STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BEVERLY HEALTH AND REHABILITATION CENTER-CORAL TRACE,	)	
Petitioner,	)	
vs.	)	Case No. 01-1606
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was conducted before the Division of Administrative Hearings, by its duly-designated Administrative Law Judge Carolyn S. Holifield, on November 15 and 16, 2001, in Fort Myers, Florida.

APPEARANCES

For Petitioner: Donna H. Stinson, Esquire
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For Respondent: Pury Lopez Santiago, Esquire
Agency for Health Care Administration
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STATEMENT OF THE ISSUE

The issue for determination is whether Petitioner committed the alleged deficiencies and, if so, whether those deficiencies constituted a basis to change Petitioner's licensure rating from standard to conditional for the period of March 1, 2001 through October 31, 2001.

PRELIMINARY STATEMENT

As a result of an annual survey completed on March 1, 2001, Respondent, the Agency for Health Care Administration (Agency), advised Petitioner, Beverly Health and Rehabilitation Center Coral Trace (Coral Trace), that its standard licensure rating was being changed to conditional. Petitioner challenged the conditional licensure rating and timely requested an administrative hearing.

On April 23, 2001, the matter was referred to the Division of Administrative Hearings for assignment of an administrative law judge to conduct the final hearing. The case was initially set for hearing on July 18, 2001. However, prior to the scheduled hearing date, on June 29, 2001, the parties filed a Joint Motion for Continuance. An Order was issued on July 2, 2001, granting the motion and rescheduling the hearing for August 23 and 24, 2001. Subsequently, on August 15, 2001, and September 28, 2001, the parties filed joint motions requesting that the scheduled final hearing be continued. Both

motions were granted and, by Order issued October 5, 2001, the case was set for hearing on November 15 and 16, 2001. An ore tenus motion for continuance made by Respondent on November 13, 2001, was denied and the hearing was conducted as noticed.

Prior to hearing, on October 30, 2001, the Agency filed a Motion for Leave to File an Administrative Complaint (Motion), setting forth with particularity, the basis for imposition of the conditional license. By the terms of the Motion, the purpose of filing the Administrative Complaint was "to provide the licensee with notice with particularity" and to "allow the Agency to explain its position before forcing the licensee to defend itself." Based on those representations, the Motion was granted, and the case proceeded based on the Administrative Complaint and the survey report. However, the Administrative Complaint is not viewed by the undersigned to allow the imposition of any penalty on the facility other than change of its licensure status, should the allegations contained therein be proven.

At the hearing, the Agency presented the testimony of six witnesses and had seven exhibits admitted into evidence. Coral Trace presented the testimony of three witnesses and had eight exhibits admitted into evidence, two of which were depositions submitted without objection in lieu of live testimony.

A Transcript of the hearing was filed on December 7, 2001. On December 18, 2001, the Agency filed an unopposed Motion for Enlargement of Time to File Proposed Orders. The motion was granted and the time for filing Proposed Recommended Orders was extended to February 19, 2002. Prior to the date the proposed orders were due, Petitioner filed an unopposed motion requesting that the time for filing Proposed Recommended Orders be extended to February 26, 2002. The motion was granted and the parties timely filed Proposed Recommended Orders under the extended time frame. The Proposed Recommended Orders have been duly considered in preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner, Beverly Health and Rehabilitation Center-Coral Trace (Coral Trace or facility), is a nursing facility located at 216 Santa Barbara Boulevard in Cape Coral, Florida, and is licensed by and subject to regulation by the Agency for Health Care Administration pursuant to Chapter 400, Florida Statutes.

2. Respondent, the Agency for Health Care Administration (Agency), is the Agency in the State of Florida responsible for licensing and regulating nursing facilities under Part II of Chapter 400, Florida Statutes.

3. The Agency conducted a re-certification survey of Coral Trace, which ended on March 1, 2001. As a result of that

survey, the Agency determined that certain deficiencies existed at Coral Trace. The Agency noted the alleged deficiencies and the findings which it believed supported each deficiency on a standard survey form, the Health Care Federal Administration Form 2567-L (survey form). The survey form identified each alleged deficiency by reference to a tag number. Each tag includes a narrative description of the alleged deficiencies and cites the relevant rule or regulation violated by the alleged deficiency.

4. In the instant case, the Agency also filed an Administrative Complaint that set forth the alleged deficiencies noted in the survey form and at issue in this proceeding.

