STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, DIVISION OF HEALTH QUALITY ASSURANCE,	)	
Petitioner,	)	
vs.	)	CASE NO. 95-5676
WILLIA'S BAHAMAS HOME CARE CENTER,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly designated Hearing Officer, Susan B. Kirkland, held a formal hearing in this case on January 11, 1996, in West Palm Beach, Florida.

APPEARANCES

For Petitioner: Linda L. Parkinson, Esquire
Agency for Health Care Administration
Division of Health Quality Assurance
400 West Robinson Street, Suite S-309
Orlando, Florida 32801

For Respondent: Willia Mae Mackey, Administrator
Willia's Bahama Home Care Center
125 Old Dixie Highway
Riviera Beach, Florida 33404

STATEMENT OF THE ISSUE

Whether a moratorium should be placed on Respondent's facility.

PRELIMINARY STATEMENT

Petitioner, Agency for Health Care Administration (Agency), imposed a moratorium on the Respondent, Willia's Bahamas Home Care Center, effective October 10, 1995 and notified Respondent verbally on that day. By letter dated October 17, 1995, the Agency notified Respondent in writing of the moratorium imposed on the facility. As grounds for the imposition of the moratorium, the Agency alleged that there were conditions which threatened the health, safety, or welfare of the facility residents. Upon receipt of the moratorium letter, Respondent requested a formal administrative hearing. The case was forwarded to the Division of Administrative Hearings for assignment to a hearing officer.

At the final hearing, the Agency called the following witnesses, Darrell Donatto, Robert Cleva, Merle McDonald, James Ison, Nathan Weitz, Polly Weaver,

Joseph Narkier, Mary Jane Battaglia, and Harold Bahlow. Petitioner's Exhibits 1-8 were admitted in evidence. Willia Mackey testified on behalf of Willia's Bahamas Home Care Center. Respondent's Exhibits 1 and 2 were admitted in evidence.

At the final hearing the parties agreed to file proposed recommended orders within ten days of the date of the filing of the transcript. The transcript was filed on January 25, 1996. The Agency filed its proposed recommended order on February 2, 1996. The Respondent did not file a proposed recommended order. The Agency's proposed findings of fact are addressed in the Appendix to this Recommended Order.

FINDINGS OF FACT

1. The Respondent, Willia's Bahamas Home Care Center (Willia's), is an Assisted Living Facility (ALF) located at 125 W. Dixie Highway, Riviera Beach, Florida, with a standard license to operate an ALF for 24 residents.

2. Petitioner, Agency for Health Care Administration (Agency), surveyed the facility on November 9, 1994 and cited deficiencies. A time frame was given to the facility for the correction of thirty deficiencies. As a result of the survey of November 9, 1994, the facility was issued a conditional license.

3. On September 28, 1995, a fire inspector from the Riviera Beach Fire Department conducted an appraisal visit of the facility. Many deficiencies were cited and the facility was furnished with a letter dated September 29, 1995, listing the deficiencies and requesting that Willia's notify the Fire Department when the deficiencies were corrected so that the Fire Department could conduct a follow up inspection.

4. During the September 28, 1995, visit, the fire inspector noticed that a lawn mower was in an inside room with a container of combustible liquid next to a gas water heater. This condition posed an immediate threat to the residents of the facility and the fire inspector had the facility move the lawn mower before he left the facility.

5. The fire inspector also noted on the September 28 visit that the fire alarm system was not working. The fire alarm system had been out of service for some time and was not being monitored. There were no reports of testing or inspection of the fire alarm system. The lack of a working fire alarm system prevented immediate identification of a fire problem, the immediate alerting of the residents for escape, and the immediate notification to the fire department.

6. On January 4, 1996, an employee of the Riviera Beach Fire Department, made a follow-up visit to Willia's. The fire alarm system was still non-functional and had been since July, 1995. The facility is a two-story building which does not have a sprinkler system. The lack of a functional fire alarm system posed a threat to the safety of the residents.

7. On September 28, 1995, the Environmental Services' section of the Department of Health and Rehabilitative Services conducted an appraisal visit of the facility. Deficiencies were cited and the facility was furnished with an inspection report dated September 28, 1995, which listed the deficiencies. The following deficiencies were a threat to the health, safety, and welfare of the residents: 1) hot water at a temperature of 122 degrees Fahrenheit; 2) an extension cord that was too long which presented a trip hazard; and 3) protruding nails.

