STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 01-0697

HEALTH CARE AND RETIREMENT CORPORATION OF AMERICA, d/b/a HEARTLAND OF ST. PETERSBURG,

Respondent.

RECOMMENDED ORDER

On April 30, 2001, a formal administrative hearing in this case was held in Largo, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Michael P. Sasso, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, Room 310G
St. Petersburg, Florida 33701

For Respondent: Alfred W. Clark, Esquire
117 South Gadsden Street, Suite 201
Tallahassee, Florida 32301

STATEMENT OF THE ISSUE

The issue in the case is whether the allegations of the Administrative Complaint filed by the Petitioner against the Respondent are correct and if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint filed on January 19, 2001, the Agency for Health Care Administration (Petitioner) alleged that Health Care and Retirement Corporation of America d/b/a Heartland of St. Petersburg (Respondent) had violated various provisions of Florida Statutes and the Florida Administrative Code. By Petition for Formal Administrative Proceeding dated February 8, 2001, the Respondent challenged the allegations and requested a formal hearing. The Petitioner forwarded the request to the Division of Administrative Hearings, which scheduled and conducted the proceeding.

The Administrative Complaint was filed following the death of a resident of the Respondent's nursing home. In order to protect the resident's right to privacy, this Recommended Order does not identify the resident by name.

Following the resident's death, the Petitioner conducted an inspection of the nursing home and cited the facility for alleged violations of state statutes and rules related to the incident. Specifically, the Petitioner alleges that the Respondent did not have policies and procedures for prompt identification of residents with advance directives and for implementation of such directives in an emergency. The Petitioner alleges that the Respondent failed to follow policies and procedures for obstructed airway management and did not have

a policy and protocol for nursing service response during a medical emergency. The Petitioner further alleges that the Respondent failed to develop a comprehensive care plan for the resident, who had been identified as having chewing and swallowing problems.

At the hearing, the Petitioner presented the testimony of two witnesses and had Exhibits numbered 1 and 5-7 admitted into evidence. The Respondent presented the testimony of three witnesses and had Exhibits numbered 1-3 admitted into evidence.

A Transcript of the hearing was filed on July 15, 2001. Both parties filed Proposed Recommended Orders that were considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. The Petitioner is the state agency responsible for licensure and regulation of nursing homes operating in the State of Florida.

2. The Respondent operates a licensed nursing home at 1001 9th Street North in St. Petersburg, Florida.

3. At approximately 7:00 p.m. on May 31, 2000, a certified nursing assistant (CNA) was feeding a resident of the nursing home an appropriate soft food meal. During the feeding, the resident began to gasp.

4. At the time of the incident, the CNA who was feeding the resident had received training related to feeding this

resident. The CNA had fed the resident previously without incident. At the time of the event, another CNA was also present in the room.

5. An off-duty nurse walking by the resident's room saw the situation, and because the resident was seated with a food tray before her, assumed that the resident was choking. The nurse responded to the situation by performing a finger sweep of the mouth to locate food, and then performing a "Heimlich" maneuver.

6. Because no food was located during the finger sweep or expelled after the "Heimlich" the nurse concluded that the resident was not choking. She also became aware that the resident was not breathing.

7. The off-duty nurse lowered the resident's bed and began to perform emergency CPR. She also directed one of the CNA's present to call for the on-duty nurse.

8. The on-duty nurse arrived shortly thereafter and began assisting with the CPR, using an "ambu-bag."

9. Both nurses have substantial experience in nursing and as caregivers in nursing homes. There is no credible evidence that the nurses were unqualified or lacked appropriate training for their responsibilities.

10. While performing the CPR, the off-duty nurse asked the on-duty nurse to determine whether the resident had "advance directive" information in her file.

11. The on-duty nurse stopped using the "ambu-bag" and went to the nurse's station approximately 30 feet from the resident's room, determined that the resident had a "living will" on file, and returned to the resident's room to inform the off-duty nurse.

12. Although there was a "living will" in the patient's file, there was no order prohibiting efforts to resuscitate the resident (commonly called a "DNR") and therefore such emergency procedures were appropriate; however, at the time the off-duty nurse initiated the CPR effort, the resident's status had not been determined.

13. Upon the return of the on-duty nurse, the off-duty nurse stopped performing CPR and went to the nurse's station to review the paperwork in the resident's file after which she called the facility's director of nursing to report the situation.

