STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

WELLINGTON SPECIALTY CARE AND REHAB CENTER (VANTAGE HEALTHCARE CORP.),

Petitioner,

vs. Case No. 98-4690

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held on February 17, 1999, by videoconference between Tampa and Tallahassee, Florida, before Carolyn S. Holifield, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: R. Davis Thomas, Jr., Esquire
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For Respondent: Thomas Caufman, Esquire
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STATEMENT OF THE ISSUE

The issue for determination is whether the Agency for Health Care Administration found deficiencies at Wellington Specialty

Care and Rehab Center sufficient to support the change in its licensure status to a conditional rating.

PRELIMINARY STATEMENT

By letter dated September 27, 1998, the Agency for Health Care Administration (Agency) advised Vantage Healthcare Corporation, d/b/a Wellington Specialty Care and Rehab Center (Wellington), that its licensure rating was changed to "conditional" effective September 10, 1998. Wellington challenged the conditional rating and, on October 6, 1998, filed a Petition for Formal Hearing. On October 22, 1998, the Agency referred the matter to the Division of Administrative Hearings for assignment of an administrative law judge to conduct the final hearing.

Prior to hearing, the parties stipulated to facts that required no proof at hearing. At hearing, Petitioner, Wellington, presented the testimony of two witnesses and submitted one composite exhibit which was received into evidence. Respondent, the Agency, presented the testimony of two witnesses and submitted one exhibit into evidence. However, the Agency's exhibit was withdrawn and replaced by Petitioner’s composite exhibit.

A Transcript of the proceeding was filed on February 22, 1999. After the transcript was filed and upon request of both parties, the time for filing proposed recommended orders was extended. Petitioner timely filed a Proposed Recommended Order

under the extended timeframe. No post-hearing submittal was filed by Respondent.

FINDINGS OF FACT

1. Wellington is a nursing home located in Tampa, Florida, licensed by and subject to regulation by the Agency pursuant to Chapter 400, Florida Statutes.

2. The Agency is the licensing agency in the State of Florida responsible for regulating nursing facilities under Part II of Chapter 400, Florida Statutes.

3. On September 10, 1998, the Agency conducted a complaint investigation at Wellington in a matter unrelated to the issues that are the subject of this proceeding. On that same date, the Agency also conducted an appraisal survey that focused on six areas of care for which Wellington had been cited as deficient in past surveys. After the investigation and survey were completed, the Agency determined that there was no basis for the complaint, and further determined that Wellington was not deficient in any of the six areas of care which were the subject of the appraisal survey.

4. Notwithstanding its findings that the complaint against Wellington was unfounded and that there were no deficiencies in the targeted areas of care being reviewed, the Agency determined that Wellington was deficient in an area not initially the subject of the September 1998 survey. Specifically, the Agency found that Wellington had failed to provide adequate supervision

and assistance devices to two residents at the facility in violation of the regulatory standard contained in 42 C.F.R. s. 483.25(h)(2). Based on its findings and conclusions, the Agency issued a survey report in which this deficiency was identified and described under a "Tag F324."

5. The basis for the Agency’s findings were related to observations and investigations of two residents at the facility, Resident 6 and Resident 8. During the September 1998 survey and complaint investigation, the surveyors observed that Resident 6 had a bruise on her forehead and that Resident 8 had bruises on the backs of both of her hands.

6. Resident 6 suffered a stroke in May 1998 and had left-side neglect, a condition that caused her to be unaware of her left side and placed her at risk for falls. Moreover, Resident 6's ability to recall events was impaired.

7. The Agency's investigation revealed that Resident 6 sustained the bruise on her forehead when she fell from the toilet on August 31, 1998. The Agency determined that Resident 6 fell because she was left alone by the staff of the facility and further concluded that Wellington was responsible for causing this fall. The Agency believed that given Resident 6's left-side neglect, the facility staff should have known not to leave the resident unattended during her trips to the toilet. The Agency suggested that Wellington should have provided constant

supervision to Resident 6, although it acknowledged that such supervision may have created privacy violations.

8. In making its determination and reaching its conclusions, the Agency relied exclusively on an interview with Resident 6, notwithstanding the fact that her ability to recall events was impaired.

