STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. BEVERLY SAVANA CAY MANOR, INC., d/b/a BEVERLY HEALTHCARE LAKELAND, Respondent.	)	Case No. 00-2465
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. BEVERLY ENTERPRISES-LAKELAND, Respondent.	)	Case No. 00-3497

RECOMMENDED ORDER

A hearing was held in this case in Lakeland, Florida, on February 1, 2001, before Arnold H. Pollock, an Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

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For Respondent: R. Davis Thomas, Jr.
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STATEMENT OF THE ISSUES

The issues for consideration in these cases are: as to Case Number 00-3497, whether the Agency for Health Care Administration should impose an administrative fine against the Respondent's license to operate Beverly Savana Cay Manor, a nursing home in Lakeland; and, as to Case Number 00-2465, whether the Agency should issue a conditional license to the Respondent's facility effective April 28, 2000.

PRELIMINARY MATTERS

On April 28, 2000, after completion of a survey of Respondent's skilled nursing facility, Beverly Savana Cay Manor, Inc. (Savana Cay), located at 1010 Carpenter's Way in Lakeland, Florida, the Agency for Health Care Administration (Agency) issued a conditional license to operate the facility to Beverly Savana Cay Manor, Inc., in lieu of the previously held standard license. This action was taken because in that survey the Agency determined that the facility had failed to have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by individual health care assessments as required

by the provisions of 42 CFR 483.30, a Class III deficiency. That deficiency, initially identified in a survey of the facility on August 31, 1999, and deemed corrected on October 13, 1999, was observed anew. The Agency also based its change in license character on its finding that the facility failed to insure that each resident received adequate supervision and assistive devices to prevent accidents, a Class II deficiency.

Based on the alleged violation of 42 CFR 483.30 on April 28, 2000, the Agency also entered an Administrative Complaint dated July 26, 2000, in which it seeks to impose an administrative fine for that violation.

The Respondent challenged each Agency action and demanded a formal hearing. Pursuant to Respondent's motion, the two cases were consolidated for formal hearing, and this hearing ensued.

At the hearing, Petitioner presented the testimony of Patricia A. Mills, a surveyor of health care facilities for the Agency; Patricia T. Gold, a health facilities evaluator for the Agency; and Marie Todd Maisel, a registered nurse specialist and a surveyor of minimum qualifications training for the Agency. Petitioner also introduced Petitioner's Exhibits 1 through 9, 14 through 16, 18, and 19.

Respondents presented the testimony of Theresa S. Vogelspohl, a gerontological clinical nurse specialist and

consultant in the care of the elderly. Ms. Vogelspohl was also qualified as an expert on falls in the care of the elderly and nursing practices and standards in nursing homes. Respondent also introduced Respondent's Exhibit A.

A Transcript of the proceeding was filed February 13, 2001. Subsequent to the receipt thereof, counsel for both parties submitted matters in writing which were carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times pertinent to the issues herein, the Petitioner, Agency for Health Care Administration, was the state agency in Florida responsible for the licensing of nursing homes and the regulation of the nursing home industry in this state. It is also the agency responsible for conducting surveys to monitor the compliance of nursing homes with the conditions of Medicare and Medicaid participation. Respondents, Beverly Savana Cay Manor, Inc., d/b/a Beverly Healthcare Lakeland, and Beverly Enterprises - Lakeland, are licensed by the Agency to operate a skilled nursing home at 1010 Carpenter's Way in Lakeland.

2. On August 31, 1999, the Agency conducted an investigation into a complaint that Savana Cay had failed to provide sufficient nursing service and related services to allow residents to attain or maintain the highest practicable

physical, mental, and psychosocial well-being as required by Federal rules governing Medicare and Medicaid. The Agency surveyor, Patricia Mills, observed several residents who did not have their call buttons within reach so that they could summon help if needed. Ms. Mills also talked with residents and family members and from these interviews determined that even when the resident could reach the call button and summon help, the response time was excessively long or, in some instances, the call went unheeded. This sometimes resulted in resident's suffering from the results of their incontinence because the staff did not timely respond to the help calls.

3. Ms. Mills concluded, based on her extensive experience in surveying nursing homes, that the number of staff on duty was not sufficient to meet the residents' needs. It did not allow for the best possible well-being of the residents. Though the information related by Ms. Mills came from her interviews with residents and their families and was clearly hearsay testimony, it was admissible and considered as corroborative of her direct observation. The parties stipulated that a follow-up survey of the facility was conducted on October 13, 1999, at which time the deficiency described was deemed to have been timely corrected. The Respondent, by stipulation, does not concede the validity of this discrepancy on the August 19, 1999, survey, and the

Agency does not rely on it to support the administrative fine sought to be imposed herein.

