STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

THE HEALTHCARE CENTER OF NAPLES, d/b/a THE ARISTOCRAT,

Petitioner,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

Case No. 02-0049

RECOMMENDED ORDER

Pursuant to notice, a formal hearing in this case was held on March 28 and 29, 2002, in Naples, Florida, before Carolyn S. Holifield, a duly-designated Administrative Law Judge, of the Division of Administrative Hearings.

APPEARANCES

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For Respondent: Dennis L. Godfrey, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether the alleged deficiency cited in the October 2001 survey report existed and, if so,

whether the deficiency is sufficient to support the change in the Aristocrat's licensure status from standard to conditional.

PRELIMINARY STATEMENT

By letter dated October 23, 2001, the Agency for Health Care Administration (Agency) advised The Health Care Center of Naples, d/b/a The Aristocrat (The Aristocrat) that its licensure rating was changed to conditional, effective October 10, 2001, as a result of the survey completed on October 10, 2001. According to the letter, the basis for the change in licensure status was that, during the survey, The Aristocrat was cited for two Class II deficiencies. Only one of those deficiencies is the subject of this proceeding. With regard to that deficiency, the Agency alleged that the deficiency was the result of The Aristocrat's "fail[ing] to adequately assess and develop a plan of care to maintain acceptable nutritional parameters for a resident resulting in significant weight loss." The Aristocrat challenged the conditional rating and timely filed a Petition for Formal Administrative Hearing. On December 27, 2001, the Agency referred the matter to the Division of Administrative Hearings for assignment of an Administrative Law Judge to conduct the final hearing.

Prior to the hearing, on March 22, 2002, the Agency filed an Unopposed Motion for Leave to Serve Administrative Complaint (Unopposed Motion). The Unopposed Motion was granted pursuant

to the Order issued March 26, 2002. In the one-count Administrative Complaint, the Agency, again, alleges that The Aristocrat "failed to ensure that a resident maintain[ed] acceptable parameters of nutritional status" in violation of Rule 59A-4.1288, Florida Administrative Code, which adopts by reference 42 C.F.R. 483.25(i)(1). The Administrative Complaint also seeks to assess The Aristocrat for costs related to the investigation and prosecution of this case pursuant to Subsection 400.121(10), Florida Statutes.

At hearing, the Agency presented the testimony of Timothy Elias, an Agency health facility evaluator and survey team coordinator, and Lori H. Riddle, a registered dietician and a public health nutrition consultant with the Agency. The Agency submitted 24 exhibits, which were received into evidence. The Aristocrat presented the testimony of John Patrick Lewis, M.D., and Janet F. McKee, a registered and licensed dietician, who was accepted as an expert in dietetics. The Aristocrat submitted three exhibits, which were received into evidence.

At the conclusion of the hearing, the time for filing proposed recommended orders was set for 10 days after the transcript of the hearing was filed. A Transcript of the proceedings was filed on April 29, 2002. Upon the request of the Agency, the time for filing proposed recommended orders was

extended to May 20, 2002. Both parties timely filed Proposed Recommended Orders.

FINDINGS OF FACT

1. The Agency is the state agency responsible for licensing and regulating nursing facilities in the State of Florida under Part II, Chapter 400, Florida Statutes.

2. The Aristocrat (The Aristocrat or facility) is a nursing home located at 10949 Parnu Street, in Naples, Florida, licensed by and subject to regulation by the Agency pursuant to Part II, Chapter 400, Florida Statutes.

3. The Agency conducted an annual survey of The Aristocrat from October 8 through 10, 2001. The results of the survey are summarized in a report known as the 2567 report.

4. The 2567 report identifies each alleged deficiency by reference to a tag number ("Tag"). Each Tag of the 2567 report includes a narrative description of the alleged deficiency and cites the relevant rule or regulation violated thereby.

5. The Tag at issue in this proceeding is Tag F 325.

6. Tag F 325 relates to quality of care and references 42 C.F.R. 483.25(i)(l), which requires that, "[b]ased on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the

resident’s clinical condition demonstrates that this is not possible.”

