STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

QUALITY HEALTH CARE CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 00-3356

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly-designated Administrative Law Judge, Jeff B. Clark, held a formal hearing in this case on January 16, 2001, in North Port, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

Whether or not Tags F224 and F281 were appropriately cited by Respondent, Agency for Health Care Administration, during a May 25 and 26, 2000, complaint survey; if so, if they warranted designation as Class I deficiencies with a severity of "J"; and, as a result, was a "conditional" licensure status appropriately issued to Petitioner, Quality Health Care Center.

PRELIMINARY STATEMENT

On May 25 and 26, 2000, the Agency for Health Care Administration (AHCA) surveyed Quality Health Care Center (Quality), North Port, Florida, and found alleged Class I deficiencies for violation of 42 Code of Federal Regulation (C.F.R.) Section 483.13(c)(1)(i), regarding "Staff Treatment of Residents" cited as "Tag F224," and 42 C.F.R. Section 483.20(k)(3)(i), regarding "Resident Assessment" cited as "Tag F281." By letter dated June 20, 2000, AHCA advised Quality that its standard license was replaced with a conditional license effective May 26, 2000.

Quality filed an Amended Petition for Formal Administrative Hearing with the Division of Administrative Hearings on August 11, 2000, contesting the deficiencies as factually and legally unfounded, or alternatively, changing the classification of the deficiencies to Class III.

On September 20, 2000, an Amended Notice of Hearing was entered setting the final hearing for November 15 and 16, 2000. On November 1, 2000, an Order Granting Continuance and Rescheduling Hearing was entered resetting the final hearing for January 16 and 17, 2001, in North Port, Florida.

AHCA presented two witnesses, Marilyn Steiner, M.A., who was accepted as an expert witness "as a health facility evaluation surveyor," and Virginia Radtke, R.N, accepted as an expert witness in "the field of nursing." AHCA presented Exhibits 1-3 which were admitted into evidence. Quality presented ten witnesses, two of whom were accepted as expert witnesses. Alexia Parker, R.N., was accepted as an expert witness in "long-term nursing," and Victor Rodriquez, M.D., was accepted as an expert "in care of death or dying or geriatric care." Quality presented Exhibits 1-7 which were admitted into evidence. Where appropriate, the name of a resident involved in the incident which gave rise to the complaint survey was redacted to protect her right of privacy.

At the close of the final hearing, the parties requested and received an extension of time, until February 19, 2001, to file proposed recommended orders. The Transcript was filed on February 6, 2001. After both parties had filed Proposed Recommended Orders, AHCA filed a Motion for Leave to File

Amended Proposed Recommended Orders, which was granted. AHCA's Amended Proposed Recommended Order was filed on March 5, 2001.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing, the following findings of facts are made:

1. At all times material hereto, Quality was a licensed nursing home located in North Port, Florida.

2. AHCA is the state agency charged with periodically evaluating nursing home facilities and making a determination as to the nursing home facilities' degree of compliance with applicable federal regulations, state statutes, and rules. As a result of an evaluation, the nursing home facility is given a licensure status described in Subsection 400.23(7), Florida Statutes (1999).

3. Subsection 400.23(7)(a) and (b), Florida Statutes (1999), defines "standard" or "conditional" licensure status based on the presence of one or more "classified deficiencies." Subsection 400.23(8)(a)(b) and (c), Florida Statutes (1999), establishes the deficiency classifications (Classes I, II, and III).

4. Ralph Ham, Quality Administrator, testified that "Quality had received superior [sic] ratings for ten years prior to the May 25-26, 2000, survey" and "had received a zero

deficiency survey a month or a month and a half" prior to the May 25-26, 2000, survey.

5. As a result of a complaint it received from Florida Adult Protective Services, a state agency, that a Quality resident (Resident 1) "had been neglected in that she had been bitten by fire ants," AHCA conducted the complaint survey on May 25-26, 2000, to review the care and treatment of Resident 1 concerning the incident.

