STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

WASHINGTON MANOR NURSING AND REHABILITATION CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 00-4035
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. BEVERLY ENTERPRISES-FLORIDA, INC., d/b/a BEVERLY GULF COAST-FLORIDA, INC., d/b/a WASHINGTON MANOR NURSING & REHABILITATION CENTER, Respondent.	)	Case Nos. 00-4735

RECOMMENDED ORDER

The parties having been provided proper notice, Administrative Law Judge John G. Van Laningham of the Division of Administrative Hearings convened a formal hearing of this matter in Fort Lauderdale, Florida, on February 20, 2001. The hearing was adjourned on February 21, 2001.

APPEARANCES

For Agency for Health Care Administration:	Alba M. Rodriguez, Esquire Agency for Health Care Administration 8355 Northwest 53rd Street Miami, Florida 33166
For Washington Manor:	R. Davis Thomas, Jr., Esquire Broad and Cassel 215 South Monroe Street, Suite 400 Post Office Box 11300 Tallahassee, Florida 32302

STATEMENT OF THE ISSUES

The issues are whether a licensed nursing home violated the provisions of Title 42, Code of Federal Regulations, Section 483.70(h) and, if so, whether the relative severity of the deficiency warrants the assignment of a conditional licensure status and the levying of a $10,000 civil penalty.

PRELIMINARY STATEMENT

From June 5 through June 8, 2000, a survey team from the Agency for Health Care Administration (the "Agency") inspected a licensed nursing home located in Hollywood, Florida, known as Washington Manor Nursing and Rehabilitation Center ("Washington Manor"). This facility is operated by Beverly Enterprises-Florida, Inc., d/b/a Beverly Gulf Coast-Florida, Inc. ("Beverly"), which is the licensee. (For ease of reference, the term "Washington Manor" is used in this Recommended Order to denote both building and licensee; context will make clear the intended meaning.)

As a result of this investigation, the Agency issued a survey report charging Washington Manor with a deficiency relating to its alleged failure to protect a resident from an indoor fire ant attack that had occurred on May 29, 2000. Based on this alleged deficiency, the Agency notified Washington Manor, by letter dated June 30, 2000, that its license was being downgraded to conditional status effective June 8, 2000. The Agency later restored Washington Manor's license to standard status, effective June 29, 2000. Objecting to the conditional license, Washington Manor filed a petition with the Agency that was transferred to the Division of Administrative Hearings on September 27, 2000, initiating DOAH Case No. 00-4035.

Meantime, on November 3, 2000, the Agency brought an Administrative Complaint against Washington Manor seeking to impose a civil penalty of $10,000 in consequence of the alleged deficiency associated with the fire ant attack. Washington Manor requested a hearing, and on November 21, 2000, the case was referred to the Division of Administrative Hearings, initiating DOAH Case No. 00-4735.

These two cases, together with a third action (DOAH Case No. 00-4734) which was settled before hearing, were consolidated by order dated November 22, 2000. The final hearing was held, as scheduled, in Fort Lauderdale, Florida, on February 20–21, 2001.

At the final hearing, the Agency presented the testimony of five witnesses: Jeff Bomberger, Gary Warnock, Debra Wilcox, Arlene Mayo-Davis, and Frank Buxton. In addition, the Agency introduced three exhibits, which were received in evidence. Washington Manor called one witness – Jeff Bomberger – and also submitted five exhibits into evidence.

Each party timely filed a Proposed Recommended Order, and these post-hearing submissions were considered carefully in the preparation of this Recommended Order.

FINDINGS OF FACT

The evidence presented at final hearing established the facts that follow.

Fire Ants Attack

1. In the first hour of Memorial Day, May 29, 2000, fire ants roamed about Room 303 in Washington Manor, unobserved, while its residents slept. No one had seen the intruders enter the single-story facility, a nursing home that accommodates 240 licensed beds, built in 1968, occupying an area more than 100,000 square feet in size. Shortly before 1:00 a.m., the aggressive ants attacked a defenseless, elderly resident in her bed, stinging her numerous times before help arrived. The injurious consequences of these ant bites were serious enough to warrant the resident's removal to a hospital, where she was treated for several days, from May 30 through June 3, 2000.

Happily, the resident recovered from the adverse health consequences that ensued from this horrible event, which was the first of its kind at Washington Manor.

Regulatory Environment

2. To participate in and receive funds under the Medicare and Medicaid programs, nursing homes must comply with numerous federal and state statutory and regulatory mandates.[1] As a "state survey agency," the Agency is authorized, on behalf of the United States Department of Health and Human Services, Health Care Finance Administration, to inspect participating facilities (such as Washington Manor) and assess their respective levels of obedience to federal health, safety, and quality standards. Assigned a dual regulatory role, the Agency performs similar functions for the state, enforcing compliance with Florida's statutes and rules.

3. The Agency carries out these responsibilities by dispatching teams of investigators ("surveyors") to conduct on-site inspections ("surveys") of the facilities under its jurisdiction. Survey teams are required to report violations, which are called "deficiencies." If a survey uncovers any deficiencies, both the federal and state regulatory agencies may impose sanctions against the facility or prescribe other remedies. The severity of the sanction or remedy depends upon the seriousness of the deficiency. It is therefore necessary to

grade each deficiency according to its perceived "severity" and, pursuant to federal guidelines, its apparent "scope."

