STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

CAPITAL HEALTH CARE CENTER,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 00-1996
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
_____	)	

RECOMMENDED ORDER

Notice was provided and on August 25, 2000, a formal hearing was held in this case. The hearing location was 2727 East Mahan Drive, Tallahassee, Florida. The authority for conducting the hearing is set forth in Sections 120.569 and 120.57(1), Florida Statutes. The hearing was conducted by Charles C. Adams, Administrative Law Judge.

APPEARANCES

For Petitioner: Jay Adams, Esquire
Broad and Cassel
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For Respondent: Christine T. Messana, Esquire
Agency for Health Care Administration
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STATEMENT OF THE ISSUES

Should Respondent, Agency for Health Care Administration, rate Petitioner, Capital Health Care Center's nursing home facility license "conditional" for the period March 9, through May 4, 2000? Section 400.23(7), Florida Statutes. In particular, has Petitioner violated the requirements of Tag F324 as determined in Respondent's periodic survey concluded on March 9, 2000? Is Tag F324 a "Class II" deficiency? Section 400.23(8)(b), Florida Statutes. In the event that Petitioner is shown to have violated Tag F324 and the Tag is found to be a Class II deficiency, the parties agree that Petitioner was subject to a "conditional" license from March 9, through April 10, 2000. Did the results of the Respondent's survey concluded on March 9, 2000, reveal violations of Tags F371 and/or F372, "Class III" deficiencies that were not corrected before April 10, 2000, the date upon which Respondent resurveyed Petitioner's nursing home facility? If the alleged violations of Tags F371 and/or F372 were proven as of the survey that concluded on March 9, 2000, and were not corrected by April 10, 2000, when the facility was resurveyed, the parties agree that Petitioner held a "conditional" license from April 10, 2000, until such time as the last of Tag F371 of Tag F372 deficiencies were corrected. Further, the parties agree that failing Petitioner's proof of the date upon which the Tag F371 and/or Tag F372 deficiencies as established were corrected, Petitioner's license was properly

rated as a "conditional" license until May 4, 2000, the date upon which Respondent conducted a third survey in the series of surveys directed to the Petitioner and found no further violations?

PRELIMINARY STATEMENT

Respondent assigned Petitioner a "conditional" license for the skilled nursing facility operated by Petitioner. The beginning period for that license was March 9, 2000. The parties agree that the concluding date was May 4, 2000. Petitioner contested assignment of a "conditional" license for that period by requesting a formal hearing to be conducted pursuant to Sections 120.569 and 120.57(1), Florida Statutes. On May 11, 2000, the Division of Administrative Hearings was notified that Petitioner desired a formal hearing. Respondent requested assignment of an Administrative Law Judge to conduct proceedings leading to a recommended order resolving the fact disputes and recommending the legal outcome. The case was assigned and the hearing ensued.

By stipulation the parties agreed that Respondent bore the burden of proof in the proceeding to show that there was a basis for imposing the "conditional" rating on Petitioner's license. In support of that proof Respondent presented the witnesses Christine Frazier, Wanda Sapp, Ethel Clinton, Edith Golden, Myra Flores, and Anne McElreath. Respondent's Exhibits numbered 1 through 15 were admitted. In reference to Respondent's Exhibits

3 through 8, those exhibits have been sealed to avoid the revelation of Resident 21's name, in that, although redacted, the name can be seen on the exhibits. Petitioner presented Patricia Johnson and Paul Kobary as its witnesses. Petitioner offered no exhibits.

The parties filed a joint pre-hearing stipulation which has been utilized in preparing the recommended order.

Certain hearsay statements are attributable to Resident 21 who resided in Petitioner's nursing home, when the initial survey was conducted in March 2000. This refers to the alleged Tag F324 violation in which the Petitioner must ensure that Resident 21 receives adequate supervision and assistance devices to prevent accidents. Respondent accuses the Petitioner through its employees of improperly transferring Resident 21 from a wheelchair to Resident 21's bed. It is alleged that two Certified Nurses Assistants (CNAs) employed by Petitioner used an improper means to lift Resident 21 resulting in a fracture in the vicinity of the resident's ankle. Whether the hearsay statements attributable to Resident 21 are exceptions recognized in Section 90.803(24), Florida Statutes, was unresolved at hearing.[1]

A hearing transcript was filed on September 27, 2000. Requests were made for additional time to file proposed recommended orders. The most recent request was granted extending the time for filing proposed recommended orders until November 3, 2000. By these arrangements the parties have waived

the requirement that the recommended order be entered within 30 days of receipt of the hearing transcript. Rule 28-106.216, Florida Administrative Code. Proposed recommended orders were filed. They have been considered in preparing the recommended order.

