STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. HOLLY HILL ASSISTED LIVING, INC., d/b/a HOLLY HILL CARE CENTER, Respondent.	Case No. 00-2973

RECOMMENDED ORDER

Pursuant to notice, this cause came on for formal administrative hearing before the Honorable Stephen F. Dean, duly-assigned Administrative Law Judge with the Division of Administrative Hearings on March 29, 2001, at the Daytona Beach Regional Service Center, Room 440, 210 North Palmetto Avenue, Daytona Beach, Florida.

APPEARANCES

For Petitioner: Michael O. Mathis, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308

For Respondent: Harry S. Hartman, Owner
Holly Hill Care Center
1562 Garden Avenue
Holly Hill, Florida 32117

STATEMENT OF THE ISSUE

The issue for consideration in Case No 00-2973, is whether the licensee, Holly Hill Care Center, Inc., should be subject to administrative fines for failure to timely correct four (4) Class III deficiencies; two (2) Class IV deficiencies, and one (1) unclassified deficiency at Holly Hill Care Center, an assisted living facility (hereinafter Respondent) and, if so, the amount.

PRELIMINARY MATTERS

The Respondent received an administrative complaint dated June 15, 2000, from the Agency for Health Care Administration (Agency). The Agency sought to impose administrative fines totaling $2,900.00, against the Respondent, the licensee of the assisted living facility (ALF), Holly Hill Care Center, 1562 Garden Avenue, Holly Hill, Florida, for the failure to timely correct four (4) Class III deficiencies; two (2) Class IV deficiencies, and one (1) unclassified deficiency. The Respondent filed a petition for a formal administrative hearing to dispute the Agency's action, and this hearing ensued.

At the hearing, the Agency presented the testimony of Robert A. Cunningham, health facilities evaluator for the Agency; Eleanor McKinnon, Registered Nursing Specialist for the Agency; and Robert Dickson, health facility evaluator supervisor for the Agency. The Agency offered one composite exhibit

containing items 1 through 8, which was received into evidence. The Respondent offered one exhibit which was received into evidence. A Transcript of the formal hearing was filed on April 19, 2001. Both parties submitted Proposed Findings that were read and considered

FINDINGS OF FACT

1. The Agency is responsible for the licensing and regulation of assisted living facilities (ALF) in Florida. The Respondent is licensed to operate Holly Hill Care Center as an ALF in Holly Hill, Florida. Mr. Robert A. Cunningham, a health facility Evaluator II, was called as a witness for the Agency.

2. Mr. Cunningham identified Item One of Composite Exhibit 1 as a copy of a survey for the ALF bi-annual licensure survey conducted on February 23, 2000. Mr. Cunningham participated in conducting that survey.

3. The Respondent was cited with Tag A-006 for providing services beyond the scope of its license, specifically, caring for eight mental health residents. The evidence presented that the residents in question were mental health residents was that they were being treated by ACT and had made application for Optional State Supplement.

4. The Respondent was cited for Tag A-520 for failing to ensure that all staff persons who had been employed for more than 30 days had documentation for a health care provider

stating they were free of the signs and symptoms of communicable disease. The evidence showed a physician at the local health department had examined the employees. The doctor had noted that the employees were in "good health" instead of certifying that the employees were free of signs and symptoms of communicable disease.

5. The Respondent was cited with Tag A-608 for failing to ensure that medication records were accurate and up to date for each resident. This related to residents for whom medications had been ordered, but not administered.

6. The facts revealed that ACT was providing their medication, but that ACT had failed to provide the medication. Although it was not documented in the records that the Respondent made an effort to obtain the medications, evidence to that effect was presented at the hearing. The Department acknowledged that ACT had suffered some cut backs that had prevented it from providing medications to some of ACT's clients.

7. An ALF's duties regarding medication administration are defined by its contract with the resident. The Department did not introduce a contract; however, it was evident from the testimony of the witnesses that provision of medications was not included in the contract for care.