4. Under the federal regulations, there are 12 separate "scope and severity" outcomes represented by the letters "A" through "L," with A being the least serious type of violation and L the most severe. The 12 outcomes are depicted in a table consisting of four rows (denoting severity) and three columns (denoting scope), the three cells of the bottom (least serious) row corresponding, from left to right, with grades A, B, and C, respectively; of the second row, with D, E, and F; and so forth. The scope of a deficiency is classified as "isolated" (left-hand column), "pattern" (middle column), or "widespread" (right-hand column). The severity of a deficiency is assigned to one of four levels, matching the four aforementioned rows: "No actual harm with potential for minimal harm" (first, or bottom, row); "No actual harm with potential for more than minimal harm that is not immediate jeopardy" (second row); "Actual harm that is not immediate jeopardy (third row); and "Immediate jeopardy to resident health or safety" (fourth, or top, row). See generally Title 42, Code of Federal Regulations, Section 488.404. Thus, a grade of L — the most severe rating in the federal scheme — falls in the top, right-hand cell of the scope and severity table and represents a finding that the facility has a

widespread deficiency which puts residents in immediate jeopardy.

5. Under the state scheme, violations are rated according to severity as either Class I, Class II, or Class III deficiencies. See generally Section 400.23(8), Florida Statutes; Rule 59A-4.128(3), Florida Administrative Code. (The Agency also recognizes a category of "Substandard Quality of Care" deficiencies, using a definition patterned after the federal description of that term. See Rule 59A-4.128(3)(a), Florida Administrative Code.) Class I deficiencies are the most serious, presenting "either an imminent danger, [or] a substantial probability of[,] death or serious physical harm." Rule 59A-4.128(3)(a), Florida Administrative Code. Next serious are Class II deficiencies, which "present an immediate threat to the health, safety, or security of the residents of the facility . . . ." Id. Finally, "Class III deficiencies are those which present an indirect or potential relationship to the health, safety, or security of the nursing home residents, other than Class I or Class II deficiencies." Rule 59A-4.128(3)(b), Florida Administrative Code.

6. For each deficiency identified, the Agency's surveyors are responsible for making an initial determination regarding scope and severity. Typically, the federal letter grade is assigned first, and that mark is allowed to drive the state

severity rating, despite substantial differences between the federal and state classification systems and their respective criteria for measuring severity. Thus, a federal J, K, or L demands a state rating of Class I. Similarly, a Class II rating always follows a grade of G, H, or I. At the other end of the spectrum, deficiencies graded A, B, or C are always placed in state Class III, and those rated D, E, or F usually are. If the surveyors would assign a grade in the G through L range (state Class I or II), then they must communicate their findings and recommendations to superiors within the Agency who make the official decision.

The Agency Inspects

7. On June 5, 2000, a survey team composed of three Agency employees arrived at Washington Manor, which is located in Hollywood, Florida, to conduct a regularly scheduled, periodic inspection of the facility. That this routine compliance survey happened to commence one week after the May 29, 2000, fire ant attack was coincidental. The surveyors, however, had been informed about the incident and, not surprisingly, were keenly interested in ascertaining how it had occurred and whether fire ants continued to pose a risk of harm to Washington Manor's residents.

8. From interviewing Washington Manor personnel and reviewing records such as the facility's 24-Hour Nursing Report

and service reports prepared by Steritech Group, Inc. ("Steritech"), the facility's pest control contractor, the surveyors were introduced to the hypothesis that fire ants may have entered Room 303 through some sort of "crack" or "crevice" in the wall.

9. The nursing report notes that upon discovering the fire ant attack, staff had attempted to kill the ants and block an opening around the window air conditioning unit. This suggests that the first person or persons on the scene — who actually saw fire ants in Room 303 and were therefore in the best position to observe the means by which the pests had invaded the building — believed that a gap or opening associated with the air conditioner might have been the portal. Because none of these individuals testified at hearing, however, the record is silent as to why staff had suspected the air conditioner.

10. The surveyors searched for empirical data in support of the explanation that implicated the air conditioner. Examining Room 303, one surveyor observed that between the air conditioner and the windowsill or frame there existed a thin space through which sunlight could be seen. Similar "gaps" or "crevices" were noticed in other rooms as well.

11. These discoveries led the surveyors to accept the theory that the fire ants responsible for the Memorial Day assault had penetrated Room 303 through the "gap" between air

conditioner and window. The surveyors also suspected that some nearby trees and railroad ties may have harbored or attracted the pests and perhaps facilitated their incursion into the facility.[2]

12. The trees were a matter of some concern, the surveyors having come to believe that Washington Manor had disregarded Steritech's recommendations to trim nearby palm trees and vegetation as a means of controlling ants' access to the building. No employee of Steritech testified at hearing, however, so the fact-finder was deprived of the opportunity to see and hear from the person who had made the recommendations. According to the service reports in evidence, a pest control technician had visited Washington Manor 14 times between the beginning of the year and May 25, 2000, which was the date of the last visit before Memorial Day. On three of these occasions, the technician had recommended that the facility trim "palm trees" (Jan 10, February 14, and March 3, 2000); once, "vegetation" (March 28, 2000); and, one other time, simply "trees" (May 25, 2000). On March 3, 2000, for the first and only time, the technician had linked the trees with ants, writing: "Please have palms trimmed. Ants are active on them and gaing [sic] access to bldg." After the fire ant attack, the Steritech technician had visited the facility on June 1, 2, 5, 6, and 8, 2000. He had made no recommendations regarding

landscaping, however, until June 8, 2000, when he had written: "Please have trees trimmed along east-side of bldg, palms along court yard. This will restrict access to bldg."