FINDINGS OF FACT

Stipulated Facts

1. Petitioner is a nursing home licensed by Respondent pursuant to the authority granted in Chapter 400, Florida Statutes. Petitioner is located at 3333 Capital Medical Boulevard, Tallahassee, Florida 32308.

2. On March 6 through March 9, 2000, Respondent conducted a survey at Petitioner's facility. As a result of that survey, Respondent alleged that Petitioner was not in compliance with the requirements of Tag F203, Tag F324, Tag F371, and Tag F372.

3. On April 10, 2000, Respondent conducted a revisit survey at Capital. As a result of that survey, Respondent determined that Petitioner had corrected the deficiencies alleged under Tag F203 and F324. Respondent alleged that Petitioner had failed to correct the deficiencies alleged under Tag F371 and Tag F372.

4. On May 4, 2000, Respondent conducted another revisit survey at Capital and determined that all alleged deficiencies had been corrected.

5. Tag F324 requires "the facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents." Respondent alleges that this requirement was not met during the March 6-9, 2000, survey, and that the deficiency had a scope and severity of "G" and constituted a Class II deficiency.

6. Tag F371 requires "The facility must store, prepare, distribute, and serve food under sanitary conditions." Respondent alleges that this requirement was not met during the March 6-9, 2000, and the April 10, 2000, surveys and that the deficiency had a scope and severity of "F" during the March survey, a scope and severity of "D" during the April survey, and constituted a Class III deficiency at both surveys.

7. Tag F372 requires "The facility must dispose of garbage and refuse properly." Respondent alleges that this requirement was not met during March 6-9, 2000, surveys and that the deficiency had a scope and severity of "D" and constituted a Class III deficiency at both surveys.

Tag F324

8. At times relevant to the inquiry Resident 21 has lived in Petitioner's nursing home.

9. On February 16, 2000, Resident 21 left the nursing home and visited her sister at the sister's home. To prepare the resident for her outing, two CNAs got Resident 21 up from her bed in the nursing home and placed her in a wheelchair. A lifting

hoist was not used for this transfer. On this morning the two CNAs did not use the mechanical lift, being unable to locate the lift device. Therefore they opted to manually lift Resident 21 from the bed to the wheelchair. A sheet was used to lift Resident 21 into her wheelchair.

10. At the time Resident 21 was paraplegic. She had had a knee cap removed and that leg was stiff. When referring to the one leg as stiff, it describes the fact that the leg will not bend at the knee.

11. On February 16, 2000, once in the wheelchair, Resident 21 was transported to her sister's house by van or bus. Resident 21 remained seated in her wheelchair for her visit with her sister. Resident 21 was transported from the sister's home back to the nursing home by van or bus, again remaining in the wheelchair. Resident 21 was taken in and out of the van or bus during the trips to and from her sister's home by use of a lift in the vehicle.

12. On February 16, 2000, while visiting with her sister Resident 21 offered no complaint about pain or discomfort in her legs.

13. When Resident 21 returned to her room following her visit with her sister, two CNAs transferred her from the wheelchair to her bed. The two persons who made this transfer were not the same persons as had placed Resident 21 in the wheelchair earlier in the day. At the moment there was no lift

pad under Resident 21 to facilitate the transfer by using the mechanical lift. The lift device attaches to the pad under the upper thigh of a resident, and with the use of the hoist elevates the resident from the wheelchair to the bed or from the bed to the wheelchair. One of the CNAs determined to manually transfer Resident 21 from the wheelchair to the bed. This followed the request of Resident 21 to be placed in her bed. Before Resident 21 was lifted from the wheelchair to the bed she complained that her legs hurt.

14. At the time that the CNAs moved Resident 21 from the wheelchair to the bed there was a fitted sheet under Resident 21.

15. When Resident 21 was returned to her bed from the wheelchair, one CNA grasped Resident 21's upper torso under her arms, while the other CNA lifted Resident 21 by grasping her in the area behind her knees.