7. The standard in 42 C.F.R. 483.25(i)(1) is made applicable to nursing homes in Florida pursuant to Rule 59A-4.1288, Florida Administrative Code.

8. The Agency is required to rate the severity of any deficiency pursuant to the classification system outlined in Section 400.23(7), Florida Statutes. The Agency assigned a Class II rating to the deficiency as well as “scope and severity” of G pursuant to federal law. The state classification is at issue in this case.

9. A Class II deficiency is one which “the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services." Section 400.23(8)(b), Florida Statutes.

10. When the Agency alleges that there is a Class II deficiency, as it did in this case, the Agency may change the facility’s licensure rating from standard to conditional. In accordance with its authority and discretion, based on the alleged Tag F 325 deficiency, the Agency changed The Aristocrat’s nursing home licensure rating from standard to conditional, effective October 10, 2001.

11. During the October survey, an Agency surveyor reviewed the clinical records of six residents at The Aristocrat. The Tag F 325 deficiency was based on the Agency's findings related to the records of one of those six residents and on interviews with facility staff.

12. In order to protect the privacy of the nursing home resident who is the subject of the alleged deficiency, the Administrative Complaint, the 2567 report, and this Recommended Order refer to the resident by number rather than by name.

13. As a result of the surveyors' review of the records, the Agency determined that one of the residents, Resident 1, had a weight loss of 7.2 pounds between July 30, 2001, and August 11, 2001. The surveyors' review of Resident 1's records further reflected that she had a total weight loss of 13.5 pounds between July 30, 2001, and August 25, 2001. According to the resident's weight records and nutritional assessment, which listed the resident's usual body weight as 136 pounds, the surveyors considered the weight loss during the aforementioned periods to be significant.

14. Once the surveyors concluded that Resident 1 had a significant weight loss, the surveyors had to determine whether the resident's weight loss was avoidable. In making this determination, the surveyors had to determine whether the

facility assessed the resident adequately, developed a care plan, implemented the care plan, and reevaluated the care plan.

15. Applying the Agency's protocol set forth in the above paragraph, the surveyors determined that the significant weight loss experienced by Resident 1 was avoidable. The Agency surveyors found that the facility failed to do the following: adequately assess and develop a plan of care to prevent Resident 1 from significant weight loss; assess and develop an adequate care plan after the resident had a significant weight loss of 5.3 percent of her body weight in less than two weeks; and adequately assess, evaluate and revise the care plan to address the resident's significant weight loss of 9.9 percent of her body weight in less than a month.

16. According to the 2567 report and the Administrative Complaint, the nutritional parameter that the Agency alleges the facility did not maintain for Resident 1 was weight loss. The Agency was concerned that Resident 1's weight dropped from 136 pounds on July 30, 2001, to 128.8 pounds on August 11, 2001, which was a 5.3 percent loss of her body weight, upon admission to the facility. Also, the Agency was concerned that the resident's weight dropped from 136 pounds on July 30, 2001, to 122.5 pounds on August 25, 2001, a 9.9 percent loss of her body weight, upon her admission to the facility. The Agency alleges

that the failure to assess and develop an adequate care plan to address weight loss caused the referenced weight loss.

17. Resident 1, a 92-year-old female, was admitted to The Aristocrat on July 30, 2001, at about 3:00 p.m. Her diagnosis included a left hip fracture, left shoulder fracture, atrial fibrillation, esophageal reflux, depression, bipolar disorder, hypertension, and chronic insomnia.

18. John Patrick Lewis, M.D., was Resident 1's treating physician at the time of and throughout her three-month stay at The Aristocrat. Upon Resident 1's admission to the facility, Dr. Lewis had "great concern" about the resident's atrial fibrillation because of her history of T.I.A.s (strokes). As a result of this concern, Dr. Lewis consulted with and reviewed the medical records of Dr. Drew, Resident 1's primary physician.