9. Since Resident 6 was admitted to the facility in May 1998, Wellington appropriately and adequately addressed her susceptibility to falls, including falls from her toilet. After Resident 6 was initially admitted to the facility in May 1998, she received occupational therapy to improve her balance. In late June 1998, following several weeks of occupational therapy, Wellington’s occupational therapist evaluated Resident 6’s ability to sit and to control the balance in the trunk of her body and determined that the resident was capable of sitting upright without support for up to 40 minutes. Based upon that assessment, Resident 6 was discharged from occupational therapy on June 25, 1998, and her caregivers were provided with instructions on how to maintain her balance.

10. At the time Resident 6 was discharged from occupational therapy, a care plan was devised for her which provided that the facility staff would give her assistance in all of her activities of daily living, but would only provide stand-by assistance to Resident 6 while she was on the toilet, if such assistance was requested. In light of the occupational therapist's June 1998

assessment of Resident 6, this care plan was adequate to address her risk for falls, including her risk for falls while on the toilet.

11. Wellington also provided Resident 6 with appropriate assistance devices. In Resident 6's bathroom, Wellington provided her with a right-side handrail and an armrest by her toilet to use for support and balance, and also gave her a call light to alert staff if she felt unsteady. These measures were effective as demonstrated by the absence of any falls from the toilet by Resident 6 over the course of June, July, and August 1998.

12. The Agency's surveyor who reviewed Resident 6’s medical records was not aware of and did not consider the June 1998 Occupational Therapy Assessment of Resident 6 before citing the facility for the deficiency.

13. Resident 8 was admitted to Wellington in February 1998 with a history of bruising and existing bruises on her body. At all times relevant to this proceeding, Resident 8 was taking Ticlid, a medication which could cause bruising and also had osteopenia, a degenerative bone condition that could increase Resident 8's risk for bruising, making it possible for her to bruise herself with only a slight bump.

14. After observing the bruising on the backs of both of Resident 8's hands during the September 1998 survey, the Agency asked facility staff about the bruising and also reviewed the

resident’s medical records. Based on her interviews and record review, the Agency surveyor found that these bruises had not been ignored by Wellington. Rather, the Agency found that when facility staff initially observed these bruises on Resident 8's hands, (1) staff had immediately notified Resident 8's physician of the bruises; and (2) the physician then ordered an X-ray of Resident 8 to determine whether there was a fracture. The X-ray determined that there was not a fracture but that there was evidence of a bone loss or osteopenia, which indicated that Resident 8 had an underlying structural problem which could increase the resident's risk for bruising.

15. The Agency surveyor found nothing in Resident 8's medical record to indicate that the facility had investigated the bruising on the resident’s hands, identified the cause of the bruising, or identified any means to prevent the bruising from reoccurring. Based on the absence of this information in Resident 8's records, the Agency cited the facility for a deficiency under "Tag F324."

16. The Agency's surveyor made no determination and reached no conclusion as to the cause of the bruising. However, she considered that the bruising on Resident 8 may have been caused by the underlying structural damage, medication, or external forces. With regard to external forces, the surveyor speculated that the bruising may have occurred when Resident 8 bumped her hands against objects such as her chair or bed siderails.

17. During the September 1998 survey, when the Agency surveyor expressed her concerns about the cause of the bruising on Resident 8's hands, Wellington’s Director of Nursing suggested to the surveyor that the bruising could have been the result of the use of improper transfer techniques by either Resident 8’s family or the facility staff, or Resident 8’s medications.

18. Despite the surveyor's speculation and suggestions by the facility's Director of Nursing, the Agency surveyor saw nothing that would indicate how the bruising occurred. In fact, the Agency surveyor's observation of a staff member transferring Resident 8 indicated that the staff member was using a proper transfer technique that would not cause bruising to the resident’s hands. The Agency surveyor made no other observations and conducted no investigation of the potential causes of the bruising on Resident 8's hands.

19. During the September 1998 survey, after the Agency surveyor inquired as to the cause of the bruises on Resident 8's hands, the facility conducted an investigation to try to identify the potential causes for the bruising. The investigation was conducted by the facility’s Care Plan Coordinator, a licensed practical nurse who was also the Unit Manager for the unit on which Resident 8 was located.

20. Included in the Care Plan Coordinator's investigation was a thorough examination of the potential causes suggested by the Agency's surveyor. The Agency surveyor’s speculation that

the bruising was caused when Resident 8 hit her hands against her chair or bed siderails was ruled out as a cause for the bruises because Resident 8 was unable to move around in her bed or chair. More importantly, there were no bedrails on Resident 8's bed and her chair was a heavily padded recliner. Also, as a part of her investigation, the Care Plan Coordinator observed the transfer techniques employed by both Resident 8's family members and facility staff. During these observations, she did not see any indication that the techniques used were improper or would otherwise cause Resident 8 to bruise her hands.

