FMG REPORT
UNITED STATES V. PUERTO RICO 99-1435 (GAG/MEL)
MARCH 29, 2021

Benchmarks and Supplement Narrative

Joint Compliance Coordinator Team

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I. Introduction

On August 7, 2020, the Court became aware through the local newspapers that on August 6, 2020, the Department of Health of the Commonwealth of Puerto Rico ("Commonwealth") had ordered the immediate closure of the Fundación Modesto Gotay Institution ("FMG") upon recommendations of the Division of Services for Persons with Intellectual Disabilities ("DSPDI" for its Spanish acronym). (See Docket No. 3004).

In light of the above, the Court issued an order directing the Commonwealth not to close FMG and not to transfer the forty-one (41) participants of the DSPDI that resided therein to other institutions or homes. Its directive was to be in effect throughout August 10, 2020. (See Docket No. 3004). The Court further instructed the DSPDI to "immediately provide the JCC all relevant information regarding the matter and further permit inspection of said facility over the weekend" and to "provide the JCC all relevant information pertaining to the intended relocation of each individual". (See Docket No. 3004).

Notwithstanding the above, the Court was compelled to issue an amended order on that same day after being informed by the JCC that the forty-one (41) participants had already been transferred to different community homes and to another institution (Shalom). (See Docket No. 3006). As of the filing of said order, the Commonwealth had still not formally informed the Court nor the JCC of any emergency situations being confronted at FMG (much less of the decision to close said institution), even though they had issued a press release regarding the matter and posted the same on the Department of Health's Facebook page.[1]

In light of the above, the Court instructed the JCC to prepare an investigative report regarding the situations surrounding the closing of FMG and the subsequent transfer of the forty-one (41) DSPDI participants that resided therein. In compliance with the above directives, the JCC furnishes the present report and recommendations.

The present report will detail the core allegations raised by the DSPDI which prompted the decision to close FMG and the transfer of the DSPDI participants.[2] Our assessment relies on the information that the JCC obtained from an on-site inspection at the FMG facilities led by nutritionist Dana Miró; analysis of the participants' available information; information obtained from monitoring questionnaires that were administered to service providers; and will include

[1] In the past, the DSPDI has procured the JCC's guiding hand to assist them in emergency situations that were less transcendental that the transfer of 41 participants. Although the JCC recognizes the communication issues that were confronted with the DPSDI throughout the year 2020, we do not understand why past practices that proved favorable for the benefit of the participants were completely disregarded in the present situation.

[2] Although the JCC has analyzed all of the allegations and findings that were raised by the DSPDI, the present report will be mainly centered on the core issues that led to the abrupt closing of FMG, given that the rest of the DSPDI's findings do not add or subtract from our assessment.

the JCC's overall assessment regarding the present matter and the safety and well-being of the transferred participants.[3]

II. Findings of fact

A. Intra-agency Investigation and Determination to Remove Participants from FMG

The Commonwealth reported through the previous DSPDI Director, Dr. Joan Rivera, that due to the situation with the *Corporación de Amas de Llaves* ("COSALL" for its Spanish acronym) contract, the DSPDI developed an emergency plan to ensure the continuity of services. Pursuant to the above-mentioned plan, the Rio Grande CTS personnel was providing services to the participants that resided at FMG. (See **Exhibit A**).

According to the above report, said personnel noticed a series of irregularities and actions that put the safety and well-being of the residents of FMG at risk, such as:

i) Poor hygiene of participants (some of which had unchanged diapers for hours with fecal matter coming out of them);
ii) Poor diet;
iii) Dirty clothes; and
iv) Showers with only cold water; among others.

The DSPDI alleges that upon receiving such information, they proceeded to conduct an intra-agency inspection, which included the participation of the Department of Health Investigations Unit, Environmental Health Inspectors, Health Facility Inspectors ("SARAF" for its Spanish acronym), among other personnel from the Department of Health and the DSPDI. Pursuant to the above, **an unannounced visit to FMG was carried out on August 6, 2020 at 5:45am**.

B. Administrative Complaint and Secretary of Health's Order to Close FMG

After the above-mentioned intra-agency investigation, on August 9, 2020, an administrative complaint was filed before the Department of Health's Administrative Hearings Division by the Department of Health's Auxiliary Secretariat for Environmental Health (SASA, for its Spanish acronym); the Auxiliary Secretariat for Regulations and Accreditation of Health Facilities (SARAFS for its Spanish acronym); the Health Department's Office of Investigations; and the Division of Services for Persons with Intellectual Disabilities (DSPDI for its Spanish acronym). The complaint requested that the Secretary of Health order the immediate and

[3] As part of the investigation, the JCC also analyzed the individual transition plans (ITPs) for each of the forty-one (41) transferred participants; prepared thorough questionnaires that were administered to each service provider that received participants from FMG through telephone and video conferences; and analyzed information available on the Therap platform, among others. Said documents are available for review upon request.

permanent closing of FMG and impose a fine of five thousand dollars ($5,000) for each infraction incurred. (See **Exhibit B**)

On that same day, the Secretary of Health, Dr. Lorenzo González Feliciano, issued an order granting the claimants' request. In said order, the Secretary of Health briefly concluded that "the establishment's operation puts at risk the health and safety of the population it serves. Therefore, the immediate closure is ordered and for a term of ten (10) days from the notification of this order to the Modesto Gotay Foundation Institution". An administrative hearing was scheduled for August 18, 2020.[4] (See **Exhibit C**).

Notwithstanding the above, we find it curious to note that by the time the DSPDI complaint was filed, and the administrative order was issued, the Department of Health had already authorized the closing of FMG and the transfer of the DSPDI participants that resided therein.

C. JCC Observations Following Monitoring Visit to FMG

Pursuant to the directives of the Court at Docket No. 3004, on August 8, 2020, Ms. Dana Miró and Mr. Javier González from the Federal Monitor's Office (JCC), conducted a monitoring visit to FMG to assess the conditions of the facilities and to validate the information provided by the DSPDI, which served to justify the request to close the institution and transfer the DSPDI participants that resided therein.

The members of the Office of the JCC indicated to FMG that they were there to corroborate the closing order and to collect information about the process that was carried out in order to notify the Monitor and the Court accordingly. The members of the Office of the JCC clarified that the Office's function is not to execute, but to ensure that the agreements established in the Joint Compliance Action Plan ("JCAP") are complied with, and to issue recommendations to the Court as to the closing of FMG, if warranted.