19. Resident 1's weight dropped from 136 pounds on July 30, 2001, to 134.8 pounds on July 31, 2001, to 133 pounds on August 4, 2001, to 128.8 pounds on August 11, 2001. Resident 1's weight began to level off on August 15 or 16, 2001, when edema was no longer noted on her records. Thereafter, beginning on August 19, 2001, the resident's weight began to stabilize. Resident 1 weighed 124.2 pounds on August 19, 2001; 122.5 pounds on August 25, 2001; 122.7 pounds on September 7, 2001; 121.2 pounds on September 14, 2001; 122.2 pounds on September 21,

2001; 121.6 pounds on September 28, 2001; and was 120.3 pounds on October 6, 2001.

20. Resident 1 came to The Aristocrat days following major surgery of her hip after she suffered a fracture of her hip and shoulder. Resident 1 was hydrated with fluids prior to and/or during the operation to ensure that she maintained a good blood pressure. As a result thereof, at the time Resident 1 was admitted to The Aristocrat, she had an increased amount of fluids in her body and was over-hydrated.

21. The over-hydration caused Resident 1 to have swelling, known as edema. Dr. Lewis testified that Resident 1's edema was actually third space fluids, which are fluids that go extravascularly into the soft tissues or into the peritoneal cavity. It typically takes a period of 7-14 days for that fluid to return to the intravascular compartment and then be urinated away.

22. At the time of her admission at The Aristocrat and throughout her stay there, Resident 1 was on a medication known as Lasix, which is a diuretic that causes the body to urinate excess fluids. Lasix was included in Resident 1’s discharge orders from the hospital where she had surgery for her hip fracture and was never discontinued. In Dr. Lewis’ opinion, there was no need to discontinue the Lasix because the resident was never dehydrated during her stay at The Aristocrat.

Moreover, Dr. Lewis is aware that in addition to being a diuretic, Lasix is sometimes prescribed for high blood pressure and this may have been another reason Lasix was included in the resident's discharge orders.

23. The presence of edema in Resident 1 was clearly noted in her chart by facility staff at or near the time she was admitted to the facility. The reference to Resident 1's edema is included in the nurse’s notes dated July 30, 2001, nurse’s notes dated July 31, 2001, a registered dietician's note dated August 1, 2001, and a physical therapy note dated July 31, 2001. The nurse’s notes dated July 30, 2001, the date Resident 1 was admitted to the facility, state that “2 plus edema noted on left upper extremity.” Another document in Resident 1's chart, dated July 31, 2001, states, “2 plus edema on left hip, incision site.” The nutritional assessment dated August 1, 2001, two days after Resident 1 was admitted to the facility, notes edema in lower and upper extremities and “some weight loss expected.” Finally, a dietary note dated August 1, 2001, mentions Resident 1’s edema, but does not mention the location of the edema.

24. The Aristocrat staff did not note Resident 1’s edema on her initial Minimum Data Set form (MDS) as preferred by the Agency. However, the resident’s edema was charted in several places in her records.

25. The Agency's surveyor acknowledged that Dr. Lewis saw Resident 1 on August 11, 2001, when her weight had dropped from 136 pounds to 128.8 pounds and did not instruct The Aristocrat's staff to alter their approach to providing adequate nutrition to Resident 1. The reason Dr. Lewis did not order that any changes be made for Resident 1 on August 11, 2001, was that he believed that none were required or necessary in that "the majority of this weight loss was to be expected." According to Dr. Lewis, "this weight loss [was] not unexpected due to her excessive hydration and third space fluids."

26. The Agency's initial concern was Resident 1's weight loss, during the period of July 30, 2001, through August 11, 2001, when she lost 7.2 pounds, or 5.3 percent of her weight at the time of her admission to the facility.

27. Surveyors are instructed to use a resident's "usual body weight" to make weight loss calculations. When calculating weight loss, the usual body weight is determined by considering the person's weight through adult life. According to the state's guidelines, an analysis of weight loss or gain should be examined in light of the individual's former life style, as well as current diagnosis.