5. In order to protect the privacy of the residents at Coral Trace, the survey form, the Administrative Complaint, and this Recommended Order refer to each resident by a number rather than by the name of the resident.

6. There are three tags at issue in this proceeding, Tag F224, Tag F314, and Tag F490.

7. Tag F224, references 42 C.F.R. Subsection 483.13(c)(1), which addresses staff treatment of residents and requires that facilities develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

8. Tag 224 in the March survey alleges that Coral Trace failed, refused, or neglected to: (1) perform physician ordered laboratory monitoring tests on Resident 1, on at least five separate occasions; (2) report signs of bleeding, relative to Resident 1, to the physician, as ordered; and (3) implement a system whereby the facility would review all physician orders to make sure the orders were properly transcribed and entered into the computer. The Agency alleged that by not implementing a system to ensure that physician orders were properly transcribed and entered in the computer, Coral Trace was "neglecting and exposing at least one resident to a potential life threatening situation and created a situation of possible imminent danger at the facility for all residents whose doctors ordered tests to be performed."

9. During the March 2001 survey, the Agency reviewed the quality of care provided to Resident 1. This resident was admitted to Coral Trace on January 26, 2001, due to a hip fracture. When Resident 1 was admitted to the facility, she was bed bound and could not move herself. However, during the course of her stay at Coral Trace, Resident 1 improved, met her goals, and was discharged from Carol Trace a few days after the survey to an assisted living facility where her husband resided.

10. While at Coral Trace, Resident 1 regained some of her mobility and was able to transfer herself from bed to her

wheelchair. During her entire stay at Coral Trace, Resident 1 was fully alert and aware.

11. While Resident 1 was at Coral Trace, her physician was Dr. Debra Roggow, who specializes in physical medicine and rehabilitation for the elderly. Dr. Roggow's initial visit with Resident 1 was on January 31, 2001. As part of the Resident 1's treatment, Dr. Roggow prescribed Coumadin, a blood thinner, and Celebrex, an anti-inflammatory drug. On that same day, Dr. Roggow also ordered a blood test, a PT/INR, to be done every Monday and Thursday to check blood thinness.

12. The PT/INR is a laboratory test which measures the thinness of a person's blood and is usually administered to a patient taking Coumadin.

13. Dr. Roggow made rounds at Coral Trace once a week, during which she saw all her patients. She was accompanied on these rounds by a nurse from her office as well as nurses and other staff from Coral Trace. It was Dr. Roggow's routine to have her own nurse transcribe her progress notes and her orders. The progress notes typically contain the physician's impressions and the order sheet indicates the physician's orders for the residents.

14. After Dr. Roggow's orders and notes were transcribed, staff at Coral Trace would then put Dr. Roggow's orders into the computer system, which would print out three copies. One of the

computer-generated copies was for the resident's medication administration record and one was for the resident's treatment administration record.

15. With regard to Resident 1, the January 31, 2001, physician's order for the PT/INR was placed on the order sheet, but the order for Coumadin was placed on the progress notes. As a result, only the order for PT/INR was put in the computer system.

16. On or about February 6, 2001, Coral Trace staff reviewed the order reflecting that Resident 1 was to have a PT/INR test on Mondays and Thursdays. However, because the order form did not include the order for Coumadin, the nurse questioned the need for the lab value derived from the PT/INR. Documentation reflects that the facility's unit nurse then called Dr. Roggow's office and, based on a conversation with the doctor's assistant, the PT/INR was discontinued. The following day, the order for Coumadin was discovered, apparently in the Resident 1's progress notes, and was then put on the order sheet, along with the PT/INR. Consistent with the practice of Coral Trace, the physician's order for Coumadin was put in the computer. However, the order for the PT/INR, which also should have been entered in the computer system was not put in the system.

17. Based on the survey form completed by the Agency, during the survey, twenty-three residents were observed by the surveyors. The survey form also indicates that the records of these twenty-three residents along with three additional records were reviewed by Agency surveyors. Except for the missing order for Resident 1, there is no evidence or indication that a physician's order for any other resident was missed by staff of Coral Trace.

18. Given the totality of the circumstances surrounding the physician's orders for Coumadin and the PT/INR, it appears that the failure to enter the order for the PT/INR in the computer system was due to an inadvertent omission, mistake, or simply, human error. Regardless of the reason the order for the PT/INR was missed, as a result thereof, Resident No. 1 did not have the PT/INR laboratory tests administered to her for two and a-half weeks.

