STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. PINEHURST CONVALESCENT CENTER (BEVERLY ENTERPRISES-FLA, INC., d/b/a BEVERLY GULF COAST-FLORIDA), Respondent.	)	Case Nos. 99-2745 99-2746 00-0049

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in these cases on January 13-14, 2000, in Fort Lauderdale, Florida, and on January 27, 2000, by video teleconference at sites in Tallahassee and Fort Lauderdale, Florida, before Errol H. Powell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Christine T. Messana, Esquire
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STATEMENT OF THE ISSUES

The issues for determination are whether Respondent committed the offenses set forth in the Administrative Complaints and, if so, what penalty should be imposed; and whether Respondent should be issued a Standard or Conditional license rating.

PRELIMINARY STATEMENT

This cause involves three cases. On May 14, 1999, the Agency for Health Care Administration (Petitioner) issued an Administrative Complaint against Pinehurst Convalescent Center (Beverly Enterprises-Fla, Inc., d/b/a Beverly Gulf Coast-Florida) (Respondent), which is Case No. 99-2745. Petitioner charged Respondent with failing to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive care plan relative to assessments of acute conditions through record review and staff interview on October 9, 1998, thereby violating the minimum standards, rules, and regulations promulgated by Petitioner under Chapter 400, Part II, Florida Statutes.

On December 21, 1999, Petitioner filed an Administrative Complaint against Respondent, charging Respondent with violating the minimum standards, rules, and regulations for the operation of a Nursing Home, which is Case No. 00-0049. Petitioner specifically charged Respondent with the following:

(1) violating Subsections 400.022(1)(j), (k), and (l), Florida Statutes, by failing to obtain informed consent, to document that informed consent was obtained, and to provide adequate and appropriate health care services, and violating Rule 59A-4.106(4)(x), Florida Administrative Code, by failing to maintain policies and procedures regarding informed consent; (2) violating Rule 59A-4.106(4)(cc), Florida Administrative Code, by failing to have policies and procedures for reporting accidents and unusual incidents in one of 20 sampled residents; (3) violating Subsections 400.022(1)(j), (k), and (l), Florida Statutes, and Rule 59A-4.1288, Florida Administrative Code, by failing to ensure that two residents in 20 in the sample received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing; and (4) violating Subsection 400.022(1)(l), Florida Statutes, and Rule 59A-4.109(2), Florida Administrative Code, by failing to maintain the acceptable parameters of nutritional status for one resident out of the sample of 20. Based on a survey completed, forming the basis for the Administrative Complaint of December

21, 1999, Petitioner changed Respondent's license rating to Conditional, effective April 21, 1999, through July 2, 1999, which is Case No. 99-2746.

These matters were referred to the Division of Administrative Hearings (DOAH) for hearing. By Orders dated August 20, 1999, and Janury 11, 1999, these matters were consolidated before DOAH.

The parties filed a Joint Pre-hearing Stipulation. Furthermore, at hearing, Petitioner stated that for the violation in Case No. 99-2745, it was relying only upon its survey findings for Resident No. 5 in the Administrative Complaint and that for the violations in Case No. 00-0049, it was relying upon its survey findings for Resident Nos. 1 and 3 in the Administrative Complaint.

At hearing, Petitioner presented the testimony of five witnesses 1/ and entered 24 exhibits (Petitioner's Exhibits numbered 1-24) into evidence. Respondent presented the testimony of three witnesses, 2/ entered three exhibits (Respondent's Exhibits numbered 1, 3, and 5) into evidence, and proffered one exhibit (Respondent's Exhibit numbered 4).

At post-hearing, Respondent filed a Motion to Strike Portions of Petitioner's Proposed Recommended Order. Petitioner filed a Response to Respondent's Motion to Strike Portions of Petitioner's Recommended Order and Request for Sanctions.

Respondent filed a Response to Petitioner's Motions for Sanctions. The premises being considered, Respondent's Motion to Strike and Petitioner's Motion for Sanctions are denied.

A transcript of the hearing was ordered. At the request of the parties, the time for filing post-hearing submissions was set for more than ten days following the filing of the transcript.

The Transcript, consisting of four volumes, was filed on March 20, 2000. The parties were granted an extension of time to file their post-hearing submissions. The parties timely filed their post-hearing submissions on April 26, 2000. The parties' post-hearing submissions were considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, Respondent was a licensed nursing home located in Pompano Beach, Florida.

2. Petitioner is charged with, among other things, periodically evaluating nursing home facilities and making a determination as to the degree of compliance with applicable federal regulations, and state statutes and rules.

3. The evaluation or survey of a facility includes a resident review or survey. A resident survey consists of record review, resident observation, and interviews with family and facility staff.

4. Review of a clinical record includes the review of a document referred to as minimum data set or MDS Assessment. The MDS Assessment is a record, in summary fashion, of information or data that a facility gathers to prepare a care plan for a resident.