6. The standard form used by AHCA to document survey findings is known as a "2567" form, titled "Statement of Deficiencies and Plan of Correction" (Agency Exhibit 2). A nursing home facility deficiency is noted on the 2567 form and referred to as a "tag." The tags cited on the 2567 form for the May 25-26, 2000, survey were tags F224 and F281.

7. Tag F224 incorporates 42 C.F.R. Section 483.13 regarding "Staff Treatment of Residents" and states:

> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

8. Tag F281 incorporates 42 C.F.R. Section 483.20(k)(3)(i) regarding "Resident Assessment" and states, "The services provided or arranged by the facility must meet professional standards of quality."

9. Resident 1 was an 87-year-old female who was "actively dying." Upon readmission to Quality on May 15, 2001, from a hospitalization, her admitting diagnosis included congestive heart failure, chronic obstructive pulmonary disease, chronic renal failure, Alzheimer's' Disease/dementia, lung congestion, edema of both upper and lower extremities, skin tears, bruising, and weeping through her skin. On the evening of May 17, 2000, a renal function test indicated "acute renal failure" which usually means that death is eminent.

10. The following is reported in a summary sheet which is a part of Resident 1's medical record (Quality Exhibit 1):

> She was resting at intervals during the night of 5/17/00, receiving incontinent care and was repositioned x2 until approximately 5:00 a.m. on 5/18/00, when she began calling out to her daughter once again. The CNA repositioned her and provided incontinent care. The CNA stated she did not observe anything unusual at this time. She also stated that the only thing in . . . bed was a beige stuffed animal. At 6:30 a.m. it was noted that she was "resting quietly."
>
> At 8:00 a.m., she was found by a staff member to have "ants" on her upper body. Several staff members, including C. Curtis, LPN, M. Richmond, CNA, (PN) J. Norman, RN, D. Waszielewski, CNA, J. Derrikson, R.N., Jeri Maxfield, R.N. and D. Francois, CNA entered room and immediately removed her from the bed and took her to the shower where all ants were removed. All dressings were removed to assure there were no further ants under any dressings. Reddened areas were noted at this time on her right upper torso.

11. While the incident of Resident 1's being bitten by fire ants while bedridden, is characterized as "catastrophic," the incident itself is not the subject of this hearing; the subject of the hearing is Quality's response to the incident.

Tag F224

12. Amplifying the general requirements of 42 C.F.R. Section 483.13(c) stated in paragraph 7, supra, the 2567 form indicates that

> This Requirement is not met as evidenced by:
>
> * * *
>
> The facility failed to identify the catastrophic event of "over a hundred ant bites" to a terminally ill resident, continuously assess the severity of the trauma which resulted from the ant bites, and satisfactorily eradicate the ant infestation around the outside of the building.

13. AHCA provided no evidence regarding the allegation that Quality failed to "satisfactorily eradicate the ant infestation around the outside of the building" other than statements contained in the 2567 form.

14. Quality offers evidence that it had a monthly pest control service for both the interior and exterior of the facility (Quality Exhibit 2) and that the service had been on-going (Quality Exhibit 3). The Quality maintenance man

testified that he checked the building and grounds for ants three times per week and that he baited ant mounds when found outside. He testified that he examined the area immediately outside Resident 1's room and did not find any ants although he found ants on the floor of Resident 1's room exiting under a baseboard after the incident. He removed the baseboard but did not find a hole. Quality had never had an ant problem prior to this incident.

15. The Quality nursing staff responded immediately upon discovery of the ants. No less than seven nursing personnel, including three registered nurses came to Resident 1's assistance. She was immediately showered, redressed, and moved to another room. All dressings were removed to ensure that no ants were in the dressing.

16. AHCA expert witness, Marilyn Steiner, who was qualified as a health facility evaluation surveyor, testified that the facility neglected Resident 1 in that "they did not identify the incident of the ant bites as separate from her terminal condition."