21. Based upon her thorough investigation, the Case Plan Coordinator determined that there were no identifiable causes of the bruising and, thus, there were no care plan interventions that the facility could have implemented then or in September 1998 to prevent the bruising suffered by Resident 8. Instead, the Care Plan Coordinator reasonably concluded that the bruising was most likely an unavoidable result of Resident 8's medications and her osteopenia.

22. The Agency is required to rate the severity of any deficiency identified during a survey with two types of ratings. One of these is "scope and severity" rating which is defined by federal law, and the other rating is a state classification rating which is defined by state law and rules promulgated thereunder. As a result of the September 1998 survey, the Agency assigned the Tag F324 deficiency a scope and severity rating of

"G" which, under federal regulations, is a determination that the deficient practice was isolated. The Tag F324 deficiency was also given a state classification rating of "II" which, under the Agency’s rule, is a determination that the deficiency presented "an immediate threat to the health, safety or security of the residents."

23. Because the Agency determined that there was a Class II deficiency at Wellington after the September 1998 survey, it changed Wellington’s Standard licensure rating to Conditional, effective September 10, 1998.

24. At the completion of the September 1998 survey, the Agency assigned the Class II rating to the deficiency although the surveyors failed to determine and did not believe that there was an immediate threat of accidents to other residents at Wellington. In fact, at the time of the September 1998 survey, the number of falls at Wellington had declined since the last survey.

25. The Agency returned to Wellington on November 6, 1998, to determine if the facility had corrected the Tag F324 deficiency cited in the September 1998 survey report. After completing that survey, the Agency determined that the deficiency had been corrected and issued Wellington a Standard License effective November 6, 1998.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this cause, pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

27. The Agency is authorized to license nursing home facilities in the State of Florida and, pursuant to Chapter 400, Part II, Florida Statutes, is required to evaluate nursing home facilities and assign ratings.

28. Section 400.23(9), Florida Statutes, provides that when minimum standards are not met, then such deficiencies shall be classified according to the nature of the deficiency. That section delineates and defines the various categories of deficiencies, with a Class III deficiency being the least severe and a Class I deficiency being the most severe.

29. Class I deficiencies "are those which the agency determines present an imminent danger to the residents or guests of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom." Class II deficiencies "are those which the agency determines have a direct or immediate relationship to the health, safety, or security of nursing home facility residents, other than Class I deficiencies." Class III deficiencies are those which "the agency determines to have an indirect or potential relationship to the health, safety, or security of the nursing home facility

residents, other than Class I or Class II deficiencies." Section 400.23(9), Florida Statutes.

30. Based on its findings and conclusions of deficiencies, the Agency is required to assign one of the following ratings to the facility: standard, conditional, or superior. These three categories of ratings for facilities are defined in Section 400.23(8), Florida Statutes, as follows:

> (a) A standard rating means that a facility has no class I or class II deficiencies, has corrected all class III deficiencies within the time established by the agency and is in substantial compliance at the time of the survey with criteria established in this part with rules adopted by the agency, or, if applicable, with rules adopted by the Omnibus Budget Reconciliation Act of 1987 (Pub.L. No. 100-203) . . . as amended.
>
> (b) A conditional rating means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part with rules adopted by the agency, or, if applicable, with rules adopted by the Omnibus Budget Reconciliation Act of 1987 (Pub.L. No. 100-203) . . . as amended. If the facility comes into substantial compliance at the time of the follow-up survey, a standard rating may be issued. A facility assigned a conditional rating at the time of the relicensure survey may not qualify for consideration for a superior rating until the time of the next subsequent relicensure survey.
>
> (c) A superior rating means that facility has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency and is in substantial compliance with the criteria established by the agency and is in

> substantial compliance with the criteria established under this part with rules adopted by the agency, or, if applicable, with rules adopted by the Omnibus Budget Reconciliation Act of 1987 (Pub.L. No. 100-203) . . . as amended; and the facility exceeds the criteria for a standard rating through enhanced programs and services in [seven designated areas]. . . .

31. According to Section 400.23(8)(b), Florida Statutes, quoted above, the Agency may issue to a facility a Conditional license when, after a survey, a facility has one or more Class I or Class II deficiencies, or Class III deficiencies not corrected within the time established by the agency.

