STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case Nos. 01-3148 01-4649
LIFE CARE CENTER OF PORT SAINT LUCIE,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in these consolidated cases on January 31, 2002, in Fort Pierce, Florida, before Patricia Hart Malono, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Luis M. Vissepo, III, Esquire
Agency for Health Care Administration
8355 Northwest 53rd Street
Miami, Florida 33166

For Respondent: R. Bruce McKibben, Jr., Esquire
Post Office Box 1798
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STATEMENT OF THE ISSUES

DOAH Case No. 01-3148: Whether the Respondent's licensure status should be reduced from standard to conditional.

DOAH Case No. 01-4649: Whether the Respondent committed the violations alleged in the Administrative Complaint dated October 15, 2001, and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

In a letter dated July 3, 2001, the Agency for Health Care Administration ("AHCA") notified Life Care Center of Port Saint Lucie ("Life Care") that, effective June 12, 2001, its licensure status had been reduced to conditional as a result of a survey of the facility completed on June 12, 2001. AHCA stated in its letter that a Class II deficiency was cited during the June 12, 2001, survey based on Life Care's failure to provide care and services to two residents because it did not monitor the sugar level of a diabetic resident and did not supervise another resident, resulting in a fall. Life Care timely disputed the facts alleged in the letter and requested an administrative hearing. AHCA forwarded the matter to the Division of Administrative Hearings for assignment of an administrative law judge. The case was assigned DOAH Case No. 01-3148.

On October 12, 2001, AHCA filed a formal three-count Administrative Complaint in DOAH Case No. 01-3148, setting forth allegations of fact to support its decision to reduce Life Care's licensure status to conditional in accordance with its authority under Section 400.23(7)(b), Florida Statutes. In the

Administrative Complaint, AHCA identified three deficiencies on which it based the reduction of Life Care's licensure status:

(a) In Count I, AHCA alleges that Life Care had a Class II deficiency on June 12, 2001, because it failed to provide care to residents E.G. and N.D. "as needed and as ordered by the physician," in violation of Section 400.022(1)(l), Florida Statutes; Rule 59A-4.1288, Florida Administrative Code; and Section 483.13(c), Code of Federal Regulations.

(b) In Count II, AHCA alleges that Life Care had an "uncorrected" Class III deficiency on June 12, 2001, because it failed to complete a comprehensive Care Plan for resident N.D. that "met her medical needs," in violation of Rules 59A-4.109(2) and 59A-4.1288, Florida Administrative Code, and Section 483.20(k), Code of Federal Regulations. The classification of the violation as an "uncorrected" Class III deficiency is based on a Class III deficiency cited during a previous survey conducted on May 9, 2001.

(c) In Count III, AHCA alleges that Life Care had a Class II deficiency on June 12, 2001, because it failed to provide services to residents E.G. and N.D. that "met professional standards of care," in violation of Rule 59A-4.1288, Florida Administrative Code, and Section 483.20(k)(3)(i), Code of Federal Regulations.

AHCA subsequently transmitted to the Division of Administrative Hearings Life Care's Petition for Formal Administrative Hearing dated October 26, 2001. The petition was filed in response to a three-count Administrative Complaint dated October 15, 2001, in which AHCA stated its intention to impose an administrative fine on Life Care in the amount of $7,000.00, pursuant to Section 400.23(8)(b) and (c), Florida Statutes. In its petition, Life Care disputed the facts set forth in an Administrative Complaint, which contains allegations identical to those contained in the Administrative Complaint forming the basis for the proceeding in DOAH Case No. 01-3148. This second case was assigned DOAH Case No. 01-4649.

Life Care filed an uncontested Motion to Consolidate the two cases, which was granted in an order entered December 14, 2001. The final hearing in these cases was scheduled for January 31 and February 1, 2002; the hearing was completed on January 31, 2002.

At the hearing, AHCA presented the testimony of Florence Treakle, a Registered Nurse Specialist employed by AHCA, and Concettina Russo, a Nurse Consultant employed by AHCA. Petitioner's Exhibits 1 through 4, 6 through 9, 11 through 16, 18 through 20, 25 through 28, 30, 31, 35, 36, and 39 were offered and received into evidence; Petitioner's Exhibit 22 was offered into evidence but rejected. Life Care presented the

testimony of the following witnesses: Nova Coleman, formerly employed by Life Care as a Certified Nursing Assistant ("CNA"); Michelle Meer, Executive Director of Life Care; and Marion Neuhaus, formerly Life Care's Director of Nursing. Respondent's Exhibits 12, 14, 16, 18, and 19 were offered and received into evidence.

The two-volume transcript of the proceedings was filed with the Division of Administrative Hearings on February 14, 2002, and the parties timely submitted proposed findings of fact and conclusions of law, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. AHCA is the state agency responsible for licensing and regulating the operation of nursing home facilities, including ensuring that nursing homes are in compliance with criteria established by Florida statute. Chapter 400, Part II, Florida Statutes (2001). AHCA is authorized in Section 400.23(8), Florida Statutes, to impose administrative fines on nursing home facilities that fail to meet the applicable criteria.