4. Another survey of the facility was conducted by the Agency on April 26-28, 2000. On this occasion, surveyor Patricia Gold interviewed residents regarding the everyday life of the facility and reviewed resident council reports to follow up on any resident or family concerns which did not appear to have been addressed by the facility staff. During the resident interviews, Ms. Gold was advised that call lights were not answered in a timely fashion. In that connection, early on the morning of April 28, 2000, Ms. Gold observed a resident request a nurse to bring something to drink. The nurse was overheard to tell the resident the request would have to wait until she finished her report.

5. Ms. Gold also noted on April 28, 2000, that dirty dishes were left uncollected over night in the facility common corridor and that one resident had two dirty trays left in the room. The dishes in the corridor were also seen by surveyors Donna Edwards and Marie Maisel. Based on their observations, the interviews, and the review of the council reports, the surveyors concluded that the staff on duty were insufficient in number.

6. Another surveyor, Joanne Stewart, reviewed the resident files and medical reports of several of the residents

and determined that in several cases the facility had failed to provide adequate supervision and assistive devices to prevent falls and inconsistently applied the interventions that were put in place. For example, Ms. Stewart observed Resident 12 on the floor at 2:40 p.m. on April 27, 2000. This resident, a cognitively impaired individual, had been placed in the facility from the hospital after he had sustained a fracture to his right hip and, at the time of the fall, still had staples in his hip.

7. Ms. Stewart's review of the kardexes maintained by the certified nursing assistant (CNA) revealed there were no entries thereon indicating a need for special care to prevent this resident from falling. Although he was supposed to wear a tab alarm at all times, the facility staff knew the resident would periodically remove it, and when Ms. Stewart saw him prior to the fall, he was not wearing it. No other interventions, such as quick-release seat belts or Velcro belts, had been implemented to prevent his falls. It was just the kind of fall that he had which caused his placement in the facility and which gave rise to the need for supervision adequate to prevent further injury. He did not get the needed supervision. In fact, though the resident sustained a skin tear and bleeding of the arm as a result of the fall, the nurse who came to the scene of the fall went back to her desk

and did some paperwork for between twenty and twenty-five minutes before the resident was provided any treatment for his injury. Ms. Stewart concluded the facility did not provide adequate supervision and assistance to Resident 12, and it is so found.

8. Due to a cognitive impairment and an inability to ambulate due to an intracerebral hemorrhage, diabetes, and a cardio-vascular accident, Resident 9 was assessed at high risk for falls, and a determination was made that the resident should wear a tab alarm while in bed and in the wheelchair. During the course of her survey, Ms. Stewart observed this resident on several occasions without the tab alarm when she should have been wearing it. The resident had previously sustained falls, one of which occurred while the resident was on leave, on March 31 and April 1, 2000, but the only caveat on the CNA kardex for the resident was the caution not to leave her on the toilet alone. Ms. Stewart did not consider the supervision and assistance rendered Resident 9 to be adequate. It is so found.

9. Ms. Edwards focused her review on the records of Resident 22 who was not at the facility at the time of the survey. The records indicated the resident had been assessed at a high risk for falls at the time of her admission and a tab alarm was used. However, according to the nurse's notes,

on April 10, 2000, the alarm went off causing the resident to lose her balance and fall while in the merry walker. She lacerated her scalp and sustained a large swelling in the occipital area. The only fall assessment of this resident was done when she was admitted to the facility. The evidence does not indicate when this was, but presumably, it was not done timely. There is a requirement that fall assessments be done quarterly, but it cannot be determined when it was done here. Even when, on April 11, 2000, the day after the fall, the physical therapy staff re-screened this resident for a merry walker, no change in care notation was noted in her record or implemented.

10. Resident 22 sustained another fall on April 16, 2000. On this occasion, the resident was found on the floor of the day room, out of the merry walker. There was no indication she was being supervised or monitored at the time of her fall. This time she sustained another head injury just above the old one. After this fall, the facility staff ordered a new merry walker even though there was no indication a different one would provide additional protection.