5. During the survey of a facility, if violations of regulations are found, the violations are noted and referred to as "tags." Petitioner's surveyors document the tags on a form prepared by Petitioner.

6. Petitioner's surveyors use the "State Operations' Manual" (SOM) as guidance in determining whether a facility has violated the federal regulation 42 CFR Chapter 483.

The October 1998 Survey

7. On October 8-9, 1998, Petitioner conducted an appraisal survey of Respondent, which is not a full survey. In an appraisal survey, Petitioner's focus is on quality of care issues, making sure that the quality of care standards are met. Petitioner used nursing home survey protocols prescribed by the federal government.

8. Petitioner's surveyor performed a resident review of Resident No. 5.

Tag F309

9. Tag F309 incorporates the requirement of federal regulation 42 CFR Subsection 483.25, which provides that "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."

10. The SOM provided, regarding 42 CFR Section 483.25, that a facility must ensure that its residents obtain optimal improvement or does not deteriorate. Therefore, the surveyor must first determine whether a resident has declined or optimally improved, and if the resident has suffered a decline or lack of improvement, determine whether the decline or lack of improvement was avoidable or unavoidable. A decline or failure to reach the highest practicable well-being is unavoidable only if: (1) the facility has an accurate and complete assessment; (2) the facility has a care plan which is consistently implemented and based on the assessment; and (3) the facility has an evaluation of the results of the interventions and revising the interventions when necessary.

11. Resident No. 5 was admitted to Respondent on July 9, 1998. The diagnosis for Resident No. 5 included dementia, but not severe because he could understand and follow directives, aggressive behavior, and agitated depression. He used a wheelchair and could ambulate with assistance.

12. Respondent was required within 14 days, by July 23, 1998, to complete a MDS Assessment of Resident No. 5. Respondent assessed Resident No. 5 as being at risk for falls.

13. Respondent was required within 21 days, by July 30, 1998, to develop a comprehensive care plan to address Resident No. 5's risk for falls. On July 29, 1998, Respondent completed and implemented the comprehensive care plan, containing interventions which included encouraging Resident No. 5 to use his call light; counseling him about his risk for falls and the need to request assistance in transfers; assisting him with transfers; instructing him about proper transfer techniques; using a night light; monitoring him for fatigue; and providing proper positioning while he was in bed or in a chair.

14. Petitioner's surveyor reviewed, among other things, the nurses' notes and the care plan for Resident No. 5. The surveyor determined that Resident No. 5 had fallen seven times since his admission: July 18, July 23, August 7, August 14, August 17, September 26, and October 5, 1998.

15. Two of Resident No. 5's falls occurred during the period for his MDS Assessment: July 18 and 23, 1998. Resident No. 5 suffered a skin tear to his elbow from the fall on August 14, 1998. On August 11, 1998, after his third fall on August 7, 1998, a wheelchair alarm was initiated to reduce the risk of falls. After Resident No. 5's fall on August 17, 1998,

Respondent obtained an order for a lap tray. On September 28, 1998, after his sixth fall on September 26, 1998, a physical therapy screen was performed and a lap buddy was to be used in conjunction with the wheelchair alarm to reduce the risk of falls. The wheelchair alarm was to be used when the lap buddy was not in use.

16. During the October survey, which was only three to four days after Resident No. 5's most recent fall, Petitioner's surveyor observed on two occasions that Resident No. 5 was without either a wheelchair alarm or a lap buddy.

17. Before using the lap buddy, Resident No. 5 used a lap tray. He did not want to give-up the lap tray. Even when he was informed that the lap tray was restrictive, Resident No. 5 wanted to continue using the lap tray.

18. A wheelchair alarm is a device, which attaches to a resident's wheelchair and is connected to the resident by a string. When the resident stands or otherwise moves from the wheelchair, the alarm sounds. The alarm's primary function is to alert the staff, not to ensure that falls will not occur, but the alarm's function is also an inhibitor and assists the staff to prevent the resident from causing himself or herself to fall. The wheelchair alarm is used only when there is a clearly demonstrated need.

19. A lap buddy is much more restrictive than the wheelchair alarm. The lap buddy is a pillow-like device that rests in the resident's lap and discourages the resident from getting up, but the lap buddy can be removed by the resident.

20. A more restrictive device than the lap buddy is the lap tray. The lap tray is a thin plywood board that is placed across the arms of the wheelchair and is secured to the wheelchair. The resident is capable of sliding underneath the lap tray and getting out of the wheelchair.

21. In addition to the skin tear that Resident No. 5 suffered in his third fall on August 14, 1998, he experienced a decline in mobility requiring two people for assistance in walking instead of one person as he had before the many falls. Even though Resident No. 5 had a decline in his mental status as he had to begin taking a medication again that he stopped taking, the evidence does not demonstrate that the falls caused the decline in his mental status.

