STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 01-1101

CENTENNIAL HEALTHCARE INVESTMENT CORP.,

Respondent.

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Port St. Lucie, Florida, on June 5, 2001.

APPEARANCES

For Petitioner: Alba M. Rodriguez
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For Respondent: James M. Barclay
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STATEMENT OF THE ISSUE

The issue is whether Petitioner properly re-rated as conditional Respondent's license to operate a skilled nursing facility.

PRELIMINARY STATEMENT

By letter dated January 31, 2001, Petitioner advised Respondent that, effective January 11, 2001, Petitioner was re-rating its skilled nursing facility license to conditional as a result of the findings of a survey conducted on January 11, 2001. The letter states that the surveyors found a Class II deficiency due to the failure of the facility to ensure that it provided all of the necessary care and services to a resident of the facility. The letter explains that a resident sustained injuries after being dropped from a Hoyer lift.

By Petition for Formal Administrative Hearing filed February 27, 2001, Respondent contested the proposed action to reduce its license to conditional and requested a formal hearing.

At the hearing, Petitioner called four witnesses and offered into evidence eight exhibits: Petitioner Exhibits 1-7 and 11. Respondent called five witnesses and offered into evidence 17 exhibits. All exhibits were admitted except Petitioner Exhibit 3 and Respondent Exhibit 8, which were proffered. Also, the Administrative Law Judge excluded from Respondent Composite Exhibit 2 all activities described in the documents if those activities took place after February 13, 2001; Respondent proffered the excluded portions of Respondent Exhibit 2.

The court reporter filed the transcript on June 28, 2001. On July 9, 2001, Petitioner filed a motion to redact the transcript. The motion asked for the deletion of the name of the resident from the transcript to preserve the resident's right to confidentiality. The Administrative Law Judge had already directed the court reporter to substitute initials each time the resident's name would otherwise appear in the transcript, but the court reporter neglected to do so. This case involves only one resident, so the Administrative Law Judge has blackened out all references in the transcript to the resident's name. The Administrative Law Judge orders Respondent to do the same to its copy of the transcript.

FINDINGS OF FACT

1. Respondent operates Emerald Health Care (Emerald), which is a skilled nursing facility in Port St. Lucie.

2. On January 11, 2001, Petitioner conducted a survey of Emerald and cited a deficiency in the quality of care. Petitioner cited this deficiency under Tag F309. Based on the findings cited in Tag F309, Petitioner reduced Respondent's license to conditional, effective January 11, 2001.

3. Tag F309 is based on 42 Code of Federal Regulations Section 483.25, which, as cited in the survey report, provides: "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest

practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." The survey reports notes, however, that Tag F309 is for "quality of care deficiencies not covered by s483.25(a)-(m)."

4. After noting the details of the discovery of the injured resident, her treatment, and Emerald's investigation, Tag F309 notes that a certified nursing assistant had inappropriately tried to transfer the resident without using the proper technique or obtaining the help of another staffperson. Tag F309 states that the resident's care plan "does not indicate measures to be taken by staff, equipment to be utilized for lifting[,] or the level of assistance needed by this resident in the Activities of Daily Living[,] which include transfers."

5. Tag F309 states that the certified nursing assistant dropped the resident while trying to transfer her inappropriately from her wheelchair to her bed and then failed to notify anyone of the incident. Tag F309 acknowledges that Respondent had instructed the certified nursing assistant five days prior to the incident, when she started working at Emerald, of the appropriate procedures for lifting residents, her immediate supervisor had repeated these instructions three times on the day of the incident, and an interpreter repeated these instructions in the native language of the certified nursing assistant an additional time on the day of the incident.

Tag F309 notes that Respondent's records indicated that the certified nursing assistant "had been instructed on the use of the lift and was believed to be competent in its use in transferring residents."

6. By letter dated January 31, 2001, Petitioner informed Respondent of the reduction to conditional of Respondent's license based on the January 11 survey. The sole explanation for the action is as follows: "During this survey a Class II deficiency was cited due to facility failure to ensure that all necessary care and services were provided to a resident in the facility. A resident sustained a fractured right shoulder and upper body bruising after being dropped to the floor from the Hoyer lift."

7. The Joint Prehearing Stipulation eliminates a couple of issues. Paragraph 5.i states that Respondent "had developed and instituted adequate policies and procedures to prevent neglect of its residents due to lifting and transferring and had written no-lift policies and procedures in effect." Paragraph 5.r states that Respondent "had a comprehensive program to address lifts and transfers. That program included assessment, care planning and on-going reassessment of its residents. The assessments and care plans for [the resident] were appropriate." The most detailed statement of an issue is in Paragraph 5.q,

which states: "[Respondent] failed to maintain the resident's highest level of functioning because of the incident."