13. That the technician had visited the facility 6 times during the nearly two months after March 28 and before May 25, 2000, without once having mentioned the trees in his written reports reasonably supports the inference that Washington Manor had been following the technician's advice; otherwise, presumably, he would have continued to press the point. That inference is reinforced by the technician's silence on the subject of tree trimming in his first two reports immediately following the fire ant attack; presumably, if the technician had watched his previous recommendations fall on deaf ears, he would have renewed the request to trim back the trees at his earliest opportunity after the tragedy. There is, moreover, no evidence that the palm trees, vegetation, and trees to which the technician had referred (both before and after Memorial Day) were the same trees, visit after visit, or whether different trees or other vegetation needed attention at various points in time. In short, the evidence does not persuasively establish that Washington Manor had been heedless of the pest control technician's recommendations.

14. The survey team members believed that Washington Manor's residents remained at risk of being attacked by fire

ants because, they surmised, various "gaps" in the facility's outer walls could potentially provide ingress for this pestilent purpose, and (to a lesser extent) because they concluded that certain trees needed to be trimmed. None, however, thought a fire ant raid was imminent.

15. Consequently, on the morning of the survey's third day, June 7, the surveyors called Angela Mayo-Davis, an Agency supervisor, to report their findings and recommend that Washington Manor be cited for a "G-II" deficiency in respect of the ant bite incident — meaning, under the federal system, an isolated deficiency involving actual harm that is not immediate jeopardy which, for purposes of the state classification scheme, would fall concomitantly in Class II.

16. The surveyors were well-intentioned and sincere, yet their estimate of the proximity of danger was excessive — at least when viewed, after the fact, in the light of all the evidence presented at hearing. The facility's interior was neither being nor about to be overrun with ants, flying insects, or rodents. Rather, Washington Manor's exterminator, Steritech, was treating the facility and its exterior grounds regularly for pests, including ants, and was doing so effectively, the Agency stipulated at hearing. True, as the pest control contractor's service reports for the months leading up to May 29, 2000, document, there were periodic complaints about various rodents

and insects (e.g. mice, flies, and ants) turning up in one place or another inside the facility. And once — on May 22 — fire ants were reported coming through windows in several rooms. But these reports give no indication (and there is no other evidence) that this level of activity was atypical or evinced an infestation. Given the lack of evidence with which to make a meaningful comparison, this record would as readily support a finding that Washington Manor was reasonably pest-free for its size, age, location, and use.

17. Further, the surveyors' theory that the so-called "gap" had served as the ants' entry point into Room 303 was merely a plausible guess. None is an entomologist, and none claimed special knowledge of fire ants. More important, the Agency introduced no substantial competent evidence concerning the likelihood that fire ants would enter through such a "gap" as opposed to other places at which the inside inescapably communicates with the outside (e.g. doors, vents, the air conditioner itself). For that matter, no evidence was adduced regarding the probability (or improbability) of a similar fire ant attack occurring under the best of circumstances (however defined) – or under seemingly "worse" conditions (e.g. open, unscreened windows; no pest control).[3] Weighing against the "gap" theory, the Steritech operator responsible for treating Washington Manor (who, from experience in the trade, should have

been familiar with the ways of fire ants) evidently never noticed the various openings observed by the surveyors, or did not consider them to be dangerous if he did, for he never checked the boxes on his service report form that would have recommended such pertinent remedial actions as:

> ☐ Wall / floor junction must be sealed
> ☐ Repair holes, cracks and loose tiles

Simply put, the evidence presented at hearing does not substantiate the surveyors' assessment that fire ants directly or immediately threatened Washington Manor's residents.

18. Agency higher-ups, however, viewed the purported risk with much alarm. In a late-afternoon telephone call on June 7, 2000, the survey team was informed that Washington Manor must be "tagged" for an isolated "immediate jeopardy" deficiency at the federal scope and severity level of J, elevating the violation to state Class I. At hearing, Ms. Mayo-Davis shed light on the Agency's rationale for sounding a red alert:

> [S]ince the situation had occurred on the 29th, there [were] still holes that were found in the air-condition[er]s, which is <u>possibly</u> the way that the ants had gotten into the resident's room in the first place, since those holes still existed then there still was a <u>potential</u> or a <u>probability</u> that ants could still gain entry into the building and that would make the residents['] environment just as we had said, unsafe and uncomfortable for residents.

T-300 (emphasis added).[4] Thus did a possibility give birth to a potential that spawned a probability which matured into "immediate jeopardy."

19. The "J-I" deficiency for which the Agency cited Washington Manor was identified by "Tag Number F465." This particular tag incorporates the standard contained in Title 42, Code of Federal Regulations, Section 483.70(h), and signifies an allegation that the facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents, staff, and the public.