22. Respondent failed to develop a care plan expeditiously and timely in order to address Resident No. 5's risk for falling.

23. No evidence was presented to demonstrate that Resident No. 5 was resistant to using the interventions.

24. Respondent had no documentation showing that the wheelchair alarm was sounding or in place at the time of

Resident No. 5's fifth fall on August 17, 1998. Respondent had no documentation showing that the wheelchair alarm was in consistent use. Such documentation would have indicated that the care plan was being implemented.

25. Respondent had no documentation showing that Resident No. 5 removed either the lap tray or lap buddy. When he fell on October 5, 1998, his seventh fall, the intervention for Resident No. 5 was the lap tray. The documentation showed that the lap tray had to be re-secured. An inference is drawn and a finding of fact is made that the lap tray was not in place when Resident No. 5 fell and that, therefore, the intervention was not consistently used.

26. The evidence demonstrates that Respondent evaluated the results of the interventions which were used with Resident No. 5 and that Respondent revised the interventions as necessary. However, the evidence also demonstrates that the interventions were not consistently implemented.

27. The evidence, in totality, demonstrates that Resident No. 5's decline was avoidable.

28. Petitioner cited Respondent for committing a violation of Tag F309 and classified the violation as a Class II deficiency. Further, Petitioner assigned a federal scope and severity rating of "G" to the Tag F309 deficiency.

Corrective Action

29. After the October survey, Respondent was required to submit a plan of correction regarding Tag F309. Respondent submitted the plan of correction, indicating corrective action by October 10, 1998. The deficiency was corrected on October 10, 1998.

Penalty

30. Based upon the Class II deficiency of Tag F309, Petitioner imposed a fine of $5,000 upon Respondent.

The April 1999 Survey

31. On April 19-21, 1999, Petitioner conducted an annual survey of Respondent. An annual survey is performed at least once every 15 months. Again, the SOM was used by Petitioner's surveyors. Decisions, regarding violations, are made by the survey team. One surveyor is responsible for the resident review of a particular resident.

Resident No. 3

32. Petitioner's resident surveyor reviewed documents and information, regarding Resident No. 3, including hospice care plan and social service notes; nurses' notes; physician orders; nurses' treatment notes; medication records; physician progress notes; comprehensive care plan, monthly summary comments; dietician's assessment; nutritional assessment; and the SOM for the pertinent tags.

33. Petitioner's resident surveyor also made personal observations, interviewed staff, and had a consultation with a registered dietician, who was Petitioner's consultant.

34. The survey team leader conducted the family interview.

35. On December 10, 1998, Resident No. 3 was admitted to Respondent's facility from an acute care hospice facility. She was terminally ill and doctors were of the opinion that her clinical conditions would cause her death within six months. As a result, Resident No. 3 remained on hospice care at Respondent's facility.

36. Resident No. 3 suffered from end-stage cardiovascular disease and congestive heart failure. She was incontinent with an indwelling Foley catheter and had contractures of the legs and Parkinson's disease. As a result of a stroke, Resident No. 3 was without speech. She was being fed through a PEG tube, which was inserted into her abdomen. Medication and hydration was also provided to her through the PEG tube. Resident No. 3 had several decubiti (pressure sores) at various stages of severity, including one at Stage IV and two at Stage III. She was receiving a continuous dose of morphine for pain caused by her compromising conditions.

37. Resident No. 3 required total and complete assistance with all her activities of daily living (ADLs). She was completely dependent.

38. The family of Resident No. 3 made the health care decisions for her, in particular, her son.

39. Regarding the pressure sores, a Stage IV pressure sore had gone completely through the skin and muscle down to the bone, with nerve endings exposed. The pressure sore was open, raw, and very painful. Often the pain of such a pressure sore is described as being like very severe sun burns or almost like a bone racking kind of pain.

40. In treating pressure sores, nutrition is one of the key components and one of the most important aspects of healing them. Development of pressure sores is related to malnutrition.

41. During Resident No. 3's stay at the acute care hospice facility, before being admitted to Respondent's facility, Resident No. 3 experienced fluid build-up in her lungs, which was related to her end-stage cardiovascular disease and congestive heart failure. The hospice facility effectively eliminated the fluid build-up by reducing the amount of fluid intake to one can per day, which provided Resident No. 3 with 240 calories per day. For most healthy adults, 240 calories per day is insufficient to maintain body weight or promote healing of wounds or diseases. Resident No. 3's overall condition stabilized on the 240 calories per day.

42. Upon admission to Respondent on December 10, 1998, a nutritional assessment of Resident No. 3's nutrition needs was

performed by Respondent's dietician. A determination was made that, in order to meet her nutritional needs and promote weight gain and healing of her pressure sores, Resident No. 3 required 1,424 calories per day and between 37 and 56 grams of protein per day, in addition to multivitamins, vitamin C, zinc, and iron.