2. Florence Treakle conducted surveys of Life Care on May 9, 2001, and June 12, 2001, as a result of complaints

received by AHCA. Because the surveys were conducted as a result of complaints received by AHCA, Ms. Treakle was the only AHCA surveyor conducting the surveys. The results of the surveys were reported on a form identified as "HCFA-2567," which is generated by the federal Department of Health and Human Services, Health Care Financing Administration, and is commonly referred to as a "Form 2567."

3. Several deficiencies were identified in the Form 2567s completed for the May 9, 2001, and June 12, 2001, surveys, which were each cited to a federal "tag number" designated as "F" tags,[1] to the applicable provision of the Code of Federal Regulations, and to the applicable Florida administrative rule. Each deficiency was also classified under Florida law as either a Class II or a Class III deficiency, and a factual narrative was included to support each deficiency cited.

May 9, 2001, survey.[2]

4. The Form 2567 for the May 9, 2001, survey included a citation for a Class III deficiency under F-279, "Resident Assessment," and Section 483.13(c), Code of Federal Regulations. This citation involved the care provided to residents L.D. and A.M. and was supported by the assertion that, "[b]ased on observation and record review[,] . . . the facility did not have comprehensive care plans in place for healing of the residents [sic] pressure sores."

5. A care plan is a tool used by the nursing staff to ensure that the resident is getting consistent care and is compiled from data included in a resident's Comprehensive Assessment. An entry in a care plan includes the identification of a problem, a goal for resolving or improving the problem, and the approaches, or means, to be used to reach the goal.

Resident L.D.

6. L.D. came into Life Care with pressure ulcers, including a Stage IV pressure ulcer[3] on his coccyx, which is located at the bottom of the backbone. L.D. was receiving wound care both at Life Care and at a wound care center pursuant to a physician's order dated April 4, 2001, which contained the following requirement: "[O]ffload[] all boni [sic] prominences as much as possible." In accordance with this order, L.D. was turned and repositioned in bed every two hours, and he was provided with a special, pressure-relieving mattress.

7. L.D. was a very quiet person, but he had no cognitive impairment and was able to communicate his needs to staff. L.D.'s wife visited him every day; she usually arrived in mid-morning and left in mid-afternoon, and she returned for a few hours in the evening. Both L.D. and his wife made it clear to the Life Care staff that L.D. wanted to sit in a wheelchair as much as possible so that he could move around the facility,

take walks outdoors with his wife, and have his meals sitting up.

8. L.D. used a special, high-backed wheelchair that he provided for his use while he was a resident of Life Care. The chair reclined so that pressure on his coccyx could be relieved somewhat, and Life Care furnished him a gel cushion for his wheelchair, also to help relieve pressure on his coccyx.

9. On May 9, 2001, Ms. Treakle observed L.D. sitting in his wheelchair for over two hours, from 10:20 a.m. until 1:00 p.m. She found nothing in L.D.'s Care Plan regarding the amount of time L.D. would be permitted to sit in a wheelchair.

Resident A.M.

10. A.M. entered Life Care with a Stage III pressure ulcer on his left buttock. A.M. was receiving wound care at Life Care in accordance with the approaches included in his Care Plan.

11. A.M. was not cognitively impaired, and he could communicate his needs to staff. His granddaughter and one year-old great-grandson visited him every day, and he enjoyed sitting outside in a wheelchair with his great-grandson on his lap. A.M. also liked to spend most of his time outside his room, moving himself around the facility in a wheelchair.

12. Life Care provided a gel cushion for his wheelchair to help relieve pressure on A.M.'s buttock.

13. On May 9, 2001, Ms. Treakle observed A.M. sitting in a wheelchair from 2:00 p.m. until 3:30 p.m. A.M.'s Care Plan did not contain an entry establishing the amount of time A.M. would be permitted to sit in a wheelchair.

Summary.

14. AHCA has failed to establish by even the greater weight of the evidence that the Care Plans developed for L.D. and A.M. were deficient. AHCA failed to present credible evidence of the contents of L.D.'s Care Plan,[4] but the evidence is uncontroverted that L.D.'s wound care orders contained approaches for healing his pressure sores. A.M.'s Care Plan included several approaches for healing his pressure sores, and AHCA has not alleged that the required wound care was not provided to either L.D. or A.M.

15. Rather, AHCA's specific complaint regarding the Care Plans of L.D. and A.M. is that there was no approach specifying the amount of time L.D. and A.M. would be permitted to sit in their wheelchairs. This complaint is based exclusively on the expectations of Ms. Treakle. Ms. Treakle expected to find this approach in the Care Plans because, in her opinion, pressure on the coccyx and buttocks can never be completely relieved when a resident is sitting,[5] and any pressure on a pressure ulcer impedes healing because it decreases blood flow to an area. Accordingly, Ms. Treakle "would expect good practice would [sic]

be for the Care Plan to indicate how long the resident was going to sit on this pressure sore."[6] AHCA did not, however, submit any evidence of a standard of care requiring that the duration of time a resident can sit in a wheelchair be included as an approach in the care plan of a resident with a pressure ulcer, especially when the resident is alert, mobile, and able to communicate with staff.

