STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BROADVIEW RETIREMENT HOME, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 97-4464
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. BROADVIEW RETIREMENT HOME, Respondent.	)	Case No. 97-5695

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in these consolidated cases on December 17, 1997, at Fort Lauderdale, Florida, before Claude B. Arrington, a duly designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Broadview Retirement Home:	Pauline Ann Black, Owner 1841 Southwest 63rd Terrace Pompano Beach, Florida 33068
For Agency for Health Care Administration:	Jennifer A. Steward, Esquire Agency for Health Care Administration 1400 West Commercial Boulevard, Suite 110 Fort Lauderdale, Florida 33309

STATEMENT OF THE ISSUES

As to DOAH Case No.97-4464, whether Broadview Retirement Home is entitled to renewal of its license as an assisted living facility.

As to DOAH Case No. 97-5695, whether Broadview committed the offenses alleged in the Administrative Complaint and the penalties, if any, that should be imposed.

PRELIMINARY STATEMENT

By letter dated July 31, 1997, the Agency for Health Care Administration (Agency) notified Broadview Retirement Home (Broadview) that its application for renewal of license as an assisted living facility (ALF) was denied. The denial was based on Broadview's alleged failure to document that the facility had passed a fire safety inspection. Broadview's timely challenge of the denial was referred to the Division of Administrative Hearings, where it was assigned DOAH Case No. 97-4464. By notice dated October 17, 1997, the formal hearing in DOAH Case No. 97-4464 was set for December 5, 1997. On November 25, 1997, the agency moved to relinquish jurisdiction on the grounds asserted in its motion. A telephone hearing was held on the motion to relinquish jurisdiction. By order dated December 3, 1997, the motion to relinquish jurisdiction was denied and the matter was rescheduled to December 17, 1997.

On October 28, 1997, the Agency served on Broadview the Administrative Complaint that underpins DOAH Case No. 97-5695.

The Administrative Complaint in DOAH Case No. 97-5695 was based on an inspection of the facility on September 23, 1997, by Agency investigator Ana Garcia-Quevedo. On September 26, 1997, Broadview was closed by the Agency and the four residents of Broadview were relocated to other facilities. The Administrative Complaint contains specific allegations of multiple violations of the statutes and rules regulating ALFs. Broadview initially requested an informal hearing to challenge the allegations of the Administrative Complaint, but later requested a formal hearing. The matter was thereafter referred to the Division of Administrative Hearings on December 11, 1997, where it was assigned DOAH Case No. 97-5695.

On December 16, 1997, the parties filed a Joint Motion to Consolidate DOAH Case Nos. 97-4464 and 97-5695, and advised that they were prepared to go to hearing on both cases on December 17, 1997. On December 17, 1997, the formal hearing was convened, the motion to consolidate was granted (while on the record), and the consolidated formal hearing was conducted.

At the formal hearing, the Agency presented the testimony of Ms. Garcia-Quevedo. The Agency presented no exhibits. Broadview presented the testimony of Mary Palmer-Miller and of Pauline Ann Black. Ms. Palmer-Miller is employed as the director of nursing at Plantation Nursing Home and Rehab Center, the nursing home to which two of Broadview's former residents (Residents 1 and 4) were transported on September 26, 1997. Ms. Black is the owner

of Broadview. Broadview offered three exhibits, two of which were admitted into evidence.

A transcript of the proceedings has been filed. At the request of the parties, the time for filing post-hearing submissions was set for more than ten days following the filing of the transcript. Consequently, the parties waived the requirement that a recommended order be rendered within thirty days after the transcript is filed. Rule 60Q-2.031, Florida Administrative Code. Broadview and the Agency filed proposed recommended orders, which have been duly considered by the undersigned in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times pertinent to these proceedings, Pauline Ann Black was the owner of Broadview Retirement Home, a licensed assisted living facility located at 1741-1743 Southwest 70th Avenue, Pompano Beach, Florida. At all times relevant to these proceedings, the facility was licensed for six residents.

2. The Agency has jurisdiction over Broadview by virtue of the provisions of Chapter 400, Part III, Florida Statutes, and Chapter 58A-5, Florida Administrative Code.