43. In January 1999, Respondent's dietician reassessed Resident No. 3 for her nutritional needs. The dietician determined that no change existed in the nutritional needs for Resident No. 3, and recommended an additional, but slight, increase in the feeding amount.

44. Around mid-January 1999, after the nutritional assessment, Resident No. 3 went into crisis care. While in crisis care, Resident No. 3's family expressed concern that she was receiving too much fluid through her feeding. Resident No. 3's physician ordered a reduction in her tube feeding to 720 calories (720 cc) per day, from six cans to three cans of formula per day.

45. On January 25, 1999, Resident No. 3's family again expressed concern that she was receiving too much fluid through her tube feeding. The next day, Respondent's dietician and the hospice nurse met to discuss Resident No. 3's situation regarding the tube feeding. The hospice nurse informed Respondent's dietician that, during Resident No. 3's acute care

at the hospice center, Resident No. 3 had experienced increased congestion and her tube feeding had been reduced to one can of formula per day and that, presently, Resident No. 3 was again experiencing increased congestion.

46. Based upon Resident No. 3's prior experience at the hospice center with increased congestion and reduction in the amount of formula, upon the family's concern that three cans of formula per day was too much, and upon the dietician's opinion that Resident No. 3's comfort would be promoted by reducing the amount of the formula, the dietician decided to recommend reducing Resident No. 3's tube feeding. On January 26, 1999, the dietician recommended reducing the formula from three cans of formula per day to one can per day, from 720 calories (720 cc) to 240 calories (240 cc). No order was given that day by Resident No. 3's physician to reduce the tube feeding from 720 calories. The physician for Resident No. 3 was willing to reduce the formula or even discontinue it if the family of Resident No. 3 agreed.

47. The family of Resident No. 3 were not willing to discontinue the tube feeding. Resident No. 3's physician did not order a reduction of the formula.

48. On January 28, 1999, the physician diagnosed Resident No. 3 with pneumonia and recommended that the pneumonia be allowed to overcome her because of her terminal illness.

49. Resident No. 3 improved and was taken off crisis care on February 3, 1999. Shortly thereafter, she began experiencing audible congestion. On February 12, 1999, Resident No. 3 was suffering from congestion, respiratory distress, and edema in her arms and thighs. On February 16, 1999, 13 days after Resident No. 3 was taken off crisis care, her physician ordered a reduction of the tube feeding to one can per day. Resident No. 3's respiratory problems became non-existent and she was removed from crisis care.

50. Resident No. 3 remained on one can of formula, 240 calories, per day for a little over two months, from February 16, 1999, until the survey in April 1999. During that period of time, either the physician or his assistant reviewed Resident No. 3's condition and did not change her feeding order of one can per day.

51. On February 26, 1999, Resident No. 3 was no longer congested. Her reduced feeding was not re-evaluated by Respondent to determine its necessity until the April survey.

52. At the initial tour of Respondent by Petitioner survey team, the team member who was responsible for resident review of Resident No. 3 and who was a registered nurse observed Resident No. 3, who appeared to be a quite frail, thin and ill female, being tube fed. The feeding bag indicated that Resident No. 3 was receiving 240 calories (240 cc) per day. Resident No. 3's

room had a strong odor, which the team member suspected was indicative of a skin infection, and a deodorizer can was on the floor next to Resident No. 3's bed.

53. Respondent had no policy or procedure in place to monitor the continued necessity or advisability of such a condition as Resident No. 3's reduced feeding. The failure to have such a policy in place potentially put other residents at risk, which is a consideration of the surveyors when they make their decisions regarding the existence of a deficiency.

54. The evidence fails to demonstrate that Respondent obtained informed consent from Resident No. 3's family for the reduced feeding. Respondent failed to fully inform the family of the effects or risks of reduced feeding on the healing of Resident No. 3's pressure sores. Respondent conducted planning meetings regarding Resident No. 3's care plan, but her health care surrogate, her son, was not invited to attend; whereas, if he was invited to attend, he would have had full knowledge of the effects or risks of the reduced feeding on the healing of her pressure sores.

55. The evidence demonstrates that the reduced feeding in Resident No. 3's situation was not compatible with the standard of palliative care and was inconsistent with acceptable end-of-life care practices.

Tag F224

56. Tag F224 incorporates federal regulation 42 CFR Section 483.13(c)(1)(i), which requires, in pertinent part, Respondent to "develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents." Neglect is defined by the SOM guidelines as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The SOM guidelines further provide that, on an individual basis, neglect occurs "when a resident does not receive a lack of care in one or more areas (e.g., absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces)." The intent of the federal regulation is provided in the SOM guidelines, which provide, in pertinent part, that the intent is "to ensure that the facility has in place an effective system that regardless of the source (staff, other residents, visitors, etc.) prevents mistreatment, neglect, and abuse of residents . . . . However, such a system cannot guarantee that a resident will not be abused; it can only assure that the facility does whatever is within its control to prevent mistreatment, neglect, and abuse of residents."