11. The resident sustained a third fall on April 18, 2000, sustaining another injury to the head which resulted in substantial blood loss. As a result of this fall, she was taken to the hospital. Because of this, she was not present

when the survey was done, but based on her review of the resident records, Ms. Edwards concluded that the facility did not provide sufficient supervision or assistive devices to this resident.

12. During the period of the survey, Ms. Gold observed Resident 3 on five separate occasions. On none of them was the resident wearing a Tabs alarm even though the facility's care plan called for one to be used. A falls assessment had been started on the resident but not completed. The record also revealed that the resident fell on March 29, 2000, resulting in a skin tear to the right arm. Based on the above, Ms. Gold concluded that the resident was not provided with adequate care and assistive devices.

13. Resident 10 was a resident with a history of falls both before and after admission to the facility. The resident's care plan called for chair alarms, a merry walker, a safety seat belt, a low bed, and a bike horn. Though Ms. Maisel, the surveyor, observed that the resident had a chair alarm, she did not see that any of the other interventions called for in the plan were provided. She did not ever see the resident with a merry walker, and on at least two occasions, she saw the resident when the chair alarm was not in use. In her opinion, the use of one intervention does not make the use of other interventions unnecessary, and she

considers the facility's supervision and assistive device provision to be inadequate.

14. Resident 4 was an individual who had sustained a hip fracture, was senile, and was taking pain medications. The resident required help in getting out of bed or a chair. The care plan for the resident called for the use of a Tabs alarm, but on none of the occasions that Ms. Stewart observed this resident was the tabs alarm in use. She considered the supervision and assistive devices provided by the facility to this resident to be inadequate.

15. Respondent does not contest that the incidents cited by the Agency took place. Rather, it contends that the interventions implemented by it were sufficient. It also disputes the effectiveness of some interventions called for, specifically the Tabs alarms, suggesting that the alarm does not prevent falls and often contributes to them by startling the wearer. There is some evidence to support that claim.

16. Respondent further contends that the safety provided by the use of an intervention device, such as the Tabs alarm, straps, bed rails, or the merry walker, restrictive as they are, must be weighed and evaluated against the loss of dignity of the resident caused by their use.

17. It is also urged by the facility that the use of certain interventions such as Tabs alarms is made unnecessary

when the resident is immobile and safety is provided by the use of other interventions such as bed rails, which are more pertinent to the condition of the resident. In the case of Resident 9, the failure to provide for the use of a Tabs alarm when the resident was on leave with her husband was off-set by the one-on-one supervision she received during that period.

18. Respondent contends that falls will occur among residents of the type in issue here regardless of the planning to identify the risks of fall, the efforts made to prevent them, and the implementation and use of interventions designed to avoid them. While this may be so, the facility nonetheless has a duty to provide necessary and adequate supervision and assistive devices to minimize to the greatest extent possible, the risk of injury as the result of falls. In some cases, this was not done here.

19. In support of its position, Respondent presented the testimony of Theresa Vogelspohl, a nursing home consultant and an agreed expert on falls, issues of the elderly, issues of care of the elderly, and nursing practices and standards in nursing homes. Ms. Vogelspohl indicated that as a general practice when patients are admitted to a nursing home they are considered at risk for falls until the facility staff gets to know them. Each facility sets its own standard as to the length of the observation period, during which the residents

are studied for their gait and safety awareness. In addition, the residents are evaluated for safety awareness by the staff of the physical and occupational therapy departments.

20. Ordinarily, the assessment includes only the minimum data set (MDS) criteria, but increasingly during the last few years, a separate falls assessment has become common. In addition to the initial assessment, the attending nurses do an independent admissions assessment, and Ms. Vogelspohl found that such an assessment process was followed as to each of the residents in issue here.

21. Ms. Vogelspohl found that an incomplete falls assessment had been done on Resident 3. Based upon her own review of the resident's records, however, had the full assessment been completed, other than the fact that she was a new resident, the resident would have been classified as a low risk for falls. She opines that the failure to complete the falls assessment did not deny the resident any care or a care plan for falls. Ms. Vogelspohl determined that the facility had opted, instead, for a more cautious approach to this resident in the care plan which, in her opinion, was appropriate for a new admission.

22. A care plan is a map for the staff to be made aware of the care being provided and the specific interventions pertinent to the resident. If the resident is at increased

risk for falls, the care plan would list the interventions designed to decrease the risk of falls.