3. Prior to July 31, 1997, Broadview applied for renewal of its license to operate as an ALF. On July 31, 1997, the Agency issued to Broadview a letter that denied the application for renewal for the following specified reason:

> The applicant's failure to provide required ALF license application information pursuant

to section 400.414(2)(g), F.S. and 58A-5.022(17), F.A.C. The requested information included a satisfactory fire safety inspection report.

4. By notice with an effective date of August 29, 1997, the Agency imposed a moratorium that prevented Broadview from admitting new residents. Whether the Agency had sufficient

grounds to impose the moratorium was not at issue in this proceeding.

5. On September 23, 1997, the Agency received a complaint from a police officer that caused it to conduct an immediate inspection of Broadview.

6. Ana Garcia-Quevedo, an experienced investigator employed by the Agency, was assigned the responsibility of conducting the inspection. Ms. Garcia-Quevedo's job title is Health Facility Evaluator I. Because there were no other investigators available, Ms. Garcia-Quevedo was the only Agency employee who participated in the inspection on September 23, 1997.

7. On September 23, 1997, Broadview did not have posted at the facility a copy of the letter denying its renewal application, or the notice imposing the moratorium on admissions. On September 23, 1997, Broadview did not have available for inspection a copy of its fire safety inspection report.[1]

8. There were four residents of Broadview on September 23, 1997, each of whom was an elderly female. By agreement of the parties, the residents were referred to by number at the formal hearing.

9. There was only one staff person on duty at Broadview when Ms. Garcia-Quevedo conducted her investigation. One of the residents was wheelchair bound and two other residents were too confused to react in an emergency. One employee was insufficient to assure the safety of the residents in the event of an

emergency, such as a fire.

10. Residents 1 and 4 did not meet the criteria for placement in an ALF as they both required the degree of care and supervision provided by a nursing home.[2] Both of these residents were unable to participate in any leisure activities and could not communicate in a meaningful way. When the residents were removed from the facility on September 26, 1997, these two residents were transferred to Plantation Nursing and Rehab Center, which is a nursing home.

11. Resident 2 suffered Insulin Dependent Diabetes Mellitus and required administration of insulin twice daily. Resident 2 was not capable of taking her medication without assistance. Broadview's employee was not aware of the amount of insulin Resident 2 required, and she was not aware of Resident 2's dietary restrictions. Although Resident 2 was transferred to another ALF on September 26, 1997, Broadview was not an appropriate placement for this resident because Broadview did not provide this resident with sufficient care and supervision in the administration of her medicine or the provision of her food.

12. Broadview did not maintain Resident 2's insulin in a locked area. This medicine was kept in a refrigerator in the butter compartment, which did not have a locking system.

13. A review by Ms. Garcia-Quevedo of the records made available to her by the Broadview employee on September 23, 1997, revealed that Broadview did not maintain current records of the condition of the respective residents. The last entries in the

records for Residents 1, 2, and 3 were made in September of 1996. Resident 4 was admitted to Broadview from a skilled nursing facility on June 4, 1997. A discharge summary prepared by that nursing home was the only record for Resident 4. There were no records describing the condition for Resident 4 subsequent to her admission to Broadview.

14. As of September 23, 1997, Broadview was unable to document that it was providing its four residents with services appropriate to their needs. The records for these residents did not contain documentation by Petitioner regarding the level of care or personal supervision needed.

15. As of September 23, 1997, there was no health assessment of Resident 4 in Broadview's records.

16. Broadview did not have available for inspection on September 23, 1997, records of the weights of the residents. [3]

17. All four residents required special diets. Residents 1, 2,and 3 had orders for restricted diets documented in their health assessments. Resident 4 did not have a health assessment, but the discharge summary from the skilled nursing home from which she had been transferred ordered a therapeutic diet.

18. The posted menu on the date of the survey was dated for the week of October 31, 1996. The posted menu documented an evening meal that was not the meal that was actually served. Broadview did not document the changes in the menu or provide a nutritional substitute for one of the menu items (fruit

cocktail). There were insufficient foods in storage to prepare the planned meals for the week. The employee on duty on September 23, 1997, did not know when additional food items would be purchased.