16. On this occasion in returning Resident 21 to her bed, the arm of her wheelchair was taken off and the foot rest adjusted. During the transfer from the wheelchair to the bed and after the resident was placed in the bed she offered no complaint about her condition.

17. The CNAs in Petitioner's nursing home are trained to use the pad with the hoist or to have two CNAs pick a person in Resident 21's condition up by the upper torso and legs in making a transfer from the wheelchair to the bed.

18. In the event the pad is not available, under Petitioner's policy, the CNAs may make a manual lift. The CNA who normally worked with Resident 21 looked for the lifting pad before seeking the assistance of the other CNA to make a manual lift. Having not located the pad, she determined to seek the assistance of the other CNA to conduct the manual lift from the wheelchair to the bed.

19. On February 17, 2000, Resident 21 complained of leg pain. This led to an X-ray being performed revealing a fracture to the right ankle.

20. As revealed in the nurses' notes for Resident 21 in explaining the physical condition, Resident 21 refers to her foot being caught under the CNA's arm when the transfer was made from the wheelchair to the bed. With this in mind, and the description by Resident 21 in the nurses' notes that an accident had taken place at that time, it is inferred that the fracture occurred to the resident's right ankle when being lifted from the wheelchair to the bed upon the return from her visit with her sister.

21. Notwithstanding the attempt by the CNAs to use an appropriate technique in the manual lift from the wheelchair to the bed, the resident's foot was caught under the CNA's arm and sometime during the process the ankle was fractured.

22. Results of in-service counseling provided to the CNAs who manually lifted Resident 21 on February 16, 2000, reveal Petitioner's intent to rely upon the use of mechanical lifting devices in contrast to manual lifts as a policy matter.

23. During the March 6-9, 2000 licensing survey conducted by Respondent at Petitioner's facility, a Tag F324 citation Class II deficiency, was noted in relation to non-compliance with the facility expectation that the preferred patient transfer technique would be to employ a mechanical assist, not a manual assist when lifting residents. As described, the circumstances were different for Resident 21. According to the summary of deficiencies in survey Form 2567 executed during the survey, the subsequent lift from the wheelchair to the bed eventuated in a fracture to Resident 21's lower extremity. The referenced deficiency for Tag F324 corresponds to 42 C.F.R. Section 43.25(h)(2).

Tag F371

24. Tag F371 is in relation to 42 C.F.R. Section 43.35(h)(2). This provision requires the nursing home facility to store, prepare, distribute, and serve food under sanitary conditions.

25. During the March 2000 survey conducted by Respondent at Petitioner's facility, it was noted on the survey Form 2567 that Tag F371 alleged deficiencies were discovered in the facility kitchen. On March 7, 2000, it is alleged that six dessert bowls

and two plates were dirty with food residue on the surfaces of those items.

26. Ms. Myra Flores was a survey team member. She is a public health nutrition consultant for Respondent. She holds a bachelor of science degree in food and nutrition, a master of public health and nutrition and is a doctoral candidate. She is a registered dietitian licensed in the State of Florida. She had undergone the Surveyor Minimum Qualifications Test allowing her to evaluate complaints of health care facilities within federal regulations.

27. In her inspection in March 2000, Ms. Flores found dessert bowls and plates that were stored, indicating that they had already been washed. Nonetheless the items had food residue on their surfaces. From her perspective as a public health nutritionist, contamination of utensils in facilities that house residents who have compromised immune capacity is a concern. There is an issue with food-borne illnesses. It can be inferred that a nursing home is a place in which residents have compromised immune capacity.

28. Ms. Ann McElreath was assigned by Respondent to re-survey Petitioner's facility. That re-survey was conducted on April 10, 2000. Ms. McElreath holds an A.S. degree in nursing and a bachelor of science degree in psychology. Her observations concerning the re-survey were recorded on a Form 2567 dated April 10, 2000. That form notes an alleged repeat Class III

deficiency Tag F371 pertaining to observation of pans in a drain rack with food particles on them. According to the report, discussion was had with staff members in which it was stated that the pans were items waiting to be re-washed. Inspection of other pans identified to be cleaned and ready for use again revealed two out of four having food particles on the surface, according to the report.