8. On October 13, 1995, Environmental Services conducted a follow-up visit and found that the most serious of the deficiencies had been corrected.

9. On September 28, 1995, the Agency conducted an appraisal visit of Willia's along with Nathan Wetiz, a member of the Ombudsman Council. Thirty one deficiencies were cited. Fifteen of these deficiencies had been previously cited during the November 9, 1994, visit by the Agency. The facility was given a statement of deficiencies along with a time frame for correcting the deficiencies.

10. Some of the residents of the facility were entitled to receive personal funds from OSS/SSI. The records at the facility showed that the residents were being asked to sign for the funds two months before the funds were due to be disbursed.

11. At the time of the September 28, 1995 appraisal visit both Mary Jane Battaglia, R.N. and Mr. Weitz found that residents' medications were being recorded in error. Medications were recorded as having been administered on the day after the survey. The records showed that residents were not being given their medications at the prescribed times. The nurse counted the medications of one resident and compared them with the medication record and found that there were medications which were not being given as prescribed. Such medications included Persantin which reduces blood clots and Verapamil which reduces the heart rate and prevents strokes.

12. During the September 28 visit, Ms. Battaglia discovered that one resident was inappropriate for an ALF. This resident required the assistance of two people to help her stand. The resident was unable to propel herself in a wheel chair and had diminished vision. She had to be given her medications, which were being administered by unlicensed staff. The resident needed 24-hour nursing supervision. During the visit, Mrs. Mackey was observed being verbally abusive to the resident, telling her to shut up and calling her stupid.

13. In addition to the deficiencies discussed in the preceding paragraphs, the following deficiencies were also cited. The weight records of the residents were being filled in without weighing the residents, thereby threatening the residents's health since there would be no way to track whether the residents were actually losing weight. One resident was being restrained by 3/4 bedside rails without a physician's order. Activities were not being provided for the residents. There was no documentation that the nutritional needs of the residents were being met. Menus were not being reviewed by a licensed dietitian. The posted menus were not being followed and the meals were not served on time. Two screw-in fuses were missing in the day room, which could lead to residents being shocked.

14. On October 10, 1995, the Agency advised the facility that it was being placed under a moratorium. At that time Willia's had a census of nine residents. By letter dated October 17, 1995, the Agency gave written notification to the facility of the moratorium.

15. A follow-up visit was conducted on November 29, 1995 by Joe Narkier and Nathan Weitz. Twenty deficiencies were cited including nineteen uncorrected deficiencies and a violation of the moratorium imposed on October 10, 1995. Eleven of these deficiencies were deficiencies which had been cited during the November 9, 1994 survey.

16. At the time of the November 29 revisit, the following conditions still threatened the health, safety, and welfare of the residents. The fire alarm system still was not working. There was an inappropriate resident in the facility, who needed care beyond that which the facility was licensed or staffed to provide. Medication records were inaccurate. Semi-annual weights were still not being recorded for all residents. Menus were not being followed and meals were not being served on time.

17. Another follow-up visit was conducted on January 10, 1996. The deficiencies which were noted in the November 29 visit had not been corrected.

18. Administrative Complaint number 9-95-639 ACLF was issued against Willia's, fining the facility $2,400 as a result of twelve deficiencies which were found at the November 9, 1994 survey which were repeat violations found during the September 28, 1995 appraisal visit. No hearing was requested by the facility. A Final Order was issued by the Agency on December 1, 1995, imposing the fine against Willia's for the repeat deficiencies alleged in the administrative complaint.

19. At the final hearing Mrs. Mackey, the administrator of Willia's stated that she was going to voluntarily surrender her license to the Agency. She tendered the license to the Agency.

CONCLUSIONS OF LAW

20. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Section 120.57(1), Florida Statutes.

21. Chapter 400, Part III, Florida Statutes, provides for the licensing and regulation of Assisted Living Facilities by the Agency.