8. The Respondent was cited with Tag A-615 for failing to engage a consulting pharmacist within the required time frame. This arose from the violation alleged above. The Respondent had difficulty engaging a pharmacist. When one was engaged, he was going on vacation and the contract could not be signed until his return.

9. The Respondent was cited with Tag A-804 for failing to provide each resident with a therapeutic diet, as ordered by the resident's health care provider and with Tag A-806 for failing to have standardized recipes available for food service staff to ensure that the nutritional needs of the residents were being met. The Respondent conceded it had violated these provisions. The Department levied fines of $500 and $150, respectively for these violations.

10. The Respondent was cited with Tag A-814 for failing to engage a consulting dietician or nutritionist within the prescribed time in response to the Tags A-804 and A-806, above. The Respondent admitted that it had been late in engaging a nutritionist/dietician; nevertheless, it appeared that it had made a good faith effort in a difficult situation in which few qualified individuals were available.

CONCLUSIONS OF LAW

11. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this case.

This order is entered pursuant to Section 120.57, Florida Statutes.

12. The Department has the burden of proof.

13. The Department alleges that the Respondent violated Section 58A-5.029, Florida Administrative Code (Tag A-006) by failing to obtain the appropriate endorsement to its ACLF license to provide services to "mental health residents." The term "mental health resident" is defined by Section 400.402(16), Florida Statutes, as:

> Any individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.

14. The rules require an affirmative statement on the Alternative Care Certification for Optional State Supplementation form that the resident is receiving SSI/SSDI due to a psychiatric disorder. Or, alternatively, a written verification provided by the Social Security Administration that the resident is receiving SSI or SSID for a mental disorder is required by the rules. Or, finally, the rules require a written statement from the resident's case manager that the resident is an adult with severe and persistent mental illness.

15. In this case, the determination was made that the Respondent was in violation of the licensing requirement because the inspection revealed "a lot" of residents who were being treated by ACT. The witness stated that ACT is an agency that treats mental health patients.

16. An effort was made by counsel for the Agency to buttress the testimony of this witness by having her identify patients from the drug records who were prescribed or receiving psycho-tropic drugs. This was only partially successful because of the witness's inability to properly identify all the drugs; however, even had this been successful, this is not the standard for identifying a mental health resident described in the rules.

17. Another effort was made to identify patients who had made application for OSS benefits; however, it is this application that must be approved before the resident receives the benefit. No evidence was received that any of the residents were receiving SSI, SSID, or OSS benefits by virtue of having a mental disorder.

18. In the absence of such a showing, the predicate for establishing that the Respondent was serving mental health residents was not established, and the violation was not shown.

19. The Agency alleges that employees of the Respondent did not have the proper documentation to show that they were free of the signs and symptoms of communicable disease (Tag A-

520). Evidence was received that the Respondent had sent its employees to the local public health department for examination and the reports of those examinations were on file. The Agency asserted that the examining physician's entry, "Good Health," on the public health examination form regarding the employee's health history was insufficient to establish the employee was "free of the signs and symptoms of communicable disease."

20. The evidence reveals that the examination form used by the local public health department is one for student health examination; however, the Agency has not adopted a specific form for this purpose. The Agency is seeking to fine a licensee because the public health physician who conducted the examination of the employee did not use a specific verbal formula. A physician's statement that the person being examined is in "good health" is sufficient to establish that the person is "free of the signs or symptoms of communicable disease." The doctor's statement the employee was in good health is more specific and definite than a statement that the person "is free from the signs and symptoms of communicable disease" because one can be free of signs and symptoms and still have a communicable disease.

21. The Agency presented evidence that the Respondent did not administer certain medications to residents in accordance with the physicians' orders for these residents (Tag A-608).

The Respondent presented un-rebutted evidence that it did not administer the medications because it did not have the medications. The issue is not simply failing to administer medications as prescribed, but failing to provide the medications to be administered.