29. When McElreath inspected the facility kitchen on April 10, 2000, she entered the kitchen and was standing by the dish-washing area where a staff member at the facility had just completed "doing the dishes" and there were aluminum-type banking pans draining. Ms. McElreath inquired of the attendant if those pans had been finished, to which the employee replied "yes." Ms. McElreath picked up the pans and examined them and some had food particles on them. This was pointed out to the employee. Mr. Paul Kobary, Petitioner's nursing home administrator, was in the kitchen at that time. In reference to those pans he stated that those were pans that were going to be re-washed. After a moment's hesitation, the other employee at the facility agreed with Mr. Kobary's comment concerning the re-wash. Ms. McElreath asked that the unnamed employee identify items that were clean. That woman pointed to a rack. Ms. McElreath pulled four additional pans identified as being clean and found two of the four to have food particles attached.

Tag F372

30. Under 42 C.F.R. §483.25(h)(3) is the reference to Tag F372. This provision requires the nursing home facility to dispose of garbage and refuse properly.

31. As noted in Form 2567 for the March 200 survey, Petitioner was alleged to have violated Tag F372.

32. During the March 2000 survey Ms. Flores observed facility practices in connection with disposing of refuse. She observed a garbage bin being transported from the facility kitchen to the dumpsters that serve the facility. The material being transported was not covered. There was trash inside the bin being removed from the facility and boxes were piled on top of the bin. Petitioner's employee took the boxes and placed those in one of the dumpsters. The dumpster in which the boxes were placed through a side opening was then closed. An untied plastic container with garbage inside was then removed from the bin used for transport and then placed through a door on the side of another dumpster. After which the dumpster where the untied container of garbage was located was left partially open in that the door providing access to the dumpster was not completely closed.

33. At hearing Ms. Flores expressed the concern that by leaving the side door opened to the dumpster in which the garbage bag had been placed invited the harborage and the feeding of pest and varmints because that dumpster contained food refuse from the

kitchen. The dumpster was located outside of the facility in the vicinity of the woods and grass making the discarded food available to those pests.

34. Based upon the incident in which the dumpster had been left open following the disposal of the garbage bag, a Tag F372 incident was recorded on Form 2567 corresponding to a Class III deficiency. In response Petitioner committed to a plan of correction to be concluded by April 8, 2000, concerning the maintenance of refuse in closed containers. This refers to closed dumpsters. Since that survey Mr. Paul Kobary the nursing home administrator checks twice a day to see that the dumpsters are closed. Other staff members are assigned to check throughout the day to assure that the dumpsters are closed.

35. In the re-survey conducted on April 10, 2000, another alleged Class III deficiency was cited under Tag F372. This citation was made by Ms. McElreath based upon the fact that one of the dumpsters behind the facility allowed liquid substances within the dumpsters to leak out the bottom. Ms. McElreath was concerned that the substance that had leaked out under the dumpster and in the immediate vicinity might have been picked up on the wheels of wheelchairs. The wheelchairs were off to the side being washed down by the staff. Ms. McElreath worried that once the wheelchairs were returned to the facility the unidentified liquid attached to the wheels would be introduced into the facility proper.

36. The problem with the leaking dumpster was reported as an uncorrected Class III deficiency associated with the problems experienced with the dumpster with uncovered garbage described in the March 2000 survey.

Nursing Home Scope and Severity Chart

37. The parties are bound by the Nursing Home Scope and Severity Chart which characterizes the severity of the alleged deficiencies. Respondent's Exhibit 15. Under this scheme a severity of "G" represents actual harm but not immediate jeopardy. Alleged deficiencies with a severity of "D" and "F" represent a potential for more than minimal harm.

CONCLUSIONS OF LAW

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

39. Respondent licenses nursing homes in Florida in accordance with Chapter 400, Part II, Florida Statutes. Petitioner is a nursing home licensed under that part.

40. Respondent evaluates nursing home facilities at least every 15 months to determine the degree of compliance by the licensee with regulatory rules adopted under Chapter 400, as a means to assign a license status to the nursing home facility. Section 400.23(7), Florida Statutes.

41. The license status assigned to the nursing home following the periodic evaluation is either a standard license or a conditional license.