19. As of September 23, 1997, the diets offered by Broadview did not meet the nutritional needs of the four residents.

20. The last recorded weight of Resident 1, in the amount of 122 pounds, was on the date of her admission, which was December 31, 1994. When she was weighed by Ms. Garcia-Quevedo on September 23, 1997, her weight was 96 pounds. When Resident 1 was weighed upon transfer to the skilled nursing home on September 26, 1997, her weight was 94.5 pounds. The last documented weight for Resident 2, in the amount of 180 pounds, was entered on July 8, 1996. Ms. Garcia-Quevedo was unable to weigh this resident because she could not slide back on the chair scale. The last documented weight for Resident 3, in the amount of 136 pounds, was entered on March 20, 1996. When she was weighed by Ms. Garcia-Quevedo on September 23, 1997, her weight was 122 pounds. The last recorded weight for Resident 4, in the amount of 105, was reflected in the discharge summary when she was transferred from the skilled nursing home to Broadview on June 4, 1997. When she was weighed by Ms. Garcia-Quevedo on September 23, 1997, her weight was 86 pounds. When Resident 4 was weighed upon transfer to the skilled nursing home on

September 26, 1997, her weight was 102 pounds.[4] The Agency established that Residents 1 and 4 suffered weight losses while residing at Broadview. The evidence was insufficient to establish that Residents 2 and 3 had also suffered weight losses.

21. Residents 1 and 4 were dressed in clothing stained with food particles.

CONCLUSIONS OF LAW

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

23. Part III of Chapter 400, Florida Statutes, is the Florida Assisted Living Facilities Act. See Section 400.401(1), Florida Statutes.

24. Section 400.401(3), Florida Statutes, provides as follows:

> (3) The principle that a license issued under this part is a public trust and a privilege and is not an entitlement should guide the finder of fact or trier of law at any administrative proceeding or in a court action initiated by the Agency for Health Care Administration to enforce this part.

25. Section 400.414, Florida Statutes, provides, in pertinent part, as follows:

> (1) The agency may deny, revoke, or suspend a license issued under this part or impose an administrative fine in the manner provided in chapter 120. At the chapter 120 hearing, the agency shall prove by a preponderance of the evidence that its actions are warranted.
> (2) Any of the following actions by a

> facility or its employee shall be grounds for action by the agency against a licensee:
>
> (a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
>
> * * *
>
> (3) Proceedings brought under paragraphs (2)(a), (c), (e), and (j) shall not be subject to de novo review.

26. The Agency established that Broadview did not provide a fire safety report with its application to renew its license and failed to have a fire safety report available for inspection on September 23, 1997. Section 400.417(1), Florida Statutes, requires that a fire safety report accompany an application for renewal of license. The failure of Broadview to attach a copy of the fire safety report to its renewal application justified the Agency's initial decision to deny the renewal application. Broadview produced at the formal hearing a fire safety inspection report that was accepted into evidence without objection. This report established that the facility passed a fire safety inspection on March 18, 1997. Consequently, it is concluded that the failure of Broadview to attach a copy of the fire inspection report should not be a grounds for denying Broadview's renewal application. If such grounds exist, they must be found in the allegations of the Administrative Complaint in DOAH Case No. 97-5695.

27. In its Administrative Complaint, the Agency alleged that Broadview's failure to produce a copy of the fire inspection

report on September 23, 1997, constituted a violation of the provisions of Section 400.441(1)(a)2m, Florida Statutes, and/or Rule 58A-023(18)(a), Florida Administrative Code. [The Agency alleged in its Administrative Complaint that Broadview violated Rule 58A-023(18)(a), which does not exist. This reference is apparently a scrivener's error, and it is assumed that the intended reference was to Rule 58A-5.023(18), Florida Administrative Code.] These provisions relate to the fire-prevention requirements of the physical plant. Broadview established that its facility met those requirements. Consequently, it is concluded that the Agency failed to establish that Broadview violated the provisions of Section 400.441(1)(a)2m, Florida Statutes, and/or Rule 58A-023(18)(a), Florida Administrative Code, as alleged by the Agency.