57. Petitioner's survey team determined that Respondent did not have procedures and policies in place to prevent the "neglect" of Resident No. 3.

58. It was within Respondent's control to attempt to ascertain medically the causative agent of Resident No. 3's congestion. Respondent failed to seek a cause, medically, of the congestion but relied upon what was related to Respondent's staff as to what occurred at the hospice facility when the hospice facility was faced with Resident No. 3's congestion. Resident No. 3's tube feeding was drastically reduced based upon this reliance.

59. It was within Respondent's control to fully inform Resident No. 3's health care surrogate of the effects of the drastically reduced tube feeding. The evidence failed to demonstrate that her health care surrogate was fully informed by Respondent regarding the effects of the reduced feeding on her pressure sores. Resident No. 3's physician indicated that he would agree with reducing the feeding if the family agreed to the reduction. The health care surrogate, not being informed of the full ramifications, agreed to the reduction in the tube feeding.

60. Whether Respondent provided Resident No. 3 the necessary goods and care was indeterminable by the survey team.

61. Respondent failed to provide goods and services to Resident No. 3 necessary to avoid physical harm or mental anguish. Respondent failed to have written policies and procedures that would have prohibited neglect to Resident No. 3;

however, in accordance with the SOM guidelines, the written policies and procedures could not have guaranteed that she would not have been neglected.

62. Petitioner cited Respondent for committing a violation of Tag F224 and classified the violation as a Class II deficiency. Petitioner also assigned a federal scope and severity rating of "G" to the Tag F224 deficiency.

Tag F280

63. Tag F280 incorporates the requirement under federal regulation 42 CFR 483.20(k)(2), which requires, in pertinent part, the development of a comprehensive care plan (Plan) within seven days of the completion of the comprehensive assessment; the Plan to be prepared by an "interdisciplinary team," which includes "the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, . . . the resident's family or . . . legal representative"; and periodic review and revision by a team of qualified persons after each assessment.

64. Respondent failed to update or revise Resident No. 3's care plan to address the symptom of congestion, which led to the reduced feeding. Respondent failed to invite or include Resident No. 3's health care surrogate to participate in any

planning of Resident No. 3's care or in any decisions regarding her nutritional needs.

65. Petitioner cited Respondent for committing a violation of Tag F280 and classified the violation as a Class II deficiency. Petitioner also assigned a federal scope and severity rating of "G" to the Tag F280 deficiency.

Tag F314

66. Tag F314 incorporates federal regulation 42 CFR Section 483.25(c), which requires, in pertinent part, a facility to ensure that a "resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable" and that a "resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." The SOM guidelines define a pressure sore as "ischemic ulceration and/or necrosis of tissues overlying a bony prominence that has been subjected to pressure, friction or shear." Furthermore, the SOM guidelines provide a "staging system," which is one method of describing the extent of tissue damage, and which provides, in pertinent part, that "Stage III" is described as a "full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue" and that "Stage IV" is described as a "full thickness of

skin and subcutaneous tissue is lost, exposing muscle and/or bone."

67. Pressure sores in a terminally ill patient are unavoidable. Resident No. 3's pressure sores were unavoidable due to her clinical conditions. For Resident No. 3, maintaining adequate nutrition and hydration was necessary to prevent her pressure sores from worsening, to promote healing, and to prevent infection and breakdown.

68. Respondent drastically reduced Resident No. 3's tube feeding to 240 calories (240 cc) per day. One pressure sore had worsened from a Stage III to a Stage IV. The dead tissue in the Stage III pressure sore was removed, and as a consequence, the pressure sore enlarged to a Stage IV pressure sore. No clinical measurements were available to indicate whether the reduction in the tube feeding negatively affected Resident No. 3.

69. Petitioner cited Respondent for committing a violation of Tag F314 and classified the violation as a Class II deficiency. Petitioner also assigned a federal scope and severity rating of "G" to the Tag F314 deficiency.

70. The evidence is insufficient to demonstrate that Respondent committed a violation of Tag F314.

Tag F325

71. Tag F325 incorporates federal regulation 42 CFR Section 4483.25(i), which, in pertinent part, requires a

facility to ensure that a resident "maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible."

72. Resident No. 3's clinical condition had a great impact on her nutritional status. Her tube feeding was reduced drastically to 240 calories (240 cc) per day. Respondent failed to properly discuss with and fully inform Resident No. 3's health care surrogate of the impact or effects of such a reduction. Moreover, no periodic review of the reduction was performed by Respondent, which was responsible for a care plan for Resident No. 3. The periodic examination of Resident No. 3's physician or the physician's assistant is no substitute for Respondent's responsibility for periodic review and update or revision, if necessary, of Resident No. 3's care plan.