42. Standard licensure status and conditional licensure status are defined in Section 400.23(7)(a) and (b), Florida Statutes, as:

> (a) A standard licensure status means that a facility has no class I or class II deficiencies, has corrected all class III deficiencies within the time specified by the agency, and is in substantial compliance at the time of the survey with criteria established under this part, with rules adopted . . .
>
> * * *
>
> (b) A conditional licensure status 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, ...
>
> * * *

43. If deficiencies are found during the periodic evaluation, they are classified in accordance with the definitions at Section 400.23(8)(a) through (c), Florida Statutes, which state 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. . . .

> (b) Class II deficiencies are those which the agency determines have a direct immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies. . . .
>
> (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. . . .

44. Respondent has authority to adopt rules to classify deficiencies. Section 400.23(2) and (8), Florida Statutes.

45. In performing the periodic evaluation resort is made to Rule 59A-4.1288, Florida Administrative Code. That rule refers to nursing homes participating in Title XVIII or XIX and the need to follow certification rules and regulations found at 42 C.F.R. 483. Petitioner must comply with 42 C.F.R. 483.

46. The evaluation process uses a Nursing Home Scope and Severity Chart which states:

NURSING HOME SCOPE AND SEVERITY CHART

Severity			
Immediate Jeopardy	J SQC	K SQC	L SQC
Actual Harm Not IJ	G	H SQC	I SQC
Potential for more than Minimal Harm	D	E	F SQC

Potential for Minimal Harm	A No remedies Commitment to Correct Not on HCFA 2567	B	C
Scope	Isolated	Pattern	Widespread

A, B, & C = Substantial Compliance

SQC = Substandard Quality Care, Section 483.13, 483.15, and 483.25

47. From March 6 through 9, 2000, Respondent performed a licensure evaluation at Petitioner's nursing home facility for purposes of assigning a licensure status. Respondent cited Petitioner for an alleged Class II and two Class III deficiencies. By virtue of the Class III deficiencies, the time was established by Respondent for Petitioner to complete correction of the alleged Class III deficiencies. A further evaluation was performed on April 10, 2000, to ascertain compliance with the need to correct the alleged Class III deficiencies and it was determined the corrections were not made.

48. The alleged Class I deficiency identified in the report Form 2567 was referred to as Tag F324. Tag F324 in identifying the protections to be afforded residents in Petitioner's nursing home is designed to make certain that:

> Each resident receives adequate supervision and assistance devices to prevent accidents.

49. Tag F324 is taken from 42 C.F.R. Section 483.25(h)(2).

50. 42 C.F.R. Section 483.25(h)(2) has as its intent:

> That the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.
>
> An 'accident' is an unexpected, unintended event that can cause a resident bodily injury. It does not include an adverse outcomes associated as a direct consequence of treatment or care, (eg., drugs side effects or reactions).

51. The alleged Class III deficiency associated with Tag F371 discovered in the March 2000 evaluation and alleged to be uncorrected on April 10, 2000, relates the obligation to "store, prepare, distribute and serve food under sanitary conditions." Tag F371 is taken from 42 C.F.R. Section 483.35(h)(2). The statement of guidance to the surveyors describing guidelines for 42 C.F.R. Section 483.35(h)(2), defines "sanitary conditions" as "storing, preparing, distributing, and serving food properly to prevent food-borne illness."

52. The Tag F372 item, an alleged Class III deficiency, discovered in the March 2000 evaluation and allegedly uncorrected before April 10, 2000, as noted in the re-inspection refers the need to "dispose of garbage and refuse properly." Tag F372 is taken from 42 C.F.R. Section 483.35(h)(3). The statement of guidance to the surveyors pertaining to 42 C.F.R. Section 483.35(h)(3), reiterates that the intent is to assure that garbage and refuse is properly disposed.

53. The parties assert, and it is accepted, that Petitioner is substantially affected by the issuance of the conditional license for the period in question. See Daytona Manor Nursing Home v. AHCA, 21 FALR 119 (AHCA 1998). Thus, Petitioner has standing to oppose the Respondent's intent to rate Petitioner's nursing home license as conditional for the period March 9 through May 4, 2000. In this context, Respondent bears the burden of proof of alleged deficiencies and consequences for the deficiencies. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1stDCA 1981); and Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1stDCA 1977). Findings of facts in association with that burden are based upon a preponderance of the evidence. Section 120.57(1)(j), Florida Statutes, failing a contrary instruction set forth in Chapter 400 Part II, Florida Statutes.