28. The medical records of Dr. Drew, Resident 1's primary physician, indicate that Resident 1 weighed 127 pounds on January 31, 2001, and weighed 125 pounds on June 8, 2001. In

light of the undisputed fact that Resident 1 was over-hydrated at the time she weighed 136 pounds, it is reasonable to assume that her weight in the months and weeks prior to surgery would be more appropriate figures to use as the resident's usual body weight.

29. Based on her 5'0" height, Resident 1's ideal weight was 100 pounds, the midpoint between the ideal weight range of 90 to 110 pounds for someone five feet tall. In fact, were 136 pounds Resident 1's true weight, she would be considered clinically obese.

30. The Agency surveyor based his calculations that Resident 1 had a significant weight loss on the assumption that the resident’s usual body weight was 136 pounds. The surveyor obtained the 136-pound weight as the resident’s usual body weight from the facility’s nutritional assessment.

31. The Aristocrat incorrectly listed the resident’s weight upon admission, 136 pounds, as her usual body weight. Even if it is assumed that the Agency reasonably relied on the facility’s records that note Resident 1’s usual weight as 136 pounds, the calculations using this weight are flawed because that is not Resident 1’s usual body weight.

32. Had the Agency based its calculations relative to the resident’s weight loss on her usual body weight of 125 pounds, a drop in weight from 125 pounds to any of Resident 1's charted

weights would not be “significant” according to surveyor guidelines.

33. One can lose 10 pounds of water weight in just a couple of days but one must burn calories to lose body weight. There are 3,500 calories in a pound. Therefore, in order lose one pound of body mass, a person would need to burn 3,500 calories.

34. Resident 1 lost one pound each day for the first three days she was at The Aristocrat. In order to lose three pounds of body mass, Resident 1 would need to burn 10,500 calories. At the time of her admission to The Aristocrat, Resident 1 was 92 years old and, for the first two weeks she was at the facility, was bed-bound, with a fractured hip and shoulder. Given Resident 1’s condition, it is reasonable to assume that she burned minimal calories.

35. It was physiologically impossible for Resident 1 to lose true body weights in the amounts quoted in the 2567 report. Resident 1 dropped from 136 pounds down to 134.8 pounds the next day and then down to 133 pounds the following day. Because it is impossible to lose a pound of actual body weight in one day, the recorded weight loss for Resident 1 was too rapid to be true weight loss. Rather, the resident's initial weight loss was the result of a decrease in her edema.

36. In determining that Resident 1 had a significant weight loss during the period of July 30 and August 11, 2001, the Agency surveyors based their calculations on an inaccurate usual body weight for the resident. Moreover, the Agency did not consider that the resident had edema and was taking Lasix, a diuretic, and that part of the weight loss could have been water weight. In fact, the 2567 report does not mention that the resident’s chart or records indicate that Resident 1 had edema and that a weight loss could be expected as the edema decreases. The Agency’s explanation for not doing so was that the facility’s records did not indicate or assess the amount of edema Resident 1 had upon her admission.

37. Even though Resident 1 was edematous, the facility staff appropriately addressed her weight issues and immediately began implementing nutritional interventions.

38. There are a number of complex factors at play in the selection and timing of appropriate interventions for a given resident. For example, there is a "warm-up time" to see how a new resident will adjust to the facility. It is not unusual for new residents to experience problems as a result of being in a new environment. However, after a couple of weeks, many of the new residents resolve their relocation issues and adjust to their new environment.

39. During the period of July 30 through August 11, 2001, The Aristocrat's staff engaged in numerous activities, which assessed Resident 1 from a nutritional standpoint, and immediately implemented interventions to enable her to maintain as much weight as possible.

40. On July 31, 2001, the day after Resident 1 was admitted to the facility, the occupational therapy staff evaluated Resident 1 to determine the level of supervision and set up assistance she needed while eating.