8. The deficiency arises out of an incident at 7:00 to 7:30 p.m. on December 24, 2000, in which one of Respondent's employees, certified nursing assistant Paulette LeBrun, dropped a resident, who sustained a broken shoulder, and failed to report the incident to anyone. Another staffperson noticed the injury the next morning, notified a physician and family members, and caused the resident to be taken to the hospital, where she was treated and returned to the facility the next day.

9. Petitioner resurveyed Emerald on February 13, 2001, and found that the deficiency previously cited no longer existed. Petitioner thus re-rated Respondent's license as standard, effective February 13, 2001.

10. Prior to the incident, Respondent had taken several precautions to avoid an accident of the type that took place in this case.

11. First, Respondent had conducted a complete assessment of the resident by April 18, 2000. In the assessment, Respondent had properly concluded that the resident was in a condition of "total dependence" for bed mobility, transfer, locomotion, and personal care.

12. Second, Respondent had adopted a comprehensive set of written policies for assessing and reassessing, care planning,

and lifting and transferring residents. Petitioner stipulated that these policies were "adequate . . . to prevent neglect of [Respondent's] residents due to lifting and transferring . . .."

13. For a substantial period of time prior to the date of the incident, Respondent had contracted with Prevent, Inc., for products and services in connection with the lifting and transferring of residents. Prevent, Inc., is in the business of supplying lift equipment and training programs to facilities such as Emerald. Facilities obtaining the products and services of Prevent, Inc., have experienced reductions of 95 percent in staff injuries and 48 percent in resident injuries in connection with lifting and transferring residents.

14. As part of the program that it supplied to Emerald staff, Prevent, Inc., prepared a "no-lift" policy. This policy, which Respondent adopted for use at Emerald, restricts manual lifting and transferring of residents. In the words of the policy, "any resident requiring 50% or greater assistance with lifts/transfers is to be lifted/transferred with a mechanical lift. The nurse aide is to use a lift with the assistance of a second nurse aide during the transfer."

15. Prevent, Inc., also prepared a lift manual for Emerald staff. The manual details the proper procedures for lifting and transferring residents using any of the mechanical lifts present at Emerald for this purpose.

16. Additionally, staff of Prevent, Inc., personally trained Emerald staff in the proper lifting and transferring procedures. The training program is thoughtfully designed with step-by-step instructions using visual props and visually driven demonstrations to overcome language barriers, as the trainer covers a list of 52 separate skills. To complete the training, each trainee must perform a number of "return demonstrations," in which he or she demonstrates to the satisfaction of the trainer the skills and techniques that are being taught.

17. Emerald's implementation of the lifting program accommodates persons of a wide range of intelligence and motivation. For example, based on frequently updated assessments of each resident, the door of each resident's room bears a colored patch that informs the Emerald employee of the size of the sling to use in the lift device in order safely to lift and transfer the resident.

18. Prevent, Inc., provides large-group training at Emerald every six to twelve months. However, the trainer visits the facility every six to eight weeks to answer questions and provide additional training, as needed, to employees who have already been trained.

19. Ms. LeBrun began working as a certified nursing assistant at Emerald on December 20, 2000. On the next day, she

received training on the use of mechanical lifts and Respondent's restricted lift and transfer policy.

20. On Christmas Eve, Ms. LeBrun was one of the certified nursing assistants working the east wing at Emerald. She worked the 7:00 a.m. to 3:00 p.m. shift. When her supervisor, who was a licensed practical nurse, found that they were going to be short of certified nursing assistants during the 3:00 p.m. to 11:00 p.m. shift, she asked Ms. LeBrun to work another shift, and Ms. LeBrun agreed to do so. Normally five certified nursing assistants work the east wing on the 3:00 p.m. shift, but, at the start of this shift, only two certified nursing assistants were present until 7:00 p.m. At that time, two more certified nursing assistants reported to work the east wing. However, at all times, a licensed practical nurse also worked each of the two main halls constituting the east wing.

21. Containing 60 residents, the east wing is the harder wing to work at Emerald because its residents are totally dependent for assistance with the activities of daily living. Although there is no difference in the level of functioning of the residents on the two main halls of the east wing, Ms. LeBrun's earlier shift that day had been in the front hall, and her later shift was in the back hall, so she was working with different residents. However, Ms. LeBrun had been oriented on the east wing.

22. Due to the minimal staff present during the Christmas Eve shift starting at 3:00 p.m., a supervisor decided not to have the east wing residents taken to the dining area for their evening meal, but to have them fed in their beds.