19. The missed order for the PT/INR was found by an Agency surveyor who reviewed Resident 1’s records during the survey. When the "missed" order was brought to the attention of Coral Trace staff, Resident 1's physician was called immediately, and the PT/INR test was performed on the evening of February 26, 2001.

20. The results reflected that Resident 1 had an INR level of 6.5, which the laboratory sheet designated at the “critical” level or outside the therapeutic range.

21. Dr. Roggow testified credibly that, with regard to the PT/INR, the benchmark that doctors like to see is between two and three. However, Dr. Roggow indicated that although, Resident 1's level of 6.5 was "too high" and required some type of intervention, it was "not outrageous." According to Dr. Roggow, even with an INR level of 6.5 on February 26, 2001, Resident 1 was not likely to suffer serious injury or death and was not in immediate jeopardy for her life.

22. After being notified of the laboratory results of Resident 1's PT/INR, Dr. Roggow ordered that the Coumadin be held and that Resident 1 be monitored for signs of bleeding which may occur if the blood is too thin. Signs of bleeding may be bruises, blood in stool or urine, or the appearance of capillaries at the skin.

23. During the two and a-half week period when the PT/INR lab tests were not being performed on Resident 1, she was seen each week by Dr. Roggow.

24. On March 1, 2001, three days after the February 26, 2001, PT/INR, another PT/INR was administered to Resident 1. The results of the March 1, 2001, lab test indicated that

Resident 1's INR level was at the high-end of normal and was coming down appropriately.

25. As a result of the missed physician's order, the Agency alleged that Coral Trace neglected to provide care to Resident 1 as ordered by the resident's physician. However, this incident was an isolated one and not a systemic problem at the facility.

26. At the time of the survey, the facility had a procedure to check to see if any orders were missed. On a daily basis, nurses would pass along information from shift to shift. Also, every month the physician orders are printed out for the physician to change. At that time, all medication administration records, treatment administration records, and orders are "checked with each other." In utilizing this system, the facility did not find discrepancies in the orders, the medication administration records, and the treatment administration records.

27. The Agency did not specify a particular procedure that the facility should use to verify or validate that all physician's orders were entered in the computer system. However, the Agency believed that any such system should require that hard copies of all orders be retained even though it provided no authority for this requirement.

28. Notwithstanding the Agency's speculation that Coral Trace did not retain such records, hard copies of the physician's orders for Resident 1 were in the resident's records at the facility.

29. Contrary to the Agency's assertion that the facility had no policy in place to address the mistreatment, abuse, and neglect of residents at the facility, Coral Trace did have such a policy. However, the policy was not as broad as the Agency apparently thought it should be because it did not address the issue of the facility's checking to validate that all physicians' orders were properly entered in the computer system.

30. On February 26, 2001, in addition to ordering a PT/INR for Resident 1, Dr. Roggow also ordered that the resident be monitored for signs of bleeding. The nurses assigned to Resident 1 carried out that order. Irrespective of Dr. Roggow's order regarding such monitoring, all nurses are generally aware that patients or residents who take Coumadin should be monitored for bleeding.

31. On February 27, 2001, there is a notation in the nurse's notes at 11:15 p.m. that "CNA [certified nurse's assistant] . . . noted few petechiae at the back-made night nurse aware." Petechiae are small red spots which could be an indication of bleeding. Shortly after the CNA examined

Resident 1, at 1:00 a.m. on February 28, 2001, the night nurse examined the resident and found no petechiae, and no signs of bleeding. Because the night nurse's examination of Resident 1 found no signs of bleeding, no call was made to the physician. In absence of any signs of bleeding, there was no need to call the physician.

32. The day after the CNA identified certain spots on Resident 1 as petechiae, on February 28, 2001, during her rounds, Dr. Roggow examined Resident 1 and found no petechiae. According to Dr. Roggow, the resident had freckles which might have been mistaken for petechiae by the CNA. If the spots had been petechiae, they likely would have been on the resident the next day and identifiable to Dr. Roggow as such.

33. Another area addressed in the March 2001 survey was Tag F490 which references 42 C.F.R. 483.75. That regulation requires that a nursing home be "administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

34. The same facts asserted by the Agency as the basis for the deficiencies under Tag F224 are also asserted as the basis for the deficiency cited under Tag F490. Both tags involve the resident identified as Resident 1.