73. Respondent failed to "ensure" that Resident No. 3's nutritional status was maintained.

74. Petitioner cited Respondent for committing a violation of Tag F325 and classified the violation as a Class II deficiency. Petitioner also assigned a federal scope and severity rating of "G" to the Tag F325 deficiency.

Resident No. 1

75. Resident No. 1 was admitted to Respondent in September 1998, with a Stage IV pressure sore. Full thickness of skin and

subcutaneous tissue was lost, exposing muscle and/or bone in a Stage IV pressure sore. To aid the healing of the pressure sore, Resident No. 1's physician ordered a variety of interventions, including ordering that she be given a protein supplement, Promod, in her juice twice a day.

76. Petitioner's registered dietician, who was a member of the survey team, personally observed Resident No. 1 during at least two meals in which Resident No. 1 did not ingest the Promod. Respondent had no system in place to track whether the physician's order was being implemented. Having no such system in place, Respondent was unable to inform the physician of the ineffectiveness of the treatment modality addressing the pressure sore to enable the physician to implement a more effective alternative.

77. During the initial tour of the facility, Petitioner's dietician noticed that Resident No. 1 had a large bruise on the left side of his forehead. The bruise was approximately the size of a quarter to a half-dollar and was a recent bruise that could have been sustained minutes or hours prior to its discovery by Petitioner's dietician. Resident No. 1 was confused and could not inform Petitioner's dietician how his forehead sustained the bruise. Respondent was unaware of the bruise until Petitioner's dietician brought the bruise to Respondent's attention.

78. Respondent had no documentation or information on the bruise. An unknown injury report was completed after Petitioner's dietician brought the bruise to Respondent's attention.

Tag F225

79. Tag F225 incorporates federal regulation 42 CFR 483.13(c), which provides, in pertinent part, that the facility "must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress; and that the "results of all investigations must be reported to the administrator or his designated representative and to officials in accordance with state law . . . ."

80. Respondent should have been aware of the bruise prior to the bruise being brought to Respondent's attention by Petitioner's dietician. The bruise was quite obvious and not hidden. Respondent failed to investigate the bruise, an injury of unknown origin. When Respondent failed to investigate the bruise, a potential risk of continued harm to Resident No. 1 and of harm to other residents existed.

81. After Petitioner's dietician, a member of the Petitioner's survey team, reported the bruise to Respondent, an investigation by Respondent ensued. Afterward, the requirements

for the investigation and reporting were complied with and adhered to.

82. Petitioner cited Respondent for committing a violation of Tag F225 and classified the violation as a Class II deficiency. Petitioner also assigned a federal scope and severity rating of "G" to the Tag F225 deficiency.

Tag F314

83. Tag F314 incorporates federal regulation 42 CFR Section 483.25(c), which requires, in pertinent part, a facility to ensure that a "resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable" and that a "resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."

84. Resident No. 1's physician ordered the ingestion of Promod. Respondent failed to ensure that Resident No. 1 ingested the Promod in accordance with the physician's order.

85. Further, Respondent had no system in place to track whether the physician's order was being implemented, and, therefore, the physician was unable to determine the type of intervention needed, if any.

86. Petitioner cited Respondent for committing a violation of Tag F314 and classified the violation as a Class II

deficiency. Petitioner also assigned a federal scope and severity rating of "G" to the Tag F314 deficiency.

Corrective Action

87. Respondent received Petitioner's survey report on April 29, 1999. The survey report contained the date by which Respondent had to correct the deficiencies, which was by April 27, 1999. The time period for Respondent to correct the deficiencies had elapsed before Respondent was notified of the date for correcting the deficiencies. Respondent submitted a plan of action to correct the deficiencies.

88. On April 27, 1999, Petitioner visited Respondent to determine the status of the Class II deficiencies. All of the deficiencies were not corrected, but, as a result of the visit, Petitioner changed Tags F224, F225, and F280 to Class III deficiencies.

89. On July 2, 1999, Petitioner re-surveyed Respondent. Petitioner determined that Respondent had corrected all of the deficiencies.

Conditional License

90. Based upon the Class II deficiencies of the April 1999 survey, Petitioner issued Respondent a Conditional license, effective April 21, 1999, through July 2, 1999, from the date of the survey to the date the deficiencies were corrected.

Penalty

91. Based upon the Class II deficiencies of Tags F224, F225, F314, and F325, cited as a result of the April 1999 survey, Petitioner imposed a fine of $20,000 upon Respondent.

CONCLUSIONS OF LAW

92. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and the parties thereto pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes.

