STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

VISTA MANOR,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No: 98-5471
	)	
AGENCY FOR HEALTH CARE, ADMINISTRATION,	)	
	)	
Respondent.	)	
_____	)	

RECOMMENDED ORDER

A formal hearing was held in this case by the Division of Administrative Hearings, before Daniel M. Kilbride, Administrative Law Judge, on March 3, 1999, in Melbourne, Florida.

APPEARANCES

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

Whether the Petitioner was properly issued a Conditional license by Respondent on November 5, 1998.

PRELIMINARY STATEMENT

On November 30, 1998, Vista Manor filed a Petition for Formal Administrative Hearing challenging the Agency's findings of a November 1998 survey of its facility and the issuance of a Conditional license. The Petition was referred to the Division of Administrative Hearings and this matter was set for hearing.

Following discovery, a formal hearing was held on March 3, 1999. At the hearing, Petitioner presented the testimony of three witnesses and three exhibits were admitted in evidence. Respondent presented the testimony of four witnesses and submitted one composite exhibit in evidence. The Transcript of the proceeding was filed on March 17, 1999. Following an Order granting the parties an extension of time to file their proposed recommended orders, Respondent filed its proposals on May 7, 1999. Petitioner has not filed proposals as of the date of this Recommended Order.

FINDINGS OF FACT

1. Vista Manor is a nursing home located in Titusville, Florida, licensed by the Respondent, pursuant to Chapter 400, Florida Statutes.

2. Each year, Vista Manor is surveyed by Respondent to determine compliance with statutes and regulatory standards that are established by the state, as well as the federal Medicare and Medicaid programs. It then determines whether the facility

should receive a Superior, Standard, or Conditional license rating.

3. On November 5, 1998, Respondent conducted its annual survey of Vista Manor. The multi-disciplinary survey team met with facility staff, then toured the facility to develop a sample of residents on which to conduct an in-depth review.

4. After the survey was completed, Respondent issued a survey report which set forth the factual findings made by the surveyors.

5. Respondent alleged that the facility was not in compliance with the regulatory standard dealing with quality of care of residents. It described the deficiency under a "Tag," numbered F309. Respondent also claimed that Petitioner was not in compliance with the regulatory standard dealing with the prevention and treatment of pressure sores on residents, and described that deficiency under Tag F314.

6. Respondent is required to rate the severity of any deficiency identified during a survey with a State Classification rating. Respondent assigned both the F309 and F314 deficiencies a State Classification rating of II.

7. Respondent issues a nursing facility a Conditional license anytime it finds a State Class I or II deficiency or anytime it finds a Class III deficiency that is not corrected within the time frame mandated by Respondent.

8. Under state law and Agency rule, a classification rating of II represents an allegation that each deficiency presented an immediate threat to the health, safety or security of the residents.

9. Because Respondent determined that there were two Class II deficiencies at Vista Manor after the November survey, it changed Petitioner's Superior licensure rating to Conditional, effective November 5, 1998.

10. By law, Petitioner was required to post the Conditional license it received in a conspicuous place near the entrance to the facility.

FALLS

11. Under Tag F309 of the survey report, Respondent alleged that Petitioner violated the standard of service to attain for its residents the highest practicable well-being because it failed to adequately assess five residents and design care plans to prevent them from falling.

12. Surveyors utilize the State Operations' Manual (the "SOM") as a guideline for determining if a facility has complied with the federal regulations. The SOM directs surveyors to first determine if a resident has suffered a decline and, if so, to then determine if the decline was unavoidable.

13. A decline is unavoidable only where a facility has assessed a resident, developed a care plan based upon that

assessment, consistently implemented the care plan, and routinely re-evaluated the care plan.

14. At Petitioner's facility, each resident is assessed for his or her risk for falls upon admission to the facility, and an interim plan of care is developed for residents that need such care. Subsequently, each resident is given a more comprehensive assessment which evaluates a resident's risk for falls. Additionally, the facility's Physical and Occupational Therapists evaluate each resident for factors that contribute to falls. A final comprehensive care plan is then developed for at-risk residents by an interdisciplinary team.

15. Any resident who falls at the facility has his or her fall examined and documented by a nurse. That information is then forwarded to the facility's Safety Committee for review.