June 12, 2001, survey.

16. The Form 2567 for the June 12, 2001, survey cited Life Care for three deficiencies:

a. A Class II deficiency was cited under F-224, "Staff Treatment of Residents," and Section 483.13(c)(1)(i), Code of Federal Regulations, involving the care provided to residents E.G. and N.D. and supported by the assertion that "[b]ased on observation, record review and interview[,] the facility did not monitor and supervise the delivery of care and services."

b. A Class III deficiency was cited under F-279, "Resident Assessment," and Section 483.20(k), Code of Federal Regulations, supported by the assertion that, "[b]ased on review of the care plan for resident #1 [N.D.], . . . the facility did not complete a comprehensive care plan that was revised to reflect all fall risks."

c. A Class II deficiency was cited under F-281, "Resident Assessment," and Section 483.20(k)(3)(i), Code of Federal

Regulations, supported by the assertion that, "[b]ased on citations at F 224[,] F 279 and F 324[,] the facility nursing staff did not provide care that met professional standards for residents #1 [N.D.] and #2 [E.G.]."

Resident E.G.

Diabetes management.

17. Pertinent to these proceedings, E.G. was diagnosed with insulin-dependent diabetes; his blood sugar generally ranged from 150 to 270, which is in the mid-range, although it once reached 348.

18. E.G. was alert, oriented, self-ambulatory, and somewhat grouchy. E.G.'s brother visited him about three times each week, and E.G. often left the facility with his brother for a meal. He did not adhere strictly to his diet, but often ate fried foods when he went out with his brother, and he kept a supply of orange juice in the small refrigerator in his room. Both fried foods and orange juice are contraindicated for diabetics.

19. Pursuant to physician's orders, E.G.'s blood sugar was to be monitored four times a day, before each meal and at bedtime,[7] and insulin was to be administered on a sliding scale, in an amount to be determined based on his blood sugar level. This order was transcribed on E.G.'s Medication Record, which, for each day of the month, included spaces for the time, the

blood sugar level, the insulin coverage (the dosage expressed in number of units administered), and the site of injection, together with the initials of the staff member providing the care. Life Care staff also maintained glucose monitoring sheets, which included spaces for the date, the time, the blood sugar level, the dosage of insulin administered, and the initials of the staff member providing the care.

20. There is no documentation in E.G.'s Medication Records, his glucose monitoring sheets, or the Nurses Notes that his blood sugar was checked at 11:30 a.m. on June 7, 2001. When his blood sugar was checked at 4:30 p.m. on June 7, it was 317, which is substantially higher than usual.

21. For the 6:30 a.m. checks on June 2, 3, and 8, 2001, E.G.'s blood sugar level was documented and there are notations that insulin was given, but the dosages and sites of injection were not noted; E.G.'s blood sugar at the 11:30 a.m. checks on these days was either virtually the same as, or less than, the levels noted at the 6:30 a.m. checks. For the 6:30 a.m. check on June 4, 2001, E.G.'s blood sugar level was documented, but there is no notation that insulin was given; E.G.'s blood sugar at the 11:30 a.m. check on June 4 was less than the level noted at the 6:30 a.m. check.

Wound Care.

22. On June 5, 2001, a dermatologist removed a lesion from the top of E.G.'s left hand. The dermatologist prescribed Bactroban ointment, which was to be applied to the wound twice a day. Wound care instructions were included with the prescription, which provided as follows:

> Leave bandage on for 24 hours only without getting wet.
> Remove bandage after 24 hours and then do not apply another bandage.
> Leave the area open and clean the wound twice daily with warm water.
> Pat the wound dry and then apply Bactroban Ointment. Bactroban Ointment is a topical antibiotic that can be purchased without a prescription.
> Continue to do this until the wound has healed.
> Normal bathing can be resumed after the bandage is removed.
> Some redness and swelling are normal in the immediate area of the wound. If the wound develops significant redness, tenderness or a yellow drainage, please contact this office immediately . . . .

23. A physician's order dated June 5, 2001, was written for E.G. for "Bactroban oint to wound on L hand, 45gm." The order did not state how often the ointment was to be applied or include the other instructions accompanying the prescription. The order was transcribed on E.G.'s Treatment Record on June 5, 2001, but the entry provided only that Bactroban ointment was to be applied to the wound once a day.

24. There is nothing in E.G.'s Care Plan, Treatment Record, or Medication Record to document that his wound was treated between June 5 and June 12, 2001, nor was there any indication in E.G.'s chart that anyone signed for the Bactroban ointment.

