STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HERITAGE HEALTH CARE & REHAB CENTER - NAPLES

Petitioner,

vs. Case No. 99-1892

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

RECOMMENDED ORDER

On August 23, 1999, a formal administrative hearing was held in this case in Naples, Florida, before William R. Pfeiffer, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: R. Davis Thomas, Jr., Esquire
Donna Stinson, Esquire
Broad and Cassel
215 South Monroe, Suite 400
Post Office Drawer 11300
Tallahassee, Florida 32302

For Respondent: Karel L. Baarslag, Esquire
Agency for Health Care Administration
2295 Victoria Avenue, Room 309
Post Office Box 60127
Ft. Myers, Florida 33901-6177

STATEMENT OF THE ISSUE

Whether there were deficiencies at Naples sufficient to support Agency for Health Care Administration's (AHCA)

decisions to issue Heritage Health Care & Rehab Center - Naples (Naples) a Conditional license on March 11, 1999, and continue that rating until June 7, 1999.

PRELIMINARY STATEMENT

Prior to the hearing, the parties filed a Joint Pre-Hearing Stipulation containing stipulations of fact and applicable law. At the hearing, Petitioner presented the testimony of two witnesses, and submitted four exhibits into evidence. Respondent presented the testimony of two witnesses, and submitted one exhibit into evidence. Two of Petitioner's exhibits and Respondent's one exhibit were deposition transcripts of witnesses who were unavailable to testify at hearing. A Transcript of the proceeding was filed on August 31, 1999.

FINDINGS OF FACT

Background

1. Naples is a nursing home located in Naples, Florida, licensed by and subject to regulation by the Agency for Health Care Administration. Each year, Naples is surveyed by AHCA to determine whether the facility should receive a Superior, Standard, or Conditional licensure rating. On March 11, 1999, AHCA conducted an annual survey of Naples. After that survey was completed, AHCA alleged that there were several deficiencies at Naples which violated various regulatory

standards that are applicable to nursing homes. However, AHCA agreed that the only deficiency relevant to the DOAH hearing was its allegation that Naples violated the requirement, contained in 42 CFR Section 483.13(c), that a nursing home develop and implement policies that prohibit abuse and neglect of residents. AHCA issued a survey report in which this deficiency was identified and described under a "Tag" numbered F224.

2. AHCA is required to assign a federal "scope and severity" rating to each deficiency identified in the survey report. AHCA assigned the Tag F224 deficiency identified in the March survey report a federal scope and severity rating of "G," which is a determination that the deficient practice was isolated.

3. AHCA is also required to assign a state classification rating to each deficiency identified in the survey report. After the March 11th survey, AHCA assigned the Tag F224 deficiency a state classification rating of Class II which, under AHCA's own rule, is a determination that the deficiency presented "an immediate threat to the health, safety or security of the residents."

4. Because AHCA determined that there was a Class II deficiency at Naples after the March 11th survey, it changed Naples's Standard licensure rating to Conditional, effective

March 11, 1999. By law, Naples was required to post the Conditional license in a conspicuous place in the facility. Naples was also required to submit a Plan of Correction (the "Plan") to AHCA. Although the plan did not admit the allegations, it did provide steps that the facility would implement to address the deficiencies cited in the survey report. The Plan also represented that all corrective action relating to the Tag F224 deficiency would be completed by April 10, 1999.

5. AHCA returned to Naples on March 29, 1999, March 30, 1999, and April 22, 1999, and re-surveyed the facility. After each survey, AHCA determined that there were deficiencies at Naples, but stipulated prior to hearing that none of these deficiencies were justification for the issuance or the continuation of the Conditional license at issue in this case. After the April 22, 1999, survey, AHCA determined that Naples completed all corrective action with regard to the March 11, 1999, Tag F224 deficiency and complied with the requirements of 42 CFR Section 483.13(c). After the June 7, 1999, survey, AHCA determined that Naples was in substantial compliance with all applicable regulations and issued Naples a Standard license effective that date.

6. Naples filed a Petition for Formal Administrative Hearing with AHCA to challenge the findings of all of the

above- cited surveys, as well as AHCA's decision to issue Naples a Conditional license. That Petition was referred to the Division of Administrative Hearings and a hearing was conducted. At hearing, the parties were ordered to file their proposed recommended orders on or before September 15, 1999.