16. The Safety Committee is comprised of representatives from the various disciplines at the facility, including the Director and Assistant Director of Nursing, the Care Plan Coordinator, the Activities' Director and the Social Services' Director.

17. The Committee reviews all falls to see if a cause can be determined. Where appropriate, it recommends new interventions for the resident's plan of care. Residents who have fallen are reviewed weekly by the Committee until they have gone without falling for four weeks.

18. Each of the five residents, cited by Respondent in the survey report under Tag F309, was assessed for his or her risk for falls using the above-described assessments, and each resident had one or more care plans developed to address that risk. Each resident who fell also had his or her fall assessed by the facility's Safety Committee.

19. Any decline experienced by any of the cited residents was unavoidable under the guidelines of the SOM.

RESIDENT 1

20. Resident 1 was assessed by Petitioner as being at risk for falls due to her past history of falling, her aggressive behavior toward others, her tendency to wander, and her incontinence.

21. Like many of the residents cited in the survey report, Resident 1 was unsteady but independent in her ambulatory abilities, and had dementia. Resident 1's care plans were typical of the common-sense interventions used by a facility to try and limit the falls experienced by a resident who has poor safety awareness but can independently ambulate: scheduled toileting based upon an incontinence pattern, prompt incontinence care after episodes; provision of a body alarm, a wander guard, a walker, use of non-skid footwear, a hazard-free and well-lit environment, eyeglasses, monitoring of her aggressive behaviors; and encouragement of her participation in activities.

22. On October 13, 1998, Resident 1 was found on the floor of her room by her door. She suffered a fracture of her leg and told the investigating nurse that the injury occurred while she was "on her way to work." The Resident removed her body alarm before climbing out of bed and suffering her injury. She had never previously removed her body alarm and her removal of it prevented the staff from being aware that she was getting out of bed and attending to her.

23. The Safety Committee reviewed Resident 1's fall and determined that the fall was a product of the Resident's unsteady gait and confusion. No new care plan interventions were implemented at that time because the Resident left the facility for the hospital, and upon return, was not at risk to get up and out of her bed due to her immobility. When the Resident's fractured leg healed and her mobility improved, the facility provided Resident 1 with a more restrictive sensor alarm to replace the body alarm that she had previously removed.

24. The Resident had a care plan which required the nursing staff to ambulate her daily to activities and meals and the Resident also ambulated herself daily.

25. In the early morning hours of October 13, 1998, her dementia caused Resident 1 to believe that she should get up and go to work. The facility placed a body alarm on the Resident to alert its staff when the Resident might get up. They could not have known that the Resident was getting up in this situation

because she removed that alarm. If it had been aware that the Resident might remove her alarm, the facility might have used a sensor alarm, which is not placed on the Resident and is triggered by any movement by the Resident. However, sensor alarms are more restrictive to a resident than body alarms and the facility's approach to fall prevention is to use the least restrictive device first. This decision was appropriate in this instance because Resident 1 had never previously removed her body alarm and thus did not give the facility any reason to believe that a more restrictive alarm was needed.

26. Respondent did not show that there was any other intervention available to the facility that it could or should have implemented prior to the incident to prevent the Resident from thinking she had to go to work, to prevent her from getting up, or to make its staff aware that she had gotten up.

RESIDENT 4

27. Resident 4 was a cognitively-impaired man who was unsteady, independently mobile, and had poor safety awareness. He was particularly headstrong about ambulating or transferring himself when he wanted. He frequently ignored staff advice.

28. Resident 4 was care-planned by Petitioner for his risk for falls with interventions that included implementing a toileting program, monitoring the Resident for fatigue, encouraging rest periods for the Resident, providing a merrywalker, supervising ambulation to the dining room, a bed and

chair alarm, reminding to the resident to request assistance from staff when attempting transfers, monitoring the Resident every 30 minutes, providing a hazard-free environment and restorative physical therapy.

29. The facility also used physical restraints - a roll-belt and side rails while the Resident was in bed, and criss-cross belt while he was in his wheel chair - in an effort to prevent the Resident from getting up and ambulating on his own. These restraints were used only after less restrictive measures had been attempted and only after appropriate assessment for their use had been completed.