20. When the surveyors concluded their inspection and left Washington Manor on June 8, 2000, the Tag F465 deficiency was downgraded to a "G-II." This reclassification resulted from a determination that there were no fire ants presently in the facility, coupled with the Agency's satisfaction that Washington Manor had undertaken to remedy areas of concern by, among other things, caulking the gaps, trimming some trees, and removing railroad ties. Nevertheless, on the allegation that a Class I deficiency had existed, the Agency assigned Washington Manor a conditional licensure status, effective June 8, 2000, and sought to impose a $10,000.00 civil penalty.

21. The Agency conducted a follow-up survey of Washington Manor on June 29, 2000, and determined that the F465 deficiency had been corrected. Convinced that the facility timely and

completely had corrected the deficiency, the Agency upgraded Washington Manor's licensure status from conditional to standard, effective June 29, 2000.

Ultimate Factual Determinations

22. There is no evidence that the Washington Manor's environment was nonfunctional — e.g. unsuitable, impractical, inoperable. Nor is there any evidence that the conditions at the facility were unclean, filthy, contaminated, or otherwise unsanitary. Finally, the record contains no convincing proof that, because of the surroundings, Washington Manor's occupants were ill at ease, insecure, discontented, or uncomfortable in any way. In sum, the Agency failed to establish — and, in fairness, made little or no attempt to prove — that Washington Manor did not afford a functional, sanitary, and comfortable environment for its occupants.

23. The occurrence of the May 29, 2000, indoor fire ant attack does not persuade the fact-finder that Washington Manor's environment was unsafe. For one reason, notwithstanding the surveyors' speculation and conjecture (which is not competent proof) and the note in the nursing report (whose author was not called to testify at hearing), there is no satisfactory evidence that the fire ants actually entered the facility through a "gap" around the window air conditioner in Room 303. That is, no causal connection between the alleged deficiency and the injury

was established — which is significant because the Agency made no effort to prove that the alleged deficiency was dangerous even if it were not the cause-in-fact of the fire ant stings on Memorial Day. For another reason, prudent human foresight does not give rise to an expectation that a similar indoor fire ant attack is likely to be substantially caused or facilitated by the failure to caulk around an air conditioner or to trim some trees – especially when, as at Washington Manor, an effective pest control program is in place.

24. In other words, though shocking and grievous, the indoor fire ant attack at Washington Manor on Memorial Day 2000 was a freak occurrence, whether the pests entered through a "gap" around the air conditioner (which was not proved) or found some other way into the building. Under the unique circumstances of this case as established by the particular evidence in this record, evaluated in light of common human experience, the injurious fire ant stings inflicted upon the occupant of Room 303 on May 29, 2000, were unforeseeable and unpredictable and thus – unfortunately – unavoidable despite the exercise of reasonable diligence and care in the maintenance of the facility.

25. Accordingly, the greater weight of evidence fails to establish – by a preponderance much less clearly and convincingly – that Washington Manor's environment was unsafe,

nonfunctional, unsanitary, or uncomfortable in violation of Title 42, Code of Federal Regulations, Section 483.70(h), as charged. Stated affirmatively, the record shows that Washington Manor met its duty to maintain the facility so as to protect the health and safety of residents, personnel, and the public.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

27. Pursuant to Section 400.23(7), Florida Statutes, the Agency is required to evaluate each nursing home facility operating in Florida at least every 15 months to determine whether it is in compliance with applicable law. In addition to the criteria set forth in Section 400.23, Florida Statutes, and in the rules adopted by the Agency in Chapter 59A-4, Florida Administrative Code, nursing home facilities in Florida must be in compliance with the rules found in Title 42, Code of Federal Regulations, Part 483.

28. The subject federal regulations govern facilities that participate in the Medicare and Medicaid programs and arise under the key federal statute respecting nursing home and long-term care facilities — namely, the Nursing Home Reform Act (the Omnibus Budget Reconciliation Act of 1987), codified at Title 42, United States Code, Section 1396r. The Florida Legislature

has directed that state licensure status be assigned based in part on compliance with these federal rules, when applicable. See Section 400.23(7), Florida Statutes. The Agency has adopted and incorporated the federal regulations by reference in Rule 59A-4.1288, Florida Administrative Code.

29. If the Agency identifies a violation as a result of a compliance survey, the violation must be classified pursuant to Section 400.23(8), Florida Statutes, as a Class I, Class II, or Class III deficiency. Class I deficiencies "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." Section 400.23(8)(a), Florida Statutes. Class II deficiencies "have a direct or immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies." Section 400.23(8)(b), Florida Statutes. Class III deficiencies "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." Section 400.23(8)(c), Florida Statutes.

30. Based on the deficiencies identified during the survey or, if none be found, on its finding that the facility is in substantial regulatory compliance, the Agency is required to

assign a "status" of "standard" or "conditional" to the facility's state license. Section 400.23(7), Florida Statutes.

31. 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" all applicable state and federal laws. Section 400.23(7)(a), Florida Statutes.