23. Ms. LeBrun's immediate supervisor was concerned about Ms. LeBrun's ability to care for the more intensive residents on the east wing. During her first shift, another certified nursing assistant had seen signs of fatigue in Ms. LeBrun during her meal break and had reported this fact to Ms. LeBrun's immediate supervisor. Acting on her concern, Ms. LeBrun's immediate supervisor asked her supervisor, at the start of the 3:00 p.m. shift, if she would reassign Ms. LeBrun to the west wing, but the supervisor declined to do so.

24. On several occasions, Ms. LeBrun's immediate supervisor reminded her of Respondent's restricted-lift policy. Ms. LeBrun speaks French Creole, although she seems functionally literate in English. Concerned that Ms. LeBrun may not have understood these reminders, the immediate supervisor found another employee who could speak French Creole, and the employee translated the immediate supervisor's instructions, including the requirement that two employees operate the lift for transfers.

25. At some point in the evening, probably after 7:30 p.m., Ms. LeBrun attempted to transfer a resident from a

wheelchair to a bed without a lift and without the assistance of another employee. In the course of doing so, Ms. LeBrun dropped the resident, who sustained a fractured right shoulder. Picking up the resident off the floor, Ms. LeBrun completed the transfer to the bed. In the course of this procedure, the resident also sustained bruising of the upper body. Ms. LeBrun did not report this incident to anyone.

26. The next morning, another staffperson noticed that the resident had been injured. The staffperson notified the resident's physician and family and caused the resident to be taken to the hospital for treatment. The hospital returned the resident the following day.

27. At the time of the incident, the resident was an 89-year-old person suffering from dementia, poor vision, contracture of her left hand, and a neck deformity resulting in a pronounced hump in her upper back. She had not been able to walk at all for a long time. She was incontinent, totally bed-ridden, and totally dependent for the activities of daily living, except that she could feed herself.

28. Prior to knowing that the resident had suffered a fracture, Respondent's staff modified the resident's care plan on Christmas Day. They identified a special way to lift and transfer the resident. Later, they modified the care plan again to require a four-person lift and to reflect the reduced range

of motion in the resident's arm, which prevented her from self-feeding. However, at the time of the final hearing and following therapy, the resident had regained her ability to lift her arm to her mouth and had begun to regain the skills that might lead to self-feeding.

CONCLUSIONS OF LAW

29. The Division of Administrative Hearings has jurisdiction over the subject matter. Section 120.57(1), Florida Statutes. (All references to Sections are to Florida Statutes. All references to Rules are to the Florida Administrative Code.)

30. Section 400.23(7) requires Petitioner to assign a rating of standard or conditional to each nursing home facility. Section 400.23(7)(a) provides for a standard license if the facility has no Class I or II deficiencies and no uncorrected Class III deficiencies. Section 400.23(8)(b) defines a Class II deficiency as one that has "a direct or immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies."

31. Section 400.23(2)(f) provides for the promulgation of rules to based on federal law for the care and treatment of residents. Rule 59A-4.1288 incorporates by reference the provisions of 42 Code of Federal Regulations Section 483.25.

32. The flush language of 42 Code of Federal Regulations Section 483.25 provides:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

33. As Respondent contends in its proposed recommended order, Petitioner's theory of liability is unclear. At the hearing, Petitioner disclaimed any reliance on the principle of strict liability event though its choice of federal regulation suggests such a theory, rather than a theory specifically focused on inadequacies in staffing, training, or supervision. There is little doubt of the neglect of Ms. LeBrun in causing the resident's injury and consequent decline, but little in the record attributes any responsibility for this neglect to Respondent. To the contrary, Respondent adequately discharged its responsibility to train its employees, including Ms. LeBrun, adequately discharged its responsibilities to assess and prepare a care plan for the resident, and adequately supervised Ms. LeBrun.

34. On the other hand, there is no doubt that this case illustrates the deficiency of Petitioner's practice of reliance upon survey reports and brief letters as charging pleadings,

rather than subjecting its implicit theory of a case to the discipline of preparing a formal charging document.

35. In its proposed recommended order, Respondent argues that Petitioner brought this case for an improper purpose, under Section 120.569(2)(e). In this case, based on a report of a another certified nursing assistant and her own observations, an immediate supervisor expressed her concerns about the fitness of Ms. LeBrun to work the more demanding east wing during her second consecutive shift that day after five days on the job and while the wing was below its customary staffing, at least during the first few hours of the shift; however, the immediate supervisor was unable to obtain a transfer of Ms. LeBrun to the less demanding east wing. These facts preclude any award of attorneys' fees and costs, despite the vagueness of the charging pleadings.

RECOMMENDATION

It is

RECOMMENDED that Petitioner enter a final order restoring a standard rating to Respondent's license retroactive to January 11, 2001.

DONE AND ENTERED this 6th day of August, 2001, in Tallahassee, Leon County, Florida.

____

ROBERT E. MEALE
Administrative Law Judge
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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 must be filed with the agency that will issue the final order in this case.