23. One of the most significant risk factors for falls is increase in age. Others are disease conditions, medications, cognitive functioning levels, eyesight, and other impairments. The interventions available to a facility to address the issue of risk of falls depend upon the condition of the resident. The first consideration should be the need to maintain a safe physical environment for the resident. Appropriate footwear is important as is the availability of assistive devices such as a cane or walker. If the resident has a history of falls, consideration should be given to changing those factors which were related to the prior falls. Included in that is consideration of different seating or a more frequent toileting schedule.

24. According to Ms. Vogelspohl, the last thing one would want to do is to apply physical restraint, but, if all else has failed, the least restrictive physical or chemical restraint may be necessary to decrease the likelihood of falls. Ms. Vogelspohl emphasizes that only the likelihood of falls can be reduced. It is not possible to prevent all falls. Room cleanliness is not something which should appear in a care plan. It is a given, and nurses know to place furniture in such a way and to reduce clutter to the extent

that the resident can safely navigate the room either with a walker or a wheelchair. Obviously, in this case the survey staff concluded the placement of the dirty trays in the hallway and in the resident's room constituted a hazard.

25. In Ms. Vogelspohl's opinion, supervision and monitoring of residents in a nursing home is a basic. That is generally the reason for the resident's being admitted in the first place. While they should be done on a routine basis, supervision and monitoring are still sometimes placed in a care plan, but the failure to have the requirements in black and white is not a discrepancy so long as the appropriate supervision and monitoring are accomplished.

26. The residents most at risk for falls, and those who are the most difficult to manage, are those who have full physical functioning yet who have almost nonexistent cognitive functioning. Ms. Vogelspohl is of the opinion that for these residents, the best intervention is the merry walker. This is better than a regular walker because the resident cannot leave it behind. If the resident is one who falls from bed, then a low bed, with rails if appropriate, is the primary option. A low bed was called for for Resident 10 but was not provided.

27. Ms. Vogelspohl does not have a high opinion of the Tabs alarm because it can cause as many falls as it prevents. It has a place with the cognitively aware resident who will

sit back down if she or he hears the alarm sound. More often than not, however, the routine resident will automatically react by trying to get away from the noise, and, thus, be more likely to engage in rapid, impulsive behavior that can lead to a fall.

28. Ms. Vogelspohl considers the use of the Tabs alarm as only one factor in assessing the degree of supervision provided. She looks at the care plan to see if the Tabs alarm even meets the needs of the resident. If the resident is cognitively alert and at no risk of falls, a Tabs alarm is not appropriate. There are other interventions which can be used such as quick release, velcro seat belts which better prevent falls because they provide a resistance when the resident attempts to stand up.

29. To determine whether a care plan has been developed and implemented, Ms. Vogelspohl reviews the record. She looks at the nurse's notes and those of the social services personnel. She evaluates the records of the physical, occupational, and recreational therapy staff. Finally, she reads the resident's chart to see what staff is actually doing to implement the interventions called for in the care plan. However, on the issue of supervision, she does not expect the notes or the record to affirmatively reflect every incident of supervision. There is no standard of nursing practice that

she is aware of that calls for that degree of record keeping. What she would expect to see is a record of any kind of unsafe behavior that was observed.

30. By the same token, Ms. Vogelspohl would not expect a facility to document every time it placed an alarm unit on a resident. The units are applied and removed several times a day for bathing, clothing changes, incontinence care, and the like, and it would be unreasonable, she opines, to expect each change to be documented. Further, she considers it inappropriate and insulting to the resident to require him or her to wear an alarm when cognizant and not displaying any unsafe behavior. If a resident who is not cognitively impaired declines intervention, it would, in her opinion, be a violation of that resident's rights to put one on. In that regard, generally, interventions are noted in the resident records when initiated. Usually, however, they are not removed until the quarterly assessment, even though the intervention may be discontinued shortly after implementation.

31. Ms. Vogelspohl took exception to Ms. Edwards' finding fault with the facility for the three falls experienced by Resident 22. The resident was under observation when the first fall occurred, but the staff member was not able to get to the resident quickly enough to catch her when she stood up and immediately toppled over in her

merry walker. The resident had been properly assessed and proper interventions had been called for in the care plan. Ms. Vogelspohl attributes the fall to the resident's being frightened by the Tabs alarm going off when she stood up and believes she probably would not have fallen had she not had the tab unit on. The second fall took place while the resident got out of her marry walker in the day room. Though the day room was visible to anyone out in the hallway, the fall was not witnessed, but Ms. Vogelspohl is of the opinion that it is not reasonably possible to keep every resident under constant visual supervision unless an aide can be assigned on a one-on-one basis to every resident.