32. 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 all applicable state and federal laws. Section 400.23(7)(b), Florida Statutes. (This subsection further provides that if "the facility comes into substantial compliance at the time of the followup survey, a standard licensure status may be assigned." Id.)

33. In addition to assigning a conditional licensure status, the Agency may punish a facility found to have one or more deficiencies by exacting a civil penalty. For each class I deficiency, the facility is subject to a fine "in an amount not less than $5,000 and not exceeding $25,000" regardless whether the deficiency is corrected. Section 400.23(8)(a), Florida

Statutes. If, however, the violation is a less serious class II or class III deficiency, then the Agency may impose a civil penalty for that only if (a) the facility fails to correct the problem within the time specified by the Agency or (b) the deficiency is a repeated offense.

34. The Agency has the burden of proving not only the grounds for assigning a conditional licensure status to Washington Manor for the period from June 8, 2000 to June 29, 2000, but also the facts upon which a fine may be levied against the facility. Emerald Oaks v. Agency for health Care Administration, 774 So. 2d 737, 738 (Fla. 2d DCA 2000); Beverly Enterprises-Florida v. Agency for Health Care Administration, 745 So. 2d 1133, 1136 (Fla. 1st DCA 1999); Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778, 789 (Fla. 1st DCA, 1981); Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349, 350 (Fla. 1st DCA 1977).

35. The alleged Tag F465 deficiency purportedly associated with the Memorial Day fire ant attack is the factual predicate for each of the sought-after sanctions. At hearing, the Agency stipulated that the facility timely had corrected the alleged Tag F465 deficiency and also that the alleged deficiency had not been a repeated offense. Thus, as the sole basis for imposing a $10,000 fine, the Agency contends, as it must, that this alleged

deficiency satisfied the criteria for and was properly assigned to class I at the time of the survey. To justify the assignment of a conditional licensure status, the Agency must demonstrate that the alleged Tag F465 deficiency was at least serious enough for class II classification, if not so serious as to be called class I.

36. In sum, if the alleged deficiency were appropriately placed in class I, then both the civil penalty and a conditional licensure status were justifiably imposed. If it were a class II deficiency, then the conditional license was warranted, but the $10,000 fine would not be authorized. Finally, if the alleged deficiency were put in class III (or, of course, if there were no deficiency), then neither the conditional licensure status nor an administrative fine would be allowed to stand.

37. The standard of proof required to make a case for assignment of a conditional licensure status is not necessarily as demanding as that for imposing a fine – even when, as here, the factual foundation for both purposes is identical.

38. The Florida Supreme Court has determined conclusively that the standard of proof for imposing an administrative fine is clear and convincing evidence, because a fine is penal in nature and "deprives the person fined of substantial rights in property." Department of Banking and Finance v. Osborne Stern

and Co., 670 So. 2d 932, 935 (Fla. 1996). On this standard, there is and can be no argument.

39. The rationale for requiring clear and convincing proof of facts alleged to warrant the levy of a fine appears to apply with equal force when the goal is to downgrade a nursing home's licensure status. As the administrative law judge explained persuasively in Heritage Health Care & Rehab Center v. Agency for Health Care Administration, DOAH Case No. 99-1892, 1999 WL 1486586, *6 (Recommended Order issued Nov. 12, 1999), "[t]he imposition of a Conditional license adversely affects the reputation of a nursing facility with the public, and thus affects its ability to operate." In addition, a stricter standard of proof is consistent with the Administrative Procedure Act. See Section 120.57(1)(j)("Findings of fact shall be based upon a preponderance of the evidence, except in penal or licensure discipline proceedings. . . .").

40. Yet, anomalously, the less stringent, preponderance-of-evidence standard has been applied routinely in license reduction hearings. E.g. Agency for Health Care Administration v. Beverly Savana Cay Manor, Inc., etc., et al., DOAH Case No. 00-2465, 2001 WL 298545, *10 (Recommended Order issued March 22, 2001); Quality Health Care Center v. Agency for Health Care Administration, DOAH Case No. 00-3356, 2001 WL 246776, *8 (Recommended Order issued March 9, 2001); Capital Health Care

Center v. Agency for Health Care Administration, DOAH Case No. 00-1996, 2000 WL 1867290, *9 (Recommended Order issued December 1, 2000); Vista Manor v. Agency for Health Care Administration, DOAH Case No. 98-5471, 1999 WL 1486416, *8 (Recommended Order issued June 8, 1999); Wellington Specialty Care and Rehab Center (Vantage Healthcare Corp.) v. Agency for Health Care Administration, DOAH Case No. 98-4690, 1999 WL 1486337, *6 (Recommended Order issued May 17, 1999); Agency for Health Care Administration v. Hobe Sound Geriatric Vill., Inc., etc., et al., DOAH Case No. 98-1270, 1999 WL 1483658, *25 (Recommended Order issued May 10, 1999); but see Heritage Health Care, 1999 WL 1486586, *7 (Agency must prove grounds for conditional licensure status by clear and convincing evidence). Although appellate courts have discussed the Agency's burden of proof in license reduction proceedings, see Emerald Oaks, 774 So. 2d at 738; Beverly Enterprises-Florida, 745 So. 2d at 1136, the standard of proof seems not to have received appellate attention.