54. As revealed in the March 2000 survey, Petitioner through its employees did not utilize the normal assistance device, the lift, in transferring Resident 21 from her wheelchair to her bed. Resident 21 was a person who was at risk for an accident. The facility through its employees failed to implement the procedure of using the lift as a means to prevent the accidental fracture in the area of the ankle when that transfer was made. This deficiency had a direct and immediate relationship to the health and safety of Resident 21. The failure to employ the lift constituted a Class II deficiency.

Given actual harm caused by using a manual lift in lieu of the normal procedure to use the mechanical lift, the incident was measured in its scope and severity as "G" on the nursing Home Scope and Severity Chart.

55. Under Tag F371 in both March and April 2000, the surveys revealed a similar problem with the storage of unsanitary food implements used for serving residents. These were Class III deficiencies representing an indirect or potential relationship to the health of the nursing facility residents.

56. The scope and severity associated with the problem of the storage of unsanitary food implements in March and April 2000 corresponds to "F" and "D" respectively, based upon the Nursing Home Scope and Severity Chart.

57. Following the April 10, 2000 re-survey no proof was presented by Petitioner concerning the date upon which corrections were made to the problem with food particles on the implements in the kitchen. It was stipulated that that problem had been alleviated on May 4, 2000, when the third survey was conducted at Petitioner's facility.

58. Failing an explanation that the problem with food on the pans observed on April 10, 2000, had been addressed prior to the third inspection on May 4, 2000, the conditional license was properly extended from the period March 9, 2000, through April 10, 2000, until May 4, 2000.

59. While problems that existed in the nursing home with the disposal of garbage under Tag F372 are properly classified as Class III deficiencies, in that they represented an indirect or potential relationship to the health of the facility residents, the deficiencies were sufficiently different to lead to the conclusion that Petitioner had not failed to correct the original Class III deficiency within the time specified by Respondent. The failure to keep the dumpster door closed can properly be described as inviting harborage and feeding by pests and varmints. The hole in the dumpster bottom provides some quality of access for pests and varmints. On the other hand, the underlying problem discovered in the March 2000 survey, the side door to the dumpster not being adequately closed was attended by having persons check to see that it was properly closed. The discovery of the problem and its correction did not portend an additional problem with the dumpster, an inadequate seal at the bottom of the dumpster. It was not a matter of failing to correct the initial problem, it was a matter of the discovery of an additional problem. Class III deficiencies on both occasions were properly identified by the Nursing Home Scope and Severity Chart as "D". The separate Tag F372 discoveries do not constitute reason to assign Petitioner's facility a conditional licensure status. See Agency for Health Care Administration v. Oak Terrace Specialty Care Center, 21 FALR 3143 (AHCA 1999).

RECOMMENDATION

Upon consideration of the findings of facts and conclusions of law reached, it is

RECOMMENDED:

That a final order be entered in which Respondent assigns Petitioner a conditional license for the period March 9 through May 4, 2000.

DONE AND ENTERED this 14th day of December, 2000, in Tallahassee, Leon County, Florida.

CHARLES C. ADAMS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 14th day of December, 2000.

ENDNOTE

1/ Section 90.803(24), Florida Statutes, states in pertinent part:

> (a) Unless the source of information or the method or circumstances by which the statement is reported indicated a lack of trustworthiness, an out-of-court statement made by an elderly person or disabled adult, as defined in s. 825.101, describing any act of abuse or neglect, any act of exploitation, the offense battery or aggravated battery or assault or aggravated assault or sexual battery, or any other violent act of the

> declarant elderly person or disabled adult, not otherwise admissible, is admissible in evidence in any civil or criminal proceeding if:
>
> 1. The court finds in a hearing conducted outside the presence of the jury that the time, content, and circumstances of the statement provide sufficient safeguards of reliability. In making its determination, the court may consider the mental or physical age and maturity of the elderly person or disabled adult, the nature and duration of the abuse or offense, the relationship of the victim to the offender, the reliability of the assertion, the reliability of the elderly person or disabled adult, and any other factor deemed appropriate; and
>
> 2. The elderly person or disabled adult either:
>
> a. Testifies; or
> b. Is unavailable as a witness, provided that there is corroborative evidence of the abuse or offense. Unavailability shall include a finding by the court that the elderly person's or disabled adult's participation in the trial or proceeding would result in a substantial likelihood of severe emotional, mental, or physical harm, in addition to findings pursuant to s. 90.804(1).
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> * * *
>
> (c) The court shall make specific findings of act, on the record, as to the basis for its ruling under this subsection.