Finding 1; Tag F224; March 11, 1999, Survey Report:

7. An unnamed resident at Naples who had fragile skin and a history of skin tears sustained a skin tear to her arm on March 8, 1999. Naples' staff obtained a doctor's order for a dressing to be applied to the area and changed daily. The dressing was applied as ordered except for an isolated instance when it was not applied on March 9, 1999.

8. On March 10th, AHCA's surveyor observed that the dressing had not been changed on the previous day. She interviewed the nurse who had obtained the order for the dressing, and was told that the dressing had not been changed on March 9, 1999, because the nurse forgot to print out the order from the computer and place it in the Resident's medical record. The nurse immediately changed the Resident's dressing.

9. The surveyor did not observe the nurse changing the dressing. Instead, she went back into the Resident's room after the dressing was changed and observed that the area covered by the dressing was bleeding. The surveyor inferred

from that observation that the old dressing had stuck to the Resident's skin because of the failure to change the dressing on March 9th. She also inferred that the nurse who changed the old dressing had not moistened it prior to removing it so as to cause it to bleed. The surveyor did not interview the nurse to verify her suspicion that the nurse changed the dressing incorrectly. Instead, she alleged that Naples neglected the Resident because the nurse failed to change the dressing pursuant to the doctor's order, and because she changed the dressing so as to cause the Resident to bleed.

10. Naples does not dispute that the Resident's dressing was not changed on the March 9th. However, the evidence was undisputed that the failure to change a dressing for one day presented no risk that the Resident's skin tear would worsen or become infected. In fact, the skin tear did not worsen as a result of the facility's failure to change the dressing on March 9th. AHCA's surveyor conceded that she had no evidence that the skin tear worsened and thus failed to provide any evidence that the failure to change the dressing presented any risk of harm to the Resident.

11. Moreover, AHCA's surveyor erroneously concluded that the nurse who changed the dressing caused it to bleed. The nurse moistened the old dressing prior to removing it and placed a new dressing on the area; the skin tear did not bleed

during that process. The evidence was clear that the old dressing would not have stuck to the skin tear even if the dressing had not been changed on March 9th because, on March 8th, she applied a triple antibiotic ointment that acted as a barrier between the gauze dressing and the Resident's skin. Finally, the Resident's skin was extremely fragile and, in the past, the Resident had caused her own arm to bleed by slighting bumping it.

Finding 2; Tag F224; March 11, 1999, Survey Report:

12. Resident 14 was issued a doctor's order for a dressing to a lesion on her back. It stated that the dressing was to be changed daily. AHCA's surveyor observed on March 10, 1999, that Resident 14 had a dressing that had not been changed since March 8, 1999, covering the lesion. The surveyor further observed that the dressing had become displaced so that the tape used to secure the wound was partially covering the wound. Despite this isolated failure to change the dressing, the surveyor cited Naples for neglecting Resident 14.

13. Naples conceded that the Resident 14's dressing had not been changed on March 9th as ordered. However, as it did with the unnamed Resident in Finding 1, Naples demonstrated

that the failure to change Resident 14’s dressing was isolated and did not present any risk that the Resident’s lesion might worsen or become infected. Naples also showed that the lesion did not, in fact, worsen. AHCA’s surveyor conceded that she had no evidence that the failure to change the dressing was repeated conduct, or that the lesion worsened, and thus failed to present any evidence that the failure to change the dressing presented any risk of harm to Resident 14.

Finding 3; Tag F224; March 11, 1999, Survey Report:

14. Resident 21 was a demented woman with a history of anxiety, aggressive behavior toward others, and attention-seeking behaviors. At approximately 1:00 a.m. on March 10th, Resident 21 was found striking her forehead with a small picture frame stating, "I’m going to kill myself, I’m tired of all this." She was not hitting herself hard enough to inflict any injury to herself, and did not damage the picture frame. Nonetheless, a nurse stopped the Resident and counseled the Resident, who then stated, "I’ll stop and go to sleep." After the nurse left the room, the Resident repeated her action. The nurse immediately returned, removed the frame, and called the Resident’s physician. The physician determined that Resident 21 was not suicidal, and ordered Ativan (a medicine given for anxiety) and a psychiatric consultation for the Resident.