In this section we will be referencing the main deficiencies set forth in the Complaint filed against FMG, which resulted in its immediate closing and transfer of forty-one (41) participants, and the JCC's observations regarding the same.

It is important to mention that similar findings and observations in other community homes and CTS facilities have resulted in the implementation of Surveillance Plans and other incident monitoring mechanisms by the DSPDI, instead of the immediate closing of the same and the transfer of the participants that reside therein without proper individualized transition plans (ITP).

[4] Neither the JCC or USDOJ were invited to the scheduled hearing, nor provided with the minutes or the. Transcript of the same. Thus, we cannot provide any comments as to the legitimacy of the proceedings or any details thereof.

Core Findings and JCC Observations:

A. Participant in the nursing area lying on the floor on a mattress without fitted sheet

During the monitoring visit that was conducted, the members of the JCC Office inquired FMG about a participant that was allegedly sleeping on the floor as the DSPDI raised in its complaint. FMG clarified that said participant has always preferred to sleep on the floor, for which her parents had brought her a mattress that she used to sleep as she desired.

The JCC finds that this type of behavior is not uncommon among participants and that the same does not constitute a negligent act on behalf of FMG. Moreover, said conduct should have been well known by the DSPDI and thus not treated as a surprising finding that warranted immediate intervention. Furthermore, even if said situation was indeed uncommon, surprising or negligent (which was not the case), it would have been an issue that could have been instantly remedied with little effort by FMG.

B. Participants were observed with unchanged diapers

After inquiring FMG as to this particular matter, they explained that the reason for participants with unchanged diapers was due to the fact that the DSPDI investigation was carried out before the first diaper change rounds that take place every morning at 6:00am.

Given that the DSPDI's inspection began at around 5:45am, the JCC considers that it was not unreasonable (although not ideal) that there were participants with unchanged diapers in the early hours of the morning.

C. The nursing area was understaffed. Only one nurse was in charge of several tasks at a time: supervising participants in the area, taking temperatures of people entering the facility, handling medications, caring for three (3) participants with delicate health conditions, and answering the phone

The above situation as well as the need to replace depleted staff is concerning to the JCC for a number of reasons, but mainly because it has the effect of curtailing or limiting the essential services the participants need. (See JCC September 2019 Report, Page 5).

Notwithstanding the above, said finding is not considered by the JCC to be an emergency issue that could serve as grounds for the immediate closing of the institution and subsequent transfer of the participants. This is yet another example of a situation that should have been previously known by the DSPDI and one that could have been easily remedied within a very short period of time before partaking in the drastic measures that were unfortunately taken.

Similar findings have been observed in the Ponce, Bayamón, Vega Baja and Cayey CTS Facilities, where multiple additional staff was needed, including nurses, psychologists, and occupational therapists, among others. However, no similar orders to close the facilities have ever been issued by the Department of Health or the DSPDI.

D. Expired and unlabeled medications

The SARAFS inspectors identified medications that were allegedly not fit for human consumption as they were supposedly expired and unlabeled. The medications identified were: Tegretol 300mg, Dorepil 100mg, Synthroid 50mg, Cefozil 250mg, Acetaminophen 50mg, Hidrogel, Levorcarnitina 100mg, Pregnisona 10mg, Laratidine 10mg, and Luminal 60mg.

Although the finding of expired and unlabeled medications is indeed an emergency issue for the JCC, there is no finding as to whether the expired medications were actually being administered to the participants or if they had simply not been discarded at the time of the DSPDI's investigation.

Moreover, the above is a situation that could be remedied expeditiously by replacing the expired medications and establishing proper quality control mechanisms that can be monitored periodically to ensure compliance.

E. Expired milk in refrigerators

As the JCC team was able to confirm, the fresh milk that was available at the time of their visit was within the consumption date. The FMG personnel indicated that on the date of the DSPDI intervention, they had about 1/2 gallons that had an expiration date of that same day. **If so, that milk was adequate for consumption on the day of the DSPDI's inspection**.

This is matter is not considered an alarming finding by the JCC. It is common knowledge that fresh milk has a short shelf-life. **If in fact the milk was not adequate for consumption the day of the DSPDI's intervention, it was just a matter of discarding the expired containers. There is also no evidence that expired milk was given to participants to consume at any moment at FMG.**

F. Crows, cockroaches and flies were found on the tables and walls in the dining room and kitchen area

As the JCC team noted, in the canned goods storage area the windows had screens but the area does not have enough ventilation, ceiling fans or AC, so the cans and pasta stored in the area were under very hot temperatures. According to the JCC's nutritionist at the time, said temperatures could alter the food and encourage the growth of insects and vermin. However,

when the JCC team visited the facilities, the floor had just been cleaned. **Therefore, no food on the floor or vermin was observed. No crows, cockroaches or flies were observed either.**

Although adequate hygienic measures should be strictly adhered to at all times, especially in the areas related to food preparation, storage and consumption, the findings set forth by the DSPDI regarding this area, if true, could be easily remedied by establishing a thorough maintenance plan that includes frequent cleaning, disinfecting and pest control, among others. Moreover, the fact that the areas were thoroughly cleaned prior to the JCC's inspection, is a perfect example that the situations that were deemed as emergencies, were all susceptible to quick remedies.

G. The person in charge of food handling does not have a safety certificate and does not have knowledge or training in the correct handling of food; the Institution did not have specialized menus based on the needs of each participant; and the person handling the food has no hygiene skills

The findings set forth by the DSPDI in this area are no different from similar findings that the JCC has encountered throughout numerous community homes and daily centers that have been visited by our team. In general terms, the JCC has observed that in some daily centers the food preparation is based on the available food and not on the model nutritional menu prepared by a nutritionist; some of them have no kitchen supervisors (most of the time the kitchen duties were being performed by auxiliary personnel); and lack of proper equipment, among others. It is also worth mentioning that a similar finding resulted in a DSDPI Surveillance Plan from June to July 2018 in Hogar Alma due to the lack of a balance diet.

Although the nutrition area is extremely important for the JCC (hence the decision to retain a licensed nutritionist for the JCC team to assist in these matters), the above is also a situation that can be remedied by providing the necessary capacitations to the available personnel or by hiring a licensed nutritionist that can ensure that participants are being provided an adequate diet that is tailored to their specific needs.