32. On the third fall, which occurred at about 10 p.m., the staff had put the resident to bed and had put a Tabs unit on her at that time, but the resident had detached the unit and gotten out of bed. There was nothing the staff could do to prevent that. The resident was able to remove the unit no matter how it was affixed to her.

33. Taken together, the actions taken by the facility with regard to this resident were, to Ms. Vogelspohl, appropriate. Some things could have been done differently, such as perhaps using a heavier merry walker, but she did not consider these matters as defects in the care plan, in assessment, in design, or in application. Further, she

concluded that the actions taken by the facility subsequent to the first fall on April 10, 2000, wherein the resident's medications were adjusted to compensate for their effect on the resident, constituted a recognition of a change in the resident's condition which was properly addressed.

34. Too much supervision becomes a dignity issue. There is no formula for determining how much supervision is adequate. It is a question of nursing discretion based on the individual resident. An unofficial standard in place within the industry calls for a resident to be checked on every two hours, but rarely will this be documented. Staff, mostly nurses and CNAs, are in and out of the residents' rooms on a regular basis, administering medications and giving treatments. Those visits are documented, but not every visit to a resident's room is.

35. Resident 12, a relatively young man of 62 with several severe medical problems, sustained a fall which resulted in a fractured hip just two weeks after admission to the facility and two weeks before the survey. He was far more mobile than expected. According to the records, he was mostly cognitive intact and had been assessed for falls. As a result of this assessment, the facility developed a care plan to address his risk for falls. Implementation of the plan was

difficult, however, because he was aware and could make up his own mind as to what interventions he would accept.

36. As to the resident's April 27, 2000 fall, the only evidence in the file shows that he was found on the floor of his room in front of a straight chair, having sustained a small skin tear in addition to the fracture. From Ms. Vogelspohl's review of the record she could find no indication that the facility had failed to do something that it should have done to prevent the fall. The staff had put a Tabs alarm on the resident, and he removed it. They tried to keep his wheel chair as close to him as possible. They tried to restrict his water intake by giving him thickened liquids to reduce his trips to the rest room. He would pour out the thickened fluids and replace them with water. Because of this resident's mobility, Ms. Vogelspohl does not accept the surveyor's conclusion that the facility did not use Tabs alarms. He was able to get out of them by himself and frequently did. She is also of the opinion, in light of the way the resident behaved, that the blank kardex observed by the surveyor in no way contributed to the resident's fall. The CNA's were aware that the Tabs units were supposed to be used, and Ms. Vogelspohl has concluded that there were no more aggressive interventions that could have been used with this resident. To attempt the use of restraints, either belt or

vest, would have been futile because he could have gotten out of them easily. The only other thing Ms. Vogelspohl feels could have been done was to put him in a geriatric psychiatric unit, and this was ultimately done, but not in the Respondent facility.

37. Ms. Vogelpohl also addressed the surveyors' write-ups as they related to Residents 9, 4, 3, and 10. Resident 4 was bed-ridden as a result of Parkinson's Disease and did not need a Tabs alarm, the deficiency cited, while in bed. When seated in a wheel chair, his postural deficits were compensated for by lateral supports and a padded cushion, and she was of the opinion that a Tabs alarm was not required. She opines its absence would not have addressed his risk for falls. His January 2000 fall apparently did not relate to the failure to use a Tabs unit.

38. Resident 3, also the subject of a write-up for failure to use a Tabs alarm, was not, in Ms. Vogelspohl's opinion, at risk for falls because she did not move around a lot due to her physical condition. Nonetheless, she experienced a fall in late March 2000 and shortly thereafter, the facility placed a Tabs alarm on her and made the appropriate entry in her care plan.

39. Resident 9 was ambulatory only with assistance and had a special seating device to keep her in her wheel chair.

After the resident sustained two falls close together, a Tabs alarm was placed on her, and from that time until the time of the survey she had no further falls. Ms. Vogelspohl contends that it was an appropriate nursing decision not to place a Tabs unit on her. The rationale for this position is not at all clear.

40. The care plan for Resident 10, also one of the residents observed without a Tabs alarm in place, was described as "somewhat cluttered." It showed multiple interventions initiated as early as April 1999. The initial care plan was crossed through and a new one substituted in September 1999 with the family's concurrence. Nonetheless, Ms. Vogelspohl did not find it too cluttered to be understood. The evidence shows that the resident's chair was outfitted with a soft seat belt and a pressure-sensitive alarm, both of which are considered to be more effective than the Tabs alarm.