25. Marion Neuhaus, the Director of Nursing at Life Care at the times pertinent to these proceedings, observed E.G.'s wound every day because E.G. came to her office to show her the wound and other bumps and scrapes he accumulated as he walked around the facility. Ms. Neuhaus noted that the wound was scabbed, that there was a pink area around the wound, and that there was no swelling or drainage. Treatment was begun on the wound on June 12, 2001, and it healed without any complications.

Summary.

26. AHCA has established clearly and convincingly that Life Care did not provide E.G. with the wound care that was ordered by his physician. AHCA has, however, failed to establish by even the greater weight of the evidence that the healing process of E.G.'s wound was compromised by this lack of treatment. Ms. Treakle observed E.G.'s wound on June 12, 2001, and noted that it was scabbed and red around the edges. Ms. Treakle concluded that this redness alone indicated that the wound was infected. This conclusion is undermined by the notation in the wound care instructions included with E.G.'s

prescription from the Dermatology Center that "[s]ome redness and swelling are normal in the immediate area of the wound." Furthermore, Ms. Treakle did not follow E.G.'s wound after June 12, 2001, and the evidence presented by Life Care that E.G.'s wound healed in a timely manner is uncontroverted.

27. AHCA has established clearly and convincingly that there are several omissions in the documentation of Life Care's monitoring of E.G.'s blood, but these omissions do not reasonably support the inference that Life Care failed to monitor E.G.'s blood sugar and administer insulin on these dates as required by the physician's orders; rather, Life Care's failure on these occasions was inadequate documentation, not inadequate care.

28. AHCA has, however, established clearly and convincingly that Life Care did not monitor E.G.'s blood sugar as required by his physician's order at 11:30 a.m. on June 7, 2001; this inference may reasonably be drawn based on the lack of documentation and E.G.'s elevated blood sugar at the next check at 4:30 p.m. Ms. Treakle assumed that E.G. suffered actual harm as a result of this omission because, in her view, hyperglycemia, or elevated blood sugar, always causes damage to the body; Ms. Treakle could not, however, identify any specific harm to E.G. caused by this one omission. AHCA has failed to establish by even the greater weight of the evidence that E.G.'s

physical well-being was compromised by Life Care's failure to monitor his blood sugar on this one occasion.

Resident N.D.

Fall from Shower Chair.[8]

29. At the times pertinent to these proceedings, N.D. was a 79 year-old woman who had been a resident of Life Care since October 26, 1999. According to the assessment of N.D. included in the Minimum Data Set completed on May 3, 2001, N.D. suffered from Alzheimer's disease, had long- and short-term memory problems, and was severely impaired and unable to make decisions; as of June 12, 2001, N.D. was almost entirely dependent on staff for all of the activities of daily living. N.D.'s Care Plan for November 6, 2000, which was updated with handwritten notes, reflects that she had poor safety awareness.

30. The Interdisciplinary Notes maintained by Life Care reflect that, on June 5, 2001, a nurse observed N.D. leaning forward in her wheelchair at breakfast; this was the first mention of this behavior in N.D.'s chart. Dr. Gil, N.D.'s physician, included a notation in the Physician's Progress Notes for June 8, 2001, that he observed N.D. leaning forward but was unable to assess her abdomen because of her anxiety. The Interdisciplinary Notes reflect that Dr. Gil visited N.D. on Saturday, June 9, 2001, and that she was again leaning forward in her wheelchair, "almost falling out of [her] chair." Dr. Gil

ordered an ultra-sound of N.D.'s abdomen and a "lap buddy while in w/c [wheelchair] to prevent falls." Dr. Gil's order was noted in the Interdisciplinary Notes for June 9, 2001, as well as on a physician's order form signed by Dr. Gil on June 10, 2001.

31. According to Life Care's written policy, physician orders are to be transcribed into a patient's care plan, treatment plan, or medication administration record, depending on the nature of the order. Dr. Gil's order for a lap buddy had not been transcribed into N.D.'s November 6, 2000, Care Plan at the time Ms. Treakle conducted her survey on June 12, 2001.[9]

32. A lap buddy was used on N.D.'s wheelchair beginning on the morning of June 11, 2001.

33. On the evening of June 11, 2001, CNA Nova Coleman was caring for N.D. Ms. Coleman had been working for Life Care for only a short time, and N.D. was one of the first patients Ms. Coleman cared for after finishing her initial training. Ms. Coleman was, however, not an inexperienced CNA, having previously worked at another nursing home.

34. At approximately 8:30 p.m., Ms. Coleman and another CNA had just finished showering N.D., and N.D. was sitting in a shower chair; her hair had been toweled dry, and she was dressed in her night clothes. The second CNA left the room, and Ms. Coleman, who had been standing in front of N.D., moved to

the back of the shower chair so she could push N.D. out of the shower area. As she moved around the chair, N.D. pitched forward and fell face-first onto the floor. Ms. Coleman tried to grab N.D. to stop her from falling, but N.D. toppled over so quickly that Ms. Coleman could not reach her. N.D. suffered severe bruises to her face and a laceration on her lip as a result of the fall, but she did not break any bones.