35. The Agency alleged that Coral Trace neglected Resident 1 by its failure to implement the physician's orders, to monitor the resident's anticoagulant blood levels, and to develop and/or implement a policy or process for the validation and reconciliation of written and verbal orders. It was further alleged that these failures constituted a violation of 42 C.F.R. 483.75. Despite these assertions, the Agency put forth no evidence to support these claims. Because the record does not support a finding that Coral Trace neglected Resident 1, the underlying factual basis for the Tag F490 deficiency was not proven. Accordingly, the Agency failed to establish that the facility is not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

36. During the March 2001 survey, the Agency also cited the facility with a Tag F314 deficiency, which incorporated 42 C.F.R. 483.25(c). According to Tag F314, a facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition later demonstrates that they were unavoidable, and a resident with pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores.

37. A pressure ulcer or pressure sore is any lesion caused by the unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed. The Agency based the Tag F314 citation on its findings regarding the surveyors' observation of three residents and review of those residents' records.

38. Resident 1 was admitted to the facility without any pressure sores. However, on March 1, 2001, during the survey, Resident 1 was discovered to have a small open area on the coccyx. The area was identified as a pressure sore.

39. Resident 1 had a care plan for prevention of pressure sores, which included turning and repositioning every two hours as she had been determined to be at risk for developing pressure sores on admission due to her immobility. These measures were appropriate at the beginning of Resident 1's stay at Coral Trace, when the resident was immobile. However, by the time of the survey, Resident 1 could move herself in bed, from bed to wheelchair, and around and outside the building.

40. The care plan for Resident 1 also required weekly skin checks, reporting of red areas, and a dietary assessment. The evidence demonstrated that these measures were taken.

41. The Agency suggested that once Resident 1 became mobile, there should have been documentation that the resident

was given education about the need to reposition herself to prevent pressure sores. However, a resident who is alert and mobile generally does not need to be told to move herself; this is done automatically, as it becomes uncomfortable to sit or lie in one position for a long time. Moreover, there is no standard suggesting that mobile residents be educated about the need to move, nor was it a measure described in Resident 1's care plan.

42. With regard to Resident 1, Coral Trace took all the reasonable and appropriate measures to prevent the development of pressure sores.

43. In 1998, when Resident 8 was initially admitted to the facility, he had pressure sores on both of his heels. Once a pressure sore develops, the skin in that area breaks down more easily and, even after the sores have been successfully treated, the person remains at risk for developing pressure sores.

44. Apparently, at some point after Resident 8's initial admission to Coral Trace, the pressure sores healed. However, the nurse's notes of February 4, 2001, indicated that the resident had developed a pressure sore on his heel. A few days later, on February 9, 2001, the open area on Resident 8's right lateral heel was documented to be a stage II pressure ulcer or sore.

45. The records of Resident 8 included an order for the daily treatment of pressure sores. The order required that

every day the open area be cleaned with normal saline and that Hydrogel and coverderm be applied to that area.

46. At the time of the survey, there was a bandage over Resident 8's heel. The surveyor had the nurse to remove the bandage so she could observe the pressure sore and the dressing. However, there was no date recorded that would allow the surveyor to determine when the dressing and bandage were put on the resident.

47. During the survey, a review of the Resident 8's treatment records indicated that the treatment required by the physician's order had not been given on six days during the month of February 2001.

48. There was also an order for Resident 8 to wear a heel protector cover. During the survey, a surveyor observed the resident at about 8:30 a.m. and noted that he was not wearing a heel protector cover. Upon mentioning this observation to a facility staff member, the surveyor was told by the staff person that Resident 8's heel protector cover was being washed, but that one would be provided to him. About four hours later, at about 12:45 p.m. the same day, the surveyor again observed Resident 8 and he still did not have on a heel protector cover.

49. Coral Trace failed to provide the required treatment for Resident 8's pressure sore or, with regard to the order

described in paragraph 45, if the treatment was provided, the facility failed to document such treatment.

50. Based on the records provided by the Coral Trace during the survey, the Agency properly determined that the facility failed to provide and/or consistently implement the treatment or services to promote healing of Resident 8's pressure sores and/or to prevent new sores.