41. Ms. Vogelspohl contends that the facility did not ignore the requirement to assess the residents for falls or the requirement to address that issue in care planning. She admits that in some cases, the plan addressing falls prevention was covered in another assessment than the one wherein it might most likely be expected, but it is her contention that if the subject is properly and thoroughly addressed somewhere in the resident's care record, that is

sufficient. She considers placing it in several areas to be a redundancy and though it is frequently done so, it is done to meet a paper compliance without having any impact on the quality of care provided.

CONCLUSIONS OF LAW

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

43. The Agency is required, by the terms of Section 400.23(7), Florida Statutes, to evaluate all nursing home facilities in the state at least every fifteen months, and to make a determination as to the facility's degree of compliance with state and federal rules and regulations. The Agency's evaluation must be based on the most recent inspection report and take into consideration findings from other official reports, surveys, interviews, investigations, and inspections. Upon completion of the evaluation, the Agency must assign either a Standard or a Conditional license rating to the facility.

44. The Agency has recognized the impact that the award of a Conditional rating to a facility can have on the facility's ability to operate. In order to receive a Certificate of Need, an applicant's ability and record of providing quality care are among the criteria for competitive

review. An existing facility cannot qualify for the state's Gold Seal program if it has received a Conditional rating within the prior thirty months. Further, a Conditional rating can substantially affect a facility's reputation in the community and can have a negative impact on staff morale and recruiting.

45. A Conditional license will be issued to a facility which the evaluation shows has, at the time of the survey, one or more Class I or II operational deficiencies, or a Class III deficiency which has not been corrected in the time established for correction by the Agency.

46. The Agency has the burden of proving the basis for changing the facility's license to Conditional and for imposing an administrative fine. The standard of proof for changing the nature of the operating to Condition is by a preponderance of the evidence. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981). The standard of proof required for imposition of an administrative fine is by clear and convincing evidence.

47. Class II deficiencies, as defined by Section 400.23(8)(b), Florida Statutes, 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. Class III

deficiencies, as defined by Section 400.23(8)(c), Florida Statutes, 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.

48. The instant case relates to deficiencies identified and described as Tag 353 and Tag 324 in the report of surveys done by the Agency on August 31, 1999, and April 28, 2000.

49. As to Tag 353, Rule 59A-4.1288, Florida Administrative Code, requires nursing homes of the category involved herein, to follow certification rules and regulations found in 42 CFR 483, Requirement for Long Term Care Facilities, September 26, 1991. That regulation, 42 CFR 483.30, requires the facility to "have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." If proven, Tag 353 would represent a Class III deficiency.

50. The key word for discussion in this matter is "sufficient" as it describes the staff members required by the regulation and rules. The parties agreed that, save for a short period of less than one day at some time during the covered period, the facility met the staffing requirements set

by Rule 59A-4.108(4), Florida Administrative Code. Instead, the Agency argues, the staff on hand, though meeting rule numerical requirements, was not sufficient to provide the appropriate care to the residents who constituted the resident census needing nursing care. In support of its contention, the Agency cites the dirty dishes in the hallway outside the dining facility and dirty trays from one or more meals in one resident room, in conjunction with the complaints of slow response times or unanswered call buttons and unprevented resident falls. While these conditions, clearly established by competent evidence of record, were not shown to be life threatening or to have resulted in any of the falls shown to have occurred, there is clearly a showing of a relationship between the conditions of the nursing service provided as described and a failure of the residents to attain the highest practicable physical, mental, and psychosocial well-being. For that reason, though the Agency's numerical standards were met, Tag 353 is found to be supported by the evidence of record.

51. Tag 324 relates to a violation of the requirements set forth in 42 CFR 483.25(h)(2), calling for the facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents, as mandated by Rule

59A-4.1288, Florida Administrative Code. If established, Tag 324 would be a Class II deficiency.

52. The care provided to six individual residents, Residents 3, 4, 9, 10, 12 and 22, as described by the Agency's representatives, serve as the basis for its determination that the facility failed to provide appropriate supervision and assistive devices to prevent the falls these residents sustained. The facility's expert contended, and the facility adopted as its position, that the supervision provided to the six residents in issue was adequate.