41. It is paradoxical that the Agency should be permitted to assign a conditional licensure status on proof that might not support the imposition of a fine, since the former punishment is likely to be as economically damaging to the facility, if not more so, than the latter. Here, however, any debate regarding the standard of proof is rendered academic by the Agency's

failure to prove its allegations by the greater weight of evidence. Because the Agency is not entitled, even under this least demanding standard, to sanction Washington Manor with a conditional license, there is no reason to reach the question whether clear and convincing evidence is required to assign a conditional licensure status. Accordingly, that decision is deferred to another day.

42. To be clear, then, on the licensure status dispute, bowing to the weight of authority, the Agency has been afforded the benefit of the preponderance standard of proof.

The Facility Was In Compliance As a Matter of Law

43. The regulation that forms the basis for Tag F465 is Title 42, United States Code, Section 483.70(h). That federal rule provides as follows:

> § 483.70 Physical environment.
>
> The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.
>
> * * *
>
> (h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and public. The facility must--
> (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;

> (2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;
> (3) Equip corridors with firmly secured handrails on each side; and
> (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

(Emphasis added.) Specifically, the Agency alleges that Washington Manor violated the standard prescribed in the underlined sentence above. Significantly, it does not contend that the facility violated subpart (4), having stipulated at hearing that Washington Manor was in compliance with the discrete duty to maintain an effective pest control program.

44. In the regulation's first and overarching provision, which precedes eight paragraphs of particulars that conclude with paragraph (h), Section 483.70 plainly prescribes a broad general duty, one aspect of which is relevant to the instant proceeding: the duty to maintain the facility so as to protect the health and safety of its occupants.[5] This general duty comprises numerous specific subsidiary duties, including those described in subparts (1) through (4) of paragraph (h). According to the Agency, the first full sentence of paragraph (h) effectively imposes another broad general duty, that being to provide a safe, functional, sanitary, and comfortable environment for the facility's occupants.

45. Read in the context of Section 483.70 as a whole, however, the specific sentence of paragraph (h) under which the Agency travels does not seem to have been intended to establish a sweeping primary duty that would encompass not only subparts (1) through (4) but also, were that its aim, paragraphs (a) through (g) of the section as well. Instead, the sentence appears to reiterate and further define the standard against which a facility's performance of the specific duties must be measured. Thus, when deciding, for example, whether a facility's pest control program is "effective" within the dictate of subpart (4), it is necessary to consider whether the facility's environment is safe, functional, sanitary, and comfortable. If the answer is "no" because of the presence of pests or rodents, then the facility is in violation of Section 483.70(h)(4).

46. Under this interpretation, the principal purpose of paragraph (h), including its subparts, is to prescribe four additional subsidiary duties that the regulation's drafters evidently felt did not fit neatly within any of the foregoing seven paragraphs — not to create a broad, section-level duty, its scope exemplified by, but not limited to, four particular, non-exclusive obligations described in subparts (1) through (4). From this it follows that a facility can properly be found in violation of Section 483.70(h)(x), with x being a number from 1

to 4, but not Section 483.70(h), where no pinpointing subpart is cited.

47. Consequently, by stipulating at hearing that Washington Manor at all times material had been in compliance with subpart (4) — that, in other words, the facility had maintained an effective pest control program and kept the premises free of pests and rodents — the Agency effectively eviscerated its case: admitting this material fact was tantamount to conceding that there had been no deficiency as a matter of law.

48. But even if the first full sentence of paragraph (h) were construed to impose an independent duty that is broader in scope than the sum of its four subparts, the question would become: Can a facility that has fulfilled the specific duty to maintain an effective pest control program, as Washington Manor undisputedly did, nevertheless be found to have violated the standard of care as it relates to guarding environmental functionality, safety, sanitation, and comfort against all threats of damage to those qualities posed by "pests and rodents," including fire ants? Put another way, does satisfying the specific duty prescribed in subpart (4) necessarily fulfill the general duty to maintain the facility so as to protect the health, safety, and comfort of its occupants against harm from pests and rodents?

49. The answer is found in a well-established rule of interpretation which holds that

> "where there is in the same statute a specific provision, and also a general one that in its most comprehensive sense would include matters embraced in the former, the particular provision will nevertheless prevail; the general provision will be taken to affect only such cases as are not within the terms of the particular provision."

Psychiatric Institute of Delray, Inc. v. Keel, 717 So. 2d 1042, 1043 (Fla. 4th DCA 1998)(quoting Fletcher v. Fletcher, 573 So. 2d 941, 942 (Fla. 1st DCA 1991)).

50. Clearly, the first complete sentence of paragraph (h), if it were considered the source of a general duty, would embrace the specific matters set forth in subparts (1) through (4). Therefore, applying the interpretive principle just discussed, paragraph (h) must be deemed to affect only those situations that are not covered by one of the particular provisions.

51. Accordingly, where, as here, the alleged deficiency is based on a charge that the facility's environment was unsafe, nonfunctional, unsanitary, or uncomfortable due to the presence of pests or rodents inside the building, the Agency must prove a violation of subpart (4), because the specific duty prescribed in that particular provision prevails over the general duty, if any, provided for in paragraph (h)'s introductory sentence.