35. Ms. Coleman had not been advised prior to the fall of N.D.'s tendency to lean forward in her chair.

36. N.D.'s tendency to lean forward in her wheelchair should have been entered in her Care Plan, together with the requirement that a lap buddy was to be used whenever she was in a wheelchair. In addition, Ms. Coleman should have been briefed on N.D.'s condition, including her tendency to lean forward, before Ms. Coleman was allowed to care for N.D. Although a lap buddy was not ordered for the shower chair and, in fact, could not appropriately have been used on a shower chair, the former Nursing Director of Life Care conceded that there were other means by which N.D.'s fall could have been prevented.[10] The former Nursing Director also conceded that the failure to brief Ms. Coleman on N.D.'s condition probably contributed to the fall from the shower chair.

Summary.

37. AHCA has established clearly and convincingly that Life Care failed to provide N.D. with the services necessary to prevent her from falling from the shower chair and injuring herself, that Life Care failed to provide services that met professional standards, and that Life Care failed to revise N.D.'s Care Plan to include the risk of her falling forward while seated and the approaches Life Care would take to prevent her from injuring herself. Life Care conceded that the Care Plan should have included N.D.'s tendency to lean forward while seated and Dr. Gil's order of June 9, 2001, that N.D. be provided with a lap buddy when she was in the wheelchair. Life Care also conceded that the CNA should have been briefed on N.D.'s condition before she was assigned to care for N.D. Life Care further conceded that, even though Dr. Gil did not specifically prescribe a restraint to be used in the shower chair, measures could have been taken to ensure that N.D. did not fall out of the shower chair.

38. AHCA has also established clearly and convincingly that Life Care's failure to provide proper care to N.D. resulted in her suffering significant injuries to her face. Although the injuries were to soft tissue and ultimately healed, N.D.'s physical well-being was adversely affected. In addition, AHCA has established clearly and convincingly that, even had N.D. not

fallen and suffered injuries, the failure to include in N.D.'s Care Plan her tendency to lean forward and its failure to transcribe the physician's orders regarding the lap buddy into the Care Plan could have caused a lapse in the care provided to N.D. that could have possibly resulted in injury.

CONCLUSIONS OF LAW

39. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2001).

40. Section 400.19(1), Florida Statutes, grants AHCA the authority to inspect a nursing home facility in response to a complaint, and AHCA is directed in Section 400.23(2), Florida Statutes, to adopt rules that

> include reasonable and fair criteria in relation to:
>
> * * *
>
> (f) The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof, based on rules developed under this chapter and the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203)(December 22, 1987), Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended.

41. Rule 59A-4.1288, Florida Administrative Code, provides in pertinent part:

> Nursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 CFR 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference. . . .[11]

Therefore, for nursing home facilities certified to participate in the federal Medicare and/or Medicaid programs, AHCA classifies deficiencies with respect to the requirements of Title 42, Sections 483.10 through .75, Code of Federal Regulations, using federal tag numbers to designate the nature of the particular deficiencies. See Rule 59A-4.128(1), Florida Administrative Code.

42. AHCA also classifies deficiencies identified in a facility survey in accordance with the criteria set forth in Section 400.23(8), Florida Statutes, as Class I, Class II, or Class III deficiencies. Relevant to the May 9, 2001, survey, a Class III deficiency is defined in Section 400.23(8)(c), Florida Statutes (2000), as one which has "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."[12] Relevant to the June 12, 2001, survey, a Class II deficiency is defined in Section 400.23(8)(b), Florida Statutes (2001), as one which "has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychological well-being, as defined by an

accurate and comprehensive resident assessment, plan of care, and provision of services"; a Class III deficiency is defined in Section 400.23(8)(c), Florida Statutes (2001), as one which "will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychological well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services."

Standards of Proof.

43. AHCA, as the party seeking to reduce Life Care's licensure status and impose an administrative fine, bears the burden of proof in both DOAH Case No. 01-3148 and DOAH Case No. 01-4649. See Board of Trustees of the Northwest Florida Community Hospital v. Department of Management Services, Division of Retirement, 651 So. 2d 170, 172 (Fla. 1st DCA 1995)(Burden of proof is on the party seeking to change the status quo.)

44. In DOAH Case No. 01-3148, AHCA seeks to reduce Life Care's licensure status from standard to conditional and, therefore, bears the burden of proving the allegations in the Administrative Complaint by a preponderance of the evidence. See Section 120.57(1)(j), Florida Statutes (2001)("Findings of fact shall be based upon a preponderance of the evidence, except

in penal or licensure disciplinary proceedings or except as otherwise provided by statute, . . ."); cf. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996)(The "clear and convincing evidence" standard applies when agency seeks to suspend or revoke a license.)

45. In DOAH Case No. 01-4649, AHCA seeks to impose an administrative fine on Life Care, and, therefore, AHCA bears the burden of proving the allegations in the Administrative Complaint by clear and convincing evidence. See Osborne Stern, 670 So. 2d at 932-33 (Fla. 1996)(The "clear and convincing evidence" standard applies when agency seeks to impose an administrative fine.)