17. This opinion is purportedly supported by her opinion that there was a significant change in Resident 1 that the facility saw as part of the terminal process and handled it accordingly, versus seeing it as a significant event of the ant bites. AHCA suggested in documents and testimony that

Resident 1 suffered anaphylactic shock as a result of the ant bites.

18. Anaphylactic shock may occur in some individuals bitten by ants. It is an almost immediate acute allergic reaction that is characterized by difficulty in breathing, occasioned by swelling in the laryngeal region, hypothermia (reduced body temperature), a drop in blood pressure, abdominal cramping, muscle constriction, and other dramatic physical reactions.

19. Both Victor Rodriquez, M.D. and Alexia Parker, R.N., who were accepted as expert witnesses testified that Resident 1's record revealed no evidence of anaphylaxis. None of the treating nurses observed any evidence of anaphylaxis. Both experts addressed apparent changes in Resident 1's condition and interpreted those changes as being part of the Resident 1's general organic failure, not changes caused by reaction to ant bites. This testimony is accepted as being more persuasive by the undersigned; no credible evidence has been presented that Resident 1 suffered anaphylaxis or a severe allergic reaction to the ant bites.

20. Tag F224, written by AHCA expert witness Steiner, further states that the facility failed to "continuously assess the severity of the trauma which resulted from the ant bites." Ms. Steiner testified that Jean Norman, R.N., Quality's

Assistant Director of Nursing, said that Tammy Lindner, L.P.N., documented an assessment in the nurse's notes and that she was not responsible for the assessment. Steiner was further critical of the fact that Norman did not have any contact with Resident 1's treating physician from the time of the ant bites until Resident 1's death.

21. Norman denies having told the surveyors that she had no personal contact with Resident 1 and denies having stated when asked if she did an assessment, "No, the LPN did one."

22. Norman was one of the seven nursing personnel who responded to the ant bite call. She was directly involved in placing Resident 1 in the shower by getting the shower chair. She went to Station 2 where Resident 1 was to be transferred and prepared the staff for her arrival. She then assisted in moving Resident 1. She and two other nurses placed Resident 1 in a new bed. Her bandages were removed and Resident 1 was moved so Norman could look at her skin. Reddened areas were observed on her shoulder, on her upper right body, under her breast and along her abdomen. Resident 1 was not in distress, pain, nor did she itch. Norman says that she was observing/assessing Resident 1 this whole time. She directed LPN Tammy Lindner to call Resident 1's treating physician. She directed the other nurse to contact Resident 1's family. About one-half hour elapsed from the actual incident until Resident 1's treating

physician was called. Norman stayed with Resident 1 to see if she was going to have any problems. She did not. Resident 1 was "calm," "she had no complaints." Norman stayed with Resident 1 until LPN Lindner returned and told her what medications Resident 1's treating physician had ordered. Norman returned to Resident 1's room three or four times that morning. Norman continued getting information on Resident 1's condition; she did not see any indication that would suggest anything other than the disease process that was already in place. To the extent that LPN Lindner had direct involvement with Norman's activities, Norman's testimony is confirmed by her.

23. Norman testified that in her professional opinion the (ant bite) incident did not require an heightened level of monitoring or evaluation or assessment to ensure that Resident 1 was properly cared for and treated.

24. Juanita Martin, LPN, who was involved in Resident 1's treatment testified that Norman was fully aware of what was going on with Resident 1 and that she was "orchestrating our behavior." She (Norman) was on the floor on multiple occasions speaking with various people.

25. Tammy Lindner, LPN, testified that Norman and another nurse, Charlene Curtis, brought Resident 1 to Station 2. Lindner cut away the dressing on both of Resident 1's arms so Norman could observe. Lindner testified that Norman examined

Resident 1 and did a "hands-on" assessment. Resident 1 said she had no pain and was not itching. Lindner observed no anaphylaxis or allergic reaction. Lindner administered Benadryl and applied Hydrocortisone cream per Resident 1's treating physician's order. Resident 1 continued to maintain that she was not in pain and did not itch.

