STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 98-3091

HERITAGE HEALTHCARE AND REHABILITATION CENTER,

Respondent.

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Naples, Florida, on February 10, 1999.

APPEARANCES

For Petitioner: Karel Baarslag
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For Respondent: R. David Thomas, Jr.
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STATEMENT OF THE ISSUE

The issue is whether Petitioner properly reduced the rating of Respondent's nursing home from Standard to Conditional.

PRELIMINARY STATEMENT

By License issued May 13, 1998, Petitioner reduced Respondent's nursing home license from Standard to Conditional following the completion of a periodic survey. By undated Petition for Formal Administrative Hearing, Respondent requested a formal hearing on this action.

At the hearing, Petitioner called three witnesses and offered into evidence four exhibits. Respondent called four witnesses and offered into evidence two exhibits. All exhibits were admitted.

The court reporter filed the Transcript on March 25, 1999.

FINDINGS OF FACT

1. Respondent owns and operates a nursing home in Naples. Petitioner conducts periodic surveys of the nursing home to determine whether the licensee should receive a Superior, Standard, or Conditional license rating.

2. Following a periodic survey, Petitioner determined that three Class II deficiencies existed. A Class II deficiency poses "an immediate threat to the health, safety or security of the residents."

3. Consequently, effective May 13, 1998, Petitioner issued a Conditional license. Immediately preceding this license, Respondent had a Standard license. Effective July 13, 1998, Petitioner issued Respondent a Standard license. This case involves only whether Petitioner properly reduced Respondent's

license to Conditional for the two-month period starting May 13, 1998.

4. The survey that started May 13, 1998, extended over three days. There is no charging document in this case. There is a revised survey report, which contains 17 findings under four tags. In its opening statement, Petitioner announced that it was proceeding under three tags: F 224, F 225, and F 353. During the hearing, Petitioner announced that it would offer no evidence under findings 2, 3, and 4 of Tag F 224. Petitioner did not present evidence under findings 1, 2, and 4 of Tag F 225, and Petitioner did not present any evidence under Tag F 353 that was not also under another tag.

5. The tags may refer to citations in a manual of Petitioner. Under each tag noted in the survey report, Petitioner cites the relevant legal provision, a summary of the reasons why the legal requirement is unmet, and detailed findings in numbered paragraphs. Next to each finding, Respondent includes a correction plan.

6. Citing "[42 Code of Federal Regulations Section] 483.13(c)(1)(i)," Tag F 224 in the survey report states:

> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

7. Tag F 224 in the survey report alleges that "this requirement" is not met because "the facility did not ensure that each resident received the care and services to prevent neglect for 2 (Residents #1 and #3) of 21 sampled residents and 3 residents interviewed."

8. Paragraph 1 of the findings under Tag F 224 in the survey report alleges that staff were not ambulating Resident Number 1; her care plan and records omitted the recommendation of the physical therapist that staff ambulate Resident Number 1 to meals; and staff failed to timely assist her in requested transfers and thus left her with no choice but to urinate in her bed or chair.

9. Resident Number 1 had undergone surgery for a hip fracture and received physical therapy to improve her balance, transfers, and gait. The physical therapist had discharged Resident Number 1 on April 30, 1998, with instructions to the nursing staff to walk her from her room to the dining room for each of her meals. The physical therapist trained the nursing staff, who were Certified Nursing Assistants, regarding ways to help Resident Number 1 ambulate safely.

10. On two days, a volunteer took Resident Number 1 in a wheelchair from an activity on the second floor to the first-floor dining room for lunch. However, volunteers did not attempt to ambulate residents who had difficulty walking.

11. One or more Certified Nursing Assistants walked Resident Number 1 on the days in question the distance between her room and the dining room. On at least one of the observed days, the Certified Nursing Assistant walked Resident Number 1 from the dining room, where the volunteer had left her, to her room, and then back to the dining room for lunch.

12. Petitioner's nurse surveyor testified that the issue in Tag F 224 is whether Respondent implemented its policies prohibiting the neglect of residents.

13. There is no credible evidence that Respondent neglected Resident Number 1, or that the care provided by staff following her hip surgery in any way contributed to a decline in the health or ability to ambulate of Resident Number 1. To the contrary, although Resident Number 1 could never regain her ability to walk without assistance, she did increase the distance that she could walk with assistance in the six weeks following the survey.

14. There is no evidence of a failure of staff to respond promptly to requests by Resident Number 1 for assistance in toileting.

15. Petitioner has failed to prove that, as to Resident Number 1, Respondent failed to implement its policies prohibiting neglect.

16. Paragraph 2 of the findings under Tag F 224 in the survey report alleges that Resident Number 3 was admitted on March 25, 1998, and was coughing up formula on March 26 at

1:00 a.m. During the afternoon of March 27, Resident Number 3 allegedly had a temperature of 100.8 degrees. The next day, the temperature was allegedly 100.7 degrees. On the afternoon of March 29, Resident Number 3 had a moist, productive cough and a temperature of 102 degrees. A nurse administered Tylenol. Seven hours later, that evening, Resident Number 3 had a temperature of 103.8 degrees, which, after another administration of Tylenol, dropped to 101.9 degrees one hour later and then 99.1 degrees, although he was having trouble breathing. At 1:00 a.m. on March 30, Resident Number 3 allegedly suffered from uneven breathing, at times labored, and, by 6 a.m., his temperature was 101 degrees. Paragraph 2 alleges that staff did not notify the physician of Resident Number 3 of these temperatures and symptoms until 3:00 p.m. on March 30, at which time the physician of Resident Number 3 arrived and examined Resident Number 3; a chest x-ray revealed pneumonia.