28. Rule 58A-5.024, Florida Administrative Code, provides the following requirement pertaining to records:

> The owner or administrator of a facility shall maintain the following written records in a place, form and system ordinarily employed in good business practice. All records required by this chapter shall be accessible to department and agency staff. All resident contracts shall be retained for five years after expiration.

30. Rule 58A-5.024(2)(c)3, Florida Administrative Code, requires that an ALF maintain the following health information:

> a. A copy of the physical examination by a health care provider as required by 58A-5.0181(4).
> b. Name, address, and telephone number of the resident's health care provider.

c. Description of resident's overall condition and level of care required, updated as needed.

d. Reports of resident illness and medical attention provided.

e. Record of height and weight which is initiated on admission. Information may be taken from the resident's physical examination. Residents receiving individual assistance with activities of daily living shall have their weight recorded semi-annually.

31. Rule 58A-5.024(6), Florida Administrative Code, requires the following:

(6) When a moratorium is placed on a facility or notification of denial, revocation or suspension of the license has been received, that notice shall be posted and visible to the public at the facility.

32. The Agency established that Broadview violated the foregoing provisions of Rule 58A-5.024, Florida Administrative Code, as alleged in the Administrative Complaint, by failing to post the notice of the moratorium and the notice that its renewal application was denied, by failing to maintain health assessments for the residents, and by failing to have the recorded weights of the residents available for inspection.

33. In addition, the Agency established that Broadview's failure to have a health assessment for Resident 4 violated the following provisions of Rule 58A-5.0181(3), Florida Administrative Code:

> (3) Admission procedures are as follows:
> (a) Residents not placed by the department, by HRS, or by an agency under contract with the department or HRS.
> 1. Each resident, in accordance with Section 400.426(4), F.S., shall be examined by a health care provider within 60 days before admission to the facility. The medical examination report shall be submitted to the administrator of the facility, who shall use the information therein to assist in the determination of the appropriateness of admission of the resident to the facility.
> 2. If a medical examination has not been completed within 60 days prior to the resident's admission to the facility, a health care provider shall examine the resident and complete an assessment report using the Health Assessment for Assisted Living Facilities, DOEA Form 1823, dated October 1995, which is hereby incorporated by reference, within 30 days following the resident's admission to the facility, to enable the administrator to determine the appropriateness of admission. A copy of DOEA Form 1823 may be obtained from the Assisted Living Coordinator, Department of Elder Affairs, 4040 Esplanade Way, Tallahassee,

Florida 32399-7000. Assessment reports using the previous edition of this form which were completed prior to October 30, 1995, shall be considered valid. In lieu of Form 1823, the Comprehensive Assessment Form Part II, DOEA Form 111B, July 1992, or the CARES Mini Assessment Form Part III, DOEA Form 111C, February 1992, may be used if signed by a health care provider.

34. Rule 58A-5.0181, Florida Administrative Code, set forth the following admission criteria pertinent to this proceeding:

(1) In order to be admitted to any facility, an individual shall meet the following criteria:
(a) The individual is able to perform the activities of daily living, with supervision or assistance if necessary.

* * *

(c) The individual is in sufficient health so as not to require 24-hour nursing supervision.
(d) With respect to medication, the individual:
1. Is capable of taking his own medication with or without supervision by trained staff, or
2. Requires administration of medication, and the facility has a nurse to provide this service when the service is needed, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service.

* * *

(f) The individual's special dietary needs, if any, can be met by the facility.
(g) The individual is able to participate in social and leisure activities.
(h) The individual is capable of self-preservation in an emergency situation involving the immediate evacuation of the facility, with assistance with transfer as

defined in Rule 58A-5.0131, if necessary.

* * *

(2) Even if an individual meets the criteria in subsection (1), the individual may not be appropriate for admission to a particular facility. The determination of the appropriateness of the admission to a particular facility of a particular individual who has the characteristics enumerated in subsection (1) is the responsibility of the administrator of the facility. The administrator shall base his decision on an assessment of the strengths, needs, and preferences of the individual, especially as revealed by the medical examination report required pursuant to subsection (3), in relation to the environment and services offered or arranged by the facility in accordance with facility policy.