41. On August 1, 2001, two days after Resident 1 was admitted to The Aristocrat, the facility's registered dietician assessed Resident 1 and, as noted in paragraph 23, above, indicated that some weight loss would be expected as her edema decreased. That same day, the facility's registered dietician reviewed some of the resident's lab values that had been taken at the hospital from which Resident 1 had been released and also ordered a multi-vitamin for the resident.

42. On August 2, 2001, the day after the registered dietician completed a nutritional assessment of Resident 1, the facility's dietary manager met with Resident 1 to assess her food preferences and find out her likes and dislikes. During this meeting, the dietary manager learned that Resident 1 wanted coffee, with four packs of sugar, with all of her meals and a danish at breakfast. The danish is considered a specialty food

and is not one usually provided on a daily basis to residents in nursing home facilities such as The Aristocrat. However, upon learning of Resident 1’s food preferences, the facility immediately began providing her with a danish with her breakfast each morning and coffee with four sugars with each meal. The facility’s providing Resident 1 with the foods she requested was an appropriate intervention that honored her preferences.

43. The assessment described in paragraph 42 is consistent with the acceptable industry standard concerning nutritional issues of new residents. That standard requires facilities to analyze the resident for a number of days, determine their food preferences, and see if their nutritional and/or caloric needs can be met through food first. As such, using specialty foods such as a danish and coffee with sugar are appropriate interventions, which honored the resident's preferences.

44. Two additional assessments were performed within a week of Resident 1’s admission to the facility. First, on August 5, 2001, a restorative assessment was completed which addressed Resident 1's ability to use utensils and open her food. The next day, the speech therapy unit of the facility completed a swallowing screening that assessed Resident 1's dysphagia and ability to swallow.

45. Throughout the month of August, including August 11, 2001, and prior thereto, nurse’s notes regularly included

information concerning Resident 1’s appetite, food intake, necessary and/or recommended interventions, and other nutritional issues. For example, prior to August 12, 2001, at least two nurse’s notes indicated that Resident 1’s appetite was fair and another nurse’s note indicated that her appetite was poor. Two of the nurse’s notes for this time period indicated that that the resident needed encouragement with oral intake.

46. In addition to the aforementioned interventions implemented by The Aristocrat’s staff during August 2001, Dr. Lewis intervened numerous times with Resident 1. Because Resident 1's room was near the front of the facility, every time Dr. Lewis went into the facility he walked by her room and encouraged her to eat. Dr. Lewis also had numerous conversations with Resident 1's family to have them bring home cooked food that she would enjoy eating.

47. To the extent that Resident 1 did not maintain “acceptable” parameters of nutritional status, the weight loss was attributable to Resident 1's clinical condition and not any failure on the part of The Aristocrat’s staff. In addition to Resident 1's having edema, she had other clinical issues that may have contributed to her weight loss. These clinical conditions involve the resident's behavioral and emotional problems and certain medication that the resident was taking to relieve the pain she was experiencing following her surgery.

48. A person's behavior and emotional problems can have a considerable impact on the resident’s appetite and eating patterns. For example, a person, such as Resident 1, who suffered from depression and a bipolar disorder, may have a low appetite. In this case, Resident 1 suffered from depression and a bipolar disorder. These conditions may likely have been exacerbated by the resident's having to leave the assisted living facility in which she had lived prior to her surgery, going to a hospital for surgery, and, after being released from the hospital, having to be admitted to yet another nursing facility, The Aristocrat.

49. Resident 1 exhibited behavior problems from the beginning of her stay at The Aristocrat, as documented in her records.

50. During the first two weeks that Resident 1 was at the facility, staff of The Aristocrat documented some of the behaviors that the resident was exhibiting. The resident's MDS dated August 8, 2001, and the MDS dated August 13, 2001, indicate that Resident 1 was experiencing mood and behavior problems, on a daily basis, as reflected in her verbal expressions.