17. The facts are as alleged, except that the physician visited Resident Number 3 on the morning of March 30. There is no credible evidence that Respondent's staff cared for Resident Number 3 improperly or should have contacted his physician at an earlier point than the morning of March 30.

18. Petitioner has failed to prove that, as to Resident Number 3, Respondent failed to implement its policies prohibiting neglect.

19. Citing "[42 Code of Federal Regulations Section] 483.13(c)(1)(ii)," Tag F 225 in the survey report states:

> The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and [must] report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry of licensing authorities.
>
> The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property[,] are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
>
> The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
>
> The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

20. Tag F 225 in the survey report alleges that "this requirement" is not met because the facility "did not thoroughly investigate injuries of unknown origin for 1 (Resident #14) of 21

residents sampled, 3 residents from group interview, 1 resident observed and 1 resident based on family interview."

21. Paragraph 3 of the findings under Tag F 225 in the survey report alleges that the nurses' notes on Resident Number 14 revealed skin tears of unknown origin on November 17, 1997, and January 19, May 5, and May 10, 1998, and a bruised and swollen great and fourth toes of the right foot on February 11, 1998. The staff allegedly failed to investigate these incidents.

22. Nurses' notes document four skin tears, as alleged, but not the bruised and swollen toes, to which Petitioner produced no admissible evidence.

23. Respondent's policy is for anyone who sees an incident or injury to report it to a nurse, who documents the report, and forwards the information to the Director of Nursing, who is a Registered Nurse. The Director of Nursing investigates the matter and reports her findings to Respondent's Executive Director.

24. The Director of Nursing investigated each incident of a tear of the skin of Resident Number 14. She determined that Resident Number 14 had fragile skin, and her wheelchair sometimes injured her feet. She reasonably concluded each time that there was no indication of abuse or neglect.

25. Petitioner has failed to prove that Respondent did not investigate possible incidents of abuse or neglect concerning Resident Number 14.

26. Citing "[42 Code of Federal Regulations Section] 483.30(a)(1) and (2)," Tag F 353 in the survey report states:

> The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.
>
> The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
>
> Except when waived under paragraph (c) of this section, licensed nurses; and other nursing personnel.
>
> Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

27. Tag F 353 alleges that "this requirement" is not met because the facility did not provide sufficient nursing staff to meet the needs of the residents.

28. There are three paragraphs of findings under Tag F 353 in the survey report. None identifies a resident by number. Paragraph 1 states that family members witnessed two Certified Nursing Assistants, and presumably no one else, serving 33 residents, whose unmet needs resulted in urination in incontinence for some. Paragraph 1 states that several residents complained that staff do not timely answer call lights due to short-staffing. Paragraph 2 alleges that one resident complained that staff replied to his requests for assistance in getting out

of bed by saying that they would "do it when they have the time" and that they "can't be bothered." Paragraph 2 alleges that one resident was not ambulated three times daily to her meal. Paragraph 3 alleges that several residents complained of untimely assistance resulting in incontinence and "rough handling" due to untrained or insufficient staff.

29. At all times, Respondent maintained the minimum required staff at the facility.

30. If this tag is merely a reallegation of the ambulatory issue regarding Resident Number 1, Petitioner has failed to prove a deficiency in her care. If Petitioner intended to raise other issues with this tag, there is no evidence in support of such allegations.

31. Petitioner has failed to prove that Respondent failed to maintain sufficient nursing or other staff.

CONCLUSIONS OF LAW

32. The Division of Administrative Hearings has jurisdiction over the subject matter. Section 120.57(1), Florida Statutes. (All references to Sections are to Florida Statutes, except where references are explicitly to the Code of Federal Regulations. All references to Rules are to the Florida Administrative Code.)

33. Title 42, Code of Federal Regulations, Section 483.13(c)(1)(i) and (ii) provides:

> (c) Staff treatment of residents. The facility must develop and implement written

> policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> (1) The facility must--
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
> (ii) Not employ individuals who have been--
> (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
> (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property[.]

34. Title 42, Code of Federal Regulations, Section 483.30(a)(1) and (2) provides:

> The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.
> (a) Sufficient staff.
> (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
> (i) Except when waived under paragraph (c) of this section, licensed nurses; and
> (ii) Other nursing personnel.
> (2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

35. Pursuant to Rule 59A-4.128, Petitioner rates nursing homes as Superior, Standard, or Conditional based on surveys conducted every 15 months. Pursuant to Rule 59A-4.1288, Respondent's facility is subject to 42 Code of Federal Regulations Chapter 483.

36. Relying on Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996), and Latham v. Florida Commission on Ethics, 694 So. 2d 83 (Fla. 1st DCA 1997), Respondent argues persuasively that the standard of proof should be clear and convincing.

37. The parties agree that Petitioner has the burden of proof. In this case, it is unnecessary to determine the standard of proof because Petitioner failed to prove the material allegations under even the preponderance standard.

RECOMMENDATION

It is

RECOMMENDED that the Agency for Health Care Administration reissue the subject license as Standard.

DONE AND ENTERED this 6th day of April, 1999, in Tallahassee, Leon County, Florida.

____

ROBERT E. MEALE
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 6th day of April, 1999.

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 must be filed with the agency that will issue the final order in this case.