35. The Agency established that three of the four residents did not meet the criteria for residency at Broadview. Ms. Black, the owner of Broadview, knew or should have known that Residents 1 and 4 needed more care than her facility could provide. In addition, Ms. Black knew or should have known that Resident 2 required insulin, but the employee on duty on September 23, 1997, did not know how to administer insulin to Resident 2. Consequently, Broadview was not an appropriate placement for Resident 2. Based on the foregoing, it is concluded that the Agency established that Broadview violated the provisions of Rule 58A-5.0181, Florida Administrative Code, as alleged in the Administrative Complaint.

36. The Agency established that Broadview violated the provisions of Rule 58A-5.0182(6)(d)3, Florida Administrative

Code, by maintaining centrally stored medicine, the insulin for Resident 2, in a refrigerator that did not have a locking system. Rule 58A-5.0182(6)(d)3, Florida Administrative Code, provides, in pertinent part, as follows:

3 Centrally stored medications shall be:
a. Kept in a locked cabinet or other locked storage receptacle or area at all times.
b. Accessible only to the staff responsible for supervision of self-administration and for administration of medication. Such staff shall have ready access to keys to medication storage areas at all times.
c. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked.

37. The Agency established that Broadview failed to meet the dietary requirements of the residents, thereby violating the provisions of Rule 58A-5.0182(2)(a), Florida Administrative Code, which provide the following standards:

(2) Facilities shall offer personal supervision, as appropriate for each resident, including the following as needed:
(a) Supervision of diets as to quality and quantity . . .

38. The Agency established that Broadview did not have adequate staff on duty on September 23, 1997. The one employee who was on duty was unfamiliar with the special diets that had been ordered for the residents, did not know how to administer medicine to Resident 2, and could not have protected the residents in the event of a fire or similar emergency. Based on the foregoing, it is concluded that Broadview violated the following provisions of Rule 58A-5.0182(1), Florida Administrative Code:

(1) The administrator shall provide staff and services appropriate to the needs of the residents living in the facility.

39. In addition, the Agency established that Broadview violated the provisions of Rule 58A-5.019(5)(a)1-4 and (6)(a), which provide as follows:

(5) The administrator of a facility shall:
(a) Employ staff in accordance with Rule 58A-5.019(6), F.A.C., and based on the following criteria to assure the safety and proper care of residents in the facility:
1. The physical and mental condition of the residents,
2. The size and layout of the facility,
3. The capabilities and training of the employees, and
4. Compliance with all minimum standards in this chapter.

* * *

(6) Staffing Ratio.
(a) Notwithstanding the minimum staffing ratio specified herein, all administrators of facilities, including those composed of apartments, shall have sufficient staff to provide or arrange services for residents as required consistent with the level of care offered and to evacuate residents identified through the assessment required under Rule 58A-5.0181(6), F.A.C., as needing assistance if an emergency evacuation is required.

40. The Agency established that Broadview failed to comply with the following portions of Rule 58A-5.20(1)(h), Florida Administrative Code:

(h) Menus.
1. Menus shall be dated and planned at least one week in advance for regular and therapeutic diets and shall match the menus reviewed pursuant to paragraph (e) or be of equal nutritional value. Substitutions shall be recorded before or when the meal is

> served. Menus as served shall be kept on file in the facility for 6 months.
>
> 2. Planned menus shall be conspicuously posted or easily available to residents. Residents shall be encouraged to participate in menu planning.
>
> (i) A one-week supply of non-perishable food, based on the number of weekly meals the facility has contracted with residents to serve, shall be on hand at all times. . . .

41. In Paragraph 4.h. of the Administrative Complaint, the Agency alleged that Broadview violated the provisions of Rule 58A-5.020(2)(f), Florida Administrative Code, a rule that could not be located by the undersigned. Consequently, no conclusions are based on that alleged violation.

42. Based on the foregoing violations, it is concluded that Broadview failed to provide for the health, safety, and welfare of the residents of its facility. The license of Broadview should be revoked pursuant to the Agency's authority. See Section 400.414(1) and (2)(a), Florida Statutes.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency enter a final order revoking Broadview's license as an assisted living facility.

DONE AND ENTERED this 3rd day of February, 1998, in Tallahassee, Leon County, Florida.