On February 16, 2000, Christine Frazier and Wanda Sapp were working at Capital Health Case Center as CNAs. They lifted Resident 21 from her wheelchair to her bed in her room. One CNA lifted Resident 21 by picking her up under her arms while the other CNA lifted the resident under her knees.

Christine Frazier testified at hearing. In her testimony she referred to the hearsay statement by Resident 21 to the effect that her legs were hurting and that the CNAs should not touch Resident 21's legs. This statement was made before the CNAs picked Resident 21 up and placed her in her bed.

According to Wanda Sapp's hearing testimony, even before the CNAs lifted Resident 21 and placed her in her bed, as Ms. Sapp walked into the resident's room, Resident 21 said "Wanda my legs hurt." As Ms. Sapp described it, she heard Resident 21 complain that Resident 21 wanted to go to bed.

During the lift and following the placement in the bed neither CNA reports hearing Resident 21 make further comment concerning her wellbeing.

As of the March 2000 survey Resident 21 was diagnosed as paraplegic, suffering from depressive disorder, hyper-tension, neurogenic bladder, and diabetes mellitus. Resident 21 was missing a knee cap which caused that leg to be stiff. Resident 21 could not feed herself and needed assistance in bathroom use.

Ms. Edith Golden who testified at the hearing, described a conversation Ms. Golden held with Resident 21. Resident 21 is Ms. Golden's aunt. This conversation concerned the February 16, 2000 incident in which Ms. Frazier and Ms. Sapp moved Resident 21 from the wheelchair to her bed. Resident 21 told Ms. Golden that one CNA braced the Resident's foot under the CNA's arm to keep it straight while she was moving Resident 21. When this occurred Resident 21 told Ms. Golden that Resident 21 exclaimed "ouch, that hurts."

According to the nurses' notes maintained on Resident 21 at the Capital Health Care Center, Resident 21 commented on the incident as "it was an accident, my foot got caught when they were putting me back to bed." It is further indicated in the nursing notes on February 18, 2000, concerning Resident 21, that Resident 21 said that her foot was caught under a CNA's arm when being transferred from W/C, taken to mean the wheelchair, to the bed on February 16, 2000.

Ms. Myra Flores took part in the survey at Capital Health Care Center in March 2000. Ms. Flores testified at hearing. In her testimony she referred to an interview conducted with Resident 21 on March 8, 2000. Ms. Flores testified that she had inquired of Resident 21 concerning the details of when the resident broke her foot. Resident 21 told Ms. Flores that on February 16, 2000, she left the nursing home in the morning for a visit with her sister. Resident 21 stated to Ms. Flores that two CNAs transferred her from her bed to the wheelchair. This was a manual transfer, according to the statement Resident 21 gave Ms. Flores. No mechanical lift was used. Resident 21 denied having any pain at that point in time. Resident 21 told Ms. Flores that when she returned to the facility she was transferred from the wheelchair to her bed by two other CNAs. Resident 21 told Ms. Flores that one CNA took the resident under her arms while the other CNA held the resident's legs behind the calves. When the two CNAs lifted her simultaneously, Resident 21 told Ms. Flores that the resident heard something snap in the vicinity of her ankle. Resident 21 denied crying out in pain.

Resident 21 told Ms. Flores she made a face. Resident 21 told Ms. Flores that the two CNAs that moved her from the wheelchair to the bed "slung her around to her bed funnily." Resident 21 told Ms. Flores that as the day progressed beyond that point in time the resident felt pain in her ankle.

Resident 21 is an elderly person and disabled adult as defined in Section 825.101, Florida Statutes. The hearsay statements attributable to Resident 21 do not constitute descriptions of acts of abuse or neglect, or exploitation, the offense of battery, or aggravated battery, or assault, or aggravated assault or any other form of activity recognized in Section 90.803(24), Florida Statutes, as an exception to hearsay.

By contrast, the statements attributable to Resident 21 found within the nurses' notes that have been referred to are exceptions to hearsay as statements for purposes of medical diagnosis or treatment. Section 90.803, (4), Florida Statutes.

Finally, all statements attributable to Resident 21 may be used to supplement or explain other competent evidence. Section 120.57(1)(c), Florida Statutes.

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.