26. Quality has a protocol for the care of terminal patients (Quality Exhibit 4) which appears to have been followed in the care of Resident 1.

27. Quality appropriately assessed the incident wherein Resident 1 was bitten by fire ants and provided appropriate treatment. Resident 1 was not mistreated, neglected, or abused by the care and services provided by Quality staff.

Tag 281

28. Amplifying the general requirements of 42 C.F.R. Section 483.20(k)(3)(i) stated in paragraph 8, supra, the 2567 form indicates:

> This Requirement is not met as evidenced by:
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> * * *
>
> The facility did not ensure that: 1. Assessments were conducted by an RN for one of one residents. 2. Medications were given per physician's order for one of one residents. 3. Licensed nursing staff did not recognize signs and symptoms of anaphylaxis/catastrophic event, therefore,

> did not report the extent of the incident to the physician.

29. Subsection 464.003(3)(a)(1), Florida Statutes, limits the performance of an "assessment" to a "professional nurse" (Registered Nurse). 42 C.F.R. Section 483.20 similarly requires that "a registered nurse must conduct and coordinate each assessment . . . and a registered nurse must sign and certify that the assessment is completed." In addition, 42 C.F.R. Section 483.20 lists specific occasions when a facility must make a comprehensive assessment.

30. 42 C.F.R. Section 483.20(b)(2)(ii) states:

> Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

31. Expert witness Alexa Parker, RN, testified that there is no standard of care which requires that an assessment of a nursing home patient be done after a significant event unless it is required by 42 C.F.R. Section 483.20.

32. Resident 1 did not suffer a "significant change" in her status, as defined in 42 C.F.R. Section 483.20(b)(2)(ii), as a result of the ant bite incident. She had redness on portions of her body and some pustules, but there was no evidence of anaphylaxis or significant allergic reaction.

33. There was no requirement that a registered nurse conduct a formal assessment and report Resident 1's ant bite incident in her medical record.

34. At the time of Resident 1's readmission to Quality on May 15, 2000, LPN Lindner called Resident 1's treating physician and, after describing her deteriorating condition, was given orders by the physician that medication was to be given Resident 1 by mouth.

35. Following the ant bite incident and after RN Norman, LPN Lindner, and LPN Curtis had examined Resident 1 at Station 2, Norman directed Lindner to call Resident 1's treating physician, report the ant bite incident, and request orders.

36. Lindner call Resident 1's treating physician's office, spoke to a nurse, described the ant bite incident, and received medication orders from the nurse for Benadryl and Hydrocortisone creme. The Benadryl was given to Resident 1 in applesauce or pudding.

37. Lindner believed that the nurse in the treating physician's office who gave her the medication order was a nurse

practitioner. It was not unreasonable for Lindner to assume that the nurse, having given medication orders, was authorized to do so.

38. Approximately two hours later, Lindner again called Resident 1's treating physician, reported Resident 1's current condition and from the physician's reported comment, "Don't you have an exterminator," believed that he was aware of the ant bite incident.

39. Lindner called Resident 1's treating physician later on May 18, 2000, and, at the urging of Resident 1's family, requested Roxanol, a medication given to medicate dying patients for anxiety, restlessness, agitation, and pain.

40. Quality staff's administration of the medications, Benadryl, Hydrocortisone, and Roxanol, was appropriate given Resident 1's medical condition and her treating physician's orders.

41. LPN Juanita Miller testified that she overheard Lindner's call to Resident 1's treating physician's office staff and reported that Lindner said that, "Resident 1 had had multiple ant bites, that we were concerned about her health, and that we had an emergency."

42. No evidence was presented as to what was reported to Resident 1's treating physician by his office staff about the severity of the ant bites.

43. RN Norman did not write anything in Resident 1's chart about her observations related to the ant bites because her standard practice is to read the LPN notes, and if she agrees with those observations, she has no reason to write on the chart.

44. Expert witness Parker testified that it would not be a deviation from the standard of care for a supervising registered nurse to receive verbal information and give verbal instructions and not record it in the chart.