Administrative Complaints.

46. The allegations in both of the Administrative Complaints at issue herein are identical, with the only difference in the two complaints being the remedy sought. It is, therefore, not practical to deal separately with the factual allegations supporting AHCA's proposed actions, and, in the interest of efficiency, the allegations in the two administrative complaints will be treated together. In addition, applying different standards of proof in weighing the sufficiency of the evidence presented herein is problematic. Nonetheless, the quantity and the quality of the evidence have

been carefully considered in determining whether AHCA has met its differing burdens of proof in these cases.

Count I.

47. In Count I of the Administrative Complaints, AHCA charged that, at the time of the June 12, 2001, survey, Life Care had a Class II deficiency with respect to the care given E.G. and N.D., based on alleged violations of Section 400.022(1) and Section 483.13(c), Code of Federal Regulations. In the Form 2567, these violations were grouped under the federal tag number "F-224."

48. Section 400.022(1)(l), Florida Statutes (2001), provides that one of the rights of residents of nursing home facilities is

> [t]he right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

49. Section 483.13(c), Code of Federal Regulations, contains a number of separate provisions, and AHCA did not identify in the Administrative Complaints the provision that Life Care had allegedly violated. However, in the Form 2567 for the June 12, 2001, survey, AHCA specifically cited Life Care for

a violation of Section 483.13(c)(1)(i), Code of Federal Regulations, which provides that "[t]he facility must develop and implement written policies that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."

50. Section 488.301, Code of Federal Regulations, defines "neglect" as the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

51. According to the Administrative Complaints, Life Care failed to monitor and supervise the delivery of care and services to E.G. with respect to wound care and blood sugar monitoring and to N.D. with respect to care and supervision to prevent falls. Based on the findings of fact herein, AHCA has proven by clear and convincing evidence that Life Care failed to provide services to both E.G. and N.D. that were necessary to avoid physical harm, and Life Care, therefore, violated Section 483.13(c)(1)(i), Code of Federal Regulations.

52. However, based on the findings of fact herein, AHCA did not prove by even a preponderance of the evidence that E.G.'s "ability to maintain or reach his . . . highest practicable physical . . . well-being" was compromised because of Life Care's failure to treat the wound on his left hand, its failure to monitor E.G.'s blood sugar on one occasion, and its

failure to document the insulin dosage administered and the site of the injection on a few occasions. Life Care's violation with respect to the care given E.G. should be classified as a Class III deficiency under Section 400.23(8)(c), Florida Statutes (2001).

53. On the other hand, based on the findings of fact herein, AHCA has proven by clear and convincing evidence that N.D.'s "ability to maintain . . . her highest practicable physical . . . well-being" was compromised because N.D. suffered significant, though transient, adverse effects as a result of Life Care's failure to advise Ms. Coleman of N.D.'s tendency to lean forward in her chair and to provide services that would have protected N.D. from falling from the shower chair.[13] Life Care's violation with respect to the care given N.D. should be classified as a Class II deficiency under Section 400.23(8)(b), Florida Statutes (2001). Accordingly, because of the injuries suffered by N.D., Life Care's violation of Section 483.13(c)(1)(i), Code of Federal Regulations, is properly classified overall as a Class II deficiency.

Count II.

54. In Count II of the Administrative Complaints, AHCA charged that, at the time of the June 12, 2001, survey, Life Care had a Class III deficiency with respect to the care given N.D., based on an alleged violation of Rule 59A-4.109(2),

Florida Administrative Code, and of Section 483.20(k), Code of Federal Regulations. In the Form 2567, this violation was identified under the federal tag number "F-279."

55. Rule 59A-4.109(2), Florida Administrative Code, provides as follows:

> (2) 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 practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.

The provisions of Section 483.20(k), Code of Federal Regulations, are virtually identical to those of Rule 59A-4.109(2), Florida Administrative Code.

56. According to the Administrative Complaints, Life Care failed to satisfy this requirement because, pertinent to these proceedings, "[b]ased on review of the care plan for resident #1 [N.D.], . . . resident #1['s] [N.D.'s] care plan was not revised to reflect all fall risks." Based on the findings of fact herein, AHCA has proven by clear and convincing evidence that Life Care failed to include in N.D.'s Care Plan information regarding her newly-acquired tendency to lean forward in her wheelchair and the physician's order to use a lap buddy while

she was in the wheelchair, and Life Care, therefore, violated Rule 59A-4.109(2), Florida Administrative Code, and Section 483.20(k), Code of Federal Regulations. Because this failure was one of documentation only and did not, of itself, result in N.D.'s suffering injuries, Life Care's violation is properly classified as a Class III deficiency under Section 400.23(8)(c), Florida Statutes (2001).

Count III.

57. In Count III of the Administrative Complaints, AHCA charged that, at the time of the June 12, 2001, survey, Life Care had a Class II deficiency with respect to the care given E.G. and N.D., based on alleged violations of Section 483.20(k)(3)(i), Code of Federal Regulations. In the Form 2567, these violations were grouped under the federal tag number "F-281."