CLAUDE B. ARRINGTON
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway

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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of February, 1998

ENDNOTES

1/ Ms. Black testified, credibly, that her facility was required to install an expensive fire sprinkler system before the facility could pass the fire inspection. As of March 18, 1997, the facility had passed the fire safety inspection, but the documentation was kept by Ms. Black at her home and was not available for inspection at the facility. The letter reflecting that the facility had passed the inspection on March 18, 1997, from a Deputy Fire Marshall for Broward County, was dated August 29, 1997.

2/ Resident 1 was described by Ms. Garcia-Quevedo as being frail, disoriented, and unresponsive to verbal interaction. Broadview's employee told Ms. Garcia-Quevedo on September 23, 1997, that Resident 1 required total assistance with showering, grooming, dressing, and toileting. Resident 1 needed assistance walking and would require assistance in the case of an emergency. Resident 1 would not be able to take her own medications without assistance. Broadview did not have staff licensed to administer medications. Ms. Palmer-Miller described Resident 1 as being alert, but confused and oriented to name only.

Resident 4 was observed by Ms. Garcia-Quevedo on September 23, 1997, to be frequently exposing her diaper by lifting her skirt. Broadview's employee made no effort to redirect this behavior. Resident 4 was described by Ms. Garcia-Quevedo as being frail with contracted knees. Her clothing was stained and her hair had not been brushed. Resident 4 was described by Ms. Garcia-Quevedo as being unresponsive on September 23, 1997, and by Ms. Palmer-Miller as being very confused and oriented to name and day only. The discharge summary from the nursing home in which she resided before being transferred to Broadview reflects that Resident 4 needed assistance with all activities of daily living, except eating, and that she required a diet with pureed consistency. Broadview's employee was not aware that Resident 4's food needed to be pureed.

3/ There was a conflict in the evidence as to whether weight records existed. Ms. Black, the owner of Broadview, testified that the residents were weighed on standard bathroom scales every six months, but that the record of their weight was maintained separately from other records pertaining to residents. Ms. Black testified that the employee who was on duty on September 23, 1997, was new and did not know Broadview's practices. She further testified that the employee did not know where the bathroom scale was kept. According to Ms. Black, the chair scale did not work and was not used by the facility. Rule 58A-5.024, Florida Administrative Code, requires that such records be available for inspection. Regardless of whether weight records

were separately kept, weight records were not made available to the Agency investigator as required by rule.

4/ This discrepancy corroborates Ms. Black's testimony that the chair scale was not accurate. That testimony is also corroborated by Broadview's Exhibit 2, which is an estimate for the cost of repairing the chair scale. Because of the questionable accuracy of the chair scale, no findings or conclusions are based on the weights ascertained by Ms. Garcia-Quevedo on September 23, 1997. The weights taken of Residents 1 and 4 at the nursing home are considered accurate and establish that Residents 1 and 4 had lost weight while a resident of Broadview.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.

[1] Ms. Black testified, credibly, that her facility was required to install an expensive fire sprinkler system before the facility could pass the fire inspection. As of August 29, 1997, the facility had passed the fire safety inspection, but the documentation was kept by Ms. Black at her home and was not available for inspection at the facility.

[2] Resident 1 was described by Ms. Garcia-Quevedo as being frail, disoriented, and unresponsive to verbal interaction. Broadview's employee told Ms. Garcia-Quevedo on September 23, 1997, that Resident 1 required total assistance with showering, grooming, dressing, and toileting. Resident 1 needed assistance walking and would require assistance in the case of an emergency. Resident 1 would not be able to take her own medications without assistance. Broadview did not have staff licensed to administer medications. Ms. Palmer-Miller described Resident 1 as being alert, but confused and oriented to name only.

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[4] This discrepancy corroborates Ms. Black's testimony that the chair scale was not accurate. That testimony is also corroborated by Broadview's Exhibit 2, which is an estimate for the cost of repairing the chair scale. Because of the questionable accuracy of the chair scale, no findings or conclusions are based on the weights ascertained by Ms. Garcia-Quevedo on September 23, 1997. The weights taken of Residents 1 and 4 at the nursing home are considered accurate and establish that Residents 1 and 4 had lost weight while a resident of Broadview.