45. Expert witness Parker testified that in reviewing Resident 1's chart that she found no deviation from the community standard of care by the nurses at Quality and that the care of Resident 1 was adequate and appropriate.

CONCLUSIONS OF LAW

46. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding. Section 120.57(1), Florida Statutes.

47. Section 400.23(7), Florida Statutes (1999), authorizes AHCA to evaluate nursing home facilities and make a determination as to the degree of compliance with established rules and to assign a licensure status to the facility. AHCA bases the facilities' licensure status on, among other things, deficiencies found during the evaluation.

48. Section 400.23(8), Florida Statutes (1999), directs AHCA to classify deficiencies in nursing home facilities. Class I deficiencies are those which AHCA determines present an imminent danger to residents of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom.

49. Section 400.23(7), Florida Statutes (1999), describes licensure status as follows:

> The agency shall assign a licensure status of standard or conditional to each nursing home.
>
> (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 established by the agency, and is in substantial compliance at the time of the survey with criteria established under this part, with rules adopted by the agency, and, if applicable, with rules adopted under the Omnibus Budget Reconciliation Act of 1987 . . . .
>
> * * *
>
> (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 with in the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part, with rules adopted by the agency, or, if applicable, with rules adopted under the Omnibus Budget Reconciliation Act of 1987 . . . .

50. Quality received a letter from AHCA dated June 20, 2000, citing the survey of May 26, 2000, as the basis for a

change in licensure status to conditional. No administrative complaint was filed by AHCA. Quality commenced the case by filing an Amended Petition for Formal Administrative Hearing which incorporated the Form 2567-L, Statement of Deficiencies and Plan of Correction. This became the charging document in this case.

51. Form 2567 contains two tags, F224 and F281. Tag F224 cites 42 C.F.R. Section 483.13(c)(1)(i), a regulation directed to "Staff Treatment Of Residents" and states,

> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> This Requirement is not met as evidenced by:
>
> Based on staff and physician interview, record review and observation, the facility staff did not provide the care and services to prevent neglect and actual harm to one resident. The facility failed to identify the catastrophic event of "over a hundred ant bites" to a terminally ill resident, continuously assess the severity of the trauma which resulted from the ant bites, and satisfactorily eradicate the an infestation around the outside of the building.

52. Tab F281 cites 42 C.F.R. 483.20(k)(3)(I), a regulation directed to "Resident Assessment" and states,

> The services provided or arranged by the facility must meet professional standards of quality.

> This Requirement is not met as evidenced by:
>
> Based on record review, staff interview and physician interview, it was determined the facility did not ensure that: 1. Assessments were conducted by an RN for one of one residents. 2. Medications were given per physician order for one of one residents. 3. Licensed nursing staff did not recognize signs and symptoms of anaphylaxis/catastrophic event, therefore, did not report the extent of the incident to the physician.

53. AHCA, as the party asserting the affirmative of the issue (that is, that there were two Class I deficiencies at Quality), has the burden of proof and of persuasion in this proceeding. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). Absent a demand to revoke or suspend Quality's license, the standard of proof should be a preponderance of the evidence. Subsection 120.57(j), Florida Statutes.

54. While there is the proven occurrence of the unfortunate and unexplained incident of Resident 1 being bitten a significant member of times by fire ants, as established by the Findings of Fact, the allegations of the deficiencies as set forth in Tags F224 and F281 have not been proved by a preponderance of the evidence.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration enter a final order finding that Quality Health Care Center did not violate Tag F224 which incorporates 42 C.F.R. Section 483.13(c)(1)(i) and Tag F281 which incorporates 42 C.F.R. Section 483.20(k)(3)(i) and restoring Quality Health Care Center's licensure status to standard for the applicable period that it was conditional.

DONE AND ENTERED this 9th day of March, 2001, in Tallahassee, Leon County, Florida.

JEFF B. CLARK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of March, 2001.

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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.