents severe risk to persons who are aged, infirm, or suffer from co-morbidities including, but not limited to, immune system deficiency, respiratory disease, diabetes, and obesity. *See generally*, Publications of the Centers for Disease Control.

16. The Governor of the State of Florida issued, on March 1, 2020, Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant

to the authority therein, several Emergency Orders have been issued by the Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most vulnerable to the effects of infection. Among those, Emergency Orders was DEM Order 20-006, dated March 15, 2020, delineating minimum screening standards for persons entering identified facilities, including nursing homes.

17. The Agency has issued Guidance and Clarification on Division of Emergency Management Emergency Order 20-006 to its licensed providers and on March 18, 2020 issued an alert notifying licensed nursing home providers that all staff or other individuals admitted to a nursing home must don face masks and that caregivers must wear gloves when providing resident care.

18. While the treatment and management of residents with infectious disease and the implementation of isolation precautions for such events are a long-standing health care issues faced by nursing homes, the ease of contagion and the effects of infection presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate prophylactic procedures to both assure appropriate treatment of a potentially infected resident and protect the remainder of a facility's population from the risk of spread of the infection.

19. Similarly, the prevalence of the COVID-19 virus in the general community mandates that providers, including nursing homes, be proactive and unwavering in implementing procedures to screen all persons entering the facility for signs or symptoms of infection and, for those not exhibiting such signs or symptoms, including residents, assuring exclusion or, where appropriate, compliance with safe preventative practices designed to minimize the risk of the virus being spread by or infecting other residents, staff, or third parties allowed entrance under

current limitations.

20. In this instance, the Respondent has demonstrated an inability or unwillingness to ensure that its practices minimize the risk of contagion within the Facility. This is illustrated in the several factual findings described above.

21. The Respondent's isolation procedures are rendered ineffective when staff do not follow PPE requirements. The utility of PPE is mooted when improperly utilized. Mitigation of contagion cannot be effective where appropriate policies are not implemented and strictly and proactively enforced by the Facility.

22. Here, the failure of the Respondent to both properly identify resident rooms for which isolation and air borne precautions are indicated results in needless risk to residents and staff of spreading infection. The failure to provide PPE in appropriate areas and the failure to provide for the safe disposal of PPE both increase the risk of cross contagion.

23. The identification of potential COVID infection of a resident is of no value to mitigation of spread where the identified potential resident is placed in proximity with residents who had not suffered exposure or are known to have previously been negative, even where symptomatic. The failure to isolate a resident suspected of contagion increases the risk of further contagion, a result clearly contraindicated and otherwise easily subject to mitigation.

24. The protections available are further weakened where staff screenings do not effectively exclude from the Facility those staff members, coming from the community, who self-identify with signs or symptoms of contagion. It is of no distinction in what capacity these staff may serve, their presence within the Facility while experiencing signs of symptoms of contagion place residents at unneeded risk of contracting infection.

25. In order to effectively implement even the most effective of policies and

procedures to combat infection, staff must be trained, and their performance monitored for compliance. Despite the Respondent's actions to date, staff exhibit a lack of knowledge of isolation and the use of PPE. PPE is not distributed and disposed of in a manner to minimize cross infection. This non-compliance is readily observable.

26. The Respondent's failure to monitor its residents' status related to COVID-19 and to appropriately respond with an increased level of supervision, i.e. isolation upon exposure, creates a fertile ground for the virus to spread within the population.

27. The Respondent's acts and omissions as described above fall below industry standards and dictates or guidance of state and federal health agencies.

28. Here, the ongoing failure of the Respondent to assure that it complies with isolation, the use of PPE, and the failure to follow community standards for isolation due to infection has resulted in conditions that place resident, and staff, at an increased and inexcusable risk.

29. These conditions demonstrate the Respondent's failure to provide adequate and appropriate health care and protective and support services consistent with established and recognized practice standards within the community. Similarly, these conditions do not demonstrate adequate or appropriate isolation measures are available to control transmission of the disease.

30. These conditions present an immediate risk to residents of the Facility, both those who are virus free and those suffering from signs and symptoms of infection.

31. The facts reflect that these failures are not isolated but have existed in the past and continue. COVID-19 does not need expansive time to inflict its contagion. Every day every opportunity for spread must be diligently identified and mitigated.

32. The Respondent's deficient practice exists presently; have existed in the recent past, and more likely than not will continue to exist if the Agency does not act promptly.

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

CONCLUSIONS OF LAW

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

35. Based upon the above stated provisions of law and findings of fact, the Agency concludes that: (1) an immediate serious danger to the public health, safety, or welfare presently exists at the Respondent's Facility which justifies an immediate moratorium on admissions to Respondent Facility, and (2) the present conditions related to the Respondent and its Facility present a threat to the health, safety, or welfare of a resident, which requires an immediate moratorium on admissions to the Facility.

36. Based upon the above-stated provisions of law and findings of fact, the Agency concludes that an Immediate Moratorium on Admissions is necessary in order to protect possible future residents from (1) the unsafe conditions and deficient practices that currently exist, (2) being placed at risk of living in an environment ill-equipped to provide a safe and sanitary living environment, and (3) being placed in a nursing home where the regulatory mechanisms enacted for residents protection have been overlooked.

37. The Respondent has failed to identify, investigate, or address deficient practices

that were or should have been known to the Respondent and its administration. Such deficient practices and conditions justify the imposition of an Immediate Moratorium on Admissions. Less restrictive actions, such as the assessment of administrative fines, will not ensure that residents receive the appropriate care and services dictated by Florida law. The emergency action taken by the Agency in this particular instance is fair under the circumstances and the least restrictive action that the Agency could take given the set of facts and circumstances of this particular matter.

38. This remedy is narrowly tailored to address the specific harm in this instance.

IT IS THEREFORE ORDERED THAT:

39. An Immediate Moratorium on Admissions is placed on the Facility based upon the above-referenced provisions of law. The Respondent shall not admit any new individuals or readmit any discharged residents unless permitted by the Field Office Manager in writing.

40. This Immediate Moratorium on Admisions shall be posted and visible to the public at the Respondent's nursing home. § 408.814(4), Fla. Sta. (2019).

41. During the Immediate Moratorium on Admisions, the Agency may regularly monitor the Facility. Should conditions continue to present risks to residents, the Agency may undertake further action to protect Florida's citizens.

42. The Agency shall promptly proceed with the filing of an administrative action against the Respondent based upon the facts set out within this emergency order and any other facts that may be discovered during the Agency's continuing investigation. The Agency shall provide notice to the Respondent of the right to a hearing under Section 120.57, Florida Statutes (2019), when the administrative action is brought.

ORDERED in Tallahassee, Florida, this 13th day of May, 2020.

Mary C. Mayhew, 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.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

DELEGATION OF AUTHORITY
To Execute
Emergency Orders

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

This delegation of authority shall be valid from the date of February 1, 2019 until revoked by the Secretary.

Mary C. Mayhew, Secretary

2/6/19
Date

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