93. License revocation proceedings are penal in nature. The burden of proof is on Petitioner to establish by clear and convincing evidence the truthfulness of the allegations in the Administrative Complaints. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); and Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

94. Regarding the issue as to whether Respondent should be issued a Conditional license, Petitioner has the burden of establishing by a preponderance of evidence that Respondent should be issued a Conditional license. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); Subsection 120.57(1), Florida Statutes.

95. A licensee is charged with knowing the practice act that governs his/her license. Wallen v. Florida Department of

Professional Regulation, Division of Real Estate, 568 So. 2d 975 (Fla. 3d DCA 1990).

96. Section 400.23, Florida Statutes (Supp. 1998), provides in pertinent par:

> (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. . . .

97. Rule 59A-4.1288, Florida Administrative Code, provides in pertinent part:

> Nursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 CFR 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference. . .

98. Section 400.121, Florida Statutes (Supp. 1998), provides in pertinent part:

> (1) The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $500 per violation per day, for a violation of any provision of s. 400.102(1). . . .
>
> (2) The agency, as a part of any final order issued by it under this part, may impose such fine as it deems proper, except that such fine may not exceed $500 for each violation. Each day a violation of this part

> occurs constitutes a separate violation and is subject to a separate fine, but in no event may any fine aggregate more than $5,000. A fine may be levied pursuant to this section in lieu of and notwithstanding the provisions of s. 400.23. Fines paid by any nursing home facility licensee under this subsection shall be deposited in the Resident Protection Trust Fund and expended as provided in s. 400.063.
> [Emphasis added]

99. Section 400.102, Florida Statutes (1997), provides in pertinent part:

> (1) Any of the following conditions shall be grounds for action by the agency against a licensee:
> (a) An intentional or negligent act materially affecting the health or safety of residents of the facility;
> * * *
> (d) Violation of provisions of this part or rules adopted under this part; or
> * * *
> (2) If the agency has reasonable belief that any of such conditions exist, it shall take the following action:
> * * *
> (b) In the case of an applicant for relicensure or a current licensee, administrative action as provided in s. 400.121 or injunctive action as authorized by s. 400.125.

100. Section 400.23, Florida Statutes (Supp. 1998), provides further in pertinent part:

> (9) The agency shall adopt rules to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature of the deficiency. The agency shall indicate the classification on the

face of the notice of deficiencies as follows:

(a) 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. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. Notwithstanding s. 400.121(2), a class I deficiency is subject to a civil penalty in an amount not less than $5,000 and not exceeding $10,000 for each and every deficiency. A fine may be levied notwithstanding the correction of the deficiency.

(b) Class II deficiencies are those which the agency determines have a direct or immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies. A class II deficiency is subject to a civil penalty in an amount not less than $1,000 and not exceeding $5,000 for each and every deficiency. A citation for a class II deficiency shall specify the time within which the deficiency is required to be corrected. If a class II deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.
(Emphasis added)

(c) 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. A class III deficiency shall be subject to a civil penalty of not less than $500 and not exceeding $1,000 for each and every

> deficiency. A citation for a class III deficiency shall specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

The October 1998 Survey

101. Regarding the October 1998 survey, Petitioner demonstrated that Respondent committed a violation of Tag F309 and that the violation was a Class II deficiency.

102. Section 400.22, Florida Statutes (1997), provides in pertinent part:

> (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:
>
> * * *
>
> (j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.
>
> (k) The right to refuse medication or treatment and to be informed of the

consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

103. Rule 59A-4.106, Florida Administrative Code, provides in pertinent part:

(4) Each facility shall maintain policies and procedures in the following areas:

* * *

(x) Resident's rights;

* * *

(cc) The reporting of accidents or unusual incidents involving any resident, staff member, volunteer or visitor. This policy shall include reporting within the facility and to the AHCA.

104. Rule 59A-4.109, Florida Administrative Code, provides in pertinent part:

(2) The facility is responsible to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical,

> nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.
>
> (3) At the resident's option, every effort shall be made to include the resident and family or responsible party, including private duty nurse or nursing assistant, in the development, implementation, maintenance and evaluation of the resident plan of care.

105. Rule 59A-4.128, Florida Administrative Code, further provides in pertinent part:

> (3) The rating assigned to the nursing home facility will be either conditional, standard or superior. The rating is based on the compliance with the standards contained in this rule and the standards contained in the OBRA regulations. Non-compliance will be stated as deficiencies measured in terms of severity. For rating purposes, the following deficiencies are considered equal in severity: Class I deficiencies; Class II deficiencies; and those Substandard Quality of Care deficiencies which constitute either immediate jeopardy to resident health or safety or a pattern of or widespread actual harm that is not immediate jeopardy. . . .

The April 1999 Survey

Resident No. 3

106. As to Tag F224, Petitioner demonstrated that Respondent committed a violation of the said Tag. Further,

Petitioner demonstrated that the deficiency was a Class II deficiency.