30. The Resident was also reviewed weekly by the facility's Safety Committee for virtually all of 1998.

31. Resident 4 fell eight times between May 10, 1998, and October 15, 1998.

32. The Safety committee notes described each of the eight falls, and the Safety Committee assessed the falls and considered various interventions for the Resident. Petitioner demonstrated that its Safety Committee reviewed all of the falls experienced by Resident 8 and that it implemented new interventions where they could be identified and if they were appropriate. In virtually all instances, the Committee could only re-emphasize the interventions that were already in place in his care plan because there was nothing more that could be done for the Resident.

33. On May 10, 1998, Resident 4 fell in the dining room while getting up out of his wheelchair after his restraint had been removed. No preventative intervention could have affected a fall that occurred in a dining room.

34. The Resident fell on May 25, 1998, because he attempted to toilet himself without staff assistance and tipped over his wheelchair in the bathroom. The Resident's risk of falling in that manner was covered by the Resident's care plan. The Resident was on a toileting program, had a belt on to prevent him from getting up out of his chair, and received reminders from the staff not to transfer himself without assistance. The Safety Committee appropriately did not order new interventions for the Resident, but did re-emphasize the importance of toileting the Resident every two hours or as needed in order to prevent future similar incidents.

35. The Committee did attempt other interventions when the circumstances of a fall reflected a need for new or different interventions. When the Resident 4 subsequently tipped over his wheelchair under circumstances that did not involve his attempt to go to the bathroom, the Committee addressed this problem by ordering a therapy screen to determine if he might need another type of wheelchair. Ultimately, the facility placed weights in the back of his chair in an effort to reduce his ability to tip it over.

RESIDENT 10

36. Resident 10 was a demented, non-ambulatory woman who was admitted to petitioner's facility on July 22, 1998. Upon admission, the facility observed her to see if she would attempt to get out of bed on her own. She demonstrated no such tendency. A care plan was devised to address her risk for falls that included mostly common-sense interventions. Because she was non-ambulatory and did not demonstrate any tendency to get out of her bed on her own, the facility did not order an alarm for her.

37. On August 6, 1998, the Resident began to demonstrate a tendency to try and get up on her own. She fell while trying to get out of her wheelchair.

38. Prior to her fall, the facility reminded her not to get up on her own; but she failed to heed that advice. The Safety Committee reviewed the fall and developed a specific falls care plan that included use of a body alarm to address the Resident's tendency to get up on her own. It also began a three-day safety observation to see if the Resident might remove the alarm.

39. On August 18, 1998, Resident 10 fell again trying to walk to her bathroom to toilet herself. Her body alarm was sounding when she was found by staff. However, the Resident attempted to go to the bathroom and fell before staff could respond to the alarm.

40. The Safety Committee reviewed this fall and re-emphasized the existing care plan approaches because they already

addressed the Resident's risk for falls under the circumstances presented in the August 16, 1998, fall.

RESIDENT 15

41. Resident 15 was a demented, ambulatory woman who manifested some problems with aggression at the facility. Between June 20 and October 10, 1998, she experienced seven incidents in which she fell or was found on the floor. One of those incidents occurred when the Resident charged another resident in the building and was pushed to the floor by that resident. Another occurred when the Resident was dancing. Four of the incidents were alleged to have occurred in the facility day room or activity room.

42. The Safety Committee reviewed every incident involving Resident 15 that was cited in the survey report.

43. The evidence was insufficient to establish that the facility failed to provide appropriate care to Resident 15. The Resident wandered through the facility and Petitioner monitored her whereabouts appropriately.

44. The facility did not fail to appropriately address the Resident's behaviors that contributed to her falls. The Resident's care plan had several provisions to address her behaviors including re-approaching her if she became agitated, monitoring her for aggressiveness, fatigue or unsteadiness; encouraging rest; escorting her away from aggressive peers; and

monitoring her anti-depressant medications. She was also under the care of a psychiatrist.

RESIDENT 16

45. Resident 16 was found on the floor by her bed on August 31, 1998, and September 9, 1998. These incidents occurred despite a care plan that provided her a lowered bed, a bed and chair alarm, and side rails for safety.

46. Respondent failed to show that the interventions that the facility had in place on August 31, 1998, were not adequate to address the Resident's risk for falling out of her bed.

PRESSURE SORES

47. Respondent alleged under Tag F314 of the survey report that Petitioner failed to provide necessary care to Residents 3, 6, 13 and 19 to prevent the development of pressure sores, and failed to provide necessary care to promote healing of Resident 3's pressure sores.