15. Twenty minutes after she was given the Ativan, Resident 21 got up and sought additional attention by pushing her wheelchair in the hallway. She was redirected to her bed by a certified nursing assistant ("CNA") and, while being put to bed, grabbed packets of air freshener and threatened to eat them. The packets were immediately removed from the Resident and taken from her room by the CNA.

16. Twenty minutes after being put to bed by the CNA, Resident 21 arose and returned to the hallway and attempted to enter other residents' rooms. She was redirected by staff to her room and bed, whereupon she stated to the staff that "The nurse gave me water. I'm going to kill myself." Twenty minutes after this incident, Resident 21 sought attention by playing her radio loudly, and stated, "I'm going to kill myself." Another dose of Ativan was given to her and shortly thereafter, she went to sleep. Although staff routinely checked on Resident 21, there were no further incidents.

17. The following morning, Resident 21 was seen by her psychiatrist who determined that she was not suicidal. Instead, he concluded that Resident 21's isolated actions during the previous night were attention-seeking behavior which did not indicate that she intended to kill herself. He ordered additional medications for her and, as a precaution,

wrote an order in her record to "remove all dangerous objects from her room and monitor resident closely."

18. When AHCA's surveyors entered the facility on March 10, 1999, picture frames and mirrors were present in Resident 21's room. The surveyor asked the staff about the level of monitoring for the Resident, and whether the facility had a policy that defined and implemented precautions for suicidal residents. The surveyor was not satisfied and cited the facility for neglecting the Resident because it failed to remove "dangerous objects" from her room, failed to adequately monitor her, and failed to have a suicide precaution policy.

19. The surveyor's conclusion that Naples neglected Resident 21 was predicated on her belief that Resident 21 was suicidal. However, the Resident's psychiatrist testified unequivocally that the Resident was not suicidal. The Resident did not strike herself hard, nor with the intent to hurt herself, but was engaged in attention-seeking actions. She demonstrated no intent to commit suicide. The psychiatrist's diagnosis, and his (and her regular physician's) decision to treat her condition with medications were effective. She exhibited no further similar behavior.

20. AHCA's surveyor did not interview Resident 21's psychiatrist prior to making her allegations of neglect, and thus did not know that the psychiatrist had determined that

the Resident was not suicidal. At hearing, she acknowledged that the psychiatrist’s conclusion would have presented "a whole different story."

21. AHCA’s surveyor also erroneously concluded that the Resident was not adequately monitored. The nursing notes concerning Resident 21 contained over thirty entries between March 10th and March 12th describing observations of the Resident. These notations exceeded any applicable nursing standard, and more than met the requirements contemplated by the psychiatrist when he ordered the staff to monitor the Resident closely.

22. The surveyor determined that the nurses’ notes reflected inadequate observation of the Resident because the notes did not reflect that the Resident was being observed every fifteen minutes, and then hourly for twenty four hours. However, the surveyor failed to offer any regulation or other source to support her contention that monitoring the Resident every fifteen minutes was the appropriate standard. To the extent that the standard was based upon the surveyor’s assumptions that Resident 21 was suicidal or because the psychiatrist ordered that level of monitoring, Naples demonstrated that those assumptions were incorrect.

23. AHCA’s surveyor also erroneously concluded that the failure to remove picture frames and mirrors from Resident

21's room was a violation of any doctor's order or applicable standard of care. The requirement that dangerous objects be removed from the Resident's room came from the order of the Resident's psychiatrist, and he testified that he did not intend for the facility to remove all picture frames or mirrors from the Resident's room. Instead, he only intended his order to cover objects such as knives or letter openers. He clarified this interpretation of his order to Naples' staff during the survey.

24. Naples is not required by any federal or state regulation to have a suicide prevention policy. Indeed, such a policy would never have an opportunity to be implemented even if it existed. If a resident at Naples is determined to be suicidal, the resident would be immediately transferred to a psychiatric hospital for observation, evaluation and treatment.

Naples Policy Regarding Abuse and Neglect:

25. Naples has a written policy that prohibits abuse and neglect of its residents. It also sets forth a process for investigating incidents of suspected abuse and neglect that includes suspending staff who might have been involved in any incident while the investigation is pending. Additionally, Naples implements policies required by federal regulations that help to assure that its residents are not neglected. It

conducts background checks of employees, and only those who have no history of abuse or neglect are hired to work at Naples. Furthermore, employees are instructed and encouraged to inform the administration about any incident which might be considered abuse or neglect of a resident, and are provided with seminars which address issues of abuse and neglect of residents. Naples conducts random audits of its residents' medical records to insure that residents are receiving their required care. These policies have been successful.