H. Poor hygiene of the areas: dirty floors, constant stench of feces and urine in the common areas; moisture in the ceiling; missing ceiling panels; and torn paint

Although the JCC team that conducted the visits noticed that some areas did in fact show torn paint, missing ceiling panels and moisture in the ceiling, the JCC is of the opinion that these are also matters that can be remedied within a short timeframe and do not justify an emergency closing and transfer of participants. At the time of said visit, the facilities had just been cleaned, thus no constant stench of feces and urine was observed. The above serves yet as another example of alleged "emergency matters" that were corrected in a very short period of time.

I. Sanitary pipes are discharging sewage to the surface of the ground

Regarding the DSPDI's allegation that the sanitary pipes were discharging sewage to the surface of the ground, FMG clarified that what the DSPDI saw was spilled water from a bucket that was used to clean the dining room. It was not sewage and the same did not come from the sanitary pipes. Although the same could have been disposed in a different manner to avoid any accidents or slips, said water did not represent a danger of any form of contamination or disease. **Instead of conducting a simple inquiry as to what was in fact a simple bucket of water that was spilled on the ground the DSPDI jumped to the conclusion and somehow inferred that it was sewage water that was discharged from the sanitary pipes**.

J. In the presence of DSPDI employees, an FMG employee dragged a participant across the floor, grabbing her by the ankle, and leading her to the bathroom area.

According to the DSPDI, this action was carried out by an ATP, knowing that the staff was in the facility. The employee was immediately instructed to release the participant, and the corresponding warnings and guidance were given to her.

Although this situation is in fact very concerning to the JCC, the same constitutes an isolated event, which was remedied immediately by the DSPDI personnel that were present during the intervention. There are no reports of physical abuse or neglect, nor there is evidence that shows a pattern of this type of conduct at FMG.

It is worth mentioning that in Hacienda Isaí Community Home a similar finding resulted in a DSDPI Surveillance Plan from May to June 2019. There was no complaint, order to close, or transfer of participants. Once again, FMG was deprived of the same treatment that other providers have always received from the DSPDI in regards to the handling of similar situations. The JCC finds that the DSPDI is applying incongruent standards to service providers in contrast to the centers that are administered by the Department of Health.

III. JCC Observations Regarding the Transfer of Participants and Remedial Recommendations

Upon investigating the matter and reviewing all furnished information, the JCC found that the DSPDI carried out their investigation on August 6, 2020 at 5:45am and the participants were transferred between the late hours of August 6 and early hours of August 7, 2020.

As our investigation showed, the participants' relatives were not included in the process of transferring the participants nor in the selection of the homes and institution where they were relocated. During the visit made by members of the JCC on August 8, 2020, the father of a participant arrived at FMG and expressed that he was made aware of the event by the press and was unaware of further details. The DSPDI had evidently not contacted him before or after

the transfer and did not even know where the participant was transferred to. This was the case for many relatives.

In addition to the above, due to the DSPDI's decision to transfer the participants immediately, no individualized transition plans (ITP) were prepared prior to the transfer of said participants. Therefore, the DSPDI did not analyze each participant's specific needs prior to placing them in community settings; they did not make an assessment as to whether the community homes where they were being placed was able to provide the specific services they needed; they did not take into account the geographical distance between the new homes and the participants' families residences, among many other important factors that need to be analyzed and included in the ITP's pursuant to the mandates of the JCAP.

Moreover, as the JCC was able to ascertain while conducting monitoring follow-ups to each of the transferred participants, the service providers that received the participants were notified of the transfer only a few hours prior to the placement. Therefore, they were not adequately oriented regarding the participants that they were going to receive, the specific needs of each of them, and if the placement was to be permanent or temporary, among other important information regarding the participants. **Furthermore, the vast majority of the participants were transferred without their files and personal belongings, including medication, assistive equipment and clothing.** During this abrupt transfer, several participants showed aggressive behavior, refusal to get into the vehicle, one of the participants had a seizure episode and another one was transported without his oxygen tank (which was placed in another vehicle at the moment of the transfer).

In addition to the above, the DSPDI did not make an assessment in regards to the number of participants that were already residing in the community homes where the participants were going to be placed. This significantly contributed to the existing overcrowding problem that the community homes were facing. Moreover, in using Hacienda Don Luis as a community home after the closing of FMG, the DSPDI deprived the program of a facility that was specifically designed to serve as an isolation center during the peak of the COVID-19 pandemic and while numerous community homes lacked an available isolated space to place participants that became infected with COVID-19.

In light of the above, the JCC has the following remedial recommendations:

1. **Updated individual transition plans (ITP) (Benchmark #6 and #8)-** Although the DSPDI prepared ITP's for all of the FMG participants **after** the transfer took place, said ITP's should be revisited to reflect the participants' current conditions as well as the viability of the current community placement. In doing so, the DSPDI shall ensure that the participants' family members and/or guardians are included in the process and that geographical concerns between the families and the community home are being considered. Moreover, the DSPDI shall ensure that the participants are receiving all the

necessary protections, supports, and services in accordance with the JCAP, and that the same are included in the ITP's;

2. **Safety and welfare analysis (Benchmark #40)**- The DSPDI shall conduct a safety, protection and welfare analysis of the transferred participants and their current residences using data available in the *Therap Service* platform (once they have concluded the full implementation of the same, as will be mentioned in the JCC's March 2021 Status Report) combined with on-site assessments and implement measures to ensure the safety, protection and well-being of the participants based on said analysis;
3. **Compliance with Order No. 3263**- Given that one of the transferred participants was transferred to another institution, the DSPDI should be aware of the directives of the Court at Docket No. 3263, whereby the Court ordered the DSPDI that **no participant shall be transferred from any institution without complying with the mandates of the JCAP and without the Court's prior approval after receiving the parties' respective or joint positions and the JCC's report and recommendations**; and
4. **Establishment of surveillance plans and incident monitoring-** In light of the findings included in the present Report, the JCC considers that all of the issues that were used by the DSPDI to justify the closure of FMG could have been adequately remedied by the implementation of proper surveillance plans and incident monitoring, as the DSPDI had previously done in multiple occasions where analogous issues were found in community homes, other institutions and daily centers. The adoption of measures that present less traumatic situations for the participants should always be the first resort, unless the participants are actually facing a life-or-death emergency situation, which was not the case at FMG.

IV. Conclusion

As explained in the present Report, the situations that the DSPDI found at FMG were undoubtedly concerning and required the corresponding attention in order to provide the participants the best living experience possible. However, the JCC is of the opinion that none of the findings that were raised by the DPSDI justify the immediate closing of FMG and the abrupt transfer of the participants that resided therein in the manner in which it was conducted.