51. Resident 1's August 5, 2001, Social Work Assessment Report indicated that Resident 1 made negative statements almost daily and wanted to return to the assisted living facility. The

Social Work Assessment Report described the resident's medical conditions that interfered with her relationship skills as "sad mood, melancholy, anxieties, fear, [and] relocation issues." With regard to the resident's relationship involvement patterns, the report indicates that Resident 1 prefers solitude.

52. The Social Work Assessment Report of August 27, 2001, confirmed that Resident 1 made negative statements almost daily and was anxious and angry. The assessment report also noted that Resident 1 was in an unpleasant mood in the morning almost daily, that Resident 1 withdrew from activities almost daily and exhibited reduced social interaction almost daily. The same document indicated that Resident 1 preferred solitude, and demonstrated a sad mood, melancholy, anxieties, fear, and relocation issues.

53. The Behavior/Intervention Monthly Flow Chart Record for August 15 through August 31, 2001, indicates that Resident 1 yelled at staff and was uncooperative.

54. Finally, the care plan priority document for Resident 1 dated August 30, 2001, indicated that her anxiety may be secondary to anger, that her anger was persistent, and that she was verbally abusive to staff.

55. Undoubtedly, Resident 1's behavior and mood could have likely affected and inhibited her appetite, and, thus, contributed to some of the resident's weight loss. Yet, despite

the facility’s documentation concerning the resident's behavioral issues, the Agency apparently did not consider either the documentation or the statements by facility staff during the survey that Resident 1's behaviors interfered with some of the attempted nutritional interventions.

56. Another factor that may have contributed to the amount of food Resident 1 ate while at the facility was the medication she was taking. Resident 1 was on a regimen of Darvocet, a narcotic and pain medication, prescribed to help manage the pain she was experiencing as a result of the surgery and/or the hip and left shoulder fracture. Darvocet is a medication that inhibits a person's appetite. In this case, Resident 1 took approximately 30 doses of the narcotic pain reliever Darvocet during the first 10 or 12 days she was at The Aristocrat. Therefore, it is very likely that as a result of Resident 1's taking Darvocet, her appetite was inhibited and she ate less food than she may otherwise have eaten.

57. The Aristocrat’s staff provided numerous interventions for Resident 1 during her first 21 days in the nursing home. They analyzed her weight and food intake through the dietary and nursing units. They offered to assist her with intake and encouraged her to eat.

58. For example, CNA flow sheets for the month of August indicate that food and fluid were offered to Resident 1 approximately 10 times per day, usually five times during the 7-3 shift and five times during the 3-11 shift, every day. This was in addition to her regular meals, specialty foods such as coffee and danish and nutritional supplements. The snacks offered to Resident 1 were foods such as crackers and juice.

59. Staff continually assessed Resident 1's needs and added interventions throughout her stay. A "significant change" MDS was completed on August 13, 2001, which related to Resident 1's percentage of meals eaten and weight loss. On August 14, 2001, The Aristocrat’s staff completed a behavior flow record that addressed Resident 1's uncooperativeness.

60. On or about August 15, 2001, the facility developed a care plan for Resident 1 that included concerns about her weight loss after the initial weight loss due to resident’s loss of "water weight." The nutritional care plan included numerous approaches such as providing increased calories and encouraging intake of diet supplements and fluid. A nursing note of August 16, 2001, indicated that Resident 1's appetite was fair but improved to quite good while a note dated August 20, 2001, indicated that Resident 1 felt she was not getting good food.

61. Staff discussed Resident 1's many dietary dislikes at a weight meeting on August 22, 2001. In order to increase the

resident's caloric intake, the dietary manager added ice cream to Resident 1's diet at lunch and dinner.

62. On or about August 23, 2001, Dr. Lewis ordered Medpass, a nutritional supplement, for Resident 1. Pursuant to the order, the resident had two 120cc of the supplement daily. Each 120cc of Medpass has 240 calories. Five days later, on August 28, 2001, Dr. Lewis increased the amount of Medpass Resident 1 was to receive from two 120cc of Medpass to four 120cc of Medpass each day. This order was immediately implemented.