51. Resident 20 had a history of pressure sores. On December 14, 2000, the Coral Trace physician ordered treatment for the pressure sores. The order required the application of Hydrocolloid dressing on the pressure sores as needed. On March 1, 2001, the surveyor saw a couple of open areas on the resident. The surveyor also observed that no dressing was applied to the areas although the resident's records indicated that dressing had been applied on February 27, 2002.

52. With regard to Resident 20, Coral Trace failed to provide treatment and services to promote the healing of and/or to prevent the development of pressure sores.

53. Resident 8 and Resident 20 acquired in-house pressure sores that were avoidable. The facility failed to provide the treatment and services to prevent the development of new pressure sores. In light of the facility's failure to implement, fully and consistently, the required services and treatment for the Resident 8 and Resident 20, and to document

the same, it is not possible to conclude that the pressure sores on Resident 8 and Resident 20 were unavoidable. Moreover, Coral Trace failed to provide the treatment and services to promote the healing of existing pressure sores.

54. The violations for which Coral Trace were cited in the March 2001 survey were classified by the Agency as Class I and Class II deficiencies. Tags F224 and F490 were deemed by the Agency to be Class I deficiencies because it determined that these deficiencies presented an imminent danger to the residents of the nursing home. Tag F314 was deemed to be a Class II deficiency because of the harm caused to the residents. An additional consideration of the Agency in making this determination was that it found that the in-house pressure sores were avoidable.

55. A single Class I violation or Class II violation or uncorrected Class III violation is a sufficient basis to warrant issuance of a conditional license pursuant to Section 400.23, Florida Statutes.

56. The Agency properly observed the residents in question and considered all records that were available at the time of the survey. Based on the surveyors' review of records and observations, the Agency properly found that, with respect to Resident 8 and Resident 20, Coral Trace failed to provide the

treatments and services to prevent the development of pressure sores and/or promote the healing of existing pressure sores.

CONCLUSIONS OF LAW

57. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and the parties thereto. Section 120.569 and Subsection 120.57(1), Florida Statutes.

58. The Agency is authorized to license nursing home facilities in the State of Florida, and pursuant to Chapter 400, Part II, Florida Statutes, is required to evaluate nursing home facilities and assign ratings. As the survey and conditional license rating occurred in March, 2001, prior to the implementation of amendments to Chapter 400 by the 2001 Legislature, Chapter 400, Florida Statutes (2000) is applicable.

59. Subsection 400.23(7), Florida Statutes (2000), requires the Agency to "at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to the facility." That section further provides that the Agency's evaluation must be based on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections.

60. Based on its findings and conclusions of deficiencies, the Agency is required to assign a licensure status to the facility. The relevant categories are defined in Section 400.23(7), Florida Statutes (2000), as follows:

> (a) A standard rating means that a facility has no class I or class II deficiencies, has corrected all class III deficiencies within the time established by the agency and is in substantial compliance at the time of the survey with criteria established in this part, with rules adopted by the agency, and, if applicable, with rules adopted under the Omnibus Budget Reconciliation Act of 1987. . . Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended.
>
> (b) A conditional rating 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 this part, with rules adopted by the agency, or, if applicable, with rules adopted by the Omnibus Reconciliation Act of 1987. . . Title IV (Medicare, Medicaid, and Other Health-Related Programs, Subtitle C (Nursing Home Reform), as amended. . . .

61. Section 400.23(8), Florida Statutes (2000), provides that when minimum standards are not met, the deficiencies shall be classified according to the nature of the deficiency. That section delineates and defines the various categories of deficiencies, with a Class I deficiency being the most severe.

62. 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." Class II deficiencies "are those which the agency determines have a direct or immediate relationship to the health, safety, or security of nursing home facility residents, other than Class I deficiencies." Section 400.23(8), Florida Statutes (2000).

63. The categories of deficiencies are further defined in Rule 59A-4.128(3), Florida Administrative Code, as follows:

> (a) Class I deficiencies are those which present either an imminent danger, a substantial probability of death or serious physical harm and require immediate correction. Class II deficiencies are those deficiencies that present an immediate threat to the health, safety, or security of the residents of the facility and the AHCA establishes a fixed period of time for the elimination and correction of the deficiency. . . .

64. The Agency alleges that the violations for which Coral Trace was cited are Class I and Class II violations and seeks to change the licensure status of Coral Trace from standard to conditional. Accordingly, the Agency has the burden of proof in this proceeding.