48. A pressure sore is a loss of skin integrity, usually over a bony prominence, that is caused by unrelieved, prolonged pressure. When a pressure sore appears on a resident, a nursing home will describe it in the resident's medical record by one of four stages. A stage I area is one in which the skin is unbroken but has nonblanchable redness. A stage II area is a very shallow wound that may present itself as a blister or a small crater. A stage III wound is a deeper wound that penetrates subcutaneous

tissue, while a stage IV wound is one which reaches muscles, tendons or bone.

49. Identifying and staging pressure sores is not an exact science, and errors in identifying violations of skin integrity on residents frequently occur. It is not uncommon for a nurse to describe any reddened area or blister that appears on a resident as a pressure sore; however, the presence of a reddened area or a blister on a resident does not always mean that the resident has a stage I or stage II pressure sore.

50. Reddened areas or blisters can only be considered pressure sores where there is corresponding deep tissue damage. A true stage I or stage II pressure sore appears as a deep, dark, dusty red area with a purple center. Because true pressure sores involve deep tissue damage, they do not heal quickly after they appear.

51. A standard program to prevent pressure sore development focuses on removal of pressure from pressure points on a resident's body. A two-hour turning and repositioning program for residents is typical. Devices such as pressure-relieving mattresses to help relieve pressure on a resident are utilized. A standard preventative program includes ensuring that a resident receives an adequate diet and adequate hydration.

52. Petitioner has a comprehensive program to identify and address its residents who are at risk for pressure sore development. A Braden Scale assessment is performed on each

resident upon admission to the facility. Those residents who meet the qualifying score of 17 have a twenty-four-hour care plan implemented to address that risk. The assessment is later performed to further evaluate a resident's risk for skin breakdown.

53. Petitioner implements a variety of interventions to address residents who are at risk for pressure sore development. Weekly skin assessments are performed by the nursing staff and biweekly skin assessments are done during showers by the Certified Nursing Assistants (CNA). Reidents are given pressure-relieving mattresses and heel protectors, and are turned and repositioned every two hours. Incontinence care is provided where needed using barrier creams for skin protection.

54. Residents who develop pressure sores are followed by the facility's Wound Committee. That Committee, which includes a physical therapist, does walking rounds each week to evaluate and treat any resident who has developed a pressure sore. The Wound Committee also measures and describes every pressure sore that is identified on a resident.

55. The facility census at the time of the survey was 114 residents. Four were identified as developing pressure sores. Accordingly, only 3.5 percent of the population at Vista Manor had in-house acquired pressure sores. The national average for in-house acquired pressure sores in nursing homes is between 7-9 percent.

56. With regard to the residents who were cited under Tag F314, Respondent failed to prove that the areas that developed on these residents were actually pressure sores.

57. Resident 6 was alleged to have developed a stage II pressure sore on his right posterior thigh on July 29, 1998. That area is not one where pressure is applied. The sore was caused by friction from the resident's wheelchair, did not have any depth associated with it, and healed within seven days after it appeared.

58. Resident 19 was alleged to have developed a stage II pressure sore on hers left inner thigh on October 23, 1998. However, the nursing staff never described the area as a pressure sore, but instead described it as a popped blister with no redness noted. The area did not appear over a bony prominence or in a place where pressure is applied to the body. The area was caused by the resident's incontinence and briefs, and had virtually healed by October 27.

59. Resident 13 was alleged to have developed a stage I pressure sore on his sacral area that was identified by the surveyors during the survey. The resident was not at risk for the development of pressure sores and the area the surveyors identified was actually located in the resident's rectum, which is not an area where pressure is applied to the body. The area was also described as blanchable redness, which is not consistent with a pressure sore. It was treated with Balmex cream and

disappeared the next day. The area was not caused by pressure but instead was caused by poor toileting habits of the resident.

60. Respondent alleged that a stage II area developed on the Resident 3's left foot on August 20, 1998. However, the area was not described as a pressure sore on the wound reports. It was initially described as an intact blister.

61. Petitioner's expert on pressure sore care opined without contradiction that the area was not a pressure sore, but instead was excessive skin growth that sometimes occurs in the elderly. The surveyor mistakenly assessed it as a pressure sore.