52. The Agency's stipulation that Washington Manor had obeyed subpart (4) compels the conclusion that there was no deficiency associated with the Memorial Day fire ant attack, as a matter of law.

The Facility Was In Compliance As a Matter of Fact

53. Suppose, alternatively, that paragraph (h) imposes a duty to guard against dangers posed by pests or rodents that are beyond the zone of risk against which an effective pest control program should reasonably and foreseeably protect. Putting aside issues that would arise concerning the required standard of conduct — about which there is no evidence in this case — the Agency still would need to prove that the facility was unsafe in fact as a result of the alleged deficiency, to establish the deficiency. For, obviously, if the facility's environment were safe, then the facility necessarily was meeting its legal obligation, whatever that obligation may require in terms of conduct.

54. On the question of safety of the physical environment, the circumstances of this case require that attention be paid to the probative value of an actual injury. Although it is not necessary for the Agency to show that an injury actually occurred as a result of an alleged deficient practice, the fact of an injury on the premises would tend to show that the facility's environment was unsafe if the act or omission alleged

to constitute the deficiency were the cause-in-fact of the harm. By establishing that an actual injury would not have occurred but for the deficiency, the Agency would demonstrate that the facility had failed to maintain a safe environment, provided the injury were a foreseeable one – a separate issue discussed below. Conversely, if the alleged deficiency were not the cause-in-fact of an injury that actually had occurred, then that injury would have no probative value on the question of environmental safety; it would be irrelevant. The Agency might still manage to prevail, but to do so it would need to offer independent proof – as though there had been no injury – that the alleged deficiency could, in fact, cause the foreseeable harm allegedly threatened thereby.

A. Cause-in-Fact

55. In the instant case, the decisional framework for the Agency's theory looks like this:

(A) Fire ants stung a resident in her bed as she slept.

(B) Ipso facto, Washington Manor's environment was unsafe.

(C) The facility failed to caulk around window air conditioners, failed to patch small openings in the building, and neglected to trim some trees.

(D) The omissions described in (C) may have allowed fire ants to enter Room 303 and might have created favorable conditions for a future fire ant invasion.

(E) Therefore, the omissions described in (C) constituted a breach of 42 C.F.R. § 483.70(h), i.e. were a deficiency.

56. As set forth in the Findings of Fact above, however, the Agency failed to prove by a preponderance of evidence that but for alleged omissions (C), injury (A) would not have occurred — and situation (B) would have been avoided. Therefore, perhaps ironically, the fact of the Memorial Day fire ant attack is irrelevant to the determination whether Washington Manor failed to maintain a safe physical environment for its occupants.

57. The Agency made no appreciable attempt and therefore failed to prove that the facility's failure to caulk around some air conditioners and seal other openings, or its failure to trim some trees, or a combination of these purported omissions, endangered the residents of Washington Manor by exposing them to the threat of fire ant attacks. The Agency's hypothesis (D) was simply too speculative and conjectural to carry that load. In a nutshell, there is no persuasive evidence in this record that the alleged deficiency (C) could in fact cause the allegedly threatened injury: an indoor fire ant attack.

58. Consequently, there is no evidential support for a finding that Washington Manor's physical environment was unsafe due to the threat of fire ants entering the building through

unsealed cracks and crevices; without that finding, there is no deficiency as a matter of fact.

B. Foreseeability

59. The incorporation of Section 483.70(h) into the Florida Administrative Code — which allows the Agency to enforce this federal standard as a state rule — cannot have been intended to impose absolute or strict liability under Florida's regulatory scheme, so that no matter what the cause, a facility would be in violation whenever an occupant suffers an injury on the premises. Such a goal would have been unreasonable and unfair and hence contrary to the legislative intent, expressed in the statutes delegating rule-making authority to the Agency, that nursing homes be required to comply with "reasonable and fair" criteria. Section 400.23(2), Florida Statutes; see also Section 400.23(1)("It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a nursing home.")(emphasis added). Therefore, for state law purposes at least, Section 483.70(h) must be construed to impose a duty to make reasonable efforts or use reasonable care — not to make nursing homes guarantors of occupant safety under all circumstances.

60. As a result, the fact question whether the facility was unsafe must entail the concept of foreseeability, else the

duty imposed by paragraph (h) — the existence of which, recall, we have assumed for this discussion — would be absolute, a legally impermissible outcome. Unless a reasonable, prudent person would consider the condition created by the alleged deficiency likely to be the substantial cause of the harm that the Agency contends is imminently, immediately, or potentially threatened, then it cannot reasonably be said that the facility is unsafe. Put another way, a facility cannot reasonably be expected to guard against an injury caused by a freakish or improbable chain of events; rather, the injury — or threatened injury — must be "proximate" to the alleged deficiency.[6]

61. As the Florida Supreme Court has explained, "harm is 'proximate' in a legal sense if prudent human foresight would lead one to expect that similar harm is likely to be substantially caused by the specific act or omission in question. In other words, human experience teaches that the same harm can be expected to recur if the same act or omission is repeated in a similar context." McCain v. Florida Power Corp., 593 So. 2d 500, 503 (Fla. 1992). "Foreseeability, as it relates to the proximate cause, is generally a question of fact left for the fact-finder." Florida Power & Light Co. v. Periera, 705 So. 2d 1359, 1361 (Fla. 1998).