65. In order to prevail, the Agency must establish by a preponderance of evidence the existence of the alleged deficiencies and that such deficiencies justify changing the

facility's license from a standard to conditional rating. Department of Transportation v. J. W.C., Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977).

66. The regulations found in 42 C.F.R. 483 and the requirements therein have been incorporated by reference into Rules 59A-4.128 and 59A-4.1288, Florida Administrative Code.

67. Tag F224 incorporates the requirements of 42 C.F.R. 483.13(c)(1), which provides that the facility "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."

68. The Agency failed to prove that Coral Trace violated 42 C.F.R. 483.13(c).

69. The evidence did not establish that Coral Trace failed to develop and implement the policies contemplated and required by 42 C.F.R. 483.23(13(c). Rather, the evidence established that the facility did have such a policy. Moreover, with regard to validating physicians' orders, the evidence established that the facility had a procedure by which it checked, on a monthly basis, physicians' orders against the residents' medication administration records and treatment administration records.

70. Although one physician's order was missed for one resident, the Agency failed to prove that the deficiency was the

result of any overall systems failure, or that there was any imminent danger or immediate jeopardy to Resident 1 or any other resident at Coral Trace. Furthermore, the Agency failed to establish that there was an imminent danger or substantial probability of death or serious physical harm, because of this isolated occurrence. Contrary to the assertion of the Agency, the evidence established that Resident 1 suffered no harm and was discharged from the facility shortly after the survey.

71. The evidence presented at hearing does not support the Agency's allegation that the one missed physician's order constitutes neglect. Even if the missed order constitutes the "neglect" of Resident 1, a single act of neglect does not demonstrate a failure to develop and/or implement policies. (See decisions of federal agency responsible for enforcing the regulations set forth in 42 C.F.R. 483, Beverly Health and Rehabilitation v. Health Care Financing Administration, Department of Health and Human Services, Departmental Appeals Board, Decision No. CR533 (1998) and Life Care Center of Hendersonville v. Health Care Financing Administration, Department of Health and Human Services, Departmental Appeals Board, Decision No. CR542 (1998), which provide that "evidence of an isolated act of neglect is not prima facie proof of a failure by a long-term care facility to implement a policy or procedure to prevent neglect. Here, the evidence established

that the missed order was an isolated occurrence which resulted in no harm to the resident.

72. Tag F490 incorporates 42 C.F.R. 483.75, which provides the following:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychological well-being of each resident.

73. The Tag F490 deficiency was based on the same factual allegations that are the basis for the Tag F224 deficiency.

74. The Agency offered no evidence to establish how the facility failed to use its resources to effectively and efficiently attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.

75. The Tag F314 incorporates 42 C.F.R. 483.25(c), which provides the following:

> (c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that-
>
> (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

76. The Agency failed to establish that the pressure sores developed by Resident 1 were avoidable. The evidence established that by virtue of the treatment and services implemented by the facility and the resident's own control over her actions, the pressure sore developed by Resident 1 was unavoidable.

77. With regard to Resident 8 and Resident 20, cited under Tag F314, the Agency established by a preponderance of evidence that the pressure sores were avoidable. The Agency established that the facility failed to consistently carry out orders and necessary treatment and services to prevent the development of pressure sores on Resident 8 and Resident 20 and/or to promote the healing of existing pressure sores. Accordingly, in regard to Tag F314 and as it relates to Resident 8 and Resident 20, the Agency met its burden.

78. Finally, the evidence established that the Tag F314 deficiency had a direct or immediate relationship to the health of the residents in the facility and, thus, was properly determined by the Agency to be Class II deficiency.

79. Based on the foregoing, the Agency established the existence of one Class II deficiency at Coral Trace during the March 2001 survey. As a result of this Class II deficiency, the Agency is required to assign conditional licensure status to

Coral Trace, pursuant to Subsection 400.23 (7)(b), Florida Statutes (2000).

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 revising the March 2001 survey report to delete the deficiencies described under Tag F224 and Tag F490; finding that Coral Trace was properly cited for the Class II deficiency listed under Tag F314 in the survey report; and sustaining the conditional licensure rating for Coral Trace that was in effect from March 1, 2001, until October 31, 2001.

DONE AND ENTERED this 16th day of May, 2002, in Tallahassee, Leon County, Florida.

CAROLYN S. HOLIFIELD
Administrative Law Judge
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Filed with the Clerk of the
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this 16th day of May, 2002.

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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.