63. The goal of the nursing home is to provide 2,000 calories per day to a resident through food. After the first two weeks Resident 1 was at the facility, she consumed an average of 50 percent of her meals, which equaled approximately 1,000 calories per day. In addition, Resident 1 received 300 calories from her daily danish, 240 calories from her coffee with sugar, 300 calories from her daily ice cream, and 480 from Medpass, a nutritional supplement. This equaled an additional 1,020 calories from the "non-diet" portion of her food consumption and exceeded the 1,600 to 1,800 calories per day that Agency believed Resident 1 needed. The number of calories was increased an additional 480 calories, on or about August 28, 2001, after Resident 1 began receiving four 120cc of Medpass.

64. The Agency alleged at hearing that the facility failed to ensure that Resident 1's estimated protein needs were being met. In determining a person's estimated protein needs, it is clinically appropriate to base such needs on the person's ideal weight. In light of that approach, Resident 1 would have needed approximately 59 grams of protein per day. The meal consumption estimates do not reflect whether the resident ate only one food item or a portion of each item. However, given that the resident's diet had approximately 100 grams of protein and that she consumed approximately 50 percent of her diet, it is reasonable to conclude that her protein needs were met.

65. Most of the time Resident 1 was at the facility, she was eating "fair" which is generally considered that she was eating about 50-75 percent of her meals. Given Resident 1's consumption of her 2,000-calorie diet plus supplements, it is reasonable to conclude that she maintained adequate parameters of nutritional status.

66. The Aristocrat's staff began interventions for Resident 1 from the day she was admitted to the facility. The staff analyzed her needs and provided her with a supplementation of calories by August 1, 2001. Staff continually assessed Resident 1's needs and added additional interventions throughout her stay at the facility. Two of the more aggressive

interventions included obtaining a psychological consultation for Resident 1 and ordering an appetite stimulant for her.

67. The Agency indicated that The Aristocrat should have implemented these more aggressive interventions much earlier than it did in order prevent Resident 1 from losing weight. Contrary to this position, it is not likely that these interventions would have prevented the resident’s initial weight loss that occurred between July 30 and August 11, 2001, because the weight loss was water weight.

68. Dr. Lewis waited until September 13, 2001, to order Megace for Resident 1 because he wanted to give other interventions a chance to work. Also, Megace is an appetite stimulant that can cause liver toxicity. Because of the known side effects of Megace, Dr. Lewis used this approach only as a “last-ditch alternative.”

69. With regard to the psychological consultation, the facility delayed this intervention although the staff was aware of and had noted the resident’s behavior problems soon after she was admitted. The consultation was appropriately delayed to give the resident a chance to adjust to her new environment and to first attempt more conservative measures. Moreover, in this case, Dr. Lewis testified that he recalled that, initially, there may have been some opposition from Resident 1's family regarding a psychological consultation.

70. Resident 1 maintained “adequate” nutritional parameters while at The Aristocrat. To the extent that she may not have maintained "adequate" nutritional parameters during the first almost two weeks at the facility, Resident 1's clinical condition made her initial weight loss unavoidable.

71. Signs or symptoms that a person has been nutritionally compromised include the development of pressure sores and malnourishment, dehydration, dull eyes, and/or swollen lips. In this case, Resident 1 did not exhibit any clinical signs of malnourishment, dehydration, or pressure sores. Moreover, Resident 1 suffered no harm as a result of the initial or subsequent weight loss noted in the 2567 report.

72. The Agency’s reason for changing the facility's licensure rating from standard to conditional is based on its conclusion that the weight loss experienced by Resident 1 was avoidable. The Agency's policy is that if there is an avoidable weight loss, there is harm, with or without a determination that there is actual harm to the resident.