58. Section 483.20(k)(3)(i), Code of Federal Regulations, provides that "[t]he services provided or arranged by the facility must meet professional standards of quality." According to the Administrative Complaints, Life Care failed to satisfy this requirement with respect to the care provided E.G. and N.D. because "the nursing staff failed to provide wound care and blood sugar monitoring as ordered by the physician for resident #2 [E.G.]" and because "the nursing staff did not have a comprehensive care plan, did not provide [an] assistive device

as ordered by the physician, and did not provide supervision required to prevent falls for resident #1 [N.D.]."

59. Based on the findings of fact herein, AHCA has proven by clear and convincing evidence that, with respect to E.G., Life Care failed to provide wound care and monitor his blood sugar as ordered and that, with respect to N.D., Life Care was required by professional standards to advise Ms. Coleman that N.D. had a tendency to lean forward in her wheelchair before allowing Ms. Coleman to care for N.D. and to take some measures to prevent N.D. from falling from the shower chair. Life Care, therefore, violated Section 483.20(k)(3)(i), Code of Federal Regulations.

60. For the reasons stated in paragraph 52 above, Life Care's violation with respect to the care given E.G. should be classified as a Class III deficiency under Section 400.23(8)(b), Florida Statutes (2001). However, for the reasons stated in paragraph 53 above, Life Care's violation with respect to the care given to N.D. should be classified as a Class II deficiency under Section 400.23(8)(b), Florida Statutes (2001). Accordingly, because of the injuries suffered by N.D., Life Care's violation of Section 483.20(k)(3)(i), Code of Federal Regulations, is properly classified overall as a Class II deficiency.

Licensure reduction.

61. In DOAH Case No. 01-3148, based on the results of the June 12, 2001, survey, AHCA issued a conditional license to Life Care, effective from June 12, 2001, to August 17, 2001.[14] Pursuant to Section 400.23(7)(b), Florida Statutes (2001),

> [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 this part or with rules adopted by the agency. If the facility has no class I, class II, or class III deficiencies at the time of the followup survey, a standard license may be assigned.

62. Because Life Care had two Class II deficiencies cited as a result of the June 12, 2001, survey, its licensure status was properly reduced from standard to conditional for the period extending from June 12, 2001, to August 17, 2001.

Administrative fine.

63. In DOAH Case No. 01-4649, AHCA seeks to impose an administrative fine on Life Care in the amount of $7,000.00, based on the results of the June 12, 2001, survey. Section 400.23(8), Florida Statutes (2001), provides in pertinent part:

> b) . . . A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread

> deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine shall be levied notwithstanding the correction of the deficiency.
>
> (c) . . . A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A citation for a class III deficiency must specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed.

64. The amendment to Section 400.23, Florida Statutes, effective May 15, 2001, also provides in Section 400.23(8) as follows:

> The agency shall adopt rules to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency. The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a

> very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents.

65. There is no indication of the scope of the deficiencies cited in the Form 2567 for the June 12, 2001, survey. Based on the findings of fact herein, however, it is clear that the deficiencies involving the care given to E.G. and N.D. were isolated and not patterned or widespread.

66. Because Life Care had two isolated Class II deficiencies at the time of the June 12, 2001, survey, an administrative fine of $2,500.00 for each Class II deficiency is appropriate pursuant to Section 400.23(8)(b), Florida Statutes (2001).

67. AHCA also seeks to impose an administrative fine on Life Care for the allegedly "uncorrected" Class III deficiency derived from Life Care's violation of Rule 59A-4.109(2), Florida Administrative Code, and Section 483.20(k), Code of Federal Regulations, relating to N.D.'s Care Plan, which was identified under F-279. AHCA asserts in the Administrative Complaint that

this Class III deficiency is "uncorrected" because Life Care was cited in the May 9, 2001, survey for a Class III deficiency identified under F-279 and based on a violation of the same requirements.

68. In the May 9, 2001, survey, AHCA cited Life Care for a Class III deficiency because it did not include in the Care Plans of L.D. and A.M. any mention of the amount of time they would be permitted to sit in a wheelchair. However, based on the findings of fact herein, AHCA has failed to prove by clear and convincing evidence that Life Care violated Rule 59A-4.109(2), Florida Administrative Code, and Section 483.20(k), Code of Federal Regulations, with respect to these omissions in L.D.'s and A.M.'s Care Plans.

69. Accordingly, the Class III deficiency cited as a result of the June 12, 2001, survey is not an "uncorrected" Class III deficiency, and AHCA cannot impose an administrative fine on Life Care for this deficiency because, pursuant to Section 400.23(8)(c), Florida Statutes (2001), an administrative fine for a Class III deficiency can only be imposed if the deficiency is not corrected within the time specified by AHCA.[15]

70. Finally, AHCA has requested an award of "reasonable attorney's fees, expenses, and costs pursuant to 400.121(10), Fla. Stat." The section provides that AHCA may assess certain specified costs "in any final order that imposes sanctions." No

proof was submitted with respect to costs, and, even if such proof had been submitted, it does not appear that the Division of Administrative Hearings has jurisdiction to recommend such an award. Accordingly, no recommendation is included herein with respect to this request.