The findings made by the DSPDI pertain mostly to matters that could have been easily remedied within a short period of time, none of which placed the participants' safety, protection and well-being in imminent danger nor presented life or death situations for them. The JCC is of the opinion that a correction and surveillance plan could have been put into effect to address and remedy the DSPDI's concerns and the deficiencies that were found in their inspection without the need of making the participants go through such traumatic events at late hours of the night without proper preparation or organization, and without even notifying their family members of such drastic measure.

The transfer of the participants was carried out in an improvised, accelerated and deficient manner, which failed to safeguard the participant's safety, protection and well-being. Moreover, **said transfer took palace amidst a global pandemic that requires heightened attentions and safety measures to avoid contagion between the participants that resided at FMG, participants that resided in the community homes where they were being placed and the staff that worked at those locations**. The best interests of the participants were not ensured, nor was their health and safety safeguarded. On the contrary, the DSPDI's reckless transfer of these participants had a direct negative impact on their lives (four of which lamentably passed away shortly after their transfers, two (2) of which passed due to COVID-19 complications) as well as the lives of other participants which were directly affected by the abrupt placement of the FMG participants in homes that were already overcrowded and those that were in need of an isolation facility that was not available for them.

After consulting the matter with the Court-appointed expert Dr. María Margarida Juliá and UMass/CDDER, it is our opinion that the abrupt removal of the participants from their stable residential placement places a significant stressor in their lives, which could potentially harm their behavioral and functional stability, as well as their adaptation and mental health. Ideally, any transition and change would need to account for a careful consideration for the individual needs of the participants, establishing a needs assessment which can then inform a coherent plan which takes into account the importance of pairing their individual characteristics and needs with prospective future placements, monitoring and preparation to manage change in their support system, (which includes caretakers, routines, friends, access to family visits, familiar environment, among some factors).

The JCC is compelled to state that although it is committed to fulfilling all mandates of the JCAP, which includes the closing of institutions and establishing community homes for the placement of participants residing in said institutions, said placements should be carried out pursuant to the terms agreed by the parties in the JCAP, the directives of the Court, and the ruling of the United States Supreme Court in Olmstead v. L.C., 527 U.S. 581 (1999) and always ensuring and safeguarding the health, protection and well- being of the participants.

In future, the JCC strongly recommends the DSPDI, the Department of Health and the Commonwealth as a whole, adhere to the mandates of the JCAP, which entails safeguarding the safety, well-being, and individualized needs of the participants before they proceed with the closing of an institution or a community home. Moreover, in taking drastic measures or declaring emergency situations that may warrant the transfer of participants, the DSPDI should apply the same standards that they apply to the services that they render in the daily centers to institutions and community homes.

V. Exhibits

Exhibit A

TRANSLATION

LOGO - Department of Health
Government of Puerto Rico
Division of Services for People with Intellectual Disabilities

PRIVILEGED AND CONFIDENTIAL COMMUNICATION

August 9, 2020

Lorenzo González Feliciano, MD, MBA, DHA
Secretary
Department of Health

Miguel A. Verdiales-Morales
Legal Counsel of the Secretary
Office of Legal Counsels

/s/ Joan Rivera Ortiz
Dr. Joan Rivera Ortiz
Director
Division of Services for People with
Intellectual Disabilities

REPORT OF ACTIONS TAKEN MODESTO GOTAY FOUNDATION

The Division of Services for People with Intellectual Disabilities (DSPDI), within its ministerial duties has, as its principal purpose, and the safeguarding of the health and safety of the 638 DSPDI participants. Of those, 41 resided at the Modesto Gotay Foundation (MGF).

In light of the situation with the Corporación de Ama de Llaves (COSALL)'s contract, we developed an emergency plan to maintain the continuity of services. For this reason, our personnel from the CTS of Rio Grande was rendering services in the Modesto Gotay Foundation Institution in Trujillo Alto. Our employees became aware of a series of irregularities and actions that placed at risk our participants and the general population sheltered in such place. Some of the notified situations included the participants' poor hygiene, some participants had unchanged diapers for hours with feces coming out of the same, poor diet, dirty clothes, showers that ran only cold water, among others.

Faced by such alarming information, we developed an interagency plan with the participation of the Investigations Unit, Inspectors of Environmental Health, Inspectors of Health Facilities

(SARAFS) and our team, among these: nurses, psychologists, social workers, an engineer, house monitors and service mediators. An unannounced inspection was scheduled and took place this past Thursday August 6, at 5:45 am. All the employees that participated in this inspection were duly identified and were divided by areas to complete the gathering of information.

Below are the findings (reports and photos attached):

Nursing Area

1. Upon arriving to the facility by the entrance space of the nursing area, we found feces on the first step of the access stairs.
2. After entering, the temperature of all team members was taken; we observed a participant in the nursing area laying down on the floor, on a mattress, without a fitted sheet.
3. Only one nurse was available in such nursing area, engaging in several tasks at the same time: supervising the participants in the area, taking the temperature of the persons that were entering the facility, managing the medications and answering the phone.
4. The SARAFS inspectors identified medications that were not fit for human consumption as they were expired and unlabeled. The medications identified were: Tegretol 300mg, Multivitamins, Dorepil 100mg, Synthroid 50mg, Cefozil 250mg, Acetaminophen 50mg, Hidrogel, Levorcarnitina 100mg, Pregnisona 10mg, Laratidine 10mg, Wit-Wipess Exp. 2016 and Luminal 60mg.
5. The SARAFS inspectors observed that one of the beds that had a bedridden patient did not have railings on one of the sides. In the hallways there were seven (7) boxes of biohazard waste. The medicine carts were dirty, and each drawer had six (6) compartments, which could cause errors in the administration of medications.
6. Vital signs of patients are not taken.
7. Does not have a crash cart.
8. There is poor lighting in the area.
9. The SARAFS inspectors indicated that the room where two bedridden patients are located does not have visibility from the nursing station. They are at risk of being assaulted by patients that have access through the open door.
10. The position bed handles are not working.
11. The armchairs and commode chair are broken.
12. In the report provided by SARAFS, the inspectors informed that the facility currently has one (1) supervisor, four (4) nurses with bachelor's degree and two (2) nurses with associate degrees to cover three 24/7 shifts and the patient census is 44. These residents are categorized as IV or V. They are patients that need direct care. This is a violation of Act 254 of December 31, 2015 that regulates the Nursing Practice in Puerto Rico, which provides that a nurse with an associate degree must be supervised by a nurse with bachelor's degree. In the 11-7 pm shift there is one nurse assigned to cover the four areas.