32. In the instant case, the Agency issued a Conditional License to Wellington from September 10, 1998, to November 6, 1998. The Agency alleges that it was proper to issue Wellington a Conditional License for that time period because the facility had a Class II deficiency at the time of the Agency's September 1998 investigation and appraisal.

33. The regulation at issue in this case and the one which the Agency alleged Wellington has violated is 42 C.F.R. s. 483.25(h)(2). That section provides:

> The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

34. The Agency has the burden of proof in this proceeding and must show by a preponderance of evidence that there existed a basis for imposing a Conditional rating on Wellington’s license. Florida Department of Transportation v. J.W.C. Company, Inc., 396

So. 2d 778 (Fla. 1st DCA, 1981); Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). Accordingly, it is the Agency's burden to (1) establish that the deficiency cited in Agency September 1998 survey report existed; and (2) that the deficiency was appropriately classified as a Class II deficiency. If that burden is met, the Agency must then demonstrate that Wellington did not achieve substantial compliance with applicable regulatory standards until November 6, 1998.

35. Moreover, when applied to the Agency's burden of proof in this hearing, the plain terms of 42 C.F.R. s. 483.25(h)(2) require the Agency to demonstrate that a resident suffered an accident and that the accident was the result of inadequate supervision by the facility or the facility's failure to provide the resident with assistance devices.

36. The Agency has failed to meet its burden in this case.

37. With regard to Resident 6, the Agency failed to provide any substantial, competent evidence that Resident 6 suffered any accident that was a result of inadequate supervision by Wellington's staff. Here, there was no evidence that Resident 6 fell off of her toilet or that she fell off because she was left unattended. The Agency provided no evidence of that fact other than Resident 6's hearsay statement to the surveyors. Because there was no evidence to corroborate Resident 6's hearsay statements that she fell or how she fell, the Agency failed to

prove that Resident 6 suffered a fall, or that such fall was caused by a lack of supervision by Wellington's staff. Kaye v. State Department of Health and Rehabilitative Services, 654 So. 2d 298 (Fla. 1st DCA 1995)

38. Assuming arguendo that Resident 6 fell while she was unattended on the toilet, there was no evidence that her fall was the result of inadequate supervision by Wellington's staff. To support its allegation, the Agency asserted that Wellington staff should have provided stand-by assistance to Resident 6 while she was on the toilet. However, the evidence adduced at the hearing does not support such a mandate. Absent any identified intervention that should have been in place for Resident 6, there can be no finding that the supervision of Resident 6 was inadequate.

39. With regard to Resident 8, the Agency failed to prove that she suffered any bruising as a result of inadequate supervision by Wellington's staff. The Agency's claim of a deficiency was based on the fact that Wellington had failed to investigate the causes of the bruises on Resident 8's hands. The evidence established that at the time of the survey, Wellington had not investigated the bruising on Resident 8's hands. However, the regulation that Wellington has allegedly violated does not require the facility to investigate accidents. Instead, it requires the Agency to identify care that a facility should

have given the resident that was not given. The Agency failed to identify that in this instance.

40. The evidence established that the Agency surveyor conducted no investigation to determine the causes of the bruises on Resident 8's hands, that she only speculated as to how they occurred, and that she saw evidence that disproved some of her speculation. The Agency not only failed to determine the cause of the bruising, but also failed to establish how the bruising could be stopped in the future. Thus, the Agency failed to show that Resident 8's bruising was the result of an accident and/or that such accident was the product of any failure of care by Wellington.

41. Contrary to the Agency surveyor's speculations, the evidence established that the bruises on Resident 8's hands were not caused by the resident's hitting her hands on bed siderails or her chair, or by the facility staff or family member improperly transferring the resident. Likewise, there was no evidence that Resident 8 should have had any intervention implemented to address the potential for bruising on her hands. Absent any identified intervention that should have been in place for Resident 8, there can be no finding that the supervision of Resident 8 was inadequate.

42. The Agency failed to establish the existence of the alleged deficiency. Accordingly, there is no basis for the

Agency's changing Wellington's licensure rating from Standard to Conditional.

RECOMMENDATION

Based on the foregoing findings of fact and conclusions of law, it is recommended that the Agency for Health Care Administration enter a final order issuing a Standard rating to Wellington and rescinding the Conditional rating.

DONE AND ENTERED this 17th day of May, 1999, in Tallahassee, Leon County, Florida.

____
CAROLYN S. HOLIFIELD
Administrative Law Judge
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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.