62. Respondent alleged that Resident 3 also developed pressure sores on her right foot and right inner ankle on October 13, 1998, and a stage II area on her coccyx on October 20, 1998. The area on her right foot was described initially as a blood blister and was not located in an area where pressure is applied to a resident's foot. Seven days later it was described as discolored but intact, which is not consistent with a pressure sore.

63. The area on her right inner ankle was never open and never had a blister, but instead was an area of discoloration that occurs in dark-skinned individuals due to a collection of melanin deposits. The area on her coccyx was a skin tear which healed in seven days.

64. Respondent also alleged that Petitioner did not adequately treat the identified pressure sores on Resident 3.

One cited example was that the facility did not act on a Dietician's September 8, 1998, Recommendation to add a Vitamin C supplement to the resident's diet until November 2, 1998. However, the resident was already receiving Vitamin C from a multi-vitamin supplement in addition to that which was provided to her from her diet.

65. Respondent did not demonstrate that the Vitamin C the resident was receiving was inadequate to meet her needs or that the wounds identified on Resident 3 did not timely heal because of the facility's failure to provide the recommended additional Vitamin C to Resident 3.

66. Another example of alleged inadequate care to promote healing alleged by Respondent was the failure to place large booties on Resident 3 prior to the survey.

67. Booties are devices which are placed over a resident's feet, presumably to protect them but there is no evidence that they effectively promote pressure sore healing. In some instances, they can cause pressure sores or friction areas to develop. Petitioner placed booties on the resident after August 20, 1998, when area on her left foot was identified, but Respondent did not demonstrate that these booties were inadequate to promote healing of any area she developed, or that larger booties would have caused any area to heal faster than it did.

CONCLUSIONS OF LAW

68. 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.

69. Section 120.569(1), Florida Statutes, applies in all proceedings in which the substantial interests of a party are determined by an agency. Section 120.57(1), Florida Statutes, applies in those proceedings involving disputed issues of material fact. Vista Manor is a facility is substantially affected by a conditional rating.

70. The Respondent has the burden of proof in this proceeding and must show by a preponderance evidence that there existed a basis for imposing a conditional rating on Petitioner'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).

71. Section 400.23(8), Florida Statutes, provides in pertinent part:

> (8) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a rating to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations and inspections. The agency shall assign one of the following

> ratings to each nursing home; standard, conditional, or superior.
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> * * *
>
> (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 under the Omnibus Budget Reconciliation Act of 1987 (Pub.L.No. 100-203) (December 22, 1987), Title IV (Medicare, Medicaid, and other Health-Related Programs), Subtitle C (Nursing Home Reform), 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.

72. The agency's Rule 59A-4.128, Florida Administrative Code, describes the same requirements as the statute cited above and adopt by reference the applicable federal regulations. With one exception, not relevant here, Rule 59A-4.128, Florida Administrative Code, was determined valid in Florida Health Care Association, Inc., et al. v. Agency for Health Care Administration (DOAH Case Nos. 96-4367RP and 95-4372RP, Order entered July 16, 1996.)

73. The federal regulations at Title 42 C.F.R., Part 483, Subsection B, provide in pertinent part:

> Section 483.25 Quality of Care

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> * * *
>
> (h) Accidents. The facility must ensure that--
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) each resident receives adequate supervision and assistance devices to prevent accidents.

74. Respondent may issue 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. Section 400.23(8)(b), Florida Statutes. Respondent also claims it may issue a Conditional license to a facility where a facility is not in substantial compliance with rules adopted under the Omnibus Budget Reconciliation Act.

75. Class II deficiencies are defined under state law as those which have "a direct or immediate relationship to the health, safety or security of the nursing home facility residents." Section 400.23(9)(b), Florida Statutes. The Agency has further defined Class II deficiencies to be those that "present and immediate threat to the health, safety or security of the residents of the facility." Rule 59A-4.128(3)(a), Florida Administrative Code. Under both state law and the Agency's rule, a Class II deficiency must be something more than an isolated

occurrences in the facility. The Respondent must show that the deficiency presents an immediate threat the health, safety, or security of residents throughout the facility. If the facility presents only an indirect or potential threat to residents in the facility, it must be classified as a Class III deficiency.