Kitchen Area – Food Services

1. The Environmental Health inspectors reported within their findings the seizing of food not safe for consumption. They seized rice packets with weevils and expired milk in refrigerators.

2. Good hygiene practices were not maintained. The food employee did not wash her hands before preparing and handling food.
3. Refrigerators and freezer did not have the correct temperature.
4. The SARAFS and Environmental Health inspectors reported the absence of wire mesh in the dining area. Birds, cockroaches and flies were observed on tables and in walls of the dining and kitchen areas.
5. The Environmental Health inspectors reported toxic substances stored along with foods.
6. The surface area in contact with food was not disinfected.
7. The person in charge is not certified and does not show knowledge in the subject.
8. Did not protect against contamination by hands.
9. The DSPDI personnel observed a plague of cockroaches on the tables while the participants consumed breakfast.

Infrastructure

1. Multiple areas of the facility were observed with moisture on the ceiling.
2. Multiple areas with torn paint.
3. Poor hygiene in the areas, dirty floors, constant stench of feces and urine in the areas.
4. Sinks in the dining hall did not have a complete faucet.
5. SARAFS inspectors notified that the shower faucet in one of the women's bathrooms was leaking, and a garbage container was observed collecting the leaks.
6. The facility does not have access to hot water.
7. Dirty clothes were found in four shopping carts in front of the laundry area without protection from the environment and vermin.
8. The storage area for patients' new clothes does not have air conditioning, [has] exposed porous wood planks, broken walls and windows, walls and ceilings with black stains.
9. In the storage area for disposable diapers, some were found on the floor. Shoes, detergents, expired medications, oxygen tanks, milk crates, and a broken IV stand were observed, and there is no air conditioning.
10. There is a lock in the Men's Pavilion that does not work; a loose sharp steel object was observed in the lock.
11. Most of the mattresses did not have fitted sheets or pillows.
12. Broken glass in the door to the Men's Pavilion.
13. The bathrooms in the Men's Pavilion have not been cleaned properly and [toilet] lids are missing from their tanks.
14. Roof did not have acoustic ceiling tiles in some areas of the facilities.
15. All closet doors in the Men's Pavilion were broken.
16. Broken windows without screens.
17. No COVID-19 disinfection stations were observed.
18. Lack of assistance equipment in the men's bathroom.
19. Unmaintained green areas surrounded by weeds.
20. Environmental Health inspectors notified that the pool had green water.
21. Environmental Health inspectors, upon inspection of the pool, notified the Executive Director, that an extreme cleaning of the interior of the water tank was to be performed.
22. Replace the lid of the water tank to fit properly.
23. Environmental Health inspectors notified that the lid of the water tank is rusty.

24. The sanitary pipes discharge sewage waste to the ground surface, in violation of the General Regulation 135 of Environmental Health. The Environmental Health inspectors notified to the Executive Director that such violation must be immediately corrected.

Staff

1. A lack of staff was observed during the entire intervention.
2. There was a woman assisting the participants of the Men's Pavilion.
3. Upon arriving to the facility, SARAFS inspectors and DSPSI personnel observed a custodial employee improperly intervening with a patient.
4. In the presence of DSPDI employees, Ms. Jeannette Ayala and Ms. Elena Rodríguez witnessed how Ms. Maria Alejandro Soto, an employee of the institution, dragged participant MRV 481 through the floor. Warnings were immediately issued to the employee.

Hygiene and Appearance

1. There were participants walking around naked or half-naked in the Men's Pavilion.
2. A participant was found with lacerations, swelling and scaly skin.
3. A participant was observed with a laceration on his foot.
4. A door was found with feces stains, and DSPDI personnel found a patient who had soiled himself and shirtless.
5. Employees were observed wearing masks but without gloves.

During this intervention, the complaint filed by the CTS Rio Grande personnel was validated; the findings identified by the interagency intervention led to the immediate relocation of the participants. These findings were notified to the executive director of the MGF and the consultant, and both admitted fault. DSPDI developed a monitoring plan to maintain an oversight of the remaining institutions and community homes contracted by the DSPDI.

EXHIBITS A, B, C AND D; REPORTS ISSUED AND PHOTOS

COMMONWEALTH OF PUERTO RICO
DEPARTMENT OF HEALTH
ADMINISTRATIVE HEARINGS DIVISION
P.O. Box 70184
San Juan, Puerto Rico 00936

DEPARTMENT OF HEALTH Auxiliary Secretariat for Environmental Health (acronym in Spanish **SASA**); Auxiliary Secretariat for Regulations and Accreditation of Health Facilities (acronym in Spanish **SARAFS**); Office of Investigations (acronym in Spanish **OI**); Division of Services for Persons with Intellectual Disabilities (acronym in Spanish **DSPDI**) COMPLAINANT VS. **INSTITUCIÓN FUNDACIÓN MODESTO GOTAY** **Dr. Carlos Rodríguez- Executive Director** **Milagros Vargas, Esq.- Consultant** RESPONDENT	**COMPLAINT QFS-2020-08-01** **RE:** Violations of: Act No. 81 of March 14, 1912; Act No. 254 of December 31, 2015; Regulation 135 of the Secretary of Health, General Regulations of Environmental Health, Act No. 101 of June 26, 1965; Regulation 6044 of November 7, 1999; Act No. 4 of June 23, 1971, as amended

COMPLAINT

TO THE HONORABLE SECRETARY OF HEALTH:

Comes now the above-captioned complainant, through its legal counsel, and respectfully **STATES, ALLEGES AND PRAYS**:

1. The defendant, Institución Fundación Modesto Gotay, is a care center for adults with intellectual disabilities, located in the municipality of Trujillo Alto.
2. At this center, the Department of Health, through the Division of Services for Persons with Intellectual Disabilities (acronym in Spanish DSPDI), provides services to 41 participants.
3. As part of the protocol established for the care of this population, following the COVID-19 pandemic, the DSPDI developed an emergency plan to maintain continuity of services to its participants.
4. The division's staff, specifically that at the Rio Grande Transitional Service Center (acronym in Spanish CTS), was providing services at the respondent institution.
5. Upon visiting the Institution, our staff noticed a series of irregularities and actions that placed the health and safety of the participants and the general population at risk. Therefore, they proceeded to carry out the official notifications to the corresponding

health and safety areas of the Department of Health.