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

1. Sustaining the reduction in the licensure status of Life Care Center of Port Saint Lucie to conditional for the period extending from June 12, 2001, to August 17, 2001; and

2. Imposing an administrative fine in the amount of $5,000.00.

DONE AND ENTERED this 15th day of May, 2002, in Tallahassee, Leon County, Florida.

PATRICIA HART MALONO
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of May, 2002.

ENDNOTES

[1/] The federal "tag numbers" correspond to specific provisions of the regulations found in Title 42, Chapter 483, Code of Federal Regulations, which are incorporated into the Florida standards for the "care, treatment, and maintenance of residents and measurements of the quality and adequacy thereof" in Section 400.23(2)(f), Florida Statutes (2001).

[2/] The results of the May 9, 2001, survey are relevant to these proceedings only insofar as AHCA seeks to impose an administrative fine on Life Care for an alleged "uncorrected" Class III deficiency in the June 12, 2001, survey.

[3/] Pressure ulcers are rated according to their seriousness, with Stage IV being the most serious.

[4/] The only evidence of the contents of L.D.'s Care Plan offered by AHCA was a set of notes prepared by Ms. Treakle during her May 9, 2001, survey. The notes included what purported to be the approaches in L.D.'s Care Plan for healing his pressure sores. A hearsay objection was made to the admission of these notes into evidence; the notes were received as Petitioner's Exhibit 39, subject to the limitations on the use of hearsay in Section 120.57(1)(c), Florida Statutes. No additional evidence was submitted to establish the contents of L.D.'s Care Plan, and the notes made by Ms. Treakle cannot provide the basis for a finding of fact as to its contents.

[5/] The federal standard on which Ms. Treakle relies provides that, if the pressure on a pressure ulcer can be totally relieved, a resident can sit up for a limited time.

[6/] Transcript at page 75.

[7/] The Medication Record included a schedule for monitoring E.G.'s blood sugar at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9:00 p.m.

[8/] In the Administrative Complaints, AHCA included as grounds for the deficiencies cited under F-224, F-279, and F-281 the presence of minor skin tears and bruises on N.D.'s arms and legs. At the final hearing, counsel for AHCA stated that AHCA was "not using the findings [in the Form 2567] on the skin tears on N[] to support Tag 224. It was included in the administrative complaint, but I believe that we did not present evidence as to that and we are not going to." No evidence was

presented by AHCA with respect to the skin tears and bruises, and no mention of skin tears and bruises was made in AHCA's Proposed Recommended Order. Accordingly, it is concluded that AHCA abandoned the skin tears and bruises as an additional factual basis to support F-224, F-279, and F-281.

[9/] The typed portion of the Care Plan is dated November 6, 2000, but it is updated with hand-written notes, as necessary. The entry requiring a lap buddy on N.D.'s wheelchair was added on June 12, 2001.

[10/] Such means would not include a gate belt as suggested by Ms. Treakle. A gate belt is buckled around a resident's body and is used by staff to assist in transferring residents and to assist them in ambulating; its purpose is to provide something for the staff person and the resident to hold onto. Had N.D. been secured to the shower chair by a gate belt, she would have toppled forward and would also have pulled the shower chair over on top of her.

[11/] Although there is no proof in the record that Life Care participates in the Medicare and Medicaid programs, the parties proceeded on the assumption that the provisions of Title 42, Chapter 483, Code of Federal Regulations, were applicable in these cases.

[12/] Chapter 400, Part II, Florida Statutes, was amended effective May 15, 2001. The results of the May 9, 2001, survey are governed by Chapter 400, Part II, Florida Statutes (2000), and the results of the June 12, 2001, survey are governed by Chapter 400, Part II, Florida Statutes (2001).

[13/] Life Care argues that, because the injuries to N.D.'s face eventually healed and had no permanent effect on her physical well-being, the deficient practice had only a limited consequence and should, therefore, not be classified as a Class II deficiency. This argument is rejected: The provision of the federal Survey Procedures for Long Term Care Facilities on which Life Care relies for this argument, Section V.B.3. in Respondent's Exhibit 12, makes it clear that the "limited consequence" exception applies only when the harm to the resident is minimal or the harm is potential and not yet realized; the harm to N.D. was realized and was substantially more than minimal.

[14/] The parties did not introduce any evidence at the hearing to establish the duration of the conditional licensure status. The duration is, however, included in the conditional license issued to Life Care, a copy of which was attached to the Motion for Leave to Serve Administrative Complaint filed by AHCA on October 9, 2001.

[15/] AHCA did not present any evidence to establish that the Class III deficiency cited in the June 12, 2001, survey was not corrected timely.

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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.