53. As to Resident 3, the facility's expert admitted that an incomplete falls assessment of the resident had been done but urged that even had a full assessment been done, the resident would have been considered as a low risk candidate for falls. That position is based on informed speculation, however. The fact remains that a falls assessment is called for by the rules governing the operation of nursing homes and a complete assessment was not accomplished. Notwithstanding this resident might have been considered a low falls risk, the fact remains that on March 29, 2000, she was found on the floor after a fall in which she sustained a skin tear to the right arm. Even after the fall, during the April 2000 survey, the surveyor observed this resident on five separate occasions without a Tabs alarm in place.

54. The care plan for Resident 4, a senile individual who suffered from Parkinson's Disease, a fractured hip, and depression, called for a Tabs alarm to be used "at all times," whether the resident was in bed or reclined in a Broda Chair. Notwithstanding this requirement, the surveyor observed the resident on two separate days, once in bed and once in the Broda chair, and on neither occasion was the Tabs alarm in place. Ms. Vogelpohl strongly contended that the Tabs alarm could contribute to falls by startling the resident when it sounded. This may well be true in some cases, but with this resident, who was mostly immobile, the likelihood of that happening is remote.

55. Resident 9's mobility also was seriously impaired and she was cognitively impaired. The use of a Tabs alarm was provided for in her updated care plan, which was changed after two falls, and was to be in place whether she was in bed or in the wheel chair. Nonetheless, the surveyor found the alarm was inconsistently applied, and the kardex used by the CNA made no mention of the requirement for the Tabs alarm.

56. To be sure, the facility cannot be held accountable for what happened to the resident while she was away from the facility on leave. However, Ms. Vogelspohl's opinion that it was an appropriate nursing decision not to use a Tabs alarm on the resident prior to her falls is not supported by the

evidence, especially when it is seen that subsequent use of the Tabs alarm after the two falls seems to have prevented further falls.

57. A comprehensive falls plan was developed for Resident 10 and numerous interventions called for. However, notwithstanding the resident's history of repeated falls, both before and after her entry into the facility, the surveyor observed only a chair alarm which was not in use when seen. The other interventions called for, including the merry walker, the low bed, the bike horn, and the safety seat belts were not in evidence. Ms. Vogelspohl contended the facility's conduct here was not an actionable failure to supervise or provide assistive devises, because it cannot be shown that the omission caused the falls. This argument is without merit.

58. Resident 12 came to the facility from the hospital to recuperate from a broken hip sustained in a fall. To be sure this resident was a difficult patient who actively resisted all efforts to restrain his activity. However, it is this very tendency that requires an even higher degree of supervision. Recognizing the need to balance the need for restraint against the rights of the individual, where it is seen that assistive devices are needed and the resident resists or removes them, then other approaches, such as transfer to a facility capable of a higher level of control,

are appropriate. This was ultimately done, and, under the circumstances, it cannot reasonably be held that the facility was below standards with regard to this resident.

59. Resident 22 sustained several falls while in the facility. The first fall was from a merry walker while an alarm was in place. The second fall was from a merry walker while unsupervised in the day room. The third fall was after the resident had removed her Tabs alarm and fell to the floor. The care plan calls for the resident to be monitored when out of the merry walker. Ms. Vogelspohl's analysis of this resident's history, which exonerates the facility of responsibility for each of the three falls, is reasonable and appears supported by the evidence or record, except for the second fall. Even in that case, there is a question of the adequacy of supervision provided, though it is not unreasonable to expect a staff member to be assigned to the day room when it is occupied by residents. Under the circumstances, the failure to have an attendant in the day room when the resident fell while unsupervised falls below standard.

60. The facility contends that falls will happen regardless of planning and the degree of supervision, unless that supervision is one-on-one. That argument is specious, however. It implies an "accepted level of injury" which is

not consistent with applicable standards and is rejected. The frequency of falls can be lessened by appropriate supervision of those identified as at high risk for falls. The intermittent failure to use an alarm is not sufficient to be classified as inadequate. However, when, as here, the supervision is found wanting again and again regarding the same residents, it is clearly indicative of a lack of proper supervision.

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 sustaining the Conditional license for the Respondent effective April 28, 2000, and, based only on the conditions observed at the facility on that date, imposing an administrative fine of $700.00.

DONE AND ENTERED this 22nd day of March, 2001, in Tallahassee, Leon County, Florida.

ARNOLD H. POLLOCK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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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.