6. Some of the irregularities pointed out by the staff are the following: poor hygiene of the participants, some participants wore diapers that had not been changed for hours, with leakage of feces; poor feeding of the participants, dirty and inappropriate clothing; lack of hot water; among others to be noted later.
7. Once the offices concerned were notified, the intra-agency inspection plan was carried out with the participation of the Office of Investigations, Environmental Health Inspectors, SARAFS Inspectors and the DSPDI team, including nurses, psychologists, social workers, engineers, home monitors and service mediators.
8. The inspection took place on Thursday, August 6, 2020, at 5:45 am. During said inspection the following deficiencies were found:

SARAFS Nursing Area

a. At the entrance to the nursing area, stool was found on the first step of the access staircase.
b. There was one participant in the nursing area lying on the floor on a *mattress with* no bedding or *fitted sheet*.
c. The area was understaffed. Only one nurse was in charge of several tasks at a time: supervising participants in the area, taking temperatures of people entering the facility, handling medications, caring for three (3) participants with delicate health conditions, and answering the phone.
d. After evaluating the medications stored in the area, expired and unlabeled medications were found. (SARAFS)
    i. Some of the drugs identified by the Department of Health's staff were: Tegretol 300 mg, Multivitamins, Dorepil 100 mg, Synthroid 50 mg, Cefozil 250 mg, Acetaminophen 50 mg, Hydrogel, Levocarnitine 100 mg, Prednisone 10 mg, Laratidine 10 mg, Wit-Wipess Exp. 2016 and Luminal 60 mg. In addition, expired controlled drugs were found.
e. Several of the beds of bedridden participants had no railings on one side. Thus, endangering the participants who may fall upon moving.
f. In the hallway there were seven (7) boxes of biomedical waste, six (6) were closed and one (1) was open and accessible.
g. The medicine carts were dirty and each drawer had six (6) compartments. These compartments are conducive to errors in the administration of medicines.
h. It was corroborated that participants' vital signs are not being taken.
i. The Institution does not have a crash cart, to assist participants in any cardiac arrest or seizure emergency.
j. There is poor lighting in the area.
k. Two bedridden patients, were alone in one of the rooms. The room has no visibility for monitoring from the nursing area. This represents a safety problem, as the door remains open and any other participant could aggress them without the possibility of immediate assistance. According to the information provided by the

nurse, one of these participants suffers from convulsions and the other requires constant monitoring since the excess saliva needs to be drained, which makes this situation more dangerous.

l. The size of the beds and the dimensions of the beds are not appropriate to the needs of the participants. Moreover, the hospital beds do not work, so they cannot be used as such.

m. Armchairs and *commode chairs* are broken.

n. The findings report submitted by SARAF, states that the respondent institution currently has one (1) supervisor, four nurses with a bachelor's degree and two (2) associate degree nurses to cover the three 24/7 shifts with a census of 44 patients or participants.

o. There was no finding to validate that the associate degree nurses were being supervised in their shifts by a bachelor's degree nurse, in contravention of the provisions of Act No. 254 of December 31, 2015, as amended.

p. The 11-7 PM shift only has one nurse to cover the four areas.

SASA &SARAFS Kitchen-Food Service Area

q. Food unsafe for its consumption was found, so it was confiscated. This included:
   i. Rice packages with weevils
   ii. Expired milk in refrigerators, for its consumption.

r. Good hygiene practices are not maintained.

s. The food preparation employee does not wash her hands before preparing and handling food.

t. The refrigerators and freezers are not at the right temperature.

u. The dining area has no screens on its windows or door.

v. Crows, cockroaches and flies were found on the tables and walls in the dining room and kitchen area. Even while participants are eating their meals, these animals are there.

w. Toxic substances were found stored with food.

x. Surfaces in contact with food are not disinfected.

y. The person in charge of food handling:
   i. Does not have a safety certificate and does not have knowledge or training in the correct handling of food.
   ii. The Institution has only one person in charge of 44 participants in total.
   iii. The Institution did not have specialized menus based on the needs of each participant.
   iv. Has no hygiene skills.

z. Hand contamination protection such as gloves, alcohol-based hand sanitizers was not available.

Infrastructure - SARAFS & SASA Engineering

aa. Multiple areas of the facility had moisture on the ceiling.

bb. Multiple areas of the Institution had torn paint.

cc. Poor hygiene of the areas: dirty floors, constant stench of feces and urine in the common areas.

dd. Dining room sink does not have a complete faucet.

ee. Leakage in the shower tap in one of the women's bathrooms, a trash can was placed underneath to collect the leak.

ff. The facility does not have hot water.

gg. Dirty clothes are placed in four shopping carts in front of the laundry area without protection from the weather and vermin.

hh. The storage room for patients' new clothes is not air-conditioned; the wooden slats are porous, the walls and windows are broken, the walls and ceilings have black stains.

ii. In the disposable diaper stockroom, some diapers were on the floor. In addition, shoes, detergents, expired medicines, oxygen tank, milk cartons, broken IV stands and no air conditioning were observed.

jj. In the Men's Pavilion the locks do not work, one had a loose sharp piece of steel.

kk. All the mattresses were without fitted sheets and pillows.

ll. Several of the Pavillion's doors had broken glass and others were cracked, in addition, all closet doors, were broken. This represents a safety issue as participants are exposed to injury with any piece of glass. One-glass pane doors did not have the glass pane. This represents a safety problem since the size of the space allows for the insertion of a head, causing an emergency.

mm. The toilets in the Men's Pavilion were poorly cleaned and the toilet tanks had no cover.

nn. Several areas of the facility's ceiling are missing acoustic tiles. The Men's Pavilion, particularly, is missing all tiles, allowing birds to enter and create a health problem.

oo. Broken windows were observed, with no operators and no window screens.

pp. There were no COVID-19 disinfection stations.

qq. The bathrooms had no assistive devices to help participants with their personal hygiene.

rr. Neglected green areas, no weeding of surroundings, and the swings were corroded and broken by rust. Some pieces of the swings had fallen on the ground. Broken and neglected fences were also observed.

ss. The pool's water is green, meaning that it is not getting the proper treatment, presenting a public health problem for both residents and the community, as it is a focus for the spread of mosquitoes.

tt. The need to clean the water tank was notified. It was noted that it contains a lid that does not fit the frame, so it does not close properly and is rusted.

uu. Sanitary pipes are discharging sewage to the surface of the ground.

vv. Showers discharge water into the pool in the absence of drainage.

ww. There are no sanitary services accessible to participants in the pool area.

xx. The fire extinguishers were expired.