22. The Respondent presented evidence that it had not administered medications for ACT patients because ACT, which was responsible for providing the medications, had not provided the medications. The Respondent had made attempts to obtain the medications from ACT, but these attempts had not been documented. The Agency asserts that the Respondent was ultimately responsible for the failure to administer the medications.

23. The law provides that the ALF will have a contract with the resident for the services to be provided. Where the family or sponsor is to provide a resident's medication, the licensee cannot be held responsible for failing to administer medications not on hand. The licensee's responsibility is to notify the resident's physician that it cannot follow the physician's orders because it does not have the medication. (It was not alleged or proven that the Respondent failed to document reporting a health care issue to a resident's physician.) Upon receiving a report that a patient is out of medication, the doctor and licensee may be obligated to report the situation to

the appropriate authorities if the resident is a child, handicapped, or elderly, once the doctor determines that the failure to provide the medication endangers the health of the resident.

24. There is no requirement to provide the medications unless the licensee agrees to provide medications in its service contract. The Agency failed to establish a key element of the alleged violation, i.e., was the Respondent obligated to provide the medications. The testimony generally establishes that ACT was to provide medication for its clients. It appears that some of the residents who did not have medication were ACT clients. In this case, the Agency has the burden of proof, and it failed to prove that the Respondent had a contractual obligation to provide the medications and failed to do so.

25. The foregoing alleged violation of medication administration was the basis for the Agency's demanding that the Respondent engage a consulting pharmacist (Tag A-615). Rule 58A-5.033(4)(a), Florida Administrative Code, provides:

> (a) Medication Deficiencies.
>
> If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, is documented by agency personnel pursuant to an inspection of the facility, the agency shall notify the facility in writing that the facility must employ, on staff or by contract, the

> services of a pharmacist licensed pursuant to s. 465.0125, F.S., or registered nurse, as determined by the agency.

26. It is noted that the Respondent did engage a consulting pharmacist, and the allegation is that it was not timely. However, if there was no violation regarding medication administration (Tag A-608), there was no basis for requiring the hiring of a consultant pharmacist (Tag A-615).

27. The Respondent stipulates that it did not ensure that each resident received the diet prescribed by the resident's physician (Tag A-804) which is a Class III dietary deficiency. The Respondent also did not have standardized recipes for meal preparation by staff, which is a IV dietary deficiency (Tag A-806). The Agency levied a fine of $500 for the first violation and $150 for the second violation.

28. If a Class I, Class II, or uncorrected Class III deficiency directly related to dietary standards as established in Rule 58A-5.020, Florida Administrative Code, is documented by Agency personnel pursuant to an inspection of the facility, the Agency shall notify the facility in writing that the facility must employ, on staff or by contract, the services of a registered dietitian or licensed dietitian/nutritionist.

29. The record reflects that there was an uncorrected Class III deficiency, and the Respondent was advised in writing to engage a registered dietitian or licensed

dietitian/nutritionist. The Respondent failed to hire a registered dietitian or licensed dietitian/nutritionist within the required time (Tag A-814). At hearing, the Respondent's owner and the facility's administrator stated that they actively sought a qualified dietitian or nutritionist, but could not find one who was available. There was one person who indicated that they would be a consultant; however, this person wanted more compensation that the consulting pharmacist to provide services. It is concluded that this person really was not interested in the engagement. The Respondent was eventually able to obtain a nutritionist or dietician; in any case, it did not do so within the applicable time frames. The Department levied a fine of $300 for failing to engage a dietician or nutritionist in time.

RECOMMENDATION

Based upon the violations proven and admitted above, the Respondent violated Tags A-804, A-806 and A-814 for which the Department levied respectively fines of $500, $150, and $300. The Department should enter its final order assessing those fines for those tags. The other violations alleged were not proven or the predicate for the requirement alleged to have been violated was not established. No action should be taken on the Tags A-006, A-520, A-608 and A-615.

DONE AND ENTERED this 11th day of June, 2001, in Tallahassee, Leon County, Florida.

____

STEPHEN F. DEAN
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 11th day of June, 2001.

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.