14. When the nurse halted her CPR effort, she had been administering "chest massage" for approximately three minutes and had gotten no response from the patient.

15. The director of nursing told the nurse to immediately call 911 for emergency assistance. As directed, the off-duty

nurse called 911, reported the information, and returned to the resident's room to resume her CPR effort.

16. An EMT team arrived at the facility quickly after the nurse's telephone call. The EMT personnel unsuccessfully attempted to intubate the resident, and ultimately were unable to revive her.

17. Approximately 25 minutes elapsed from initiation of efforts by the off-duty nurse to the EMT personnel determination to halt resuscitation attempts.

18. The resident suffered from end-stage Parkinson's disease. According to the Certificate of Death, the immediate cause of death is listed as "debility of age."

19. There is no evidence that the employees of the nursing home were the cause of or contributed to the resident's death. There is no evidence that the resident choked on food. There is no evidence that resident’s "gasping" sounds were caused by any foreign obstruction within her airway.

20. The facility properly notified the Petitioner of the incident. The Petitioner conducted an investigation on June 2, 2000. The results of the inquiry were set forth on a form identified as a "HCFA 2567" which identifies alleged deficiencies in the Respondent's procedures and activities related to the resident's death.

21. Deficiencies are identified on a "2567" form as "tags." Such alleged deficiencies also include a narrative description of the Petitioner's review and citation to a provision of the Florida Administrative Code rule. Insofar as relevant to this proceeding, the "2567" form identifies tags F156 and F280.

TAG F156

22. Tag F156 alleges that the Respondent failed to "employ a system which ensured the prompt identification of residents who had formulated advance directives for purposes of implementation. The Petitioner charges that the Respondent failed to have policies and procedures for prompt identification of residents who had formulated advance directives for purposes of implementation, especially during an emergency.

23. The Respondent maintained records of each resident's advance directive information in a red folder contained within the resident's medical file. The files were maintained at the nurse's station to facilitate immediate location and provide for a proper response by facility staff. Such record maintenance provided access to information for medical staff while maintaining each resident's rights to privacy. The evidence fails to establish that the facility's system did not provide for "prompt identification of residents who had formulated advance directives for purposes of implementation."

TAG F280

24. Tag F280 alleges that the Respondent failed to review and revise the comprehensive interdisciplinary care plan for the resident to indicate chewing and swallowing problems. The tag also states that "the staff did not implement use of compensatory safe swallow techniques as recommended by the speech language pathologist, resulting in an emergency choking situation which compromised the life of a resident."

25. The Petitioner charges that the Respondent failed to develop a comprehensive care plan for the resident "who was identified with chewing and swallowing problem."

26. The evidence establishes that the interdisciplinary care plan prepared for the resident appropriately addresses the resident's potential for chewing and swallowing difficulty. The care plan identifies the specific steps to be taken in providing nutrition to the resident, including the type of diet, the positioning of the resident's body for feeding, the actual timing of food provision, and indicates that observation is required to ascertain whether the resident was aspirating or choking. The care plan set forth goals for nutrition consumption and established a deadline for achieving the goal with the resident.

Tag 281

27. At the hearing, the Petitioner initially indicated that Tag F281 was not at issue in this proceeding. The Administrative Complaint alleges that the Respondent failed to follow the policies and procedures for obstructed airway management and did not have a system-wide policy and protocol for how nursing services respond during medical emergencies. Evidence was presented at the hearing related to this issue, which appears to be included within Tag F281. Accordingly, the following findings of fact are set forth.

28. There is no evidence that the facility failed to maintain policies and procedures in the area of nursing services. The facility policy related to obstructed airway management is set forth in the "Nursing Policy & Procedure Manual." The types of maneuvers identified as appropriate are "abdominal thrusts" and "finger sweeps." An "abdominal thrust" is commonly referred to as a "Heimlich" maneuver.

29. There is further no evidence that the off-duty nurse failed to follow the facility policy on obstructed airway management. The greater weight of the evidence establishes that the off-duty nurse appropriately performed both procedures on the resident prior to initiation of CPR activities.

30. As to the provision of CPR, the off-duty nurse's CPR certification had expired at the time of the incident, but there

is no evidence that she administered the CPR incorrectly during the time her efforts were made.

CONCLUSIONS OF LAW

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

32. The Petitioner has the burden of establishing by a preponderance of the evidence, entitlement to the relief sought. Florida Department of Transportation v. JWC Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981). Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). In this case, the burden has not been met.