SARAFS & DSPDI Staff

yy. Lack of personnel was observed throughout the intervention.

zz. The Men's Pavilion had a female to care for all participants.

aaa. A maintenance worker was observed intervening with a patient in an inadequate manner.

Aggression and Abuse

In the presence of DSPDI employees, an employee of the Institución dragged a participant across the floor, grabbing her by the ankle, and leading her to the bathroom area. This action was carried out by Mrs. María Alejandro Soto, ATP, knowing that our staff was in the facility. Mrs. Alejandro was immediately instructed, requiring her to immediately release the participant, and the corresponding warnings and guidance were given to her.

Hygiene and Appearance

bbb. Participants were found wandering naked and half-naked in the Men's Pavilion.

ccc. A participant was found with lacerations, swelling and scaly skin.

ddd. One participant had a foot ulcer.

eee. A door was stained with fecal material and DSPDI personnel found a patient with excrement on himself and with no shirt.

fff. Employees were observed wearing masks, but no gloves.

9. During this intervention, the report issued by the Rio Grande CTS staff was certified, and the findings identified by the intra-agency intervention led to the immediate relocation of the participants.
10. Our staff documented this intervention through reports, immediate notification of findings and taking photographs.
11. The conditions in which our staff found these patients and participants indicate this institution’s serious disregard for health and safety.
12. The aggression observed by our inspectors calls into question the ability of the staff to deal with this very vulnerable population. If there were no qualms about mistreating them in our presence, we do not doubt that they are being mistreated by personnel of the Institución, who are notably incapable of handling participants with disabilities.
13. In addition, fecal matter was found outside the institution, right at the entrance, which means that there is no adequate monitoring of the participants, who manage to get out, at least, up to the steps of the entrance.

APPLICABLE LAW

1. The Department of Health was created under Act No. 81 of March 14, 1912, and elevated to constitutional status in Article IV, Section 6 of the Constitution of the Commonwealth

of Puerto Rico.

2. The Secretary of Health has the ministerial duty to take all necessary measures to ensure the health and safety of all Puerto Ricans.
3. Similarly, the Secretary of Health may order the closure of any facility when emergency circumstances so warrant. In this regard, Section 30 (subsection (a)) of Act No. 81, supra, provides

> "(a) (a) The Secretary of Health or his/her authorized representatives, are hereby empowered to enter any building, house, shop or place at any hour of the day, to inspect and report on the sanitary conditions thereof, or to cause the prompt removal or correction of any public nuisance, in the form and manner prescribed in the sanitary regulations. ***The Secretary may likewise order the closing of any building, house, shop, or place, or similar establishment, when he/she confirms that the sanitary conditions thereof or the way that they operate, present an imminent public health problem***. Likewise, and without impairing the power of the Secretary or his/her authorized representatives to close any building, house, shop, or place when they do not meet the minimum health requirements, the Secretary shall be empowered to impose fines on the owners, agents or persons in charge thereof for deficiencies in the sanitary conditions and requirements of said places, in accordance with Section 33 of this Act. [...]" (Emphasis added)

4. Section 33 of Act No. 81, above, empowers the Secretary of Health to impose penalties up to and including imprisonment:

> (a) Any natural or juridical person who violates the provisions of this chapter or the regulations issued by the Department of Health thereunder shall incur a misdemeanor, and upon conviction, may be sentenced to imprisonment that shall not exceed six (6) months, or a fine of not more than five thousand dollars ($5,000), or both penalties in the discretion of the court. In addition to the penalties imposed by the court, the penalty of restitution shall be imposed.
>
> (b) Any natural or juridical person who violates the provisions of this chapter or the regulations set forth by the Department of Health hereunder for the first time, shall be liable for an administrative fine of not more than five thousand dollars ($5,000), as provided in §§ 2101 et seq. of this title; in the case of a new violation of this chapter or the regulations set forth by the Department by virtue thereof within the term of one (1) year, the fine imposed may be raised to a maximum of ten thousand dollars ($10,000). (3 L.P.R.A. Sec. 187)

5. Moreover, Regulation 135 of the Secretary of Health (registered as Regulation No. 7655 with the Department of State on December 29, 2008), establishes that "no person, firm, union, corporation, institution, enterprise of any kind, or public establishment, as defined in these regulations, shall operate in Puerto Rico without first obtaining a health license issued by the Secretary [of Health] or his authorized representative." Regulation 135, Article VII, Section 3.01.
6. The Regulation also provides that the Secretary of Health may suspend a health license "when it is determined that a situation or problem exists which by its nature poses a serious threat to public health." Regulation 135, Article VII, Section 3.04(4).

7. In addition, Regulation 6044 of November 7, 1999 adopts by reference the federal regulation concerning health care facilities for persons with intellectual disabilities, *Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities*.

CONCLUSIONS

1. The inspection carried out evidences the institutional mistreatment and the subhuman conditions in which the residents of the Institución are kept.
2. Not only do they not meet the minimum health criteria, but they have neither the qualified nor sufficient personnel to tend to this population, which depends on said personnel for their daily living.
3. Infrastructure conditions are a danger to both residents and the community, as the proliferation of rodents, cockroaches and birds, which carry rotten food, feces, mosquitoes, are prevalent and a public health problem.
4. The respondent's actions preclude the ministerial function of the Department of Health to ensure public health and safety, and therefore violate the above-mentioned laws and regulations.
5. The current rule of law authorizes the Secretary of Health to take immediate action when situations that constitute an imminent risk to public health arise. Among the actions available to the Secretary of Health are the imposition of fines, the cancellation or suspension of a health license, and the closing of the facility or establishment that creates the risk.
6. In addition, it is our responsibility as public officials to notify the Department of Justice of the commission of crimes and violations of laws.

WHEREFORE, we very respectfully request the Honorable Secretary of Health to grant the following remedies:

1. Order the immediate and permanent closure of the institution Institución Fundación Modesto Gotay.
2. Impose a fine of five thousand dollars ($5,000.00) for each infraction incurred.