62. With that in mind, using the shorthand initiated in paragraph 55 above, even if it is assumed that (C) was the

cause-in-fact of (A), there is yet insufficient evidence of (B). This is because the specific harm at issue here — multiple fire ant stings inflicted on a patient sleeping in her bed — is not the reasonably foreseeable consequence of the omissions described in (C). Under the factual details of this case, a reasonable person simply would not expect such harm to occur (or recur) as a result of failing to caulk around a window air conditioner or to trim some trees.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency enter a final order in DOAH Case No. 00-4035 that: (a) restores Washington Manor's license to the status of "standard" for the period from June 8 through June 29, 2000, and (b) requires or effects an amendment of the Form 2567 report of the June 2000 survey to omit the unsubstantiated charges concerning the alleged Tag F465 deficiency. It is further RECOMMENDED that the Agency enter a final order in DOAH Case No. 00-4735 dismissing the Amended Administrative Complaint with prejudice.

DONE AND ENTERED this 7th day of May, 2001, in Tallahassee, Leon County, Florida.

JOHN G. VAN LANINGHAM
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of May, 2001.

ENDNOTES

[1]/ To the extent the next few paragraphs discuss the law, the perspective is that of the fact-finder, who needed to know something of (and was presented evidence concerning) the legal environment in which the actors were operating.

[2]/ None of the surveyors saw ants in the facility, however, or ants crawling through gaps or holes in residents' rooms. One surveyor observed two or three active fire ant mounds outdoors, in the gravel of the parking area, about ten feet from the building and in the vicinity of Room 303. Another also saw some ants on the outside, but he did not identify what type or what number he saw.

[3]/ If fire ants were inclined to enter dwellings through thin gaps and thereafter sting human inhabitants, as the Agency presupposed, then such attacks should be commonplace in areas where fire ants are found. For, as common experience teaches, no dwelling is airtight, and many must be more vulnerable to fire ant invasion than Washington Manor was shown to be. Yet, although there is no evidence in the record on which to make a finding on this point, common knowledge suggests that indoor fire ant attacks on humans such as the one that occurred at Washington Manor are rare events, making the Agency's premise counterintuitive. Thus, the Agency's failure to offer any proof concerning the degree and proximity of risk that fire ants pose

to persons sheltered inside buildings is a striking defect of its case.

[4]/ Ms. Mayo-Davis also frankly revealed her telling opinion that a nursing home is always "at fault" when fire ants sting a resident because the facility is "responsible for all things that are happening [inside]." T-288.

[5]/ The Agency neither alleged nor attempted to prove any deficiencies either in the design or construction of, or concerning the sufficiency of equipment at, Washington Manor.

[6]/ The focus here is on whether the facility's environment was unsafe. Foreseeability in this context is concerned with whether the injury which occurred (or is alleged to have been threatened) could reasonably have been expected to be caused by the act or omission alleged to constitute the deficiency. If a reasonable person could not foresee the injury in question, then the facility was "safe" under any fair and reasonable understanding of that term.

Foreseeability of harm, as that concept is understood in relation to causation, must be distinguished from the related but distinct notion of proximity of danger, which is pertinent to the assessment of a deficiency's severity. The former (which looks at the actual or threatened injury) raises the question: Is this injury likely to be substantially caused by this condition? It bears on the question whether the facility's environment was unsafe. The latter (which looks at the actual or potential cause) poses the question: If this condition is not corrected, is the foreseeable injury likely to occur momentarily (imminent danger), soon (immediate relationship), or sometime (indirect relationship)? It is the factor that determines the severity of the deficiency if the environment was unsafe. A negative answer to the first question obviates the need to consider the second.

To appreciate the difference between these two concepts, imagine a resident who is in imminent danger of suffering an unforeseeable harm. The facility would reasonably be considered safe up to the point of the resident's injury, the proximity of danger being unperceived. Therefore, the facility's environment could not fairly be deemed unsafe – and the facility held accountable for a Class I deficiency — after the unpredictable harm had occurred, despite the fact, apparent only in hindsight, that the proximity of danger would have satisfied the Class I

criteria could the potential for harm reasonably have been appreciated. Conversely, imagine a handrail that is gradually becoming loose due to inattention. A patient could fall and break a hip as a result of this deficient condition: the injury is foreseeable. Yet, even though the injury may be highly foreseeable, the danger may not be imminent or even immediate; rather, depending on how loose the handrail is, the threatened danger may be merely potential, warranting the assignment of a Class III rating to the deficiency.

COPIES FURNISHED:

Alba M. Rodriguez, Esquire
Agency for Health Care Administration
8355 Northwest 53rd Street
Miami, Florida 33166

R. Davis Thomas, Esquire
Broad and Cassel
215 South Monroe Street, Suite 400
Post Office Box 11300
Tallahassee, Florida 32302

Sam Power, Agency Clerk
Agency for Health Care Administration
Fort Knox Building 3, Suite 3431
2727 Mahan Drive
Tallahassee, Florida 32308-5403

Julie Gallagher, General Counsel
Agency for Health Care Administration
Fort Knox Building 3, Suite 3431
2727 Mahan Drive
Tallahassee, Florida 32308-5403

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.