107. Regarding Tag F280, Petitioner demonstrated that Respondent committed a violation of the said Tag. In addition, Petitioner demonstrated that the deficiency was a Class II deficiency.

108. As to Tag F314, Petitioner failed to demonstrate that Respondent committed a violation of the said Tag. Because no violation was found, it is not necessary to determine whether the alleged violation was a Class II deficiency.

109. Regarding Tag F325, Petitioner demonstrated that Respondent committed a violation of the said Tag. In addition, Petitioner demonstrated that the deficiency was a Class II deficiency.

Resident No. 1

110. As to Tag F225, Petitioner demonstrated that Respondent committed a violation of the said Tag. Further, Petitioner demonstrated that the deficiency was a Class II deficiency.

111. Regarding Tag F314, Petitioner demonstrated that Respondent committed a violation of the said Tag. In addition, Petitioner demonstrated that the deficiency was a Class II deficiency.

Penalty

112. As to the October 1998 survey, in which Respondent committed a violation of Tag F309, a Class II deficiency, Respondent corrected the deficiency by the day after the survey, October 10, 1998.

113. Regarding the April 1999 survey in which Respondent committed violations of Tags F224, F225, F280, F314, and F325, all Class II deficiencies, Petitioner's imposition of a $20,000 was based upon its determination that Respondent had Class II deficiencies of Tags F224, F225, F314, and F325, excluding F280. When Petitioner conducted a re-visit to Respondent to determine the status of the said deficiencies, the deficiencies had not been corrected. The undersigned has determined that Respondent did not commit a violation of Tag F314 as the violation relates to Resident No. 3, but that Respondent did commit a violation of Tag F314 as it relates to Resident No. 1.

114. Furthermore, a Class II deficiency is subject to a fine from $1,000 to $5,000 for each deficiency even though Petitioner "may" impose a fine of $500 per day.

115. Additionally, for rating purposes a Class II deficiency is equal in severity to a Class I deficiency.

116. Petitioner demonstrated that changing Respondent's license to a Conditional license, as a result of the April 1999 survey, was warranted. Petitioner further demonstrated that

designating the effective date from April 21, 1999, which was the day of the survey, through July 2, 1999, which was the date that Petitioner observed that all of the deficiencies were corrected, was appropriate and warranted.

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 and therein:

1. Dismiss the charge, as it relates to Resident No. 3 of the April 1999 survey, that Pinehurst Convalescent Center (Beverly Enterprises-Fla, Inc., d/b/a Beverly Gulf Coast-Florida) violated Tag F314, which incorporates federal regulation 42 CFR Section 483.25(c).

2. Find that, as to the October 1998 survey, Pinehurst Convalescent Center (Beverly Enterprises-Fla, Inc., d/b/a Beverly Gulf Coast-Florida) violated Tag F309, which incorporates federal regulation 42 CFR Section 483.25, and Rule 59A-4.1288, Florida Administrative Code; and that the violation is a Class II deficiency.

3. Find that, as to the April 1999 survey, Pinehurst Convalescent Center (Beverly Enterprises-Fla, Inc., d/b/a Beverly Gulf Coast-Florida):

a. Violated Tag F224, which incorporates federal regulation 42 CFR Section 483.13(c)(1)(i), Subsections 400.022(1)(j), (k), and (l), Florida Statutes, and Rule 59A-4.106(4)(x), Florida Administrative Code.

b. Violated Tag F225, which incorporates federal regulation 42 CFR Section 483.13(c)(1)(ii), and Rule 59A-4.106(4)(cc), Florida Administrative Code.

c. Violated Tag F314, which incorporates federal regulation 42 CFR Section 483.25(c), Subsections 400.022(1)(j), (k), and (l), Florida Statutes, and Rule 59A-4.1288, Florida Administrative Code.

d. Violated Tag F325, which incorporates federal regulation 42 CFR Section 483.25(i)(1), Subsection 400.022(1)(l), Florida Statutes, and Rule 59A-4.109(2), Florida Administrative Code.

4. Impose a penalty of $2,500 for the violation committed as to the October 1998 survey.

5. Impose a penalty of $5,000 per violation for the four violations committed as to the April 1999 survey, totaling $20,000.

6. Uphold the change in the license rating of Pinehurst Convalescent Center (Beverly Enterprises-Fla, Inc., d/b/a Beverly Gulf Coast-Florida) to a Conditional license, effective April 21, 1999, through July 2, 1999.

DONE AND ENTERED this 30th day of June, 2000, in Tallahassee, Leon County, Florida.

ERROL H. POWELL
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of June, 2000.

ENDNOTES

[1/] Considering the proof required, this Administrative Law Judge found the opinions of Petitioner's expert to be more credible than those of Respondent's experts. Realizing that, as to the October 1998 survey, only Respondent had an expert, this Administrative Law Judge did not find the expert's opinions credible.

[2/] Ibid.

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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.