I HEREBY CERTIFY having sent a true and exact copy of this complaint to the institution Institución Fundación Modesto Gotay at its mailing address: 876 Km. 4.8, Bo. Las Cuevas, Trujillo Alto, Puerto Rico 00978 or by e-mail: fmgotay@gmail.com.

RESPECTFULLY SUBMITTED. In San Juan, Puerto Rico, August 9, 2020.

[Signed]

JESUS HERNANDEZ, MBA, CFE
Department of Health
Director
Office of Investigations

JOAN RIVERA ORTIZ, PhD

Department of Health
Director
DSPDI

DORIS BORRERO TORRES
Department of Health
SARAFS Inspector

MÓNICA VÉLEZ CAMACHO
Department of Health
SASA Interim Supervisor

CERTIFICATION: I, BEATRIZ M. SIFONTES-SOTOMAYOR, attorney and translator, DO HEREBY CERTIFY that the foregoing document is a legally accurate, true and correct translation from Spanish into ENGLISH to the best of my knowledge and abilities. In San Juan, PR, August 10, 2020.

TRANSLATION

COMMONWEALTH OF PUERTO RICO
DEPARTMENT OF HEALTH
ADMINISTRATIVE HEARINGS DIVISION
P.O. Box 70184
San Juan, Puerto Rico 00936

DEPARTMENT OF HEALTH **Office of the Assistant Secretary for Environmental Health (SASA)** **Office of the Assistant Secretary for the Regulation and Accreditation of Healthcare Facilities (SARAFS)** **Office of Investigations (OI)** **Division of Services for People with Intellectual Disabilities (DSPDI)** CLAIMANT VS. **MODESTO GOTAY FOUNDATION INSTITUTION** **Dr. Carlos Rodríguez – Executive Director** **Milagros Vargas- Consultant** RESPONDENT	**COMPLAINT QFS-2020-08-01** **RE**: Violations to Act No. 81 of March 14, 1912; Act No. 254 of December 31, 2015; Regulation 135 of the Secretary of Health, General Regulation of Environmental Health, Act No. 101 of June 26, 1965; Regulation 6044 of November 7, 1999; Act No. 4 of June 23, 1971, as amended.

NOTIFICATION OF ORDER FOR IMMEDIATE ACTION

Considered the request by the **Office of the Assistant Secretary for Environmental Health, the Office of the Assistant Secretary for the Regulation and Accreditation of Healthcare Facilities, the Office of Investigations and the Division of Services for People with Intellectual Disabilities**, to issue an order for **immediate action** against the respondent, its employees, agents and attorneys-in-fact to **immediately cease and desist from continuing operating the business** mentioned in the complaint due to the existence of conditions that may endanger and cause immediate risk to the health, life and public safety, the same is hereby **GRANTED**.

1. The following preliminary findings of fact are made:

   According to the inspection carried out on August 6, 2020, serious deficiencies were found in the Modelo [sic] Gotay Foundation Institution. They are detailed in the complaint.

CONCLUSIONS OF LAW

1. The establishment's operation puts at risk the health and safety of the population it serves.

THEREFORE, the **immediate closure** is ordered and for a term of ten (10) days from the notification of this order to the Modesto Gotay Foundation Institution. An administrative hearing is scheduled for August 18, 2020, **at 10:00 am**. It will be to consider the continuation, modification or cancellation of this order and **carried out virtually through the TEAMS Platform**.

Once this Order has been received, the Respondent must notify its e-mail to proceed with the scheduling of the hearing and provide the corresponding access. If the videoconference hearing is not feasible, the Respondent must notify, within five (5) days following receipt of this Order, the impossibility of attending the hearing by videoconference, and the hearing will be conducted in person at the date and time previously indicated.

The respondent may submit, prior to the date of the hearing, information that shows, certifies and evidences the actions taken to address the deficiencies notified in the complaint and the Department of Health, upon confirming compliance, may render this closure order and subsequent hearing without effect. The respondent is advised that it must answer the complaint within 20 days

with all the defenses that may assist, pursuant to the Regulation No. 85 on Adjudicatory Procedures. A copy of the answer must be delivered to the Office of Legal Counsels, Administrative Hearings Division of the Department of Health.

NOTICE RELATED TO COVID-19

In accordance with Executive Order OE-2020-041 of May 21, 2020, issued by the Honorable Wanda Vázquez Garced, administrative hearings carried out in our Division shall meet the following requirements:

- Every person summoned to a hearing must arrive at the Department's Office of Legal Counsels no later than five (5) minutes before the hearing is to be held.

- Any person summoned to an administrative hearing must cover the mouth and nose area with a mask or scarf made of cloth or other material. Every person shall be responsible for using personal protective equipment in accordance with the recommendations of use by the Department of Health. The presence of persons without masks shall not be allowed in the Office of Legal Counsels, or in the administrative hearing room, without any exception. The Office of Legal Counsels will not provide masks to its visitors.

- Any person summoned for a hearing shall have their temperature taken upon entering the Office of Legal Counsels. If the person's temperature is equal to or greater than 38°C or 100.4°F, they will be denied access to the Office of Legal Counsels and the hearing will be rescheduled.

- If the summoned person refuses to take his/her body temperature, access to the Office of Legal Counsels will be denied and the hearing will be re-scheduled. If the person is summoned for a second time and refuses to take his/her temperature while the emergency is in place, it will be understood that the person refuses to appear at the hearing.

- Every person must maintain, at all times, a minimum of six (6) feet of distance with relation to the other persons present during the hearing and while in the Office of Legal Counsels and in the hearing room.

- During the hearing, only one (1) witness, the one who is bearing testimony, may be present at a time. Additional witnesses will be kept waiting outside the hearing room, taking safety precautions regarding the use of masks and physical distancing.

- During the hearing, only the following will be present in the hearing room: the Examining Officer, the attorney for the Parties. If the Respondent appears with a lawyer, it must notify it at least three (3) days in advance of the hearing date to take the corresponding protective measures.

- The Parties must bring to the hearing, for the Examining Officer, a copy of the documents they wish to submit to evidence. Copies of documents that are intended to be submitted at the hearing will not be copied at the Office of Legal Counsels.

In San Juan, Puerto Rico, this August 9, 2020.

BE NOTIFIED.

/s/ Lorenzo González Feliciano
LORENZO GONZÁLEZ FELICIANO, MD, MBA, DHA
SECRETARY OF HEALTH

/s/ Miguel A. Verdiales-Morales
MIGUEL A. VERDIALES-MORALES
LEGAL COUNSEL