33. The Petitioner asserts that the deficiencies at issue in this proceeding are violations of Sections 400.102, 400.121, and 400.23, Florida Statutes.

34. Section 400.102, Florida Statutes, sets forth grounds for action by the agency against a licensee. Such grounds in relevant part include "an intentional or negligent act materially affecting the health or safety of residents of the facility" and violations of the Petitioner's rules.

35. Section 400.121(1), Florida Statutes, provides that the Petitioner may impose an administrative fine "not to exceed $500 per violation per day, for a violation of any provision of" Section 400.102, Florida Statutes. Section 400.121(2), Florida

Statutes, provides that the Petitioner may "as part of any final order issued by it under this part" impose "such fine as it deems proper, except that such fine may not exceed $500 for each violation." The section further provides that "[e]ach day a violation of this part occurs constitutes a separate violation and is subject to a separate fine, but in no event may any fine aggregate more than $5,000. A fine may be levied pursuant to this section in lieu of and notwithstanding the provisions of s. 400.23."

36. Section 400.23, Florida Statutes, provides for classification of deficiencies according to the risk posed to residents of a facility. Section 400.23(8)(a) provides as follows:

> Class I deficiencies are those which the agency determines present an imminent danger to the residents or guests of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. Notwithstanding s. 400.121(2), a class I deficiency is subject to a civil penalty in an amount not less than $5,000 and not exceeding $25,000 for each and every deficiency. A fine may be levied notwithstanding the correction of the deficiency.

37. The deficiencies in this case are identified as Class I deficiencies.

38. The Administrative Complaint charges that the Respondent failed to have policies and procedures for prompt identification of residents who had formulated advance directives for purposes of implementation, especially during an emergency. The Petitioner asserts that such deficiency is a violation of Rule 59A-4.106(6), Florida Administrative Code.

39. Rule 59A-4.106(6), Florida Administrative Code, provides as follows:

> Each nursing home shall have written policies and procedures, which delineate the nursing home's position with respect to the state law and rules relative to advance directives. The policies shall not condition treatment or admission upon whether or not the individual has executed or waived an advance directive. In the event of conflict between the facilities policies and procedures and the individual's advance directive, provision should be made in accordance with section 765.308, Florida Statutes.

40. The evidence fails to establish that the facility's system did not provide for "prompt identification of residents who had formulated advance directives for purposes of implementation." The evidence also fails to establish that the facility failed to comply with the requirements of Rule 59A-4.106(6), Florida Administrative Code.

41. The Administrative Complaint charges that the Respondent failed to develop a comprehensive care plan for the resident "who was identified with chewing and swallowing

problem." The Administrative Complaint fails to cite a specific rule applicable to the alleged deficiency, but Rule 59A-4.109(2), Florida Administrative Code, provides as follows:

> The facility is responsible to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.

42. The evidence establishes that the care plan provided for the resident appropriately addresses the resident's potential for chewing and swallowing difficulty.

43. The Administrative Complaint charges that the Respondent failed to follow the policies and procedures for obstructed airway management and did not have a system-wide policy and protocol for how nursing services respond during medical emergencies. In the Administrative Complaint, the Petitioner asserts that such deficiency is a violation of Rule 59A-4.106(4)(n), Florida Administrative Code. The cited section requires that the facility maintain policies and procedures related to "loss of power, water, air conditioning or heating." It appears that the applicable section is Rule 59A-4.106(4)(r), Florida Administrative Code, which requires that each facility

maintain policies and procedures in the area of nursing services.

44. There is no evidence that the facility failed to maintain policies and procedures in the area of nursing services. The facility policy related to obstructed airway management is set forth in the "Nursing Policy & Procedure Manual." There is no evidence that the off-duty nurse failed to follow the facility policy on obstructed airway management.

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 dismissing the Administrative Complaint filed in this case.

DONE AND ENTERED this 1st day of August, 2000, in Tallahassee, Leon County, Florida.

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WILLIAM F. QUATTLEBAUM
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 1st day of August, 2001.

COPIES FURNISHED:

Michael P. Sasso, Esquire
Agency for Health Care Administration
525 Mirror Lake Drive, Room 310G
St. Petersburg, Florida 33701

Alfred W. Clark, Esquire
117 South Gadsden Street, Suite 201
Tallahassee, Florida 32301

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

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

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.