22. Section 400.415, Florida Statutes, provides:

> The agency may impose an immediate moratorium on admissions to any facility when the agency determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility. A facility the license of which is denied, revoked, or suspended as result of a violation of s. 400.414 may be subject to immediate imposition of a moratorium on admissions to run concurrently with licensure denial, revocation, or suspension.

23. Rule 10A-5.033(3), which is now numbered 58A-5.033(3), Florida Administrative Code, provides:

> (a) An immediate moratorium on admissions to the facility shall be placed on the facility by the central Office of Licensure and Certification when it has been determined that any condition in the facility presents a potential threat to the health, safety, or welfare of the residents in the facility. The following conditions are examples of

> potential threats constituting grounds for a moratorium:
>
> 1. Unsafe practices relating to medication.
> 2. Presence of resident inappropriately placed in the facility according to the criteria in Rule 10A-5.0181, F.A.C.
> 3. Food supply inadequate for proper nutrition of the residents.
> 4. Deficiencies relating to fire safety.
> 5. Lack of proper supervision to meet the needs of the residents.
> 6. Actions by a facility or its employee that are grounds for denial, revocation, or suspension of a license pursuant to Rule 10A-5.033(4), F.A.C.
> 7. Multiple Class I or Class II deficiencies or uncorrected Class III deficiencies.
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> * * * *
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> (c) Moratoriums shall not be lifted until the deficiencies have been corrected and the department has been assured by a monitoring survey that there is no longer any threat to the residents' health, safety, or welfare. The removal of the moratorium will be communicated by a telephone call and confirmed by a written notification.

24. Class II and Class III deficiencies are defined in Section 400.419(3), Florida Statutes as follows:

> (b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of facility residents, other than class I violations. . . .
>
> (c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents, other than class I or class II violations. . . .

25. The agency has grounds for the imposition of the moratorium. The facility had unsafe practices relating to medication. The medications were not correctly recorded. Residents were not being given their medications at the prescribed times.

26. The facility had a resident which was inappropriate for the facility. The resident could not perform the activities of daily living, required 24-hour nursing supervision, was not capable of taking her own medication, and was not capable of self preservation in the event of an emergency. Thus, the resident

did not meet the criteria for admission to the facility as set forth in Rule 58A-5.0181, formerly 10A-5.0181, Florida Administrative Code.

27. There were multiple Class II deficiencies which included an inappropriate resident, inaccurate medication records, and medications administered by unlicensed staff.

28. As of the date of the final hearing there were uncorrected Class III deficiencies, which included semi-annual weights of the residents not being recorded, menus not being followed and meals not being served on time.

29. As of the date of the final hearing, the fire alarm system was still inoperable.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a Final Order be entered affirming the imposition of the moratorium.

DONE AND ENTERED this 15th day of February, 1996, in Tallahassee, Leon County, Florida.

SUSAN B. KIRKLAND, Hearing Officer
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The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675

Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of February, 1996.

APPENDIX TO RECOMMENDED ORDER, CASE NO. 95-5676

To comply with the requirements of Section 120.59(2), Florida Statutes, the following rulings are made on the Petitioner's proposed findings of fact:

Petitioner's Proposed Findings of Fact:

1. Paragraphs 1-9: Accepted in substance.
2. Paragraph 10: Accepted to the extent that the resident were signing for funds before the funds were due to be disbursed. Rejected that the residents were not receiving funds as hearsay.
3. Paragraphs 11-12: Accepted in substance.
4. Paragraph 13: The tenth sentence is rejected as hearsay. The remainder is accepted in substance.
5. Paragraph 14: Accepted in substance.
6. Paragraph 15: The eighth sentence is rejected as hearsay. The tenth sentence is rejected as unnecessary. The remainder is accepted in substance.

7. Paragraph 16: Accepted in substance.
8. Paragraph 17: Rejected as unnecessary.
9. Paragraph 18: Accepted in substance.
10. Paragraph 19: Accepted in substance to the extent that Mrs. Mackey intended to voluntarily surrender the license for the facility.

Respondent's Proposed Findings of Fact:

The Respondent did not file proposed findings of fact.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions to this recommended order. All agencies allow each party at least ten days in which to submit written exceptions. Some agencies allow a larger period within which to submit written exceptions. You should contact the agency that will issue the final order in this case concerning agency rules on the deadline for filing exceptions to this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.