26. Additionally, Naples demonstrated that it followed its written policy with regard to the incidents cited under Tag F224 of the March survey report. Pursuant to that policy, the facility's Director of Nursing investigated all of the cited incidents in a timely manner and suspended one nurse pending that investigation. The Director of Nursing appropriately concluded that neglect of the residents cited in the report had not occurred and did not call any investigative agency regarding the incidents.

CONCLUSIONS OF LAW

27. 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.

28. Section 120.569(l), Florida Statutes, applies in all proceedings in which the substantial interests of a party are determined by an agency. Section 120.57(l), Florida Statutes applies in those proceedings involving disputed issues of material fact.

29. A facility is substantially affected by a conditional rating. For example, Section 408.35, Florida Statutes, governing certificates of need, provides that an applicant's ability and record of providing quality of care are among the criteria for competitive review. Additionally, a facility cannot qualify for the Gold Seal program if it has had a conditional rating within the previous thirty months. Section 400.235, Florida Statutes. Finally, a conditional rating can substantially affect the reputation of a facility in the community and have a negative impact on staff morale and recruiting. See Spanish Gardens Nursing & Convalescent Center (Beverly Health & Rehab Svcs., Inc.) v. Agency for Health Care Administration, 21 FALR 132 (AHCA, 1998)

30. AHCA has the burden of proving the basis for changing Naples's licensure rating to Conditional. 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); Spanish Gardens, supra. The Florida Supreme Court has determined that, where fines are imposed, the burden of proof must be by clear and convincing evidence, because a fine "deprives the person fined of substantial rights in property." Department of Banking & Finance v. Osborne Stern, 670 So. 2d 932, 935 (Fla. 1996) The requirement of clear and convincing evidence has also been applied to actions which affect reputation and good name. In Latham v. Florida Commission on Ethics, 694 So. 2d 83 (Fla. 1st DCA 1997), the Court dismissed arguments that the lack of a fine relieved the Commission of its burden to prove its findings by clear and convincing evidence. In looking "to the nature of the proceedings and their consequences to determine the degree of proof required" (citing Osborne Stern, supra), the Court determined that loss of a good name was equally as severe as a monetary fine.

31. The imposition of a Conditional license adversely affects the reputation of a nursing facility with the public, and thus affects its ability to operate. Furthermore, findings from a survey in which Class II deficiencies are found can result in the imposition of monetary penalties or even criminal charges. See, e.g. Section 400.23(9)(b) and 400.241(3), Florida Statutes. Clearly, the effect of an

adverse survey and the Conditional rating emanating therefrom is penal in nature, and can deter consumers from doing business with the facility. The nature of these proceedings, and the consequences from them require AHCA to prove its case by clear and convincing evidence.

32. AHCA may issue a facility a Conditional license when, after a survey, a facility has one or more Class I or Class II deficiencies, or where it has a Class III deficiency not corrected within the time established by the agency. (§400.23(8)(b), Florida Statutes). In the instant case, AHCA alleges that it was proper to issue Naples a Conditional license from March 11, 1999, through June 7, 1999, because there was one Class II deficiency at Naples at that time.

33. Accordingly it is AHCA's burden to establish by clear and convincing evidence, (1) the existence of the deficiency cited under Tag F224 of the March survey report, and (2) that the deficiency was appropriately classified as a Class II deficiency. If that burden is met, AHCA must then demonstrate that Naples did not achieve substantial compliance with applicable regulatory standards until June 7, 1999. AHCA failed to meet its burden in this case.

AHCA Failed to Prove, and Naples Disproved, That There Was Any Deficiency Under Tag F224:

34. AHCA claims under Tag F224 of the March survey report that Naples failed to meet the requirements of 42 CFR §483.13(c), which provides:

> 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.

This standard is made applicable to nursing homes in Florida pursuant to 59A-4.1288, Florida Administrative Code.