73. The credible testimony of Dr. Lewis was that Resident 1 recovered “very successfully from two major fractures, even in the setting of depression and advanced age.” At the end of Resident 1's stay at the facility she was ambulating on her own with a walker and performing some of her own activities of daily living; and after approximately three

months in the facility, the resident returned to the assisted living facility where she previously lived.

CONCLUSIONS OF LAW

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

75. 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.

76. Section 400.23, Florida Statutes, provides that when minimum standards are not met, such deficiency shall be classified according to the nature of the deficiency. That section delineates and defines the various categories of deficiencies, with a Class IV deficiency being the least severe and a Class I begin the most severe.

77. Class I deficiencies are those which the Agency determines present "a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, impairment or death." Class II deficiencies are those which "the [A]gency determines [have] compromised the resident's ability to maintain or reach his or her highest practicable physical, mental and psychosocial well-being, as defined by an accurate and

comprehensive resident assessment, plan of care, and provision of services." Class III deficiencies are those which "the [A]gency determines 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 practical, physical, mental or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services." Class IV deficiencies are those which "the [A]gency determines [have] the potential for causing no more than a minor negative impact on the resident." Section 400.23 (8), Florida Statutes.

78. Based on its findings and conclusions of deficiencies, the Agency is required to assign one of the following ratings to the facility: standard or conditional. These categories of ratings are defined in Subsection 400.23(7), Florida Statutes, as follows:

> (a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all Class III deficiencies within the time established by the [A]gency.
>
> (b) 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 [A]gency, is not in substantial compliance at the time of the survey with criteria established under this

> part with rules adopted by the [A]gency. If the facility has no class I, class II or class III deficiencies at the time of the follow-up survey, a standard licensure status may be assigned.

79. According to Section 400.23, Florida Statutes, quoted above, the Agency may issue to a facility a conditional license when, after a survey, a facility has one or more Class I or Class II deficiencies, or Class III deficiencies not corrected within the time established by the Agency.

80. In the instant case, the Agency issued a conditional license to The Aristocrat on October 10, 2001. The Agency alleges that it was proper to issue The Aristocrat a conditional license because the facility had a Class II deficiency at the time of the Agency's October 21, 2001, annual survey.

81. The regulation at issue in this case, and the one that The Aristocrat allegedly violated is 42 C.F.R. 483.25(i)(1). That section provides:

> Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status such as body weight and protein levels, unless the resident's clinical condition demonstrates that this not possible.

82. The Agency has the burden of proof in this proceeding and must show by a preponderance of evidence that there existed a basis for imposing a conditional rating on The Aristocrat based on a violation of Tag F 325. <u>Florida Department of</u>

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). Accordingly, it is the Agency's burden to (1) establish that the deficiency cited in the October 2001 survey report existed; and (2) that the deficiency was appropriately classified as a Class II deficiency.

83. Moreover, when applied to the Agency's burden of proof in this hearing, the plain terms of 42 C.F.R. 483.25(i)(1) require the Agency to demonstrate that the resident did not maintain acceptable parameters of nutritional status and that the resident's clinical condition demonstrated that it was possible to maintain acceptable parameters of nutritional status.

84. The Agency has failed to meet its burden in this case.

85. With regard to Resident 1, the Agency failed to provide any substantial, competent evidence that Resident 1 did not maintain acceptable parameters of nutritional status and that her body weight deviated significantly below her usual weight.

86. The evidence established that to the extent Resident 1 did not maintain acceptable parameters of nutritional status, Resident 1's clinical condition did not allow her to maintain her body weight of 136 pounds, her weight upon admission to the

facility on July 30, 2001. Also, the greater weight of the evidence at hearing demonstrates that the weight loss was expected due to the edema, substantial consumption of pain medication, behavioral issues and a general lack of appetite due to the surgeries.

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 issuing a standard license rating to The Aristocrat and rescinding the conditional license rating.

DONE AND ENTERED this 14th day of August, 2002, in Tallahassee, Leon County, Florida.

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CAROLYN S. HOLIFIELD
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 should be filed with the agency that will issue the final order in this case.