76. In the instant case, Respondent alleges that it was proper to issue Petitioner a Conditional license, effective November 4, 1998, because there were two Class II deficiencies identified during the November survey of the facility. Accordingly, it is Respondent's burden to establish by a preponderance of evidence the existence of at least one of the Class II deficiencies cited in the November survey report, and that either of the deficiencies met the definition of a Class II deficiency. If that burden is met, Respondent must then demonstrate that this deficiency remained uncorrected until the date on which Respondent terminated the Conditional rating. Respondent failed to establish those elements in this case.

77. Respondent claimed that Petitioner failed to maintain five residents' highest level of functioning because it allowed them to suffer on-going falls. It chose to cite this as a deficiency under Tag F309.

78. Respondent was then required to show that any fall experienced by a resident was unavoidable. That burden, in turn, required Respondent to show that a cited resident fell because Petitioner failed to assess the care plans or periodically review

its care plans for fall prevention for that resident. Respondent failed to meet its burden of proof.

79. The regulation at issue does not authorize Respondent to base a deficiency solely on the fact that a resident fell once or multiple times. To rule otherwise would be contradict an unfortunate reality in the elderly. Falls for some residents--particularly those that are demented and independently ambulatory--are common and cannot be prevented. A facility cannot be held liable for negligent care of those residents unless there is a specific intervention that the facility should have identified and could have provided to the resident to prevent a fall.

80. Petitioner demonstrated it had a comprehensive program to address each of its residents' risks for falls. That program included assessment, care planning and on-going reassessment of its residents. It also demonstrated that the assessments, care plans, and on-going evaluations for each of the cited residents were more than adequate to address their risk for falls. Accordingly, there was no deficiency established under Tag F309.

81. Under Tag F314, Respondent must prove that a pressure sore developed on a resident while in the nursing home. Respondent failed to meet that burden for any of the residents cited under Tag F314.

82. Although Tag F314 of the survey report identified areas on the cited residents as pressure sores, the residents' medical

records described those areas in terms that clearly showed that they were not pressure sores. Instead, the areas were skin discolorations, skin tears, skin growths, or blisters. Because the cited residents did not have pressure sores, the facility cannot be found negligent in its failure to prevent the development of pressure sores.

83. In addition, pressure sores are unavoidable if a facility can demonstrate that it identified a resident as being at risk for pressure sore development; that it provided routine preventative care to the resident; and that it implemented that care plan consistently.

84. Petitioner showed that all of the cited residents were assessed for their risk of pressure sore development. Of the four residents cited in the survey report, only three of them were determined at risk for pressure sore development, and each of those residents had a routine preventative care plan. No evidence was introduced which suggested that these care plans were not consistently administered. Accordingly, to the extent that pressure sores developed on the cited residents, they were shown to be unavoidable.

85. As to Resident 3, Petitioner provided treatments to promote healing of her sores, regardless of their nature.

86. Respondent alleged that Petitioner failed to place large booties on Resident 3 and it failed to timely act on a dietician's recommendation for more Vitamin C for the resident.

However, Respondent did not demonstrate that these interventions were necessary; nor did it demonstrate that the areas that developed on Resident 3 did not timely heal because of the absence of those interventions. To the contrary, Petitioner demonstrated that the areas healed quickly. Accordingly, there was no basis for a deficiency regarding the absence of necessary treatments to promote healing of pressure sores on residents at Petitioner's facility.

87. In the instant case, Respondent failed to show that residents at Petitioner's facility were in danger of an immediate threat to their health or safety due to the deficiencies described under either Tag F309 or Tag F314. Both deficiencies were shown to be isolated practices.

88. The Respondent presented no evidence that the problems at Vista Manor were systemic problems and that other residents in the facility were likely to fall, contract pressure sores or otherwise be harmed. To the contrary, Petitioner demonstrated that it had effective systems in place to protect its residents from falls and pressure sore development. With regard to pressure sores, the systems in place at Vista Manor produced an in-house acquisition rate of pressure sores that is half of the national average.

89. The Respondent failed to meet its burden of proving that Class II deficiencies and substandard quality of care

deficiencies existed at Petitioner at the time of the November 1998 survey. The Conditional rating was not appropriate.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration enter its final order granting Petitioner's request to change its Conditional license rating to the Standard rating for the period contemplated by the November 1998 survey.

DONE AND ENTERED this 8th day of June, 1999, in Tallahassee, Leon County, Florida.

DANIEL M. KILBRIDE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of June 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 should be filed with the agency that will issue the final order in this case.