35. Guidelines for determining whether a facility has complied with the requirements of the regulation have been set forth as follows:

> The regulation requires a long-term care facility to develop and implement written policies and procedures that prohibit abuse, mistreatment or neglect of residents. In evaluating a long-term care facility's compliance with the regulation, the questions that must be answered are: (1) has the facility developed written polices and procedures that prohibit abuse, mistreatment or neglect of residents; and (2) have those policies been implemented?
>
> Life Care Center of Hendersonville v. Health Care Financing Administration, DAB CR 542 at 33 (1998); Beverly Health & Rehabilitation - Springhill v. Health Care Financing Administration, DAB CR 553 (1998)

36. There is no dispute in this case that Naples had written and unwritten policies which were designed to prevent

neglect of its residents. The issue is whether Naples properly implemented its policies that prohibited abuse, mistreatment, and neglect of its residents. AHCA claims that Naples failed to implement its policies because its surveyors found three examples which they determined to be neglect of residents at Naples. However, AHCA failed to show that any of the cited instances constituted neglect of the cited residents.

37. Neglect is "the failure to provide goods and services necessary to avoid physical harm, mental anguish and mental illness." 42 C.F.R. Section 488.301. Determining whether a facility neglected a resident under the regulation requires AHCA to show that the facility withheld care to a resident and that the care withheld was necessary to prevent physical harm to a resident. See Springhill, supra.

38. With regard to the alleged failure of Naples to change the dressings of the Residents cited under Findings 1 and 2 under Tag F224 of the survey report, the evidence was undisputed that the facility only failed to change the dressings on one day for each Resident, and the failure to change a dressing for one day does not retard healing nor present risk of infection or worsening of the wound. The withheld care (i.e., the failure to change the dressings for

one day) was not "necessary" to prevent harm to the Residents. See Springhill, supra.

39. With regard to Finding 3 under Tag F224 of the March survey report, the surveyor determined that Resident 21 required constant monitoring and removal of picture frames from her room because she believed the Resident was suicidal. However, the expert evidence showed that Resident 21 was not suicidal, and that she was not at risk of harming herself due to the failure of staff to remove pictures or to monitor her more frequently than every 30 minutes. The facility's failure to remove the frames or its failure to monitor her more frequently was not "necessary" to prevent harm to the Resident. See Springhill, supra.

AHCA Failed to Prove that the Deficiency Cited Under Tag F224 was Properly Classified as a Class II Deficiency:

40. Although the evidence is insufficient to support a finding of a deficiency under Tag F224 (which it is not), AHCA failed to prove that any of the deficiencies were appropriately classified as a Class II deficiency. 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." 400.23(9)(b), Florida Statutes. AHCA has further refined this definition of Class II deficiencies to be those that "present an immediate threat to the health, safety or security of the

residents in the facility." 59A-4.128(3)(a), Florida Administrative Code. Under the statute and AHCA's implementing rule, a Class II deficiency must be something more than an isolated occurrence in the facility and present an immediate threat to residents in the facility at the time of the survey. If the deficiency presents an indirect or potential threat to residents in the facility, it must be classified as a Class III deficiency. Rule 59A-4.128(3), Florida Administrative Code.

41. AHCA failed to show that the deficiency cited in this case presented an immediate threat to "the nursing home facility residents." The deficiency must be looked at for its impact on all of the residents in the facility, and a Class II rating can only be found where, at the time of the survey, there is an immediate threat to general resident health or safety due to the deficient practice. AHCA offered no evidence which suggested that residents in the building were in immediate threat of being neglected or abused. To the contrary, it assigned the deficiency a federal scope and severity rating of "G," which is an acknowledgement that the deficient practice was isolated.

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 Naples and rescinding the Conditional rating.

DONE AND ENTERED this 12th day of November, 1999, in Tallahassee, Leon County, Florida.

____

WILLIAM R. PFEIFFER
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the Division of Administrative Hearings this 12th day of November, 1999.

COPIES FURNISHED:

R. Davis Thomas, Jr., Esquire
Donna Stinson, Esquire
Broad and Cassel
215 South Monroe, Suite 400
Post Office Drawer 11300
Tallahassee, Florida 32302

Karel L. Baarslag, Esquire
Agency for Health Care Administration
2295 Victoria Avenue, Room 309
Post Office Box 60127
Ft. Myers, Florida 33901-6177

Julie Gallagher, General Counsel
Agency for Health Care Administration
Fort Knox Building 3, Suite 3431
2727 Mahan Drive
Tallahassee, Florida 32308

Sam Power, Agency Clerk
Agency for Health Care Administration
Fort Knox Building 3, Suite 3431
2727 Mahan Drive
Tallahassee, Florida 32308

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.